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ECUADOR

LOAN REFORMULATION PROPOSAL
INSTITUTIONAL STRENGTHENING FOR COMPETITIVENESS PROGRAM (4928/OC-EC)
TO FINANCE THE PROGRAM TO SUPPORT THE REDUCTION OF CHILD MALNUTRITION IN ECUADOR

(EC-L1250)

REFORMULATION PROPOSAL

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REQUIRED

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2. Monitoring and evaluation plan
3. Procurement plan

OPTIONAL

1. Project economic analysis
2. Reformulation request
3. Prioritized health benefits comparison with scientific literature
4. Gender and diversity assessment
5. Operating Regulations
6. Safeguard Policy Filter and Safeguard Screening Form Report

ABBREVIATIONS

ENSANUT	Encuesta Nacional de Salud y Nutrición [National Health and Nutrition Survey]
e-SIGEF	Sistema Integrado de Gestión Financiera [Integrated Financial Management System]
INEC	Instituto Nacional de Estadísticas y Censos [National Statistics and Census Institute]
MEF	Ministry of Economy and Finance
MSP	Ministry of Public Health
STECSDI	Secretaría Técnica Ecuador Crece Sin Desnutrición Infantil [Ecuador Grows without Child Malnutrition Technical Secretariat]
UNICEF	United Nations Children's Fund
WHO	World Health Organization

PROJECT SUMMARY
ECUADOR
INSTITUTIONAL STRENGTHENING FOR COMPETITIVENESS PROGRAM (4928/OC-EC)
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(EC-L1250)

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<tr><td colspan="5">Project objective/description: The general objective is to help reduce chronic child malnutrition through delivery of the priority health benefits to pregnant women and children under 2, using cross-sector interventions with a focus on civic engagement and interculturality and concentrating interventions in priority parishes. The specific objectives are to: (i) improve delivery of priority health benefits to pregnant women and children under 2; (ii) improve health competencies through nutritional education and counseling, encouraging civic engagement and coordination with local governments, to act on the determinants of health; and (iii) improve individual monitoring with the target population by improving information systems, in order to measure the indicators on the delivery of the priority health benefits.</td></tr>
<tr><td colspan="5">Special contractual conditions precedent to the first disbursement of the loan proceeds: That the borrower, through the MSP, has provided evidence that the program Operating Regulations have been approved and are currently in effect under the terms previously agreed with the Bank (¶2.52).
Special contractual conditions for execution: None.</td></tr>
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(a) Under the terms of the Flexible Financing Facility (document FN-655-1), the borrower has the option of requesting changes to the amortization schedule as well as currency, interest rate, commodity, and catastrophe protection conversions. The Bank will take operational and risk management considerations when reviewing such requests. The financial terms of this reformulation are within the parameters originally approved by the Board of Executive Directors on 4 December 2019.

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

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

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

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

I. PROGRESS ON THE INSTITUTIONAL STRENGTHENING FOR COMPETITIVENESS PROGRAM

A. Purpose and request from the government to reformulate the Institutional Strengthening for Competitiveness Program

1.1 The purpose of this document is to request that the Bank's Board of Executive Directors to approve the reformulation of the Institutional Strengthening for Competitiveness Program (loan 4928/OC-EC) in order to use those loan resources to finance the Program to Reduce Child Malnutrition in Ecuador (EC-L1250).

1.2 **Reformulation request.** The Ministry of Economy and Finance (MEF) requested, via note MEF-VGF-2020-1082-O on 15 October 2020, and the ratification forwarded by the new Government of Ecuador on 19 August 2021 (optional link 2), that all resources from loan 4928/OC-EC be reformulated to finance a new "Program to Reduce Child Malnutrition in Ecuador," to support the national government's goal of reducing chronic child malnutrition. Preparation of the proposed reformulation began in January 2022, once the government set the priorities and strategic lines for the program to address chronic child malnutrition. This reformulation is a complete revision of the original program's objective, components, and outcomes.

B. Background, progress, and proposed changes to the Institutional Strengthening for Competitiveness Program

1.3 **Background and progress on the Institutional Strengthening for Competitiveness Program.** On 4 December 2019, the Bank approved a US$42 million loan for the "Institutional Strengthening for Competitiveness Program" (loan 4928/OC-EC). Its objective was to improve the country's competitiveness and the economy's transparency to grow the productive sector. Due to a shift in its priorities for the 2021-2025 period, the Government of Ecuador never signed the contract, and no funds were disbursed, so it is requesting that loan 4928/OC-EC be reformulated.

1.4 **Proposed changes.** The full US$42 million from the Institutional Strengthening for Competitiveness Program (loan 4928/OC-EC) will be redirected to support the Program to Support the Reduction of Child Malnutrition in Ecuador. This represents 100% of the resources from the original project.

1.5 All the activities from the previous program, by component, that will no longer be funded correspond to: (i) under Component 1, strengthening of mechanisms for dialogue and coordination between the public and private sectors, and improvement of innovation and productivity in priority strategic productive sectors and areas and support for the implementation of the Competitiveness and Entrepreneurship Committee; (ii) under Component 2, strengthening the institutional mechanisms supporting regulatory quality and transparency in the business environment; and (iii) under Component 3, improvement of the management of government entities, processes, and assets that contribute to the productivity of the private sector.

1.6 **Environmental and social risks of the reformulation.** The original project (classified as Category "C") never started, so there are no social or environmental liabilities resulting from its reformulation.

II. Proposed Changes and Rationale

A. Background, problem addressed, and rationale

2.1 **Background.** On 20 December 2020, the government issued Executive Decree 1211 approving the Ecuador Grows without Malnutrition National Strategy to prevent and reduce chronic child malnutrition. Then on 6 September 2021, the government approved the Cross-sectoral Strategic Plan for the Prevention and Reduction of Chronic Child Malnutrition (see paragraph 1.2). This program will support and complement the Ecuador Grows without Malnutrition National Strategy with concrete actions as described in this document.

2.2 **Macroeconomic and social context.** Ecuador's economy was facing challenges prior to the pandemic. Fiscal sustainability had been compromised by very high public spending since the mid-2010s, something which low tax revenue was unable to address. The pre-pandemic macroeconomic situation was largely due to the economy's high vulnerability to external shocks, an inherent condition of a dollarized, petroleum-based economy.

2.3 At the beginning of the pandemic, the Ecuadorian government issued lockdown and social distancing orders that further restricted domestic supply and demand, while oil prices fell significantly. The expectation of declining liquidity from exports and tax revenue led the government to accelerate its fiscal sustainability agenda. In 2020, the government negotiated an arrangement under the International Monetary Fund (IMF) Extended Fund Facility for US$6.5 billion over three years,[1] on the condition that it implement fiscal and structural reforms.

2.4 After GDP fell 7.8% in 2020, the economy grew by 4.2% in 2021 due to prudent fiscal management. Ecuador continues to show signs of economic recovery in 2022 with solid growth, fiscal and financial accounts, and balance of payments. Social indicators have also improved in recent months. Between May 2021 and May 2022, the unemployment rate fell from 6.3% to 3.7% of the economically active population. By December 2021, the poverty rate was 27.7% (4.9 million people) and the extreme poverty rate was 10.5% (1.9 million people); in December 2020, these were 33% and 15.4%, respectively.

2.5 Inflation caused by outside factors may affect these improved social indicators, especially when it comes to food security: in May 2022, annual inflation was 3.38%, the highest rate since October 2015. If inflation gets worse, it could have serious effects on the population, as households in the first three income deciles dedicate 40% of their total spending to foodstuffs.[2]

2.6 **Problem to be addressed. Epidemiological and nutritional transition.** Ecuador has found itself in an epidemiological and nutritional transition since before the pandemic, which presents several challenges: the double burden of chronic child malnutrition and a significant rise in overweight and obesity in children under 5. It is also facing an upturn in acute malnutrition, more infectious diseases, and chronic illnesses, all of which add stress to the health system. It is not uncommon to find

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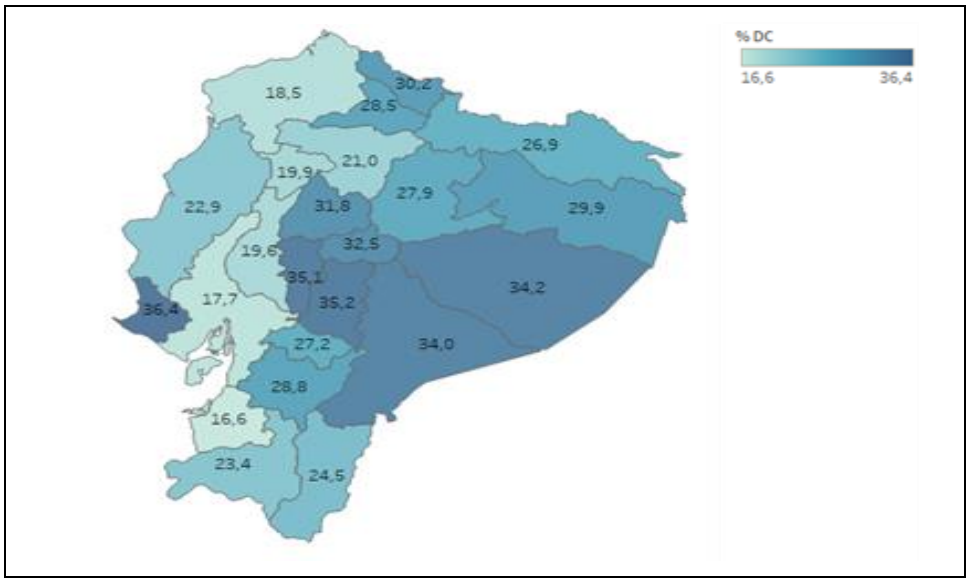
1 IMF (2020): Ecuador. Request for an Extended Arrangement under the Extended Fund Facility.

