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ECUADOR

SUPPORT FOR HEALTH SERVICE DELIVERY AND THE SOCIAL SAFETY NET IN THE CONTEXT OF THE CORONAVIRUS/COVID-19 PANDEMIC

(EC-L1270)

LOAN PROPOSAL

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ABBREVIATIONS	
CAF	Andean Development Corporation
CARPHA	Caribbean Public Health Agency
COE-N	Committee for Operations in National Emergencies
ECLAC	Economic Commission for Latin America and the Caribbean
ECV	Living Conditions Survey
HDB	Human Development Bond
ICU	Intensive Care Unit
MEF	Ministry of Economy and Finance
MIES	Ministry of Economic and Social Inclusion
MSP	Ministry of Public Health
OAS	Organization of American States
PAHO	Pan American Health Organization
PCH	National Hospital Contingency Proposals in Response to the COVID-19 Health Emergency
PCR (test)	Polymerase Chain Reaction coronavirus lab test
SMS	Short Message Service
SPRP	COVID-19 Strategic Preparedness and Response Plan
WHO	World Health Organization

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<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">Republic of Ecuador</td><td>Amortization period:</td><td>25 years</td></tr>
<tr><td colspan="3">Executing agency:</td><td>Disbursement period:</td><td>2 years</td></tr>
<tr><td colspan="3" rowspan="2">Ministry of Public Health (MSP) and Ministry of Economic and Social Inclusion (MIES)</td><td>Grace period:</td><td>6 years[b]</td></tr>
<tr><td>Interest rate:</td><td>LIBOR-based</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">250,000,000</td><td rowspan="2">100</td><td>Inspection and supervision fee:</td><td>[c]</td></tr>
<tr><td>Weighted average life (WAL):</td><td>15.22 years</td></tr>
<tr><td>Total</td><td>250,000,000</td><td>100</td><td>Approval currency:</td><td>U.S. dollars</td></tr>
<tr><th colspan="5">Project at a Glance</th></tr>
<tr><td colspan="5">Project objective/description: The general objective of this project is to help reduce the morbidity and mortality caused by COVID-19 and to mitigate other indirect impacts of the pandemic on health and on the minimum levels of quality of life of vulnerable populations in response to the crisis caused by COVID-19. The specific objectives are to: (i) improve case detection and monitoring; (ii) enhance health service delivery capacity; and (iii) support minimum income levels of people affected by coronavirus in the immediate future.</td></tr>
<tr><td colspan="5">Special contractual conditions precedent to the first disbursement of the loan proceeds: None.
Special contractual execution conditions: None.</td></tr>
<tr><td colspan="5">Exceptions to Bank policies: None</td></tr>
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<tr><td colspan="2">Challenges:[d]</td><td colspan="3">SI ☑ PI ☐ EI ☐</td></tr>
<tr><td colspan="2">Crosscutting themes:[e]</td><td colspan="3">GD ☑ CC ☐ 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, and commodity 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 life of the loan or the last payment date as documented in the loan contract

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

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

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

I. OBJECTIVE, DESCRIPTION, AND RESULTS MONITORING

A. Background, problem to be addressed, and rationale

1.1 **Background.** On 11 March 2020, the World Health Organization (WHO) declared the outbreak of COVID-19, the disease caused by the 2019 novel coronavirus, or SARS-CoV-2, which affects the respiratory system, a pandemic. To date (27 April), WHO has reported more than three million confirmed cases in 185 countries, resulting in more than 209,000 deaths.[1] The first cases in Latin America and the Caribbean were reported in late February, including in Ecuador. Since then, the number of cases has grown rapidly, with over 1,094,828 confirmed cases of COVID-19, and the number of cases is expected to double every four days, while over 56,000 deaths have been reported.[2] The number of cases, the number of deaths, and the number of affected countries is expected to continue growing.

1.2 COVID-19 can be easily spread from person to person through respiratory secretions[3] and direct contact. For this reason, social distancing and isolation measures are essential features of the public health response with the goal of reducing the number of healthy people whom a patient can infect (known as the reproduction number) over time, to a value below 1. These measures slow the spread of COVID-19, to delay a sudden spike in cases that would overwhelm the health system's capacity to care for patients.[4] [5] [6] [7]

1.3 **Macroeconomic and/or social context.** The economic impacts of COVID-19 will be felt through different channels at different times. The first, associated with the priority of saving lives in the very short term, involves the direct costs of the health sector response. The second is the costs associated with the necessary changes in people's behavior to "flatten the curve" of COVID-19 progression, which will contribute to saving lives. These behaviors may be the result of government mandates (closing schools, canceling public events, etc.), decisions made by companies and other institutions (teleworking, cutting back production, etc.), and decisions made by consumers (reducing social contact). This will lead to a very significant economic downturn with immediate manifestations and lingering effects, even once the health emergency is over.

1.4 From a macroeconomic perspective, in addition to shrinking domestic demand, the Economic Commission for Latin America and the Caribbean (ECLAC) sees at least five channels through which the impacts of the crisis will be passed on to the

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1 See: https://experience.arcgis.com/experience/685d0ace521648f8a5beeeee1b9125cd.

2 See: https://www.paho.org/en/topics/coronavirus-infections/coronavirus-disease-covid-19.

3 See: https://www.who.int/es/emergencies/diseases/novel-coronavirus-2019/advice-for-public/q-a-coronaviruses.

4 *Hellewell, J., S. Abbott, A. Gimma, N.I. Bosse, C.I. Jarvis, T.W. Russell, et al. Feasibility of controlling COVID-19 outbreaks by isolation of cases and contacts.* Lancet 2020;*8(4):488-496.* doi:10.1016/S2214-109X(20)30074-7.

5 *Day, T., A. Park, N. Madras, A. Gumel, J. Wu. When is quarantine a useful control strategy for emerging infectious diseases?* American Journal of Epidemiology 2006;*163(5): 479–485*. doi:10.1093/aje/kwj056.

6 *Ferguson, N., D. Cummings, C. Fraser, J.C. Cajka, P.C. Cooley, D.S. Burke. Strategies for mitigating an influenza pandemic.* Nature 2006;*442:448–452.* doi:10.1038/nature04795.

7 *Dénes, A., A. Gumel. Modeling the impact of quarantine during an outbreak of Ebola virus disease.* Infectious Disease Modelling 2019;*4:12–27*. doi:10.1016/j.idm.2019.01.003.

region's economy:[8] (i) slowing economic activity of key trading partners that will impact the demand for exports; (ii) less demand for tourism services; (iii) interruption of global value chains; (iv) falling commodity prices; and (v) worsening financial terms. In its recent 2020 macroeconomic report on Latin America and the Caribbean, the IDB estimates that, considering solely the external shock to demand, the decline in commodities prices, and the shock to the financial markets, the region will experience a major recession in 2020 that will probably be worse than the one experienced in 2009 (around 2% of GDP). According to one of the more extreme scenarios, it would result in a recession of over 5% of GDP.[9]

1.5 Latin America and the Caribbean have made notable progress in reducing poverty over the last 30 years, reaching percentages near 30% at the end of 2019. However, while transitioning from poverty to higher levels of well-being, 37% of the population are income vulnerable, i.e., highly likely to fall into poverty in the event of major economic shocks of this type. Those living in poverty or vulnerability before the crisis have no way of offsetting the possible decline in their income.

1.6 **Problem addressed.** The rapid increase in the number of cases has been putting pressure on health care systems, potentially compromising their capacity to respond to the pandemic in a timely and efficient manner, as well as to maintain essential care for people with other conditions. A recent analysis by WHO found that most countries in Latin America and the Caribbean are unprepared to handle pandemics.[10] On a five level scale based on the capacity to manage a public health event of this magnitude (where one=low and five=high), seven Latin American and Caribbean countries are classified as level two (low capacity), 15 as level three (medium capacity), including Ecuador, and only four have been classified as level four.[11] These gaps impact the entire pandemic management cycle: rapid identification, diagnosis, and contact tracing; infection prevention and control; health care measures for travelers; communication to the public of general knowledge about the illness, symptoms, risk factors, and prevention measures; and care (human resources and supplies both for patients with COVID-19 and for other vulnerable patients).

1.7 In turn, the repercussions of the crisis will hurt the income of most people, especially the poorest groups, who depend on their largely informal work activities to support their consumption. In this regard, ECLAC estimates that the number of people living in poverty will increase by at least 35 million (rising from 185 million to 220 million throughout the region), including many informal workers at risk of

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8 See: https://www.cepal.org/es/comunicados/covid-19-tendra-graves-efectos-la-economia-mundial-impactara-paises-america-latina.

9 See: https://publications.iadb.org/es/informe-macroeconomico-de-america-latina-y-el-caribe-2020-politicas-para-combatir-la-pandemia.

10 Operational capacity was evaluated based on the percentage of compliance with 13 areas of capacity for handling public health events established in the International Health Regulations (IHR 2005), an agreement between 196 countries to build their capacities to manage public health events in 13 areas: legislation and financing, coordination, zoonotic events, food safety, laboratory, surveillance, human resources, national health emergency, health service delivery, risk communication, points of entry, chemical events, and radiation emergencies.

