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USAID/BOLIVIA: HEALTH STRATEGY PORTFOLIO REVIEW

FY2005-FY2009

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CONTENTS

APPENDICES

ACRONYMS

ACS	Agente Comunitario de Salud/ Community Health Agent
AIEPI (IMCI)	Atención Integral a las Enfermedades Prevalentes de la Infancia/Integrated Management of Childhood Illness
ALS	Autoridad Local de Salud/Local Health Authority
AO	Activity Objective (formerly SO, or Strategic Objective)
CAI	Comités de Análisis de Información/Information Analysis Committees
CARE	Cooperative for Assistance andRelief Everywhere
CDC	Centers for Disease Control and Prevention
CDVIR	Centros Departamentales de Vigilancia y Referencia de ITS/SIDA/Departmental Centers for Surveillance and Referral of HIV/AIDS and STIs
CEASS	Central de Almacenamiento de Suministros de Salud/ Central Depository for Health Supplies
CHP	Proyecto de Salud Comunitario (de PROCOSI)/Community Health Project (CHP)
CLS	Comité Local de Salud/Local Health Committee
CSP	Country Strategic Plan
CSRA	Consejo de Salud Rural Andino
DAIA	Disponibilidad Asegurada de Insumos Anticonceptivos/Contraceptive Security
DILOS	Directorio Local de Salud/Local Health Directorate
DIU	Dispositivo intrauterino/Intrauterine Device (IUD)
EAPC	Estrategia de Acción Participativa Comunitaria/Strategy for Particatory Community Action
ENDSA	Encuesta Nacional de Demografía y Salud/ Demographic and Health Survey (DHS)
FCI	Family Care International
FEMME	Foundations to Enhance Management of Maternal Emergencies
FIM	Farmacia Institucional Municipal/ Municipal Institutional Pharmacy
FY	Fiscal Year
GBV	Gender-based Violence
GCS	Gestión y Calidad en Salud/Management and Health (Implemented by John Snow International-JSI)/Management and Quality in Health Project
GDA	Global Development Alliance
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS)

HR	Human Rights
ITS	Infecciones de Transmisión Sexual/Sexually Transmitted Infections (STI)
JICA	Japan International Cooperation Agency
JSI	John Snow, Inc
M&E	Monitoreo y Evaluación/ Monitoring and Evaluation
MAC	Metodología de Acción Comunitaria/Community Action Methodology
MSD	Ministerio de Salud y Deportes/Ministry of Health and Sports
ODM	Objetivo(s) de Desarrollo del Milenio, NNUU 2000/Millennium Development Goal (MDG)
ONG	Organizacion No Gubernamental/Nongovernmental Organization (NGO)
OPS	Organización Panamericana de la Salud/Pan American Health Organization (PAHO)
OMS	Organización Mundial de la Salud/World Health Organization (WHO)
PAI	Programa Ampliado de Inmunizaciones/Expanded Immunization Program
PDA	Programa de Desarrollo Alternativo/Alternative Development Program
PDC	Programa de Desnutrición Cero/ Zero Malnutrition Program
PND	Plan Nacional de Desarrollo/National Development Plan
POA	Plan Operativo Anual/Annual Operational Plan
PROCOSI	Programa de Coordinación en Salud Integral/Coordination of Integrated Health Program (Network of 34 NGOs working on Health in Bolivia)
PROSIN II	Proyecto de Salud Integral (Fase II)/Integrated Health Project
RRHH	Recursos Humanos/Human Resources
SAFCI	Salud Familiar Comunitaria Intercultural/Intercultural Family and Community Health
SEDES	Servicio Departamental de Salud/Departmental Health Services
SIAL	Sistema de Información para la Administración Logística/Logistics Management Information System
SNIS	Sistem de Informacion/Nacional de Salud/National Health Information System
SNUS	Sistema Nacional Único de Suministros/National Universal Medical Supply System
SO	Strategic Objective
SOAg	Strategic Objective Agreement
SpD	Socios Para el Desarrollo/Partners inDevelopment
SPS	Seguro Público de Salud
SRH	Sexual and Reproductive Health
SSR	Salud Sexual y Reproductiva
SUMI	Seguro Universal Materno Infantil/Maternal Child Health Insurance Program
SUS	Seguro Universal de Salud/Universal Health Insurance
SUSAT	Seguro Universal de Salud de Tarija/Tarija Departmental Universal Health Insurance
SUSACRUZ	Seguro Universal de Salud de Santa Cruz /Santa Cruz Universal Health Insurance
TB	Tuberculosis

TBP	Tuberculosis Pulmonar/Pulmonary TB
U.N.	United Nations
UNFPA	United Nations Fund for Population Action
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development

EXECUTIVE SUMMARY

In preparation for the design of a new strategy, a five person team undertook a portfolio review of USAID/Bolivia's health Program. A portfolio review was more appropriate assessment than a final evaluation as midstream changes to the FY2005-FY2009 strategy in 2007 made it unrealistic to measure impacts of interventions implemented for barely two years.

As defined in ADS 200.6, "a Portfolio Review is a periodic review of all aspects of a USAID Mission/Office's AOs, projects, and activities, often held prior to preparing the annual joint Operational Plan." This portfolio review was conducted as input into the design of a new strategy by the same five person team.

The Portfolio Review Team[1] consisted of an Expat team leader with expertise in implementation and evaluation of health programs and extensive knowledge of Bolivia; an Expat reproductive and sexual health expert; a Bolivian maternal health and policy expert; a Bolivian neonatal, child health, and nutrition expert; and a Bolivian sociologist and community health expert. The team spent two months in Bolivia from May 25 to July 24, 2008.

STRUCTURE OF THE REPORT

The period covered by the strategy reviewed in this report was a time of considerable change in Bolivia which caused a great deal of instability in programs funded by USAID. The health portfolio, consequently, went through a number of changes in organization and geographical location. At the same time there were a number of changes in leadership in both the USAID Health Office and in the Ministry of Health, as well as in some of the partner organizations. All of this contributed to making it quite difficult to review the portfolio without providing a great deal of detail on the context in which the USAID Health Strategy was implemented. This makes for a very detailed and dense rendering of what happened, when, and how. The report is structured to capture all this detail but to also allow readers to skip to the information of most interest. The first part of the report provides background on the objectives of the portfolio review and on the Bolivian health context. The second section focuses on a description of the 2005-2009 health strategy. The third section of the report is a description of the activities and implementing partners framed first in a historical account of implementation of the Rural Health portion of the strategy, and secondly in an explanation of how other activities and implementing organization contributed to the three intermediate results. The fourth section presents the strengths and weaknesses of the major activities implemented under the strategy. The fifth section examines the overall performance at the SO level. The final section provides key lessons and recommendations for the design of the 2011-2015 strategy.

METHODOLOGY

The portfolio review team examined an extensive body of documents from current and past projects funded under the strategy, the government, NGOs, and other donors. See Appendix E for a complete list of documents.

The Team spent two and a half weeks in La Paz meeting with USAID and their partner organizations, as well as with governmental officials, other donors, and project implementers

[1] Deborah A. Caro, Ph.D., Team Leader; Marco Arevalo, MD, Reproductive Health and Family Planning Specialist; Victor Conde Altamirano, M.D., Maternal Health Specialist; Marica Ramirez, M.D., Neonatal, Child Health and Infectious Disease Specialist; and Gretzel Jove, M.B.A; Sociologist and Gender specialist.

funded by other donors. The team prepared a detailed work plan and interview guides for different types of stakeholders.

The Team then spent 3 weeks traveling to the Departments of Tarija, Santa Cruz, and Chuquisaca, and within the Department of La Paz (Los Yungas and El Alto) where they made a number of field trips to project sites. They also met with local and departmental health authorities. They had a chance to interview participants at all levels of the health system who had participated in activities funded by USAID, including healthcare administrators; departmental, municipal and community governmental leaders; healthcare providers; clients of healthcare facilities; community members; and leaders and members of indigenous organizations.

Upon return to La Paz, the Team continued to interview a wide array of stakeholders, with an emphasis on donors and the La Paz Departmental Health Services and El Alto Regional Health Services. The Team followed up with program implementing organizations to clarify information encountered on field trips and to deepen and broaden their understanding.

OVERVIEW OF THE STRATEGY

The Strategic Objective (SO), "Improved Health of Bolivians, Contributing to Their Quality of Life" anchors the five year health strategy (FY2005 – FY2009) built on the hypothesis that "the necessary conditions for improved health are created when: (1) communities, families and individuals are enabled to more effectively address the factors compromising their health, resulting in more healthful behaviors and environments; (2) the coverage and quality of public health interventions is improved; and, (3) the capacity of the public sector and nongovernmental organizations (NGOs) to deliver and manage decentralized health services is enhanced." The FY2005-FY2009 Strategy was extended through fiscal year 2010 to allow adequate time to compensate for implementation delays, to ensure that the development of the new strategy is participatory, and to build on collaboration between USAID and the Ministry of Health on a number of key policy and implementation issues, such as IMCI-Nut, integrated intercultural and family health services, maternal health, and post-partum family planning.

Through its intermediate results, the strategy addresses three levels of the health system: (1) self-care and prevention in households and communities, by promoting behavior change and community empowerment; (2) healthcare services by expanding the delivery of high impact, cost-effective interventions that address key public health problems; and (3) healthcare management and policies by building a sustainable service delivery platform in both the public and NGO sectors.

The primary technical intervention areas supported through the strategy are:

- Maternal and Child Health (MCH- including nutrition and hygiene promotion)
- Family Planning and Reproductive Health (FP/RH) (including post-abortion care and adolescent health)
- HIV/AIDS (including Sexually Transmitted Infections (STIs)
- Tuberculosis (TB)
- Other Public Health Threats (OPHT - including Chagas disease, Leishmaniasis, Yellow Fever, and Dengue)

The indicators chosen to measure achievement of the Strategic Objective include:

- Under 5 (child) mortality rate
- Infant mortality rate (IMR)

- Neonatal mortality rate (NMR)
- Total fertility rate (TFR)
- Modern Contraceptive Prevalence Rate

Focus of the Portfolio Review

The Portfolio Review focused on the principal activities and implementing partners of the USAID Health Strategy. The review team focused principally on the partners implementing the most important interventions of the Rural Health Strategy. They include:

- *PROSIN* II provided direct technical and managerial assistance to the Ministry of Health (MSD) through a team of technical advisors who were embedded in the MSD and SEDES
- *The Community Health Project* (PROCOSI) promoted self-care and prevention in households and communities, through behavior change communication, training of community health volunteers, and community and women's empowerment
- *Socios Para Desarrollo (SpD)/Partners for Development* (PROSALUD) provided grants to grassroots organizations and NGOS for community- based health education interventions, mostly in rural communities and among other vulnerable populations. They also trained municipal governments on health planning and budgeting policies and procedures.
- *Management and Quality in Health* (John Snow International-JSI) worked with the SEDES, municipal governments, and health services to improve the delivery of clinical IMCI, neonatal survival and logistics management
- *ACQUIRE* (EngenderHealth) provided technical and training assistance to the SEDES, municipal governments, and health services to improve the delivery of reproductive and maternal health and family planning

The Team did not assess the quality of the technical assistance provided to implementing partners by globally funded programs, such as MSH, Manoff, Abt (Health Systems 20/20), CDC, etc. These partners are described in Appendix D.; the other projects, including Socios para el Desarrollo (SpD), CIES, PROSALUD, and the two Save the Children Projects, were reviewed with less intensity. At the same time that the overall evaluation was underway, there were also case studies conducted of PROCOSI's support for training of community health workers; JSI's and PROCOSI's interventions related to IMCI; and of women's empowerment activities supported by Save the Children and CIES. The Team did not have time to assess the HIV/AIDS program in any depth. The focus of the Portfolio Review reflects the emphasis driven by topics that were most relevant to the new strategy design.

The other projects and partners the team did examine through interviews or field visits were:

- *Management and Quality* in Health's (JSI) work in the Yungas, funded by alternative development funds, where they strengthened Tuberculosis management, infectious disease response and surveillance. In the Yungas, with funding from USAID's Integrated Alternative Development Program, JSI also supported work on TB, malaria, oral health and Leishmaniasis.
- Socios para el Desarrollo, a project that provided technical and research support to the HIV/AIDs program, provided small grants to grassroots organizations on reproductive and child health, and was responsible for coordinating reporting of results through the PMP.
- *Making Decisions,* an adolescent reproductive health project implemented by Save the Children.
- *Improving our Life,* was a school-based health education program for school age children implemented by Save the Children.

- *CIES*, the Bolivian IPPF affiliate and largest private provider of sexual and reproductive health and family planning services. They also run an adolescent program called *You Decide/Living Our Sexuality (Tu Decides/Viviendo Nuestra Sexualidad),* and two women's empowerment/community mobilization programs.
- *PROSALUD, founded in 1985*, is a nonprofit network of modestly priced health services throughout Bolivia.
- *PROCOSI* is a network of 32 Bolivian and expatriate NGOs working in Bolivia. PROCOSI has received support from USAID since the late 1980s through umbrella grants in child and reproductive health. Member organizations competed for and ran individually designed projects financed by sub-grants. The CHP marked a change for PROCOSI as the sub-grantees were all required to implement the same set of interventions in a fairly uniform fashion. The Manoff Group provided both management and technical assistance to PROCOSI to improve their technical implementation of the Community Health Project and its implementing organizations, especially in the area of nutrition, and to ensure financial sustainability of the PROCOSI NGO network.

FINDINGS

The Portfolio Review found the design of the strategy to be closely aligned with GOB policy. During the first year of the strategy period, USAID's implementing partners, PROSIN, working with the MSD and Departmental Health Services (SEDES) in 130 municipalities; JSI (child health and infectious diseases) and EngenderHealth (reproductive health), working in municipal centers in conjunction with municipal officials, health networks, and SEDES; and PROCOSI and Partners for Development, working at the community level; focused their efforts on Chuquisaca, Potosi, and La Paz.

During the second year, as tensions in U.S and Bolivian relations grew around a number of issues, the implementing organizations were forced to redirect their efforts to Tarija, Santa Cruz and Beni in order to withdraw from areas where Cuban doctors were working. This change came at a great cost to all organizations who had invested considerable efforts in baseline data collection, building relations with communities and municipal governments, and with local counterparts in the health networks. The change of intervention area resulted in approximately a year delay in implementation.

Despite the hardship and delay, and closure of PROSIN (at the request of the MSD), the remaining implementing partners were able to re-establish good working relations with the MSD and SEDES in the new areas of La Paz, Chuquisaca and Potosi. Socios para el Desarrollo continued to work in the original areas. PROCOSI worked closely with the MSD to develop community level materials for community-based IMCI and the National Zero Malnutrition Program related to child nutrition. JSI worked with the MSD on the clinical guidelines for IMCI. Both CIES and PROSALUD continued to provide private sector services in capital cities and to work collaboratively with SEDES, despite some contretemps of their own with the government.

By the end of the strategy period, USAID partners had solidified relations at all levels of government, and several, including CARE and PROCOSI were working closely with the MSD and SEDES to implement the SAFCI and emergency obstetric and neonatal care networks in the intervention areas.

The greatest challenge to effective implementation of the Strategy was the lack of coordination among USAID implementing partners. Changes in the implementation approach, with the closure of PROSIN, and the change in geographic regions midway through the Strategy

hampered coordination of activities at different levels of the health system. It was particularly problematic that there was little coordination among PROCOSI's Community Health Project (CHP), John Snow International's Health Management and Quality Project (GCS), and EngenderHealth's ACQUIRE. Activities implemented by CHP with community health agents (ACS) were disconnected from activities aimed at strengthening the health services. Similarly activities to strengthen the functioning of the health services, such as logistics and information management were divorced from activities directed at improving municipal management of health services, until fairly recently.

Lessons Learned and Recommendations for the Next Strategy

1. The new strategy should have a more explicit focus on the reduction of social exclusion from healthcare. The orientation of the 1998-2004 strategy prior to the 2005-2010 strategy focused on areas of greatest need and was able to demonstrate greater impact on health indicators, especially in areas targeted by USAID programs (see PROSIN final report) such as neonatal mortality rate, malnutrition, maternal mortality ratio, infant mortality, and contraceptive prevalence rate, than is evidenced by the latest 2008 DHS. There is increasing evidence that in Bolivia, the poor and indigenous population, especially in rural areas, suffers disproportionally from health problems and is least likely to access health services.

2. Strengthen articulation of levels, processes, and different social actors in the health system:
    - Among households, communities, municipalities, departments, and the national level
    - Across different levels of care (household, ACS, primary, secondary, tertiary healthcare facilities)
    - Across different sectors
    - Between Rural/Peri-urban/Urban areas (e.g. such as between El Alto and the municipalities from which migrants come)
3. Improve understanding of municipal governments of the importance, and strengthen support, and management of local government for healthcare (both at Prefectural and Municipal level).

4. Develop more appropriate and effective technical assistance and training models to improve provider technical skills, attitudes, and intercultural and gender competence. Many of the gender and cultural competence materials are oriented toward program managers rather than healthcare providers. It would be worthwhile investing in the development and dissemination of more culturally appropriate and gender sensitive materials for healthcare providers and administrators.[2]

5. The best way for USAID to strengthen the MSD's stewardship role is through collaborative partnerships such as those modeled by GCS and CHP, and now ENLACE. These were efforts where USAID funded programs bring technical and social knowledge to helping MSD develop the tools to effectively implement policies. In the process of working through

[2] Some examples are: PROCOSI/Population Council's Gender-friendly Services Accreditation materials (http://www.procosi.org.bo/index.php?mc=55&c=3#doc_tec_Grupo Temático de Género)
Family Concern International's series on intercultural approaches to SRH and Maternal Health (http://www.familycareintl.org/fr/resources/publications?language_id=3&sort=title), and CARE Peru's and the Peruvian government's gender and intercultural module (http://www.unfpa.org.pe/publicaciones/publicacionesperu/MINSA-Avanzando-Maternidad-Segura-Peru.pdf).

implementation modalities, weaknesses in the policies often come to light and are more easily addressed when the changes solve particular implementation problems. At this time this is a better approach than USAID taking on a direct role in influencing policy making. Another potential role for USAID funded organizations is in developing grassroots capacity in advocacy and oversight of health services (see recommendation 8 below). This builds on other successes, such as GCS work on municipal CAIs and PROCOSI's work on community CAIs.

6. The original intention of the Rural Health Strategy to focus on municipal health services was consistent with MSD policies and good policy overall at the time the strategy was developed. The lack of an integrating mechanism during implementation of the Rural Health Strategy, however, meant that there was little synergy or interrelationship among the interventions at different levels of the health system. Both the MSD and USAID have now turned their focus to health networks which will contribute to strengthening integration among different levels of the health system. It is recommended that the new strategy focus on health networks from a health systems approach within the policy framework of SAFCI. The results should be integrated across levels of the health system rather than organized by level as in the 2005-2010 results framework.

7. Develop creative solutions to high turnover of healthcare providers, especially in rural areas. PROSIN offered some interesting possibilities in terms of human resource planning. PROCOSI might be a good interlocutor to reopen discussions with the MSD about a Masters Degree or residency in family and community medicine focused on integrated primary care for doctors and nurses based in health centers, to complement rather than compete with the SAFCI residency.

8. Reactivate and potentially build grassroots support for SRH in order to advocate more effectively at the national level. It is important to build this support among indigenous organizations, to more actively engage men, especially indigenous men, and to build support among municipal and community leaders. Renewing USAID's former leadership in IEC/BCC and community mobilization is key to this effort.

9. Operationalize SAFCI by strengthening social networks/movements and ensure broad and diverse participation in planning, management, and oversight (take advantage of best practices, community census, CAI, social mobilization approaches (e.g., WARMI II, MAC, EAPC, etc).

10. A complex program, like the one undertaken in support of the USAID 2005-2010 requires a strong coordination mechanism, especially when so many interdependent actors and activities are involved. It is neither feasible nor practical for the USAID Health office to play that role. USAID should consider developing a comprehensive bilateral project capable of coordinating an integrated implementation of all health elements at all levels, or have multiple implementers but designate one entity as the coordinating and monitoring mechanism.

BACKGROUND AND CONTEXT

In preparation for the design of a new strategy, a five person team undertook a portfolio review of USAID/Bolivia's health Program. A portfolio review was more appropriate assessment than a final evaluation as midstream changes to the FY2005-FY2009 strategy in 2007 made it unrealistic to measure impacts of interventions implemented for barely two years. The Portfolio Review Team consisted of an Expat team leader with expertise in implementation and evaluation of health programs and extensive knowledge of Bolivia; an Expat reproductive and sexual health expert, a Bolivian maternal health and policy expert; a Bolivian neonatal, child health, and nutrition expert, and a Bolivian sociologist and community health expert. The team spent two months in Bolivia from May 25 to July 24, 2008 during which they conducted the portfolio review and facilitated the design of a new strategy. [3]

The team conducted an extensive review of program, project, and national policy documents. It interviewed project implementers, donors, national, departmental, municipal and community policy makers and government officials, community and neighborhood groups, representatives of indigenous organizations, volunteer community health workers, and the men, women, and adolescent boys and girls who are participants in the USAID-funded programs. The team conducted field visits in five of Bolivia's nine departments: Tarija, Santa Cruz, Chuquisaca, La Paz, and Potosi. In addition to presenting the preliminary results to USAID and its implementing partners, the team conducted two workshops with participants from the Ministry of Health and Sports (MSD) to share the results of the evaluation and to present ideas for the new strategy. This report summarizes the findings of the evaluation. A second report presents ideas for the new strategy.

OBJECTIVES OF THE PORTFOLIO REVIEW

The portfolio review team was asked to assess the current Mission Health Strategy (FY2005-FY2009). The Team reviewed progress and performance of USAID/Bolivia's health program over the period covered by the strategy. The team examined the effectiveness of the strategy in relation to its objectives and the relevance of the different approaches taken by USAID implementing partners to Bolivian national health policy. The portfolio review team also assessed the strengths, weakness, and challenges of the current health program activities linked to different areas of healthcare (e.g. reproductive and sexual health, maternal and neonatal mortality reduction, child health, and infectious disease prevention and treatment).