2 Household Budget Survey 2012.

small children with arrested growth (low height for age or chronic child malnutrition) in the same household with older siblings or parents with overweight or obesity and women of childbearing age with iron deficiency anemia. The rise in overweight and obesity in children is especially notable in children under 5 and is equally common in urban and rural households living in poverty.

2.7 **Chronic malnutrition in Ecuador.** While chronic child malnutrition has trended downward or stabilized in neighboring countries, it has been increasing in Ecuador.[3] In 2012, 24% of children under 2 had stunted growth, a rate that increased to 27% in 2018 according to the National Survey of Health and Nutrition (ENSANUT). It is most prevalent in rural areas (31%), La Sierra (29%), La Amazonía (31%), and among the indigenous population (39%).[4] For example, approximately 78% of indigenous children under 2 in Pastaza Province (La Amazonía) are at risk of malnutrition (optional link 4).[5]

Map 1. Chronic malnutrition in children under 5 by province, Ecuador (2018)



Source: Created by the authors. ENSANUT data (2018), excluding Galapagos.

2.8 In 2018, 5% of children under 2 in Ecuador were found to be acutely malnourished (low weight for height). This rose to 6% in rural areas, highlighting the multiple shocks of recurring illness, poor nutrition, and poverty. To complicate things further, the rate of overweight and obesity in children ages 5 to 11 increased to 35% in 2018, surpassing chronic child malnutrition rates.[6]

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3 Peru: from 15% in 2015 to 12% in 2019; Colombia: from 13% in 2010 to 13% in 2016. https://globalnutritionreport.org/resources/nutrition-profiles/latin-america-and-caribbean/

4 ENSANUT, 2018.

5 Gea-Izquierdo E., Patiño N., editors. *Características socioculturales, demográficas y de salud pública de las nacionalidades indígenas del Ecuador*. Quito: Pontificia Universidad Católica; 2021.

6 Ibid.

2.9 Micronutrient deficiencies also contribute to child malnutrition, particularly iron deficiency anemia. According to data from 2012, 64% of children ages 6 to 11 months and 26% of children ages 6 to 59 months present with anemia.[7] Indigenous children have a higher prevalence of anemia; in that same year, 46.3% had some type of anemia (11.8 percentage points higher than *mestizo,* or mixed-race, children).[8]

2.10 Maternal malnutrition is a significant contributor to chronic child malnutrition in children under 2. Multiple forms of malnutrition in girls and adolescents lead to reproductive issues and other health problems, especially during pregnancy,[9] while limited prenatal care exacerbates maternal malnutrition. Anemia during pregnancy increases maternal morbidity and mortality risks[10] and is associated with low birth weight and therefore chronic child malnutrition. In 2019, the prevalence of anemia was 17% in women of childbearing age and 22.3% in pregnant women, statistics that have not changed since 2012 (16.8% and 22.2%, respectively).[11] Maternal anemia and malnutrition are associated with low birth weight, which contributes to chronic child malnutrition. In 2000, 12% of live births had low birth weight. The numbers were similar 15 years later (11%).[12] Even among babies with a normal birth weight, 87% suffer from chronic child malnutrition by age 2.

2.11 Nutritional deficiencies raise the risk of infant morbidity and mortality. Infant mortality has increased from 8.5 per 1,000 live births in 2014 to 10.2 in 2019, according to vital statistics from the National Statistics and Census Institute (INEC). Acute respiratory infections and acute diarrheal illnesses are among the top 10 causes of death in children ages 5 to 11.[13] According to INEC, 34% of children under 5 had an episode of acute respiratory infection in the seven days preceding the survey in 2018. The rate of diarrhea in the same group over the same period was 11%. The estimated prevalence of acute diarrheal illness is higher in rural areas than in urban ones, 12.7% vs. 9.7%, respectively. In the Amazonian region, it is 13.4%. Children ages 12 to 23 months old have the highest prevalence of diarrheal illness (18%). Child morbidity also affects nutritional status.[14] Deficiencies in breastfeeding and diet in children under 2 reduces and

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7 Finkelstein, J., C. Guitron L., W. Chu, et al. Anemia and Iron, Vitamin B12 and Folate Deficiencies in Women of Reproductive Age in Ecuador: Results from the Ecuadorian National Health and Nutrition Survey CurrDevNut 3(1).

8 ENSANUT 2018: Children under 5 from the cantons of Sucúa, Taisha, and Tiwintza in Morona Santiago province.

9 Victora C.G., Christian P., Vidaletti L.P., Gatica-Domínguez G., Menon P., Black R.E. Revisiting maternal and child undernutrition in low-income and middle-income countries: variable progress towards an unfinished agenda. Lancet. 2021;397(10282):1388-99.

10 The maternal death ratio shows an upward trend, rising from 42.8 per 100,000 live births in 2017 to 57.6 in 2020 (INEC, 2019).

11 Global Nutrition Report, 2021, https://globalnutritionreport.org/resources/nutrition-profiles/latin-america-and-caribbean/south-america/ecuador/.

12 https://data.worldbank.org/indicator/SH.STA.BRTW.ZS?locations=EC.

13 INEC-Statistical Record of Overall Deaths, 2019. https://www.ecuadorencifras.gob.ec/defunciones-generales/.

14 Less than 2,500g, Black R.E., Victora C.G., Walker S.P. et al. Maternal and child undernutrition and overweight in low-income and middle-income countries. Lancet. 2013; 382: 427-451.

worsens dietary intake, impacting child malnutrition.[15] Four out of every 10 children under six months old are not exclusively breastfed, and four out of every 10 children under 2 have monotonous and unvaried diets, according to 2018 data.[16] An unvaried diet reduces consumption of calories and micronutrients. Lack of variety is observed alongside low quantity and frequency of meals, and inadequate food consistency.[17]

2.12 **Impact of the COVID-19 pandemic on the health and nutrition sector.** The first global efforts to calculate the pandemic's impact on nutrition predict roughly a 15% increase in acute malnutrition in children under 2 due to the shock of increased household poverty, rising food prices, and more illness.[18] The prevalence of chronic child malnutrition is also expected to rise due to declines in maternal nutrition, and higher prevalence of low birth weight and early childhood illnesses due to lack of health care and reduced immunization coverage. Finally, rates of overweight and obesity in children are expected to increase due to worsening diet quality and increased inactivity among children caused by lockdowns.[19]

2.13 These global trends and predictions are also expected to manifest in Ecuador, creating an even larger burden on the health system.[20] Prenatal care coverage during the first trimester fell from 36% to 27% between January and December 2020 and from 34% to 22% between January and July 2021. Pentavalent vaccine coverage in children under 12 months dropped from 87.5% in 2019 to 44.8% in July 2021, and pneumococcal vaccine coverage slipped from 86.5% to 51.8% over the same period. These drops were initially due to a drastic reduction in demand and the fact that many health facilities were closed; more recently, it is the result of vaccine scarcity due to the supply chain crisis.[21]

2.14 **Problem to be addressed.** The Ministry of Public Health (MSP), as the governing body of Ecuador's health system, plays a fundamental role in the awareness, prevention, recovery, and healing of malnutrition, and faces several challenges on the road to reducing chronic child malnutrition. These are the main challenges confronting Ecuador's health system when it comes to improving the nutritional status of pregnant women and children under 2.

2.15 **Inadequate health benefits coverage.** The priority health benefits are a set of goods and services designed by the Government of Ecuador to reduce chronic child malnutrition in a target population (expectant mothers and children under 2). The benefits include individual delivery and monitoring. It has three elements: (i) a

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15 Keats, E. et al. Effective interventions to address maternal and child malnutrition: an update of evidence. Lancet, Child Adolesc Health, 2021;5: 367-84.

16 ENSANUT, 2018.

17 Publications on child feeding practices from Alive and Thrive: https://www.aliveandthrive.org/en/research-and-learning.

18 Headey, D. & M. Ruel. Economic Shocks and Child Wasting. 2020. IFPRI Discussion Paper 01941.

19 Roberton, T., E.D. Carter, et al. Early estimates of the indirect effects of the COVID-19 pandemic on maternal and child mortality in low-income and middle-income countries: a modelling study. Lancet Glob Health 2020; 8: e901-08.

20 UNICEF. The COVID-19 shock on poverty, inequality, and social classes in Ecuador, 2020.

21 *Diagnóstico situacional de la prestación de servicios de salud en el primer nivel, data from Gobierno por Resultados*, Ecuador, 2020 at https://gpr.administracionpublica.gob.ec September 2021.

timely, complete vaccination schedule; (ii) prenatal care; and (iii) well-child visits. The priority health benefits are designed to address nutrition and health issues that directly and indirectly contribute to chronic malnutrition. They are aligned with the scientific literature (optional link 3) regarding direct nutritional interventions for pregnant women and children under 2.[22]

2.16 Delivery and monitoring of goods and services in the priority health benefits occurs at primary care facilities (in 2022, there were 1,938 nationwide).[23] The national birth registry captured 84% of live births in 2019, but due to the pandemic, this fell significantly to 58% in 2020, especially for births to adolescent mothers. The registry is essential for calculating coverage of these benefits.[24]

2.17 The principal gaps in coverage of the priority health benefits are (i) prenatal care: 28% coverage in the first trimester, and just under four visits per pregnancy on average (data from 2021) when it should be at least four prenatal visits for all pregnancies; (ii) the complete vaccine schedule for children under 1 (the target is 89%, compared to 74.2% coverage achieved for the pentavalent vaccine and 78.2% for the pneumococcal vaccine in 2020);[25] (iii) delivery of micronutrients for children under 2 (iron and other powdered micronutrients, plus vitamin A) with 39% coverage in 2018; and (iv) growth checks: the average is 2.4 checks in the first year of life and 2.9 in the second in 2021 (standards specify one per month for children ages 0 to 7 months, one every two months for children ages 8 to 11 months, and one every three months for children ages 12 to 23 months). Coverage of the priority health benefits is even lower among populations living in extreme poverty.[26] The challenges are to gradually increase MSP's yearly coverage targets in the strategy's target areas and achieve higher coverage of priority health benefits in an appropriate, clearly defined manner.