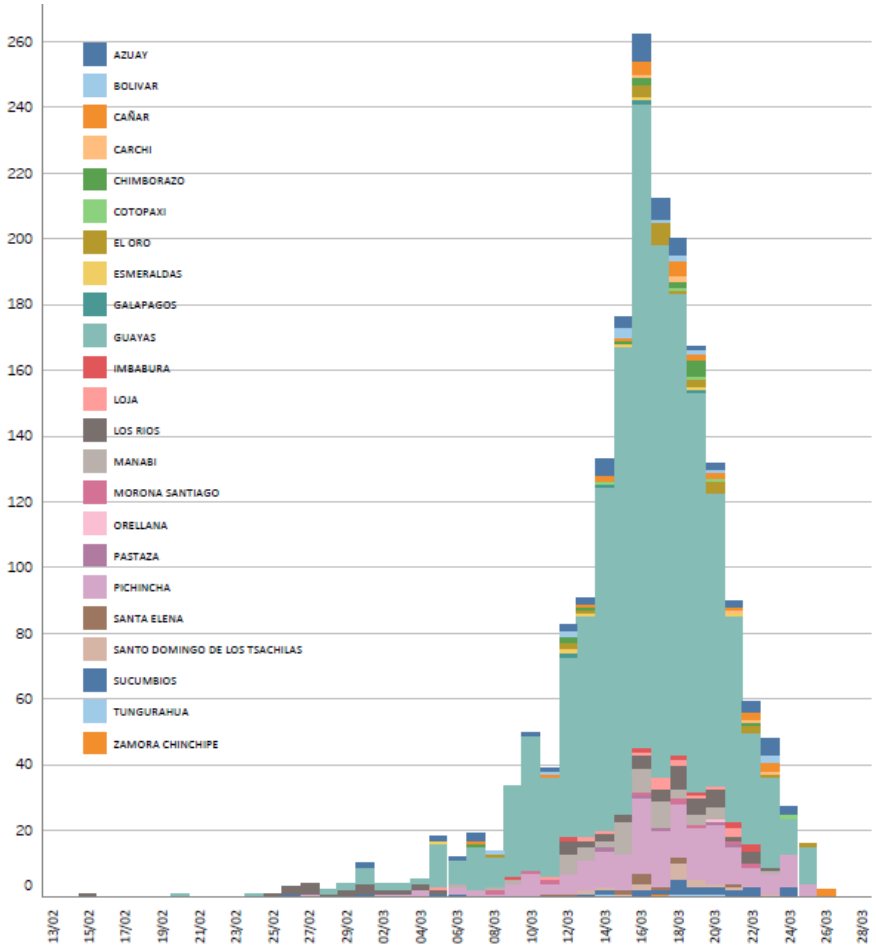
11 Countries classified as level two (low capacity) are: Bolivia, Haiti, Honduras, Nicaragua, Venezuela, Guatemala, and Paraguay; level three (medium capacity): Argentina, Barbados, Belize, Colombia, Ecuador, Guyana, Jamaica, Peru, Suriname, Trinidad and Tobago, El Salvador, Dominican Republic, Panama, and Uruguay; and level four: Brazil, Mexico, Chile, and Costa Rica (WHO, February 2020).

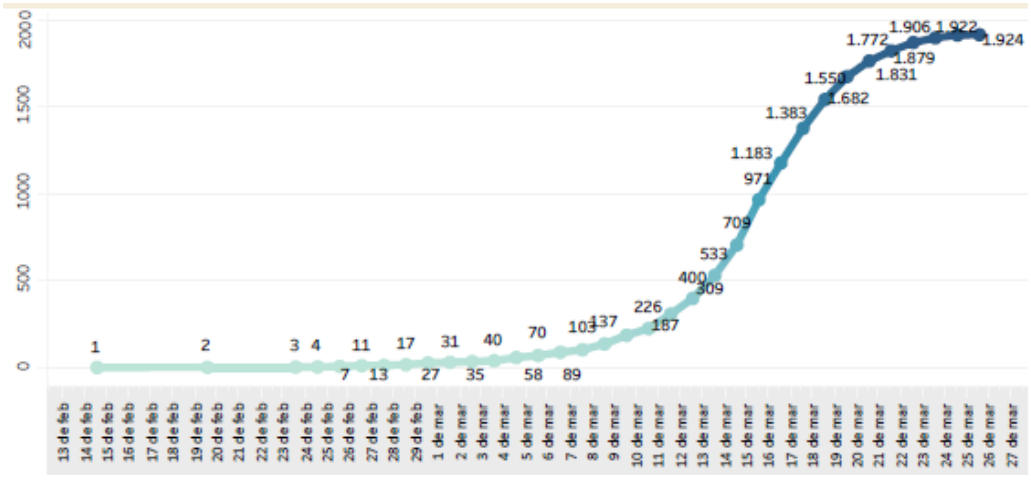
falling below the poverty line. According to data from the IDB's Information System on Labor Markets and Social Security (SIMS) for 18 countries of the region, an estimated 66 million people currently work in the affected sectors of tourism, commerce, restaurants and hotels, and transportation, approximately 45% of whom are informal (30 million).

1.8 Women, women heads of household and minor children, certain groups of people such as persons with disabilities, indigenous peoples, Afro-descendants, and others are overrepresented among the groups vulnerable to COVID-19. In general, these groups had greater difficulty in the labor market prior to the crisis. For example, 40% of women had income below the minimum wage for their country, compared with 30% for men (Sociometer data, IDB). In Ecuador, 88% of poor or vulnerable households included in the Social Registration form database have a woman head of household, and 19% of those households belong to indigenous peoples, Montubio, or Afro-descendant communities.

1.9 **Challenges and progress.** Since the first Ecuadorian case of COVID-19, confirmed on 29 February in Guayas province, cases have increased to over 23,240 cases official recorded nationally as of 27 April, most of them in Guayas (see Figure I-1).

Figure I-1: Distribution of confirmed COVID-19 cases by date of onset of symptoms and province as of 27 April 2020, and its national development since 13 February 2020





Date of onset of symptoms

Source: MSP COVID-19 epidemiological bulletin 27 (of 27 April 2020), with data from the Committee for Operations in National Emergencies (COE-N).

1.10 However, this number is an under-representation of the actual values. In fact, Ecuador's President, on national television, explained that there are "tens of thousands of cases."[12] In line with the evidence found for other countries, the actual number of COVID-19 cases in Ecuador could be 5 to 10 times greater than the officially confirmed cases today (Bhatia et al., 2020; Russell et al., 2020). One of the reasons for this under-representation is the lack of supplies for the health sector in the short term, such as test kits and the capacity to analyze their results in laboratories.[13] For 2020, the MSP expects to conduct 300,000 PCR tests nationally (and for 2021, 400,000 tests), in addition to 1.4 million rapid tests.[14] A solid surveillance strategy, with the capacity to detect cases in a timely manner, and rapid-response teams, to manage the search for close contacts and the respective quarantine, will be extremely important for the post-lockdown period, when the population returns to work and school, while there is still no vaccine and a limited care capacity in the health services. For 2020, the MSP estimated (based on an attack rate of 5%) that 104,812 people could require hospitalization in Ecuador, with 5,241 in intensive care. Depending on the scenarios of concentration of the new cases over time and by day, the current availability of functional intensive care beds would fall far short, so the MSP plans to quintuple their number

12 National network on 2 April 2020.

13 Up to 2 April, more than a month after the detection of the first case, only 350 to 400 samples could be processed per day in the entire country; for this reason, approximately one third of the samples taken to date are still awaiting results. The delayed results impact the curves of estimated cases and hinder a timely response in terms of epidemiological surveillance and isolation of infected individuals.

14 Polymerase Chain Reaction (PCR) tests detect the genetic material of the SARS-CoV-2 coronavirus with high specificity and sensitivity in respiratory samples (such as saliva) and require analysis in microbiological laboratories that have special equipment and trained staff. On the other hand, the rapid tests provide a direct diagnosis (not requiring laboratory analysis) by detecting proteins of the virus in respiratory samples or antibodies produced in response to the virus that are detectable in blood samples and can be performed at home.

in the short term, placing emphasis on the province of Guayas.[15] The aforementioned situation would also have an indirect adverse effect of displacement of care on those patients requiring hospitalization for conditions unrelated to COVID-19 (such as those with chronic illnesses or pregnant women). In turn, government estimates show potential deaths related to officially confirmed COVID-19 cases of 2,500 to 3,500 in the province of Guayas alone over the coming months (not including deaths not formally recorded as caused by COVID-19), for which there is currently insufficient capacity in burial and corpse disposal services.

1.11 Ecuador's government declared a state of national emergency[16] on 11 March 2020, and a state of exception on 16 March 2020, including increasingly strict provisions for a national curfew. Schools and businesses are closed, and all traffic by vehicles and private individuals is restricted to one day per week, only for essential activities[17] outside the hours of the curfew, which is currently in effect from 2:00 p.m. to 5:00 a.m. The respective operation of basic services, food industries and home deliveries, oil companies, funeral homes, etc. is governed by the same curfew or requires a pass. These drastic social distancing measures aim to slow the exponential curve of contagion, spread out cases requiring hospitalization, and gain time to reorganize and prepare the services of intensive care units (ICUs), intermediate care units with isolation, and others. The Committee for Operations in National Emergencies (COE-N) was called into service on 13 March 2020 and is coordinating government activities at the national level, with participation by WHO/PAHO and a number of relevant actors (including academia and other entities with required expertise) on the technical round tables.

