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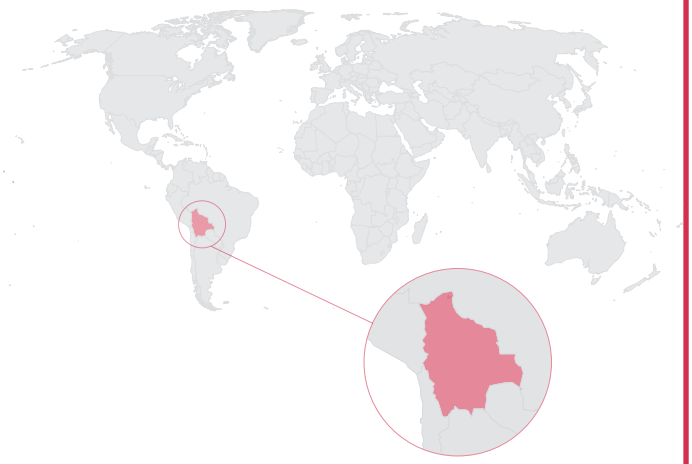
Bolivia



Carmen Ledo

The Health Care System in Bolivia

Global Dynamics of Social Policy CRC 1342

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Content

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1. Country overview (latest data available)

Source: https://ontheworldmap.com/bolivia/ (Accessed September 19, 2024)

- Sub-Region: South America
- Capital: Sucre constitutional capital; La Paz seat of the government
- Official Language: Spanish and Indigenous Languages
- Population size: 12,388,571 in 2023
- Share of rural population: 29% in 2023
- GDP: 45,85 billion US$ in 2023
- Income group: Lower-middle-income in 2023
- Gini Index: 40.9 in 2021
- Colonial period: In 1824, with the battle of Ayacucho, the Spanish empire's army was defeated, the vice-royalty of Peru was beaten, and Marshal Sucre led the territories that would later become Bolivia. In 1825, the new Republic of Bolivia announced its independence.

Source: World Bank 2023, Table 1

2. Selected health indicators

Indicator	Bolivia	Global Average
Male life expectancy	62.9(2021)	68.9(2021)
Female life expectancy	68.4(2021)	74(2021)
Under-5 mortality rate	24.8(2021)	38(2021)
Maternal mortality rate	161 (2020)	223(2020)
HIV prevalence	0.4(2021)	0.7(2021)
Tuberculosis prevalence	108(2022)	133(2022)

Source: World Health Organization 2024a, Table 2

3. Legal beginning of the system

Name and type of legal act	Public Health Service and Social Security
Date the law was passed	December 14, 1956
Date of *de jure* implementation	December 14, 1956.
Brief summary of content	Two events marked the beginning of the health system: 1. The creation of the Inter-American Cooperative Service of Public Health (SCISP) in 1942, and 2. The opening of Social Security in 1956. The SCISP was created to establish actions in the areas of disease prevention and to organize the sanitary infrastructure, which contributed to the establishment of public health. (Andre 2023, 48; Mendizábal 2002, 196; Barrios 2004, 21). Social Security, conceived during the period of revolutionary nationalism, required strong State intervention in economic and social policy. The system, designed for salaried workers and overseen by the Bolivian Central Workers' Union, has a corporatist vision that has hindered the formation of a comprehensive health system. This was due to the duality between the nascent public system and social security (Andre 2023, 49).
Socio-political context of introduction	Until 1952, the Bolivian State was in the early stages of development, with a limited geographical presence within the Bolivian territory. The provision of essential services, including health, education, public security, and the administration of justice, was severely limited, with only a few cities offering these services. From 1952 onwards, a process of rebuilding the nation-state began, with variants introduced by military interventions, changes in the predominant social articulations, and external solicitations (characteristic of a dependent society). The process of cohesion and internal organization was based, firstly, on the expansion of privileges for the armed forces and, secondly, on the centralization and control of the leading economic institutions of the state, as well as the direction of the administrative management of regional political apparatuses (Regional Development Corporations, Prefectures of Departments and Municipal Mayors' Offices). The centralization of both the productive apparatus and the political and social control resulted in a redefinition of the national management system. These processes created a significant public sector in urban areas (and to a lesser extent in rural areas, through establishing rural schools, health centers, and other essential services), which became an increasingly important component of the employment structure.

