SIMULTANEOUS DISCLOSURE

DOCUMENT OF THE INTER-AMERICAN DEVELOPMENT BANK

BOLIVIA

IMPROVED ACCESS TO HOSPITAL SERVICES IN BOLIVIA

(BO-L1078)

LOAN PROPOSAL

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CONTENTS

ANNEXES

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

ELECTRONIC LINKS

REQUIRED

1. AWP (Plan of activities for the first disbursement and for first 18 months of execution)
   http://idbdocs.iadb.org/wsdocs/getDocument.aspx?DOCNUM=37027359
2. Monitoring and evaluation arrangements
   http://idbdocs.iadb.org/wsdocs/getDocument.aspx?DOCNUM=37019731
3. Itemized procurement plan
   http://idbdocs.iadb.org/wsdocs/getDocument.aspx?DOCNUM=37071635
4. Environmental and Social Management Report (ESMR)
   http://idbdocs.iadb.org/wsdocs/getDocument.aspx?DOCNUM=37025939

OPTIONAL

1. Costs chart
   http://idbdocs.iadb.org/wsdocs/getDocument.aspx?DOCNUM=37019434
2. Potosí medical architecture program
   http://idbdocs.iadb.org/wsdocs/getDocument.aspx?DOCNUM=37021047
3. Equipping the El Alto Norte Hospital
   http://idbdocs.iadb.org/wsdocs/getDocument.aspx?DOCNUM=37024300
4. Potosí equipment for scenarios
   http://idbdocs.iadb.org/wsdocs/getDocument.aspx?DOCNUM=37024312
5. Human resource proposal for Potosí
   http://idbdocs.iadb.org/wsdocs/getDocument.aspx?DOCNUM=37024327
6. Cost-benefit analysis
   http://idbdocs.iadb.org/wsdocs/getDocument.aspx?DOCNUM=37026080
7. Safeguard Policy Filter Report and Screening Form
   http://idbdocs.iadb.org/wsdocs/getDocument.aspx?DOCNUM=37026024

ABBREVIATIONS

AWP	Annual work plan
ENDESA	Encuesta Nacional de Demografía y Salud [National Demography and Health Survey]
ESMR	Environmental and Social Management Report
FSO	Fund for Special Operations
ICB	International competitive bidding
INE	National Institute of Statistics
MEFP	Ministry of the Economy and Public Finance
MSD	Ministry of Health and Sport
OC	Ordinary Capital
PEU	Program executing unit
SAFCI	Salud Familiar, Comunitaria e Intercultural [Family, community, and intercultural health]
SEDES	Servicio Descentralizado de Salud [Decentralized Health Service]
SIGMA	Sistema de Gestión y Modernización Administrativa [Administrative management and modernization system]
SNIS	Sistema Nacional de Información de la Salud [National Health Information System]
SUS	Sistema Único de Salud [Single Health System]
UDAPE	Unidad de Análisis de Políticas Sociales y Económicas [Social and Economic Policies Analysis Unit]

PROJECT SUMMARY
BOLIVIA
IMPROVED ACCESS TO HOSPITAL SERVICES IN BOLIVIA
(BO-L1078)

<table>
<tr><th colspan="6">Financial Terms and Conditions</th></tr>
<tr><td colspan="3" rowspan="4">Borrower: Plurinational State of Bolivia
Executing agency: Ministry of Health and Sport</td><td></td><td>Ordinary Capital (OC)</td><td>Fund for Special Operations (FSO)</td></tr>
<tr><td>Amortization period:</td><td>30 years</td><td>40 years</td></tr>
<tr><td>Grace period:</td><td>6 years</td><td>40 years</td></tr>
<tr><td>Disbursement period:</td><td>5 years</td><td>5 years</td></tr>
<tr><td>Source</td><td>Amount</td><td>%</td><td>Interest rate:</td><td>SCF fixed</td><td>0.25%</td></tr>
<tr><td>IDB (FSO) (20%)</td><td>US$7,000,000</td><td>14</td><td rowspan="2">Inspection and supervision fee:</td><td rowspan="2">*</td><td rowspan="2">N/A</td></tr>
<tr><td>IDB (OC) (80%)</td><td>US$28,000,000</td><td>57</td></tr>
<tr><td>Local</td><td>US$14,200,000</td><td>29</td><td>Credit fee:</td><td>*</td><td>N/A</td></tr>
<tr><td>Total</td><td>US$49,200,000</td><td>100</td><td>Currency</td><td>Single Currency Facility (SCF) of the Bank’s Ordinary Capital</td><td>U.S. dollars</td></tr>
<tr><th colspan="6">Program at a Glance</th></tr>
<tr><td colspan="6">Program objective: To improve the efficiency of service production and the curative/treatment capabilities of health networks in El Alto and Potosí, to meet departmental healthcare needs. This will make it possible to treat cases that have been postponed or discouraged, particularly for women, children, and persons belonging to indigenous groups. Given Bolivia’s epidemiological profile, the project will have an impact on reducing mortality rates, particularly mother-child mortality. The building and equipping of specialized hospital services complements and completes the functioning of healthcare networks in Potosí and El Alto (paragraph 1.14).</td></tr>
<tr><td colspan="6">Special conditions precedent to the first disbursement: (i) creation of the Program Executing Unit (PEU) with sufficient administrative, legal, and financial capacity (including installation of the State financial management system) to implement program activities; and the appointment of key staff, pursuant to the terms of reference agreed upon with the Bank; and (ii) approval of the program’s Operating Regulations by the executing agency, under the terms previously approved by the Bank, including the items stipulated in the Environmental and Social Management Report (ESMR) (paragraph 3.4). Special contractual execution condition: Disbursements in component II will be subject to selection of the management firm, in accordance with terms of reference previously agreed to by the Bank (paragraph 3.1). Special contractual program condition: A special condition for the program requires evidence of the annual incremental allocation of resources in the General State Budget, in accordance with the Implementation Plan, to cover expenses related to wages and benefits, inputs, maintenance, and other operating expenses for the El Alto Norte hospital, once it begins operations (paragraph 2.9).
Retroactive financing of expenses: The Bank may retroactively finance all expenses related to the procurement of medical and industrial equipment for the El Alto Norte hospital up to the equivalent of US$3 million, as a charge against the loan proceeds (paragraph 3.7).
Special disbursement: Once the loan contract has entered into force and the general conditions precedent to the first disbursement have been fulfilled, as specified in Article 4.01 of the General Conditions of the loan contract, the Bank may disburse to the executing agency up to US$100,000 as a charge against the loan proceeds, to support the executing agency in hiring the team needed for the PEU team (paragraph 3.4).</td></tr>
<tr><td colspan="6">Procurement: All program procurement will be undertaken in accordance with the Bank’s policies and procedures, as defined in documents GN-2349-9 and GN-2350-9.</td></tr>
<tr><td colspan="6">Exceptions to Bank policies: None</td></tr>
<tr><td colspan="6">Project consistent with the country strategy: Yes [X] No [ ]
Project qualifies as: SEQ [X] PTI [X] Sector [ ] Geographic [X] Headcount [ ]</td></tr>
</table>

(*)The credit fee and inspection and supervision fee will be established periodically by the Board of Executive Directors as part of its review of the Bank’s lending charges, in accordance with the applicable provisions of the Bank’s policy on lending rate methodology for Ordinary Capital loans. In no case will the credit fee exceed 0.75% or the inspection and supervision fee exceed, in a given six-month period, the amount that would result from applying 1% to the loan amount divided by the number of six-month periods included in the original disbursement period.

I. DESCRIPTION AND RESULTS MONITORING

A. Background, problems addressed, and rationale

1.1 Bolivia has made progress on a number of social development indicators in the last few years. The nationwide extreme poverty index fell from 41% to 26.1%, between 1996 and 2009;[1] the prevalence of chronic malnutrition among children under three years of age dropped from 37.7% to 20.3%; and the national infant mortality rate declined from 81.9 to 50 per 1,000 live births in the same period. Nonetheless, the country still shows a performance gap in regional comparisons. Bolivia has the second-highest infant mortality rate in Latin America, mainly resulting from pneumonia and diarrheas. This is concentrated in neo-natal mortality, where rates are 27 per 1,000 live births nationally, and 35 and 47 per 1,000 live births in La Paz and Potosí, respectively.[2] The maternal mortality rate has declined slightly: the leading causes of maternal mortality are, first, hemorrhaging during pregnancy and childbirth;[3] second, infections; and third, complications arising from abortions performed under risky conditions.[4]

1.2 Maternal and infant mortality largely reflects unequal access to quality health services, compounded by economic, geographic and cultural barriers, and the population's habits. For example, in 2008, 71% of childbirths nationally were attended by skilled staff, compared to 51% in rural areas and just 31.7% in Potosí.[5] Indigenous women in rural areas are four times more likely to die from complications arising in pregnancy, childbirth, and postpartum than women living in cities.[6] A universally accepted mother-child healthcare principle is the importance of early identification of pregnancies and prenatal checkups, plus timely healthcare. Nonetheless, the vast majority (>70%) of obstetric complications during delivery occur unexpectedly, among expectant mothers who do not display risk factors, which is evidence of the low prediction and prevention capacity of these checkups. In this context, it is essential to overcome obstetric emergencies and prevent associated perinatal deaths when the problems occur, which requires greater curative/treatment capabilities in healthcare networks, particularly hospitals with the relevant specialist facilities.[7] Another decisive factor for maternal mortality is

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1 Source: United Nations Development Programme: millennium Development Goals, Bolivia Human Development Report; UDAPE/ENDESA 1989-2008.