1.12 In turn, the country has fallen into a virtually total economic standstill, which could give rise to a decline of growth of close to 6% of GDP in 2020,[18] with a major effect on poverty, which could add 1.4 million to its ranks, according to World Bank estimates (2020). Particularly vulnerable groups include those vulnerable due to their income levels (living just above the poverty line) and informal workers.[19] To mitigate this impact, the Government of Ecuador ordered the expansion of social protection measures beyond the existing conditional cash transfer program, the Human Development Bond (HDB).[20] This refers to the introduction of a new temporary compensatory cash transfer program for the poor and vulnerable population, the Contingency Bond.[21] In principle, this will deliver, for a period of two months, partial relief for 950,000 poor and vulnerable households during the hardest part of the stay-at-home order under the state of exception (paragraph 1.29).

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15 If Ecuador's official mortality rate as of 2 April (3.8%) is considered, along with the factor that 20% of cases require hospitalization, a total of 1,350 hospital beds would be required over this period in the province of Guayas alone.

16 MSP Ministerial Resolution 00126-2020, published in the Official Gazette of the Republic of Ecuador, Supplement 160, dated 12 March 2020: Supplement 160 - Publication of the Declaration of Emergency.

17 These include purchases in supermarkets, use of financial services, medical services, gas stations, etc.

18 According to estimates by the Economist Intelligence Unit, 2020.

19 Many people in these two groups will be counted among the 1.4 million new poor.

20 Executive Decree 804 of 20 June 2019, establishing cash transfers under the Comprehensive Social Safety Net, including the HDB.

21 Contingency Bond refers to the Family Protection Bond in Response to the COVID-19 Emergency, pursuant to Executive Decree 1026 of 24 April 2020.

1.13 **Rationale.** As the number of cases of COVID-19 increases in the country, more investment will be needed to close gaps in the preparedness and response capacity, to be able to take key measures to contain transmission of the illness and mitigate the health and economic consequences of the pandemic. To respond to these challenges, WHO has prepared guidelines for drafting a COVID-19 Strategic Preparedness and Response Plan (SPRP) (optional link 2). Moreover, the Pan American Health Organization (PAHO) and the Caribbean Public Health Agency (CARPHA) are leading technical support initiatives to help the region's governments prepare their own SPRPs, including priorities, actions, and financing needs. In Ecuador, the first part of this plan is called the "National Hospital Contingency Proposals in Response to the COVID-19 Health Emergency (PCH)" and was prepared by the MSP and reviewed by WHO/PAHO (optional link 6).

1.14 In this context, the eight pillars proposed under the SPRP are: (i) coordination, planning, and monitoring; (ii) risk communication and community engagement; (iii) surveillance, rapid-response teams, and case investigation; (iv) points of entry; (v) national laboratories; (vi) infection prevention and control; (vii) case management; and (viii) operational support and logistics. There is evidence of the effectiveness of the proposed interventions (optional link 3). Ecuador's PCH and the corresponding investment strategy (paragraph 1.11) give priority to pillar (vii), in addition to areas (ii) and (iii).

1.15 To offset the loss of income of the most vulnerable as a result of the social isolation measures to response to COVID-19, large-scale compensatory policies will also be necessary. Experience shows that cash transfer program amounts or coverage can be temporarily increased, which requires clear communication and transparent milestones. The use of extraordinary transfers, which would have eligibility criteria but not conditions, is proposed.

1.16 These strategies will be implemented with differential approaches to promote participation by women, persons with disabilities, indigenous peoples, and Afro-descendants. For example, in the health area, special attention will be devoted to the continuity of care for pregnant women through referrals to the private sector. For the Contingency Bond, beneficiary households are slated to include: 88% with women heads of household, 9% Montubio population, 8% indigenous, 2% Afro-descendant, and 2% disabled, according to the available records to be used to grant the temporary transfers. There are plans to prepare differentiated communication guidelines through provincial radio stations, national television, social media, and digital press, taking into account gender and sociocultural diversity.

1.17 **The Bank's experience and lessons learned.** The Bank has been supporting country responses to the pandemic in the health sector since its onset. The government's initial strategy in the form of the PCH is being cofinanced with US$23 million through a contractual amendment of the "Multiphase Program to Improve Quality in the Provision of Social Services – Phase I" (EC-L1227; 4364/OC-EC).[22] In addition to supporting new investment strategies for the sector, this operation supplements the aforementioned investments, for example, by financing the daily operation of a portion of the new ICU beds, including staff, medications, and supplies (Component 2.1). The experience of preparing procurement processes for COVID-19 under loan 4364/OC-EC shows that the

[22] Amendatory contract 1 signed on 13 April 2020.

availability of medical equipment, personal protective equipment, and medications on the national and international markets represents a major challenge, and prices vary daily, so bidders maintain their bids for just 2 to 4 days, in addition to demanding advanced payments to provide the best delivery times. For these reasons, it is necessary to be as flexible as possible in procurement processes, especially with regard to required administrative processes within and between government institutions in order to obtain the respective guarantees and approvals in each phase of the process. This lesson learned was incorporated into this operation through a statement by the Ministry of Economy and Finance (MEF) to the MSP on the applicability of the expedited internal regulations issued for the procurement processes that will take place for the health emergency, including those planned under Components 1 and 2.

1.18 Another recent Bank experience in supporting country initiatives in response to the health emergency is an innovative private sector initiative financed by IDB Lab that uses big data and digital tools[23] to improve access to timely quality information for decision-makers during public health emergencies. The initial work on this initiative has demonstrated the importance and the potential for close public-private coordination to leverage synergies and consistency between estimates and data and to accelerate the channeling of representative empirical information for policy decision-making in order to manage the emergency. The IDB is proactively contributing to the aforementioned public-private coordination, and the activities under Component 1 ensure that the MSP will work to supplement and coordinate with the initiative financed by IDB Lab, in the sense that the IDB Lab project is supporting a digital application for case monitoring and alerting contacts to the COE-N service, and Component 1 of this operation is supporting the expansion of the government's case diagnostic capacity, which will boost the effectiveness of case monitoring from the aforemention application in decision-making.

1.19 Lastly, in terms of policies to protect the vulnerable populations before and during emergency situations like this one, the Bank has supported the design, implementation, and evaluation of cash transfer programs in 18 countries in the region since the mid-1990s. For example, it was a pioneer in supporting the development of conditional cash transfer programs in Honduras and Nicaragua, and in helping to strengthen them in Mexico. In 2009, in the context of the response to the international financial crisis, the Bank supported the introduction of the nutritional component in transfers in Mexico. The evaluation of these programs found that cash transfers are the most effective instrument for redistributing resources and supporting consumption in the most vulnerable families. In this time, the Bank has developed leading-edge technical expertise in all phases of the operating cycle, including areas of particular relevance to this operation, such as beneficiary identification and implementation of the payment process. This operational experience shows that evaluating the vulnerability of households, inputting records in information systems, and processing payments requires time and field work. In a context of social distancing and rapid response to a crisis, this suggests that it is strategic to base the project on existing social safety net systems (beneficiary registries and systems) and to prioritize payments that prevent people from congregating in groups, which was incorporated into the design of Component 3. On the operational level, the design of this operation incorporates the lessons learned from loan 2787/OC-EC in the form of a coexecution structure

[23] In line with the principles for digital development endorsed by the IDB in 2018: https://digitalprinciples.org/.

with independence and ownership by each executing agency, which is also being applied in loan 4634/OC-EC with the MIES, MSP, and others without problems to date.

1.20 **Coordination with other multilaterals and/or donor agencies.** WHO's regional organization (PAHO) and its country offices in the region are helping countries with the preparation of their SPRPs. Since the IDB's response is in line with WHO's proposed intervention pillars, coordination of efforts is under way to identify the most appropriate areas for Bank support. The IDB is also in constant communication with the World Bank and CAF to report on requests for support for the countries and thus explore specific areas for collaboration. In the case of Ecuador, this coordination takes place through a virtual multilateral cofinancing coordination committee of the World Bank, CAF, and the IDB, coordinated by the MEF, and with the participation of the MSP and WHO/PAHO, in which the consolidated investment strategies proposed by the government are validated. For example, the MSP and the MEF have agreed on a partial investment strategy in the form of the PCH, focused on increasing the number of hospital beds, which anticipates cofinancing from the World Bank, the Andean Development Corporation (CAF), and the IDB to install or adapt 1,198 ICU beds for COVID-19 in addition to the 253 operational beds at present in the public sector. In the case of the IDB, this initial strategy is being cofinanced with US$23 million (paragraph 1.17). Moreover, in terms of surveillance and monitoring, the MSP's plan to implement rapid-response teams and to conduct 300,000 PCR tests and 1.4 million rapid tests in 2020 will be cofinanced by CAF, the private sector (Roche), and the IDB through this operation. Operationally, the IDB and World Bank procurement units are working closely to find and consolidate providers for the WHO supply list (optional link 4 and optional link 5) for COVID-19 actions.[24] Actions are also being coordinated through the Inter-American Government Procurement Network, which is managed by the Organization of American States (OAS).