4. Characteristics of the system at introduction

a. Organisational structure

The organizational structure is dual. On the one hand, the public system is centralized, with the primary responsibility resting on the State through the Ministry of Health. This ministry is mandated to articulate with relevant actors in the defense of health, and its actions are focused on the care of vaccine-preventable diseases. On the other hand, the social security system is implemented through delegated insurance, representing a form of privatization

of social security in the short term. Article 6 of the Code states that social security benefits are available to "all national or foreign persons of both sexes who work in the territory of the Republic and render remunerative services", except temporary workers, individuals affiliated with a foreign official institution for purposes of disability, old age or death insurance, and foreign persons employed by diplomatic, consular or international agencies. Furthermore, the legislation excluded several categories of individuals from the scope of the social security system, including those with their headquarters in Bolivia and those engaged in remunerated work in foreign currency up to an amount determined by the regulations. Additionally, artisans, merchants, independent peasant workers, and unemployed persons were excluded (Andre 2023, 87; Mendizábal 2002, 192).

The Ministry of Health is responsible for creating the conditions for providing care to the population. Hospitals, statistics offices, vaccination offices, health policies, and public clinics depend on the central government. Short-term Social Security (SSCP) was privatized and is regulated by the General Labour Law for private sector employees. This fact has had two significant implications: the establishment of workers' and professionals' unions (always separately organized) that exert pressure and influence not only on labor rights issues but also on management and executive decisions.

» Coverage (principal health insurance)

Percentage of population covered by government schemes	30
Percentage of population covered by social insurance schemes	14
Percentage of population covered by private schemes	20
Percentage of population uncovered	36

b. Coverage

Coverage was incomplete because social security has excluded the peasant population, which was the majority in the 1950s. The historical scheme's workerist character linked to union interests marginalized a large part of the Bolivian population, and its corporatist culture fragmented the health system. The structural changes of 1985 resulted in the shrinking of the state and the escalation of privatization of state enterprises. In the public health sub-sector, the health reform was as follows:

» Focus the actions and resources of the state only on the poorest.
» Privatization of all profitable activities and outsourcing of services.
» Deregulation of the sector and management autonomy in tertiary care hospitals.
» Management based on projects developed by non-governmental organizations.

These measures have contributed to the opening up of social insurance, which is aimed at the care of the poorest and offers reduced benefit packages.

c. Provision

According to WHO's figures for 2000-2009, Bolivia had 10,329 doctors, 18,091 nurses and 5,997 dentists. The ratio is 1.2 doctors, 2.1 nurses, and 0.7 dentists per 1000 inhabitants. (World Health Organization 2010). According to National Institute of Statistics (INE) data in 1976, 80% of the health facilities depended on the Ministry of Social Provision and Public Health and 20% on the social security system (Instituto Nacional de Estadística 1976). In 1997, only 2% of the facilities were third level, 6% second level, and 92% first level (Instituto Nacional de Estadística 2024). Bachelor-level nurses dominate the first level, while doctors and specialized nurses staff the second and third levels. In rural areas, nursing assistants predominate (World Health Organization 2010). International organizations provided greater cooperation, e.g., the World Bank and the IDB, sought to strengthen the health system in the urban centers with the highest population concentrations. They also supported local health systems through PAHO, as well as support and expansion to urban areas in terms of physical infrastructure and human resources, with financial support from the World Bank and the IDB.

d. Financing

Health spending in Bolivia is dominated by public spending, which accounts for 63.8% of total health spending. The social security subsector accounts for just under 60% of public resources. Finally, private spending is out-of-pocket mainly (82.8% of total private spending).

The financing regime established by the Code determined that long-term insurance (disability, old age, and death) would be applied to the pay-as-you-go system with collective capitalization and staggered premiums. Contributions varied for active and passive insured persons. Contributions to Social Security reached 46% of the total wage bill, only 34% of the employer's contributions, and 12% of those of the active and passive labor sector (Mendizábal 2002, 194). Financing is fragmented and predominantly out-of-pocket, benefiting only the middle class with salaried jobs; poor households are forced to resort to private services or to self-medicate by buying from pharmacies.

e. Regulation

The management model indicates that the Ministry of Health has the highest leadership level. The ministry is legally in charge of acting as the system's rector and, to that extent, regulating the management of services and formulating strategies, policies, plans, and programs at the national level for the national health system.