2 National Institute of Statistics (INE) - National Demography and Health Survey (ENDESA) 2008.

3 A. L. Prieto and C. Cid, "Análisis del Sector Salud de Bolivia" [Analysis of Bolivia's Health Sector], IDB, August 2010, page 20.

4 Source: Social and Economic Policies Analysis Unit (UDAPE), Statistics Dossier 2009.

5 National Health Information System (SNIS) 2011A.

6 National Strategic Plan on Sexual and Reproductive Health 2009-2015. MSD. Bolivia 2010. Page 13.

7 Cordero, Luis Muñoz, "Salud de la Mujer Indígena" [Health of the Indigenous Woman]; Inter-American Development Bank; 2010.

the high number of unplanned pregnancies[8] and the lack of access to family planning services.[9] The literature shows that strategies to reduce maternal mortality include institutional childbirth attended by skilled professionals, and the existence of comprehensive emergency obstetric care to deal with obstetric and neonatal complications.[10, 11]

1.3 Bolivia is at an incipient stage of the epidemiological and demographic transition. In this context, infectious and transmissible diseases remain the predominant causes of morbidity and mortality. Nonetheless, chronic nontransmissible diseases are becoming increasingly important among the leading causes of mortality, including ischemic heart diseases, cerebro-vascular diseases, liver cirrhosis, nephritis, diabetes, and cardiac hypertension.[12] For example, current access to hemodialisis services is estimated to cover just 20% of needs.[13] Given this situation, the stock of hospital beds and specialized outpatient care in Bolivia is low, ranking the country among those with least coverage in the region (just over one bed for every 1,000 inhabitants).[14] At the same time, the distribution of hospital beds across the country is asymmetric, and curative/treatment capabilities are modest owing to the lack of specialized staff, compounded by scarce, obsolete, or poorly maintained equipment. In terms of hospital infrastructure in the Department of La Paz, there are 12.57 hospital beds per 10,000 people, compared to 30.06 in Chuquisaca, 17.17 in Cochabamba, and 11.44 in Potosí.[15] This demonstrates both the insufficiency[16] and the unequal distribution of hospital beds nationwide.[17]

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8 In the five years prior to the ENDESA, 61% of total births and 70% of births in the rural area were unplanned.

9 The report by the UN Commission on Information and Accountability "Countdown to 2015" states that one in every three poor women would prefer to space their pregnancies, and/or does not have access to family planning services.

10 Campbell, Oona M.R.; W. Graham, J 2006 "Strategies for reducing maternal mortality: getting on with what works" *The Lancet Maternal Survival Series Steering Group; The Lancet* 368:1284-99.

11 Jamison, et al., *Disease Control Priorities in Developing Countries*; 2006; The World Bank; page 513.

12 Programa Fortaleciendo Redes de Servicios de Salud – Bolivia [Program to Strengthen Health Service Networks - Bolivia], page 24; WHO, *Global Burden of Disease: 2004 Update*.

13 http://www.clc.cl/clcprod/media/contenidos/pdf/MED_21_4/01_Dr_Flores.pdf. Bearing in mind the epidemiological conditions prevailing in Bolivia compared to those of Chile, in Potosí 300 persons per million are estimated to need dialysis. This means that 225 people should be undergoing hemodialisis.

14 (http://new.paho.org), Data and Statistics, Tables Generator, latest figure available for Bolivia on the variable E.22.0.0 "Hospital beds ratio (per 1,000 inhabitants)" 26 July 2012.

15 Source: INE, Projection 2009.

16 According to the report by the Pan American Health Organization (PAHO) "Health Situation in the Americas: Basic Health Indicators, 2009," the average number of hospital beds per 10,000 inhabitants is 18 in Latin America and the Caribbean as a whole, but only 11 in Bolivia.

17 In the absence of specific information on morbidity, information is only available on infrastructure.

1.4 **Health situation in El Alto.** The departments of Potosí and La Paz (particularly the city of El Alto) account for a large proportion of the inequalities in access and care quality. The city of El Alto, with a population of roughly 1 million and 2,633.13 inhabitants per km^2 has the highest population density in Bolivia.[18] Over half of this population is poor, identifies itself as "indigenous," and speaks a native language at home (mainly Aymara and Quechua).[19, 20] The 2000 maternal mortality survey reported a maternal mortality rate of 326/100,000 live births in the Department of La Paz.[21] In 2009, just 54% of deliveries took place in a healthcare facility, and only 36% of children younger than one year suffering from pneumonia were cared for in such facilities.[22] In 2009, the Los Andes Hospital, operating at full capacity, assisted a total of 3,448 childbirths,[23] just 50% of the number expected in that network.[24] This situation calls for an increase in curative/treatment capabilities and a doubling of infrastructure and installed capacity for delivery and newborn care.

1.5 The El Alto population continues to suffer mainly from infectious diseases, particularly diarrheas, pneumonia, and bronchitis. Given the habit of only seeking healthcare when the situation is seen to be worsening, hospital services, which include outpatient care with diagnostic and curative/treatment capabilities, are ultimately the most effective way of saving lives.[25] At the same time, increasing numbers of cases of morbidity and mortality for chronic diseases are being reported. For example, the detection and treatment of cases of hypertension quadrupled between 2008 and 2010.[26] In the same period, the Boliviano-Holandés hospital reported a substantial increase in cases of type I and type II diabetes mellitus. Lack of access to medical care for timely diagnosis and treatment of chronic diseases makes it highly likely that morbidity and mortality in these population groups is under-recorded; so these diseases are not currently being reflected among the main causes of mortality.

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[18] Source: Diagnóstico Rápido Redes de Salud [Rapid health networks diagnostic] – MSD, 2011. La Paz, in a valley, and El Alto, on the high plain of the Andes, are contiguous. El Alto accommodates recent migrants from rural areas in haphazard settlements that obtain basic services over time.

[19] Source: UDAPE Statistics Dossier 2009.

[20] UDAPE Statistics Dossier 2009.

[21] Source: Post-Census Survey on Maternal Mortality 2000.

[22] Source: UDAPE Statistics Dossier 2009.

[23] Source: SNIS 2011.

[24] The percentage hospital bed occupancy rate in the Los Andes hospital maternity area was 95% in 2011 (SNIS 2012).

[25] According to Jamison, to reduce infant mortality, integrated control of respiratory diseases requires potential referral to a hospital with diagnostic and curative treatment capacity; in *Disease Control Priorities in Developing Countries;* 2006; The World Bank; page 488.

[26] Source: Boliviano-Holandés hospital, SNIS-VIG EPI presentation - comparison 2010-2011.

1.6 **Access to hospital services in El Alto.** The municipal network of El Alto comprises five health networks, including 40 level one health centers[27] and five level two hospitals. In 2011 the Boliviano-Holandés, El Alto's most sophisticated hospital, referred 16% of internal medicine cases and 12% of pediatric cases to hospitals in the city of La Paz, because it could not provide the necessary treatment owing to a lack of specialists and specialized equipment.[28] Against this backdrop, in 2011, the municipal government of El Alto and the Office of the Governor (*Gobernación*) of La Paz financed the construction of the Gemelo Norte hospital (hereinafter the El Alto Norte hospital) with specialized curative/treatment capacities. The La Paz Decentralized Health Service (SEDES) is in the process of assigning the staff needed to operate the hospital, and it has asked for Bank support to provide financing to equip it. This new hospital should focus on urgent care and chronic diseases prevalent among the population, since it will be the only level three unit serving that population. At the same time, it must address the coverage shortfall for normal childbirth and obstetric emergencies in the network.

1.7 **Health situation in Potosí.** The Department of Potosí is one of the country's poorest: in 2000, the maternal mortality rate was 352/100,000 live births; the perinatal mortality rate was 43/100,000 live births; and the neonatal mortality rate was 41/100,000 live births.[29] The department has a population of 788,406 inhabitants (7.7% of Bolivia' total population), of whom the vast majority is of Quechua (59%) or Aymara (7%) origin.[30] According to the Municipal Health Index,[31] Potosí has the worst health situation of all departments. The leading causes of emergency hospital visits in 2009 were injuries and poisoning, digestive illness, and diseases of the nervous system.[32] Workplace accidents are the cause of early mortality among men, thereby shortening life expectancy.[33] Bearing in mind that the Potosí population is exposed to pollutants and harm caused by mining activity, specialized care is needed for diseases that are prevalent among this population group, such as lead and/or mercury poisoning, lung and skin diseases, and industrial accidents. Moreover, the high maternal and neonatal mortality rates point to the need for increased care in childbirth services. Providing this care requires a number

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27 26 health centers; 14 health centers with beds; Source: Rapid network diagnostic; MSD, 2011.