1.21 With respect to social consequences, the Bank shares the assessments of the International Monetary Fund, the World Bank, and ECLAC, and the proposals presented herein are consistent with the goal of protecting the most vulnerable from COVID-19 and supporting the necessary health measures to deal with the pandemic and promote economic recovery in the medium term. In the case of Ecuador, the MEF and the MIES have called for a virtual roundtable with the World Bank and the IDB to coordinate cofinancing for the Contingency Bond.

1.22 **Strategic alignment.** The program is consistent with the second Update to the Institutional Strategy (document AB-3190-2) and is strategically aligned with the development challenge of social inclusion and equality, through its focus on strengthening the delivery of health services to patients suspected of or diagnosed as having COVID-19 and through support for maintaining minimum levels of income and welfare of the populations most vulnerable to COVID-19. In addition, the program will contribute to the Corporate Results Framework 2020-2023 (document GN-2727-12) through the indicator on beneficiaries receiving health services and the indicator on beneficiaries of targeted anti-poverty programs. The program is also aligned with the crosscutting area of gender equality and diversity, through the use of differential approaches that ensure access to information for

[24] This is a nonexhaustive list subject to frequent updates.

diverse populations and coordination mechanisms between indigenous authorities without health services and the Ministry of Health, and also by prioritizing the populations vulnerable to COVID-19 including pregnant women, women heads of household, and certain vulnerable groups, such as people with chronic illnesses, indigenous peoples, and Afro-descendants. The program is aligned with the Strategy on Social Policy for Equity and Productivity (document GN-2588-4) in the areas of enhancing equity and supporting vulnerable populations. It is also consistent with the Social Protection and Poverty Sector Framework Document (document GN-2784-7), which underscores the importance of supporting vulnerable populations, particularly in cases of external shocks, through responsive social protection policies, and with the Health and Nutrition Sector Framework Document (document GN-2735-7), by supporting the strengthening of service delivery, including providing the necessary equipment and supplies and training health care professionals. This project is consistent with the Proposal for the IDB Group's Governance Response to the COVID-19 Pandemic Outbreak (document GN-2996).

B. Objectives, components, and cost

1.23 **Objectives.** The general objective of this project is to help reduce the morbidity and mortality caused by COVID-19 and to mitigate other indirect impacts of the pandemic on health and on the minimum levels of quality of life of vulnerable populations in response to the crisis caused by COVID-19. The specific objectives are to: (i) improve case detection and monitoring; (ii) enhance health service delivery capacity; and (iii) support minimum income levels of people affected by coronavirus in the immediate future.

1.24 **Component 1. Case detection and monitoring (US$7,973,000, MSP).** This component will support actions to speed up timely case detection and monitoring, even in the medium term, when the population returns to work and school.

1.25 **Subcomponent 1.1. Surveillance, rapid-response teams, and case investigation in the medium term.** The following will be financed: (i) the formation and operation of the first rapid-response teams in the country, for the active search for and detection of cases, including technological equipment for the digital monitoring of cases; and (ii) the procurement of laboratory services from the private sector to supplement the number of PCR diagnoses available.[25]

1.26 **Component 2. Improvement of the capacity for service delivery (US$172,027,000, MSP).** This component will support building capacity for case management and ensuring the continuity of essential care for other people during the emergency.

1.27 **Subcomponent 2.1. Delivery of health care for COVID-19 patients in the public network.** Actions will be financed in health care facilities to ensure adequate medical care for the disease, as well as expanding the capacity to care

[25] The purchase will be made from private laboratories authorized to perform the test by the Agencia de Aseguramiento de la Calidad de los Servicios de Salud y Medicina Prepagada [Prepaid Health Services and Medicine Quality Assurance Agency] (ACESS) (as of the cut-off date of 31 March 2020, there were 13 in the entire country). The IDB will finance approximately 18,270 diagnostic tests of a total of approximately 100,000 PCR tests to be purchased from the private sector, of a total of 300,000 tests (by public and private laboratories) planned nationwide for 2020, with cofinancing from public/fiscal resources, international cooperation (IDB and CAF), and the private sector (Roche). In addition, there are plans to procure 1,400,000 rapid tests.

for cases, including: (i) the procurement and installation of equipment to adapt existing adult ICU beds to care for COVID-19 patients; (ii) the operation of hospital beds in intensive and intermediate care units, including the cost of staff, medications, supplies (including personal protective equipment to prevent and control the infection, protecting health care personnel), and/or required clinical and nonclinical support services; (iii) the contracting and training[26] of professionals for COVID-19 care in the sector's sentinel hospitals; and (iv) the services and supplies required for burial and disposal of corpses. This subcomponent will also finance the management of the program in the MSP and the costs of evaluation and auditing of the entire program.

1.28 **Subcomponent 2.2. Continuity of essential care and care for COVID-19 patients through referrals to the private sector.** This subcomponent will help ensure the continuity of care for sensitive and vulnerable populations, such as patients with chronic conditions or pregnant women through the purchase of care services from private health units. Financing will be provided to care for the following types of vulnerable patients in health care institutions by purchasing services from private providers: (i) patients with chronic illnesses (such as chronic kidney disease and comprehensive cancer care); (ii) vulnerable patients with non-chronic clinical presentations (such as respiratory or abdominal illnesses or stroke); and (iii) pregnant women.

1.29 **Component 3. Protection through the use of existing cash transfers (US$70,000,000, MIES).** This component will finance cash transfers under the Contingency Bond, which was established by the government as extraordinary compensation for household consumption, using the Social Registration Form platform[27] available for the management of other existing cash transfer programs. The Contingency Bond consists in payments of US$60 per household per month,[28] and is expected to be paid over a period of two months to a total of 950,000 poor or vulnerable households, of which 550,000 will be financed with this project.[29] The following will be financed: (i) Contingency Bond cash transfers to households that

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26 Training will be provided on content such as 'Emerging respiratory viruses, including COVID-19: methods of detection, prevention, response, and control' in cooperation with PAHO, COVID-19 case management, molecular biology testing techniques (PCR methodology), etc.

27 The Social Registration Form consists in a registry of current and potential beneficiaries of social programs that contains socioeconomic information, which can be used to calculate an index that predicts a household's status in terms of poverty or vulnerability. The 550,000 beneficiaries of the Contingency Bond to be financed under Component 3 will be identified using the Social Registration Form database, by selecting poor or vulnerable households that currently do not receive another government bond or pension. In the case of records with outdated information, the MIES will ensure that socioeconomic information will be updated before proceeding with the selection of beneficiaries.

28 The value corresponds to 25% of the income of a family living in poverty or at risk of falling into poverty due to the inability to work caused by the quarantine and curfew required to combat COVID-19.

29 Of the total amount, 400,000 households will be financed through the World Bank, starting in the month of April 2020, and 550,000 through the IDB under this program, during the following two months (May and June) of 2020.

are not currently beneficiaries of government cash transfers or similar programs,[30] but are included in the Social Registration Form; (ii) technical assistance in information technology, as well as the procurement of equipment for managing and updating the MIES database; (iii) short message service (SMS), calls to users through the MIES call center, and a mass communication campaign to orient the population on the distribution of the Contingency Bond and to support behavioral changes that will help create a digital culture in this population; and (iv) administrative costs of the program in the MIES.

1.30 **Beneficiaries.** Under Components 1 and 2, the program will benefit people who have contracted COVID-19 and who require specialized health care, and vulnerable individuals such as patients with chronic conditions or pregnant women who require continuity of other health care services during the pandemic. The aforementioned health care beneficiaries are patients of the MSP's free public system who do not have any other public or private health insurance. Under Component 3, beneficiaries will be the members of 550,000 households who will receive the extraordinary Contingency Bond transfers. The beneficiary households will be identified using the Social Registration Form database, identifying the poor or vulnerable population.

C. Key results indicators

1.31 **Expected outcomes.** The program aims to help reduce the morbidity and mortality caused by COVID-19 and to mitigate other indirect impacts of the pandemic on health and on the minimum levels of quality of life of vulnerable populations in response to the crisis caused by COVID-19. The main expected outcomes are to increase the number of tests per 1,000 inhabitants, increase the capacity for COVID-19 ICU hospitalizations with respect to those required, increase the capacity for all hospitalizations in the public sector, and provide support through cash transfers to people vulnerable to COVID-19 who do not benefit from the country's social safety net programs of transfers and pensions, but are vulnerable in the current context, through the indicator of the percentage of households who receive this type of extraordinary transfer.

1.32 **Economic viability.** A cost-benefit analysis was prepared for the measures included in Components 1 and 2, recommended under WHO guidelines. The analysis took into account the impact of these interventions to reduce COVID-19 mortality and morbidity rates under a treatment scenario with implementation of a package of measures, versus a counterfactual scenario in the absence of countermeasures. Scenarios were simulated using a basic SIR model (Susceptible - Infectious - Recovered), with evidence-based conservative parameters and assumptions available in published articles on COVID-19 or similar epidemics. The costs associated with interventions are those estimated by WHO in its COVID-19

[30] Through the Ministry of Economic and Social Inclusion (MIES) the national government provides payments and pensions to 1,025,000 households living in poverty or extreme poverty. These payments and pensions have a total annual budget in excess of US$900 million. The beneficiaries are identified through the Social Registration Form database and socioeconomic index. Payments are made by disbursement to users' personal bank accounts or in cash. The Social Registration Form observation unit is the household made up of one or more groups of people who have come together to share housing and a kitchen. In other words, it corresponds to the group of people who habitually reside in the same dwelling or portion thereof (who live under the same roof), who may or may not be related, and who cook together for all members of the group (who eat from the same pot).