As defined in ADS 200.6, "a Portfolio Review is a periodic review of all aspects of a USAID Mission/Office's AOs [SO], projects, and activities, often held prior to preparing the annual joint Operational Plan." This portfolio review was conducted as input into the design of a new strategy by the same five person team. In line with the ADS, the Bolivia Health Portfolio Review assessed overall progress towards achievement of the SO and evidence that:

- Projects/activities adequately support corresponding Intermediate Result(s) (IRs) and their potential for contributing to the achievement of the SO;
- Activities had adequate and timely mobilization of inputs for producing planned outputs;

[3] Deborah A. Caro, Ph.D., Team Leader; Marco Arevalo, MD, Reproductive Health and Family Planning Specialist; Victor Conde Altamirano, M.D., Maternal Health Specialist; Marica Ramirez, M.D., Neonatal, Child Health and Infectious Disease Specialist; and Gretzel Jove, M.B.A; Sociologist and Gender specialist.

- The performance indicators selected in the PMP are the correct measures of progress and impact.

The primary focus of the review was on the effectiveness of partner organizations to contribute to the achievement of IRs and the SO. The Portfolio Review Team also examined the validity of critical assumptions and causal relationships defined in the Results Framework, along with the related implications for performance, especially in light of major changes in the political environment in Bolivia during the strategy period. The team analyzed the status of cross cutting topics, such as gender and local governance. The Team did its best to assess both partner and USAID performance within the context of numerous changes in leadership in the Health Office and within Ministry of Health during the strategy period.[4]

STRUCTURE OF THE REPORT

The period covered by the strategy reviewed in this report was a time of considerable change in Bolivia which caused a great deal of instability in programs funded by USAID. The health portfolio, consequently, went through a number of changes in organization and geographical location. At the same time there were a number of changes in leadership in both the USAID Health Office and in the Ministry of Health, as well as in some of the partner organizations. All of this contributed to making it quite difficult to review the portfolio without providing a great deal of detail on the context in which the USAID Health Strategy was implemented. This makes for a very detailed and dense rendering of what happened, when, and how. The report is structured to capture all this detail but to also allow readers to skip to the information of most interest. The first part of the report provides background on the objectives of the portfolio review and on the Bolivian health context. The second section focuses on a description of the 2005-2009 health strategy. The third section of the report is a description of the activities and implementing partners framed first in a historical account of implementation of the Rural Health portion of the strategy, and secondly in an explanation of how other activities and implementing organization contributed to the three intermediate results. The fourth section presents the strengths and weaknesses of the major activities implemented under the strategy. The fifth section examines the overall performance at the SO level. The final section provides key lessons and recommendations for the design of the 2011-2015 strategy.

Methodology

The team examined an extensive body of documents from current and past projects funded under the strategy, the government, NGOs, and other donors (see Appendix E for a complete list). The Team spent an initial two and a half weeks in La Paz meeting with USAID and their partner organizations, as well as with governmental officials, other donors, and project implementers funded by other donors. In preparation for interview with stakeholders throughout the country, the team prepared a detailed work plan and interview guides. They spent 3 weeks traveling to the Departments of Tarija, Santa Cruz, and Chuquisaca, and within the Department of La Paz (Los Yungas and El Alto) where they made a number of field trips to project sites. They also met with local and departmental health authorities. They had a chance to interview participants at all levels of the health system who had participated in activities funded by USAID, including healthcare administrators; departmental, municipal and community governmental leaders; healthcare providers; clients of healthcare facilities; community members; and leaders and members of indigenous organizations.

[4] There were four different Directors of the USAID Health Office and approximately the same number of Ministers of Health during the strategy period.

Upon return to La Paz, the Team continued to interview a wide array of stakeholders, with an emphasis on donors and the La Paz Departmental Health Services and El Alto Regional Health Services. They followed up with program implementing organizations to clarify information encountered on field trips and to deepen and broaden their understanding.

During the last two weeks, the Team presented preliminary findings from the evaluation and suggestions for the design of the new strategy to USAID. With USAID feedback, the Team developed an interactive presentation on the findings and forward planning which were presented to the Ministry of Health (MSD) and USAID partner organizations in two separate workshops. Before leaving Bolivia, the Team Leader and Bolivian Team members hosted another workshop with the Ministry of Health (MSD) to develop some of the possible activities and indicators for the new strategy.

The process of writing the portfolio review (and the strategy) has been a participatory and iterative process with full participation of the USAID Health Team. The document reflects input from many different perspectives.

Bolivian Health Context

In 2004, Bolivia still faced immense health challenges. The rates of neonatal, infant, young child and maternal mortality were the second highest in the Americas. There were large and increasing gaps between rural and urban health indicators, with the largest discrepancies between self-identified indigenous and non-indigenous groups. Approximately 26% of children younger than 5 years of age were chronically malnourished in 2003. Infectious and parasitic diseases, such as malaria, tuberculosis, Chagas disease, leishmaniasis, and yellow and dengue fevers, also plagued large proportions of the Bolivian population. Bolivia also faced a critical point in its HIV/AIDS epidemic even though its overall prevalence was less than 1%, as a few high risk populations continued to have significantly higher rates.

The FY2005-FY2009 Strategy was written in 2004 during a very tense and unstable time in Bolivia's history, less than a year after President Gonzalo Sanchez de Losada was forced to resign by a populist uprising against his gas and water policies, and in reaction to firing on protestors in front of the Presidential Palace, and less than a year before President Carlos Mesa resigned over irreconcilable differences with the Congress over gas. Within a year of the strategy's initiation, Mesa had resigned, Eduardo Rodriguez, formerly the Chief Justice of the Supreme Court, had assumed the presidency on an interim basis and had moved the 2007 elections up to December 2005. By the time Evo Morales was elected, the Strategy had been in place about a year.

Despite the high degree of political instability in the period leading up to the FY2005-FY2009 Strategy, successive governments had maintained a commitment to previous health policies, such as the Maternal Infant Universal Health Insurance (SUMI), and municipal funding of health services apart from personnel costs. The 2003 DHS demonstrated that the long-term commitment to this key policy was having an impact on reducing infant and maternal mortality, as there were notable decreases in both indicators between 1998 and 2003, such as a decrease in the number of infants who die before their first birthday from 67 per 1000 live births to 54 (infant mortality rate). The percentage of married women using modern family planning methods increased from 25 to 34%, and total fertility rate had decreased to 3.9 children in 2003 from 4.2 as measured in 1998. The continuation of a commitment to a decentralized health system financed (except for human resource expenses) by municipal funds based on local decision making, also was beginning to produce improvements in local management of health resources.

Increasingly, local populations and their elected officials were assuming a greater role in allocating, managing, and overseeing the use of health resources.

THE USAID HEALTH STRATEGY

The USAID FY2005-FY2009 Health Strategy was aligned closely with GOB policy. It supported all major Bolivian Health Policies on reproductive, maternal and child health, nutrition, and infectious diseases. Over the tenure of the strategy, the policy environment changed significantly. The USAID implementing partners adapted skillfully to these changes and continued to support MSD policies. They helped to develop implementation mechanisms and supported implementation of public and private health services according to national policies.

While largely a continuation of the previous five-year strategy, the FY2005-FY2009 Health Strategy aimed to build local participation and capacity, as well as support the MSD's transition from a centralized service provider to a standards-setting and supervisory role. The strategy also recognized a transition implied greater integration of services at the local level, and therefore emphasized strengthening the capacity to deliver an integrated package of quality healthcare. [5]

The original USAID/Bolivia FY2005-FY2009 Health strategy was intended to begin on October 1, 2004, and to end on September 30, 2009. However, changes in the both the local political arena, and between the U.S. and Bolivia led USAID to extend implementation through the end of 2010. Implementation of the health strategy was supported though a bilateral strategic objective agreement (SOAg) signed by the Bolivian government in 2005 that ended in September 2009. It contained the overarching framework for the PROSIN project, which contained a program implementation unit within the Ministry of Health and Sports (MSD) supported with USAID funds, that was designed to provide technical assistance to the MSD and to Departmental Health Services (SEDES). The health strategy also provided the framework for bilateral technical support contracted by USAID for specific areas of health, such as reproductive and maternal health, child health, infectious diseases, and nutrition. USAID's support to U.S. and Bolivian NGO partners remained outside of the SOAg at the MSD's insistence.

In response, the USAID Health Strategy proposed the SO of *Improved Health of Bolivians, Contributing to Their Quality of Life* by expanding the previous focus on health awareness building through communications messages and social marketing to empowering individuals, families and communities to take action to improve their health through culturally sensitive approaches. The prior focus on expanding coverage and improving quality of health services was more narrowly defined by emphasizing a basic package of services and continuous quality improvement in municipal health networks, with a particular focuses on different types of healthcare providers in both public and NGO services. The final pillar of the strategy focused on strengthening public and NGO health management at four levels: national, departmental, municipal and community.

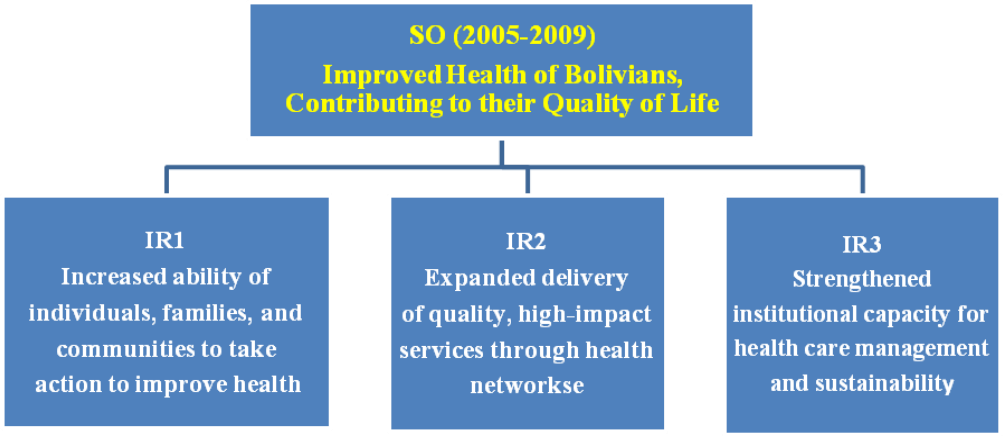
These key concepts were translated into three Intermediate Results (IRs) which were considered necessary to support achievement of the SO:

IR 1: Increased ability of individuals, families and communities to take action to improve health
IR 2: Expanded delivery of quality, high-impact services through health networks
IR 3: Strengthened institutional capacity for health care management and sustainability

[5] See Appendix C for a list of functions of the Bolivian Health System.

The *development hypothesis* held that the necessary conditions for sustained improvement in the health of Bolivia's population would arise when communities, families and individuals are able to more effectively address the factors compromising their health, resulting in more healthful behaviors and environments; the coverage and quality of public health interventions is improved; and the capacity of the public sector and NGOs to deliver and manage decentralized health services is enhanced.[6]

Figure 2:



The operational program elements were:

1. Family Planning and Reproductive Health, including Post-abortion Care and Adolescent Health
2. Maternal and Child Health, including Nutrition and Hygiene Promotion
3. HIV/AIDS, including Sexually Transmitted Infections
4. Tuberculosis
5. Other Public Health Threats (e.g. Chagas, Leishmaniasis, Yellow Fever, and Dengue)

The indicators measured both health outcomes and institutional strengthening of USAID's two key private health service providers, CIES, the Bolivian IPPF affiliate, with 14 health centers and clinics in 8 Departments, and PROSALUD, a network of moderately priced health centers (10); policlinics (11); and second-level referral hospitals (5) throughout the country.

Table 1:

Level	Indicator[7]	Baseline (2003)	Target (2008)	Actual (2008)
SO	Under 5/Infant/neonatal mortality	75/54/27	60/45/24	63/ 50 /27
SO	Contraceptive Prevalence Rate	35	40	34.6
SO	Total Fertility Rate	3.8	3.5	3.5
		(2005)	(2008)	(2008)
IR1	Couple Years of Protection	366,330	326.200	309,569
IR1	Total # of Condoms Sold	6,838,657	6,600,000	5,520,800

[6] This section is based on information from the Mission Strategic Plan FY2005-FY2009
[7] Indicator data comes from the Health Strategic Objective Performance Plan, Strategy Period 2005-2010, updated March 2009, and the 2009 Final Report of the 2008 Bolivia DHS.

IR1	# of Houses Improved to Prevent Chagas Disease	604	679	571
IR2	# of Receiving VCT at USAID assisted sites in a one year period	1248	9500	13,026
IR2	% of infants under age 1 who received the 3rd dosage of pentavalent vaccine in target rural geographic areas in one-year period	81%	84.6%	81%
IR2	Tuberculosis Treatment Success Rate in Target Geographical Areas	81%	90.5%	83%
		2006	2009	2008
IR3	Self-sufficiency of Key Bolivian NGOs: PROSALUD (PS) and CIES	88% (PS) 56% (CIES)	100% (PS) 75% (CIES)	95% (PS) 63% (CIES)
IR3	2 MSD Indicators dropped in 2009; % of target facilities with no stock outs AND % of target facilities using MSD policies and norms as evidenced by their presence on site			

Major Bolivian Health Policies Supported by USAID Activities

SUMI (2003) - Universal Maternal and Child Health Insurance, which provides health coverage for pregnant and post-partum women until their babies reach 6 months of age, and for children under five years of age. In 2005 SUMI was expanded to cover screening for cervical cancer, contraceptives, treatment of pre-cancerous lesions, and treatment of STIs for all women.

The National Development Plan (2006) guarantees all Bolivians access to health services through the Unitary System for Intercultural and Community Health, which supports the promotion of healthy individual, family, and community practices and behaviors. The Plan views universal access as the means to achieve a productive population that participates fully in the economic, social and cultural transformation of the country. To accomplish this ambitious goal, the GOB developed the intercultural model of family and community health (SAFCI) which is now a comprehensive policy for restructuring national health healthcare.

The SAFCI Policy (2008) aims to improve health and nutrition by eliminating social inequalities, and addressing the social, economic, and environmental determinants of poor health (e.g., water and sanitation, poverty, ethnic discrimination). The new approach to health rests on four principles: (1) *Social Participation* in decision-making as part of co-management of health facilities by rural and urban communities, municipal governments, and healthcare providers and administrators; (2) *Interculturality* (interculturalidad) as a dialogic process to develop solutions that draw from biomedicine and indigenous healing beliefs and practices in a respectful and complementary fashion to improve quality of healthcare in households and health facilities; (3) *Integrality* of care that regards health as the totality of a person's bio-psycho-social state of being in relation to his/her family, community, and environment and encompassing a continuum of care from promotion, prevention, to rehabilitation and recuperation; and (4) *Cross-sectoral* interventions to address the socioeconomic determinants of health through strategic alliances among different sectors, including education, basic sanitation, production, housing, justice, and others to address multidimensional problems and optimize resources.

Zero Malnutrition Program (2006)-The Zero Malnutrition Program is a major policy initiative of the GOB which aims to reduce malnutrition in the country by focusing on the most food insecure municipalities with a number of interventions across different sectors which involves actions on the part of 8 ministries.

Bono Juana Azurduy (2009) - In an effort to stimulate greater use of services, GOB passed a supreme decree in May 2009 establishing the Bono Juana Azurduy, a conditional cash transfer (CCT) program, that provides cash payments to women for antenatal visits, delivery in a health facility, and twelve well child visits for children less than two years of age.

Political Constitution of the Plurinational State (2009) - The new constitution of Bolivia ratified in 2009 guarantees a number of rights to Bolivian citizens and ethnic groups that directly affect their health. There are specific articles that guarantee the right to health (Articles1 and 18), reproductive and sexual rights (Articles 14 and 15), and the right to food (Article 75). The constitution also guarantees gender and cultural equality.

THE PORTFOLIO AND KEY IMPLEMENTING PARTNERS [8]

The USAID Health Program had a projected budget of $76,450,000 over five years. Slightly more than half of the budget was invested in the Rural Health Strategy. It was originally supposed to be implemented through PROSIN (originally $9,000,000, but reduced to $2,000,000); Gestion y Calidad (JSI at $15,190,000); PROCOSI ($18,000,000) and the Manoff Group ($2,662,000). The remainder of the budget was invested in other health partners: Socios para el Desarrollo ($15,796,000); CIES ($8,991,990) for reproductive health services; PROSALUD ($7,990,000) for integrated health services; CDC ($200,000) for HIV AIDS; and Save the Children (total of about $3,000,000) for adolescent reproductive health and hygiene for school children. The remainder paid for contraceptive procurement ($2,950,000), and technical support from globally funded programs (total of $229,000), and UNICEF ($75,000) for improved MCH.

The technical focus of the program was largely driven by Congressional earmarks from USAID/Washington and not necessarily by priorities or needs perceived by either the mission or the Bolivian government. Money for many of these elements, especially for infectious diseases and HIV were either cut severely or terminated part way through the strategy period, seriously affecting the ability of the program to meet expectations and commitments made by the program to regional and municipal governments and communities.

The Rural Health Strategy and its Implementing Organizations

The original implementation plan contemplated USAID Health Program's tripartite design composed of: (1) a national project, PROSIN, to improve management and health system functioning at the national and departmental levels (primarily supporting achievement of IR3) but with a coordinating function linked to IRs 1 and 2; (2) an institutional contractor, providing technical assistance to PROSIN and to NGO networks and service providers, mostly in support of IR2; and (3) an NGO umbrella project to work in conjunction with PROSIN and the

[8] The Portfolio Review focused on the principal activities and implementing partners of the USAID Health Strategy which are described below. The Team did not assess the quality of the technical assistance provided to implementing partners by globally funded programs, such as MSH, Manoff, Abt (Health Systems 20/20), CDC, etc. These partners are described in Appendix D. The review team focused principally on the partners supporting the most important interventions related to the implementation of the national health policy, and then on Partners for Development (SpD), CIES, PROSALUD, and the two Save the Children Projects, with less intensity. At the same time that the overall evaluation was underway, there were also case studies conducted of PROCOSI's support for training of community health workers; JSI's and PROCOSI's interventions related to IMCI, and of women's empowerment activities supported by Save the Children and CIES. One review team member was also able to assess JSI's work in the Yungas on Leishmaniasis and TB, carried out with funding from the Integrated Alternative Development Program. The Team did not have time to assess the HIV/AIDS program in any depth. The focus of the Portfolio Review reflects the emphasis driven by topics that were most relevant to the new strategy design.

institutional contractor primarily at the community level (IR1). The efforts of all three were to be coordinated through a Strategic Objective Agreement (SOAg) coordinating committee composed of the MSD, USAID, and the Directors of PROSIN, the institutional contractor, and the NGO Umbrella project, awarded to PROCOSI, and called the Community Health Project (CHP).

From 2005-2006, implementation of a large portion of the portfolio through the Rural Health Strategy grouped PROSIN with other implementing and technical assistance organizations to work in a coordinated fashion across different levels of the Health System. The Rural Health Strategy was designed to strengthen municipal public health services, to consolidate community empowerment, and improve the availability and demand for culturally appropriate quality services. It was designed to more effectively and efficiently respond to the needs of rural families and communities for healthcare. The three foci of the rural strategy mirrored those of the overall strategy: promotion of healthy behaviors and community empowerment; improve the cost-effectiveness and impact of services on the principal health problems; and sustain the availability of public and private services.

CHP/PROCOSI's role in the rural health strategy, as the NGO Network, was to work on improving health through self-care and prevention at the community level through training of healthcare volunteers, implementing IEC strategies, conducting women's empowerment activities, and strengthening of community health surveillance. Socios para el Desarrollo provided competitively bid small grants to NGOs and grassroots organizations to implement community-level health and gender projects. GCS/JSI (institutional contractor) worked with municipalities to improve their capacity to fund and run quality health services, with a particular focus on child health, nutrition, and infectious disease. ACQUIRE/EngenderHealth mirrored the work of GSC but with a focus on reproductive, family planning, and maternal health. ACQUIRE also worked with healthcare organizations on decreasing stigma and discrimination for HIV affected populations. PROSIN's role, in tandem with the MSD, was to integrate all rural health strategy partners' actions and support Departmental Health Services called SEDES to fulfill their role of coordination and oversight of healthcare planning, budgeting, and service delivery interventions in 130 municipalities.

The original geographic focus of the Rural Health Strategy was in the Bolivian altiplano and valleys, with primary emphasis on 131 rural municipalities with the worst social and health indicators. While PROSIN worked in all Departments except Santa Cruz, the major focus of its efforts was in La Paz, Potosi, Beni, and Chuquisaca. The other programs, PROCOSI-Community Health Program (Umbrella NGO), and JSI-Management and Quality in Health (GCS) and EngenderHealth-ACQUIRE (Institutional Contractors) worked in the same municipalities as PROSIN.

While each leg of the implementation team had primary responsibility for a particular IR, the original design included considerable overlap and integration across the central, departmental, municipal, and community levels. At the central level PROSIN was supposed to be responsible for providing overall technical direction/leadership. The NGO Umbrella was supposed to promote local networking and partnerships and disseminate best practices on technical interventions and capacity building. The Institutional Contractor was supposed to work under the direction of PROSIN to develop an annual operation plan, provide technical, logistical, and procurement support to PROSIN and other partners.

At the departmental level, PROSIN was to be responsible for developing capacity of the SEDES to manage and supervise decentralized health networks, with logistical and technical support from the Institutional Contractor. The PROSIN advisors to the SEDES were to provide

technical oversight to the DILOS (municipal level), with planning and management support from the NGO Umbrella project , and data collection and compilation support from the Institutional Contractor. PROSIN and the Institutional Contractor were to have primary responsibility for improving the performance and quality of services delivered by health networks (municipal level) by developing management, logistics, and technical capacity. The NGO Umbrella was to help health networks systematize and expand innovative models for NGO management of health facilities to increase the effectiveness, efficiency, and quality of services. Finally, at the community level, the NGO Umbrella was to partner with PROSALUD on social marketing, develop and implement BCC and women's and adolescent girls' empowerment strategies, and to strengthen the role and effectiveness of social networks' advocacy and participation in municipal decision-making on healthcare.[9]

Rural Strategy Activities and Implementing Partners 2004-2009

PROSIN II- Integrated Health Project (Ministry of Health and Sports)- The PROSIN) Project also included a technical and normative unit integrated within the MSD and its departmental entities. PROSIN focused on capacity-building at the central (MSD), departmental (SEDES) and health network management levels, providing technical assistance in the areas of IMCI, sexual and reproductive health, malaria, tuberculosis and other infectious diseases. PROSIN also assisted the MSD, SEDES and health networks to fulfill their roles and responsibilities in supporting the development, negotiation, implementation and monitoring of local health plans in target municipalities. These plans served as a basis for the implementation of JSI's GCS project and were linked to community-based services supported through the CHP implemented by PROCOSI. PROSIN facilitated the coordination of actions between USAID and the MSD, and activities among USAID's implementing partners in the health sector. The project ended by mutual agreement of the MSD and USAID in August 2006.

