SIMULTANEOUS DISCLOSURE

DOCUMENT OF THE INTER-AMERICAN DEVELOPMENT BANK

BOLIVIA

"GROW WELL TO LIVE WELL" EARLY CHILDHOOD DEVELOPMENT PROGRAM

(BO-L1064)

LOAN PROPOSAL

This document was prepared by the project team consisting of Julia Johannsen (SPH/CBO), Project Team Leader; Isabel Nieves (SCL/SPH); Patricia Jara (SCL/SPH); Florencia López Boo (SCL/SPH); Zoraida Arguello (PDP/CBO); Roberto Laguado (PDP/CBO); Jorge Cossío (CAN/CBO); Javier Jiménez (LEG/SGO); and Sheyla Silveira (SCL/SPH).

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Annex II	Results matrix
Annex III	Fiduciary agreements and requirements

ELECTRONIC LINKS

REQUIRED

1. Annual work plan
   http://idbdocs.iadb.org/wsdocs/getDocument.aspx?DOCNUM=36282082
2. Monitoring and evaluation plan
   http://idbdocs.iadb.org/wsdocs/getDocument.aspx?DOCNUM=36282131

OPTIONAL

1. Economic evaluation
   http://idbdocs.iadb.org/wsdocs/getDocument.aspx?DOCNUM=36283584
2 Detailed execution plan
   http://idbdocs.iadb.org/wsdocs/getDocument.aspx?DOCNUM=36282098
3. Detailed procurement plan
   http://idbdocs.iadb.org/wsdocs/getDocument.aspx?DOCNUM=36282115
4. Itemized cost table
   http://idbdocs.iadb.org/wsdocs/getDocument.aspx?DOCNUM=36426214
5. Safeguard and Screening Form for Classification of Projects
   http://idbdocs.iadb.org/wsdocs/getDocument.aspx?DOCNUM=36282894

ABBREVIATIONS

ECD	Early childhood development
FPS	Fondo Nacional de Inversión Productiva y Social [National Productive and Social Investment Fund]
FSO	Fund for Special Operations
IMCI-Nutrition	Integrated Management of Childhood Illness and Nutrition (Clinical, or Family and Community)
LIBOR	London Interbank Offered Rate
MSD	Ministry of Health and Sports
OC	Ordinary Capital
PAN	Programa de Atención a Niños y Niñas Menores de 6 Años [Program to Care for Children under 6]
SIGMA	Integrated Administrative Management and Modernization System
UDIT	Early Childhood Development Technical Unit
UGESPRO	Project and Program Management Unit

PROJECT SUMMARY

BOLIVIA
"GROW WELL TO LIVE WELL" EARLY CHILDHOOD DEVELOPMENT PROGRAM
(BO-L1064)

<table>
<tr><th colspan="6">Financial Terms and Conditions</th></tr>
<tr><td colspan="3" rowspan="5">Borrower: Plurinational State of Bolivia

Executing agency: Ministry of Health and Sports (MSD) with support from the National Productive and Social Investment Fund (FPS)</td><td></td><td>OC</td><td>FSO</td></tr>
<tr><td>Amortization period:</td><td>30 years</td><td>40 years</td></tr>
<tr><td>Grace period:</td><td>6 years</td><td>40 years</td></tr>
<tr><td>Disbursement period:</td><td>5 years</td><td>5 years</td></tr>
<tr><td>Interest rate:</td><td>Single Currency Facility-LIBOR</td><td>0.25%</td></tr>
<tr><td>Source</td><td>Amount</td><td>%</td><td>Inspection and supervision fee:</td><td>*</td><td>n/a</td></tr>
<tr><td>IDB Ordinary Capital (OC)</td><td>US$15,000,000</td><td>68</td><td>Credit fee:</td><td>*</td><td>n/a</td></tr>
<tr><td>IDB Fund for Special Operations (FSO)</td><td>US$ 5,000,000</td><td>23</td><td rowspan="3">Currency:</td><td rowspan="3">U.S. dollars from the Single Currency Facility</td><td rowspan="3">U.S. dollars</td></tr>
<tr><td>Local</td><td>US$ 2,000,000</td><td>9</td></tr>
<tr><td>Total</td><td>US$22,000,000</td><td>100</td></tr>
<tr><th colspan="6">Project at a Glance</th></tr>
<tr><td colspan="6">Project objective/description: The general objective of the program is to help improve the cognitive, social, emotional, and physical development of Bolivian children in a way that is sustainable and culturally appropriate. More specifically, it seeks to implement a model early childhood development program through improved access and higher quality of care for children under 4.</td></tr>
<tr><td colspan="6">Special contractual conditions:
Conditions precedent to the first disbursement of the loan: (i) regulatory evidence of the creation of the Early Childhood Development Technical Unit as described in paragraphs 3.2 and 3.3; and (ii) approval and entry into force of the program Operating Regulations under the terms previously approved by the Bank (see paragraph 3.3).
Conditions precedent to the first disbursement of the loan for Component 3: As a condition precedent to the disbursement of resources for Component 3, a subsidiary agreement must be signed by the Ministry of Economy and Public Finance, the Ministry of Development Planning, and the Ministry of Health and Sports with the FPS, delegating to the FPS the responsibility for executing infrastructure and equipment activities for Component 3 under the supervision of the MSD, which must be completed before the resources allocated to the FPS are executed (see paragraph 3.4).
Special conditions for execution: Submittal of evidence that 100 job positions for government employees in childhood development in the health sector have been created or reassigned, as follows: (i) the first 50 government positions, when 70% of the loan proceeds have been disbursed or at the end of year three of program execution, whichever occurs first; and (ii) the remaining 50 positions when 90% of the loan proceeds have been disbursed or at the end of year four of program execution, whichever occurs first (see paragraph 2.2).</td></tr>
<tr><td colspan="6">Procurement: All procurement processes for the program will be in accordance with the Bank's procurement policies and procedures, as set forth in documents GN-2349-9 and GN-2350-9 (see Annex III, "Fiduciary agreements and requirements").</td></tr>
<tr><td colspan="6">Exceptions to Bank policies: No exceptions to Bank policies are expected.</td></tr>
<tr><td colspan="6">Project qualifies as: SEQ [X] PTI [ ] Sector [X] Geographic [X] Headcount [ ]</td></tr>
</table>

* 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 provisions of the Bank's policy on lending rate methodology for Ordinary Capital loans. In no case will the credit fee exceed 0.75% or the inspection and supervision fee exceed, in a given six-month period, the amount that would result from applying 1% to the loan amount divided by the number of six-month periods included in the original disbursement period.

I. DESCRIPTION AND RESULTS MONITORING

A. Background, problems to be addressed, and rationale

1.1 **Social context of children in Bolivia.** With its sizable rural and indigenous populations, Bolivia has long been recognized as one of the most ethnically and socially diverse countries in Latin America. Nearly half of its approximately 10 million people belong to one of 36 indigenous groups, and 68.3% of the country's rural population is indigenous.

1.2 Bolivia is also the second-poorest country in Latin America, after Haiti. It is marked by sharp inequalities between urban and rural areas: while the urban poverty rate is 50.9%, the poverty rate in rural areas is 77.3% (the extreme poverty rate is 23.6% in urban areas and 63.9% in rural areas). Bolivia's poverty rate is closely tied to its age structure.[1] In addition to a lack of income, the particular vulnerability of children in early childhood is manifested in a pattern of risks and delays in physical and mental development, which are then transmitted throughout the life cycle.

1.3 Bolivia's infant mortality rate—50 for every 1,000 live births—is the highest in the region, and results from adverse developmental, nutritional, and health conditions from the moment of conception. The chronic malnutrition rate in children under 24 months is 21%,[2] and nearly 44% in rural and indigenous areas.[3] Iron-deficiency anemia affects 57% of all rural children and 61% of children in the altiplano.[4] Though data are lacking, significant delays in cognitive and psychosocial development are likely to occur in a child's early years as a result of malnutrition and a lack of early stimulation services. This leads to learning deficiencies caused by delays in the development of psychomotor, language, and reasoning skills.

1.4 **Why and when to intervene with child development actions.** A series of articles published in 2008 in the scientific journal *The Lancet* noted that damage caused by malnutrition in a child's early years not only leads to permanent delays but also can affect future generations.[5] In addition, a household's environment and socioeconomic status includes opportunities for physical and mental development from birth, placing at a disadvantage those children born into homes of low socioeconomic status that lack access to effective child development services.[6] In

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1 In 2007, 68% of all Bolivian children under 4 (and 77% in rural areas) were from poor households, compared to 51% of similarly situated adults ages 45 to 64 (Economic and Social Policy Analysis Unit, 2009, based on data from the National Statistics Institute, 2007).