2.18 On the supply side, health facilities have limited capacity to fulfill the priority health benefits. Data from 2021 show that at least 50% of facilities don't have the equipment they need to guarantee coverage of the priority health benefits, particularly infantometers to adequately track growth and hemoglobinometers to check for iron and other micronutrient deficiencies in pregnant women and children under 2.[27] Lack of ultrasound equipment for monitoring fetal growth makes the gap even larger (94%). Supplies are also a barrier to implementing the priority health benefits: 99.6% of facilities had inadequate lab supplies for testing and lacked micronutrient supplements.

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22 The priority health benefits do not address acute malnutrition or overweight or obesity in children. The Bank will engage in discussion about the nutritional and epidemiological transition with the Government of Ecuador during this operation (see paragraphs 2.6-2.8 and 2.29).

23 Ecuador without Child Malnutrition Project Management Unit.

24 Presentation by the Ecuador Grows without Child Malnutrition Technical Secretariat.

25 These vaccines are provided through the Pan American Health Organization's Revolving Fund, so this operation does not include resources for vaccines.

26 The priority health benefits covered less than 1% of pregnant women and children under 2 nationwide between 2019 and 2021. MSP data.

27 The Ecuador Grows without Chronic Child Malnutrition Technical Secretariat looked at 922 health facilities, 878 (95%) of which were primary care facilities.

2.19 **Limited staff available to address child malnutrition.** The total number of health care professionals in the country is low: in 2018, Ecuador had 20.4 doctors per 10,000 inhabitants, when the average for Latin America was 24 per 10,000. The combined density of nurses and midwives was 25.1 per 10,000, far below the Latin American average of 83.3 per 10,000.[28] The availability of public sector health care workers is affected by high turnover and people leaving the sector altogether. Estimates are that the country only has 2,562 (41%) of the 6,219 comprehensive health care teams it needs.[29]

2.20 **Low social engagement in health and nutrition services, especially among indigenous populations.** MSP needs to update its standards, protocols, and advisory services for nutritional education and care to align them with the scientific literature[30] and international recommendations.[31] It should also continuously train health professionals to use protocols with regional and population differences in mind. Creating a community approach to incorporating better educational communication practices to change the food behaviors of pregnant women and children under 2 requires local-level coordination to make interventions sustainable, taking into account specific steps regarding culture and beliefs. However, lack of capacity (human resources) and cooperative mechanisms have had a large impact on implementing programs[32] to identify, care for, and monitor at-risk women and children under 2. Lack of institutional coordination means that there are no epidemiological surveillance mechanisms to identify, prevent, or promptly provide care for malnutrition cases, as there is no network management of health services. The challenge of community epidemiological surveillance and nutritional education and counseling is providing mothers and caregivers of children with quality advisory services and support on maternal and child dietary practices rooted in hiring, training, supervising, and motivating community counselors and monitors.[33]

2.21 Addressing the nutritional status of indigenous groups is a long-standing challenge. The prevalence of chronic child malnutrition is consistently higher among indigenous infants and all age groups—30% in 2018 and trending upward. Rates of diarrheal and respiratory infections are also higher. Nutritional education and counseling efforts must be adapted to local cultures and native languages, ensuring timely individual follow up with key actors in the priority parishes.[34]

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28 World Health Organization, Global Health Statistics, 2020, www.who.int.

29 MSP, National Office on Primary Health Care, 2020.

30 Arikpo, D., Edet, E.S., Chibuzor, M.T., Odey, F., Caldwell, D.M.. Educational interventions for improving primary caregiver complementary feeding practices for children aged 24 months and under.

31 WHO & UNICEF. 2021. Indicators for assessing infant and young child feeding practices: definitions and measurement methods. ISBN (WHO) 978-92-4-001838-9.

32 Gillespie, Stuart. Strengthening Capacity to Improve Nutrition. (2001).

33 UNICEF, 2021, https://www.unicef.org/media/107226/file/Fed%20to%20Fail%20-%20BRIEF%20-%20ENGLISH%20-%20Final.pdf.

34 *La Desnutrición en la Población Indígena y Afroecuatoriana Menor de Cinco Años*, INEC 2008, https://www.ecuadorencifras.gob.ec/documentos/web-inec/Bibliotecas/Estudios/Estudios_Socio-demograficos/La_Desnutricion_en_la_Poblacion_Indigena_y_Afroecuat.pdf.

2.22 **Low individualized follow up and traceability of priority health benefits care.** The MSP has identified weak points in the prompt registration of pregnancies and births, data digitization, IT infrastructure, connectivity, and the protection and safe transmission of data, which is collected from several sources, especially at the township and parish level.[35] Health professionals should be quickly notified of updates to the IT system so that they can record care and verify individual and overall compliance with requirements for quality service. Continuous knowledge transfer of new system functionalities in health facilities and monitoring the quality of recorded information are necessary to determine the epidemiological profile and generate data to define, build, test, and refine better monitoring indicators and standardize regular data collection.

2.23 **The Government of Ecuador's actions to reduce child malnutrition.** Since 1993, Ecuador has implemented approximately 12 health and nutrition programs;[36] however, the trend in the chronic child malnutrition curve in children under 5 has not met expectations. As a result, the Ecuador Grows without Malnutrition National Strategy to prevent chronic child malnutrition and reduce its prevalence in children under 2 is creating a set of priority health benefits with goods and services targeting pregnant women and children under 24 months. In addition to the three elements of the priority health benefits (see paragraph 2.15), the Strategy includes a mechanism for individual identification and monitoring to verify timely service delivery to the target population across multiple sectors. The Cross-sectoral Strategic Plan for the Prevention and Reduction of Chronic Child Malnutrition,[37] approved on 6 September 2021, has six cross-cutting focus areas designed to amplify sector-specific measures: (i) creation of an enabling environment; (ii) resource mobilization; (iii) territorial integration; (iv) data management; (v) human talent and improved institutional management; and (vi) shared responsibility and transparency. The Ecuador Grows without Child Malnutrition Technical Secretariat (STECSDI), which will participate in the program for the purposes of this operation, is responsible for developing and executing the plan through cross-sector and interagency cooperation.

2.24 **Program strategy.** The program will help the Government of Ecuador execute the strategic plan through the MSP, addressing the three issues identified: (i) low priority health benefits coverage; (ii) low social engagement and monitoring of

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35 (i) TAMEN: Record of neonatal metabolic screening; (ii) REVIT: Vital Data Records System; (iii) MÉDICO DEL BARRIO (neighborhood doctor): Data from outside care; (iv) PRAS: La Plataforma de Registro de Atención en Salud (The health care record platform); and (v) RDACAA: A tool to collect data on paper and then enter it into PRAS. MSP investment project, September 2021.

36 Some of the more significant programs are: *Programa de Alimentación Complementaria Materno Infantil* [Complementary Mother-Child Nutrition Program] (1993), *Programa Integrado para el control de las deficiencias de Micronutrientes* [Comprehensive Program to Fight Micronutrient Deficiencies] (1995), *Programa Nacional de Acción y Nutrición PANN* [National Action and Nutrition Program] (1999), *Programa Aliméntate Ecuador* [Nourish Yourself, Ecuador Program] (2004), *Programa Desnutrición Cero* [Zero Malnutrition Program] (2010), *Estrategia Acción Nutrición Infancia Plena* [Whole Child Nutrition Action Strategy] (2013), *Proyecto Emblemático Acción Nutrición* [Action for Nutrition Flagship Project] (2015) and *Programa Infancia Plena* [Whole Child Program] (2017). The Ecuador Grows without Child Malnutrition National Strategy was approved in 2020.

37 https://www.infancia.gob.ec/wp-content/uploads/2021/09/Plan-Intersectorial.pdf.

nutritional interventions; and (iii) low individual monitoring and traceability of care for priority health benefits.

2.25 To address the first problem, the project will give health facilities anthropometric equipment to monitor and promote growth, as well as micronutrients for pregnant women and children under 2. They will also provide the supplies and materials needed to support the following interventions, which have nutritional ramifications, during childbirth and post-pregnancy care: (i) immediate skin-to-skin contact; (ii) delayed clamping of the umbilical cord; and (iii) exclusive breastfeeding beginning in the first hour postpartum. Evidence shows that this set of interventions can be scaled while maintaining quality and high coverage.[38] This will increase the success rate of health facilities to improve all services included in the government's priority health benefits.

2.26 To respond to the second problem, the project will build dietary and nutritional capacity in Ecuador by forming work groups with social organizations, civic engagement committees, and/or local governments to create cross-sector work plans to identify pregnant women and children under 2 and provide advice for them on dietary practices. This is the first step to creating platforms from which to launch community actions to change dietary behavior using education communication based on the literature and international experience. To supervise the interventions, the program will hire technical staff to monitor priority health benefits in priority areas and to actively go door to door to deliver services to pregnant women and children under 2. These activities will support counseling on dietary practices for pregnant women and children under 2 in priority parishes.

2.27 To address the third problem, the project will help MSP staff supervise and train health professionals on the individual monitoring system, how to record priority health benefits, and the guidelines and protocols for humanized childbirth; support, protection, and encouragement of breastfeeding; and the nutritional counseling and education model focused on chronic child malnutrition. Equipment and resources to mobilize health workers will also be provided to oversee delivery of the priority health benefits in the field.

2.28 Nonreimbursable technical assistance will be provided to encourage policy dialogue and improvement of guides and protocols for nutrition care in the context of the nutritional epidemiological transition and for effective communication strategies around dietary behavior change.

2.29 In summary, the program will help resolve low coverage of priority health benefits for expectant mothers and children under 2, low social engagement with health and nutrition counseling, monitoring and follow up on interventions in the field, and low individual monitoring and traceability of care for priority health benefits, as part of the strategy to reduce chronic child malnutrition in Ecuador.