Management and Quality (*Gestion y Calidad en Salud* -GCS) implemented by John Snow, Inc. (JSI) - The objectives of the project include: (1) improve the management capacities of local health clinics and hospitals; (2) increase the quality of services provided in the public health sector; and (3) provide municipalities with opportunities to address local health priorities through matching funds to develop initiatives that improve infrastructure and quality of care. The project provides ongoing staff training and technical assistance to public health facilities' staff to facilitate the application of IMCI-Nut, which focuses on nutrition; improves epidemiological surveillance of infectious diseases; improves the pharmaceutical logistics system to ensure the adequacy of supplies; and trains lab technicians and provides basic supplies to strengthen the capacities of local laboratory networks. The project also helps the MSD respond to epidemics and outbreaks. In selected areas that do not have access to health facilities, JSI supports SEDES mobile health units to deliver services on an intermittent basis. The project also promotes increased municipal investments in health through a program that offers municipalities the opportunity to apply for matching funds for locally-generated projects.

ACQUIRE (EngenderHealth)- The project improved and expanded quality reproductive health service delivery in public and private sector facilities through training and technical assistance in family planning, maternal health, post abortion care, supervision, continuous quality improvement, infections prevention, and involving men as partners in health. CARE, as a subcontractor, worked on developing 9 rural maternal and neonatal health networks to provide emergency obstetric care, gender and culturally sensitive maternal health services to reduce maternal mortality. EngenderHealth worked with the Sucre Urban health network as well.

[9] Information for this section comes from an internal document titled "Design Concepts for New HSOT Procurements (Public Sector and NGOs).

Community Health Project (Proyecto de Salud Comunitario –CHP) implemented by PROCOSI (*Programa de Coordinación en Salud Integral*)- PROCOSI is a network of 32 NGOs working to improve the health of low-income populations, with a focus on rural areas. The USAID-financed Community Health Project (CHP) is implemented by PROCOSI and 18 of its members. The principle purpose of the project is to extend community health services to underserved families, especially in rural municipalities. The CHP trains community health workers in the fields of reproductive health, integrated health care and nutrition for children under five, and infectious diseases (tuberculosis, malaria, Chagas, and STIs). The project also includes a housing improvement component to reduce the incidence of Chagas disease.

CHANGES IN USAID'S RURAL HEALTH STRATEGY, IMPLEMENTATION, AND IN BOLIVIAN HEALTH POLICY[10]

The program did not have adequate time or opportunity to work the way it was designed. Coordination was hampered by different start times for the three different parts of the strategy. PROSIN had been in place since the prior strategy. It had to reorient from direct implementation as a semi-autonomous program to a decentralized technical support program to the MSD and coordinating mechanism for other USAID funded programs. Delays in PROCOSI's competitive sub-grants process and subsequent awarding of the grants delayed their readiness for implementation until June 2006. By that time, USAID had notified the Rural Health Strategy implementing partners to stop activities.

During the second half of 2006, as tensions in U.S and Bolivian relations grew around a number of issues, USAID directed the implementing organizations to redirect their efforts to Tarija, Santa Cruz and the Beni in order to withdraw from La Paz, Potosi, and Chuquisaca where the Bolivian government had assigned the Cuban doctors to work.[11] This change came at a great cost to all organizations who had invested considerable efforts in baseline data collection, building relations with communities and municipal governments, and with local counterparts in the health networks. The change of intervention area resulted in an implementation delay of more than a year.

The change in area also challenged the ability of the different Rural Health Strategy organizations to coordinate across different levels of the health system. Up until this point, PROSIN had primary responsibility for coordinating among the MSD, SEDES, ACQUIRE, GSC, and CHP. Once PROSIN closed, there was no one organization designated to assume this role in its entirety. JSI took it on in part, at the SEDES level, but that left all projects without an interlocutor with the MSD in La Paz. CHP and GCS developed their own direct relationships

[10] A timeline of the changes in the Rural Health Strategy can be found at the end of Appendix D.

[11] Cuban doctors were sent out to rural areas where Bolivian doctors were reluctant to go. Cuba and Venezuela teamed up to provide medical assistance to rural Bolivia as a form of joint foreign assistance. The Cuban government sent doctors and nurses and the Venezuelan government provided funds for their salaries and living expenses. There were a number of misunderstandings and miscommunications between USAID and the GOB around this issue and others. The Embassy interpreted a U.S. law stating that US assistance could not be given in conjunction with Cuban foreign assistance. Although the Cuban doctors were financed by funds provided by the Venezuelan government, and not the Cubans, the U.S. Embassy and USAID determined that there was no way to exclude Cuban doctors living in the municipalities where USAID projects were located from participating in USAID funded project activities. At the same time, the MSD was troubled by a Masters Degree program in community medicine sponsored by USAID and the Bolivian College of Medicine through SpD. The MSD felt the program had not been agreed to by them and that it conflicted with the SAFCI Residency Program. By mutual decision, the MSD and USAID decided that it would be preferable for USAID to close PROSIN and to move other Rural Strategy interventions to the eastern part of the country.

with the MSD around IMCI-Nut (CHP and GCS), Infectious Diseases and Contraceptive Logistics (GCS) and around SAFCI (CHP).

Coordination was further complicated by problems that prevented all three implementers from co-locating in all of the same municipalities. Objection by the Guarani communities in Camiri to ACQUIRE and CIES' family planning activities restricted all USAID funded organizations from working in the Chaco region of Santa Cruz. Therefore, all the Rural Health Strategy implementers moved to more remote regions that made coordination more difficult. While coordination continued for some time in La Paz, over time, it was increasingly difficult to coordinate activities in the field. Nevertheless, there were some notable exceptions in Bermejo and San Ignacio de Velasco, where the CHP implementing NGOs forged collaborative working relationships with the GCS Team, departmental SEDES, and the municipal governments.

The move to a new geographical area also coincided in timing with an U.S. Inspector General's (IG) audit of the Community Health Project (CHP). In the Audit, the IG strongly recommended that PROCOSI drop some of its key activities, such as WARMI, a women's empowerment methodology developed by PROCOSI organizations to work with communities on social mobilization around maternal health, family planning, and gender-based violence.[12] This challenged many of the CHP PROCOSI NGOs to have to change the design of their activities at the same time they were trying to move into unfamiliar communities and municipalities. This resulted in turnover in staff and implementation delays. During this same period, ACQUIRE had a change in Bolivian leadership. The new director had a very different understanding of the scope of work than the previous directors, and USAID. As a result, they focused their efforts on developing a new training program which was more theoretical, classroom-based and less grounded in hands on skills development. GCS had to reorient from being principally a technical assistance provider, to assume some of the system strengthening activities previously performed by PROSIN.

The Bolivia health policy environment was also undergoing considerable change during this period of time. There was also frequent turnover of personnel in the MSD and in some of the Departmental Health Services (SEDES). Despite all the upheaval caused by the move, the USAID funded programs were able to build collaborative relationships with the MSD to develop the protocols for implementation of several new policies, including SAFCI and Zero Malnutrition, at both the community and clinical levels. GCS was also able to successfully replace PROSIN in the SEDES as technical advisors, particularly in the Beni and Tarija. In Santa Cruz and Chuquisaca, where they were not situated in the SEDES, programs were able to develop close working relationships nonetheless. The SEDES in Tarija and Chuquisaca also established strong working relationships with and appreciation of the work of CHP PROCOSI NGOs.

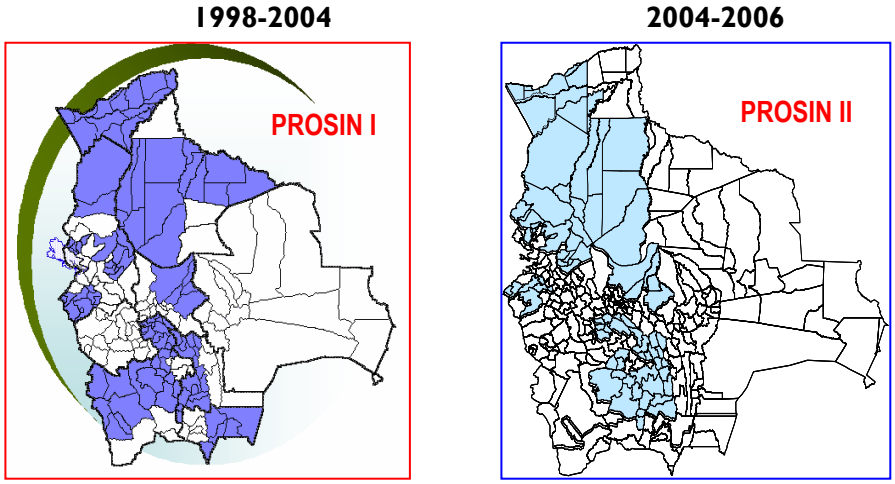
ACQUIRE met with more difficulty in forging as seamless working relationships with both the MSD and SEDES because the policy of the new national government was less supportive of Reproductive Health and Family Planning. CARE, which was a subgrantee under EngenderHealth had better success as their scope of work focused on maternal mortality reduction which is a

[12] A publication on WARMI which won the PAHO prize for best practice in gender and intercultural health in 2008 states that implementation of WARMI "demonstrated that a) Educating and empowering women reduces maternal deaths and improves women's sexual and reproductive health and b) The delays that cause maternal mortality in rural, indigenous areas can be reduced by working on low-cost actions that focus on gender and culture where Women's Community Organizations and local promoters help women overcome the obstacles that prevent them from receiving life-saving healthcare services (Silva de la Vega 2008: p.vi)".

priority of government. CARE worked closely with the MSD's Services and Quality Unit, especially after a former member of their team assumed the position of director of that unit.

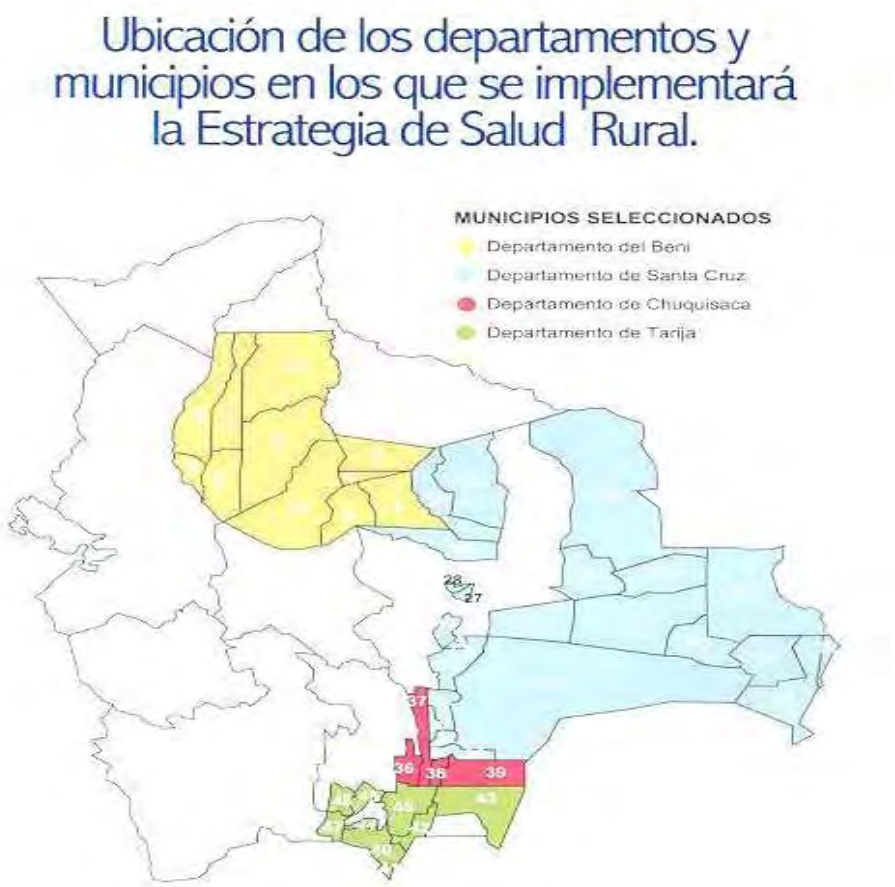
Finally, changes in USAID funding and programs further complicated achievement of results. USAID/Bolivia experienced cuts in funding for infectious diseases and HIV/AIDs in FY 2009. The Title II Program which generated many of the results for maternal and child health and hygiene (through water and sanitation) ended in FY 2008, significantly reducing coverage of USAID funded MCH interventions. As a result, the USAID Health Office had to cut the Chagas house improvement program that was part of CHP even though it was extremely popular. The malaria and dengue prevention activities in the programs also had to be cut.

Figure 3: Rural Health Strategy Change in Geographical Area 2007-2010[13]



[13] Map taken from USAID *Estrategia de Salud para el Área Rural*

Figure 4: Location of the Departments and Municipalities where the Rural Health Strategy was implemented



OTHER STRATEGIC ACTIVITIES AND IMPLEMENTING PARTNERS

In addition to those that worked under the Rural Health Strategy, there were many other contributors to all three of the Intermediate Results of the FY2005-FY2009 Strategy. USAID/Bolivia also funded two unsolicited proposals from Save the Children: one project provided health education for school age children. USAID continued to support PROSALUD's social marketing program with the importation of contraceptive commodities, and CIES' adolescent sexual and reproductive health program.

IR1, Increased Ability of Individuals, Families, and Communities to Take Action to Improve Health, was supported by adolescent sexual and reproductive health programs implemented by Save the Children, called Tomando Decisiones (Making Decisions), and CIES, called "Para Vivir Nuestra Sexualidad (Living our Sexuality) which also incorporated leadership training. Save the Children also implemented a Global Development Alliance (GDA) Partnership, funded by USAID and GlaxoSmithKline (GSK), which supported a school-age education program focused on improving health, hygiene and oral health, called "Mejorando Nuestras Vidas (Improving Our Lives). PROSALUD continued as the nation's chief supplier of socially marketed contraceptives. SpD funded grants to grassroots organizations and NGOs for social mobilization, IEC, and BCC. EngenderHealth continued workshops on reducing stigma and discrimination in the context of HIV.

Partner organizations that supported IR2, Expanded Delivery of Quality, High Impact Services Through Health Networks, included PROSALUD, PROCOSI, and CIES, as important private sector service providers supported by USAID. Both CIES and PROSALUD formed important partnerships with many of the municipal governments where they work. PROCOSI members are active in health education and service delivery in rural and peri-urban areas of Bolivia, reaching approximately half of the rural population. SpD strengthened the capacity of Voluntary Counseling and Testing (VCT) Centers to deliver quality services JSI, through GSC worked in municipalities in the Chapare until 2008 and in the Yungas through 2010 on improving the quality of treatment and prevention of Tuberculosis, Leishmaniasis, and Malaria.

Although PROSIN II was the primary implementing partner of IR3**,** Strengthened Institutional Capacity for Health Care Management and Sustainability, other partners also contributed to strengthening the institutional capacity for healthcare management and sustainability in Bolivia. Under the strategy, USAID made significant investments in strengthening the financial sustainability of USAID private sector health partners. MSH provided management and finance technical assistance to CIES. The Manoff Group assisted PROCOSI in strengthening its management systems and fundraising capacity. Abt Associates, through the USAID globally funded HS 20/20 project, provided assistance to PROSALUD on developing a financial and institutional sustainability plan. JSI (in Los Yungas) and SpD (in multiple municipalities) worked on strengthening the capacity of municipal governments to plan, finance, and manage municipal-based health networks. Under IR 3, all major USAID funded organizations, including the PROCOSI network, helped the Bolivian government to respond to the 2008 outbreak of Hemorrhagic Dengue Fever in the lowland areas of Bolivia. GCS also worked with health networks to improve their management of drugs and supplies. PROCOSI worked with the MSD to develop guidelines and implementation mechanisms for SAFCI and for the Zero Malnutrition Strategy. JSI collaborated with the MSD in developing guidelines for the implementation of clinical IMCI. USAID supported institutional strengthening of PROCOSI, PROSALUD and CIES and publicly financed HIV/AIDS VCT Centers.

OTHER STRATEGIC HEALTH ACTIVITIES AND IMPLEMENTING PARTNERS 2005-2009

(1) *Reproductive Health Services* (CIES): USAID supports CIES, a Bolivian NGO, in its efforts to increase access to quality health services for women, men and adolescents through support for: (1) the direct provision of health services; (2) educational activities targeting urban populations in eight departments of Bolivia; (3) educational activities targeting rural, indigenous populations in Chuquisaca and Beni; and (4) training and technical assistance in management in order to improve CIES' sustainability. CIES is the largest private provider and second only to the public health services, of reproductive health and family planning services in Bolivia.

(2) *Integrated Health Services (*PROSALUD): USAID supports the operational costs of PROSALUD's network of 27 primary and secondary health care facilities, which currently serve a population of about 600,000 in six departments in peri-urban areas of Bolivia, which represents 13% of Bolivia's urban population. PROSALUD also manages a social marketing program, which distributes condoms, oral contraceptives, injectables, and multivitamins nationwide. These products are dispensed to the public and private sectors through a distribution system that serves public health facilities, private pharmacies, non-traditional outlets, and other NGOs.

(3) *Socios Para el Desarrollo* (PROSALUD): Originally called the *Socios en Salud* project, *Socios para el Desarrollo (SpD)* aims to improve the health status of Bolivians through a variety of interventions: (1) provide small grants and technical assistance to NGOs and community-based

organizations to increase access and coverage of quality and culturally appropriate health services in underserved areas; (2) provide technical assistance on a range of technical and management issues (maternal and child health, reproductive health, infectious diseases, performance monitoring, financial management, etc.) to USAID partner organizations, including the Ministry of Health; and (3) manage specific projects to address critical intervention areas or gaps. These have included support for voluntary counseling and HIV testing services through NGOs; support to the National HIV/AIDS program; extension of basic health services in El Alto through use of mobile units; and support for Family and Community Health through a training program with the Colegio Medico (National Association of Medicine).

(8) *Tomando Decisiones* (Save the Children) contributed to IR1 and IR2. The objective of the *Tomando Decisiones* Project (Making Decisions) was to increase quality and access to health services for adolescents and youth through youth-defined and youth-led initiatives to promote responsible behavior and engage youth in public advocacy. The Project emphasizes delayed onset of sexual debut and the development of life-skills among teens. Project activities primarily focus on adolescent peer communication programs on reproductive health and on increasing knowledge of healthcare providers about adolescent health and how to deliver adolescent-friendly services.

(9) *Mejorando Nuestra Vida* (Save the Children): The *Mejorando Nuestra Vida* Project (Improving Our Lives) is based on a partnership between USAID, GlaxoSmithKline, Vitamin Angels Alliance, Save the Children (SC) and municipal governments. Its objective is to improve the health of the poorest children of La Paz, Oruro, El Alto, Cochabamba and Santa Cruz by strengthening the capacity of local governments, schools and communities to deliver nutrition-related services through school-based interventions. The project trains and educates teachers on nutrition-related issues to enhance their knowledge and to enable them to reach 65,000 children under five years, as well as their mothers, caretakers and older siblings with messages concerning nutrition.

ASSESSMENT BY INTERMEDIATE RESULT (IR)

IR1: INCREASED ABILITY OF INDIVIDUALS, FAMILIES AND COMMUNITIES TO TAKE ACTION TO IMPROVE HEALTH

Context

IR1 supports goals related to SAFCI and community participation, health prevention and promotion of healthy practices. It also contributes to the goals of the GOB's Malnutrition Zero Program and to generating demand for maternal, neonatal, and child health services under the Universal Maternal and Child Health Insurance (SUMI). In 2009, the MSD introduced the Bono Juana Azurduy Program, a conditional cash transfer program, designed to pay women for attending 4 antenatal care visits; delivering in health facilities; making timely postnatal visits for both the mother and newborn; and completing well baby visits for children under two years of age. Although designed prior to the development of SAFCI, Malnutrition Zero, and the Bono Juana Azurduy, the USAID IR1 programs have been very adept at adapting to new policy frameworks and to supporting their health objectives.

IR1focuses interventions on individual's, families' and communities' responsibilities for their own health and well-being. It aimed to empower individuals, households, and communities to engage in preventative and self-care practices and to have a greater role in negotiation with health services when the need for curative care arose. Achievement of IR1 was based on a combination of behavior change communication and community mobilization strategies to change individual behavior and social norms. IR1 was supported by three sub-results:

- IR1.1-Improve health practice by promoting healthy practices
- IR1.2-Increase access to products that promote health and help to prevent illness
- IR1.3-Increase the capacity of communities to develop effective organizations to support local health services

The illustrative activities originally planned under IR1 in USAID Bolivia's Strategic Plan included:

- Train community groups to identify, negotiate, and participate in local health activities
- Award small grants to community groups to design and implement local health projects
- Build capacity within social networks to strengthen their advocacy and oversight roles within municipal health systems
- Conduct communication and community mobilization activities to improve practices in infant/child feeding, household hygiene, condom use among HIV-risk groups, use of anti-malarial bed nets, modern family planning methods, Chagas prevention, and timely health care seeking behavior (for cough, fever, prenatal care, and avoiding delays to prevent maternal deaths)
- Expanded distribution networks for social marketing products, focusing on rural areas
- Conduct market research to assess viability of expanded range of social marketing products

IR1 Indicator Performance

The indicator data demonstrates little change over the 3 years measured, and for all three indicators is less than what was projected. All have logical explanations having to do with changes in geographical area, limited political support for FP, tax issues around the importation of contraceptives for social marketing, and cancelation of the ACQUIRE project which focused on improving the health services response to demand generated under IR1 for family planning. As will be clear from the discussion below, there was also little effective focus on family planning

at the community level through the programs. The poor performance of the Chagas indicator is more a reflection of budget cuts and implementation delays than lack of demand.