2 National Demographic and Health Survey, 2008, of the National Statistics Institute.

3 Global database on child growth and malnutrition, accessed online on 15 September 2010. World Health Organization.

4 Global database on anemia, accessed online on 15 September 2010. World Health Organization.

5 Victora et al, 2008: "Maternal and Child Undernutrition: Consequences for Adult Health and Human Capital." *The Lancet*, 371 (9608).

6 Lozoff et al., 2006: "Double Burden of Iron Deficiency in Infancy and Low Socioeconomic Status: A Longitudinal Analysis of Cognitive Test Scores to Age 19 Years. Archives of Pediatric & Adolescent Medicine, 160:1108-1113.

countries where scholastic performance has been predicted by cognitive development indicators, children from lower-income households or from households of lower socioeconomic status tend to perform below average in school.[7] The evidence indicates that investments during early childhood are more effective than at any other stage of life, with rates of return of 15% to 17%.[8]

1.5 The period during which child-development interventions can have a significant effect is short, covering the first 36 months of life (or, alternatively, the first 1,000 days, including pregnancy). Corrective measures in later stages of life have a higher cost and in some cases are no longer possible. Comprehensive interventions include health, nutrition, early stimulation, and parent education. They may be grouped into two categories: (i) institutional care, through childcare centers and health facilities; and (ii) community and home care, aimed at modifying the family environment and parental behavior.

1.6 **How to intervene in child development.** The literature and experience in the region provide solid evidence of the effectiveness of various modalities of care in childcare centers and specialized early stimulation rooms. Specifically in Bolivia, daycare centers have been shown to have positive impacts on cognitive and psychosocial development when they are of high quality and have professional facilitators (Behrman, Cheng, and Todd, 2004). These effects are achieved with greater exposure to the program, especially in older children. As for care in specialized early stimulation rooms offering professional temporary treatment to children with clinical delays in speech, motor skills, or other areas, though no impact evaluations have appeared in academic publications, various countries are using this modality with increasing coverage and quality.[9] Such is the level of excellence of this modality, in fact, that many Southern Cone governments are currently seeking to adopt it.

1.7 As for modalities focused on working with parents of children under 4 through home visits, the literature and multiple previous experiences in the region provide positive evidence. Home visits provide support to the families in childrearing, early stimulation, or nutrition. Examples include "Kallpa Wawa," a small program in Bolivia, the "Roving Caregivers" program in the Caribbean, or the early-stimulation pilot initiatives in Jamaica (Grantham McGregor et al., multiple years). Also, Behrman, Cheng, and Todd (2004) have documented that caring for a group

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[7] Examples of this type of study include Peru, Nicaragua, Colombia, and Ecuador. In Ecuador, on a vocabulary test that serves as a predictor of scholastic performance, the lowest decile of 5-year-old children score, on average, one and a half years below the average (Paxson and Schady, 2007: "Cognitive Development among Young Children in Ecuador: The Roles of Wealth, Health, and Parenting." *Journal of Human Resources*, 42(1): 49-84.

[8] Heckman, 2006: "Skill Formation and the Economics of Investing in Disadvantaged Children," *Science*, 312(5782): 1900-1902.

[9] A pioneering example is the "Chile Crece Contigo" [Chile Grows with You] social protection network, which has been successfully using this modality since 2008.

of children in the home of a community mother had positive effects in Bolivia, but only for children over 3 and at a cost that is not sustainable over time.

1.8 **Current public policies on child development in Bolivia.** The government's response to challenges related to early childhood development includes programs that since 2006 have focused on improving health and nutrition. The programs of the Ministry of Health and Sports (MSD) include the Universal Maternal and Child Insurance, which provides some health care benefit to 83% of all women and 90% of all children under 5;[10] the Zero Malnutrition Program, with its significant Integrated Management of Childhood Illness (IMCI) strategy within the framework of the "zero malnutrition" target at the clinical, community, and home levels; and the Juana Azurduy subsidy program for pregnant women and children under 2 (with an estimated current enrollment of nearly 100% of children and 54% of women who are eligible[11]).

1.9 The Ministry of Justice coordinates the Program to Care for Children under 6 (PAN), which covers approximately 6% of children in this age group. Aside from its low coverage rate, the program is implemented by the municipios under the supervision of the departmental governments, which leads to disjointed services with varying PAN interventions depending on the circumstances in each department and municipio and no clear or consistent quality standards, and this makes it difficult to view PAN as a truly nationwide program. The quality-related challenges include a lack of quality standards, a lack of stimulation components provided by trained personnel, and the lack of an effective system for enrolling beneficiaries and monitoring coverage and quality at the national level. As a result, PAN is currently playing the role of daycare provider, rather than providing for comprehensive child development.[12]

1.10 The "Avelino Siñani and Elizardo Pérez" Law 70 on Education, passed in 2010, is a significant development. For comprehensive child development, the law makes early education compulsory from 0 years of age, to be provided in a scholastic environment from 4 to 5 years of age and in a nonscholastic environment for children under 4, with the latter being the shared responsibility of the family, the community, and the State (Article 12). The law also calls for quality in education to be viewed from an intracultural, intercultural, and multilingual perspective that incorporates social and community knowledge and values. Once the law is regulated and implemented, and especially with the required expansion of school

[10] National Demographic and Health Survey, 2008, of the National Statistics Institute.

[11] Estimate by the Economic and Social Policy Analysis Unit, based on population projections from the 2001 census.

[12] At one time in its long history, PAN did provide quality services. This was when it had supervisors who would monitor caretakers and ensure compliance with protocols. PAN's cost per child at the time was extremely high (approximately US$430 per child per year, while other programs in the region spend US$200 per child per year), and it did not achieve financial and institutional sustainability without external financing. Thus, the challenge in this new program is not only to provide quality service, but to do so in a cost-effective manner.

coverage to 100% of children over 4, the composition of beneficiaries in childcare centers (PAN and non-PAN), and in any other direct-care family or community modality, will change and be limited to children under 4. Specific curricula and quality standards will need to be developed for various modalities of care, including cultural adaptation of the service as required by the law.

1.11 In conclusion, current services related to various aspects of early childhood development have room for improvement in coverage rates of comprehensive services, implementation of standards and supervision of quality of care, and activities to prevent services from being fragmented and to allow for coordinated policies between sectors. These issues will be approached in a comprehensive manner through this program in the departments of Chuquisaca and Potosí, which were selected using the criteria set forth in paragraph 1.22.

B. Objective, components, and costs

1.12 The general objective of the program is to help improve the cognitive, social, emotional, and physical development of Bolivian children in a way that is sustainable and culturally appropriate. More specifically, it seeks to implement a model early childhood development program through improved access and higher quality of care for children under 4.

1.13 **Component 1. Implementation of complementary early child development (ECD) services (US$10.12 million).** This component will use two modalities of care that currently do not exist among the policies and services offered by the health sector: (i) care in child development centers with daycare (with an estimated coverage of 3,060 children in 90 centers); and (ii) care in specialized early stimulation rooms in health centers to treat children with clinical delays (with an estimated coverage of up to 9,000 children served in 60 rooms). This component will also support crosscutting activities, including supervision of benefits and a municipal fund.[13]

1.14 This component will finance the following activities: (i) educational material and operating expenses for care in childcare centers and early stimulation rooms; (ii) training for existing community educators in childcare centers, based on quality standards and best practices in child development; (iii) education or training and operation of new human resource professionals who will provide specialized care in the two modalities, following quality standards and best practices in this area and considering progress in designing a strategic professional training and curriculum

[13] The autonomous municipal governments may use this fund for eligible projects and thereby complement the program's interventions with their own operational initiatives at the municipal level. A predecessor to this model is the municipal fund of the multisector "Zero Malnutrition" program, and the regulations for the planned fund will be based on the procedures used and lessons learned in this previous experience.

development plan using nonreimbursable resources;[14] (iv) design and operation of the training supervision system by the appropriate entities of the departmental governments (Departmental Health Service and Departmental Social Management Service); (v) development and negotiation of interagency agreements with municipal and departmental governments; (vi) development or supplementation and reproduction of guidelines, standards, curricula, and care protocols for ECD services under the modalities of care in childcare centers and specialized stimulation rooms (care protocol in stimulation rooms, quality standards, and curriculum standard for childcare centers, etc.); and (vii) financing of projects to be executed at the local level by municipal governments and financed through a municipal incentive fund established with program resources, including the design and operational implementation of the fund.[15] The incentive will consist of one-time financial support up to a maximum amount (to be determined) for each prioritized municipio that submits an eligible project.