2.30 **Bank experience and lessons learned.** The program design includes several technical lessons learned: (i) at the operational level, the program incorporates lessons from the loan "Support for Health Service Delivery and the Social Safety

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[38] Bhutta, Z. et al. How countries can reduce child stunting at scale: lessons from exemplar countries. Am J. Clin Nutr 2020;112(Suppl):894S-904S.

Net in the Context of the Coronavirus/COVID-19 Pandemic" (loan 5031/OC-EC),[39] which used compatible procurement mechanisms between the Bank and the Government of Ecuador to create a web app for mass hiring of primary care personnel (epidemiologists, general practitioners, nurses, and primary health care technicians) for the comprehensive health care teams defined in Component 2. The reasonable assurance audits have not found any issues, showing that this is a reasonable method for quickly hiring staff to fill identified vacancies in the field; (ii) there are two important lessons from the IDB's experience with vaccination in Ecuador: first, financing must be in place and vaccines must be available, and second, perhaps most importantly, appropriate conditions, human resources, supplies, and processes must be in place to guarantee that vaccines get where they need to go. This will be relevant to delivering the nutrition and child priority health benefits in Component 1; and (iii) lessons were learned from purchasing equipment for the "Multiphase Program to Improve Quality in the Delivery of Social Services-Phase 1" (loan 4364/OC-EC),[40] "Support Program for the Social Inclusion of People with Disabilities in Ecuador" (loan 4634/OC-EC),[41] and "Program to Support the Extension of Social Protection and Comprehensive Health Care" (loan 2431/OC-EC).[42] These will be applied in Components 1 and 2 to avoid delays setting technical specifications and preparing the terms of reference. Monitoring planning and establishing technical specifications is key prior to the operation launch, as is supporting the MSP to strengthen processes and strategic actions. For experience specific to chronic malnutrition care, lessons are being taken from the "Community Health Program for Rural Municipios" (loan 3696/BL-NI)[43] regarding counseling to improve child dietary practices at the community level. These are laid out in Component 2 (see paragraph 2.36).

2.31 **Coordination with other multilateral organizations and cooperation agencies.** The Japan International Cooperation Agency is in the process of approving a concessional policy-based loan, as parallel financing to the "Support for the Social Expenditure Protection and Employment Recovery Program" (loans 5520/OC-EC[44] and 5230/OC-EC),[45] which includes a child malnutrition component. The Bank also coordinated with the Pan American Health Organization to develop the National Plan for Quality in Health, which will enhance service delivery processes and the creation of a digital transformation strategy in Ecuador. Among other things, this will enable the use of an electronic prescription system and improve basic processes to digitize the sector, which will help improve individual monitoring, referral and counter referral systems, and the health care record platform PRAS. Ecuador will monitor progress in fighting chronic child malnutrition using the National Child Malnutrition Survey, which will be conducted annually beginning in 2022. It will receive financing and technical support from the

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39 Approved 18 May 2020 for US$250 million.

40 Approved 8 November 2017 for US$246,993.

41 Approved 26 October 2018 for US$45,170,991.

42 Approved 27 October 2010 for US$102.5 million.

43 Approved 23 June 2016 for US$103,233,762.

44 Approved 27 April 2022 for US$250 million.

45 Approved 10 March 2021 for US$200 million.

World Bank, UNICEF (for the water and sanitation components) and the IDB (for the early child development component) through the technical cooperation operation, “Support to Strategies to Reduce Chronic Malnutrition and Promote Early Childhood Development in Ecuador” (ATN/JF-19522-EC).[46]

2.32 Lastly, the technical cooperation operation “Support to Strategies to Reduce Chronic Malnutrition and Promote Early Childhood Development in Ecuador” (ATN/JF-19522-EC) financed by the IDB Japan Special Fund complements this operation by enhancing STECSDI’s coordinating role and supporting the development of a behavior change strategy for dietary practices for pregnant women and children under 2 who receive MSP services.

2.33 **Strategic alignment** This 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 health care delivery. It is also aligned with the cross-cutting area of gender equality and diversity through the use of differentiated approaches to ensure access to culturally relevant information for indigenous peoples (Components 1 and 2) and coordination mechanisms between indigenous authorities without health services and the MSP, including pregnant women and female heads of household (Component 2) to improve the care, diet, nutrition, and health of pregnant women. The program also advances the IDB Group Corporate Results Framework 2020-2023 (document GN-2727-12) under the indicator on the number of beneficiaries receiving health services. The project is consistent with the Gender Action Plan for Operations 2020-2021 (document GN-2531-19) and the Diversity Action Plan for Operations 2019-2021 (document GN-3001), which establish specific actions to promote gender equality and development with identity for indigenous groups. The program is also consistent with the Health Sector Framework Document (document GN-2735-12) because it improves service delivery, including the provision of necessary equipment, supplies, and training for health professionals. Lastly, the program is aligned with the new IDB Group Country Strategy with Ecuador 2022-2025 (document GN-3103), currently awaiting approval, specifically with strategic objective seven “Expand access to and improve coverage of basic and social services” and indicator 7.2.1 “Chronic child malnutrition (children under 5)”.

B. Objectives and components

2.34 **Objective.** The general objective is to help reduce chronic child malnutrition through delivery of the priority health benefits to pregnant women and children under 2, using cross-sector interventions with a focus on civic engagement and interculturality and concentrating interventions in priority parishes. The specific objectives are to: (i) improve delivery of priority health benefits to pregnant women and children under 2; (ii) improve health competencies through nutritional education and counseling, encouraging civic engagement and coordination with local governments, to act on the determinants of health; and (iii) improve individual monitoring with the target population by improving information systems, in order to measure the indicators on the delivery of the priority health benefits.

[46] Technical cooperation operation approved 15 September 2022 for US$1.5 million.

2.35 **Component 1. Delivery of the priority health benefits (US$28 million).** The objective is to improve delivery of the priority health benefits to pregnant women and children under 2. This component will finance the procurement of: (i) anthropometric equipment and hemoglobinometers to monitor and encourage growth in children under 2 and weight gain in pregnant women, including regular calibration and maintenance services for said equipment; (ii) printing/reproduction of the Comprehensive Health Passbook, to record the health benefits children and pregnant women received; (iii) supplies for a micronutrient and vitamin supplement regimen for pregnant women and children under 2; (iv) laboratory medical devices to check hemoglobin; and (v) supplies and materials for the toolkit to adopt integrated childbirth practices. This component will be implemented nationwide and will report on facilities that serve dispersed rural and indigenous areas.

2.36 **Component 2. Building health competencies through nutritional education and counseling (US$11.5 million).** The objective is to improve health competencies in the target population through nutritional education and counseling, encouraging civic engagement and coordination with local governments, to act on the determinants of health. This component will finance: (i) operating expenses (transportation, logistics, materials, and printing) to hold workshops on preparing healthy foods to recover knowledge, in coordination with community leaders; (ii) printing instructional materials for counseling on breastfeeding and complementary feeding; (iii) operating expenses for organizing parish-level cross-sectoral workgroups with social organizations, civic engagement committees and/or local governments to make and implement work plans for identifying and working with pregnant women and children under 2; (iv) operating expenses to train community monitors, with an emphasis on chronic child malnutrition (including cultural adaptation for indigenous groups); (v) hiring nutritionists at the zone, district, and community level to enhance community work to identify pregnant women and children under 2 and deliver priority health benefits;[47] and (vi) hiring central technical and administrative staff to support coordination and monitoring of delivery of priority health benefits. This component will be implemented in priority parishes as indicated in paragraph 2.39.

2.37 **Component 3. Individual monitoring (US$2.3 million).** The objective is to improve individual monitoring[48] of the target population by improving information systems to measure priority health benefit indicators. This component will finance: (i) operating expenses for training, supervision, and tracking of the individual monitoring system and delivery of priority health benefits; (ii) services to print and reproduce regulatory and technical material for health workers for individual beneficiary monitoring (culturally adapted for indigenous groups); and (iii) procurement of equipment for individual beneficiary monitoring, as well as for training, supervision, and monitoring on the ground. This component will be implemented nationwide, with an emphasis on priority parishes, as indicated in paragraph 2.39.

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47 In the parishes with a large indigenous population, efforts will be made to hire nutritionists from those communities.

48 Registering each beneficiary, monitoring their health conditions, and providing services.

2.38 **Auditing (US$200,000).** Resources will be allocated for auditing during the program execution period.

2.39 **Targeting and beneficiaries.** The Government of Ecuador carried out the geographic targeting in two stages. First, it selected the 195 cantons with the highest prevalence of chronic malnutrition in children under 5 and poverty variables such as unmet basic needs and housing deficits. Then it chose parishes in the targeted cantons. There is no parish-level nutrition data, so potential demand for nutrition services among mothers and children was calculated using data on poverty, maternal education, and access to water and sanitation in the home.[49] These variables are statistically linked to chronic child malnutrition. They also introduced a supply indicator: health services coverage for pregnant women and health and development services coverage for children under 4. This ensures that there would be care available for pregnant women and children under 2 at the parish level. This is how they narrowed it down to 728 parishes in the selected cantons. Lastly, Component 1 of this program will provide equipment and micronutrients for all primary care facilities in the country (approximately 1,900). Components 2 and 3 will be implemented in parishes within the 728 that meet the geographic criteria for rural dispersion and indigenous population. The Bank will work with the Government of Ecuador during the initial months of the program to finish prioritizing. The program beneficiaries will be pregnant women and children under 2. In 2023, this is estimated to be 310,092 expectant mothers and 678,000 children under 2 across the country. These beneficiaries will receive priority health benefits at 1,938 primary care facilities that also serve the indigenous population (approximately 45%).