28 Source: Boliviano-Holandés hospital, SNIS-VIG EPI presentation - comparison 2010-2011.

29 ENDESA Post-Census survey 2000.

30 INE and Vice Ministry for Indigenous Affairs, 2001Census.

31 Source: PAHO; Municipal Health Index, 2009. This index measures health inequalities, including relevant indicators such as the population health status and the determinants of health. A value of 1 is interpreted as an ideal state, whereas a value of 0 can be interpreted as the worst relative situation.

32 Emergency medical register – Daniel Bracamonte hospital, 2009.

33 Ramírez Hita, S. 2009. "La Contribución del Método Etnográfico al Registro del Dato Epidemiológico. Epidemiología Sociocultural Indígena Quechua de la Ciudad de Potosí" [The contribution of the ethnographic method to recording epidemiological data. Quechua Indigenous sociocultural epidemiology of the city of Potosí]. *Salud Colectiva*. 5(1).

of sub-specializations to be added to the four basic specialties,[34] such as traumatology, neonatology, neurosurgery, kinesiotherapy, ophthalmology, urology, and pediatric surgery.[35]

1.8 **Access to health services in Potosí.** The department has 40 municipal services in 11 functional health networks. These networks operate 330 neighborhood clinics, 145 health centers (38 beds), four basic hospitals with a total of 129 beds (all in the urban area), and a general hospital (the Daniel Bracamonte hospital, with 153 beds). Most of healthcare facilities need improvements to their infrastructure and equipment, as well as more regular supply of inputs and medications.[36] Several care areas in the Bracamonte hospital are already saturated; given the small space available, there is no room to accommodate the additional care services needed, such as emergency childbirth, x-rays, or hemodialisis.

1.9 Given the weak response capacity of the primary care network, people who are sick tend to delay seeking help until their symptoms are serious, and then they go to hospital. To address this situation, the Bank is supporting the Bolivian government in strengthening the operation of the Potosí departmental network, through loan 2614/BL-BO. This project will finance the construction and equipping of first- and level two healthcare units, as well as a general hospital with specialist facilities in the city of Llallagua. The project also supports SEDES Potosí in strengthening its departmental referral and counter-referral system, improving its staff needs planning capacity, including their initial and in-service training, and undertaking promotion activities. At the same time, the World Bank is financing preinvestment for a level two hospital in Ocurí[37] (in the north of the department), the actual building of which will be financed by the same IDB loan. In addition, the Bank is financing infrastructure improvements and level one equipment in the municipio of Ocurí through loan 2252/BL-BO. To complete the Potosí departmental network, this operation will also support the Bolivian government in constructing a new hospital with curative/treatment capabilities in the urban center of the city of Potosí.

1.10 **Organization of the health sector**. The Autonomies and Decentralization Framework Law defines the Ministry of Health and Sport (MSD) as the governing body of the health sector at the national level. The Ministry is responsible for preparing national health policy and national standards regulating its operation, as well as the functioning of the Single Health System (SUS), including the payment of staff wages under this system.[38] Departmental governments oversee the

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[34] Obstetrics and gynecology, internal medicine, pediatrics, and surgery.

[35] In the case of internal medicine specialists, it is assumed that some of these are pulmonologists, cardiologists, and/or gastroenterologists.

[36] "Estudio de Brechas en Cuidados Obstétricos y Neonatales Esenciales (CONE) Potosí" [Study of deficits in essential obstetric and neonatal care, Potosí]; *Encuestas y Estudios*; 2011.

[37] Through an Adaptable Program Loan (APL) III for the health sector in Bolivia.

[38] The "Andrés Ibáñez" Framework Law on Autonomies and Decentralization, Law 31 of 19 July 2010, Article 81.

departmental system. Their responsibilities also include providing and maintaining level three infrastructure, cofinancing policies, programs, and health projects, in coordination with the central level; and strengthening SUS human resource development. The municipios formulate and implement the Municipal Health Plan, administer infrastructure and equipment, including the maintenance of first- and level two healthcare facilities, and providing them with water and sanitation, equipment, furniture, medications, and inputs.[39]

1.11 **Organization, care structure, and hospital management**. The current hospital management model is inefficient on both the demand and the supply sides. Outpatient consultations occur on an unscheduled basis without prior appointment, based primarily on a perception of urgency and resulting in long patient waiting times. This model does not make it possible to adequately plan the use of the external consultation, hospitalization, and urgent care areas. It also promotes the hospitalization of serious cases, owing to the delay in seeking care, as well as diagnostic examinations, and long pre-and post-surgery stays, thereby increasing the cost of care. A specialized outpatient care model is proposed, together with a triage system for emergencies, and better quality hospitalization. This model produces better results by improving the timeliness of care, keeping patients in their daily environment, reducing intrahospital infections, and freeing capacity for more complex patients. Systems will be developed to manage the specialists' agendas on a programmed basis, allowing for referral and counter-referral within the network, according to firm availability of specialist hours, thereby ensuring continuity of care.

1.12 **Country strategy with Bolivia 2011-2015 (document GN-2631-1).** One of the priorities defined in the 2010-2015 government plan is to create a health system that eliminates social exclusion, with an intercultural family-community orientation that includes traditional medicine and promotes gender equity. The Bank's participation in the sector for the period 2011-2015 will aim to help improve the quality and coverage of the health service supply for poor and indigenous population groups. It will focus on strengthening the management and organization of the health system, including the structuring of networks, training, and resource management, along with quality and effectiveness in service delivery; the development of programs to stimulate the demand for services; support for the supply of services through investment in infrastructure and health equipment; and the integration of information and monitoring systems in the health sector in line with the new regulations for the "Family, community, and intercultural health" (SAFCI) model.

1.13 The proposed operation will directly contribute to improving human capital, pursuant to the health and social security targets contained in the "Bolivia DIGNA" pillar, in the framework of the National Development Plan, which puts special emphasis on public policy actions in health, and in line with the millennium Development Goals (goals 4 and 5). The proposed operation is also consistent with

[39] Op. cit.

the social policy of promoting equality and productivity, promoted by the mandate of the Bank's Ninth General Increase in Resources (document AB-2764). The project will also contribute to the strategy of the Bank's Social Department, particularly in terms of providing support in coping with the dual burden of disease resulting from the epidemiological transition. The expected outcomes of this operation will sustain the regional development target of reducing maternal and infant mortality, and contribute to the indicator of persons (all and indigenous) who enjoy quality health services. Lastly, the operation will sustain institutional efforts to support the least developed countries.

B. Objectives, components, and cost

1.14 The program's objective is to improve the efficiency of service production and the curative/treatment capabilities of health networks in El Alto and Potosí, to meet departmental healthcare needs. This will make it possible to treat cases that have been postponed or discouraged, particularly for women, children, and persons belonging to indigenous groups. Given Bolivia's epidemiological profile, the project will have an impact on reducing mortality rates, particularly mother-child mortality. The building and equipping of specialized hospital services complements and completes the functioning of healthcare networks in Potosí and El Alto.

1.15 The program will have the following components:

1.16 **Component I: Improvement of curative/treatment capacities in El Alto (US$9.53 million).** This component will finance: (i) the purchase and installation of medical and industrial equipment and furniture for the Alto Norte hospital (List of equipment); (ii) activities to strengthen the El Alto municipal health network, including the referral and counter-referral, promotion and prevention system; and (iii) improvement of hospital and network management capacity, particularly the implementation of a new hospital management model.

1.17 **The Alto Norte hospital.** The hospital will have a total of 213 beds for inpatient, specialized outpatient, and emergency services. The project will finance the procurement of medical and industrial equipment and furniture for the hospital's operation. The hospital will have the following areas:[40] dentistry, pediatrics, neonatology, gynecology-obstetrics, internal medicine, cardiology, pulmonary medicine, nephrology, gastroenterology, endocrinology, nutrition, rheumatology, hematology, neurology, general surgery, neurosurgery, otorhinolaryngology, traumatology, ophthalmology, urology, psychiatry, psychology, kinesiology, dermatology, and clinical oncology. The examination rooms will be equipped to meet the needs of the different specialist areas, such as instruments for ophthalmology, obstetric ultrasound, radiology, and dental equipment. To support diagnostics and therapeutics, the facility will have an equipped laboratory, as well as imaging and hemodialysis equipment. Hospitalization services will include pediatrics and gynecology, along with surgery, traumatology, neurosurgery, neurology, and other

[40] For a full list of the areas included in the hospital, see Medical architecture program.

medical specialties and subspecialties. The total number of staff required for the hospital is estimated at 579, of whom 396 are doctors and nursing professionals, and 183 are administration and support staff. The estimated annual human resource cost is US$4.12 million.