1.15 **Component 2. Strengthening of existing services in the health sector (US$3.63 million).** This component will seek to strengthen and complement services offered or planned by the health sector, by incorporating specific content for early stimulation in two existing modalities of care: (a) a medical visit in the health facility to perform a checkup and monitor growth, as provided for in the Clinical IMCI-Nutrition protocols[16] (also recognized by the Juana Azurduy subsidy program as coresponsibility for payments); (b) home and community visits as provided for under the Family and Community IMCI-Nutrition strategy (with an estimated coverage of 7,200 children), including work with parents and caretakers;

[14] A perspective sensitive to gender and the local culture will be integrated into the curricular content used in personnel education and training activities. Examples of programs in the region that serve indigenous populations include Peru, Colombia, Mexico, Chile, Ecuador, and Bolivia. Where sizable indigenous populations exist and are served by a program, or where indigenous populations are exclusively served, the programs include services and materials adapted to the language and cultural practices of these families. Examples of this type of program include the "Conozca a su Hijo" program in Chile and the "Wawakamayuk Wasi" Child Development Fund in Ecuador (Araujo and López-Boo, 2010, Technical Note IDB-TN-188).

[15] The fund will be designed to provide incentives for fulfilling targets for the comprehensive development of children in municipios prioritized by the program, and will operate in such a way that each eligible municipio may submit one or more projects based on a predetermined menu of eligible projects. Project eligibility will be defined so that eligible projects complement this program's activities, either through greater coverage or through intervention modalities that complement those implemented by the Ministry in this program. The eligibility criteria and fund operation guidelines are currently under design with technical cooperation resources and will be included as an annex to the Operating Regulations.

[16] Integrated Management of Childhood Illness (IMCI) is a strategy developed by the World Health Organization and the United Nations Children's Fund. It was introduced in 1996 as the leading strategy for improving children's health. It focuses on caring for children under 5 in terms of their health, more so than treating the illnesses that may occasionally affect them. In Bolivia, two components have been pursued for more than 10 years now, each with an additional focus on nutrition: improving the skills of health care personnel (Clinical IMCI-Nutrition) and improving family and community practices (Community IMCI-Nutrition), with a focus on social actors and their networks.

and (c) crosscutting activities, including an information and dissemination strategy and training for local authorities.

1.16 For item (b), mobile health brigades will be implemented or strengthened with personnel qualified in early stimulation and nutrition; these brigades are called for in the Intercultural Family and Community Health policy, but have not yet been implemented in all regions of the country. Based on prior evidence in Bolivia (see paragraph 1.7), this operation will provide care through individual home visits for children under 2, and group care in community centers for children over 2. This will be implemented under the regulatory framework previously established by the sector, using professionals from the mobile brigades to be expanded or built.

1.17 This component will finance the following activities: (i) equipment, educational material, and operating expenses for the home and community care modalities; (ii) education, training, and operation of human resource professionals who will provide specialized in-home and community care, and training of human resources to provide care at the health center, based on quality standards and best practices in this type of training; (iii) training of relevant local actors for the implementation and interagency coordination of the program at the local level; (iv) information and dissemination strategy for the program; and (v) development or supplementation and reproduction of guidelines, standards, curricula, and care protocols for ECD services in the planned modalities of care (Clinical IMCI-Nutrition and Community IMCI-Nutrition protocols, etc.).[17]

1.18 **Component 3. Improvement of infrastructure (US$6.45 million).** This component will be executed by the FPS and includes all design activities as well as preinvestment and investment in infrastructure for the various modalities of care used in the program, including: (i) infrastructural repairs (including improvements in basic services and safety) and equipping childcare centers;[18] (ii) infrastructural repairs and equipping of health facilities or Comprehensive Nutrition Units to provide early stimulation rooms; and (iii) infrastructural repairs and equipping of community care sites (community centers, etc.) for meetings with parents and caretakers.

1.19 **Component 4. Monitoring and evaluation (US$900,000).** This component will strengthen the planning and monitoring capacity of the executing agency and

[17] Footnote 14 applies to training activities. In developing curricula and care protocols, particularly for the modalities of care involving home and community visits, efforts will be made to improve some aspects of the gender dynamic in the households of beneficiary families—especially to raise the awareness of men (fathers or caretakers) and involve them in early stimulation activities and educational chats with parents on gender roles and behaviors, on the importance of sharing caretaking responsibilities in the home, and to secure their agreement to their children's participation in the program, including matters related to the prevention of sexual abuse. This activity is now starting to be designed with technical cooperation resources.

[18] No new childcare centers or health centers are expected to be built; rather, physical improvements will be made to existing centers in prioritized municipios, whereby local actors collaborate through interagency agreements by covering the operating costs of certain intervention modalities, infrastructure maintenance, and/or financial sustainability of the program.

relevant actors at the central and departmental levels, through financing for: (i) a registry of beneficiaries and/or ECD service provision sites; (ii) a thorough impact evaluation and process evaluation; and (iii) documentation of experiences.

1.20 **Administration and auditing (US$890,000).** Financing will be provided for a technical and fiduciary team in the MSD and FPS, operating costs, and financial auditing.

1.21 **Program cost and financing**. The total cost is US$22 million equivalent, of which the program will finance US$20 million as follows: US$15 million from the resources of the Single Currency Facility of the Bank's Ordinary Capital, and US$5 million from the resources of the Fund for Special Operations. The Plurinational State of Bolivia will provide, as counterpart resources, US$2 million equivalent. Further details about program costs are available at the link "Itemized cost table."

Table I-1. Program cost and financing (in US$)*

Investment category	IDB	Counterpart	TOTAL
Component 1. Implementation of complementary ECD services	8,978,220	1,141,140	10,119,360
Child centers subcomponent	5,750,857	31,140	5,781,997
Stimulation rooms subcomponent	1,549,751	-	1,549,751
Crosscutting support for Component 1	1,677,612	1,110,000	2,787,612
Component 2. Strengthening of existing services in the health sector	2,926,409	707,400	3,633,809
Clinical IMCI-Nutrition subcomponent	30,000	-	30,000
Community IMCI-Nutrition subcomponent	2,088,409	707,400	2,795,809
Crosscutting support for Component 2	808,000	-	808,000
Component 3. Improvement of infrastructure	6,454,559	-	6,454,559
Component 4. Monitoring and evaluation	900,000	-	900,000
Administration and auditing	740,812	151,460	892,272
TOTAL	**20,000,000**	**2,000,000**	**22,000,000**

* Financial costs, interest, and the credit fee will be paid by the borrower outside the program.

1.22 **Geographical scope.** This operation is a demonstrative program, given its limited geographic scope, based on a universe of eligible health networks and municipios. All selected health networks have an average extreme poverty rate over 65% and a municipal health index[19] under 0.55. The universe of eligible municipios may only be changed through prior coordination with the Bank. The following health networks and their corresponding municipios are eligible: Padilla, Azurduy, and

[19] The municipal health index uses a scale from 0 to 1; the better the municipio's relative health conditions, the higher the index. A score below 0.5 is considered low. The index consists of 10 different variables related to health and other social factors affecting health (e.g., education, financial poverty, and basic services). The methodology for the index is described in detail at http://www.ops.org.bo/textocompleto/nsp17172.pdf.

Camargo in Chuquisaca; and Uyuni, Uncía, Tupiza, and Ocurí in Potosí; as well as the departmental capital cities of Sucre and Potosí. The universe of eligible municipios has been prioritized using the following criteria: (i) intervention concentrated in only two departments selected by the MSD for their high poverty rates and health needs, and in municipios grouped together so as not to dilute the demonstration effect; (ii) organization of the sector into health networks that include multiple neighboring municipios through consistent institutional and functional management, thereby ensuring that only complete health networks are selected; (iii) consideration of those networks in the departments of Chuquisaca and Potosí that are eligible for other operations in execution with external financing in the area of maternal and child health, thereby ensuring complementarity in a comprehensive child development service, without the need to include investments in this area by this program; and (iv) low development indices according to the municipal health index and the extreme poverty rate, to justify a priority intervention in accordance with needs.

1.23 **Relationship with the country strategy and GCI-9.** The Bank's recently approved Country Strategy with Bolivia 2011-2015 (document GN-2631-1) identifies ECD as a priority sector. The proposed operation will directly contribute to the country strategy's objectives of supporting the development and implementation of projects that diversify ways of meeting ECD needs with an intersector approach, while seeking to improve the quality and effectiveness of the provision of ECD services and strengthen intersector management at the central and municipal levels, including the production of information for monitoring and evaluating ECD interventions. The proposal is also consistent with the sector priorities set forth in the strategy of the Ninth General Increase in the Resources of the Bank, which include the Social Policy on Equity and Productivity, with ECD as one of its areas of development.