C. Key results indicators

2.40 **Expected outcomes.** There are three types of indicators for the development objectives: (i) those related to the target population in health facilities that provide nutrition care in priority parishes; (ii) those that measure community actions for preventive nutrition; and (iii) those related to the individual monitoring system for priority health benefit delivery to program beneficiaries. The development indicators specifically relate to: (i) the percentage of children under 2 and pregnant women in primary care facilities that are covered by the priority health benefits and delivered micronutrient regimens; (ii) the percentage of primary care facilities that implement integrated birth practices with nutritional implications; and (iii) the percentage of priority parishes with cross-sector working groups that coordinate advisory actions on breastfeeding and complementary feeding with at least one community nutritionist to improve identification of expectant mothers and children under 2 and delivery of priority health benefits in the community.

2.41 **Economic viability.** To determine the project's ex ante viability, the Bank conducted a cost-benefit analysis in line with the results matrix (Annex II), the current literature, and its usual methodologies, to assess anticipated impacts on beneficiaries' health. Based on established assumptions, in a base-case scenario

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[49] Targeting variables from the first stage: (i) prevalence of chronic child malnutrition in children under 5; (ii) concentration of chronic child malnutrition in children under 5 within the canton; (iii) overcrowding; (iv) consumption poverty; (v) water deficits; (vi) housing deficits; and (vii) population projection for children under 5.

the net present value is an estimated US$19.9 million, with a benefit-cost ratio of 1.5, and an internal rate of return of 34%. The base-case scenario forecasts a 1.5 percentage point drop in chronic child malnutrition over the life of program and a discount rate of 3%. Even so, the Bank ran a sensitivities analysis with interest rates of up to 12% and smaller changes in chronic child malnutrition (1.25-0.95 percentage points) to model an unfavorable scenario. The project is robust in all proposed scenarios.

D. Financing

2.42 Given the scope and the fact that the project components cannot be split apart without affecting the vertical logic and the interventions are fully planned, the reformulated program remains a specific investment loan for a total of US$42 million, which will be financed from the Bank's Ordinary Capital. The disbursement period will be 24 months.[50] This was determined based on annual needs, the budget allocated per year, and the detailed projections in the project execution plan.

Table II.1. Estimated program costs (US$)[51]

Components	IDB	%
1. Delivery of priority health benefits	**28,000,000**	**67**
Procurement of anthropometric equipment, hemoglobinometers, and laboratory equipment for checking hemoglobin	4,000,000	
Procurement of micronutrients, iron, vitamins, and zinc	23,500,000	
Procurement of supplies and materials for childbirth-related care	500,000	
2. Building health competencies through nutritional education and counseling	**11,500,000**	**27**
Food preparation workshops, counseling tools on breastfeeding and complementary feeding, and operation of cross-sectoral workgroups to identify expectant mothers and children under 2	500,000	
Staff to deliver the priority health benefits and identify pregnant women and children under 2 (Nutritionists and central staff)	11,000,000	
3. Individual monitoring	**2,300,000**	**5.5**
Procurement of equipment for the individual monitoring system	1,300,000	
Operating expenses and printing for the individual monitoring system (Reproduction of regulatory material, resources for supervision and monitoring)	1,000,000	
Auditing	**200,000**	**0.5**
Total	**42,000,000**	**100**

Table II.2. Annual projection of loan disbursements (US$)

	2023	2024	Total
Amount	31 million	11 million	42 million
Percentage	74	26	100

[50] The program's timeline is considered viable because: (i) this is a flagship program for the government; (ii) it has an allocated budget; (iii) the anticipated procurements are standard. To hire staff (nutritionists) efficiently, the team expects to use the procurement method for "service delivery contractors" as laid out in paragraph 2.54; and (iv) the MSP, with support from the team, is making progress in preparing the technical specifications.

[51] The costs per subcomponent and activity are indicative.

E. Social and environmental safeguard risks

2.43 Under Directive B.3 of the Operational Policy on Environment and Safeguards Compliance (Operational Policy OP-703), this is classified as a category "C" operation, because it is not expected to have significant negative environmental or social effects. The program does not include any physical infrastructure, so it does not anticipate associated environmental and social impacts or risks. This will be highlighted in the coordination mechanisms with local authorities and actors as set forth in Component 2.

F. Fiduciary risks

2.44 The following were found to be medium-high fiduciary risks: (i) difficulties getting endorsements from the MEF as part of budget execution (even though the project is a priority), which could delay procurement and therefore delay or block expected disbursements; (ii) challenges interpreting the application of IDB procurement and contracting policies that may interfere in their usual course; (iii) delays in internal MSP procedures to begin procurement, impacting whether the program's annual physical and financial targets are met; and (iv) delays in hiring an external auditing firm due to lack of allocated financial resources and delays in the issuance of multiyear and budgetary certifications by the MEF. These risks could be mitigated with the following measures: (i) continuous monitoring between MSP-MEF with Bank support to identify and plan activities that have the approval, endorsement, and relevant certifications to move forward with the respective precontractual and contractual processes; (ii) determine, in the program eligibility process, the technical specifications, terms of reference, and formats and/or bidding conditions needed for efficient procurement and contracting; (iii) determine, in the program Operating Regulations, the minimum required internal procedures for procurement, and the delegation of the respective administrative, legal, and financial responsibilities to ensure timely action from the MSP Program Management Unit under the current institutional structure; and (iv) coordination between MSP and MEF with Bank support to quickly address resources and certification required for procurements and compliance with the program's external audit.

G. Other risks and key issues

2.45 There is a medium-high risk of not incorporating best practices for behavior change communication as regards the dietary behaviors of pregnant women and children under 2. The MSP is open to conducting a systematic review of current education efforts and bringing them into line with scientific evidence,[52] international recommendations,[53] and best practices and experiences gleaned over the past 15 years from the Bank's Salud Mesoamérica Initiative. This risk will be mitigated through a policy dialogue. The first steps will be to review existing material and the

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[52] Arikpo, D., Edet, E.S., Chibuzor, M.T., Odey, F., Caldwell, D.M. Educational interventions for improving primary caregiver complementary feeding practices for children aged 24 months and under. Cochrane Database of Systematic Reviews 2018, Issue 5. Art. No.: CD011768. DOI: 10.1002/14651858.CD011768.pub2.

[53] WHO & UNICEF. 2021. Indicators for assessing infant and young child feeding practices: definitions and measurement methods. ISBN (WHO) 978-92-4-001838-9 (electronic version).

methodology used to create it,[54] the available data and information, followed by a dialogue between international subject-matter experts and their MSP counterparts, and the creation of evidence through a formative research project with the target population. This will guide the development of an educational strategy for behavior change in specific Ecuadorian populations, including indigenous groups, using for example methodologies created by the National Institute of Public Health of Mexico[55] and/or the Nutrition Research Institute of Peru.[56]

2.46 There is a medium-high risk that the probable gaps between the supply of and demand for trained public sector health care workers (doctors, nutritionists, nurses, etc.) and persistent turnover among primary care health workers and workers leaving the profession could put program execution at risk. To mitigate this risk, the operation will include a mass hiring process to ensure staff are available for project execution and to provide continuity for these staff after the project is over. The program is also prioritizing the following issues as part of primary care staff training in health centers and in the wider community: (i) increase the practice of delayed umbilical cord clamping; (ii) increase early breastfeeding in the first hour postpartum; (iii) increase exclusive breastfeeding in the postpartum period up to 6 months and continuing until 24 months, incorporating growth promotion into growth checks; (iv) improve complementary feeding of children ages 6 to 23 months with respect to the introduction, quantity, frequency, consistency, and diversity based on evidence and incorporating growth promotion; (v) prevent diarrhea and promote hand washing; and (vi) promote a healthy diet and physical activity in populations with childhood overweight and obesity in the operation's target areas.

2.47 **Sustainability.** The program is part of the Government of Ecuador's public policy to fight child malnutrition. The medium to long-term horizon anticipates that the interventions will continue. The program will also ensure continuity by taking steps to link nutrition services to the delivery of regular health services. The sustainability of interventions in the health sector is based on the Government of Ecuador's determination to fight child malnutrition, and so it has created an institutional framework to legitimize its implementation, and solidified strategies such as regulatory changes to encourage private sector participation and international cooperation to ensure medium- and long-term financing for the Cross-sector Strategic Plan for the Prevention and Reduction of Chronic Child Malnutrition.

H. Summary of implementation arrangements

2.48 **Borrower and executing agency.** The Republic of Ecuador will be the borrower and the MSP will act as the executing agency in its role as the health steering agency and a health services provider. The main divisions responsible for project execution within the MSP will be: (i) the Ecuador without Child Malnutrition Project

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54 MSP, 2015. *Paso a paso por una infancia plena*.

55 Bonvecchio, A., W. Gonzalez et al. Translating Evidence-Based Program Recommendations into Action: The Design, Testing, and Scaling Up of the Behavior Change Strategy EsIAN in Mexico. Jnl Nut 2019, 149 (Suppl 1):23102-2322S.

56 R. Robert, H. Creed-Kanashiro et al. Strengthening health services to deliver nutrition education to promote complementary feeding and healthy growth of infants and young children: formative research for a successful intervention in peri-urban Trujillo, Peru. Mat Child Nut 2017, 13.

Management Unit/National Undersecretariat for the Promotion of Intercultural Health and Equality; and (ii) the IDB Projects Management Unit, which will: (i) be authorized to allocate program-related budget expenses; (ii) have a coordinator who will act as signatory with the Bank; and (iii) have staff in charge of fiduciary execution (procurement, finance, and monitoring specialists). The IDB Projects Management Unit will be delegated maximum authority by the MSP to authorize program expenditures for procuring goods, services, and consulting services. A mechanism will be established in the program Operating Regulations for operating expenses and mass hiring. The IDB Projects Management Unit will be financed from the Ministry's budget for different programs and investment projects. Following recommendations from the institutional capacity assessment, the executing agency will receive assistance with the following over the life of the project: (i) maintaining autonomy over program procurements and contract administration; and (ii) hiring the required staff for planning and monitoring, procurement, and financing. This is aligned with the risks identified in paragraphs 2.44, 2.45, and 2.46 and Annex III.