5. Subsequent historical development of public policy on health care

a. Major reform I: 1994

Name and type of legal act	Popular Participation and Administrative Decentralization within the framework of the Political Constitution of the State.
Date the law was passed	20/04/1994
Date of *de jure* implementation	11/08/1996
Brief summary of content	The Decentralized and Participatory Health System (Sistema Público de Salud-SPS) was consolidated with Supreme Decree 24237. The SPS aimed to achieve levels of equity, quality, and efficiency in providing health services, as well as solidarity and universality in access and coverage of the population. The objectives of the SPS were: a) to define the priorities governing the health care model; b) to define and establish the organization of services; and c) to define and establish the structure of sectoral management and shared management with popular participation in health. Law 1551 on Popular Participation transfers health infrastructure to the municipal governments, expanding their attributions and competencies to include the administration and control of equipment, maintenance, and improvement of the transferred infrastructure, as well as the provision of equipment, furniture, inputs, and supplies, including medicines, and food. The administration, supervision, and control of human resources in health are not transferred. Moreover, the payment of these resources is maintained through the prefectures with resources from the General Treasury of the Nation (TGN), which through the Law of Administrative Decentralization of 28 July 1995 delegates the competencies of the central government in the administration, supervision, and control of human resources to the Departmental Treasury, which is responsible for the organization and administration of economic, human and physical resources and the processes of budget execution and control (Mendizábal 2002, 368-370)
Population coverage	According to data from the INE census (Instituto Nacional de Estadística 1992), about 30% of the population had access to public health services, 14% to social security, 20% to private facilities, and 36% had no coverage. The social security entities were coordinated by INASES, which consisted of eight health funds and two comprehensive insurances with a special regime (Instituto Nacional de Estadística 1992).

Type of benefits	The public sector comprises a network of services administered locally and jointly by the community, the departmental government, and the municipal government. This network of services is organized into three levels of care. The first level encompasses ambulatory care, with activities inherent to the health center (health post, medical office, health center with transit beds, and polyclinic). The second level includes the modalities of care established in the primary support hospital. Finally, the third level corresponds to the general support hospital (hospitals and specialized institutes). The facilities of the three levels of care correspond to those transferred to the municipal governments for their administration, infrastructure maintenance, provision of essential services, inputs, and supplies (according to Law 1551 and D.S. 23813). A sub-system of patient referral and counter-referral is contemplated, which guarantees the continuity and follow-up of care between facilities according to the level of complexity of the network of facilities. SUMI affiliates provide care for: a) pregnant women, b) neonatology, c) pediatrics, d) dentistry, and e) laboratory, cabinet and imaging, blood, and traumatology services. Thanks to international cooperation, the EXTENSA program has coverage in rural areas. This program operates based on Mobile Health Brigades (BRISAS), which work in coordination with community health agents (ASISTES). The social security subsector offers the insured and their beneficiaries coverage for common illnesses, maternity, and professional risks. The insurance provides the right to receive medicines, medical and dental care, and both general and specialized outpatient and inpatient rehabilitation. It also provides benefits in kind, such as temporary disability benefits and family allowances (prenatal, childbirth, breastfeeding, and unemployment benefits), among others.
Socio-political context of introduction	The implementation of shared management of the Public Health System, decentralized and participatory, required high coordination and joint responsibility in providing health care services. This involved coordination between the prefecture (responsible for human resources paid with TGN, investments, and inputs), municipal governments (in charge of equipment, infrastructure, medicines, food, training resources, and investments), and the neighborhood councils, peasant communities, indigenous peoples, or original communities (responsible for control and social production) (Mendizábal 2002, 373). These actors needed high social commitment and coordination, which has proven challenging to establish. Bolivia is a country with permanent revolutions and changes. During this period the population has been concentrated in a few cities in correspondence with the economic and social policies implemented since the twentieth century. This situation has determined the transformation of the urban growth model from a North-South settlement pattern located predominantly in the highlands to a model that integrates the West (La Paz) with Santa Cruz (lowlands). The new territorial configuration has led to changes from the rural predominance in Bolivia until the second half of the 1980s to an urban predominance. The urban growth model has also changed from a primate model with a center in the city of La Paz to another model that involves three ecological contexts: La Paz, Cochabamba, and Santa Cruz. In each ecological context, intra-ecological concentration processes are reproduced in the surrounding areas. In Bolivia, by 2012, around 65% of the urban population declared that they live in one of the three metropolitan areas, i.e., in no more than 20 municipal sections, in the face of an acute dispersion of the Bolivian territory, it is expected that this proportion will have increased to 70% by 2024.