C. Key indicators in the results matrix

1.24 The expected outcomes of the program are focused on coverage and quality indicators for the interventions, in addition to outcomes related to improved information and evaluation systems. The main outcomes are summarized in the following table:

Table I-2. Main impact and outcome indicators

Key indicators	Frequency of measurement	Rationale for selection
Percentage of children with delays in cognitive development (psychomotor and speech test) in municipios targeted by interventions.	Upon program completion (2016/2017)	Provides an impact measure (measured against the corresponding international standard) for the program objective related to children's cognitive development.
Percentage of children with chronic malnutrition in municipios targeted by interventions.	Upon program completion (2016/2017)	Provides an impact measure for the program objective related to children's physical development.
Absolute ECD coverage of children 0 to 4 in prioritized municipios[20]	Annually	Provides a measure of the outcome related to coverage of delivered ECD services.
Ratio of children 0 to 4 per qualified ECD personnel member under Community IMCI-Nutrition in prioritized municipios	Annually	Provides a measure of the outcome related to quality of the delivered service, measured in a modality where coverage is expected to be high in this program.
Rate of children 0 to 4 per trained caretaker (community-based or professional) in childcare centers in prioritized municipios	Annually	Provides a measure of the outcome related to quality of the delivered service, measured in a significant, high-cost modality planned under this program.
Percentage of personnel in childcare centers trained in quality standards and current curricula in prioritized municipios	Annually	Provides a measure of the outcome related to quality of the delivered service, measured in a significant, high-cost modality planned under this program.
Beneficiaries 0 to 4 years of age included in the ECD registry	Annually	Provides a measure of the outcome related to improvement of weak ECD information systems in Bolivia.
Impacts of the various program modalities analyzed and disseminated	Annually	Provides a measure of the outcome related to impact evaluation activities.

II. FINANCING STRUCTURE AND RISKS

A. Financing instruments

2.1 This program is an investment loan. The disbursement period for this operation is five years. Program disbursements will be made in accordance with the following schedule:

Table II-1. Disbursement schedule (in millions of US$)

Source	Year 1	Year 2	Year 3	Year 4	Year 5	Total	%
IDB	0.52	6.81	8.61	3.43	0.63	20.0	91
Local	0	0.04	0.95	0.97	0.04	2.0	9
Total	**0.52**	**6.85**	**9.56**	**4.40**	**0.67**	**22.0**	**100**

[20] This rate includes children 0 to 4 in prioritized municipios served by: (i) ECD services in stimulation rooms; (ii) ECD services in childcare centers; (iii) ECD services as part of Clinical IMCI-Nutrition; and (iv) in-home ECD services as part of Community IMCI-Nutrition.

2.2 Post-program financial sustainability will be strengthened through a special condition for execution requiring the submittal of evidence that 100 job positions for government officials in child development in the health sector have been created and/or reassigned, as follows: (i) the first 50 government positions, when 70% of the loan proceeds have been disbursed or at the end of year three of program execution, whichever occurs first; and (ii) the remaining 50 positions when 90% of the loan proceeds have been disbursed or at the end of year four of program execution, whichever occurs first.

B. Environmental and social safeguard risks

2.3 No potential adverse environmental impacts were identified, as this operation only involves minimal adaptations and adjustments of infrastructure. Thus, in accordance with the Bank's Environment and Safeguards Compliance Policy (OP-703), this has been classified as a Category "C" operation. If, in view of ongoing diagnostic assessments, the need for larger-scale works arises during the approval and ratification processes for this operation, or on its path toward eligibility in 2012, this classification will be revised. The project team will ensure compliance with the Operational Policy on Indigenous Peoples (OP-765) during the program, especially as it pertains to cultural appropriateness and intercultural adaptation of ECD services and delivery modalities to protect traditional indigenous culture, identity, language, and knowledge (in accordance with paragraph B.4.4.e of policy OP-765). Service providers will be from the same communities or will be familiar with the culture and will be able to speak the languages of the beneficiary population. The educational materials will be designed with attention to intercultural considerations and will be produced in both the local language and Spanish.

C. Fiduciary risks

2.4 Both of the program's executing agencies, the FPS and the MSD, have fiduciary capacity and experience in implementing multiple programs with international financing, for Bank programs as well as programs of other financing entities. However, experience with loans 1839/SF-BO and 2252/BL-BO, which are ongoing, and the updated analysis of the Institutional Capacity Assessment System indicate that considerable fiduciary risks remain, along with considerable room for improvement in responsive and efficient program execution. In the effort to identify and evaluate risks, which was performed jointly with the executing agency, four fiduciary risks were identified, three of them at the medium or high level. They include: (i) the risk of financial delays in budgeting by the MSD; (ii) delays in completing procurement processes on schedule; and (iii) a potential lack of knowledge of policies and procedures related to procurement processes with external financing. As mitigation measures, the Operating Regulations will require early budgeting in October of the previous fiscal year, and will contain provisions to help establish a timetable and process for early budgeting, the functional continuity of the fiduciary team of the Project and Program Management Unit at the MSD, and installation of the initial team of the Early Childhood Development

Technical Unit (UDIT) with nonreimbursable technical assistance before loan proceeds are executed. The UDIT will be made operationally functional (see paragraph 3.2 and Annex III) and will be provided outside assistance in preparing bid documents, and the MSD's administrative and legal personnel will be trained in the Bank's procurement policies.

D. Other considerations and risks

2.5 **Nonfiduciary risks.** Nine nonfiduciary risks, seven of which are at the medium or high level, were identified and evaluated. They include: (i) potential delays in ratification of the loan by Congress; (ii) still limited appropriation of the field of ECD, its investment needs, and high rates of social and economic return on these investments by country officials; (iii) potential difficulties in maintaining the municipios' commitment to provide complementary resources, for sustainability and maintenance of the works, basic services, and municipal human resources in child development; and (iv) weak mechanisms for recording and monitoring coverage and outcomes in child development at the national level. Identified mitigation measures include advocacy and publicity activities with officials, sound design of agreements with municipal and departmental governments in a participatory manner with municipios' executive and legislative branches, and creation of a registry of ECD beneficiaries and/or services with program resources.

2.6 **Financial sustainability of the program.** The high-level risks that were evaluated include the sustainability of human resources involved during and after program execution. Though this type of program promises high long-term rates of economic return (see paragraphs 1.4 and 2.6), achieving these returns requires special attention to quality standards in care and qualified human resources, which entails hiring and training suitable professional and technical personnel. This makes it necessary to ensure that these investments are sustainable by promoting the partial absorption of human resources trained during the program out of the national budget after the end of the operation. The corresponding agreement is reflected in the special condition for execution requiring the creation and/or reassignment of 100 job positions for government employees in child development, the number and priority functions of which were determined by the sector.

2.7 **Economic evaluation of the program.** The economic evaluation (a cost-benefit analysis of planned investments) identified economic benefits in three areas: nutrition, cognitive and motor development, and psychosocial development in children under 4. The effects of the interventions in these three areas lead to higher future income from employment, through intermediate effects on the schooling of beneficiary children. The estimated increase in income is 1.25% due to nutrition, 3.34% due to expected improvements in cognitive skills, and 2.2% due to increased psychosocial skills. The estimated aggregate effect of investments in nutrition, cognitive development and motor skills, and psychosocial development on beneficiaries' future wages is a 6.79% wage increase. In view of program costs per modality and component, estimated coverage per modality of care, and assumptions of limited absorption and compensation capacity in the rural and periurban labor

market, the aggregate benefit/cost ratio for the program as a whole ranges from 1.02 to 1.15, depending on the scenario. If less conservative assumptions of progress in labor market development are used, the net present value and rates of return would be higher.

III. IMPLEMENTATION AND MANAGEMENT PLAN

A. Program execution and administration

3.1 The Ministry of Health and Sports (MSD) is organized into three vice ministries, which have bureaus that in turn are organized into various technical units. For example, under the Vice Ministry of Health and Promotion there is the Health Services Bureau, which contains various units, including the Health Services and Quality Unit.

3.2 The MSD will be the executing agency and will carry out program activities through an Early Childhood Development Technical Unit (UDIT) established to execute the program within the functional structure described above, but with sufficient administrative, legal, and financial capacity to ensure that it is operationally functional. The UDIT will be supported by the Project and Program Management Unit (UGESPRO) in fiduciary matters.[21] The UDIT will be under the MSD's Vice Ministry of Health and will have responsibilities related to technical and administrative coordination. Its duties will include: (i) making technical decisions related to program execution; (ii) preparing annual work plans for inclusion in the country's general budget; (iii) requesting and authorizing operation-related payments; (iv) submitting disbursement requests and audited financial statements to the Bank; (v) preparing initial, semiannual, and other Bank-required reports and making them available to the public; and (vi) complying with provisions of the loan contract. UGESPRO, in supporting the UDIT, will have the following duties: (i) taking the steps needed to process the loan and prepare, on an annual basis, the budget to be executed; (ii) opening separate bank accounts and maintaining accounting records; (iii) conducting bid processes; (iv) making payments to suppliers and contractors; and (v) preparing bank conciliations and financial reports for the program.