1.18 **Strengthening the management of the Los Andes network.** Funding will be provided for activities to get the El Alto Norte hospital up and running, to guarantee its operations within the los Andes network, placing special emphasis on the new management model described above. Financing will be provided for the preparation of manuals, procedures and processes, staff training for application in the emergency areas with triage, outpatient consultation, and hospitalization. The staff will also be trained in intercultural health and proper treatment, in fulfillment of national standards in this area. Hospital staff will be trained to be able to provide counseling services on family planning, spacing pregnancies, with an intercultural, gender-based approach for emergency obstetrics cases that are escalated to level three care.[41] Lastly, training will be provided for staff on how to provide medical, psychological, and forensic services to victims of domestic violence, pursuant to local law.

1.19 **Management of the network, referral and counter-referral system in the Los Andes network.** The following activities will be financed: (i) the development of systems and training in the application of the referral and counter-referral protocol; and (ii) preparation and training in new protocols and procedures for outpatient diagnostic referral.

1.20 **Component II: Supplementing the Potosí departmental network with a level three hospital (US$21.43 million).** Financing will be provided to build and equip a new hospital with 298 beds with specialist facilities in the city of Potosí, to supplement the treatment capacities of the departmental network. Hospital management activities will also be covered, stressing the implementation of a new management model.

1.21 The hospital will offer the following specialties and services: internal medicine, cardiology, pulmonary medicine, gastroenterology, neurology, endocrinology, nutrition, diabetes, nephrology, immunology, rheumatology, hematology, dermatology, geriatrics, oncology, general surgery, abdominal surgery, thoracic surgery, vascular surgery, proctology, traumatology, neurosurgery, otorhinolaryngology, ophthalmology, urology, plastic surgery, burns treatment, maxilo-facial surgery, dentistry, obstetrics-gynecology, pediatrics, neonatology, pediatric surgery, infant traumatology and orthopedics, mental health, including psychiatry and psychology, physical medicine and rehabilitation, including

[41] The training events will be based on the 18 practices defined by the MSD for obstetric and neonatal care, the Intercultural Maternal Health Care Guide (*Guía de Atención Intercultural de la Salud Materna*), the manual on dealing with sexual violence in health services, and the Manual on Standards, Rules, Protocols, and Procedures for Contraception (*Manual de Norma, Reglas, Protocolos y Procedimientos de Anticoncepción*) and Strategic Guidelines for Gender in Health 2012-2015 (*Lineamientos Estratégicos 2012-2015 para Género en Salud*).

physiatry, kinesiology, traditional medicine, and other specialties according to needs. There will also be an emergency area with triage and examination rooms for diagnostics and specialized outpatient care for the specialties mentioned above. For these purposes, the program will finance the medical and industrial equipment needed for these areas to operate (List of Equipment). For the full functioning of the hospital, an estimated 604 staff will be required; 454 doctors and nursing professionals, and 150 in the areas of administration, services, and support. The annual human resource cost amounts to US$4.6 million (see Human resource proposal).

1.22 **Improvement of hospital management.** Funding will be provided to design the hospital management model, together with training in hospital management and administration, systems and protocols for outpatient care, emergencies, and hospitalization, preparation of manuals and procedures for the functioning of the new hospital, referral and counter-referral of patients, and a monitoring and control system for implementation. Financing will also be provided for the application of continuous quality improvement methods in the areas of outpatient consultation, emergencies, operating rooms, and intensive therapies (as a minimum).

1.23 For the obstetric emergencies dealt with in the hospital, counseling services will be offered on pregnancy spacing, through family planning with an intercultural gender-based approach. Lastly, a training program will be financed for hospital workers on the issues of quality and good treatment, with intercultural gender-based approach.

1.24 **Component III: Administration and monitoring (US$3.16 million).** This component will finance the creation of a Project Executing Unit (PEU), which will have administrative, financial, technical, and legal autonomy. Its responsibilities will include contracting and supervising the program management firm, and procuring equipment for the El Alto Norte hospital. The PEU will be responsible for program management, monitoring, and evaluation.

1.25 The following PEU staff posts will be financed: a project coordinator, an administrator, a financial specialist, a procurement specialist, two technical specialists, a monitoring specialist, and a legal adviser. Funding will also provide for the costs associated with hiring the program management firm and audit costs.

C. Key results indicators

1.26 A semiannual indicators report will be produced, and it will be supervised through management agreements with the involved departments.

Table I.1
Summary of results matrix (impacts and outcomes)(See Results Matrix)

Increase in access to/use of services at the El Alto and Potosí hospitals
a. Number of patients discharged and consultations in the hospital, by gender
Fulfillment of national standards of efficiency and service production (discharges)
b. Percentage occupancy and average number of days' stay
c. Strengthening of healthcare networks: referral and counter-referral
d. Percentage of referred patients attended in the hospital and reduction of maternity overload in other hospitals
Reduce discouraged and postponed care
e. Number of patients discharged for diarrhea and pneumonia in children under five
f- Deliveries in childbirth service

1.27 The cost-benefit analysis shows that 10 years after the construction of the hospital, bed-day capacity will have doubled, 22,118 patients will be attended per year (4.18 days stay); there will be 2.4 times more childbirth deliveries (5,681), 3.8 times more specialized consultations, and 4.5 times more emergency care. Using a discount rate of 5.7%, the project's present value is US$28.1 million, with an internal rate of return of 15.4%, producing positive social benefits. Further information can be obtained through the cost-benefit link.

II. FINANCING STRUCTURE AND RISKS

A. Financing instruments

2.1 The program will be financed through a specific investment loan. Its total cost is US$49.2 million, of which US$35 million will be financed by the Bank as follows: US$28 million from the Single Currency Facility of the Ordinary Capital, and US$7 million from the Fund for Special Operations (FSO). The local counterpart contribution will be up to the equivalent of US$14.2 million devoted to the operation during execution. The consolidated budget by component is shown below. The execution period is estimated at five years, with disbursements over five and one half years (see Itemized budget).

Table II-1
Project costs

Component	IDB	Counterpart	Total	%
Component I: Equipping and implementation: El Alto	9,531,250	11,000,000	20,531,250	42
Component II: Building, equipping, and implementation: Potosí	21,431,050	3,200,000	24,631,050	50
Component III: Management, monitoring, and evaluation	3,160,498	0	3,160,498	6
Contingencies	877,202	0	877,202	2
TOTAL	**35,000,000**	**14,200,000**	**49,200,000**	**100**

Table II-2
Disbursements

Annual disbursements	1	2	3	4	5	Total
Bank	9%	18%	18%	28%	28%	100%
Counterpart	0%	12%	15%	33%	40%	100%

2.2 Estimated annual operating costs are US$5.9 million for the El Alto Norte hospital, and US$8.4 million for the Potosí hospital, once they reach full capacity. This expenditure includes wages, maintenance, and inputs. For the local counterpart, account will be taken of the fact that the hospitals will increase their operating capacity gradually, starting at 20% in the first year of implementation, and reaching 85% capacity in the fifth. Accordingly, a total counterpart of US$11 million is calculated for El Alto[42] and US$4.8 million for Potosí[43] for the hospitals' operating expenses. The departmental government of Potosí will also cofinance investments for up to US$1.2 million. The borrower, through the executing agency, agrees to submit as evidence of fulfillment of the local counterpart, the allocation of resources to cover the operating expenses of the hospitals in the General State Budget and in the La Paz Governor's Budget starting in 2014, and in the State and governor's budget for Potosí starting in 2017.

B. Environmental and social risks

2.3 Under the Bank's Environment and Safeguards Compliance Policy (Operational Policy OP-703), this operation has been classified as a category "B" operation, since the potential negative impacts and socioenvironmental risks are localized and short-term, and the mitigation measures are well-known and easy to apply. The main socioenvironmental risks identified for this operation relate to the operation stage of the El Alto and Potosí hospitals. The most important are: higher energy and drinking water demand, drinking water quality, discharges of hospital and common effluents, generation of domestic and hazardous hospital solid waste (medical sharps; bioinfectious, pharmaceutical, and chemical materials), and greenhouse gas emissions arising from heating systems and electric power generators.

2.4 The respective environmental analysis has been submitted, the results of which are contained in the Environmental and Social Management Report (ESMR). The Environmental and Social Management Plan will include specific measures and procedures to mitigate and control the potential risks and negative socioenvironmental impacts that need to be taken into consideration both in the building stage and in the operation of the hospitals. The loan contract will include the requirements highlighted in Section VI of the ESMR. Lastly, the operation does not provide for, or foresee, the need for population resettlement for construction of the new hospital in Potosí.

[42] Based on 43 months' activities.

[43] Based on 7 months' activities.

C. Fiduciary risks

2.5 **Procurement**. Project procurement and contracting processes will be undertaken in accordance with the Policies for the Procurement of Works and Goods Financed by the Inter-American Development Bank (document GN-2349-9) and Policies for the Selection and Contracting of Consultants Financed by the Inter-American Development Bank (document GN-2350-9), respectively, both dated March 2011. Given its executing agency's fiduciary capacity, procurement processes costing up to 30% of the thresholds specified for international competitive bidding (ICB) will be subject to ex post review, according to the procurement plan and its updates.