6. Description of current health care system

With Law No. 1152 of 20 February 2019, Bolivia attempted to undertake a profound health reform called: "Hacia el Sistema Único de Salud, Universal y Gratuito", which required extending the benefits provided in Law No. 475 to the entire Bolivian population. The former subsector of social security was composed of the mandatory scheme granting benefits to formal workers and the long-term care granting benefits to pensioners. Therefore, the reform includes the informal sector, which was previously excluded. Its principles focused on efficacy, equity, gratuity, integrality, interculturality, intersectionality, opportunity, preeminence of people, progressiveness, solidarity, universality, universal access to medicines, and health technologies. The Law also introduced a fourth level of care (Article 3) consisting of health institutes in charge of offering the highest technology available in the area, generating new knowledge to feed the development of the health system. Article 7, in turn, provided mandatory access through first-level health facilities, from which a staggered transit should be followed, except in emergencies.

a. Organizational structure

The decentralization model adopted by Bolivia integrated three actors with different degrees of power and, in some cases, with relevant differences in their political projects: the Ministry of Health, the departmental service, and the municipal service. Health services have tried to self-regulate without delegating administrative competencies, developing a "decentralized management model" with a strong dependence on the central level (Ministry of Health). Under these conditions, it has been challenging for the health services to act as operational integrators in each of the services provided by the health services, which are highly concentrated in relation to the number of establishments in the first level, which absorbs 92% and does not have specialized staff. The health system is segmented and fragmented, with weak institutions to strengthen the decentralization necessary to bring "power to the local level", with an essential weight of structural determinants in the health situation (Andre 2023, 64).

The health system is organized into three main sectors: the public system (Ministry of Health and Sports—MSD), social security (short-term social insurance for salaried employees and long-term social insurance provided by the Pension Fund Administrators), and the private sector. The private sector provides services for 10% of the population and operates mainly based on out-of-pocket payments. About 30% of the population has no access to health care services other than those offered by traditional medicine, which are charged directly to their income.

According to data from the National Health Information and Epidemiological Surveillance System (SNIS—Structure of health facilities, all sub-sectors Bolivia, as of 5 December 2019), there were 3,984 health facilities (92% corresponded to first-level facilities, 6% to second-level facilities and barely 2% to third-level facilities) and 34 public hospitals to serve around 12 million people. The construction of new hospitals has not been prioritized, and the few existing ones face structural difficulties.

The organizational characteristics of the Bolivian territory are typical of marked social inequality, with concrete manifestations of segregation and physical "marginality." The poorest people live in rural areas and in the less consolidated peri-urban areas of the cities. Households with a low socio-economic level, lacking habitability conditions, and in precarious self-built dwellings are located in areas lacking all kinds of essential services such as drinking water, sewage, and solid waste disposal. Since they settled on irregularly occupied private lands, they gained access to them through the speculative informal market. Around 80% of the population is dedicated to the informal sector, a heterogeneous group regarding educational achievements and access to social security. There are traders with small, medium, and large infrastructure and street vendors who work in a subsidiary way for the owners of the capital. What is visible is that the poorest of the poor in this sector are women, children, and adolescents who work, in many cases, in an environment of violence, labor exploitation, and abuse, often based on family relationships or patronage. All of this is taking place at a time when the country's epidemiological profile is changing, and SNIS statistics reveal an increase in chronic non-communicable cases due to the economic crisis and the lack of health education for the population. Cases of diabetes, hypertension, obesity, kidney damage, and other pathologies resulting from metabolic damage caused by lifestyles and the consumption of cheap food have increased, and it is the poorest and most vulnerable people who are excluded from the health system.