3.3 In addition to its Chief, the UDIT will include a technical coordinator with responsibilities for planning, management, administration, and general coordination of the program, and at least two other people with technical profiles related to child development. It will also include an attorney and an administrative official. Also, as this program will increase UGESPRO's workload, it will be strengthened with additional personnel in accounting/financial management and procurement, and with equipment and supplies to help it take on additional fiduciary responsibilities for this operation. In addition to the UDIT's operational, administrative, and

[21] UGESPRO has already been established as part of the Administrative Affairs Bureau, and it has responsibilities in budgeting, accounting/finance, and procurement for the execution of MSD projects financed with external funds. It does not, however, make technical or operational decisions.

financial sufficiency for ensuring more flexible execution, the UDIT will have outside support in the form of specialized technical assistance, both national and international, from a group of advisers and consultants per output who will provide specialized technical advisory services and technical and scientific inputs, and who will support the UDIT in designing and planning activities and developing terms of reference and bid documents. The Operating Regulations will detail the duties of, and the complementarity between, the UDIT and UGESPRO. The following will be special conditions precedent to the first disbursement: **(i) regulatory evidence of the creation of the UDIT as described in paragraphs 3.2 and 3.3; and (ii) approval and entry into force of the program Operating Regulations under terms previously approved by the Bank.**

3.4 Infrastructure works (repairs, expansion, remodeling) and equipping of health centers, childcare centers, and community rooms for the program will be executed by the FPS in its capacity as coexecuting agency. As a special condition precedent to the first disbursement for Component 3, a subsidiary agreement must be signed by the Ministry of Economy and Public Finance and the Ministry of Development Planning with the FPS, delegating to the FPS the responsibility for executing the infrastructure and equipment activities for Component 3 under the supervision of the MSD, which must be completed before the resources allocated to the FPS are executed. The Operating Regulations will set forth the parties' responsibilities and duties, as well as the execution mechanism for the program.

3.5 In addition, the Early Childhood Development Advisory Committee will be formed and given the technical authorities designated by the Minister of Health and Sports. This committee will support and monitor the program and will ensure that it remains consistent with other health policies.

3.6 At the departmental level, a departmental program coordinator will be placed at the office of the Departmental Health Service, as coordination liaison. The role and function of this coordinator will be laid out in the Program Operating Regulations. The coordinator will not have fiduciary duties and will not provide services to the public, nor will resources be executed through departmental governments or services. In each municipio, the municipal autonomous government will be responsible for providing facilities and basic services to health establishments and childcare centers, cleaning and maintaining facilities, and using its own resources to provide in-kind inputs to complement ECD services, by agreement between the municipal government and the Departmental Health Services, as appropriate. These relationships will be governed by management agreements between the MSD, the Departmental Health Service, and the Departmental Social Management Service, and between these departmental services and the municipal autonomous government. The link "Detailed execution plan" provides detailed information on the participation of departmental and municipal entities.

B. Monitoring and evaluation arrangements

3.7 The essential elements of the monitoring plan for this program are, first, the creation of a registry to monitor the delivery of comprehensive child development services (benefits) and/or a registry of beneficiary children. This will help monitor progress in the various interventions planned for this age group, as well as progress in coverage. Second, a supervision system will be created with resources from the departmental governments (the Departmental Health Service and the Departmental Social Management Service), with qualified personnel and with protocols and procedures for documenting information, which will improve the available information and the quality and implementation of services offered at the local level.[22]

3.8 In addition, the impact of the program's three main interventions on variables of interest for children under 4 (chronic malnutrition, cognitive and social/emotional development, etc.) will be evaluated to assess and compare the effectiveness of these modalities and to compare the effects of variations in implementation.[23] The three interventions to be evaluated are: (i) childcare centers; (ii) home and community visits as part of the Intercultural Community and Family Health policy; and (iii) specialized stimulation rooms in health centers to treat children with delays. The methodology will be based on various strategies for randomizing interventions at the level of childcare centers, municipios, and referrals to stimulation rooms, as appropriate. Once the control group is created, the difference-in-difference estimator assumes that, in the absence of treatment, the average difference in the outcome variable between the treatment group and the control group would remain constant. The electronic link "Monitoring and evaluation plan" provides the research questions and more information on this plan.

C. Design activities during execution

3.9 Though the health sector has a track record in implementing ECD components as part of its IMCI-Nutrition policies, this represents a new area of intervention for the MSD in terms of comprehensive operational implementation, including early stimulation. The program, therefore, includes an initial phase for developing guidelines, care protocols, curricular standards, preinvestment studies, etc. In particular, design activities during execution include: a care protocol for stimulation rooms, a curricular standard and quality standards for childcare centers, a care protocol for Community IMCI-Nutrition for home visits, preinvestment studies for repairs, design of a system for training supervision, for the registry of beneficiaries and benefits, and for the communication strategy.

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[22] These and other aspects of program monitoring are currently being designed.

[23] Both the comparison of modalities of care in a given context and the comparison of operational variations in each modality constitute a void in the academic literature on impact evaluations in child development, and are part of the current research agenda of the Bank's Social Sector. The findings of the evaluation will help adjust the operational design of each modality and make strategic decisions on the massive expansion of some modalities over others, in a future nationwide program based on effectiveness and costs.

Development Effectiveness Matrix			
Summary			
I. Strategic Alignment			
1. IDB Strategic Development Objectives	Aligned		
Lending Program	(i) Small and vulnerable countries, and (ii) Reduce poverty and to promote social equity.		
Regional Development Goals	(i) Reduce extreme poverty rate, and (ii) Increase share of children that complete ninth grade.		
Bank Output Contribution (as defined in Results Framework of IDB-9)	Aprox. 25,000 children 0-4 will benefit from ECD programs.		
2. Country Strategy Development Objectives	Aligned		
Country Strategy Results Matrix	GN-2631-1	Lower the gap in coverage, information on suppliers and indicators for ECD.	
Country Program Results Matrix	GN-2617	In preparation.	
Relevance of this project to country development challenges (If not aligned to country strategy or country program)			
II. Development Outcomes - Evaluability	Highly Evaluable	Weight	Maximum Score
	8.9		10
3. Evidence-based Assessment & Solution	7.6	25%	10
4. Ex ante Economic Analysis	10.0	25%	10
5. Monitoring and Evaluation	7.9	25%	10
6. Risks & Mitigation Monitoring Matrix	10.0	25%	10
Overall risks rate = magnitude of risks*likelihood	Medium		
Environmental & social risk classification	C		
III. IDB´s Role - Additionality			
The project relies on the use of country systems (VPC/PDP criteria)	Yes	Budget and Treasury.	
The project uses another country system different from the ones above for implementing the program			
The IDB's involvement promotes improvements of the intended beneficiaries and/or public sector entity in the following dimensions:			
Gender Equality			
Labor			
Environment			
Additional (to project preparation) technical assistance was provided to the public sector entity prior to approval to increase the likelihood of success of the project	Yes	BO-T1114; additional to technical assistance and fiduciary trainings to the two executing agencies (MSD-UGESPRO and FPS) under loan in execution (2252/BL-BO, 1839/SF-BO).	
The ex-post impact evaluation of the project will produce evidence to close knowledge gaps in the sector that were identified in the project document and/or in the evaluation plan.	Yes	The comparison between models in a given context, and variations in the implementation of a model is a significant knoledge gap that will be addressed in the evaluation of this project. The results will support the design of each model and will inform strategic decisions on the scale up of some models based on the effectiveness and cost.	

This is an investment loan for Bolivia, which contributes to the objective of lending to small and vulnerable countries. The project is financed by ordinary capital and special operations fund. It aims to increase coverage of Early Childhood Education programs and to improve information on the sector, thus contributing to reduce extreme poverty and enhance equity, and improving schooling perspectives among participants. The project is aligned to the priorities of the government and to the Bank´s Country Strategy with the country.

The loan proposal presents a good description of the social background of children in the country, as well as evidence on the importance of investing in early childhood programs. It also describes the existing supply and the challenges in terms of coverage and quality of the system. All of this is analyzed in the legal and institutional context that poses challenges in Bolivia. The document emphasizes the cultural pertinence of services, and the proposed solutions are well developed and backed with evidence and analyses. Being this a demonstrative project, monitoring and evaluation will allow assessing scaling up alternatives.

The project has an adequate and solid logic as it proposes technically founded solutions. The results matrix has adequate indicators. The Monitoring and Evaluation Plan and the Economic analysis are adequate, and they will allow monitoring and measuring the impact of the interventions proposed. The risk matrix is adequate, with mitigation measures and indicators to monitor them.

RESULTS MATRIX

Project objective	The general objective of the program is to help improve the cognitive, social, emotional, and physical development of Bolivian children in a way that is sustainable and culturally appropriate. More specifically, it seeks to implement a model early childhood development program through improved access and higher quality of care for children under 4.