Strategic Preparedness and Response Plan. Under the base case scenario for treatment, the cost-benefit analysis showed a net present value of US$153,418,019 and a benefit/cost ratio of 6.95, suggesting that the proposed series of interventions is economically beneficial. Based on the analysis, the earlier the reproduction number is reduced, the higher the benefit/cost ratio—both because the costs of containing the outbreak are higher over time and because the benefits in terms of lives and work time saved are lower (optional link 1).

1.33 The economic rationale for the actions proposed in Component 3 is based on the lives saved by reducing the COVID-19 transmission rate through the implementation of social distancing measures. Income compensation for poor and vulnerable people amid the COVID-19 crisis will reinforce health measures and help households maintain minimum levels of well-being. Based on the foregoing, a cost-benefit analysis was conducted in which a net present value of US$29,332,518 and a benefit/cost ratio of 1.42 were estimated in the base case scenario, suggesting that the set of proposed actions are economically beneficial. The analysis also suggests that the sooner the reproduction number is reduced, the greater the benefit/cost ratio will be, inasmuch as the effects on household income will be lessened.

II. Financing Structure and Main Risks

A. Financing instruments

2.1 This operation is a specific investment loan, with a total amount of US$250 million, and it will be financed from the Bank's Ordinary Capital. The disbursement period will be 24 months.

Table II-1. Estimated program costs (US$)

Components	IDB total	%
Component 1. Case detection and monitoring	7,973,000	3.2
Component 2. Improvement of the capacity for service delivery, including MSP management, audits, and program evaluation	172,027,000	68.8
Component 3. Protection through the use of existing cash transfers	70,000,000	28.0
Total	**250,000,000**	**100**

Table II-2. Disbursement schedule (US$)

Source	Year 1	Year 2	Total
IDB	224,693,000	25,307,000	250,000,000
%	**89.9**	**10.1**	**100%**

B. Environmental and social risks

2.2 In accordance with Directive B.3 of the Bank's Environment and Safeguards Compliance Policy (Operational Policy OP-703), the program has been classified as a category "C" operation inasmuch as it not expected to not cause any negative environmental or social impacts. The program will not finance any physical infrastructure component, so no associated environmental or social impacts are anticipated.

C. Fiduciary risks

2.3 The following medium level fiduciary risks have been identified: (i) difficulties in recording and identifying available funds in the treasury single account (CUT) for each coexecuting agency, which could delay or hinder the planned disbursements; (ii) difficulties in the interpretation and application of the regulations, internal preparatory procedures for the MSP on procurement, and a lack of delegation for finalizing bidding processes and signing contracts for the supply of key goods for the pandemic response; and (iii) complex verification of accounts due to the massive, dispersed payments and/or care provided. The following measures are considered to mitigate these risks: (i) the borrower and executing agencies will demonstrate to the IDB that they have a monthly mechanism to reconcile the movements and balances available for each executing agency; (ii) an agreement will be set forth in writing with the MEF and the MSP on the minimum internal procedures necessary between the two ministries, as well as the respective administrative, legal, and financial delegation to ensure timely management for the IDB program management team in the MSP; and (iii) verifications will be requested of a sample of the payments by the financial auditors as part of the justification of expenditures.

D. Other key risks and issues

2.4 Four development risks have been identified, three are classified as high, and one as medium. The high-level risks are: (i) interruption of the global supply chain of key items needed to respond to the pandemic—including personal protective equipment (PPE) for health care providers, such as surgical gloves, face masks and respirators, ventilators, and diagnostic kits; (ii) border closures and global air transport disruption could affect delivery time and costs of supplies for the country; (iii) potential shortage of health care professionals, due to the high number of patients requiring medical care and the disproportionate way the disease affects front-line hospital personnel could affect the timeliness or quality of the planned interventions; and the medium-level risk is: (iv) a lack of mechanisms whereby the banking institutions and cooperatives pay the Contingency Bond that ensure social distancing, which could cause an increase in infections.

2.5 To mitigate risks (i) and (ii), the following measures will be taken: (i) coordination with public procurement agencies from Latin America and the Caribbean (through the Inter-American Government Procurement Network managed by the OAS) to evaluate available supply and demand, as well as current framework agreements, in order to analyze the potential for aggregated, faster purchases via virtual platforms; (ii) with support from international organizations such as PAHO, the World Economic Forum (WEF), and the World Bank, work is also under way to identify available suppliers, with a special focus on domestic suppliers and/or those located in Latin America and the Caribbean. This is intended to match available supply with the region’s demand for goods and services and to seek a fast agreement mechanism; and (iii) access is being provided to the COVID-19 Action Platform of the WEF’s Global Pandemic Supply Chain Network. To mitigate risk (iii), sector actors are preparing contingency plans to mobilize professionals; and the actions to mitigate risk (iv) involve agreeing on control measures under WHO standards and establishing a system to monitor compliance with social distancing in order to prevent people from congregating in groups to collect the cash transfer. Moreover, under the leadership of the MIES, a call center will be set

up to orient beneficiaries in order to prevent them from unnecessarily traveling and congregating in groups.

2.6 The following medium-level reputational risk was also identified: the payment of the Contingency Bond to beneficiaries who are not poor or vulnerable; to mitigate this risk, the following measures are considered: (i) agreement with the MIES on the internal validation protocol and Contingency Bond payment reconciliation report; and (ii) an independent audit with a sample-based field review.

2.7 A medium-level monitoring and accountability risk involves the difficulties or delays in obtaining data for the recording and accounting of health care services by patients served in the public network and referrals to the private network; this could delay or hinder the planned disbursements or the justification thereof. As a mitigation measure, an agreement with the MSP is being considered on sample-based fiduciary and/or audit guidelines for the rendering of accounts of payments for medical services and referrals to the private health system.

2.8 Lastly, a medium-level public management and governance risk is the lack of coordination between the MEF, MIES, MSP, and Planifica Ecuador, which could delay the launch of precontractual, legal, payment management, and other processes, generating distrust among suppliers in the market and/or delays in execution. The following mitigation measures are being considered: written confirmation with the competent authorities that the expedited public administration processes for the emergency will apply to this operation throughout the time it is in effect, a dialogue established during the emergency will be maintained at the highest level between the country authorities and the Bank to resolve bottlenecks and ensure smooth execution, and the Bank will maintain the offer of simplified procurement processes for emergency procurement.

2.9 **Sustainability.** The interventions financed under the project follow WHO recommendations for the containment, management, and treatment of epidemics/pandemics due to infectious diseases such as COVID-19. This project will strengthen country capacities for the detection, treatment, and control of these diseases in the medium term. It will also improve the preparedness of the health sector to confront future outbreaks, epidemics, and pandemics, including organizational capacity and knowledge, and staff experience to face future outbreaks. In addition, containing and overcoming health challenges is considered a prerequisite for sustainable economic and social recovery in the medium and long terms.

III. Implementation and Management Plan

A. Summary of implementation arrangements

3.1 **Borrower and executing agency.** The borrower will be the Republic of Ecuador and the executing agencies for the program will be the MSP in its capacity as the lead health agency and the main provider of public services for Components 1 and 2, and the MIES for Component 3.

3.2 **Coexecution structure.** In the MSP, the program will be executed by the IDB Project Management Unit established for such purposes in the General Administrative-Financial Coordination Division, ensuring the continuity of the management team that is being strengthened with other recent IDB loans in the health area (loan 4364/OC-EC and “Support Program for the Social Inclusion of

People with Disabilities in Ecuador" EC-L1236; 4634/OC-EC) throughout the life of this operation.[31] In the MIES, program execution will be the responsibility of the Office of the Deputy Minister for Economic Inclusion, through a temporary execution team of at least two people. For the execution of the components under their responsibility, each of the executing agencies will develop its own planning and operational and fiduciary management (procurement and financial management), and each of them will be able to request disbursements from the Bank and justify the advances received independently from the other. The executing agencies will also prepare and submit to the Bank separate multiyear execution plans (and/or annual work plans), procurement plans, semiannual progress reports, financial plans, and other instruments required by the Bank to supervise program execution. Under this independent coexecution structure, each executing agency will comply with the contractual clauses related to the submission of plans and reports separately. Program audits and the final evaluation will be contracted and subsequently submitted to the Bank by one of the executing agencies, the MSP. The MIES will provide in a timely manner any necessary input and collaboration to the MSP, or to consultants and/or auditors contracted by it, to ensure compliance with the time frames for submission of audit and evaluation reports to the Bank.

3.3 **Interagency coordination.** The MEF, through the internal body assigned to coordinate the pandemic emergency response (currently the Expenditure Quality Department), will provide strategic coordination for crosscutting issues affecting the program as a whole and/or requiring decisions or solutions by high-level sector or country authorities, including steps to ensure budgetary allocation with Planifica Ecuador. The MEF will also monitor overall execution of the program in the context of the portfolio reviews with the Bank. For these purposes, the MEF will be copied on submissions of semiannual reports by each coexecuting agency. In addition, program activities and their progress and execution status will be coordinated within the framework of the multilateral round table called and coordinated by the MEF and will be consistent with the policies and actions determined by the COE-N, by means of the participation and coordination of the MSP and the MIES on that committee.