Surprisingly, none of the indicators specifically measure empowerment, so it is difficult to determine if the results related to family planning are flat because of lack of empowerment, or because of lack of availability of contraceptives, services (at health facilities, or through social marketing).

Although the activities have consistently met their process indicator targets, it is difficult to measure the health impact of the activities as the implementing organizations were not responsible for collecting impact data and the activities under the Rural Health Strategy have only been operational for barely 2 years. The DHS data and data from the PMP have been included at the beginning of the IR section to demonstrate the trends in the country. The evaluation of each IR focuses on the strengths and weaknesses of the activities undertaken by different implementing partners.

Table 2:
Couple Years of Protection

FISCAL YEAR	TARGET	ACTUAL
2005 (Baseline)		366,330
2006	375,000	397,035
2007	333,308	326,197
2008	326,200	309,569
2009	340,000	---

Total # of Condoms Sold

FISCAL YEAR	TARGET	ACTUAL
2005 (Baseline)		6,838,657
2006	6,000,000	6,230,582
2007	6,400,000	7,380,896
2008	6,600,000	5,520,800
2009	7,701,000	---
2009	TBD	---

Number of Houses Improved to Prevent Chagas Disease

FISCAL YEAR	TARGET	ACTUAL
2004 (Baseline)		0
2005	?	604
2006	1,500	190
2007	354	354
2008	679	571
2009	1,588	---
2010	0	---

Key Partners and Description of their Activities

The key partners contributing to IR1 were:

- CHP composed of a technical staff in PROCOSI and implemented by 18 PROCOSI member NGOs organized in 8 consortia, working in 30 municipalities in the Departments of Tarija, Chuquisaca, Santa Cruz, and Beni. PROCOSI received additional managerial and technical support from the Manoff Group, a technical assistance contractor. They were also responsible for implementation of the Chagas prevention project that entails house improvements and moving animals and corrals away from the home.
- Tomando Decisions (Making Decisions) implemented by Save the Children, focused on improving access and quality of adolescent friendly sexual and reproductive health services and education for adolescents. The project worked in 15 medium and large cities emphasizes citizen rights, gender equity, and cultural identity with objective of improving adolescents' capacity to make responsible decisions in their sexual and reproductive lives. Its activities include adolescent training, teacher and parent training; youth-friendly services, including pharmacies; and peer education and advocacy.
- Mejorando Nuestra Vida (Improving our life) was also implemented by Save the Children through a Global Development Alliance with GlaxoSmithKline which provided hygiene kits for all participants. The program reached 150,000 school age boys and girls with health and hygiene education in the city of El Alto and the Departments of Cochabamba, Santa Cruz, and Oruro. It also provided educational talks to parents about preventative health practices for their pre-school children. The program also distributed iron supplements and Vitamin A through the schools to prevent micronutrient deficiencies.
- Tu Decides (You Decide) and Viviendo Nuestra Sexualidad (Living our Sexuality) are two consecutive iterations of CIES' adolescent sexual and reproductive health and leadership program. It fosters sexual health education in schools through peer educators. CIES establishes adolescent centers in their health clinics as safe spaces for adolescents to meet, participate in leadership training, and to prepare outreach activities for schools and health fairs.
- CIES, the Bolivian IPPF affiliate, also implemented two women's empowerment programs, one rural (EAPC) and one urban (MAC). The programs used a very similar approach to the WARMI (PROCOSI) and the ReproSalud Program implemented in PROSIN I and then through the SpD small grants program. These programs are based on a community mobilization methodology which engages women, and occasionally men, in a diagnostic process to identify critical reproductive health problems in their communities, to rank them by either degree of gravity or pervasiveness, and then to develop a solution which the group can implement. The solutions are almost always some form of health education via community volunteers. The topics commonly selected by the groups in both urban and rural areas are sexually transmitted infections, maternal mortality, gender-based violence, and lack of access to family planning.
- Small Grants-Socios para el Desarrollo (SpD), implemented a grants program for grassroots organizations and NGOs, focused mostly on reproductive health. The program provided technical assistance to grantees for the preparation, implementation, and monitoring of proposed projects.
- Social Marketing of Contraceptives by PROSALUD provided contraceptives to non traditional outlets and municipalities.

IR1.1-Improve Health Practice by Promoting Healthy Practices

Outcomes

The Community Health Project (CHP), with technical assistance from the Manoff Group, was designed to reduce inequities in access to health services through the delivery of a basic package of integrated community-based health services. The project worked closely with the Ministry of Health and Sports and in coordination with the Departmental Health Services (SEDES), health network managers, and municipal governments.

The CHP was implemented by 18 PROCOSI member NGOs and grouped in eight consortia. The project was originally designed to strengthen the provision of a package of community-based preventive and self-care practices and to link communities to health services through outreach by community health volunteers. With the change in government and the accompanying changes in policies in 2006, member organizations[14] adapted activities to be in line with the GOB's Intercultural Community and Family Health (SAFCI) model. This policy aims to improve the health management capacity of community organizations and families. The principal agents of the process of change are community health volunteers (ACS) and the local health authorities (ALS). The former are responsible for health promotion and education in the community, and the latter are charged with representing community interests to the health services by leading annual health planning, facilitating monthly health status analysis, and providing ongoing oversight of health services. *PROCOSI*, *Manoff,* and USAID worked with the MSD to establish a minimum package of health interventions that included reproductive, maternal, and sexual health, integrated child health and nutrition for children under 5 years of age, infectious diseases (TB and Chagas), and hygiene, water and sanitation. With the policy change, the aforementioned also worked with the MSD to develop guidelines and training modules to implement the management components of SAFCI which include citizen planning, management, and oversight of health services at all levels of the health system.

USAID contracted the *Manoff Group* to address a perceived weakness in the PROCOSI Network, common to many NGO networks, which is that despite being networked, NGOs implement their own loosely coordinated programs. USAID perceived that to be a liability for demonstrating collective and widespread impact. The Manoff Group's objectives were to: (1) strengthen and standardize the technical capacity and actions of CHP NGOS and collaterally, the PROCOSI network as a network to deliver a standardized package of community-based health interventions and; (2) to strengthen the management capacity of the PROCOSI network to improve health program administration and institutional sustainability.

CIES was one of the first organizations in Bolivia to develop a reproductive and sexual health program for adolescents. Its "*Tú Decides*" (You Decide) Program is over 17 years old. The original program combined leadership, community-based distribution of contraceptives, recreation, and health services. In 2005 it was redesigned as an educational program with an empowerment and rights focus, and renamed "Viviendo Nuestra Sexualidad (Living our Sexuality). It develops youth leaders who disseminate information on SSR to in-school youth through games, arts activities, and talks. They also participate in public events such as health fairs where they do outreach to youth in the wider urban contexts where they live. The youth leaders also do outreach to parents and teachers. They work with teacher partners in

[14] PROCOSI is a network of 31 NGOs working on health in Bolivia. The network was created initially by USAID to streamline the grant making process to NGOs in the country. As a membership organization, it is governed by an assembly and a rotating board. The network supports an executive secretariat that runs programs and provides technical assistance to its membership. Slightly more than a third of members were involved in the CHP.

participating schools. In addition, CIES health centers all provide space for *Rincones Juveniles* (Youth corners) which provide spaces for CIES youth leaders to interact with their peers, use the library, and engage in recreational and arts activities facilitated by CIES staff and provides adolescent-friendly health services within the CIES medical-educational model . Youth leaders are active participants of the youth networks in each department where they work on advocacy for sexual and reproductive health. Those activities were soon available in both El Alto, and in Cochabamba and Municipal Resolutions were created which stipulate that free services are to be provided to adolescents.

Tomando Decisiones (Making Decisions), implemented by Save the Children, is a school-based program for adolescents (10-18) and young adults (19-24) in 15 urban municipalities (9 departmental capitals and 6 intermediate sized cities). The project objectives are to: (1) Improve adolescents' knowledge attitudes, and practices on sexual and reproductive health and HIV/AIDS; (2) increase the availability of tailored health services for adolescents; (3) improve the quality of and access to services; and (4) improve political and social support for adolescent access to RH/FP/HIV services. The project has also worked with the public health services and pharmacies in the cities where the project is active to develop youth-friendly SSR services. The program's central focus is the adolescents themselves. It aims to increase both availability of adolescent-friendly services and the demand for services by adolescents through peer education activities; by raising awareness and building capacity of health providers regarding an array of youth friendly sexual and reproductive health services; and by promoting advocacy by the adolescents themselves. The program's various activities have reached over 90,000 adolescents with behavior change and empowerment messages. Themes including human rights, gender, age, interculturality and empowerment cut across all program activities and strategies.

(9) Mejorando Nuestra Vida (*Improving our Life)* is also implemented *by* Save the Children. It received funding from an unsolicited proposal to work with primary school students on hygiene and health education. *Mejorando Nuestra Vida* focuses on school age children in order to address the health and nutrition needs of their infant and preschool sibling, in addition to their own. By promoting hygiene, self-care, and healthy eating practices the project aims to establish lifelong healthy habits among the direct school age participants and prevent nutritional deficiencies in children under 5 years of age. The project trains teachers to incorporate key messages and practices in their classroom instruction. The project was designed as a GDA partnership with the pharmaceutical company, GlaxoSmithKline.[15] It provided tooth brushes, soap, and other hygiene products. It also included the implementation of GSK's PHASE (Personal Hygiene and Sanitation Education) methodology - a simple hand-washing program designed to teach children how to prevent the spread of germs and parasites. Children were taught how to wash their hands and a personal hygiene routine, using cloth books and story cards that contain images which relate directly to their daily lives. Teachers and other members of the community are also taught the basic techniques and children are encouraged to share what they have learned with others.

[15]GDA is a Global Development Alliance between the public and private sectors in support of USAID's development objectives. Potential alliance partners are expected to bring significant new resources, ideas, technologies, and/or partners to development activities. Partners include a wide range of organizations such as: foundations, U.S. and non-U.S. non-governmental organizations (NGOs), U.S. and non-U.S. private businesses, business and trade associations, international organizations, U.S. and non-U.S. colleges and universities, U.S. cities and states, other U.S. Government agencies, civic groups, other donor governments, host country governments, regional organizations, host country parastatals, philanthropic leaders including venture capitalists, public figures, advocacy groups, pension funds and employee-welfare plans (from USAID Website http://www.usaid.gov/our_work/global_partnerships/gda/aps.html).

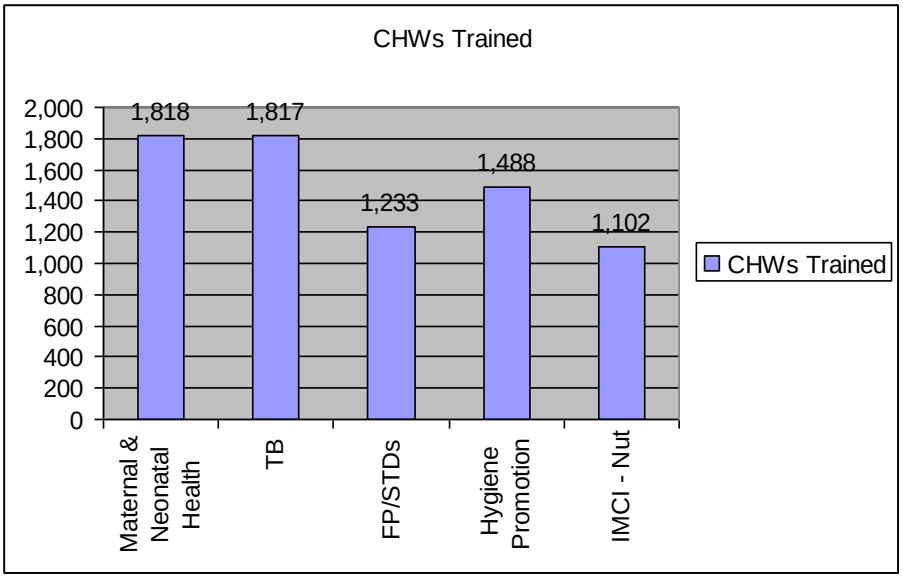
Partners for Health ran an umbrella grants program that provided sub-grants to grassroots and non-governmental organizations. SpD called on a cadre of consultants in each Department to provide technical assistance to potential sub-grantees in the preparation of their proposals for funding. The consultants worked with the grassroots organizations, in particular, to help them identify projects and often paired them with an NGO or provided continued TA throughout implementation. Most projects, however, were implemented directly by the sub-grantee. The projects focused on different issues in reproductive health, gender, and rights. The program worked with a very diverse portfolio of 133 sub-grantees in all 9 Departments of the country.

Strengths and Weaknesses

Most of the implementers under this IR work with community-based groups and individuals to improve health practices with regard to self-care and prevention. The Evaluators were not able to determine if practices had improved, but they were able to assess the quality of the information and the methodologies used to transmit key messages. For the CHP, the main vehicle for transmitting those messages was the Community Health Agent *(Agentes Comunitarios de Salud,* or ACS in Spanish). The perceived strengths and weaknesses of the approach are assessed below.

Strength: Appropriate role defined for ACS (CHW)-The CHP made a major contribution to the Bolivian health system by carefully defining the role of community health workers as promoters of preventative and self-care practices. Throughout Bolivia, the community health volunteer has been a pillar of most health community-based health projects, but their roles have been ambiguous. As the sole resource in many communities, there was a tendency for them to be overloaded way beyond what was reasonable for a volunteer position and beyond their knowledge and competence, with responsibilities for health education, communication, and curative interventions, such as first aid, oral rehydration for diarrheal disease and distribution of antibiotics for acute respiratory infections in children, as well as participation in vaccination campaigns. In the past, this created resentment among auxiliary nurses, often the sole representatives of the national health system at the community level, who perceived these minimally trained volunteers as competitors.

Figure 5:



The CHP identified two categories of health workers- one responsible for maternal, reproductive, and child health information, preventive practices, and self-care and another with a

focus on hygiene, TB, and water and sanitation within households and the community. The ACS are responsible for conducting community censuses, making regular visits to households, especially to homes with pregnant women and children under five. Project facilitators used 8 standard training modules to prepare ACS for their principal duties in:

- Regular growth monitoring of children under 5 to identify those who are malnourished
- Identification of children with acute respiratory disease and prolonged diarrheal disease for referral to the health services
- Counseling on age-appropriate nutrition and on how parents can treat children with colds and episodic diarrhea
- Referral of pregnant women for pre-natal care and help them to develop a birth preparedness plan
- Collection of TB samples and monitoring of treatment compliance through the DOTS methodology.

One of the greatest challenges faced by CHP was the development of materials for training and guiding the ACS. The original materials were developed for a different cultural context than where the project ended up working. Therefore, some of the illustrations and vocabulary were more appropriate to the highlands than the lowlands. Nevertheless, CHP was successful in working with the MSD, particularly the Zero Malnutrition Unit, to develop the materials in line with national health policy and to have them officially sanctioned and adopted by the MSD. The MSD later came out with some minor revisions which improved the accessibility of the materials and added a child development component.

The PROCOSI network had been involved in home improvement activities to prevent Chagas disease since 2003. In 2005, USAID funded the program with the addition of components to minimize diarrheal and acute respiratory infections. This was addressed by adding water and sanitation activities and the installation of smokeless cook stoves to reduce respiratory infections. In order to prevent the Vinchuca bugs (Chagas vector) from nesting inside the house, improvements to the walls, ceilings, and floors were made.

Strength: House improvement is a very effective intervention for preventing infection of Chagas. At the same time, these improvements may lead to additional housing improvements (listed above) which may reduce the incidence of diarrhea, and acute respiratory infection. Although the project did not track these additional benefits, the changes made in the reconstructed houses are likely to decrease water borne diseases by providing access to a safer and more reliable source of water and sanitation inside home. It is virtually impossible to measure the impact on reducing Chagas infection as this involves a costly diagnosis process and the symptoms do not show up until years later. It is possible, however, to observe a decrease in the Vinchucas, the Chagas vector, in and around houses. The approach taken in the project is a best practice recommended by both the WHO and CDC for Chagas vector control.[16] Unfortunately, the projects did not collect baseline and impact data on ARI or Diarrhea.

[16] A study conducted in Brazil demonstrated that type of house construction was a more significant indicator of infection rates (Mott KE, Muniz TM, Lehman JS Jr, Hoff R, Morrow RH Jr, de Oliveira TS, Sherlock I, Draper; Am J Trop Med Hyg. 1978; 27(6):1116-22). Other research points to the impact of removing animals from in and around the home (Influence of humans and domestic animals on the household prevalence of Trypanosoma cruzi in Triatoma infestans populations in northwest Argentina. Gurtler RE, Cohen JE, Cecere MC, Lauricella MA, Chuit R, Segura; Am J Trop Med Hyg. 1998;58(6):748-58).

Weakness: The process was very slow and it took almost 14 months on average to complete a house because of delays in counterpart funding from municipalities, and because households had to work on the houses between other jobs and agricultural labor production activities. Thus, although highly effective at removing vectors and the risk of infection from the household by plastering walls and removing clutter and animals from within and around the home, the process takes a long time. Unfortunately, funds for infectious diseases were cut, and the program had to reduce the total number of houses to be improved.

Strength: Save the Children's *Tomando Decisiones* Program and CIES's Tu Decides/Viviendo Nuestra Sexualidad Programs both focus on increasing adolescents' knowledge and healthy practices in reproductive health. The greatest strength of the projects is their explicit focus on a population that has very little access to sexual and reproductive health information and services. CIES and Save the Children are implementing programs to address this critical need of adolescents. Both programs were evaluated by a separate evaluation team[17] and both programs work through trained peer educators and school teachers. The mini evaluation praised both programs for their innovative approaches, including the use of theater, community fairs, and dance used to engage adolescents in a dialogue about sexual and reproductive health. Both programs have reached sizeable populations. Since 2006, SAVE has trained 4500 peer educators and reached a population of 90,000 pre-teens, adolescents, and young adults between the ages of 10 and 24. It is harder to count exactly how many CIES youth promoters have participated since 2004, as youth peer educators move in and out of active status quite fluidly, but peer educators have engaged in 301,113 educational activities in schools and in their communities. The CIES program also trained 334 teachers 176 schools to use the *Para Vivir Nuestra Sexualidad* Methodology (Living Our Sexuality).

CIES' *Tu Decides* program was one of the first programs in Bolivia to advocate and provide for differentiated adolescent health education and services through public health services. It offers an effective model for reaching out to large numbers of in- and out-of- school adolescents. Recently, CIES has made a special effort to incorporate street children and orphans into the peer education program. The SAVE program worked with pregnant adolescents who had either temporarily or permanently dropped out of school, but did not include any other outreach to out of school youth, or work with parents and teachers to discourage them from forcing girls out of school once they are visibly pregnant.

Weakness: Both programs would benefit from strengthening the materials on gender and sexual and gender identities, as well as providing for an incremental education program that would allow peer educators who have gone through one round of training to increase and deepen their knowledge on SRH and gender issues, as well as to learn additional participatory and facilitation techniques so they can grow as educators. There is a need to develop greater outreach to parents and the general community on gender equality, decision making, and gender-based violence to complement messages on SRH.

[17] This was one of the mini evaluations which took place at the same time as the GHTech evaluation. The evaluation team was composed of Maria Dolores Castro, Silvia Salinas, and Beatriz Murillo. This summary in this paragraph is based on their findings presented in the report: "*Evaluacion: Metodologias de Trabajo Con Adolescentes y de Empoderamiento en SSR (CIES y Save the Children)---Informe Borrador*, June 22, 2009." Two members of the GHTech evaluation team sat in one of the focus CIES focus groups facilitated by Silvia Salinas and Maria Dolores Castro in Santa Cruz.

IR1.2- Increase Access to Products that Promote Health and Help to Prevent Illness

PROSALUD Programs. Through this project, USAID supported provision of services, construction, institutional capacity building, and the distribution of contraceptive commodities. The project also worked to consolidate PROSALUD's capacity to procure commodities and provide logistic support so the commodities reach the public and private facilities that request their service. At the moment, PROSALUD is the only organization in Bolivia with the capacity to project, procure and distribute contraceptives to meet needs across the country.

Strengths and Weaknesses

Many of the USAID funded programs involved the promotion of healthy messages. Almost all of these interventions were via community-based peer education or group health education. Overall there was little use of social marketing techniques or mass media campaigns.

PROSALUD's contraceptive marketing program is the major single provider of contraceptives for the nonprofit private and public sectors (i.e. municipalities). Proceeds received from the sale of the donated contraceptives capitalize a rotating fund which is to finance the direct purchase of contraceptives by PROSALUD to reduce the portion of USAID's budget dedicated to contraceptive purchases. Since 2003, PROSALUD has been USAID's only social marketing partner and one of the principal source of contraceptives in the country. Between 2003 and 2005, PROSALUD included IEC campaigns and operational research as part of the program. Between 2005 and 2009, their social marketing program was primarily a contraceptive marketing program with little "social" in the marketing.

On a much smaller scale, both Mejorando Nuestra Vida and CHP distributed self-care products to their participants. Mejorando Nuesta Vida distributed soap and oral hygiene kits donated by GlaxoSmithKline to school children. CHP distribute feeding bowls designed by the Manoff Group for children 6 months to 5 years to illustrate to caretakers the quantity and frequency of infant feeding. CHP also supported the distribution of Chispitas a nutritional supplement for children under 5 years old and Nutribebe, a weaning food. None of these products were socially marketed, although they certainly could be, and probably should be to increase use and to become sustainable.

Weakness: During the prior strategic planning period, USAID funded a social marketing program implemented principally by Population Services International. However, under the current strategy, PROSALUD did not receive USAID funding for a more integrated IEC/Social Marketing program. In addition, USAID instructed PROSALUD to stop public information campaigns to promote contraceptives, because of a misinterpretation of the ABC policy of the former US administration and because of fear of the MSD's reaction to any mass media campaigns on SRH. Consequently, PROSALUD was unable to implement a proper social marketing program, complete with broad marketing activities and behavior change activities – meaning that the social part of the marketing program was effectively dropped.