2.6 **Disbursements**. The loan will be disbursed through advances of funds, without prejudice to any other mechanism that the Bank may use to make payments or reimburse expenses. The frequency of the advances will be based on the project's financial programming, to be updated periodically by the MSD. The Bank may make a new advance when at least 80% of all funds disbursed as advances have been justified.

2.7 **Fiduciary supervision.** Financial supervision of the PEU will be conducted on an ex post basis, including at a minimum the following actions: (i) an onsite visit to the locations where the financing is invested; and (ii) a visit to verify compliance with agreements on the internal control recommendations made by the program's external audit. For procurement, ex post review visits will take place at least once a year, depending on the status of awards and contracting processes.

2.8 **Audits**. During execution, the MSD will submit annual audited financial statements for the project, duly certified by an independent audit firm acceptable to the Bank. The MSD will select and contract the external audit firm and will be responsible for submitting the aforementioned reports within 120 days following the end of each fiscal year. The final audit report will be submitted within 120 days following the date of the last disbursement of the loan proceeds.

D. Other risks

2.9 Risks have been identified in relation to operation of the hospitals, which may not have the full complement of specialized staff, due to administrative and accounting constraints and limited availability of professionals trained in the required specialties. To address this risk, the MSD will specify the necessary items in the budget, and include a number of new specialties to be offered in the El Alto and Potosí hospitals in Bolivia's training curriculum. At the same time, the departmental governments agree to finance training abroad in specialties for which training cannot be provided nationally. The hospitals will also start up operations in phases, so not all specialists will be needed from the outset. Another significant risk identified is not having sufficient financial resources to guarantee the hospitals' operating costs, once they are functioning. The two hospitals represent a 2.4% increase in total national health spending, which has grown by 57% between 2006 and 2010. To mitigate this risk, counterpart resources are being allocated for the project, which will be financed by the central and departmental governments, as

applicable. A special condition for the program requires evidence of the annual incremental allocation of resources in the General State Budget to cover expenses related to wages and benefits, inputs, maintenance, and other operating expenses, according to the Implementation Plan for the El Alto hospital, once it begins operations. The Bank is supporting the government with technical assistance and dialogue on the differential fiscal impact on the departments, as well as other issues related to the operational sustainability of the hospitals.

III. IMPLEMENTATION AND PLAN OF ACTION

A. Summary of implementation arrangements

3.1 The MSD will serve as executing agency and will implement program activities through a PEU created for this purpose, with technical-operational, administrative-fiduciary, and legal independence. It will be responsible for launching and processing the bidding process to procure medical and industrial equipment for the El Alto Norte hospital and also the request for proposals and selection of a project management firm for the construction and equipping of the Potosí hospital. In both cases, it will receive technical assistance from consultants for preparation of the technical files and bidding documents, and response to queries during the bidding process and during bid evaluation. The PEU will be responsible for the viability of all contracting processes under the program. The management firm, hired by the PEU for the construction and equipping of the Potosí hospital will be responsible for the final design, preparation of bidding documents, and supervision of contracts for hospital equipment and construction. The PEU will seek approval of the final design of the hospital to be built from the Potosí Governor's Office. The first disbursement of component II resources will be subject to selection of the management firm, in accordance with the terms of reference previously approved by the Bank.

3.2 The PEU's technical-operational functions will include: (i) liaising between the MSD and the Bank on all matters related to project execution, including: (a) preparing, executing, and reporting on annual work plans (AWPs), with support and advice from the consulting firm; (b) planning and implementing bidding processes for works and equipment and consulting services, including the issuance of the contract award decision and signing of contracts (supported by the management firm when applicable); (c) ensuring compliance with contractual clauses and adherence to the Bank's processes and procedures; (d) requesting and authorizing payments related to the operation; (e) submitting disbursement requests and audited financial statements to the Bank; and (f) contracting the audit firm; (ii) awarding, signing, and supervising the management firm contract for equipping and construction of the Potosí hospital; (iii) approving payments according to works progress; (iv) approving potential amendments to the works contract as proposed by the management firm; (v) agreeing with the MSD and management firm on a plan to transfer technical and management knowledge to the corresponding units of the MSD; (vi) facilitating consensus-based involvement by the Potosí Governor's

Office in supervising the works and equipment; and (vii) contracting consulting services to conduct the final evaluation.

3.3 On financial matters, the PEU will: (i) ask the MSD's Bureau of Administrative Affairs to complete procedures for registering the loan, and enter it annually in the budget to be executed; ask the Ministry of Economy and Public Finance (MEFP) to open exclusive program bank accounts; (ii) maintain accounting records; (iii) make payments to suppliers and contractors; and (iv) prepare bank reconciliations and financial reports for the program. The PEU will notify the Office of the Minister of the following at a minimum: (i) the launch of international competitive bidding processes; (ii) the corresponding contract awards; and (iii) the signing of those contracts.

3.4 **Composition of the unit**. The unit will consist of a coordinator and two staff with technical profiles specializing in infrastructure, medical and industrial equipment, and health management. It will also include specialists in procurement, monitoring and finance, a lawyer, and administrative support.[44] Once the loan contract takes effect and the general conditions precedent to the first disbursement have been fulfilled, as set forth in the General Conditions of the respective loan contract, the Bank may release up to US$100,000 as a charge against the loan proceeds to support the executing agency in hiring the PEU team. All of this will be set out in detail in the project's operating regulations. **The following will be special contractual conditions precedent to the first disbursement: (i) creation of the program executing unit with administrative, legal, and financial capacity (including installation of the State financial management system) to undertake the program's activities, and the appointment of key staff pursuant to the terms of reference agreed upon with the Bank;[45, 46] and (ii) approval of the Operating Regulations by the executing agency, under the terms previously approved by the Bank, including the elements specified in the ESMR.**

3.5 **Functions of the project management firm**. The functions of the management firm in terms of hospital construction will include: (i) preparing final designs for the level three hospital in Potosí, based on medical-technical designs previously agreed upon with the Bank (including the preparation of technical specifications); (ii) preparing terms of reference and bidding documents for the construction; (iii) supporting fiduciary management, planning, and execution of the works bidding processes; (iv) evaluation and technical recommendation for awarding the work; (v) directly supervising works construction until completion, including engineering and technical-sanitary aspects, and giving a technical opinion on possible amendments to the contract; and (vi) recommending final acceptance of the work. In the case of medical and industrial equipment and furniture, the

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[44] Some of these posts could be part-time, depending on needs.

[45] Technical coordinator; administrative-financial chief; infrastructure or medical equipment specialist.

[46] Setting up the PEU will be financed from nonreimbursable technical cooperation resources.

management firm will: (i) prepare the technical specifications in coordination with SEDES Potosí, and advertise to receive expressions of interest; (ii) prepare bidding documents for the procurement of equipment; (iii) support the fiduciary management, planning, and implementation of bidding processes; (iv) evaluate bids and recommend procurement awards; and (v) coordinate the reception, delivery, and installation of the equipment as the works proceed.

3.6 **Procurement**. Project procurement and contracting will be undertaken according to the Policies for the Procurement of Works and Goods Financed by the Inter-American Development Bank (document GN-2349-9) and the Policies for the Selection and Contracting of Consultants Financed by the Inter-American Development Bank (document GN-2350-9), respectively, both of March 2011. Given the MSD's current fiduciary capacity, procurement will be subject to ex post review for up to 30% of the threshold for ICB, according to the procurement plan and its updates. As the formation and operation of the PEU advances, this threshold may be revised.

3.7 **Retroactive financing of expenses.** To move ahead in putting the El Alto Norte hospital into operation, the Bank may retroactively finance, as a charge against the loan proceeds, expenses related to the procurement of medical and industrial equipment for that hospital, up to an amount equivalent to US$3 million (27.3% of the total cost). Expenses will only be recognized if they were incurred during the 18 months prior to the loan approval date, but after the approval date of the project profile (24 May 2012). For these expenses to be eligible, procurement processes must be substantially analogous to those set forth in the loan contract. These procedures are consistent with the Bank's policy on retroactive financing (Operational Policy OP-504).

B. Summary of arrangements for monitoring results

3.8 The PEU will be responsible for monitoring project execution and reporting on the status of the results matrix indicators. It will periodically receive data on the status of the works and medical equipment procurement processes from the management firm and the Potosí and La Paz SEDES, together with hospital output data recorded by each municipio and department. The PEU will also have direct responsibility for execution, and for generating monitoring reports on activities related to staff training and the implementation of the hospitals. Monitoring data for these activities will be produced from the PEU's internal systems.