3.4 **Specific eligible expenses for payments by care, service, or transfer delivered.** For Subcomponents 2.1(iii), eligible expenses may include an amount per patient served, based on the average cost of care. The potential care pursuant to this mechanism includes: (i) inpatient care for patients with COVID-19 in an isolated area other than an Intensive Care Unit (ICU); and (ii) inpatient care for patients with COVID-19 in an ICU. The expense will be verified against the outlay for the care by patient, with the respective nominal information available in the production systems and the sector medical records. Expense reimbursement is also possible, with the borrower submitting the list of records and the Bank disbursing the amount per patient.

3.5 For Subcomponents 2.1(iv) and 2.2(i), an amount per service purchased from the private sector may be established as an eligible expense, according to the costs for each service, as established in the 2014 "Rates for Services in the National Health System" or a previously agreed upon updated calculation for specific

[31] This includes the financing of at least three specialists (monitoring and evaluation, financial, and procurement) and nine analysts for the IDB Project Management Unit starting in January 2021.

COVID-19 care, pursuant to the criteria and processes established in the 2017 "Replacement Technical Standard on Relations for Health Service Delivery and Recognition of Expenses between Institutions in the Comprehensive Public Health Network and the Supplementary Private Network." Expense reimbursement is also possible, with the borrower submitting the list of records and the Bank disbursing the amount per service purchased.

3.6 Component 3 (i) will establish the amount of the cash transfer of US$60 per household per month, plus administrative expenses and value-added tax as an eligible expense. The borrower must have liquidity for all of the aforementioned options involving expense reimbursement.

3.7 **Special procurement measures.** Plans have been made for the application of the special measures under the procurement policies approved by the Board of Executive Directors and set forth in document GN-2996, paragraph 4.2 and Resolution DE-28/20, paragraph 2.

3.8 **Retroactive financing.** The Bank may retroactively finance eligible expenditures incurred by the borrower prior to the loan approval date for the procurement of equipment to adapt the adult ICU beds, the operation of ICU beds, services and supplies for the burial of corpses, care for vulnerable patients via the purchase of services from private providers, cash transfers under the Contingency Bond, text message services (SMS), calls to users through the MIES call center, and/or a mass communication campaign, up to the amount of US$75 million (30% of the loan amount), provided that requirements substantially similar to those established in the loan contract have been met. Such expenditures must have been incurred on or after 30 January 2020, when WHO declared COVID-19 a global health emergency. Even though this predates the project officially entering the pipeline (document GN-2259-1), authorization of the retroactive financing on an exceptional basis is justified as of that date, given the exceptional circumstances surrounding the global health emergency.

3.9 **Procurement.** In addition to the exceptions mentioned in paragraph 3.7 and detailed in Annex III, the procurement financed in whole or in part with Bank resources will be undertaken pursuant to the Policies for the Procurement of Goods and Works Financed by the Bank (document GN-2349-15) and the Policies for the Selection and Contracting of Consultants Financed by the Bank (document GN-2350-15) and the simplified fiduciary processes prepared by the IDB Group in response to the COVID-19 outbreak. The procurement plan (required link 2) includes details of the planned procurement processes.

3.10 **Disbursements.** Disbursements will be made through advances of funds based on liquidity needs, and supporting justification for advances will be provided pursuant to the provisions of the Financial Management Guidelines for IDB-financed Projects (document OP-273-12) or the guidelines in effect at the time of execution. They will be determined based on payment needs, following the provisions of the Financial Management Guidelines for IDB-financed Projects (document OP-273-12) and the Fiduciary Arrangements and Requirements (Annex III). At the borrower's request, reimbursement of expenses and/or direct payments to suppliers may also take place.

3.11 **Audit.** Throughout the loan disbursement period and within 120 days following the close of the fiscal year, or within 120 days following the date of the last disbursement, each executing agency will submit the program's audited annual

financial statements to the Bank. The audit will be conducted by a Bank-eligible independent audit firm. Assurance reports will also be requested along with the expense vouchers. The audit's scope and related considerations will be governed by the Financial Management Guidelines (document OP-273-12) and the Guide for Financial Reports and Management of External Audit. Audit costs will be financed with project resources.

B. Summary of arrangements for monitoring results

3.12 **Monitoring.** The executing agencies will be responsible for implementing the monitoring and evaluation plan for their respective components. In light of the crisis, the main monitoring tools for this project will be the results matrix and the procurement plan. The main sources for monitoring impact, outcome, and output indicators will be the service delivery records from the health system and the epidemiological data for local, regional, and national monitoring, as well as the administrative and beneficiary records of the cash transfer programs. The executing agency will prepare a multiyear execution plan and an annual work plan once the crisis has stabilized. The main reporting tool will be the progress monitoring report (PMR), which will use the project's annual and semiannual reports as its main sources of information.

3.13 **Evaluation.** Given the nature of this operation, the evaluation will assess the project's contribution to its specific objectives: (i) improve case detection and monitoring; (ii) enhance health service delivery capacity; and (iii) support minimum income levels of people affected by coronavirus in the immediate future. Wherever feasible, the evaluation will also evaluate the program's contribution to the ultimate objectives of reducing mortality and morbidity caused by COVID-19 and ensuring a minimum quality of life for vulnerable persons in light of the crisis caused by COVID-19 and its social and economic repercussions. To that end, a "before and after" analysis will be conducted, using information from available time series on the results indicators. For the purpose of attributing the observed results to the project intervention, the quantitative analysis will be supplemented with a review of the theory of change supported by relevant evidence of the effectiveness of similar interventions in comparable contexts.

Development Effectiveness Matrix		
Summary	EC-L1270	
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	
CRF Level 2 Indicators: IDB Group Contributions to Development Results	-Beneficiaries receiving health services (#) -Beneficiaries of targeted anti-poverty programs (#)	
2. Country Development Objectives		
Country Strategy Results Matrix		
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)		¶1.8-1.11
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	8.5	
5.1 Monitoring Mechanisms	2.5	
5.2 Evaluation Plan	6.0	
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		

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

The 0peration EC-L1270, for an amount of US$250 million, is part of the Bank's operational response to the COVID-19 Pandemic "Immediate Public Health Response to Contain and Control the Coronavirus and Mitigate its Effect on Service Provision" and "Support for Vulnerable Populations Affected by Coronavirus." The general objective of the project is to help reduce morbidity and mortality from COVID-19 and mitigate the other indirect effects of the pandemic on the health and minimum levels of quality of life of vulnerable populations in the face of the crisis caused by COVID-19. The specific objectives are (i) to improve the detection and monitoring of cases; (ii) improve the capacity to provide health services; and (iii) support minimum income levels for people affected by the coronavirus in the immediate period.

The loan proposal presents a solid diagnosis of the problem, as well as a review of international evidence. 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 results and impacts. The outcome indicators are appropriately defined to measure the achievements of the program and the achievement of its specific objectives. The impact indicators reflect the contribution to the health (number of deaths caused by COVID-19) and economic (consumption level of vulnerable families compared to consumption level of non-vulnerable families) objectives of the operation.

The economic evaluation shows that the operation is efficient, with a benefit: cost ratio of 6.95 for components (i) and (ii) of health, and 1.42 for component (iii) of protection through the use of existing monetary transfers. In a context of high uncertainty, the health cost-benefit analysis considers the benefits in employment and labor income derived from the reduction of the mortality and morbidity rates due to COVID-19, while the costs are those associated with the implementation of a standard intervention package proposed by WHO. The cost-benefit analysis of component (iii) estimates the health benefits derived from social distancing achieved by compensating income for poor and vulnerable populations.

The monitoring and evaluation plan proposes a reflective analysis of the outcome and impact indicators included in the result matrix, complemented by a review of the theory of change and an updated review of international evidence. The monitoring and evaluation activities will be carried out by the executing agencies (MSP and MIES).

RESULTS MATRIX

EXPECTED IMPACT

Indicators	Unit of measure	Baseline	Baseline year	End of project (2022)	Means of verification	Observations
GENERAL OBJECTIVE: To help reduce the morbidity and mortality caused by COVID-19 and to mitigate other indirect impacts of the pandemic on health and on the minimum levels of quality of life of vulnerable populations in response to the crisis caused by COVID-19.						
Number of deaths caused by COVID-19[1]	Deaths	142,166	2022 (without intervention)	121,680	MSP Planning Coordination Report based on hospital and MSP surveillance data	Baseline represents the "control" scenario (estimated number of deaths nationally (public and private systems), if the MSP does not expand the supply of beds in intensive care units (ICUs) as expected in the response plan, maintaining only the 253 available ICU beds). The target represents the estimation of deaths in the event of an expansion of capacity by the MSP to 1,451 ICU beds. The estimates include deaths caused by COVID-19 from confirmed and suspected cases, and deaths due to comorbidity in confirmed cases due to saturation of services. The desired direction of the indicator is to minimize the value by the end of the project.
Consumption level of vulnerable families with respect to the consumption level of nonvulnerable families	%	48.1	2016	48.1	Living Conditions Survey (ECV)	The baseline uses the 2016 ECV. Calculated as the consumption expenditure of households from the three poorest quintiles divided by the consumption expenditure of the two richest quintiles. The desired direction of the indicator by the end of the project is to maintain or surpass the baseline value.