The PROSALUD social marketing program, once a hallmark of mixed media campaigns and adept product placement, focused more on distribution and sales, rather than social marketing.[18] This is indicative of an overall weakness and lack of investment in broad-based IEC, BCC, and social marketing, especially in reproductive health, beyond individual localized interventions,

[18] The only written information available to the Team on PROSALUD was a PowerPoint presentation that did not include data on social marketing, but did include the program description. The social marketing data on PROSALUD's website has not been updated since 2004.

such as Tomando Decisiones and Tu Decides. In part this is attributable to the political climate which has not been welcoming of such public efforts around FP and sexual and reproductive health. However, RH/FP IEC and BCC were also not the specific objectives of any project or activity funded under the 2005-2010 Health Strategy.

Strength: Perhaps the most effective product promoted under the program was a product promoted by CHP, which was the weaning bowl introduced by Manoff. This bowl showed parents how much food children between the ages of 6 months and 5 years should consume each meal and how many times a day. The bowls were extremely popular in the communities that the Evaluators visited. The ACS said they were also of great use in getting their nutritional messages across.

Figure 6: The Weaning Bowl

(Source: Manoff)

Manoff tested the bowl with 28 mothers whose children had deficient food intake. All mothers using the bowls reported being able to successfully increase the amount of food appropriately for the age of the child. Children also enjoyed eating out of the bowls and fathers took a greater interest in feeding their children as well.

Strength: The CIES Tu Decides Program made use of several communications techniques to reach out to adolescents in and out of school. Peer educators participated in health fairs, hosting events designed to draw in other teens and their parents. Peer educators were also encouraged to come up with innovative ways to reach students and teachers in schools.

Strength: The Mejorando Nuestra Vida Program used the opportunity to distribute soap and toothbrushes provided by GlaxoSmithKline for teaching about hygiene, clean water, and nutrition. The program also administered iron, vitamin A supplements, and anti-parasite medicine to participants. The program received a very positive response from municipal leaders in the cities where it was implemented. The products stimulated interest in the educational messages and encouraged parents to be engaged.

Strength: SpD updated and improved the STI/HIV web portal ITSDA to make it more accessible to the public. The web portal has been accessed by nearly 4000 adolescents, registered 12,000 visits for educational purposes, and 1,000 visits for virtual counseling.

IR1.3- Increase the Capacity of Communities to Develop Effective Organizations to Support Local Health Services

CHP, SpD, and CIES were the main USAID-funded implementers of social mobilization programs aimed at increasing community involvement in health decision-making and oversight of health services. CIES and SpD contributed by implementing women's empowerment methodologies in rural and urban communities. CHP worked on improving the use of health information by communities to make decisions about their health, and by developing the process and materials for training Local Health Authorities to take an active role in SAFCI participatory management processes.

Consolidando un Modelo de SSR para Mujeres, Hombres y Jóvenes de Bolivia, implemented by CIES. CIES incorporated two types of community and women's empowerment methodologies that had originally been developed and implemented by other organizations earlier in the Strategy period. The Community Action Methodology, or MAC in Spanish, was adapted by CIES from the Community Post-abortion Care (PAC) methodology that USAID first supported through PATHFINDER (for first 7 months), and then through SpD. It was designed as a community planning and action tool for communities to address the rising incidence of first trimester hemorrhage. During the last two years of the strategy, CIES adapted the methodology for use in urban areas to address a range of reproductive health issues within their communities, including maternal mortality, gender-based violence, uterine cancer, and other issues identified by urban neighborhood groups.[19]

CIES also adopted and adapted the Manuela Ramos (MR)/WARMI II methodology to work with rural communities on addressing gender inequalities in the context of reproductive and sexual health. Like MR and WARMI, the Strategy for Community Participatory Action, or EAPC in Spanish, selects rural women's groups to participate in a series of diagnostic, educational, and advocacy steps that lead to negotiation with the health services aimed at improving access, equity and quality of care. CIES has used the methodology in conjunction with their rural mobile units that make a monthly circuit through the Monteagudo, Juana Azurduy, and Sopachuy health networks in Chuquisaca.[20]

PROSALUD's *Partners for Development* (SpD) Project, implemented a small grants program which was designed to provide funding and technical assistance to non-governmental organizations (NGOs) and community-based organizations (CBOs) to increase access to and coverage of high quality and culturally-acceptable health services in rural and other underserved areas. The focus of the project was on community-based bottom-up participatory planning and implementation to identify and address local health issues. The project has issued close to 150 grants to organizations throughout the country.

[19] The strategy has not really been assessed, except in its WARMI and ReproSalud reincarnations. There has been some pressure from USAID to collapse all the women's empowerment methodologies into one. Before doing this, it is recommended that there should be a more systematic assessment of the variations in relationship to the contexts in which they have been applied, taking into consideration gender differences in different contexts.

[20] The Acquire Project also had initiated design of a "Men as Partners" training module to engage men constructively in addressing their men's sexual and reproductive health needs; developing more equitable gender relations; and being more supportive of women's reproductive health rights and decision making. They hadn't progressed very far with the men's module before the project was terminated, therefore. we did not include it in our analysis.

CHP: At the time of the portfolio review, PROCOSI had begun work with the MSD to develop guidelines for implementing the Intercultural Family and Community Health Policy (SAFCI) at the community and municipal levels. PROCOSI developed a manual for training Local Health Agents (ALS) responsible for working with health personnel on planning and budgeting for local health posts and clinics and also lead the community in providing oversight of healthcare services in communities.

Strengths and Weaknesses

Strength: CHP helped the MSD to develop materials and define specific functions for the Local Health Authorities (ALS), a role defined in the SAFCI Policy. The ALS is an elected official who is responsible overseeing the management of local health posts, collecting information from community members about their preferences for the tenor and quality of health of services and on their health priorities. By the time of this review, CHP had trained 597 Local Health Authorities were trained and 113 Local Health Committees were established to support SAFCI implementation.

Table 3:

Support to SAFCI	Total
Local Health Authorities Identified	639
Local Health Authorities Trained	597
Local Health Committees Established	124
Local Health Committees Trained	113

(Source: PROCOSI performance reports)

Strength- Collection and use of information by ACS in support of better prevention, self-care, and community health information analysis (CAI) –The CHP standardized the type of information collected by the ACS in a format that requires limited writing, making it easy to use even by ACS with limited literacy and numeracy skills. The information collected by the ACS is aggregated by regional facilitators who enter the aggregated information into a program called PAYA, which is then analyzed by the CHP Team, the implementing NGO staff, and the Monitoring and Evaluation Committee, which is composed of representatives of all 8 implementing NGOs. Information obtained from PAYA is then used to make program adjustments as needed. The standardization of the information and forms has facilitated aggregation of information across the project sites; however PROCOSI has not yet negotiated with the MSD how the information in PAYA (the project's MIS system) on the number of visits and referrals will be used by local healthcare providers or incorporated into national health information system (SNIS).

Weakness: ACS is not prepared to facilitate group meetings: ACS trained by CHP perform most of their activities through home visits. They were also trained to facilitate community health information analysis (CAI) sessions once a month as part of routine epidemiological surveillance. The expectation was that they would conduct other types of health education meetings in community-wide fora. It did not appear that they had the necessary skills to do so based on field visits to communities in San Ignacio de Velasco and Saavedra in the Department of Santa Cruz. The evaluation team concluded that the ACS lacked adequate skills to facilitate group meetings effectively and that there was a need for greater training and support from the facilitators to prepare ACS in group facilitation methods. It is likely, however, that the ALS will assume the role of facilitating community health planning and surveillance activities. The training module designed by CHP and the MSD better prepares them for this role than does the training modules for the ACS who are taught more one on one interpersonal communication skills. The

MSD has not yet decided on the role ACS will play in SAFCI, if any. The roles and obligations of the ALS are more clearly defined.

Weakness: Lack of formal plan for use and reporting of ACS collected information
Currently CHP reports the information from PAYA to USAID but not to MSD, although the PAYA information system is set up to provide supplemental information for the SNIS to demonstrate the contribution of ACS to the national health system. It would also be useful to return the information to the local health services and the ACS so they could use it as the basis for decision making.

Weakness: The population projections used for formulating coverage targets were not realistic
This is a general problem plaguing all health programs in Bolivia, especially on family planning promotion. National census figures initially used by CHP to develop targets for measuring the uptake of contraceptives were severely inflated, as there were fewer women residing in CHP communities than originally estimated. These population estimates have now been revised through a community census methodology which is updated every six months through visits to all households. Migration, both permanent and seasonal, has had a major effect on health planning in both rural and urban areas of Bolivia. The reason is that many people return to their natal communities to be counted during the national census in order to maximize the revenues their municipalities receive from the national government which is calculated on a per capita basis. Concerned about the welfare of their relatives left behind in rural communities urban migrants return to their communities of origin to be counted for the census and then return to intermediary and capital cities to live. Thus the number and composition of households based on the census is often unreliable. As such, seasonal migration results in an overestimation of rural populations and underestimation in urban areas for the demand for health services. In the future, it would be a good idea for programs to base their indicator targets on baseline data, rather than relying on the census as the data includes many people who have migrated to cities.

The CHP did make an effort to establish a baseline to verify real population numbers in the communities in the project area. While these numbers were more accurate, there is considerable outflow from rural communities from both seasonal and more permanent migration. As many CHP organizations are now using the household census methods developed by Consejo de Salud Rural Andino (CSRA), it would be more realistic to set yearly targets based on household data collected by the ACS through this process. The CSRA methodology entails visits to all households every six months, and quarterly visits to households with pregnant women or children under 5 years to record health status. The ACS have completed community mapping and census taking using the CSRA methodology fairly recently.

Strength: Previous experiences of PROCOSI member organizations provided a strong foundation for development of materials and community interventions-PROCOSI's experience as a network and individual member's field experience and methodological approaches contributed to CHP being able to help the MSD shape the implementation of SAFCI and to being able to work in regions where PROCOSI member organizations had little previous experience. CSRA's household census methodology which was adopted by most of the 18 implementing groups as a standard approach for ACS keeping track of household health status. The Centro de Promocion Agropecuaria Campesina, or CEPAC, utilized the participatory CAI methodology, which is now being used by many organizations as the basis for training the ALS to lead CAI's at the community level. APROSAR's profile of community health workers served as a basis for defining the role of ACS. In addition, the organizations' previous experience with materials development and training of community health workers assisted them in moving forward with ACS training, even when the final approval and production of the materials was delayed.

Weakness: Could have taken more advantage of individual NGO methods and processes in CHP
At the same time, informal adoption of some of the methods cited above could have been more deliberately and explicitly incorporated into the operational model of SAFCI. The recommendation of the RIG Audit to reduce the scope of PROCOSI's CHP activities in 2007 had consequences for the ability of CHP to have an effective social mobilization methodology.[21] It was the Health office which decided to terminate WARMI as a component of CHP. It is not clear to the Evaluation Team why that component was terminated, but the upshot of the termination is that CHP does not have an effective approach for empowering the community and particularly women in assuming a more prominent role in healthcare decision making. The use of WARMI had the potential to strengthen implementation of SAFCI by providing a well developed process for strengthening the capacity of community members to negotiate with the health services in order to achieve an acceptable intercultural and gender-responsive model of quality of care.

CHP also did not sufficiently take advantage of educational materials developed by PROCOSI under their earlier *Reproductive and Sexual health* and *Integrated Health* Programs. While considerable thought and attention went into the IMCI-Nut and TB materials, the reproductive and sexual health and maternal and newborn materials were not of the same quality, despite the fact that PROCOSI produced high quality materials for these elements for WARMI and their project on Quality of Care from a Gender Perspective funded by USAID's Cooperative Agreement to PROCOSI on Reproductive Health. While all projects should take advantage of materials/tools developed previously, it is an even larger issue if USAID funded-projects developed materials that were not used as the basis for the current project's work. The materials for the latter Quality of Care from a Gender Perspective were even adapted for use in different regions of the country.[22]

Strength: The Epidemiological Surveillance of Chagas, diarrheal and acute respiratory infection that was part of the Chagas house improvement activity was adopted by and functional in 100% of communities or health facilities where the activity was implemented (project monitoring data).

Strength: Successful negotiation with municipalities to provide incentives for ACS
CHP did a good job of engaging municipal governments in support on the ACS. They were able to convince municipal governments of the value of the ACS to communities within the municipalities and to elicit financial backing to provide incentives and recognition of the volunteer efforts of ACS. In many municipalities, local governments provided funding for

[21] Ironically, a year after WARMI was cancelled, PROCOSI was the first ever winner of the Pan American Health Organization's Regional Prize for Best Practices in Gender and Health for the WARMI strategy.
[22]The context for the lack of emphasis on FP is partially attributable to the problems in Camiri, described above in the timeline. In May 2007, the CHP was asked to leave the "Provincia Cordillera", given that the APG from Camiri did not accept family planning in its territory. This branch of the Asociacion del Pueblo Guarani (APG, Guarani's People Association) was at odds with the opinion of the APG in Tarija and Chuquisaca, both of which welcomed CIES and CHP. But there was also little support for FP at the MSD during this period. The "Director General de Servicios de Salud" Dr. Igor Pardo told PROCOSI that "Debo señalar que la planificación familiar no es política del Ministerio de Salud" (Letter dated October 22, Cite: MSD-DGS/0550/x/08). Given this adverse scenario, PROCOSI continued its work with the MSD, negotiating different options and approaches to implement this Module. At the end, the "Family Planning Manual for CHWs" Module was changed to "Cuidados para contribuir a mejorar la salud sexual y reproductiva" and it was presented jointly with the Sexually transmitted Diseases component. The training material does not include sexual and reproductive rights, because they were included in the WARMI strategy that finally was implemented only in the Asocio 6.

backpacks, uniforms, transportation and per diem during training. A few municipalities also recognized the most active and productive ACS publically with prizes and honors. In interviews conducted during the evaluation, ACS expressed how important this type of recognition was for them.

Nevertheless, the MSD is somewhat equivocal about what kind of incentives ACS should or should not receive and whether they should be paid or not. Although volunteer community health workers have been a longstanding resource to the health system in Bolivia, there has never been a clear policy on how they fit into the formal health system. The SAFCI Policy does not include a category of volunteer community healthcare worker; rather it supports an approach in which healthcare professionals and SAFCI teams, play the principal role in health education and engaging all community members in preventative and self-care practices. SAFCI designates the ALS as an unpaid elected official to be the key agent for ensuring that community interests are reflected in the delivery of healthcare services.

The efforts of the Zero Malnutrition Unit in the MSD are somewhat contradictory to the position of the Social Promotion Unit on the ACS. The Zero Malnutrition Program views the ACS as the primary agents for implementing Community IMCI. The recent launch of the wider distribution of the bowls and materials seems to support a continued role for the ACS. CHP has delicately balanced the different emphases of the two principal policies of the MSD.

Weakness: Lack of formal link of ACS training and supervision to first level health services
The most serious weakness of the CHP is the limited success the project has had in involving local healthcare providers in training and supportive supervision of the ACS. This weakness is partially attributable to the design of the USAID Strategy which designated separate implementers to deal with the community and the health services. It is also partially a factor of the contradictions in MSD policies as discussed above, as well as a consequence of the abrupt change in geographical area in 2006 which weakened coordination between different USAID implementing partners. There are several direct consequences of the lack of coordination between CHP and local health services in most areas. First, poor coordination threatens sustainability of community education and monitoring provided by the ACS. Second, lack of coordination limits the impact of the referral process from the household to the primary health services as there is no institutionalized accountability if there is not a direct process of communication between the health care personnel and the ACS to follow through on referrals and counter-referrals. Third, the absence of meaningful coordination limits the usefulness of the information the ACS collects. In addition, once the project ends, it is not clear who will be responsible for aggregating the information for use in the CAI or for use by the health system. Currently this is a role performed by CHP facilitators and coordinators in the project areas.

The recent initiative by the Zero Malnutrition Unit of the MSD to involve PROCOSI member organizations more widely in training healthcare providers to train and support ACS is a positive development that may counter this problem. It is not clear, however, where the funding for this initiative is coming from, as there are obvious costs for PROCOSI and its member organizations.

Attention to gender and intercultural issues:

Strength: Social mobilization/ rights strategies (SOCIOS, SAVE, CIES, PROCOSI)
A review of the different methodologies to address gender issues in health programs during the evaluation demonstrated that there is considerably more capacity within USAID implementing organizations to address gender inequalities and women's empowerment than there was at the beginning of the current five year strategy.

The organizations that were most invested in addressing gender issues were CIES, Save the Children, and Socios para el Desarrollo.

CIES' Community Participation Action Methodology (MAC) is designed to empower community groups composed of women, men, and adolescent girls and boys, although adult women tend to participate more, and many groups are solely composed of women.[23] Through a five stage process, MAC seeks to empower participants to improve their sexual and reproductive health practices, enable them to exercise their rights, and develop strategies for addressing the health related problems they identify and prioritize.[24] The methodology guides the group from problem identification and prioritization to thorough development and implementation of an action plan. The plans identify very specific and concrete actions the group can take, such as referring women affected by gender-based violence to health or legal services. The plans are less effective in addressing the underlying structural constraints and factors that contribute to the problems. Part of the reason is that the groups do not receive funding for more strategic types of interventions and therefore chose interventions that require minimum expenditures or rely on funding from other organizations. The methodology would benefit from a greater focus on advocacy to prepare groups to engage in a more sophisticated problem analysis and to provide them with the skills to lobby existing services and funding organizations for support for more profound structural changes.

EAPC (Estrategia de Acción Participativa Comunitaria/Strategy for Participatory Community Action) is similar to MAC but with a longer time horizon to accommodate for the challenges presented by distance and constraints on women's time in rural areas. EAPC similarly guides the groups through problem identification and prioritization, development of an activity to address a priority problem, evaluation, and an advocacy component. It is modeled on the Manuela Ramos and WARMI II methodologies which, in contrast to MAC, provide funding to participant women's groups for a community-level intervention, which is usually educational. The participating women's group receives funding to implement the activity. They are responsible for administering the funds, implementing the activity, and sharing the results with the wider community. The final phase of the project involves engaging participants' male partners, community and municipal authorities, and healthcare providers in an educational and advocacy process to negotiate for health services to be more attuned to community needs, of higher quality, and more accessible. The methodology was designed to incorporate men and local leaders until the last stage of the process. In many areas, women have complained that their partners should be brought in earlier. In response to women participant's requests, both WARMI II and MR developed a parallel process for involving men, a strategy which would also enhance the impact of EAPC in the future.

Both approaches, as well as the *Manuela Ramos* strategy that was implemented prior to EAPC by SpD and PROSIN contribute to strengthening women's SRH decision-making power and rights in their households and communities. The direct funding of women's groups that is part of EAPC is particularly important as it provides them with fiscal experience that many groups have been able to use to gain subsequent funding from municipal governments and donor

[23] CIES has 17 MAC groups in Oruro, 20 in El Alto and 21 in Santa Cruz. All of the groups have completed application of the methodology to two different problems, with implementation of their respective action plans. In Sucre, CIES recently initiated MAC groups which are in the process of developing their first cycle action plans.

[24] The 5 steps are: 1) community organization; 2) SRH problem identification and prioritization; 3) development of consolidated group action plans; 4) implementation and monitoring of the plans; 5) participatory evaluation.

organizations. The advocacy component also has enhanced their capacity to negotiate with the health services and municipal authorities, which is one of the basic tenets of the GOB's SAFCI policy.

Weakness: Community mobilization and women's empowerment programs operate at the margins of the health system- and with the elimination of WARMI, the rural health strategy lacked a methodology for community mobilization and empowerment. While women's empowerment and adolescent SRH programs have contributed to raising awareness among participants about the inequalities in gender relations that compromise women's and men's, and adolescent girls' and boys' sexual and reproductive health, they were not always effective at strengthening women's and men's capacity to negotiate with healthcare providers and administrators to improve the quality and accessibility of healthcare in their communities. The two women's empowerment methodologies used by CIES have not yet achieved a clear link to improvements in health services, as they operate at the margins of CIES' health services and only somewhat tangentially with public health services. As a result, the knowledge acquired by the participants has not yet demonstrated an impact on women's increased capacity to exercise their sexual and reproductive rights, to access SRH services, or to make healthcare services more gender equitable. One of the major limitations of both methodologies is their failure to effectively engage men as equitable partners. [25]

Strength: WARMI and EAPC were designed to empower communities to advocate for their health rights and to engage with the health services to communicate and lobby for their preferences, quality of care, and respectful treatment. SpD also implemented the ReproSalud Methodology which is similar to both EAPC and WARMI. The three methodologies have really become one. The Evaluation Team did not have the opportunity to assess any of these activities through site visits. The ReproSalud version of the methodology, like WARMI and EAPC, explicitly focuses on promoting a dialogue between the community, led by women, and the health services.

After the shutdown of PROSIN II which implemented the ReproSalud/WARMI II methodology for women's empowerment and elimination of WARMI from CHP, attention to gender was concentrated in projects that were outside of the rural health strategy. The original design of the CHP project included a gender component based on the WARMI II methodology which was intended to complement the ACS strategy by working directly with women's and men's groups in the community to empower them to identify sexual and reproductive health problems in their communities and to take collective actions to address them through education (on gender equality, women's empowerment, and masculinities, GBV prevention, and SRH), advocacy, and negotiation. In 2007, the Health Office's decided to drop the WARMI component because the RIG audit concluded the CHP design was too complex. This was a decision that was made without sufficiently understanding that WARMI was designed to empower communities to assume an active role in co-managing and overseeing the performance of community health services.

[25] The two programs operate fairly separately from the health services in both Santa Cruz and Sucre. While the programs are only a few years old, CIES has not made any deliberate efforts to continue their earlier commitment (which is part of their institutional mission and vision) to ensure that their providers receive gender training, or to involve providers in their community outreach activities. After the field work for the evaluation was concluded, CIES did have all their staff undergo a thorough a gender and gender-based violence training. This bodes well for the future, and suggests a renewed commitment to integrating educational and service delivery activities.