Impact	Baseline	Final target	Comments
Percentage of children with delays in cognitive development (psychomotor and speech test) [1] (in municipios targeted by interventions).	Forthcoming	Increase of 5%–6% of one standard deviation [2]	The indicator will be disaggregated by sex and culturally appropriate in terms of its measurement instrument. Source: Baseline to be determined after the 2011 baseline indicator becomes available through the impact evaluation of the Juana Azurduy subsidy program, which is currently being executed as part of loan 2252/BL-BO. The target will be measured in the impact evaluation of the program.
Percentage of children with chronic malnutrition (in municipios targeted by interventions).	21% (2008)	17%	The indicator will be disaggregated by sex. Source: The baseline is from the 2008 National Demographic and Health Survey and is for the nationwide population 6 to 24 months of age. It will be revised after the 2011 baseline becomes available from the impact evaluation of the Juana Azurduy subsidy program, which is currently being executed as part of loan 2252/BL-BO. The target will be measured in the impact evaluation of the program.

Outcome	Baseline	Year 1	Year 2	Year 3	Year 4	Year 5	Final target	Comments
Improved access for children under 4 to ECD services								
Absolute ECD coverage of children 0 to 4 in prioritized municipios[3].	0	0	0	16,200	16,200	0	25,200	The indicator will be disaggregated by sex. Stimulation rooms: 9,000 (30 teams*300), different children served in each year of the program. Community visits: 7,200 (180 educators*40), same children served in each year of the program [4]. Source: MSD semiannual progress report, with data from each Departmental Health Service.
Beneficiaries 0 to 4 years of age included in the national ECD registry.	0	0	0	0	4,625	4,625	4,625	The indicator will be disaggregated by sex. All children born in health institutions, and at least 25% of the children who will participate in the ECD modalities, are in the registry.

Outcome	Baseline	Year 1	Year 2	Year 3	Year 4	Year 5	Final target	Comments
Improved quality of available ECD services								
Ratio of children 0 to 4 per qualified ECD personnel in Community IMCI-Nutrition in prioritized municipios	n/a	n/a	n/a	40	40		40	Based on cost and size of brigades, 40 children per educator and week in mobile brigade (footnote 4 applies). Source: MSD semiannual progress report, with data from each Departmental Health Service.
Ratio of children 0 to 4 per trained caretaker (community or professional) in childcare centers in prioritized municipios[5]	XX	XX	XX	7 children 0-2 per adult 11 children 2-4 per adult	7 children 0-2 per adult 11 children 2-4 per adult	7 children 0-2 per adult 11 children 2-4 per adult	7 children 0-2 per adult 11 children 2-4 per adult	Average baseline value to be determined in accordance with the baseline from the impact evaluation. Target based on exceptional ratios at Bolivia's best current childcare centers. Source: MSD semiannual progress report, with data from each Departmental Health Service.
Percentage of personnel at childcare centers trained in quality standards and current curricula in prioritized municipios	0	0	5%	20%	25%	25%	75%	The indicator will be disaggregated by sex. Includes current personnel (community caretakers).

Outputs	Baseline	Year 1	Year 2	Year 3	Year 4	Year 5	Final target	Comments
Component 1. Implementation of complementary early childhood development (ECD) services								
1.1 Childcare center subcomponent								
1.1.1 Caretakers trained in curriculum of childcare centers	0	0	0	270	306	0	576	The indicator will be disaggregated by sex. 306 community caretakers (10 children per caretaker), 180 qualified educators, and 90 nutrition specialists at 90 centers; indicator differentiated by sex.
1.2 Stimulation room subcomponent								
1.2.1 Specialized personnel trained in delay-related interventions	0	0	0	60	60	0	60	The indicator will be disaggregated by sex. 2 persons on each of 30 teams, and (re)hired annually.

Outputs	Baseline	Year 1	Year 2	Year 3	Year 4	Year 5	Final target	Comments
1.3 Crosscutting support for Component 1								
1.3.1 Standards and protocols developed and approved	0	0	0	2	0	0	2	Centers (quality standards, standard curricula), rooms (protocol).
MILESTONE 1.3.1.1: Quality standard developed for infrastructure at childcare centers	0	0	1	0	0	0	1	
1.3.2 Agreements signed between MSD, FPS, autonomous departmental government (SEDEGES, SEDES), and autonomous municipal government	0	0	0	1	0	0	1	Autonomous municipal government: on infrastructure at community room/childcare centers, minimum wage for caretaker at centers, basic services, maintenance. SEDES/SEDEGES: supervision service.
1.3.3 SEDES and SEDEGES training supervision system implemented	0	0	0	1	0	0	1	
1.3.4 Municipal fund for child development up and running	0	0	0	25%	50%	25%	100%	With regulations established on the basis of the regulations of the "Zero Malnutrition" program. Interpretation of the measurement of percentage progress (in financial terms of the fund's resources, or in terms of the number of total projects planned for the fund) will be determined after the regulations and detailed costs are finalized.
MILESTONE 1.3.4.1: Regulations and procedures for municipal ECD fund finalized, including eligible model projects	0	0	1	0	0	0	1	
Component 2. Strengthening of existing services in the health sector								
2.1 Clinical IMCI-Nutrition subcomponent								
2.1.1 Health care personnel trained to use ECD protocols and instruments	0	0	0	700	0	0	700	The indicator will be disaggregated by sex. The networks in the city of Potosí City and in Tupiza, Uyuni, and Uncía in Potosí department have about 174 health establishments, and the networks in Sucre, Azurduy, Padilla, and Camargo in Chuquisaca have some 197 health establishments (average 2 persons each).

Outputs	Baseline	Year 1	Year 2	Year 3	Year 4	Year 5	Final target	Comments
2.2 Community IMCI-Nutrition subcomponent								
2.2.1 Personnel of ECD mobile brigades operating under Community IMCI-Nutrition	0	0	0	180	180	0	180	The indicator will be disaggregated by sex. 60 brigades to 3 educators, on average.
2.3 Crosscutting support for Component 2								
2.3.1 Standards and protocols developed and approved	0	0	0	2	0	0	2	Clinical IMCI-Nutrition (promotion of growth and identification of delays), Community IMCI-Nutrition (protocol for home and community visits to promote growth).
MILESTONE 2.3.1.1: Consulting services commissioned for specialized technical assistance	0	2	2	1	0	0	5	
2.3.2 Personnel at sector and local entities trained in the ECD program	0	0	0	500	500	0	1,000	The indicator will be disaggregated by sex. Estimated coverage of key actors (in health, education, child advocacy, mayoral office, departmental government, social organizations).
2.3.3 The program's information, education, and dissemination strategy implemented	0	0	0	1	0	0	1	
Component 3. Improvement of infrastructure								
3.1 Centers reconditioned and equipped in accordance with standards	0	0	0	40	50	0	90	
3.2 Early stimulation rooms installed and equipped	0	0	0	0	60	0	60	The 30 professional teams working in the 60 rooms will serve an estimated 9,000 children per year (300 per team).
Component 4. Monitoring and evaluation								
4.1 Registry of beneficiaries and provision sites, developed and implemented	0	0	0	1	0	0	1	
4.2 Participatory documentation of experiences, commissioned	0	0	0	0	1	0	1	

Outputs	Baseline	Year 1	Year 2	Year 3	Year 4	Year 5	Final target	Comments
4.3 Impact and process evaluation commissioned	0	0	0	0	0	1	1	
Administration and auditing	ONLY FOR COSTING; NO ANNUAL TARGETS (in accordance with the Progress Monitoring Report format)							
Team in execution/coordination unit and departmental personnel								
Audit								

1. Delays will be measured against the corresponding international standard. For measurement purposes, an instrument such as the ASQ-3 (Age and Stage Questionnaires, 3rd Edition) will be used for evaluations from 0 to 60 months in at least five areas: communication, gross motor skills, fine motor skills, problem solving, and personal/social relations. They are easy to understand and use, they are available in Spanish, and they are supported by international organizations (American Academy of Neurology, Child Neurology Society, First Signs), which describe them as high-quality instruments for monitoring child development; they have also been validated through implementation in countries with conditions similar to those in Bolivia. To ensure effective measurement in various cultural contexts in Bolivia, the measurement instruments are being adapted to the local language.

2. We base our estimate on similar evidence in Latin America. Though the intervention is different, the average effect of Ecuador's human development subsidy for cognitive and behavioral measures (vocabulary, memory, and visual integration tests, and the scale behavioral problems) was only 5% of one standard deviation with a standard error of 7%. The average effect of physical measures (hemoglobin, height, and fine motor control) was 6% of one standard deviation with a standard error of 7% (Paxson and Schady, 2010). These outcomes are relatively modest.

3. This indicator includes all children 0 to 4 in prioritized municipios served by: (i) ECD services in stimulation rooms; and (ii) at-home and community ECD services as part of Community IMCI-Nutrition. Coverage in childcare centers is excluded because this is not additional coverage to that which already exists, but rather an improvement in care.