Development Effectiveness Matrix			
Summary			
I. Strategic Alignment			
1. IDB Strategic Development Objectives	Aligned		
Lending Program	(i) Lending to small and vulnerable countries, and (ii) Lending for poverty reduction and equity enhancement.		
Regional Development Goals	Infant mortality ratio.		
Bank Output Contribution (as defined in Results Framework of IDB-9)	Individuals (all, indigenous, afro-descendant) receiving a basic package of health services.		
2. Country Strategy Development Objectives	Aligned		
Country Strategy Results Matrix	GN-2631-3	Reduction of mother-child mortality.	
Country Program Results Matrix	GN-2661-4	The intervention is included in the 2012 Country Program Document.	
Relevance of this project to country development challenges (If not aligned to country strategy or country program)			
II. Development Outcomes - Evaluability	Highly Evaluable	Weight	Maximum Score
	8.7		10
3. Evidence-based Assessment & Solution	8.8	25%	10
4. Ex ante Economic Analysis	10.0	25%	10
5. Monitoring and Evaluation	6.0	25%	10
6. Risks & Mitigation Monitoring Matrix	10.0	25%	10
Overall risks rate = magnitude of risks*likelihood	Medium		
Environmental & social risk classification	B		
III. IDB´s Role - Additionality			
The project relies on the use of country systems (VPC/PDP criteria)	Yes	SIGMA, Sicoes (Sistema Electrónico de Contrataciones del Estado).	
The project uses another country system different from the ones above for implementing the program			
The IDB's involvement promotes improvements of the intended beneficiaries and/or public sector entity in the following dimensions:			
Gender Equality	Yes	The project will improve the quality of service by providing training in service provision sensitive to gender and cultural diversity. The project will also provide training to health providers on special attention to victims of domestic violence.	
Labor			
Environment			
Additional (to project preparation) technical assistance was provided to the public sector entity prior to approval to increase the likelihood of success of the project	Yes	Technical assistance through BO-T1164 to provide contents for tenders and support. Also, contracts for persons in UEP wil be made to meet previous conditions for first disbursement and provide support to meet environmental safeguards.	
The ex-post impact evaluation of the project will produce evidence to close knowledge gaps in the sector that were identified in the project document and/or in the evaluation plan.			

The program finances the equipment of a third level hospital and the strengthening of the health net in El Alto as well as the construction and equipment of a third level hospital in Potosí. The goal is to improve the production of services and the resolution capacity of the health nets in these cities and satisfy demand at the department level, with expected impacts on the reduction of mortality, especially in infant mortality.

The diagnostic is adequate. The infant mortality rate is the second highest in the region. The main factors identified are inequality in access and prediction and prevention of birth complications. Empirical evidence of these factors is provided. The interventions are aimed to mitigate these problems. The evidence on effectiveness on these interventions is weak but supports the justification of actions proposed. The beneficiaries are defined as the population in the catchment areas. The results matrix presents a clear vertical logic. Impact, results and output indicators are SMART and have baseline and target values. The project includes an ex ante cost-benefit analysis. For the monitoring and evaluation plan, data collection will be done through the Ministry of Health and Sports, statistics provided by hospitals and the National Health System. An ex post cost-benefit analysis is considered for the evaluation of the program.

The main risks identified are related to management, lack of technical and financial sustainability and fiduciary related risks. Specific measures are proposed to mitigate each identified risk including supervision, specific and concrete action plans, and contracting to support them.

RESULTS MATRIX

Project objective	To improve the efficiency of service production and the curative/treatment capabilities of health networks in El Alto and Potosí, to meet departmental healthcare needs. This will make it possible to treat cases that have been postponed or discouraged, particularly for women, children, and persons belonging to indigenous groups. Given Bolivia's epidemiological profile, the project will have an impact on reducing mortality rates, particularly mother-child mortality. The building and equipping of specialized hospital services complements and completes the functioning of healthcare networks in Potosí and El Alto.

Impact indicators	**Baseline** *Departments of Potosí and La Paz*	**Target** *Departments of Potosí and La Paz*
Infant mortality per 1,000 live births, Department of La Paz (Source: Ministry of Health and Sport – MSD)	2011: 14.9[1]	2017: -20%
Infant mortality per 1,000 live births, Department of Potosí (Source: MSD)	2011: 21.2[2]	2017: -20%
Early neonatal mortality per 1,000 live births, Department of La Paz (Source: MSD)	2011: 7.5[3]	2017: -25%
Early neonatal mortality per 1,000 live births, Department of Potosí (Source: MSD)	2011: 12.2[4]	2017: -25%

1 Indicator under review.
2 Indicator under review.
3 Idem.
4 Idem.

Final outcome indicators	Baseline 2011	2013	2014	2015	2016	Target 2017
Increased access to/use of hospital services						
Patients discharged from hospital, by gender, in the municipio of El Alto (Source: National Health Information System (SNIS) and hospital administrative records)	Male: 9,077 Female: 29,725	9,080 29,725	9,080 29,725	10,210 33,440	10,500 34,000	10,760 35,240
Patients discharged from hospital, by gender, in the municipios of Potosí and Betanzos (Source: SNIS and hospital administrative records)	Male: 6,202 Female: 12,144	6,200 12,145	6,200 12,145	6,200 12,145	6,200 12,145	6,760 13,240
Outpatient consultations, by gender, in the municipio of El Alto (Source: SNIS and hospital administrative records)	Male: 233,681 Female: 316,813	233,680 316,810	233,680 316,810	261,723 354,831	268,000 364,000	275,744 373,839
Outpatient consultations, by gender, in the municipios of Potosí and Betanzos (Source: SNIS and hospital administrative records)	Male: 79,039 Female: 109,159	79,040 109,160	79,040 109,160	79,040 109,160	72,000 113,000	86,153 118,983
Fulfillment of the national standard for service production efficiency (patients discharged)						
Patients discharged per bed in the municipio of El Alto (Source SNIS)	73	74	71	70	70	70
Patients discharged per bed in the municipio of Potosí (Source SNIS)	56	56	58	60	62	70
Percentage occupancy of beds at Gemelo Norte, El Alto (Source: hospital statistics)	0	0	10	20	40	60
Percentage occupancy of beds at the new hospital, Potosí (Source: hospital statistics)	0	0	0	0	5	10
Average number of days' stay at Gemelo Norte, El Alto (Source: hospital statistics)	0	0	0	0	3.5	6
Average number of days' stay at Bracamonte hospital, Potosí (Source: hospital statistics)	3.6	3.6	4	4.5	6	6

Final outcome indicators	Baseline 2011	2013	2014	2015	2016	Target 2017
Strengthening of healthcare networks: implementation of the referral and counter-referral standard						
Percentage of referred patients attended at the Gemelo Norte hospital (Source: MSD SNIS-Service production statistics)	0	0	10	20	20	30
Reduction of overload in other hospitals in the municipio of El Alto (maternity)						
Percentage occupancy rate of Los Andes Hospital	94.5	95	90	90	85	85
Percentage occupancy rate of Boliviano-Holandés hospital	97.6	97	97	97	95	90
(Source: MSD SNIS- Service production statistics)						
Reduction of discouraged and postponed healthcare						
Patients discharged in cases of diarrhea among children <5 years old in the municipio of El Alto (per 1,000 patients discharged, Source: MSD)	5.30 per 1,000	5 per 1,000	5 per 1,000	4 per 1,000	4 per 1,000	3 per 1,000
Patients discharged in cases of diarrhea among children < 5 years old in the municipio of Potosí (per 1,000 patients discharged, Source: MSD)	14.73 per 1,000	15 per 1,000	14 per 1,000	12 per 1,000	10 per 1,000	9 per 1,000
Patients discharged in cases of pneumonia among children < 5 years old in the municipio of El Alto (Number, Source: MSD)	5.21 per 1,000	5 per 1,000	5 per 1,000	4 per 1,000	4 per 1,000	3 per 1,000
Patients discharged in cases of pneumonia among children < 5 years old in the municipio of Potosí (Number, Source: MSD)	10.67 per 1,000	10 per 1,000	9 per 1,000	8 per 1,000	7 per 1,000	5 per 1,000

Midterm outcome indicators**	Baseline 2011	2013	2014	2015	2016	Target 2017
Babies delivered in health service facilities, municipio of El Alto (Source: SNIS, MSD)***	15,229	15,300	17,985	18,853	19,201	20,032
Babies delivered in health service facilities, municipios of Potosí and Betanzos (%, Source: MSD departmental management targets)	7,641	9,400	9,400	9,400	9,400	11,000
Referrals and counter-referrals in the municipio of El Alto (Source: MSD SNIS-Service production statistics)	12,666	To be defined	To be defined	To be defined	To be defined	To be defined
Referrals and counter-referrals in the municipios of Potosí and Betanzos (Source: MSD SNIS-Service production statistics)	2,799	To be defined	To be defined	To be defined	To be defined	To be defined

* The 2017 infant mortality targets are those of the Millennium Development Goals as agreed upon by Bolivia, which will be very hard to achieve at current rates of progress. The neonatal mortality rate is estimated on a survey basis, given the major problems that exist with healthcare system data on births and neonatal deaths. This infant mortality rate is expected to be below 20 when the next national demography and health survey (ENDESA) is conducted. No neonatal mortality target has been agreed upon for Bolivia.