Although it is difficult to argue what might have happened had WARMI continued, there is some evidence, in the few places where CHP organizations implemented WARMI activities they had begun prior to the RIG recommendation, that communities with WARMI activities are more receptive and actively responsive to messages promoted by the ACS than in other CHP communities.[26]

Strength: Involvement of groups representing indigenous communities in the planning and implementation of CHP. The Community Health Project coordinated with several indigenous organizations in the process of translating the SAFCI policy into an operational model of participatory management and social control. The Guarani's People Association (APG), Consejo de Capitanes Guaranies de Chuquisaca (CCCh), Consejo Indígena de la Chiquitanía – Roboré (CICHAR), Central Indígena Chiquitana Turubó, Central Indígena de Concepción y Lomerio (CICOL), and Gran Consejo T'smané all participated actively alongside CHP implementing organizations in their respective areas of influence to adjust application of the model to local contexts and governance practices. The benefits of these partnerships were to:

- Cement and legitimize alliances between the Project and local communities
- Carry out community censuses and problem analyses (with the photo voice methodology) with full community agreement and participation in setting priorities and developing action plans
- Disseminate information about community leadership roles (ALS) that are intrinsic to implementation of the SAFCI policy
- Develop procedures for electing ALS based on local governance practices
- Establishment of local health committees (Comités Locales de Salud) and participatory operational procedures
- Development of training methods and materials for ALS and Local Health Committees.

The MSD recognized CHP's work in this area as a major contribution to translating SAFCI policy into concrete action.

CIES also works in areas with indigenous groups through its rural mobile outreach units which operate in the valleys and Chaco of Chuquisaca. In the Chaco, CIES joined forces with the globally-funded Health Policy Initiatives Project to implement a culturally and gender sensitive approach to prevention and responding to gender-based violence. CIES has plans to implement this methodology in all 9 regions and they are involving both health educators and providers in the process.

Key Achievements and Main Challenges

The most notable achievement under IR1 was CHP's work with MSD and indigenous organizations to develop an operational model to implement of SAFCI and Zero Malnutrition (Desnutrición Cero) policies. Given that this took place during a period of tense relationships between the two governments made this achievement especially significant. PROCOSI has played a prominent role in helping the MSD to both formulate and implement health policies in rural areas for the last 20 years, so this most recent achievement also reflects both the value of

[26] This is based on discussions that the evaluation team had with World Vision (Vision Mundial) in San Miguel in the Department of Santa Cruz. World Vision is implementing WARMI in some of its CHP communities and not in others. As they had begun implementation of WARMI prior to the audit, USAID allowed them to continue implementation in the communities where they had already begun. This allows them to compare outcomes in communities within the same municipality to assess the impact of WARMI.

USAID's long-term commitment to and investment in PROCOSI as well as the strength of CHP's leadership and depth of experience on rural healthcare in Bolivia.

The PROCOSI member organizations implementing CHP bring considerable experience to executing community health programs. The design of the CHP diverged from earlier USAID funded PROCOSI network health programs by imposing a more uniform approach to program operations and materials than had characterized earlier programs. Earlier programs set common objectives and indicators but left implementation modalities up to the individual organizations. The uniform design and fairly standardized operational procedures of CHP was not a wholly comfortable modus operandi for PROCOSI.

Although there are both advantages and disadvantages to the approach, as evidenced by the discussion of strengths and weaknesses above, it is not clear that uniformity translates into better health outcomes, more efficient and effective implementation, or cost savings. Insistence on the use of standardized materials resulted in approval and production delays which delayed implementation of the program in the field. The materials were also not sufficiently adapted to the local sociocultural contexts in which the different implementing organizations worked, motivating some organizations to develop their own materials at additional effort and cost. Other processes, while valuable in theory, such as the collection of standardized information by the ACS, did not always have a clearly defined procedure for practical application. Many of the CHP approaches reinvented the wheel less successfully than innovative and proven approaches and materials previously developed by the PROCOSI network and individual member organizations. For example, CEPAC's participatory epidemiological surveillance and problem solving process (CAI), or APROSAR's experience training community health promoters were proven approaches. Other approaches that have been standardized across the network after considerable review and testing in different contexts were not part of the project. This was particularly true with regard to community mobilization and women's empowerment (e.g.,WARMI II) and IEC approaches (e.g., Esperanza's radio health education programs and interactive SRH materials from Quality of Care from a Gender Perspective Program, which was funded by USAID, implemented by PROCOSI and evaluated by the Population Council) which were sorely lacking.[27] Finally, standardization also constrained the capacity of the participating organizations from developing new innovative approaches, especially those adapted to the new areas in which they are working, as has been characteristic of earlier USAID PROCOSI funded programs. In the past, funding allowed organizations to pilot new approaches and then share them with other network members through the regional and technical working groups. Those deemed most successful after a technical review became part of the technical and operational toolkit of the network.

The USAID/Bolivia Health Team has supported the development and application of gender and women's empowerment approaches for years. During the 2005-2010 Strategy period, these efforts were relatively small and independent from the health services they were meant to influence. In addition, there were no focused indicators, evaluations or research on the impact of these programs on changes in either health practices or gender equality. Although there is slightly more information on the number of adolescents participating in the two adolescent programs under the Strategy (*Tomando Decisiones* and *Tu Decides*) and number of adolescents using health services (especially CIES), it is not possible to demonstrate the relationship between adolescent use of services and participation in the educational programs.

[27] For a full description of the Quality of Care from a Gender Perspective activity and evaluation results, see Palenque de la Quintana, Erica, Ma. Patricia Riveros Hamel and Ricardo Vernon 2007.For WARMI II, see Silva de la Vega, 2008.

Two principal factors restricted the measurement of the health impact of IRI programs. First, the programs only report on process indicators, and although the adolescent and gender/empowerment programs conduct pre- and post-tests on information transmitted, they do not have a process for linking changes in knowledge to changes in practices. Second, CHP's short implementation time horizon of barely 2 years, most of which was spent on training ACS, makes it unrealistic to try to measure impact on changes in self-care and prevention at this time.

The adolescent programs, and the empowerment methodologies implemented initially by PROSIN and SpD, and then by CIES and Save the Children, offer a solid base for building a comprehensive and equitable approach to implementing the SAFCI policy during the next five years, especially if those approaches can be more effectively integrated with health service delivery in municipalities.

IR2: EXPANDED DELIVERY OF QUALITY, HIGH-IMPACT HEALTH SERVICES THROUGH HEALTH NETWORKS

Context

The principal objective of IR2 is to improve the availability and quality of primary and secondary health services in municipalities through the provision of technical assistance and training. The original focus was on improving the clinical and interpersonal skills, and knowledge of healthcare policies and protocols of healthcare providers, as well as to improve critical healthcare systems, such as referral and counter-referral, logistics management, supportive supervision, and epidemiological surveillance. Specifically this IR aimed to:

- Strengthen health networks to improve population coverage with a basic package of high-impact clinical and community services in reproductive health/family planning, child health and nutrition, maternal health, and infectious diseases (including TB, Dengue, HIV/AIDS, Malaria, Leishmaniasis, and Chagas)
- Improve the quality and cultural responsiveness of health services
- Make referral counter-referral systems functional and effective among different levels of care from the household and community to secondary and tertiary care for sexual and reproductive, maternal, neonatal, and child healthcare

Three sub-IRs support the achievement of IR2:

- IR 2.1 Improve the provision of clinical services
- IR 2.2 Improve the provision of community health services
- IR 2.3 Improve the quality of health services according to national norms, protocols, and user satisfaction

The move to new areas in 2007, the termination of PROSIN in 2006 and of ACQUIRE in 2008 made it difficult to integrate interventions across implementing organizations and across levels of the health system. Furthermore, a cutback in funds for infectious diseases caused a disruption in a number of activities under this IR. In large measure, this was complicated by the lack of an effective coordinating mechanism, once PROSIN II was closed in 2006. It was also complicated by an approach that fractured implementation by health element and level of the health system. Rather than having one partner responsible for implementing the whole basic package across one level which coordinated with an implementer responsible for the entire package at another level and for coordination across levels, the approach had multiple and uncoordinated actors at all levels. Even an approach that made one organization for implementation of particular elements across different levels (the more usual vertical programming approach) could have contributed to better integration as that partner would have had to focus on logistics, referral,

and supervision systems pertinent to their area of healthcare. The strengths and weaknesses reflected in this IR review section represent a contrast between some real technical advances and unique instances of coordination (strengths) and limitations in advances to system strengthening and integration (weaknesses).

The illustrative activities originally planned under IR2 included (from USAID/ Bolivia's Strategic Plan):

- Support a basic package of high-impact services in targeted health networks
- Improved access to quality HIV/AIDS Voluntary Counseling and Testing at Treatment and Surveillance Centers (CDVIRs) and other sites focusing on outreach to high-risk groups
- Improved quality and cultural responsiveness of priority community-based health services
- Continued support to the national confidential HIV/AIDS hotline
- Expand use of Continual Quality Improvement (CQI) within clinics and hospitals[28]

Table 3: IR2 Indicators

Level	Indicator[29]	Baseline (2003)	Target (2008)	Actual (2008)
IR2	# of Receiving VCT at USAID assisted sites in a one year period	1248	9500	13,026
IR2	% of infants under age 1 who received the 3rd dosage of pentavalent vaccine in target rural geographic areas in one-year period	81%	84.6%	81%
IR2	Tuberculosis Treatment Success Rate in Target Geographical Areas	81%	90.5%	83%

Key Partners

The major partners for achieving the IR are:

(1) JSI/GCS project for quality of care improvement and strengthening of clinical IMCI-nutrition and neonatal practices, and treatment of infectious diseases. JSI's *Gestion y Calidad en Salud* Project is the Mission's flagship Project for strengthening child health services. Up until this year when funding was cut by USAID/Washington, it was also principally responsible for strengthening the public sector's capacity to manage and treat infectious diseases such as tuberculosis, malaria, and dengue. In addition to its Rural Health Strategy activities, JSI implemented an activity in the Yungas, with Alternative Development funding, to detect and treat leishmaniasis, TB, and Malaria. JSI was particularly instrumental in helping the MSD to roll out its IMCI-Nut policy in clinical settings through collaboration with the Departmental Health Services (SEDES). The project supported municipalities in the construction of Integrated Nutritional Units (UNIs) for treating moderately and severely malnourished children under five. GCS has provided extensive training and technical assistance in all of

[28] "CQI is an approach to quality management that builds upon traditional quality assurance methods by emphasizing the **organization** and **systems**: it focuses on "process" rather than the individual; it recognizes both internal and external "customers"; it promotes the need for objective data to analyze and improve processes (http://www.fpm.iastate.edu/worldclass/cqi.asp)."

[29] Indicator data comes from the Health Strategic Objective Performance Plan, Strategy Period 2005-2010, updated March 2009, and the 2009 Final Report of the 2008 Bolivia DHS.

these areas in the four focus Departments of the Rural Health Strategy (Tarija, Santa Cruz, Chuquisaca, and Beni). In addition, Population Council, a sub-contractor to JSI, has conducted a number of operational research studies on child health and infectious diseases.

(2) ACQUIRE project for reproductive health in-service training and quality assurance for reproductive health and family planning. EngenderHealth, with funding provided initially through the field support mechanism through Global Health (USAID), and later through a direct Agreement with the Mission, was responsible for: 1) increasing the number of quality RH (MH/FP and PAC) facilities/services; 2) improving health providers' performance; and 3) strengthening the environment for reproductive health service delivery. As the project was terminated in 2008 as a consequence of poor performance and a failure to implement according to the terms of their scope of work, the evaluation team faced many challenges in reconstructing what activities had actually been implemented. Overall, EngenderHealth supported extensive training of public and private sector healthcare providers in maternal and neonatal health and contraception. Shortly (one year) before ending in June 2008, EngenderHealth had begun to work through a sub-grant with CARE on a program to strengthen emergency obstetric and neonatal care (EmONC) in ten health networks based on the Femme model developed by CARE in Peru.

(3) CIES provides Reproductive Health Services through its 9 health centers and 15 clinics. It is the largest NGO provider of family planning and SRH services, responsible for approximately 37% of all FP services in the country. USAID funding for CIES provided support for:

- Increasing the use and improving the quality of services
- Implementing clinical and educational models that promote individual's ability to exercise their sexual and reproductive rights
- MSH technical assistance to improve CIES's management systems and administrative staff capacity
- Developing more effective strategies for attaining financial sustainability In the last two years (2007 and 2008)

CIES averages a total of 250,000 clinical consultations per year, which is nearly double the number they had in 2004. During the FY2005-FY2009 Strategy period, CIES has expanded services in rural areas of Chuquisaca through its mobile health units which cover 121,000 people in 7 municipalities, and diversified services in its 15 clinics in Departmental capitals and intermediate cities of Quillacollo, Huanuni, and Guaryamarin through contract arrangements with private doctors.

(4) Socios para el Desarrollo (PROSALUD) provided training and equipment to the MSD's Centers and Diagnostic Laboratories for STIs/HIV/AIDS (CDVIRs), and sub-grants to NGOs for HIV voluntary counseling and testing services. They also supported a mobile medical van in EL Alto to extend medical services to parts of El Alto not easily accessible to health centers.

(5) PROSALUD provides integrated health care in its 26 health centers and clinics. Through its social marketing program, it also supplies contraceptives to some municipalities and NGOs. PROSALUD averages about 525,000 consultations per year through its 10 health centers in Santa Cruz, and 11 policlinics and 5 referral hospitals in La Paz, Santa Cruz, Oruro, Tarija, Beni, and Cochabamba.

(6) Tomando Decisiones (Save the Children) trains health workers to provide adolescent friendly services in public health centers and works with pharmacists to improve adolescents' access to contraceptives.

IR2.1- Improve the Provision of Clinical Services

GCS and ACQUIRE worked mainly with public sector services in support of the Mission's Rural Health Strategy. CIES, the Bolivian IPPF affiliate, and PROSALUD, the largest private health network in Bolivia, serve lower and moderate income families throughout the country. In the first two years of the strategy, PROSIN, also contributed in part to this IR, although it mainly supported achievement of IR3.

SpD provided financial support, testing supplies, and technical assistance to 8 NGOs that in the aggregate run 10 HIV/STI Voluntary Counseling and Testing (VCT) services centers, including CIES and PROSALUD, to enable them to provide HIV counseling in support of the national HIV/AIDS program.

In 2008, SpD contracted 24 professionals to improve the functioning of the diagnostic laboratories (CDVIRs) and the national HIV/AIDS program. SpD provides subgrants to10 MSD CDVIRs to equip them with computers and diagnostic kits. As of 2008, SpD had also conducted 15 training workshops for CDVIR personnel and other organizations working on HIV

PROSIN II- Integrated Health Project (MSD): PROSIN focused on capacity-building at the central (MSD), departmental (SEDES) and health network management levels, providing technical assistance in the areas of IMCI, sexual and reproductive health, malaria, tuberculosis and other infectious diseases.

ACQUIRE (EngenderHealth): The project improved and expanded quality reproductive health service delivery in public and private sector facilities through training and technical assistance in family planning, maternal health, post abortion care, supervision, continuous quality improvement, infections prevention, and involving men as partners in health. CARE, as a subcontractor, worked on developing 9 rural maternal and neonatal health networks to provided emergency obstetric care and gender and culturally sensitive maternal health services to reduce maternal mortality. EngenderHealth worked with the Sucre Urban health network as well.

M*anagement and Quality* (*Gestion y Calidad en Salud* -GCS) worked on improving the quality of services provided in the public health sector with a particular focus on IMCI, nutrition, neonatal survival, and infectious diseases. The staff facilitated the application of clinical IMCI practices, with a focus on nutrition and the project also helped to improve epidemiological surveillance of infectious diseases.

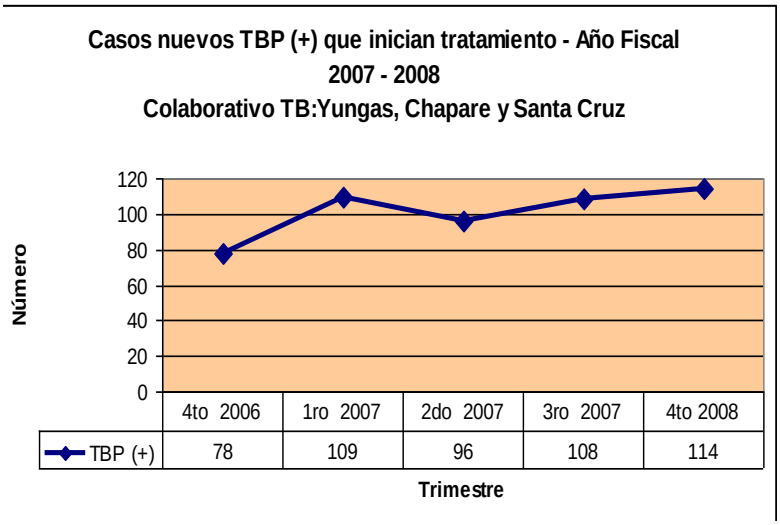
Strengths and Weaknesses

Strength: The management and technical skills of the JSI team has ensured high productivity and quality of Gestion y Calidad de Salud project (GCS) implementation. The SEDES and municipal governments and health services greatly appreciated the Regional Technical Advisors' knowledge of the local context and actors. Their familiarity with the local context facilitated their strong working relationships with their counterparts at the municipal and departmental levels. The GCS team has played a prominent role in supporting the MSD's development and evolution of the IMCI-Nut and Zero Malnutrition policies and implementation strategy, by

providing a tightly integrated package of training, technical assistance, instruments, and health facility infrastructural improvements.

Strength: Leishmaniasis and Tuberculosis strategy in Yungas had a positive impact on people's health and their acceptance of USAID/Bolivia's Integrated Alternative Development (IAD) Program which financed an independent activity in the Yungas to address the high incidence of TB and Leishmaniasis in the IAD project area. The activity operated independently of other GCS Rural Health Strategy activities. The mayors of the four municipalities (Chulumani, Irupana, Coripata, and Coroico) in the project area praised the project for effectively managing both diseases. The TB program has been administered using the Directly Observed Treatment, Short-course (DOTS) strategy managed by the director of the health network in Chulumani. GCS provided Pentosan for the treatment of Leishmaniasis. GCS interventions consisted in improving the quality of services (see below), strengthening the capacity of healthcare providers in the DOTS methodology, establishment of municipal pharmacies with the appropriate array of pharmaceuticals for the epidemiological profile of the region, and increased access for the local population to diagnostic services for both diseases. The project also helped to develop the Referral Center for Leishmaniasis (CEDELEI) in Chulumani into a nationally recognized demonstration and training center.

Figure 7: Newly Treated Cases of TB – FY 2007-2008



Weakness: ACQUIRE'S technical assistance model was limited to theoretical training with limited opportunity for hands-on practice and did a poor job of selecting the trainees. In 2006, the Acquire Project reoriented their approach to Sexual and Reproductive Health to be a classroom training program. This had a profound effect on the delivery of SRH services, especially in public health facilities. New management that took over the project in 2006 decided to respond to a perceived underwhelming demand for project sponsored training by linking it to Diploma and Masters programs through the Universidad Nur. Participants paid between $50 and $150 each to enroll in a 14 module training program. Former participants said the classroom instruction was mostly theoretical rather than practical. It was taught through a series of PowerPoint presentations with occasional opportunities for trying out some of the techniques and procedures on models set up in the hotel conference sites rather than in clinical settings. There were no opportunities for direct clinical practice, and rarely did all of the participants have a chance to practice on the models. The training also was not targeted to ensure that the appropriate health care workers received the appropriate training. Anyone could take all 14

courses – including auxiliary personnel. It didn't make sense and changed the entire dynamic of the program to focus on the Diploma rather than on ensuring that people at appropriate levels of the health system could apply appropriate training in the health center setting.
After completing the training, there was virtually no follow-up or direct observational supervision by the project or support to the SEDES or Health Network Directors to provide post-training support to participants.

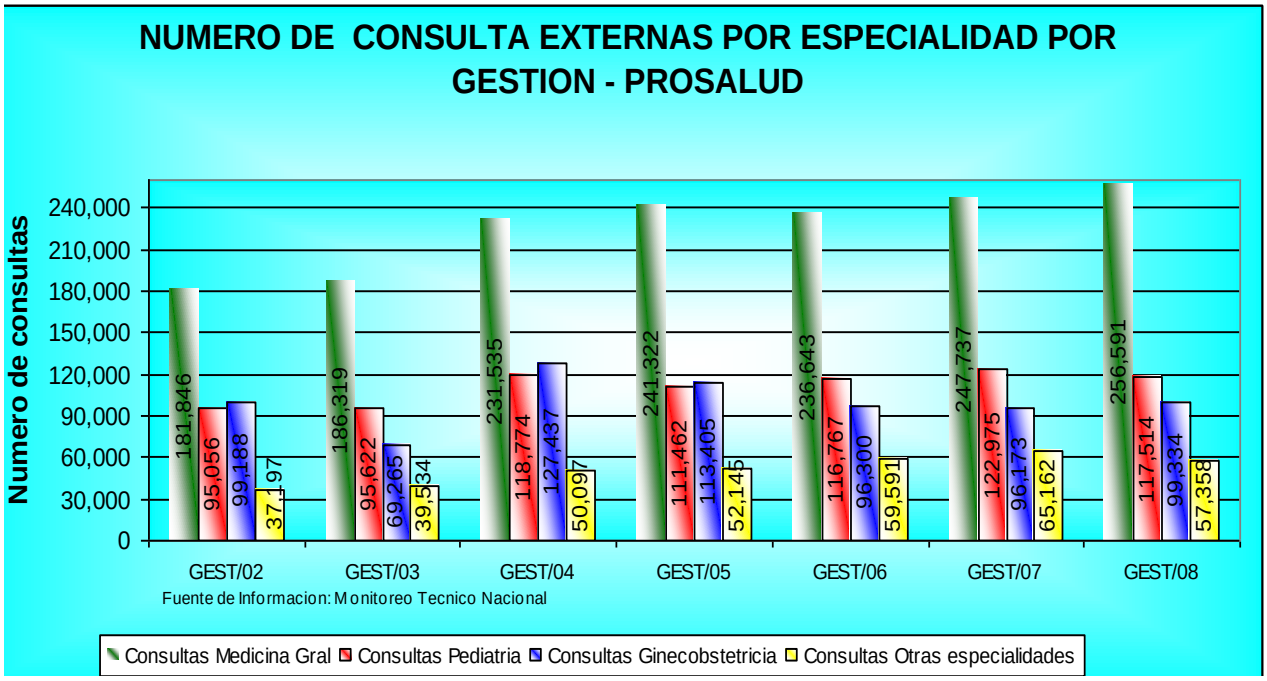
In comparison with five to ten years ago, there appears to be an erosion of knowledge and clinical skills in contraceptive technology and counseling in the sites visited by the evaluation team. It was also the perception of the two team members who work in the Bolivian health system that this was fairly generalized across the country. The EngenderHealth training did not improve this situation appreciably, as the training was very theoretical and afforded little hands on practice for participants. This situation was compounded by factors outside of the control of the program, such as a lack of a strong SRH curriculum in medical school, and lack of strong political support for SRH during the five years covered by the strategy.