[1] For the case of Ecuador and this project, the alternative impact indicator proposed in the health prototype project "Confirmed cases of COVID-19" is not considered because the country has a substantial undercount of cases, making the estimation of future scenarios difficult, especially when trying to differentiate by scenarios with and without the intervention. Given the extreme assumptions that would have to be used to make these estimations, it is considered more feasible to omit this indicator. In addition, in the program's vertical logic (see Figure 1), it would represent a duplication of impacts for the same results.

EXPECTED OUTCOMES

Indicators	Unit of measure	Baseline	Baseline year	2020	2021	End of project (2022)	Means of verification	Observations
SPECIFIC OBJECTIVE 1: Improve detection and monitoring of cases								
Number of tests conducted per 1,000 inhabitants	Tests conducted	2	2022 (without intervention)	153	162	314	MSP report based on the MSP's Epidemiological Surveillance System (VIEPI)	Baseline represents the "control" scenario (estimated number of PCR and rapid tests, if the MSP does not expand diagnostic capacity as expected in the response plan, maintaining only the April 2020 diagnostic capacity). For 2020 (2021), calculated as 300,000 PCR + 1.4 million rapid tests (400,000 PCR + 1.4 million rapid tests) for 11.1 million MSP users. The desired direction of the indicator is to maximize the value at the end of the project (which is the sum of the two preceding years). The desired direction of the indicator is to maximize the value at the end of the project.
SPECIFIC OBJECTIVE 2: Enhance service delivery capacity								
ICU hospitalization capacity with respect to what is required	%	7.2	2022 (without intervention)	28.4	41.2	41.2	MSP report based on Coronavirus/COVID-19 epidemiological bulletins and hospital data	Baseline represents the "control" scenario (estimated number of ICU beds to serve the MSP user population, if the MSP does not expand the supply of beds as expected in the response plan, maintaining only the 253 available ICU beds). The target represents the estimation of ICU hospitalization capacity in the event of an expansion of capacity by the MSP to 1,451 ICU beds. As an indicator of supply capacity, the desired direction of the indicator is to maximize the value at the end of the project.

Indicators	Unit of measure	Baseline	Baseline year	2020	2021	End of project (2022)	Means of verification	Observations
Capacity for all hospitalizations in the public sector	Hospitalizations	37,392	2019	40,000	43,000	43,000	MSP report based on Coronavirus/COVID-19 epidemiological bulletins, Patient Management System (SGP) and Comprehensive Public Health Network System (RPIS)	Measures the number of patients hospitalized in the MSP public subsector (COVID-19 or otherwise) + referrals to the private sector (COVID-19 or main diagnoses). As an indicator of supply capacity, the desired direction of the indicator is to maximize the value at the end of the project.
SPECIFIC OBJECTIVE 3: Support minimum income levels of people affected by coronavirus in the immediate future								
Households receiving extraordinary transfers that were not participating in existing transfer programs, but appear in the information systems (Social Registration Form)	%	0	2019	31.0	0	31.0	MIES report based on the Social Registration Form and MIES administrative system	There are 2.8 million households in the Social Registration Form database. 1.025 million receive transfers. The number of households that do not receive transfers is 1.775 million (denominator). Of these, transfers will be paid to 550,000 (numerator). 550,000 / 1.775 million = 0.3099. The desired direction of the indicator is to maximize the value at the end of the project.

OUTPUTS

Outputs	Unit of measure	Baseline	Baseline year	2020	2021	Final target (2022)	Means of verification	Observations
Component 1: Case detection and monitoring								
1.1. Number of professionals on rapid-response teams for active search and case detection operating in the field	Professionals	246	2020	510	0	756	MSP report based on human resources documents (signed contracts, distribution of staff).	The 2020 baseline (until April) combines the total number of epidemiologists per district + zone coordination offices + national offices (there is still no concept of rapid response).
1.2. Number of rapid response professionals with hardware to enter data online	Professionals	0	2019	756	0	756	MSP report based on contracts completed, certificates of receipt prepared.	
1.3. Number of diagnostic tests purchased from non-public laboratories	Diagnostic tests	9,736	2020	18,272	0	28,008	MSP report based on invoices and laboratory deliveries; and the VIEPI SNS system that has information from public and private laboratories.	Baseline is 2020 until April. In total, 250,000 tests will be purchased from the private sector in 2020-2021, of which 18,272 will be contributed by the program.
Component 2: Improvement of the capacity for service delivery								
2.1. Number of ICU beds for adults adapted for COVID-19 patients	Beds	0	2019	128	0	128	MSP report based on contracts completed, certificates of receipt prepared.	Of the expected 1,451 ICU beds for COVID-19, the program will contribute 128.
2.2. Number of patients cared for in ICU for adults	Patients	0	2019	3,243	0	3,243	MSP report based on human resources documents (distribution of staff, salaries paid), and contracts completed and delivery/receipt of medications/supplies.	Refers to the operation of hospital beds, including the cost of staff, medications, supplies, and/or (non)clinical support services. Hospitalization is estimated at 20 days per patient.
2.3. Number of patients cared for in intermediate care units for adults	Patients	0	2019	2,520	0	2,520		Refers to the operation of hospital beds, including the cost of staff, medications, supplies, and/or (non)clinical support services. Hospitalization is estimated at 15 days per patient.

Outputs	Unit of measure	Baseline	Baseline year	2020	2021	Final target (2022)	Means of verification	Observations
2.4. Number of additional health professionals caring for COVID-19 patients	Professionals	0	2019	2,000	2,156	4,156	MSP report based on human resources documents (signed contracts, distribution of staff)	
2.5. Number of health professionals trained in COVID-19 patient care protocols	Professionals	0	2019	1,330	0	1,330	MSP report based on list of participants.	
2.6. Number of corpses released for burial	Corpses	0	2019	2,096	0	2,096	MSP report based on contracts completed or invoices.	
2.7. Number of vulnerable patients with chronic conditions referred to the private sector	Patients	73,430	2019	1,600	0	75,030	MSP report based on the Patient Management System (SGP) and Comprehensive Public Health Network System (RPIS).	
2.8. Number of vulnerable patients with nonchronic conditions referred to the private sector	Patients	114,803	2019	4,500	0	119,303		
2.9. Number of maternal health patients referred to the private sector	Patients (female)	7,048	2019	600	0	7,648		Monitoring of gender issues.
Component 3: Protection through the use of existing cash transfer programs								
3.1 Households receiving extraordinary transfers that were not participating in existing transfer programs, but appear in the information systems (Social Registration Form)	Households	0	2019	550,000	0	550,000	MIES report based on the Social Registration Form and MIES administrative system.	The program finances the Contingency Bond for 550,000 households for two months in 2020. Monitoring of gender issues.

Country: Ecuador **Sector:** SPH **Project number:** EC-L1270 **Year:** 2020
Cofinancing: N/A. **Coexecution:** MSP and MIES

FIDUCIARY AGREEMENTS AND REQUIREMENTS

Executing agency: Ministry of Public Health (MSP) and Ministry of Economic and Social Inclusion (MIES)

Project name: Support for Health Service Delivery and the Social Safety Net in the Context of the Coronavirus/COVID-19 Pandemic

I. FIDUCIARY CONTEXT OF THE EXECUTING AGENCY

1. Use of country systems in the project[1]

Budget	■	Reports	☐	Information system	■	National competitive bidding	☐
Treasury	■	Internal audit	☐	Shopping	☐	Advanced national competitive bidding	☐
Accounting	■	External control	☐	Individual consultants	☐	Consulting firm	☐

Governing laws/regulations: Organic Code of Planning and Public Finances (COPLAFIP); Organic Law of the National Public Procurement System (LOSNCP); and the Resolutions, Recommendations, and Orders arising from the COVID-19 health emergency issued by the National Public Procurement System of Ecuador (SERCOP).

2. Fiduciary capacity of the executing agency

Both the MSP and the MIES have coexecuted or subexecuted IDB-financed operations (EC-L1235, EC-L1236, and EC-L1227), and at the time, each ministry's execution capacity was assessed, so a new assessment was not conducted. Both ministries have management teams for the aforementioned programs and will be strengthened with more staff for the execution of this operation.

3. Fiduciary risks and mitigation actions

Fiduciary risk: High ☐; Medium ■; Low ☐

[1] Any system or subsystem that is subsequently approved may be applicable to the operation, in accordance with the terms of validation by the Bank.