** The results for the intermediate years will be reported by the MSD SNIS.

*** This assumes an increase resulting from improvements in the quality of the information reported by the networks.

Component 1: El Alto	**Baseline**	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Target**	**Comments**
Outputs (Source: Executing agency reports)								
(i) El Alto Norte Hospital equipped	0	0	0	1	1	1	1	*Cumulative target*
(ii) Referral and counter-referral plan	0	0	1	1	1	1	1	*Cumulative target*
(iii) Implementation plan	0	0	1	1	1	1	1	*Cumulative target*
Component 2: Potosí	**Baseline 2012**	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Target**	**Comments**
Outputs (Source: Executing agency reports)								
(i) Potosí Hospital Center built and equipped	0	0	0	0	0	1	1	
(ii) Referral and counter-referral plan	0	0	0	0	1	1	1	*Cumulative target*
(iii) Implementation plan	0	0	0	0	1	1	1	*Cumulative target*
Component 3: Administration and management (Source: Executing agency reports)	**Baseline 2012**	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Target**	**Comments**
(i) Management firm contract	0	0	1	1	1	1	1	*Cumulative target*
(ii) Executing unit set up	0	1	1	1	1	1	1	*Cumulative target*

Output: Fulfillment of national treatment capacity standard: technical and human quality; service effectiveness (application of intercultural and gender health protocols and standards).

FIDUCIARY AGREEMENTS AND REQUIREMENTS

Country:	Plurinational State of Bolivia
Project number:	BO-L1078 Improved Access to Hospital Services in Bolivia
Executing agency:	Ministry of Health and Sport (MSD)
Prepared by:	Roberto Laguado (PRM) and Zoraida Argüello (FM)

I. EXECUTIVE SUMMARY

1.1 The institutional capacity analysis of the Ministry of Health and Sport (MSD) used the institutional capacity assessment system (ICAS) methodology, and was based on the Bank's knowledge of this ministry's performance in executing other IDB-financed operations.

1.2 The conclusion reached by the analysis was that the MSD has to strengthen the financial and procurement areas with skilled staff, and hire a project management firm to provide support in complex procurement tasks. The operation will involve contracting for complex hospital works and procurement of medical and industrial equipment, which will also be supported by the management firm.

II. FIDUCIARY CONTEXT OF THE EXECUTING AGENCY

2.1 As a public sector entity, the MSD is governed by the Government Administration and Control Law (SAFCO) (No.1178) of 20 July 1990, which regulates systems for the management and control of State resources and their relation to the national planning and public investment systems.

2.2 For all of its financial records, this entity uses the integrated administrative management and modernization system (SIGMA), which provides budgetary execution data in a secure and reliable form. Nonetheless, this system does not provide information in currencies other than the local currency, nor according to the investment categories defined in the project cost chart, so the SIAP-BID system[1] will be used for accounting and financial reporting. This system will be used by the executing agency until such time as another integrated government accounting system becomes available.[2]

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[1] IDB integrated project management system.

[2] The Ministry of the Economy and Public Finance (MEFFP) is working to develop the SIGMA accounting and reporting module with Bank support, with a view to providing the reports required by lenders. It is estimated that by the time this operation begins, the unit could use this system for accounting purposes and for submitting the program's financial statements.

2.3 As a government agency, the MSD and all of its deconcentrated units are supervised by the Office of the Comptroller General of the State (CGE), specifically by the Internal Audit Unit.

2.4 Application of the local system of basic rules on goods and services procurement is acceptable to the Bank only for use of the government contracting system (SICOES) (www.sicoes.gob.bo) as a mechanism for advertising requests for proposals and the results of national bidding processes and simplified processes in Bolivia.

III. FIDUCIARY RISK EVALUATION AND MITIGATION MEASURES

3.1 To facilitate smooth project execution, the MSD will create a deconcentrated Project Executing Unit (PEU) with responsibility for program implementation. The PEU will use country systems for fiduciary management and will form a team of technical professional staff for program execution, with a view to streamlining internal MSD processes. This team will be strengthened with external consultants for the preparation of technical specifications for the procurement of goods and works to be financed with the loan proceeds. It will also be responsible for contracting processes and managing the contract with the project management firm. The latter[3] will be responsible for the design of the Potosí hospital, as well as for implementing all bidding process related to its construction and equipping. The PEU and management firm will transfer technical and managerial knowledge to the corresponding areas of the MSD.

FIDUCIARY RISKS

3.2 **Coordination.** To optimize dealings with the Bureau of Administrative Affairs (DGAA), the Bureau of Legal Affairs (DGAJ) and other areas of the MSD, the Operating Regulations will define autonomous and exclusive functions and responsibilities (administrative and legal) as well as the coordination mechanism that will bind all parties involved in developing the program.

3.3 **Public procurement.** Frequent turnover among local authorities has impaired the transmission and perpetuation of procurement knowledge. Accordingly, the PEU's procurement and legal staff will receive periodic training to apply the Bank's procurement policies (documents GN-2349-9 and GN-2350-9). Given the complexity of the works to be tendered and constructed, a supporting management firm will be hired to fulfill key fiduciary functions, thereby reducing the level of risk in procurement execution.

3.4 **Procedures inside the executing agency.** A PEU will be created for program execution, reporting directly to the Office of the Minister. The PEU will be authorized to enter into contracts and make direct payments, thereby mitigating potential delays in processing operations and fiduciary transactions.

3.5 **Financial management.** The PEU will have direct access to SIGMA, thereby make it possible to reduce the risk of delays in the operation's administrative and financial processes. Based on the annual work plan (AWP) agreed upon between the MSD and the Bank, the PEU will make the arrangements to record and register the loan proceeds in the General State Budget, thereby ensuring adequate execution during the lifetime of the project.

IV. CONSIDERATIONS FOR THE SPECIAL CONDITIONS OF THE CONTRACTS

SPECIAL CONDITIONS PRECEDENT TO THE FIRST DISBURSEMENT

4.1 **Program Operating Regulations**. The Operating Regulations will include the execution plan and information flows between the PEU, the management firm, the MSD, and any other party involved, as previously agreed upon between the parties and the Bank, as well as the application of procurement procedures.

Exchange rate agreed upon with the executing agency for accounting purposes. The exchange rate agreed upon by the executing agency to convert expenses in local currency into the currency of the operation, will be the rate prevailing in the borrower's country on the date the expense was actually paid.

4.2 **Financial statements and other audited reports.** The program's audited financial statements, duly certified by an independent audit firm acceptable to the Bank, will be submitted to the Bank within 120 days following the end of each fiscal year of the executing agency, during the loan disbursement period. The last of these reports will be submitted within 120 days following the date specified for the last disbursement of the loan proceeds.

4.3 **Contracting of a project management firm.** The Proposal for Operation Development (POD) specifies the functions to be assigned to the project management firm to ensure the project's fiduciary and technical execution. The firm's specific functions and relationship with government agencies will be defined in detail in the program's Operating Regulations.

4.4 **Accounting records.** A condition precedent to the first disbursement requires the PEU to have the SIGMA (soon to be SIGEP) installed and operating.

V. AGREEMENTS AND REQUIREMENTS FOR PROCUREMENT EXECUTION

5.1 **Procurement execution.** Procurement processes will be implemented according to the policies set out in documents GN-2349-9 and GN-2350-9, with no exceptions anticipated. Local regulations will not be applied. The online dissemination mechanism SICOES will be used.

5.2 **Procurement of works, goods, and nonconsulting services**. Contracts for works, goods, and nonconsulting services arising under the program, and subject to international competitive bidding (ICB), will be executed using the Bank's standard bidding documents (SBDs), and those authorized by the Bank's Country Office in Bolivia. Bidding processes subject to national competitive bidding (NCB) will be

conducted using national bidding documents agreed upon with the Bank (or satisfactory to the Bank if not yet agreed upon). Procurement using shopping procedures will use the standard document prepared by the Bank's Country Office in Bolivia, which is included in the Operating Regulations. Changes to these documents will require the Bank's no objection. For the construction of the level three hospital (component II), the document pertaining to major FIDIC works will be used, adapted as necessary.

5.3 **Selection and contracting of consultants.** Consulting services for the project will be executed using the standard request for proposals (SRP) issued by or agreed upon with the Bank (or satisfactory to the Bank if not yet agreed upon).

(i) Consulting firm selection: The standard request for proposals (SRP) issued by the Bank will be used in this project;

(ii) Shortlist of consulting firms: This shortlist may consist entirely (100%) of Bolivian firms[4] for contracts in amounts below the thresholds set by the Bank for the country. In the case of Bolivia, this threshold is US$200,000;

(iii) Individual consultant selection: Individual consultants will be selected on the basis of their qualifications for the work in question, following a comparison of the qualifications of at least three candidates. In the case of Bolivia, if the executing agency considers it advisable, the SICOES may be used as a tool for disseminating requests for proposals for individual consultant selection. In cases where large numbers of consultants with basic qualifications need to be hired, the program may use service delivery contractors (document GN-2350-9 paragraph. 3.21), as described in the Operating Regulations.