4. In stimulation rooms and home visits, the coverage targets refer to the capacity that, in view of operating costs and size, would be reached by the planned interventions, even in the absence of certainty as to actual demand, the existence of delay cases, and the logistical feasibility of achieving that coverage in the intervention area. Due to a lack of relevant data in Bolivia, coverage targets will be revised after completion of the field study that is currently ongoing, for a diagnostic assessment by sampling of conditions in the intervention areas. As soon as the total number children is known, along with factors such as distance and accessibility that affect coverage in logistical and operational terms in the intervention areas, absolute targets may be converted to net rates.

5. The four most important proxy variables of quality of services in child development centers (and which enjoy academic consensus) are class size, human capital of the teacher/caretaker, ratio of children to teacher/caretaker, and curriculum content and application (Kagan, 2010). Given the nature of the intervention in Bolivia, it makes sense to combine the first three variables into one and examine the percentage increase in trained personnel separately, in view of the emphasis on training with quality protocols.

FIDUCIARY AGREEMENTS AND REQUIREMENTS

Country:	The Plurinational State of Bolivia
Project number:	BO-L1064, "Grow Well to Live Well" Early Childhood Development Program
Executing agency:	Ministry of Health and Sports and the National Productive and Social Investment Fund
Prepared by:	Roberto Laguado (PRM) and Zoraida Argüello (FM)

I. EXECUTIVE SUMMARY

1.1 The institutional capacity analysis of the Ministry of Health and Sports (MSD) applied the methodology adopted by the Bank for the Institutional Capacity Assessment System. Based on the Bank's knowledge of the MSD's performance on other Bank-financed operations, it may be concluded that the MSD has medium Development capacity and medium fiduciary risk.

1.2 However, in fiduciary matters the MSD has low capacity for executing the program, in view of the current institutional framework for executing an additional program. It is recommended, therefore, that its financial and procurement areas be strengthened with trained personnel, and that a technical unit be created specifically for the program. The levels of delegation and authorization of duties should be adjusted between this newly created Early Childhood Development Unit (UDIT) and the Project and Program Management Unit, which will carry out the program's fiduciary activities within the MSD. These delegation and coordination efforts for the program will be agreed upon and set forth in the Operating Regulations for the sake of effective program functioning.

1.3 The program will not have other external financing. It will be executed by two government entities, the MSD and the National Productive and Social Investment Fund (FPS), and the FPS will be the coexecuting agency for infrastructure investments. Each entity will manage its own financial information, including for progress reports. Both participating entities will be audited, but a single consolidated audit report will be submitted.

II. FIDUCIARY CONTEXT OF THE EXECUTING AGENCY

2.1 Law 1178 on Governmental Administration and Oversight of 20 July 1990, known as the SAFCO Law, governs the systems of administration and control over national resources and their relationship with country planning and public

investment systems. It establishes the subsystems for planning (programming of operations, administrative organization and budgeting), execution (treasury and public credit, integrated government accounts, personnel management, administration of goods and services), and government control (internal and external control). Application of this law is mandatory.

2.2 Although the systems contribute to comprehensive and transparent execution of public finances, there are areas in which further strengthening is required, such as:

2.3 **Government accounting.** The integrated administrative management and modernization system (SIGMA) provides information on budgetary execution in a reliable and secure form. However, it still lacks a reporting module for international cooperation purposes, one that recognizes the investment categories established in the loan contracts and issues reports that comply with the financial monitoring and evaluation requirements of the Bank or other cooperation organizations and in multiple currencies, for the purpose of monitoring budgetary execution of projects.

2.4 **Governmental oversight.** Governmental oversight is exercised through the Office of the Comptroller General (CGE), which has scant human resources for performing ongoing and timely reviews of projects funded with resources from multilateral cooperation agencies.

2.5 **Administration of goods and services (procurement).** The system of basic rules for the procurement of goods and services and its local regulations are not used in Bank operations, though discussions have begun with the Ministry of the Economy and Public Finance (MEFP) to use them in Bolivia. Therefore, the MSD's fiduciary capacity for procurement is low. The FPS is expected to participate in infrastructure-related procurement processes; the FPS was created by the Government of Bolivia to carry out all bidding processes, contracting, and supervision of works by agreement between the agencies of the central government and the FPS. The FPS has the fiduciary capacity to perform these activities.

III. FIDUCIARY RISK EVALUATION AND MITIGATION MEASURES

3.1 The MSD has a Program and Project Management Unit (UGESPRO) that is responsible for executing projects financed by external sources. In UGESPRO, World Bank and IDB projects have a team that specializes in SIGMA procedures, national procurement requirements, and Bank policies and procedures. Payments from the financing and the local counterpart can be made directly through SIGMA. However, this process creates delays because procurement authorizations require the administrative step of turning to the Administrative Affairs Bureau (DGAA) and the Legal Affairs Bureau (DGAJ), which leads to delays in executing processes.

Fiduciary risks

3.2 **Coordination.** To avoid problems and adverse situations in the relationship with the DGAA and the DGAJ, the Operating Regulations will provide flow diagrams with functions to help shorten processes (legal and administrative) and the coordination mechanism to which the parties involved in the implementation of the program will be subject.

3.3 **Public procurement.** A regular turnover of local authorities has been observed, which compromises the transmission and continuity of procurement know-how. Procurement personnel and legal personnel will therefore be trained in the application of the Bank's procurement policies (documents GN-2349-9 and GN-2350-9).

3.4 **Procedural delays and overburdened internal processes in legal matters.** The personnel in the entity's legal offices need to strengthen their knowledge of fiduciary management in Bank requirements, so as not to slow processes in Bank-financed projects. To mitigate this risk, an attorney with knowledge and experience in Bank-financed programs will be hired.

3.5 **Public financial management.** The integrated government chart of accounts, developed in the SIGMA public finance system, provides a basis allowing expenses to be recorded under budget headings and effective handling of expenditure recording and monitoring. It also allows the use of the program funds, managed through the Single Treasury Account (CUT), to be monitored. This system provides an adequate basis for external auditors to issue an opinion on the accounting records. The IDB Integrated Project Administration System (SIAP) will be used to generate financial execution and loan investment reports (investment category, currency type, accounting basis, etc.).

IV. CONSIDERATIONS FOR THE SPECIAL CONDITIONS OF THE CONTRACT

4.1 **Program Operating Regulations.** The execution arrangement and information flows between the UDIT and UGESPRO, as previously agreed between the parties and the Bank, need to be included, along with procurement procedures.

4.2 **Exchange rate agreed with the executing agency for financial statements delivered**. The exchange rate used will be that in effect in the borrower's country on the effective date of the payment in the currency of the borrower's country.

4.3 **Financial statements and other audited reports.** An annual operational audit will be performed to verify and validate compliance with procedures and agreements in program execution.

V. AGREEMENTS AND REQUIREMENTS FOR PROCUREMENT EXECUTION

5.1 **Procurement execution.** Procurement will be governed by the policies set forth in document GN-2349-9 and GN-2350-9, to which no exceptions are foreseen. The use of the electronic dissemination mechanism SICOES is considered acceptable.

5.2 **Procurement of works, goods, and nonconsulting services.** Contracts for works, goods, and nonconsulting services arising as a result of the project and subject to international competitive bidding (ICB) will conform to the standard bidding documents issued by the Bank and authorized by the Bank's Country Office in Bolivia. Bidding subject to national competitive bidding (NCB) will be executed using national bidding documents agreed upon with the Bank (or satisfactory to the Bank, if not agreed to date). In the case of shopping, the standard documents prepared by the Bank's Country Office in Bolivia will be used. These will be included as part of the Operating Regulations. Any amendments to these documents will require the Bank's no objection.

5.3 **Selection and contracting of consultants.** Consulting services contracts arising under the project will be listed in the initial procurement plan and executed using the standard request for proposals issued by the Bank or agreed with it (or satisfactory to the Bank if not agreed to date).

(i) **Selection of consulting firms:** The Standard Request for Proposals (RFP) issued by the Bank will be used for the project;

(ii) **Shortlist of consulting firms:** This list may be comprised solely (100%) of Bolivian firms[1] in the case of contracts for a value of less than the threshold amounts set by the Bank for the country. For Bolivia, this threshold is US$200,000;

(iii) **Selection of individual consultants:** Individual consultants are selected on the basis of their qualifications for the assignment, through a comparison of the qualifications of at least three candidates. For Bolivia, if the executing agency deems it advisable, SICOES may be used to disseminate announcements for the selection of individual consultants. For the mass-scale contracting of consultants with basic qualifications, the program may rely on service contractors (document GN-2350-9, paragraph 3.21), as set forth in the Operating Regulations if applicable. If mass-scale contracting is used, a complementary fiduciary arrangement will be needed for on-time, quality execution.

5.4 The program sector specialist will be responsible for reviewing the terms of reference for the contracting of consulting services. Moreover, the specialist will indicate whether it is advisable to have external support available to assist the

[1] Foreign firms will not be barred from participating.

executing agency during bid evaluation, in view of the nature and technical complexity of the procurement in question.