Risk	Risk level (Medium/High)	Mitigation plan
Verification of accounts will be complex due to the massive, dispersed payments and/or care provided.	Medium	Verifications will be requested of a sample of the payments by the financial auditors as part of the justification of expenditures.
Difficulties in recording and identifying available funds in the treasury single account (CUT) for each coexecuting agency, which could delay or hinder the planned disbursements.	Medium	The borrower and executing agencies will demonstrate to the IDB that they have a monthly mechanism to reconcile the movements and balances available for each executing agency.
Difficulties in the interpretation and application of the regulations, internal preparatory procedures for the MSP on procurement, and a lack of delegation for finalizing bidding processes and signing contracts for the supply of key goods for the pandemic response could impact the timing and/or quality of procurement.	Medium	Agree with the MEF and the MSP on the minimum necessary procedures between and within the two ministries, as well as the respective administrative, legal, and financial delegation to ensure timely management

II. CONSIDERATIONS FOR THE SPECIAL PROVISIONS OF THE CONTRACT

Conditions precedent to the first disbursement: There are no conditions of a fiduciary nature.
Exchange rate: For the rendering of accounts, the applicable exchange rate will be the rate in effect on the day when the borrower, executing agency, or any other individual or legal entity delegated the authority to incur expenses makes the respective payments or transfers. Article 4.01(b)(ii) of the General Conditions.
Audited financial statements for the program: Each executing agency will submit, within 120 days following the close of each fiscal year of the executing agency and throughout the original disbursement period or its extensions, and within 120 days following the date of the last loan disbursement, the annual audited financial statements for the program, duly audited by an independent audit firm acceptable to the Bank. Likewise, the auditors will issue assurance reports on fulfillment of the criteria agreed upon with the executing agencies for the payments presented in the expense vouchers.
Other: N/A.

III. AGREEMENTS AND REQUIREMENTS FOR PROCUREMENT EXECUTION

Exceptions to policies and guidelines:

Pursuant to the IDB Group's Governance Response to the COVID-19 Pandemic Outbreak (document GN-2996), there are plans to apply special measures to the Policies for the Procurement of Goods and Works Financed by the IDB and the Policies for the Selection and Contracting of Consultants Financed by the IDB, for the immediate response in the public health area. The following is anticipated in this operation:

- Expansion of Bank eligibility to nonmember countries, applicable as of 7 April 2020 to 7 April 2021;
- Direct contracting and/or recognition of agreements with procurement agencies, specialized agencies (when acting as procurement agencies), or adhesion to aggregate procurement mechanisms (for example: UNOPS, UNDP, PAHO, IOM, UNFPA, UNICEF, IICA, UNESCO, WFP, OEI, COMISCA, BFP of the World Bank, etc.) until 7 April 2021;
- Acceptance of the use of the LOSCNP and the Resolutions, Recommendations, and Orders arising from the COVID-19 health emergency issued by the SERCOP.

Retroactive financing and/or advanced procurement	• The Bank may retroactively finance eligible expenditures incurred by the borrower prior to the loan approval date for the procurement of equipment to adapt the adult ICU beds, the operation of ICU or intermediate care beds, services and supplies for the burial of corpses, care for vulnerable patients via the purchase of services from private providers, cash transfers under the Contingency Bond, text message services (SMS), calls to users through the MIES call center, and/or a mass communication campaign, up to the amount of US$75 million (30% of the loan amount), provided that requirements substantially similar to those established in the loan contract have been met. Such expenditures must have been incurred on or after 30 January 2020, when the WHO declared COVID-19 a global health emergency. Even though this predates the project officially entering the pipeline (document GN-2259-1), authorization of the retroactive financing on an exceptional basis is justified as of that date, given the exceptional circumstances surrounding the global health emergency.
Supplementary procurement support	• N/A.
Alternative procurement arrangements	• N/A.
Projects with financial intermediaries	• N/A.

Procurement agents	• The possibility of recognizing adhesion to the aggregate procurement mechanism of COMISCA, which is in process, is anticipated; in addition to other agreements as indicated in section III of this document.
Direct contracting	• Training services (by universities with public health departments) to 1,333 health professionals on COVID-19 care, US$200,000. • Processing services for approximately 18,272 COVID-19 diagnostic tests (contracts with authorized providers for the type of service in the country, based on the capacity to process tests), US$2.19 million. • Equipment for adapting 128 existing ICU beds for COVID-19 care, US$22.88 million. • Services and supplies provided by cemetery in Guayaquil for the burial and disposal of 2,096 corpses, US$3.56 million. • Care for 1,600 patients with chronic conditions via the purchase of services from private providers (applying rates per service established by the MSP), US$17.60 million. • Care for 4,500 vulnerable patients with nonchronic conditions referred for purchase of services from private providers (applying rates per service established by the MSP), US$9.16 million. • Care for 600 vulnerable patients with maternal health conditions referred for purchase of services from private providers (applying rates per service established by the MSP), US$465,000. • Text messaging services (SMS) by mobile telephone operators in Ecuador (Claro, Movistar, and CNT), calls to users through the MIES call center and a mass communication campaign to orient the population on the delivery of the Contingency Bond, US$734,000.

Operating expenses will be financed: ☐ N/A.	**Domestic preference:** ☐ N/A.

General supervision methods for project procurement: N/A.	
Supervision method: Ex ante or ex post.	**For:** As agreed in the project procurement plan.

Country thresholds: www.iadb.org/procurement

IV. FINANCIAL MANAGEMENT AGREEMENTS AND REQUIREMENTS

Programming and budget	• The Organic Code of Planning and Public Finances (FOPLAFIP) establishes the rules governing budget programming, formulation, approval, execution, control, evaluation, and performance. • Each executing agency is responsible for the processes necessary to include the corresponding budget items in its budget. The MIES will incorporate the budget in an existing prioritized investment program, and the MSP will create a new program.
Cash and disbursement management	• The disbursement method will use advances of funds to each executing agency independently. At the borrower's request, expense reimbursements and direct payments to suppliers may also be used. In IDB systems, the components executed by each executing agency will be handled as a subloan to enable to management of independent advances for each executing agency. • The disbursement mechanisms will use the presentation of physical disbursement requests, considering that e-disbursements have not be implemented in Ecuador. • Bank account: The CUT will be used. The e-SIGEF only allows the creation of a single record account in the CUT, so it is not possible to have independent record accounts for each executing agency (see fiduciary risks). • Financial plan: Advances will be made for a period of up to six months, based on the actual liquidity needs of each executing agency, in accordance with the financial plan and itemized cash flow. • Percentage for rendering of accounts: 80% of the balance of advances pending justification. Each justification of expenditures will be accompanied by an assurance report by the external auditors, except for the justifications of the first advance to each executing agency, which may be justified on a preliminary basis without the assurance report, and once received, any necessary adjustments will be made. • Project cash flow: The funds will be disbursed to the borrower in the account opened in the BCE, and from there will be transferred to the Treasury Single Account. • Component 2, executed by the MSP, in addition to the purchase and installation of equipment, also includes the delivery of health and funeral services, where, given the complexity and operational difficulty of financing, purchasing, and verifying the inputs for their delivery, in these cases, the eligible expenses will be the services delivered to the population, monetized based on the MSP's rates for the eligible services or other previously agreed upon service rates. However, in the disbursements for this component, the cumulative value recognized for services rendered will not be greater than the cumulative payments made by the MSP in the investment project presented to the national planning authority, and in each justification or reimbursement for payments, this verification will take place.

Accounting, information systems, and reporting	• Specific accounting standards: Governmental accounting standards. In 2021, the International Public Sector Accounting Standards (IPSAS) will begin to apply. • Reports for rendering of accounts: Cash flow statement and cumulative investment statement, prepared based on data from the e-SIGEF or SINAFIP when it enters into operation in 2021 and auxiliary reports in Excel. • Accounting method and currency: Accounting will be done on an accrual basis, but the financial reports will be prepared on a cash basis in U.S. dollars, which is the legal tender in Ecuador.
External control	• In agreement with the Bank, the MSP will select and contract the services of an eligible auditor, in accordance with the previously agreed upon terms of reference, to conduct the audits of both executing agencies. • The audit firm will be asked to provide an individual opinion on the financial reports of each executing agency, as well as the compilation of reports to obtain aggregate information for the program.
Financial supervision of the project	• Financial supervision will take place through visits, working meetings, and review of the assurance reports and audited financial reports.

V. Relevant Information for the Operation

Policies and guidelines applicable to the operation

Financial management	**Procurement**
• Document GN-2811 [OP-273-12]	• Document GN-2349-15 [ES] • Document GN-2350-15 [ES] • Simplification of IDB Group procurement processes in response to COVID-19 https://www.iadb.org/es/coronavirus/respuesta-fiduciaria

Records and files

Each executing agency will keep its records independently, in digital and physical files, and have procedures and instructions for their proper maintenance.

DOCUMENT OF THE INTER-AMERICAN DEVELOPMENT BANK

PROPOSED RESOLUTION DE-__/20

Ecuador. Loan ____/OC-EC to the Republic of Ecuador
Support for Health Service Delivery and the
Social Safety Net in the Context of the
Coronavirus/COVID-19 Pandemic

The Board of Executive Directors

RESOLVES:

That the President of the Bank, or such representative as he shall designate, is authorized, in the name and on behalf of the Bank, to enter into such contract or contracts as may be necessary with the Republic of Ecuador, as borrower, for the purpose of granting it a financing to cooperate in the execution of the program “Support for Health Service Delivery and the Social Safety Net in the Context of the Coronavirus/COVID-19 Pandemic”. Such financing will be for the amount of up to US$250,000,000 from the resources of the Bank’s Ordinary Capital, and will be subject to the Financial Terms and Conditions and the Special Contractual Conditions of the Project Summary of the Loan Proposal.

(Adopted on ___ _____ 2019)

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