5.4 **Recurring expenses.** These consist of operating and maintenance expenses needed to operate the program during its useful life, covering items including the following: office rent, public utilities, radio, print, or televised communication, translations, bank fees, basic office supplies, advertising expenses or announcements, photocopies, mail, fuel, short courses. These expenses will be financed by the project within the annual budget approved by the Bank, and have been included in the program's procurement plans. Recurring expenses will be contracted pursuant to the executing agency's administrative procedures.

5.5 **Direct contracting:** Expenses for less than US$500, individually, and not exceeding US$5,000 as a block, may be contracted directly to promote efficient and streamlined execution. Nonetheless, they must be approved by the Project Team Leader in the procurement plan. If necessary, specialized staff may be hired to provide support during fulfillment of the conditions precedent, depending on the special expertise in question.

[4] Foreign firms will participate.

5.6 Table of thresholds (US$ thousands)

Works			Goods[5]			Consulting services	
International competitive bidding	**National competitive bidding**	**Shopping**	**International competitive bidding**	**National competitive bidding**	**Shopping**	**International advertising of the consulting services**	**Shortlist 100% national**
> 3,000,000	< 3,000,000	< 250,000	> 200,000	< 200,000	< 50,000	> 200,000	< 200,000

5.7 Major procurement processes

	Amount	Method
1. Works		
Construction of the hospital in Potosí	12,000,000	ICB
2. Goods and services		
Procurement of medical equipment and furniture	9,500,000	ICB
Procurement of equipment to be installed in the works for the Potosí hospital (tomography scanner and other items; industrial equipment)	2,500,000	ICB
Procurement of medical equipment and furniture for the Potosí hospital (light equipment)	6,300,000	ICB
Computers and other equipment for the deconcentrated unit	25,000	Shopping
3. Consulting firms		
Training for implementation of the family, community, and intercultural health (SAFCI) model – Potosí	200,000	QCBS
Training for SAFCI implementation – La Paz	200,000	QCBS
Management firm	2,480,000	QCBS
Audit	350,000	QCBS
Final evaluation	60,000	QCBS
4. Individual consultants		
Coordinator	122,000	3 CVs NICQ
Procurement specialist	38,400	3 CVs NICQ
Financial specialist (administrator)	97,600	3 CVs NICQ
Legal specialist	19,200	3 CVs NICQ
Technical specialist – architect	9,600	3 CVs NICQ
Technical specialist – engineer	19,200	3 CVs NICQ
Technical specialist – engineer	38,400	3 CVs NICQ
Technical specialist – engineer	9,600	3 CVs NICQ
Monitoring specialist	97,600	3 CVs NICQ
Administrative assistant	73,200	3 CVs NICQ
Technical specialist – nurse	57,000	3 CVs IICC
Technical specialist – nurse	57,000	3 CVs IICC
Technical specialist – nurse	20,800	3 CVs NICQ
Technical specialist – nurse	20,800	3 CVs NICQ
Technical specialist – hospital management	21,000	3 CVs IICC
Technical specialist – hospital management	21,000	3 CVs IICC
Technical specialist – hospital management	8,000	3 CVs NICQ
Technical specialist – hospital management	8,000	3 CVs NICQ
Technical specialist – physician, hospital management	30,000	3 CVs IICC

[5] Including nonconsulting services.

	Amount	Method
Technical specialist – physician, hospital management	30,000	3 CVs IICC
Technical specialist – physician, hospital management	16,000	3 CVs NICQ
Technical specialist – physician, hospital management	16,000	3 CVs NICQ

5.8 **Procurement supervision.** Given the MSD's fiduciary capacity, procurement for amounts up to 30% of the threshold for ICB will be subject to ex post review, pursuant to the procurement plan and its updates, and according to the table below:

Works	Goods	Consulting firms	Individual consultants
Shopping	**Shopping**		
Processes costing less than US$900,000 will be reviewed ex post	Processes costing less than US$60,000 will be reviewed ex post	Processes costing less than US$60,000 will be reviewed ex post	All processes will be reviewed ex post irrespective of amount

5.9 **Records and files.** The PEU will be responsible for determining the supporting documents, procedures, and controls needed for program execution, and for their conservation, as specified in the loan contract and in local laws.

FINANCIAL MANAGEMENT

5.10 **Programming and budget.** The PEU will schedule activities on the basis of the execution of programmed activities and works.

5.11 **Accounting and information systems.** The SIGMA system will be used, which integrates the different accounting events in a single record; budget record (budget execution), property record (assets, liabilities, capital, and retained earnings), and cash management record (cash transfer). Accounts will be maintained on an accrual basis, using International Accounting Standards (ISAs) alongside government standards, since the program will be implemented through SIGMA, which is governed by the latter. For loan accounting purposes, the project management system (SIAP-BID) will be necessary, as accounting support for reporting, until such time as another system approved by the Bank for accounting in the loan currency becomes available.

5.12 **Disbursements and cash flow.** Disbursements will be released primarily in the form of advances, without prejudice to any other mechanism that the Bank may use to make payments or reimburse expenses. Disbursements in the form of advances will be released according to liquidity needs, justified in a financial program for a period of up to six months. To request new advances, it will be necessary to have justified at least 80% of cumulative prior disbursements. Expenses paid with the proceeds of the advance of funds will be reviewed on an ex post basis.

5.13 **Management of the loan proceeds.** Project disbursements will be deposited in a special account opened at the Central Bank of Bolivia (BCB) and subsequently transferred in local currency in the respective account pursuant to the procedures defined by the Office of the Deputy Minister of the Treasury. The exchange rate used for disbursements will be the buying rate prevailing on the day of the transfer,

as determined by the BCB. The PEU is responsible to the MSD for management of the funds, subject to compliance with institutional internal control systems.

5.14 **Internal control and internal audit.** Despite the fact that the PEU is a deconcentrated entity, as it will be subject to local regulations and laws, it will be evaluated by the Internal Audit Department, which reports directly to the MAE and has the resources and staff needed to perform internal control tasks.

5.15 **External control and reports.** The project will include a budgetary item in the loan to cover the project's external audit (external control).

5.16 **Financial supervision plan.** Financial supervision of the PEU will be done on an ex post basis, with supervision plans including, at a minimum, the following actions: an on-site visit to the locations where the loan proceeds are invested; and a visit to verify compliance with agreements on internal control recommendations made by the program's external audit.

5.17 **Execution arrangements.** The MSD will serve as executing agency and will implement program activities through a PEU created for that purpose with technical and operational, administrative-financial, and legal independence. The PEU will be strengthened with the necessary staff, including accounting-financial management and procurement specialists, so that the unit can fulfill the additional fiduciary responsibilities of this operation.

5.18 The MSD will delegate the authorization of payments related to the operation to the PEU; and it will submit disbursement requests and audited financial statements. The PEU, supported by the MSD, will fulfill the following functions: (i) annually register the budget to be executed; (ii) make arrangements with the Ministry of the Economy and Public Finance to open specific bank accounts for the program; (iii) conduct bidding processes; (iv) make payments to suppliers and contractors; and (v) prepare bank reconciliations and program financial reports.

DOCUMENT OF THE INTER-AMERICAN DEVELOPMENT BANK

PROPOSED RESOLUTION DE-___/12

Bolivia. Loan ___/BL-BO to the Plurinational State of Bolivia
Improved access to hospital services in Bolivia

The Board of Executive Directors

RESOLVES:

That the President of the Bank, or such representative as he shall designate, is authorized, in the name and on behalf of the Bank, to enter into such contract or contracts as may be necessary with the Plurinational State of Bolivia, as Borrower, for the purpose of granting it a financing to cooperate in the execution of program for improved access to hospital services in Bolivia. Such financing will be for the amount of up to US$28,000,000 from the resources of the Single Currency Facility of the Bank's Ordinary Capital, corresponds to a parallel loan within the framework of the multilateral debt relief and concessional finance reform of the Bank, and will be subject to the Financial Terms and Conditions and the Special Contractual Conditions of the Project Summary of the Loan Proposal.

(Adopted on __ _____ 2012)

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DOCUMENT OF THE INTER-AMERICAN DEVELOPMENT BANK

PROPOSED RESOLUTION DE-___/12

Bolivia. Loan ___/BL-BO to the Plurinational State of Bolivia
Improved access to hospital services in Bolivia

The Board of Executive Directors

RESOLVES:

That the President of the Bank, or such representative as he shall designate, is authorized, in the name and on behalf of the Bank, to enter into such contract or contracts as may be necessary with the Plurinational State of Bolivia, as Borrower, for the purpose of granting it a financing to cooperate in the execution of a program for improved access to hospital services in Bolivia. Such financing will be for the amount of up to US$7,000,000 from the resources of the Bank's Fund for Special Operations, corresponds to a parallel loan within the framework of the multilateral debt relief and concessional finance reform of the Bank, and will be subject to the Financial Terms and Conditions and the Special Contractual Conditions of the Project Summary of the Loan Proposal.

(Adopted on __ _____ 2012)

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