5.5 **Recurring expenses.** These are operating and maintenance costs necessary for program operation during its lifetime and cover, *inter alia,* expenses relating to: lease of offices, cost of public services, radio, press or television communication, translations, bank charges, basic office supplies, cost of advertising, photocopies, mail, fuel, and short courses. These will be funded by the project within the annual budget approved by the Bank and included in the program's procurement plans. Recurrent expense items will be contracted following the executing agency's administrative procedures, subject to expense eligibility reviews. A report on the expenses incurred under this heading will be submitted to the Bank each quarter.

5.6 **Direct contracting.** For the sake of efficiency and rapid execution, expenses less than US$500 each, and which as a block do not exceed US$5,000, may be contracted directly. These expenses must be approved by the team leader in the procurement plan. If required, specialized personnel may be hired to provide support during the fulfillment of conditions precedent, depending on the specialty in question.

Table of threshold amounts (US$)

Works			Goods[2]			Consulting services	
International competitive bidding	**National competitive bidding**	**Shopping**	**International competitive bidding**	**National competitive bidding**	**Shopping**	**International publicity consulting**	**100% national shortlist**
Greater than 3,000,000	Less than or equal to 3,000,000	Less than 250,000	Greater than 200,000	Less than or equal to 200,000	Less than 50,000	Greater than 200,000	Less than or equal to 200,000

Main procurement items

Activity	Procurement method	Estimated date	Estimated amount
Goods			
Games and game materials	ICB	I - 2013	652,950
Educational material	ICB	I - 2013	408,720
Equipment and furnishings for development centers	ICB	I - 2013	401,742
Office supplies	NCB	I - 2013	57,930
Growth checkup materials	NCB	I - 2013	170,750
Office equipment (computer and other)	NCB	I - 2013	196,571
Inputs for nourishment	NCB	I - 2013	170,681
Equipment for implementation of ECD registry	NCB	II - 2013	150,000
Works			
Improvement of 45 centers in department 1	NCB	I - 2014	1,575,000
Improvement of 45 centers in department 2	NCB	I - 2014	1,575,000
Improvement of 70 early stimulation rooms	NCB	I - 2014	1,225,000

[2] Includes nonconsulting services.

Main procurement items

Activity	Procurement method	Estimated date	Estimated amount
Nonconsulting services			
Printing and distribution of standards and protocols; reproduction and dissemination of the Community IMCI-Nutrition methodology	ICB	I - 2013	500,000
Firms[3]			
Development of the quality standard for infrastructure in childcare centers, curricular design by age and other standards (management, safety, financial, etc.); for delay treatment rooms, care protocol, and other standards; complementation of the Community IMCI-Nutrition methodology (including protocol for home and community visits, differentiated by age); complementation of the Clinical IMCI-Nutrition protocol	QCBS	I - 2012	290,000
Development of final designs for centers and rooms—preinvestment (architectural and functional design)	QCBS	I - 2013	306,250
Supervision of centers and rooms (improvements to infrastructure)	QCBS	II - 2013	218,750
Design of the registry, including ECD indicators and coordination with the National Health Information System and the Education Information System	QCBS	I - 2013	250,000
Impact and process evaluation commissioned/baseline	QCBS	II – 2012	225,000
Monitoring survey	QCBS	II – 2015	225,000
External audit	QCBS	II – 2012	110,000
Development and implementation of strategy design	QCBS	I – 2012	150,000
Implementation of training of professionals and caretakers	QCBS	I – 2013	288,000
Initial ECD education/training	QCBS	I – 2013	90,000
Design of supervision system (methodology, protocols, and supervision plan)	CQS	I – 2013	50,000
Participatory documentation of experiences	CQS	I – 2015	50,000
Design of training with curriculum for professionals and community caretakers at childcare centers and mobile brigades	CQS	I – 2013	80,000
Training of SEDES/SEDEGES personnel	CQS	I – 2013	68,000
Design and execution of training for the outcome of health personnel trained to use ECD protocols and instruments	CQS	II – 2012	30,000
Design and implementation of training—certificate program	CQS	I – 2013	68,000
Individuals			
Specialized technical or professional personnel (auxiliary nurse, nutritionist, elementary or nursery school teacher) for childcare centers	NCQS	I – 2012	685,440
Specialized technical or professional personnel (auxiliary nurse, nutritionist, elementary or nursery school teacher) for childcare centers	NCQS	II – 2013	4,697,417
Technical or professional personnel (psychomotor and speech therapist)	NCQS	II – 2013	822,857
Supervisory personnel	NCQS	II – 2013	154,286

[3] In the case of consulting services, this means the shortlist comprises firms of various different nationalities. See the "Policies for the Selection and Contracting of Consultants Financed by the Inter-American Development Bank" (document GN-2350-9), paragraph 2.6.

Main procurement items

Activity	Procurement method	Estimated date	Estimated amount
Technical or professional personnel (auxiliary nurse, elementary or nursery school teacher) for the brigades	NCQS	II – 2013	1,851,429
Specialized technical assistance	ICQS	II – 2012	250,000
Human resources for the UDIT	NCQS	II – 2012	321,429
Human resources for the Departmental Health Services	NCQS	II – 2012	116,571
Human resources for UGESPRO	NCQS	II – 2012	164,572
Subprojects			
Autonomous municipal government municipal fund		2014-2015-2016	1,867,326
FPS overhead		II – 2012	234,063

5.7 Individual consultants will be contracted through mass-scale bidding processes with long lists.

5.8 **Procurement supervision.** Ex post reviews will be used for the FPS up to 100% of the NCB threshold. Ex post reviews will be used for the UDIT as follows:

Works	Goods	Consulting firms	Individual consultants
Shopping	**Shopping**		
Below $250,000, ex post reviews	Below $50,000, ex post reviews	Below $50,000, ex post reviews	No threshold, ex post reviews

5.9 **Records and files.** The MSD and the FPS will be responsible for establishing the supporting documents, procedures, and controls necessary for program execution and for ensuring that they conform to the terms of the loan contract and local laws.

VI. FINANCIAL MANAGEMENT

6.1 **Programming and budget.** The MSD's Planning Bureau, in coordination with the UDIT, will schedule the activities and work for execution as agreed jointly with the Bank.

6.2 **Accounting and reporting systems.** SIGMA will be used, which brings together into a single registry the various stages of accounting: budgetary records (budget execution), asset records (affecting assets, liabilities, net worth, and profits and losses), and treasury records (cash transfers) made. Accounting will be based on the accruals method and apply International Accounting Standards (IAS), in parallel with government standards, due to the fact that execution must be carried out through SIGMA, which is governed by the latter. The IDB Integrated Project

Administration System (SIAP) will be used for accounting records, as an aid for reporting purposes.

6.3 **Disbursements and cash flow.** Loan proceeds will be deposited in a special account at the Central Bank of Bolivia (BCB) and subsequently transferred in local currency. The exchange rate for disbursements will be the rate set by the BCB in force on the date of transfer. UGESPRO will be responsible for administration of resources vis-à-vis the MSD and the FPS, subject to fulfillment of internal institutional control systems.

6.4 **Internal control and internal audit.** The MSD and the FPS have an Internal Audit Division that reports directly to the MAE, which has the resources and the personnel to carry out internal controls.

6.5 **External control and reports.** The project will have a budget item as part of the financing for the external audit of the project (external control).

6.6 **Financial supervision plan.** Financial supervision will be subject to ex post review for both entities (MSD and FPS). The supervision plans will include the performance of the following activities at least once a year: (i) a comprehensive visit (procurement and finance) by the Bank; (ii) an on-site visit to the locations where the financing is being invested; and (iii) a visit to verify fulfillment of the agreements with the internal control recommendations made by the external audit on the program.

6.7 **Execution mechanism.** The UDIT will be supported by UGESPRO in fiduciary matters, and UGESPRO will be strengthened with additional personnel for accounting/financial management and procurement, so that it may take on additional fiduciary responsibilities in this operation. Activities related to infrastructure repairs and expansion at health centers, childcare centers, and community rooms for the program will be delegated directly to the FPS, which will manage these resources administratively and financially.

6.8 At the MSD, the UDIT will report to the Office of the Deputy Minister of Health, and will have responsibilities related to technical and administrative coordination. It will request and authorize operation-related payments, and will submit disbursement requests and audited financial statements.

6.9 UGESPRO, in supporting the UDIT, will do the following: (i) annually register the budget to be executed; (ii) open separate bank accounts and maintain accounting records; (iii) conduct bidding processes; (iv) make payments to providers and contractors; and (v) prepare bank conciliations and financial reports for the program.

VII. OTHER FINANCIAL MANAGEMENT AGREEMENTS AND REQUIREMENTS

7.1 The fiduciary sector does not deem it necessary to include any other agreements or requirements for financial management of the operation or for its procurement processes.