IR 2.2 Improve the Provision of Community Health Services

Strengths and Weaknesses

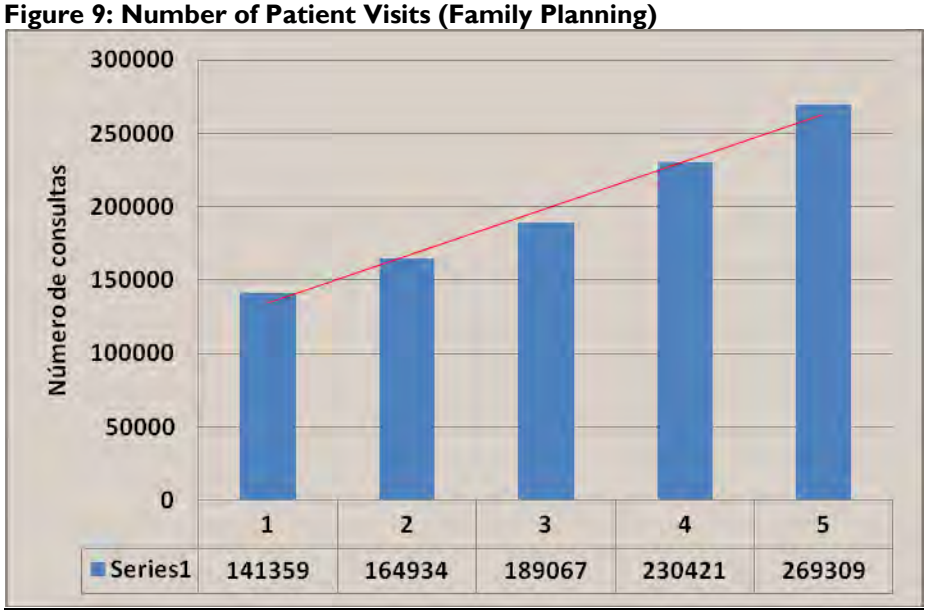
Strength: USAID support to PROSALUD and CIES has contributed to increased health coverage by the nonprofit private sector, including to poor populations. PROSALUD has steadily increased its provisions of services to the community, despite closure of 6 clinics in El Alto in 2008. In 2008, PROSALUD almost conducted 420,000 consultations. In addition, despite their increased focus on sustainability, they have been able to maintain the percentage of free services slightly over 20%.

Figure 8: Number of Outpatient Visits by Specialty - PROSALUD



CIES almost doubled the number of consultations from 2004 to 2008. They have also increased the number of family planning visits by 50%.

Figure 9: Number of Patient Visits (Family Planning)



Strength: Save the Children and CIES increased the availability of services for adolescents. The SAVE program (*Tomando Decisiones*) also worked with healthcare providers and pharmacists to develop adolescent friendly services. Although the CIES program (*Tu Decides*) is located in the same buildings as CIES health services, there currently no dedicated adolescent health services, although all staff are trained on how to deliver youth friendly services. Between 2007 and 2008, the number of adolescent health consultations in CIES clinics increased by 169% from 7,891 to 22,385. The major contribution of the SAVE program was their support for developing public sector adolescent friendly services in urban areas. The project also developed adolescent specific indicators, such as adolescent pregnancy for analysis in the CAI, with the longer term intention of convincing the MSD to incorporate these indicators into the SNIS.

Weakness: It is not clear how sustainable the Save the Children intervention is. Without direct external support, these services do not seem to continue, as evidenced by earlier efforts, such as those undertaken by Pathfinder.[30] To make them sustainable, it is necessary for Save the Children to: 1). negotiate an ongoing commitment from the municipalities to budget funds for the services; 2). receive a commitment from the MSD to continue supporting dedicated positions for adolescent specialists or trained non-specialists; 3). and reach a commitment from the SEDES to support ongoing supervision and monitoring.

Strength: SpD's improvement of STI/HIV VCT services. In the last year, three of these NGOs (SexSalud, CIES, and PROSALUD) have exceeded their testing targets by an average of 128%.

[30] In Medellin Colombia, a similar type of effort (Sol y Luna) has continued because the Municipality of Medellin committed to funding the services after project funds ran out. Save the Children should consider advocating for a similar commitment in all the POAs of the cities where they are working. Without that, there is little likelihood the services will be sustained.

Table 5: SpD's Improvement of STI/HIV VCT Services

Source: USAID/Bolivia Monitoring Data	Target	Result	% Achieved
PROSALUD	**3900**	**5203**	**133.40%**
- **Cochabamba**		**1071**	
- **Puerto Quijarro**		**645**	
- **Yacuiba**		**852**	
- **El Alto**		**1710**	
- **Tarija**		**925**	
CIES	**3000**	**3616**	**120.50%**
- **La Paz**		**1242**	
- **Oruro**		**1210**	
- **Potosi**		**529**	
- **Trinidad**		**635**	
SEXSALUD	**600**	**748**	**124.70%**
Total Acum.	**7500**	**9567**	**127.6**

IR 2.3 Improve the Quality of Health Services According to National Norms, Protocols, and User Satisfaction

Strengths and Weaknesses

Strength: JSI's follow-up supervision (after training) in conjunction with SEDES and health network managers has been institutionalized in some SEDES (Tarija and Chuquisaca).To ensure that child health services included competent application of the IMCI-Nut protocols, GCS developed strong working relationships with the SEDES and municipal governments. The center piece of the project was a cascade process to train all clinical personnel from municipal health networks in IMCI-Nut protocols within the project areas. To ensure effective post-training implementation, the GCS team worked with the SEDES and managers of the health networks to develop a supportive supervision system or regular periodic visits to all health facilities within a network. In some project sites, such as San Ignacio de Velasco, GCS and CHP have worked together to ensure that a local institution, the Auxiliary Nurse Training School, acquired the training capacity and assumed responsibility for replicating all training offered in conjunction with the Rural Health Strategy. In most regions, such as in the case of Hospital San Juan de Dios, in Santa Cruz, the local institution selected to be the training site has not yet fully embraced the IMCI-Nut or EmONC training capacity as part of its institutional identity.

Strength: SpD supported a Masters Degree program in family and community medicine in conjunction with the Colegio Medico. It combined 8 modules of classroom study with fieldwork

practicums. Over 100 (103) participants received scholarships to study, of which 91(88%) presented and defended a thesis. Participants were able to reach 138,000 patients during the practical part of their training. Twenty six (26) of the graduates were incorporated into health networks. The effort represented an attempt to put into practice the new SAFCI Policy.

Weakness: The lack of coordination with the MSD on the Masters Program resulted in its premature termination. Unfortunately, the MSD did not see the Masters Degree program in family and community medicine as a genuine effort to implement SAFCI, but rather as a parallel or competing program established in Departments led by opposition leaders to undermine national policy. The program ended because the MSD viewed it as an illegitimate program that had not been approved by them and as an unauthorized competitor to their own SAFCI residency. In a different political climate, the Masters Degree program could have been a significant contribution to increasing access to health services in communities.

Strength: GCS strengthened health networks' capacity to deliver quality services in communities and health facilities at different levels according to national norms and client satisfaction (includes logistics) Joint Planning and Monitoring with SEDES and NGOS on IMCI (Tarija and planned in Chuquisaca). The most notable change that GCS has brought about in the SEDES with whom they work is the institutionalization of supportive supervision and monitoring as routine practices.

Strength: ACQUIRE generated interest and commitment among several of the health networks in the Rural Health Strategy areas to improving their response to obstetric and neonatal complications. CARE, a partner in ACQUIRE, introduced the FEMME model, based on Columbia University's Averting Maternal Death and Disability program. By the time the ACQUIRE Program stopped in 2008, all ten networks had completed a baseline assessment, most had developed an action plan, and one (Bermejo) was well along in implementation. It is the model that has been adopted by the MSD. CARE started to develop this approach in 10 rural networks in Tarija (Bermejo, Villamontes, and Entre Rios), Chuquisaca (Monteagudo, Juana Azurduy, and Sopochuy), Santa Cruz (San Ignacio de Velasco, San Jose de Chiquitos) and Beni (Guarayos and Trinidad). By the time project activities ended in June 2008, most networks had developed little more than implementation strategies. However, Bermejo, and to a lesser degree, San Ignacio de Velasco, had begun to make their plans somewhat operational by identifying several basic and one comprehensive EmONC facilities in the network, but still lacked hands on training at a EmONC facility at a tertiary care facility, such as Hospital Percy Boland in Santa Cruz.[31]

Weakness: None of the Obstetric and Neonatal networks are fully operational due in part to ACQUIRE dispersing their resources on two different approaches to EmONC. The ACQUIRE Project promoted two different approaches to developing obstetric and neonatal networks. The first was an approach promoted by CARE based on its FEMME Project in Ayacucho, Peru. The other model was implemented by EngenderHealth in Sucre without support from CARE. EngenderHealth found very receptive partners in both the tertiary-level Gineco-Obstetrico Jaime Sanchez Porcel Hospital in Sucre (part of the University of San Xavier in Sucre) and two secondary referral hospitals (San Pedro Claver and Poconas) with satellite health centers. The network also incorporated health centers in the two nearby rural municipalities of Potolo and Chuqui Chuquí. With the backing of the SEDES, the Sucre urban health networks established an active obstetric and neonatal health committee which oversees the EmONC network, a training

[31] As a postscript, the USAID Health Office financed a new integrated approach to EmONC led by CARE in September 2009. It integrates post-partum and post abortion family planning, post-abortion care, community mobilization, and strengthening of municipal healthcare management into the FEMME model. The project is working in 10 networks, with concentrated efforts on 2-4.

center at Jaime Sanchez Porcel Hospital. The network has held several training workshops since the end of ACQUIRE for health personnel from all three level facilities and has also developed operational and procedural manuals. One of the portfolio review team members was able to observe a training workshop for primary care providers organized by the network. The Evaluator believed that the training suffered from some of the same weaknesses as the type of training promoted by ACQUIRE: the training did not offer adequate hands on practice or sufficiently respond to the participants' training needs. Although the networks have a procedure for auditing maternal and neonatal deaths and near misses, a process for using the audit information for decision-making has not been developed yet. The process and logical steps of the AMDD/FEMME approach provide a more effective and clearer sequencing for implementation and monitoring.[32]

Weakness: Cascade training model provided by staff and consultants based in La Paz, rather than in the target areas. The cascade model of training used by both GCS and EngenderHealth is not the most effective means of ensuring strong capacity building of front-line primary healthcare providers who are furthest removed from the top of the cascade, especially in the absence of high quality and frequent supportive supervision and monitoring of trainees. GCS was more successful in developing a supervision capacity at the departmental and municipal levels than ACQUIRE, but lack of funding, human resources, and transportation available to the SEDES and Municipal Health Networks severely constrained the impact of GCS's efforts. Another weakness of the model is that it was dependent on external trainers based in La Paz. That made it logistically challenging and expensive to provide ongoing technical support and refresher training in the program implementation areas. Creating regional training capacity, in addition to the existing regional technical coordination, would have been a better model for an approach so heavily dependent on training.

In the future, it would be useful to develop some alternative models, such as peer review and supervision, periodic internships for frontline workers in secondary and tertiary hospitals, and internships by specialists in rural areas. SEDES Chuquisaca has implemented a new policy along these lines for medical residents who are required to spend two years in a rural hospital before receiving their degrees. This is producing some very positive outcomes, such as municipalities offering salary incentives for the residents to stay beyond their required tenure. It also means that the people who are likely to train primary care physicians in the future will have spent a significant amount of time dealing with the challenges of practicing medicine in rural areas. An alternative model is one the FEMME model in Peru implemented, which establishes in-service short residencies or internships for doctors and nurses located in primary care facilities. They spend 2-3 weeks in referral hospitals honing their knowledge and skills in delivery and post-delivery care. They get to know the doctors and nurses to whom they would refer women in the event of an emergency. The nurses and doctors at the secondary referral hospitals also get to know their colleagues who work at lower levels of the system. A further twist on this process involved medical staff based in referral hospitals spending time in primary care facilities as well to make them more sensitive to the challenges their colleagues face in responding to maternal and neonatal emergencies, which helps them to be less judgmental and to provider better supervisory advice. In addition to providing practical training opportunities for primary healthcare providers, the policy gave personnel from both types of facilities a chance to get to know each other personally which greatly enhanced the referral and counter referral process.

Weakness: Both PROSALUD and CIES have excessively high rates of cesarean sections which is indicative of poor quality of care, as do other health centers in Bolivia. Both institutions argue

[32] Postscript 2: The Sucre network is now part of the ENLACE Project, which has been operational since September 2009.

that they are being responsive to client demand (CIES) and or that they see a higher percentage of complicated deliveries (PROSALUD). A recent WHO survey of maternal health provides compelling evidence that C-sections that are not medically necessary produce adverse short-term maternal outcomes as well (Souza et al 2010). The only place where the percentage is around the norm is in El Alto, where users have cultural preferences for vaginal births. This appears to be a health education issue, as much for doctors as for the general public in Bolivia. The practices and explanations are not in line with international standards from WHO which specify that C-sections should be no more than 15% of total births. The evaluation team did not monitor this through the SNIS as it was not available at the time of the evaluation for comparable data. The MSD has adopted the U.N. Process Indicator which makes this norm clear.

Table 6: Birthing Methods by Health Facilities

Health Facilities (Source: CIES)	Vaginal	C-Section	Total	%
C.S. C.I.E.S. SUCRE	0	2	2	100.0
H.B. CLINICA PROSALUD	54	646	700	92.3
C.S. LAS MISIONES BOLIVIANO A.	32	184	216	85.2
C.S. C.I.E.S. SANTA CRUZ	63	238	301	79.1
C.S. SANTA MONICA	28	75	103	72.8
HOSP. PROSALUD CHIMBA	186	332	518	64.1
CLINICA PROSALUD TABLADITA	100	139	239	58.2
HOSP. SAN GABRIEL	51	45	96	46.9
C.S. C.I.E.S. ORURO	277	162	439	36.9
CLINICA 16 DE JULIO PROSALUD	111	58	169	34.3
C.S. C.I.E.S.EL ALTO	196	87	283	30.7
C.S. OCURI	70	14	84	16.7
HOSP. MALLCO RANCHO	106	21	127	16.5
C.S. ALTO MIRAFLORES PROSALUD.	33	5	38	13.2

Strength: Approach to quality in IMCI and TB empowered providers to identify and put into practice creative solutions. One of the most innovative and appreciated interventions supported by JSI was their methodology for improving quality of care called short-cycle quality improvement. It empowers healthcare providers to monitor and analyze the application of 14 standards of quality of care. GCS was particularly successful at institutionalizing the use of this methodology in the TB and Leishmaniasis programs in the Yungas. In other areas, healthcare providers, particularly in secondary level health facilities mentioned how useful and easy to use they found it. They were particularly appreciative of how it transferred responsibility and decision-making power to them to assess problems and develop their own solutions.

Weakness: The USAID program did not have a unified approach to quality of care monitoring even for the same health element. Each implementing agency/T.A. provider had their own approach. GCS promoted Short-cycles; ACQUIRE promoted COPE; and CARE used Criterion-based Audits. It caused a lot of confusion, especially when several implementers worked in the same health networks and facilities.

Strength: Operational research positively engaged personnel in hospitals to adopt international protocols new to Bolivia, and putting them into practice GCS supported operational research

supervised by the Pop Council that contributed positively to influencing the adoption of evidence-based practices that are part of IMCI-Nut and maternal and neonatal health care, such as active management of the third stage of labor in conjunction with delayed cutting of the umbilical cord and immediate initiation of breastfeeding. The research strengthened the commitment of teaching hospitals and secondary level referral hospitals in remote areas to adopting recommended practices for treating severely malnourished children through an integrated approach that includes biomedical, educational, and psychosocial support. CHP integrated Save the Children's protocol for doing post-partum visits as soon as possible within the first 7 days after birth based on SC's operations research in Oruro (funded by the Gates Foundation). PROCOSI and the MSD integrated the messages and practices into their ACS materials.

Strength: USAID-funded community-level programs implemented by PROCOSI (CHP), SpD (Sub-grants), CIES (EAPC and MAC), and Save the Children (*Mejorando Nuestra Vida*) are supportive of SAFCI and Zero Malnutrition Policies. The CHP staff worked closely with the MSD Office of Social Promotion to develop materials and procedures that closely adhered to the SAFCI and Zero Malnutrition policy norms and procedures. The Manoff Group contributed to the design of the highly appreciated IMCI-Nut bowl for helping parents to accurately measure appropriate food quantities for children of different ages. CHP collaborated with the MSD on the development of training procedures, materials, and manuals for the ACS. They also helped to develop accessible measurement and diagnostic tools for assessing infant and children's nutritional and health status. The Project worked with the MSD to translate the clinical guidelines for IMCI-Nut into Community IMCI which helps parents and other household members understand how to apply practices that prevent childhood disease and malnutrition, as well as contribute to improving maternal and neonatal health outcomes.

Weakness: Unlike the efforts under IR1, there were few explicit efforts to make SRH and CH clinical services more gender equitable or intercultural. The activities dedicated to making health services more gender equitable and culturally acceptable were sporadic and disconnected from the main interventions under both projects. Neither was highlighted as an important dimension of either project in our discussion with project staff. The lack of attention to these issues is partially a consequence of the segmentation of the Strategy which caused a disconnection between community level processes and technical support to the health services. Even with that in mind, there was little attention to gender relations within the health services, either between clients and providers, or among providers. Similarly, despite the specter of SAFCI as national policy, there was little attention by either project to how facility based services could more support implementation of the policy.[33]

Summary of IR2 Findings

Through GCS, USAID has been a strong partner of the MSD and the SEDES in translating the Zero Malnutrition policy into action in the health services. Their strong management capacity permitted GCS to react with flexibility and alacrity to the changes in the Rural Health Strategy midway through its implementation, as well as to adapt to changes in national policy from SUMI to IMCI to Zero Malnutrition (and IMCI-Nut). GCS' activities in the Yungas demonstrate what might have been possible had they been able to implement activities in one region for the full five year period. In the Yungas, GCS has been able to work at all levels of the health system without the segmentation imposed by the allocation of institutional responsibilities in the Rural Health Strategy. In other project areas, the disarticulation of their interventions in service

[33] The brief experience of the masters program in community medicine supported by Socios para el Desarrollo was an exception to this general conclusion.

facilities suffers from the lack of integration with activities at the community level. With the closure of PROSIN, GCS assumed greater responsibility for IR3 type activities, especially for Zero Malnutrition, as did CHP for community-level SAFCI. Consequently, there was more integration between MSD policies and implementation at both levels than there was among USAID supported activities under IR1 and IR2. Although CIES and PROSALUD are not part of SUMI, they both offer free vaccines and reduced or no fees for a percentage of their clients. CIES and PROSALUD follow MSD policies, and in many instances have also been partners in safe motherhood and IMCI policy development. By setting institutional goals for quality of care, they also challenge the public services, indirectly to raise the bar. PROSALUD has supported improved quality of care in VCT centers and has helped to improve the processing of diagnostic tests by strengthening CDVIRs.

IR3: STRENGTHENED INSTITUTIONAL CAPACITY FOR HEALTH CARE MANAGEMENT AND SUSTAINABILITY

Context

IR3 contributes to sustainability of the improvements generated through actions under the other two IRs. IR3 supports strengthening the MSD capacity to use resources more effectively at all levels, to generate and disseminate national norms and standards, and to provide strategic and policy leadership for health. This IR promotes more effective and coordinated actions among the MSD, municipal governments, and NGOs to ensure a strong and integrated service delivery. This is achieved by improving the skills, tools, and systems needed for planning health services, allocating and managing resources, and monitoring and evaluating performance. The IR was designed to provide technical assistance directly to the MSD at the national, and departmental levels, and to work with local governments, local health directories (DILOS), health networks, and NGOs at the facility and community-levels. The focus of the IR is on improving the use of management tools and systems to improve the efficiency and effectiveness of health service delivery. In addition to focusing on systems strengthening, IR3 supports developing models for improved medical waste management at USAID-supported sites. The Strategy was designed to assist the public sector to:

- Improve the capacity of the central, department and municipal level to make informed decisions;
- Support the improvement of logistics and commodity management;
- Address human resource needs, such as training and allocation;
- Strengthen quality of care, including making services more culturally accessible to indigenous groups;
- Promote more effective community health models that build on local traditions and beliefs;
- Strengthen the capacity to plan and monitor key health programs (child survival, maternal-neonatal health, family planning/reproductive health, infectious diseases, including HIV);
- Help the MSD develop policies for population, health and specific interventions such as immunizations.

As the public sector has limited capacity to cover all Bolivians who are not insured by private health insurers or the social security system, this IR also supports strengthening the financial sustainability of NGO healthcare providers, which provide a significant proportion of health services to the peri-urban and rural poor, and in many parts of the country, work in close partnership with the public health system. For both public and NGO health networks, the IR supports improvements in:

- management of health services

- health information systems and increase the their use for decision making
- epidemiological surveillance systems
- logistics management systems

The Indicator for measuring achievement of IR3 is:

(1) Self-sufficiency of key Bolivian health NGOs: PROSALUD and CIES[34]

PERFORMANCE DATA TABLE				
FISCAL YEAR	TARGET CIES	ACTUAL CIES	TARGET PROSALUD	ACTUAL PROSALUD
2006	Baseline	56	Baseline	88
2007	59	N/A	95	N/A
2008	60	63	95	81
2009	75	---	100	---
2010	TBD	---	TBD	---

The other two indicators, were dropped in February 2009 as a consequence of the early close-out of the ACQUIRE Project. GCS/JSI continues to track the indicator in the facilities it supports.