» Coverage

Percentage of population covered by government schemes 2019	46%
Percentage of population covered by social insurance schemes 2019	11%
Percentage of population covered by private schemes 2019	1%
Percentage of population uncovered 2019	34%

b. Coverage

The main challenge facing the Bolivian health system is to reduce the exclusion of the population from the health system. The social security subsystem, which concentrates most of the resources, covers 20 percent of the population belonging to the middle-income classes. It is a pending task for the state to include the indigenous and native peasant population in social security benefits. More appropriate legislation must be developed. Moreover, technical human resources must be generated at the regional or municipal level to carry out this planning. Similarly, awareness-raising processes will have to be generated in the decision-making spheres on the importance of

reducing inequalities. National, regional, and local authorities should, in coordination with the population, seek measures to guarantee the right to health and ensure strategies that allow the poorest and most vulnerable sectors of society to have access to this service since pathologies resulting from the lack of access to common goods translate into death among the most deprived groups.

c. Provision

According to WHO figures for 2021, the ratio of doctors is around 1.2 and nurses 1.6 per 1000 inhabitants (World Health Organization 2024b). Second and third-level hospitals represent 8% of facilities and absorb 62% of beds with a hospital density of 1.1 beds per 1000 inhabitants (OECD/The World Bank 2020, 93-115). Most of the nurses are in rural areas and at the first level. On the other hand, doctors are at the second and third levels. The management of human resources is a significant challenge, considering that up to 85% of health problems could be solved at the first level of care, which indicates that the first level of care would have to have medical professionals working at this level to reduce the collapse of the third level. In other words, medical personnel should be assigned to the first-level centers. Furthermore, they should have a high level of competence to decongest the more complex services, which require the incorporation of new professional profiles, particularly in high-risk units such as emergencies, intensive care, diagnostic support services, and outpatient and inpatient transit areas.

d. Financing

The financing for the public sector is from the TGN, which is destined to pay human resources for the third and fourth levels. On the other hand, the financing of the Autonomous Municipal Governments for the first and second levels of care comes from the Municipal Tax Co-participation, which amounts to 15.5%. Health spending in Bolivia is 480 dollars, representing a number rated lower than the average in Latin America. The percentage of health spending or out-of-pocket spending is 25 dollars (higher than the average). Taking into account that the population regularly spends more than 10% of its budget as out-of-pocket spending on health, 6.0% (close to the average), and the population that falls below the poverty line due to health spending is close to 1.7%, close to the overall average (Andre 2023, 61).

e. Regulation of dominant system

The determination of Law 1152 regarding the regulatory body is set out in paragraphs e and f of point I, which states: e) Public health services are obliged to provide preferential attention in providing services and administrative procedures to people in vulnerable situations, including but not limited to. Furthermore, it is established in point f) that the Ministry of Health shall regulate the referral and counter-referral system to guarantee continuity of care and that services are provided in the most appropriate health facilities for each case. In Point III., the Ministry of Health shall regulate all population access processes to universal and free care".

7. Co-existing systems

Three main systems coexist in the Bolivian healthcare system: public, short-term social security, and private. These are disjointed actors that have produced significant vulnerability in the neediest population. The weakness of the Ministry's steering role in regulating health, administrative, and financial aspects in each subsystem must be modified. There is an inadequate allocation of resources and an absence of effective mechanisms for monitoring and evaluating health actions and programs, which translates into inefficiencies in using resources allocated to health. There is an urgent need for change in human resources management. More than half of the health facilities in rural areas and in the first and second-level facilities are under the responsibility of nurses and health promoters. Therefore, mechanisms should be sought to increase the allocation of medical personnel, given that 98% of the facilities are concentrated at these levels, and health personnel do not have job stability. These actors' function in a fragmented manner without responding to the most relevant needs of the Bolivian population.

8. Role of global actors

Historically, various international organizations and bilateral cooperation between countries have played a significant role in providing and financing healthcare in Bolivia. The country is characterized by deep economic, social, political, environmental, spatial, and cultural gaps across its territory. The redistribution of the population in Bolivia has led to a decline in the importance of the agricultural sector and the growth of the urban tertiary sector due to domestic and international migration. These changes have created extensive pockets of contamination, particularly harmful for children who lack adequate protection against bacterial aggression. Rural areas and urban peripheries continue to experience the highest rates of morbidity and mortality due to air, soil, and drinking water contamination. Despite advancements in residential areas of major cities, rural, and marginalized urban regions still face significant setbacks in healthcare.