2.49 **Functions of the Ecuador without Child Malnutrition Project Management Unit.** This unit's role will be to: (i) coordinate delivery of technical and operational inputs with the GFE to draft and update the multiyear execution plan, the annual work plan, and the procurement plan; (ii) centrally manage the technical aspects set out in the results matrix; (iii) provide data to update requirements and technical specifications for the bidding processes; and (iv) monitor and supervise progress and the results matrix output indicators for the GFE.

2.50 **The role of the MSP's IDB Projects Management Unit will be to:** (i) prepare and regularly update the multiyear execution plan throughout the life of the program; (ii) prepare the annual work plan, the financial/cash flow plan, and procurement plan; (iii) conduct the procurement process for goods, nonconsulting services, and consulting services and sign program-financed contacts; (iv) conduct program monitoring activities and present the Bank with progress reports; and (v) manage program finances, including preparing supporting documents for disbursement requests, rendering of accounts, and turning in information for audits, among other tasks.

2.51 **Interagency coordination mechanism.** The MSP will carry out cross-sectoral and interagency coordination under the Cross-sectoral Strategic Plan for the Prevention and Reduction of Chronic Child Malnutrition, with all the actors involved in the "Ecuador Grows without Child Malnutrition National Strategy" [Ministry of Economic and Social Inclusion (MIES), Ministry of Education (MINEDU), and the Ecuador Grows without Child Malnutrition Technical Secretariat (STECSDI), among others.]

2.52 **Special contractual conditions precedent to the first disbursement of the loan: (i) that the borrower, through the MSP, has provided evidence that the program Operating Regulations have been approved and are currently in effect under the terms previously agreed with the Bank.** This condition is critical because the program Operating Regulations will contain the key technical and operating guidelines for efficient program execution. They will define: (i) the roles and responsibilities of participating entities; (ii) the minimum composition of the MSP's IDB Projects Management Unit; (iii) the regulations and procedures for

selecting and procuring works, goods, and services; (iv) the regulations and procedures for administrative and financial management; (v) the monitoring procedures; (vi) the regulations and procedures for internal control; and (vii) auditing. Specifically, they must include an annex for the mass hiring of staff under Component 2 under the terms and conditions approved by the Bank. They should also detail the procedures for managing program operating expenses.

2.53 **Procurement of works, goods, nonconsulting services, and consulting services.** Procurements financed in whole or in part with Bank resources will be conducted under the Policies for the Procurement of Goods and Works (document GN-2349-15) and the Policies for the Selection and Contracting of Consultants financed by the Inter-American Development Bank (document GN-2350-15).

2.54 Selection of service delivery contractors: The program must hire a large number of nutritionists to enhance community work, and to identify pregnant women and children under 2 and deliver priority health benefits (Component 2). Due to the features and geographic dispersion of services, the consultant type is "service delivery contractors" under paragraph 3.22 of document GN-2350-15. The description of roles, minimum qualifications, conditions of employment, selection procedures, and the extent to which the Bank reviews those procedures and documents will be agreed on with the Bank and form part of the program Operating Regulations, ensuring that the financing source is included in the program investment budget so that exceptions under Presidential Decree 858/2019 can be applied. Exceptions to this Decree refers to the authorization to conclude contracts for occasional services to meet ad hoc institutional needs that may be financed with resources from the public investment budget.

2.55 **Disbursements.** The disbursement method for the reformulated program will be advances of funds based on liquidity needs. Accounting for these advances will be conducted in accordance with the Financial Management Guidelines for IDB Financed Projects (document OP-273-12) or the policy in place at the time of execution. Disbursements will be determined based on liquidity needs, according to the Financial Management Guidelines for IDB Financed Projects (document OP-273-12) and the Fiduciary Agreements and Requirements (Annex III). Payments can also be reimbursed or made directly to suppliers at the borrower's request.

2.56 **Auditing.** The program's audited financial statements will be requested annually within 120 days of the close of each fiscal year or the end of the program's final disbursement period. Audits will be financed using program resources. Based on budgetary management and availability, the auditing team for this program should be hired in the framework of auditing for other programs that are currently being executed by the MSP with IDB financing.

2.57 **Retroactive financing.** Using resources from the reformulated loan, the Bank may retroactively finance up to US$2 million (4.7% of the proposed loan amount) in eligible expenses incurred by the borrower prior to loan approval for activities under Components 1 and 2 of the reformulated program, provided they meet requirements substantially similar to those in the loan contract. These expenses must have been incurred on or after 28 June 2022, but in no case will the Bank

reimburse expenses incurred more than 18 months prior to the loan approval date. (See document GN-2349-15, document GN-2350-15 and the Recognition of Expenditures, Retroactive Financing, and Advance Contracting (document GN-2259-1)).

I. Summary of arrangements for monitoring results

2.58 **Monitoring.** Program progress will be measured using the outcome and output indicators for each component in the results matrix and reflected in the progress monitoring report. The MSP, through the IDB Projects Management Unit, will be responsible for maintaining data collection and monitoring systems. The management instruments are the: (i) results matrix; (ii) annual work plan; (iii) multiyear execution plan; (iv) procurement plan; and (v) monitoring and evaluation plan. Semiannual progress reports will be submitted within 60 days after the end of each six-month period. Tools for monitoring the program are detailed in the monitoring and evaluation plan.

2.59 **Evaluation.** As stated in the monitoring and evaluation plan, the program will be assessed based on the targets, outcome indicators, and output indicators in the results matrix. A final evaluation will cover technical, administrative, and financial elements as well as an ex post cost effectiveness analysis. The evaluation will take place when at least 95% the IDB loan resources have been disbursed. The goal of the evaluation is to verify progress on: (i) the projected targets for each of the expected outcomes; and (ii) outputs by component.

2.60 To assess the program's contribution to the specific objectives, the evaluation will include a before and after analysis using available administrative records and time-series data on outcome indicators. It will use a quasi-experimental method, and the proposed methodology for the evaluation is synthetic cohort construction. The evaluations will be financed using nonreimbursable technical assistance from the IDB.

III. RECOMMENDATION

3.1 In accordance with: (i) the provisions of Subsection B, paragraph 4 of the Operations Administration Manual (OA-430) titled "Substantial and Fundamental Changes to Operations"; (ii) Annex I of document GN-2601-2; and (iii) the information and analysis in this document, Management recommends that the Board of Executive Directors approve the modification of the Institutional Strengthening for Competitiveness Program loan contract 4928/OC-EC as described in this document, by the short procedure. To that end, and in accordance with the provisions of paragraph 3.29(c) of the Regulations of the Board of Executive Directors of the IDB (document DR-398-19) and paragraph 6 of the list of issues that the Board may take up by the short procedure (document CS-3953-4), the Board has the authority to approve this reformulation proposal by the short procedure.

Development Effectiveness Matrix		
Summary	EC-L1250	
I. Corporate and Country Priorities		
Section 1. IDB Group Strategic Priorities and CRF Indicators		
Development Challenges & Cross-cutting Issues	**-Social Inclusion and Equality -Gender Equality and Diversity**	
CRF Level 2 Indicators: IDB Group Contributions to Development Results	**-Beneficiaries receiving health services (#)**	
2. Country Development Objectives		
Country Strategy Results Matrix	**GN-3103**	**Mejorar el acceso y cobertura a los servicios sociales y básicos**
Country Program Results Matrix		**The intervention is not included in the 2022 Operational Program.**
Relevance of this project to country development challenges (If not aligned to country strategy or country program)		
II. Development Outcomes - Evaluability		Evaluable
3. Evidence-based Assessment & Solution	**10.0**	
3.1 Program Diagnosis	**2.5**	
3.2 Proposed Interventions or Solutions	**3.5**	
3.3 Results Matrix Quality	**4.0**	
4. Ex ante Economic Analysis	**10.0**	
4.1 Program has an ERR/NPV, or key outcomes identified for CEA	**1.5**	
4.2 Identified and Quantified Benefits and Costs	**3.0**	
4.3 Reasonable Assumptions	**2.5**	
4.4 Sensitivity Analysis	**2.0**	
4.5 Consistency with results matrix	**1.0**	
5. Monitoring and Evaluation	**10.0**	
5.1 Monitoring Mechanisms	**4.0**	
5.2 Evaluation Plan	**6.0**	
III. Risks & Mitigation Monitoring Matrix		
Overall risks rate = magnitude of risks*likelihood	**Medium Low**	
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, Accounting and Reporting, External Control. Procurement: Information System, Price Comparison, Contracting Individual Consultant, National Public Bidding.**
Non-Fiduciary	**Yes**	**Strategic Planning National System, Monitoring and Evaluation National System, Statistics National System, Environmental Assessment National System.**
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		

***Evaluability Assessment Note:** The document presents the reformulation of an approved operation for Competitiveness that had not started disbursing that will now be used for an investment loan in Health with the general objective of contributing to the reduction of chronic malnutrition in infants and children by improving coverage of the basic package of nutrition services for pregnant women and children. The loan source comes from IDB Ordinary Capital for US$42 million. The operation has the following specific objectives: (i) delivery of a basic package of nutrition services for pregnant women and children under age 2; (ii) development of health competencies and education, and participation of citizens and local governments with a cultural focus; (iii) improvement of monitoring of population on health and nutrition.*

The diagnosis is satisfactory and well-documented by international evidence, highlighting the specific problems of the Health and Nutrition sectors and the lack of supply of prioritized services. The main problems are related to the impact of the pandemic on health and nutrition outcomes for pregnant women and children, especially in indigenous communities, low coverage of the basic package of nutrition services, and poor monitoring of population nutrition indicators and nutrition interventions at health centers. The results matrix is consistent with the vertical logic of the operation and presents impact indicators and expected results, well specified and adequate to measure the achievement of the specific objectives. It is important to note that there is a large body of experimental evaluations worldwide for the main interventions, growth monitoring and distribution of micronutrients, showing evidence of success in decreasing chronic malnutrition in the medium term. The program evaluation plan consists of: (i) a final evaluation, including an ex-ante and ex-post evaluation.