9. List of additional relevant legal acts

1938 Establishment of the Ministry of Health

1953 Creation of the Social Security System for Workers

1956 Enactment of the Social Security Code

1979 Creation of the Expanded Programme of Immunization and the National Cold Network

1984 Regionalization of health care

1996 Certification of the eradication of poliomyelitis by PAHO and WHO

1997 Structural Reform of the social security system

2003 Universal Maternal and Child Insurance, replacing the Basic Health Insurance

2006 Publication of the Bases of the Health Plan 2006-2010

2009 Political Constitution of the State

2010 Law Nº 65 of 10 December 2010 "Law of the Integral Pension System"

2012 Restructuring Plan of the National Health Fund, DS Nº 1403, 9 November 2012.

2013 Law Nº 341, law of participation and social control.

2018 Law Nº 1069, 5 June 2018, in its chapter v: attention to affiliates of the managing entities in public health establishments and automatic debit.

References

Andre, Rosario. 2023. *Diseño de un Marco Teórico Referencial Para la Construcción de una Estrategia en Salud*. La Paz: Academia Boliviana de Medicina. Accessed July 15, 2024. https://drive.google.com/file/d/1X5EMd21LbcNpia79en1QJLfcuTRL7HTG/view

Barrios Artaza, Osvaldo., Mauricio Bustamante, and Inés Ordoñez. 2004. *Reformas y Financiamiento de Sistemas y Servicios de Salud en la Subregión Andina*. Lima: Organismo Andino de Salud.

Bolivia. *Law N° 1152, Ley del Sistema de Salud Integral*. January 20, 2019. Accessed July 22, 2024. https://www.lexivox.org/norms/BO-L-N1152.html.

Instituto Nacional de Estadística (INE). 1992. *Censo Nacional de Población y Vivienda 1992*. La Paz, Bolivia: Instituto Nacional de Estadística (INE). Accessed September 4, 2024. https://anda.ine.gob.bo/index.php/catalog/47.

Instituto Nacional de Estadística (INE). N.d *Bolivia: Establecimientos de salud, según departamento y tipo, 1997 – 2019,* visitado 20 julio, 2024. https://www.ine.gob.bo/index.php/registros-administrativos-salud/

Mendizábal Lozano, Gregorio. 2002. *Historia de la Salud Pública en Bolivia: de las Juntas de Sanidad a los Directorios Locales de Salud*. La Paz: OPS/OMS.

Ministry of Health and Sports (Bolivia). 2019. *Bolivia SNIS-VE Weekly Epidemiological Surveillance 2019*. La Paz, Bolivia: Ministry of Health and Sports (Bolivia). Accessed September 4, 2024. https://ghdx.healthdata.org/record/bolivia-snis-ve-weekly-epidemiological-surveillance-2019.

OECD and The World Bank. *Education at a Glance 2020: OECD Indicators*. Paris: OECD Publishing, 2020. Accessed July 28, 2024. https://doi.org/10.1787/6089164f-en.

On The World Map. n.d. Bolivia Map. Accessed July 15, 2024. https://ontheworldmap.com/bolivia/.

OPS, 2004, Análisis del Sector Salud, Bolivia Resumen Ejecutivo, Iniciativa Regional de Reforma del Sector de la Salud en América Latina y el Caribe. NUMERO 10. Washington, D.C. https://www.social-protection.org/gimi/Media.action;jsessionid=FmjD_CZanFHeMGmttculkMfgV_jvqV4LbPGXeQBr1IoNAilxcr2x!-688150444?id=9004

World Bank. 2023. GDP per Capita (Current US$) – Bolivia and Other. Last modified 2023. Accessed July 14, 2024. https://data.worldbank.org/indicator/NY.GDP.PCAP.CD?locations=XO-BO.

World Health Organization. 2010. *World Health Statistics 2010*. Geneva: World Health Organization. Accessed July 25, 2024. https://www.who.int/publications/i/item/9789241563987.

World Health Organization. 2024a. *Under-Five Mortality Rate (Probability of Dying by Age 5 per 1,000 Live Births)*. Accessed September 4, 2024. https://www.who.int/data/gho/data/indicators/indicator-details/GHO/under-five-mortality-rate-(probability-of-dying-by-age-5-per-1000-live-births).

World Health Organization. 2024b. *Country Health Profile: Bolivia*. Accessed July 20, 2024. https://data.who.int/countries/068.