The economic analysis includes a cost-benefit analysis applied to 2 components of the project (representing 96% of costs) and concludes that their application will generate economic benefits, with an average IRR of 33.9%.

The project has received a medium-low overall risk rating, primarily due to potential risks related to MoF annual budget volatility, procurement and audit capacity, and shortage of trained health sector personnel and high rotation. Appropriate and monitorable mitigation or escalation measures have been proposed throughout the project.

RESULTS MATRIX

Project objective:	The specific objectives of this operation are to: (i) improve delivery of the priority health benefits to pregnant women and children under 2; (ii) improve health competencies through nutritional education and counseling, encouraging civic engagement and coordination with local governments, to act on the determinants of health; and (iii) improve individual monitoring in the target population by improving information systems, in order to measure the indicators on the delivery of the priority health benefits. Achieving these objectives will contribute to the general objective, which is to help reduce chronic child malnutrition through delivery of priority health benefits to pregnant women and children under 2, using cross-sector interventions with a focus on civic engagement and interculturality and concentrating interventions in priority parishes.

GENERAL DEVELOPMENT OBJECTIVE

Indicators	Unit of measure	Baseline value	Baseline year	Expected year achieved	Target	Means of verification	Notes
Chronic malnutrition in children under 2 falls by 2 percentage points	Percentage points	27.17	2018	2024	25.17	ENSANUT National Survey on Child Malnutrition (ENID)	As a reference, the Opportunities Creation Plan target: Reduce chronic child malnutrition in children under 2 by 6 percentage points by 2025.

SPECIFIC DEVELOPMENT OBJECTIVES[1]

Indicators	Unit of measure	Baseline value	Baseline year	Year 1	Year 2	End of project	Means of verification	Notes
1.1 Children under 2 who receive the priority health benefits	Percentage	0	2021	15	41.6	41.6	MSP administrative data	The baseline value is zero, because the strategy was launched in 2021. Measured at the national level. Growth and development checks include growth-monitoring activities.
1.2 Indigenous children under 2 who receive the priority health benefits		0	2021	15	42	42		The baseline value is zero, because the strategy was launched in 2021. Measured at the national level. The target is the same for the indigenous and nonindigenous population, to ensure health equity.
1.3 Pregnant women who receive the priority health benefits, by gestational age		0	2021	17	46	46		The baseline value is zero, because the strategy was launched in 2021. Measured at the national level. **The indicator will be disaggregated for the indigenous population.**
1.4 Health facilities that implement integrated childbirth practices	Percentage	0	2021		50	50	MSP reports	Integrated practices are immediate skin-to-skin contact, delayed clamping of the umbilical cord, and exclusive breastfeeding in the first hour postpartum. 728 priority parishes. The certificates issued based on policy ESAMyN 00030-2022 will be used as a basis.

[1] Targets calculated after a review of outcomes—nationally, subnationally, and for health providers. A hybrid approach was suggested for setting targets, using the following qualitative and quantitative data:
a. An economic model based on a simple cost-benefit framework.
b. Review of the literature, international experiences, historic trends of national health indicators, and the impact of specific interventions.
c. Statistical power calculations.
d. Country's operating requirements, consultations with experts.

Indicators	Unit of measure	Baseline value	Baseline year	Year 1	Year 2	End of project	Means of verification	Notes
2.1 Parishes with community workgroups established and functioning to coordinate delivery of the priority healthy benefits.	Percentage	0	2021	17	50	50	MSP reports	728 priority parishes.
2.2 Priority parishes that have at least one community nutritionist to: (i) identify pregnant women and children under 2; and (ii) provide nutritional counseling at the community level		0	2021	60	60	60		A community nutritionist (172 will be hired in total) is provided for in priority parishes (728) (high and medium priority).
3.1 Parishes that are doing training, oversight, and monitoring activities to improve the individual monitoring system for beneficiaries		0	2021	80	80	80		Considering the 728 parishes prioritized by the government.

OUTPUTS

Indicators	Unit of measure	Baseline value	Baseline year	Year 1	Year 2	End of project	Means of verification	Notes
Component 1. Delivery of the priority health benefits								
1.1 Health facilities that have medical equipment and supplies to monitor and encourage growth in children and monitor weight gain in pregnant women	#	0	2022	1,148	1,148	1,148	Certificates of delivery and receipt of equipment	The medical equipment and supplies cover: anthropometric equipment, hemoglobinometers, and laboratory medical devices for checking hemoglobin. Corresponds to primary care facilities (Type A, B, and C). Total of 1,938 primary care facilities. The equipment must be calibrated and operational. Facilities that serve indigenous and Afro-Ecuadorian populations are represented among the priority health facilities.
1.2 Health facilities that have units of: (i) iron and folic acid; and (ii) iron polymaltose for pregnant women	#	0		1,550	1,550	1,550	Certificate of delivery and receipt at the health facilities	"Units" are tablets to dose all pregnant women at a given time and pregnant women found to have anemia in a set period. Total of 1,938 primary care facilities. Facilities that serve indigenous and Afro-Ecuadorian populations are represented among the priority health facilities.
1.3 Health facilities that have units of: (i) powdered micronutrients; (ii) iron polymaltose; (iii) vitamin A; and (iv) zinc for children under 2	#	0		1,550	1,550	1,550		"Units" are packets of powdered micronutrients, bottles of syrup and drops for iron polymaltose, capsules of vitamin A and bottles of zinc syrup. Enough for complete courses of powdered micronutrients for all children ages 6 to 24 months at a given time, and all children found to have anemia and all children ages 6 to 24 months for a dose of vitamin A in a set time period—for vitamin A no more than six months and for zinc for treatment of at least four episodes of diarrhea per child per year. Total of 1,938 primary care facilities. Facilities that serve indigenous and Afro-Ecuadorian populations are represented among the priority health centers.

Indicators	Unit of measure	Baseline value	Baseline year	Year 1	Year 2	End of project	Means of verification	Notes
1.4 Health facilities that have the Comprehensive Health Passbook and counseling toolkit for childbirth and postpartum issues: (i) immediate skin-to-skin contact; (ii) delayed clamping of the umbilical cord; and (iii) exclusive breastfeeding in the first hour postpartum	#	0	2022		245	245	Certificate of delivery and receipt at the health facilities	For the Comprehensive Health Passbook: Corresponds to primary care health facilities (Type A, B, and C). Total of 1,938 primary health care facilities. For the toolkit: 245 facilities in high-priority parishes.
Component 2: Building health competencies through nutritional education and counseling								
2.1 Workshops on preparing healthy foods	#	0	2022	245	245	245	MSP Reports	245 workshops for the beneficiary population of facilities in high-priority parishes.
2.2 Health facilities with instructional tools for counseling on breastfeeding and complementary feeding	#	0	2022	245	245	245		Facilities in high-priority parishes.
2.3 Priority parishes with cross-sector parochial working groups established and functioning to coordinate activities for the delivery of priority health benefits in the territory	#	0	2022	356	356	356	Working group charter	There are charters for the working groups. Established with social organizations, citizen engagement committees, and/or local governments.
2.4 Community monitors trained, with an emphasis on chronic child malnutrition	#	0		1,225	1,225	1,225	MSP Reports	
2.5 Nutritionists at the zone, district, and community level hired for at least 12 continuous months to enhance: (i) identification of pregnant women and children under 2; and (ii) provision of nutritional counseling at the community level	#	0		172	172	172	Contracts signed	In zones, districts, and communities that are majority indigenous, nutritionists will preferably belong to the predominant indigenous community.
2.6 Central technical and administrative staff hired to support delivery of priority health and nutrition benefits	#	0		17	17	17		Description according to the matrix.

Indicators	Unit of measure	Baseline value	Baseline year	Year 1	Year 2	End of project	Means of verification	Notes
Component 3: Individual monitoring								
3.1 Zone level health coordination with resources to begin training, supervision, and monitoring related to strengthening the individual monitoring system for beneficiaries and delivery of the priority health benefits	#	0	2022	9	9	9	Integrated Financial Management System (e-SIGEF) report that planned resources have been transferred to zone coordination offices	They must have the three inputs.
3.2 Packets of regulatory and technical materials edited and reproduced, culturally adapted for health care workers for individual monitoring of beneficiaries	#	0	2022	1	1	1	Semiannual report	“Edited and reproduced” means any audiovisual and print medium. The regulatory materials packets will be culturally adapted.
3.3 Monitoring staff equipped for the individual beneficiary monitoring system	#	0		189		189		“Equipment” means central and regional hardware for training, monitoring, and supervision.

Country: Ecuador **Division:** SPH **Operation No.:** EC-L1250 **Year:** 2022

FIDUCIARY AGREEMENTS AND REQUIREMENTS

Executing agency: Ministry of Public Health (MSP)

Operation name: Reformulation of the "Institutional Strengthening for Competitiveness Program to Finance the Program to Support the Reduction of Child Malnutrition in Ecuador"

I. FIDUCIARY CONTEXT OF THE EXECUTING AGENCY

1. Use of country systems in the operation (any system or subsystem that is subsequently approved may be applicable to the operation, in accordance with the terms of its validation by the Bank).

☒ Budget	☒ Reports	☒ Information system	☐ National competitive bidding (NCB)
☒ Treasury	☐ Internal audit	☐ Shopping	☐ Other
☒ Accounting	☐ External control	☐ Individual consultants	☐ Other

2. Fiduciary execution mechanism

☒	Fiduciary execution details	The MSP is the program executing agency. The Ministry of Economy and Finance (MEF) will participate in the program, acting as the borrower's representative. It will have a strategic role facilitating and supporting the program's progress.

3. Fiduciary capacity

Fiduciary capacity of the executing agency	The most recent assessment of the executing agency's institutional capacity was in 2018. Since then, the MSP has been satisfactorily executing three Bank-financed operations, which demonstrates its experience with the financial management and project procurement policies.

4. Fiduciary risks and risk response

Risk taxonomy	Risk	Level of risk	Risk response
Institutional	Difficulties in the annual budget process and getting endorsements from the MEF as part of budget execution (even though the project is a priority), which could delay procurement and therefore delay or prevent expected disbursements.	Medium-High	Continuous monitoring between MSP-MEF with Bank support to identify and plan activities that have the approval, endorsement, and relevant certifications to move forward with the respective precontractual and contractual processes.
Institutional	Challenges interpreting the application of IDB procurement and contracting policies that may interfere in their usual course could cause contractual proceedings to take longer and/or be declared void.	Medium-High	In the program eligibility process, determine all the technical specifications, terms of reference, and formats and/or bidding conditions needed for efficient procurement and contracting.
Institutional	Delays in internal MSP procedures to start procurement processes, impacting whether the program's annual physical and financial targets are met, and lack of delegation to arrange bids, conclude contracts, and properly administer contracts for the provision of key goods for the priority health benefits.	Medium-High	In the program Operating Regulations, determine the minimum required internal processes for procurement, and the delegation of the respective administrative, legal, and financial responsibilities to ensure timely action from the MSP Program Management Unit under the current institutional structure.
Institutional	Delays in hiring an external auditing firm due to lack of allocated fiscal resources and delays in the issuance of multiyear and budgetary certifications by the MEF.	Medium-High	Coordination between the MSP and MEF with Bank support to quickly address resources and certifications required for procurements and compliance with the program's external audit.

5. Applicable policies and guidelines: documents GN-2349-15; GN-2350-15; and OP-273-12.

6. Exceptions to policies and guidelines: Not applicable.

II. CONSIDERATIONS FOR THE SPECIAL PROVISIONS OF CONTRACTS

Special conditions precedent to the first disbursement:
Exchange rate: For the purposes of Article 4.10 of the General Conditions, the parties agree that the exchange rate to be used will be the rate stipulated in Article 4.10(b)(i). For the purposes of determining the equivalency of expenditures incurred in local currency chargeable against the local contribution and for reimbursement of expenditures chargeable against the loan, the exchange rate will be the rate in effect on the date on which the borrower, the executing agency, or other person or corporation with delegated authority to incur expenditures makes the respective payments to the contractor, vendor, or beneficiary.
Type of audit: Audited special-purpose financial statements for the program must be presented to the Bank annually within 120 days of the close of the fiscal year (31 December) or the date of the last disbursement. The audit must be conducted by a Bank-eligible firm.

III. AGREEMENTS AND REQUIREMENTS FOR PROCUREMENT EXECUTION

☒	Bidding documents	Contracts for works, goods, and nonconsulting services generated according to the Procurement Policies (document GN-2349-15) and subject to international competitive bidding will use the Bank's standard bidding documents or those agreed to by the Bank and the executing agency for individual procurements. Consulting services will be selected and contracted in accordance with the Policies for the Selection of Consultants (document GN-2350-15) and use the Bank's standard request for proposals or those agreed to by the Bank and the executing agency for the individual selection. The program must hire a large number of nutritionists to strengthen community work and to identify pregnant women and children under 2 and deliver priority health benefits (Component 2). Due to the features and geographic dispersion of services, the consultant type is "service delivery contractors" under paragraph 3.22 of document GN-2350-15. The description of roles, minimum qualifications, conditions of employment, selection procedures, and the extent to which the Bank reviews those procedures and documents will be agreed on with the Bank and form part of the program Operating Regulations, ensuring that the financing source is included in the program investment budget so that exceptions under Presidential Decree 858/2019 can be applied.
☒	Recurring expenses	Required recurring expenses to launch the project approved by the Project Team Leader will be executed according to the executing agency's administrative procedures. These procedures will be reviewed and accepted by the Bank provided they are in line with the principles of economy, efficiency, and competition; see

<table>
<tr><td></td><td></td><td>guidelines for the treatment of recurring expenses and the policy on eligible expenses (document GN-2331-5) and updates.</td></tr>
<tr><td>☒</td><td>Advance procurement / Retroactive financing</td><td>Using resources from the reformulated loan, the Bank may retroactively finance up to US$2 million (4.7% of the proposed loan amount) of eligible expenses incurred by the borrower prior to loan approval for activities in Components 1 and 2 of the reformulated program, provided they meet requirements substantially similar to those in the loan contract. These expenses must have been incurred on or after 28 June 2022, but in no case will the Bank reimburse expenses incurred more than 18 months prior to the loan approval date. (See document GN-2349-15, document GN-2350-15 and the Recognition of Expenditures, Retroactive Financing, and Advance Contracting (document GN-2259-1)).</td></tr>
<tr><td>☒</td><td>Procurement supervision</td><td>Supervision will be ex post except in those cases where ex ante supervision is justified. Procurements executed through the country system will be overseen by the country system for supervision. The method [(i) ex ante, (ii) ex post, or (iii) country system] will be determined for each selection process. Ex post reviews will take place each calendar year in accordance with the project’s oversight plan, subject to change during project execution. Ex post review reports must include a visit to physically inspect procurement processes subject to ex post review, selected at random and with representation of no less than 10%. The thresholds for ex post review are listed below:
<table>
<tr><th>Executing agency</th><th>Works</th><th>Goods / services</th><th>Consulting services</th></tr>
<tr><td>MSP</td><td>US$3 million</td><td>US$250,000</td><td>US$200,000 companies
US$50,000 individuals</td></tr>
</table></td></tr>
<tr><td>☒</td><td>Records and archives</td><td>The MSP must maintain up-to-date records and files properly arranged in chronological order. Documentation concerning procurement and contracting must be kept in a single file, in both physical and digital format. It must be fully discernible from program elements financed by other sources.</td></tr>
</table>

Main procurement items

Procurement description	Selection method	New procedures / tools	Estimated date	Estimated amount (US$000)
Goods				
Anthropometric equipment	International competitive bidding		2023	1,900
Nutritional medications for pregnant women, supplies for taking samples during pregnancy exams, nutritional medications for children under 2	International competitive bidding		2023	22,637
Equipment for training, supervision, and monitoring – year 1, equipment for training, supervision, and monitoring – year 2	International competitive bidding		2023	575
Nonconsulting services				
Printing services for booklets on care for pregnant women; printing services for booklets on comprehensive care for children under 5; printing services for regulatory and technical materials for health care workers	International competitive bidding		2023	898
Maintenance and calibration services for anthropometric equipment	International competitive bidding		2023	440
Companies				
Financial auditing of program	Quality- and cost-based selection		2023	200
Individuals				
Team of professionals to process priority health benefits (16 professionals)	Individual consultant selection (3CV)		2023	433

Procurement description	Selection method	New procedures / tools	Estimated date	Estimated amount (US$000)
Nutritionists to enhance community work and to identify expectant mothers and children under and deliver priority health benefits (Component 2)	Individual consultant selection (by open invitation)		2023	14,100

To view the 18-month procurement plan, click link.

IV. Agreements and Requirements for Financial Management

☒	Programming and budget	The Public Finances and Planning Code sets forth regulations governing budget programming, creation, approval, execution, monitoring, evaluation, and rendering of accounts. The executing agency is responsible for submitting paperwork to have the corresponding line items in their budget.
☒	Cash flow and disbursement management	The Central Bank of Ecuador will hold a program-specific account from which the resources will be disbursed. Financing will be transferred same day to the Single Treasury Account. Project payments will be made from this account and reimbursements will be paid into this account. Disbursements may be processed through the Online Disbursements Platform or manually. The operation will be managed in U.S. dollars (US$). The official currency in Ecuador is the U.S. dollar. The disbursement method will be advance of funds, which must be justified within 180 days based on real liquidity needs, in line with a financial plan and detailed cash flow. In all, 80% of the cumulative balance of previous advances of funds must be justified. Payments can also be reimbursed or made directly to vendors at the borrower's request in accordance with the Financial Management Guidelines (document OP-273-12).
☒	Accounting, information systems, and reporting	E-SIGEF, which integrates budget processes for executing expenses, will be used for program accounting. All program commitments and payments will be recorded in the system. The system must be able to create the program's financial statements, and non-accounting records will also be required to show a breakdown by component.
☒	External control and financial reporting	The executing agency, in agreement with the Bank, will select and contract the services of a Bank-eligible auditing firm, to audit the special purpose financial statements in accordance with the Financial Management Guidelines for IDB Financed Projects; the manual on financial statements and management of external auditing; and the agreements on the Terms of Reference previously agreed to with the Bank. The cost of external auditing may be paid for with loan resources.
☒	Financial oversight of the operation	Supervision will be focused on cash flow and disbursement programming, portfolio reviews and oversight visits (in person or virtually), and an analysis of the audited financial statements, the program, and findings from the internal control reports, and an analysis of data and trends from the program's financial performance.

DOCUMENT OF THE INTER-AMERICAN DEVELOPMENT BANK

PROPOSED RESOLUTION DE-__/22

Ecuador. Modification to the “Institutional Strengthening for Competitiveness Program” to finance the “Program to Support the Reduction of Child Malnutrition in Ecuador”
(Modification to Loan No. 4928/OC-EC)

The Board of Executive Directors

RESOLVES:

1. To approve the modification to the “Institutional Strengthening for Competitiveness Program” to finance the “Program to Support the Reduction of Child Malnutrition in Ecuador”, in accordance with the terms and conditions established in document PR-4750-1.

2. That the President of the Bank, or such representative as he shall designate, is authorized, in the name and on behalf of the Bank, to enter into such contract or contracts as may be necessary with the Republic of Ecuador, as borrower, to implement the modification to which reference is made in paragraph 1.

(Adopted on ___ _____ 2022)

LEG/SGO/CAN/EZSHARE-26331146-20378
EC-L1250 - Modification