(2) Percentage of target facilities with no stock-outs of essential commodities (Contraceptives and Vaccines)[35]

FISCAL YEAR	TARGET	ACTUAL	ACTUAL Contraceptives	ACTUAL Vaccines
2005	Baseline	80.5	---	---
2006	82.9	87.0	---	---
2007	85.3	86.5	---	---
2008	87.5	89.0	---	---
2009	87.5	---	---	---
2010	N/A	---	---	---

[34] This indicator is defined as "The percentage of PROSALUD's and CIES's operating costs per year covered with non-USAID income (from services and products, other donors, municipalities, etc.). [Since PROSALUD receives free contraceptive donations from USAID, which it sells in a social marketing program, the cost of and income generated from selling USAID contraceptive donations is excluded in calculating their self-sufficiency.]"

[35] This indicator is defined as "Percentage of total health facilities surveyed in the intervention coverage area with no stock-outs observed on the day of the survey visit of Contraceptives (Depo-Provera (DEPO) and condoms) or vaccines (BCG, Polio, Pentavalent and Tetanus Toxoid). This composite index gives 50% weight to contraceptives and 50% weight to vaccines."

(3) Percentage of target facilities using MSD policies and norms (as evidenced by their presence in facilities)[36]

PERFORMANCE DATA TABLE		
FISCAL YEAR	TARGET	ACTUAL
2005	Baseline	28.7
2006	40.2	48.0
2007	51.7	72.5
2008	81.0	78.0
2009	81.0	---
2010	N/A	---

The two sub-IRs that support achievement of the IR3 are:

- IR 3.1 Increase the capacity of the public and private health services for results-based management in select municipalities
- IR 3.2 Increase the financial sustainability of public and private health services

The principal partners implementing programs or providing technical assistance under IR3 are (or were):

(1) PROSIN: The Integrated Health Project (PROSIN) was a technical and normative unit integrated within the MSD and its 2,261,000 departmental entities. PROSIN focused on capacity-building at the central (MSD), departmental (SEDES) and regional (health network) management levels, providing technical assistance in the areas of IMCI, sexual and reproductive health, malaria, tuberculosis and other infectious diseases. PROSIN also assisted the MSD, SEDES and health networks to fulfill their roles and responsibilities in supporting the development, negotiation, implementation and monitoring of local health plans integrated municipalities. These plans served as a basis for the implementation of JSI's GCS project and were linked to community-based services supported through the Community Health Project implemented by PROCOSI. PROSIN facilitated coordination between USAID and the MSD, and among USAID's implementing partners in the health sector. The project closed in August, 2006.

(2) GCS: The Management and Quality in Health Project assumed much of the coordination and system strengthening role that PROSIN played in SEDES. The project also promotes increased municipal investments in health through municipal matching funds. GCS worked closely with the MSD on developing implementation approaches for Zero Malnutrition's integrated nutrition units (UNI) and on the IMCI-Nut clinical protocols. After the DELIVER project ended, GCS took on the role of logistics management trainer and technical assistance provider for SEDES and health networks.

(3) ACQUIRE: (closed June 2008): ACQUIRE worked with the MSD to develop protocols for the implementation of Emergency Obstetric and Neonatal Care networks. They contributed to policies on referral and counter-referral systems.

[36] This indicator is defined as the "percentage of all target PROSALUD, CIES, and MOH health facilities surveyed with presence of all of the following reproductive health (RH) norms: 1) technical procedures for prevention and control of infections; 2) norms, regulations, protocols and procedures for contraception; 3) norms and technical procedures for management of hemorrhage in first half of pregnancy; 4) and child survival (CS) norms on Integrated Management of Childhood Illness. [This composite index gives 50% weight to RH norms and 50% weight to CS norms.]"

(4) SpD: Has an extremely flexible cooperative agreement mechanism and scope of work that allows it to act much like a contractor. USAID has taken advantage of this flexibility to assign a variety of implementation and technical assistance roles to SpD. As needs arose, USAID/Bolivia amended SpD's agreement to incorporate the response to new needs. For IR3, SpD provided TA to a number of national health programs (e.g. Malaria, STI/HIV/AIDS, Avian Influenza, H1N1 Influenza), especially to strengthen epidemiological surveillance and emergency response systems. SpD was also responsible for managing the Mission's performance monitoring plan (PMP) and aggregating data from all USAID-funded programs. In addition, SpD also has responsibility for improving the management of medical waste through training and technical assistance to hospitals. SpD plays a key role in strengthening the capacity of municipalities to plan, finance, and manage health services through their municipal management training program.

(5) Manoff Group: The Project provides technical assistance to the PROCOSI NGO network in the areas of reproductive health (maternal health and family planning); integrated health care for children under five (including nutrition and newborn care); infectious diseases (tuberculosis, malaria, Chagas, leishmaniasis, STIs); and institutional capacity building to strengthen PROCOSI members' technical and administrative capacities to implement activities under the Community Health Project.

(6) DELIVER (JSI): The project provided technical assistance to the MSD Pharmaceutical Unit in developing its logistics system for essential pharmaceuticals and commodities. The project also helped improve PROSALUD's social marketing program by improving their capacity to disseminate health commodities at service delivery points.

(7) MSH: This project provided technical assistance to CIES to improve its management capacity and sustainability.

(8) URC: In support to the National Tuberculosis Program, and in coordination with the Gestión y Calidad Project, (GCS) the Project documented the extent of current use of the Tuberculosis CD with public health workers and in universities, and it introduced a "collaborative approach" to improve the implementation of DOTS in USAID target areas through in-service training (based on use of the CD) and the use of team-based continuous improvement methodologies.

(9) Health Systems 20/20: This is a USAID field support project that provides technical assistance to PROSALUD to improve its management and organizational systems in order to make it more sustainable, while maintaining its mission of providing services to under-served areas.

IR 3.1 Increase the Capacity of the Public and Private Health Services for Results-Based Management in Select Municipalities

Strengths and Weaknesses

Management and Coordination Issues:

Strengths and Weakness: Contraceptive Security Issues: Contraceptive security is a perpetual challenge in the Bolivian health system. USAID has been one of the major donors, and sometimes the only donor, to consistently focus programmatically on this issue. USAID provided technical assistance to the Bolivian government through the DELIVER project for more than 10 years, when the essential pharmaceutical and commodities logistics component was

integrated into GCS. GCS has been supporting the municipal institutional pharmacies which are the key distribution points for drugs and supplies for health networks. The project has been successful in computerizing the old manual tracking system; developed a user's manual; conducted a training workshop; and by the summer of 2009, had conducted workshops in almost all municipalities where GCS was working.[37] The weakness of the approach is that many health posts within health networks do not have consistent access to computers or even electricity. They continue to be dependent on calling in their monthly reports via antiquated two-way radios that also do not function consistently. The other weakness is that once the supply lists are put together by the health network, it is still up to the municipal government to budget for and purchase the supplies and drugs; however, municipal officials have not been included in the training. SpD offers a parallel training (not always in the same municipalities, however), that focuses on the municipal health and finance authorities. During the evaluation process, JSI and SpD had begun to better coordinate their training schedules and respective content of the trainings. To further complicate matters, the period also coincided with problems in the provision of contraceptives to the public sector as Bolivia no longer receives donations, except for the contraceptives donated by USAID for distribution through sale by PROSALUD. The GOB's tax authority has insisted that any new donated contraceptives designated for sale, should be taxed. Many municipal governments are among PROSALUD's social marketing clients; therefore, this new ruling has wide-reaching consequences for family planning programs and users throughout the country. The issue is unlikely to be resolved until the U.S and Bolivia renew diplomatic relations at the ambassadorial level.

Strengths and Weaknesses: Municipal management training by SpD municipal management training was not offered in Rural Health Strategy municipalities until fairly recently: The municipal management training offered by SpD is for municipal officials responsible for funding and overseeing the administration of health services within their jurisdiction. It complemented the logistics management training provided by GCS to healthcare personnel. Unlike the GCS training however, the SpD training brought together municipal authorities with healthcare administrators to help them understand the different roles they play in the procurement of essential drugs and medical supplies and the training also covered the different laws and regulations that affect the procurement of supplies for different programs and anticorruption laws. Over the last several months, GCS and SpD have coordinated the trainings to offer them in the same municipalities. For the majority of GCS municipalities, the additional training by SpD has occurred considerably later than the GCS training, causing considerable delays and frustration with the procurement of drugs and supplies. The joint training resolved problems in understanding between the health services and municipal government about the importance of purchasing the supplies in a timely manner but they do not resolve problems of storage and the division of bulk purchases into smaller quantities and distribution to health clinics and posts throughout the municipality. There are additional constraints that also need to be addressed,

[37] GCS was also responsible for helping health networks to improve the timely availability of drugs and supplies by training the pharmacy technical advisors in the SEDES and people responsible for managing supplies in health networks in the MSD's logistics management software (SNUS). The process has improved the knowledge of people at the apex of the supply chain, usually located in the secondary level hospitals or the offices of the directors of the health networks, but there are still problems lower down the demand chain at health posts and primary clinics, as well as at the top of the chain among municipal government officials who are responsible for allocating the budget and purchasing the drugs and medical supplies. At the lower end of the demand chain, healthcare providers are hampered by poor management skills and limited access to electricity and computers to input the data. At the upper levels, the problem is that GCS did not include municipal officials in the training so they have little understanding or appreciation for the quantities and timing of the need for specific drugs and supplies.

such as shortages of certain drugs and supplies in the market, municipal budget constraints, and competing political priorities for funding in the municipalities. It is necessary to engage local officials, healthcare administrators, and local populations in developing some creative solutions. If the multi-tiered health committees that are a pillar of the SAFCI model work, they will provide a social and political mechanism for addressing some of these challenges.

Strength: USAID and the MSD had found a mechanism in PROSIN II that satisfied both MSD's role as national health leader/steward and USAID's need for fiscal and technical accountability. PROSIN II was able to move beyond the limitations of PROSIN I where it was sometimes perceived as a parallel MSD to a more integrated role of coordinator or activities in support of national health policy and MSD and technical advisor. PROSIN II was more directly integrated at both the national and departmental (SEDES) levels. The project also played a more effective role in coordinating other USAID funded programs in support of national health priorities. Some of the key lessons learned noted in the final report[38] that are instructive for USAID's design of the 2011-2015 Strategy are:

1. The alignment of USAID's strategy/programs with MSD plans strengths financial, technical, and social sustainability, and program impact.
2. A strong coordination mechanism ensures interagency cooperation; synergies among programs and health components; and averts duplication of activities and efforts, facilitating the likelihood of greater program impact.
3. Intersectoral and interdisciplinary collaboration make health services more responsive to demand.
4. Operations research is important to the development of better policies and health programs.
5. The lack of a plan for human resources development undermines the efficacy of training.
6. Failure to document and systematize experiences leads to wasteful and unnecessary spending on consultancies that constantly reinvent the wheel.
7. Support and strengthening of the stewardship role of the MSD will positively impact technical quality and sustainability of the health system.
8. Strengthening the knowledge of municipal authorities regarding their health responsibilities and support functions will improve health outcomes.
9. Strengthening inter-institutional coordination between the SEDES and DILOS will result in better and more opportune decisions.
10. Social participation in the DILOS is critical in order for them to to function effectively.

Weakness: Upon Cancellation of PROSIN, the USAID Health Team did not establish a formal mechanism for communicating and collaborating across implementing organizations.
While PROSIN was by no means a perfect mechanism, it was an effective vehicle for helping the MSD and USAID to coordinate of activities implemented at different levels of the health system. PROSIN II was based on a model in which there were advisors in both the MSD in La Paz as well as in the SEDES. PROSIN played a critical role in negotiating with the municipalities to include healthcare as a priority area for funding in the 5-year Municipal Development Plans (PDMs) and the Annual Operational Plans (POAs). Regional PROSIN advisors facilitated negotiations between the SEDES and municipalities, while also making both entities aware of the requirements of national health policies. As part of the negotiations, PROSIN II also brought in

[38] Lopez, Jhonny 2006, "Proyecto de Salud Integral (PROSIN): Informe Final 1999-2009 (ended 6/7/06)." Ministerio de Salud y Deportes y USAID.

communities to participate in the POA process. The Manuela Ramos/WARMI II methodology was instrumental in ensuring that both women and men had a say in the POA process. PROSIN II was structured in order to coordinate activities across the three IRs. Once PROSIN ended, GCS, CHP, and EngenderHealth formed a coordinating committee to try to integrate activities at different levels of implementation. With the change in regional focus, each organization focused inward to get activities up and running in new areas, and lost sight of trying to coordinate, especially when their implementation schedules diverged. By default, responsibility for coordination shifted to the USAID Health Team, but it was neither feasible not practical for them to take on coordination of activities in the field. The USAID/Bolivia health team was understaffed and had undergone several leadership changes in a short period of time; all this occurred at the same time the USAID health office had to make radical adjustments in the Strategy in response to changes in bilateral relations.

Strength GCS has contributed to improved coordination in some Departments (Tarija and Chuquisaca). In Tarija, GCS worked with the SEDES Technical Director for Child Health to establish an IMCI-Nut coordinating committee composed of the SEDES, GCS, and CHP implementing organizations. They developed a yearly operating plan and a monitoring and supervision plan which they have implemented for the past two years. In Chuquisaca, the SEDES, with GCS support, has invited all NGOs implementing health programs in the Department to participate in the development of the annual operating plan for 2010. For this first time, the SEDES will incorporate the NGO activities along with public sector healthcare as part of the operational plan for the Department.

Improved policies:

Strength: USAID-supported implementing partners (particularly GCS, CHP, Save the Children, and CIES) supported the MSD in interpreting and developing replicable implementation models. During the evaluation, MSD officials praised CHP and GCS for technical collaboration in helping to define and implement SAFCI and Zero Malnutrition policies. CHP helped the MSD to develop viable and practical implementation strategies for SAFCI. This was a major breakthrough as there were many different visions within the MSD about what implementation of the policy should look like. PROCOSI worked with the Social Promotion Unit in the MSD on developing processes and materials that were consistent with both SAFCI and Zero Malnutrition. In the process, they helped to clarify the policy, especially with regard to the roles procedures to be followed by the ALS and the Local Health Committees (CLS). PROCOSI also helped to develop a community IMCI-Nut approach that is complementary to the clinical model. GCS supported the MSD in the development and implementation of Zero Malnutrition and IMCI-Nut. GCS worked with the MSD to develop the IMCI-Nut clinical practices and protocols necessary to implement the Zero Malnutrition policy. Both PROCOSI and JSI have a great deal of policy credibility with the MSD. It would be in everyone's interests, especially that of rural populations, for the two organizations to engage the MSD and civil society organizations in policy dialogue on aspects of policies, such as the UNIs in Zero Malnutrition, or aspects of the Bono Juana Azurduy, that have technical weaknesses that may impact on successful implementation. USAID implementing partners have also had a role in supporting the development and implementation of other policies. Save the Children and CIES have been key participants in the development of the national adolescent strategy. PROCOSI and SAVE have also been involved in the development and review of the National Plan for Maternal and Neonatal Health. Unfortunately, there has been less engagement than in the past of USAID implementing organizations in the development and review of the National Sexual and Reproductive Health Plan which is supposed to be issued shortly.

Weakness: There was a lack of critical technical analysis of the requirement in Zero Malnutrition to build a UNI in every municipality categorized as having a high level of food insecurity.
GCS co-financed the building of Integrated Nutritional Units (UNI) in several municipalities without a careful analysis of whether they would be staffed, used, or maintained by the municipal government. GCS rightly asserts that they are merely assisting municipal governments to implement national policy. It was evident during the evaluation, however, that few of the UNI's would ever be used sufficiently to justify the cost of their construction, staffing, and maintenance. Despite the policy, it seemed doubtful that the MSD, the SEDES, or the municipalities had the financial and human resources to staff the UNIs according to the requirements of the policy. One of the most surprising findings was that GCS had made no visible effort to engage the MSD in a policy dialogue about the feasibility of implementing the policy as it is written, rather than doing an assessment of whether it might not make more sense to establish regional UNIs to serve several food insecure municipalities with contributions for funding from all of the participating municipalities. Most food insecure municipalities are clustered together in particular parts of the country. Food insecure municipalities also tend to be poor municipalities with highly dispersed populations. Even if they could all received counterpart funding, few municipalities will be able to afford to maintain the UNIs. [39]

IR3.2 Increase the Financial Sustainability of Public and Private Health Services

Strengths and Weaknesses

Strength: Support to PROCOSI (Manoff Group), CIES (MSH) and PROSALUD (Abt) on management and financial sustainability. There are visible improvements in the management plans and financial sustainability of all three organizations. CIES has been able to turn the page on a very difficult period during which it experienced major threats to its institutional viability. CIES management systems have improved and it is nearly 85% financially sustainable. PROSALUD weathered the closing of multiple health centers in El Alto which probably improved their bottom line but were a serious blow to their public image. PROSALUD has also been able to recuperate fairly rapidly from the global economic crisis as a result of good financial decisions and management practices. Both organizations have benefitted from new and dynamic leadership by strong and highly competent directors. PROCOSI has also diversified its financial strategies and improved its information and financial systems. PROCOSI is currently piloting a healthcare and consumer debit card financed by remittances from emigrants to Spain (and eventually in the US as well) for their families in Bolivia. They have also launched a US –based NGO called Friends of PROCOSI to try to raise funds in the United States.

Weakness: In order to meet financial sustainability objectives, CIES and PROSALUD are straying somewhat from their original mission. At least temporarily, CIES's and PROSALUD's strategies for to achieve financial sustainability appear to have come somewhat at the expense of the provision of SRH services. The total number of SRH at PROSALUD has declined, while CIES SRH consultations have held constant but are now a smaller percentage of overall consultations than they were previously. While it might appear that the general climate in the country has

[39] Despite some real accomplishments on the development of protocols and implementation approaches to MSD policies, the general climate of US-Bolivian relations has meant that USAID and its partners have had very limited capacity to engage in dialogue on major policy issues. On technical themes, there is more space – but on major policy issues, not so much.

contributed to the lack of growth in SRH services, it might also be a factor of both organizations' attention to other services that are more lucrative. It may also be a factor of a lack of innovation and activism. In the same period of time, for example, Marie Stopes' SRH services have grown, as they focused on increasing volume and decreasing costs. Marie Stopes offers similar services to both PROSALUD and CIES at much lower costs. They have also expanded access to surgical contraception, even in rural areas through mobile clinics. Both CIES and PROSALUD told the evaluation team that there is very little interest or demand for surgical contraception (either tubal ligation or vasectomies) in the country, but Marie Stopes' experience seems to prove otherwise.

Summary of IR 3

The relationship between the Health Team the MSD cooled with the decision to change the location of the Rural Health Strategy and the closure of PROSIN II. Despite the hardship, delay, and closure of PROSIN, the remaining implementing partners were able to re-establish good working relations with the MSD and SEDES in the new areas. Partners for Development (SpD) continued to work in the original areas in Chuquisaca, La Paz, and Potosi. PROCOSI worked closely with the MSD to develop community level materials for the National Zero Malnutrition Program. GCS worked on the clinical guidelines. Both CIES and PROSALUD, despite some contretemps of their own with the government continued to provide private sector services in capital cities and to work collaboratively with SEDES.

To their great credit, many of USAID's implementing partners continued to work with the MSD on a technical level. These ongoing positive relationships have managed to keep open channels of communication between the MSD and USAID, and more recently have been a contributory factor to improved communication between USAID Health Team and MSD leadership. They have also resulted in some real achievements that are of direct benefit to the Bolivian population, such as PROCOSI's support to the MSD in developing a practical approach to SAFCI participatory co-management at the community and municipal levels; JSI's and PROCOSI's inputs into AIEPI-unit clinical and community training and materials; Save the Children's contributions to the national adolescent policy; and SpD's strengthening of HIV policy and national program implementation. Additionally, the Mission made the Evaluation Team aware of some other achievements that were not brought to their attention during the evaluation process. These are:

GCS participated in the development of the MDH National Guidelines in CAIs methodology. Their training in CAI methodology and health management has been an important part of the interventions. In FY08, a total of 606 health professionals participated in training courses related to data analysis, data quality and CAI methodology. In FY09, the training has been more during the different events- having trained a total of 93 health professionals. In FY08, a total of 102 people were trained in health management and development of municipal annual work plans.

GCS together with WHO/ OPS is training personal from SEDES and those responsible for statistics and data management in special data analysis packages, that facilitate the data analysis and presentation.

GCS has also provided support for donor coordination at departmental level. They helped to reactivate interagency committees at departmental level and the functional and meet regularly in the 4 departments. In Chuquisaca, the technical support of GCS to SEDES has been fundamental for the organization of the first meeting, providing tools for the mapping of other institutions and logistical and technical support. This committee is now meets regularly.

GCS's municipal matching funds included projects developed by municipalities (and approved by USAID). Municipal POAs have witnessed an increase in municipal investments in health interventions. GCS performed due diligence on the municipalities' counterpart portions of the construction to ensure that all commitments are met.

SpD and GCS have collaborated on strengthening the development of the health portion of annual operating plans at municipal level. This intervention has been conducted partially with management (to their municipal management perspective). The Project has participated in the development of these work plans in more municipalities than the ones targeted with SpD. The Project has conducted follow-up of the implementation of the municipal Annual Operational Plans (POAs). GCS has also assisted the DILOS to develop the annual workplans using the participatory approach (during FY08 58% of all DILOS in the intervention area of GCS received support) in 33 out of 57 targeted DILOS.

PROGRAM ANALYSIS: ACHIEVEMENT OF THE STRATEGIC OBJECTIVE

Through GCS's work on logistics and TB and PROCOSI's work on community SAFCI, USAID Rural Health Strategy implementers have had an impact beyond the municipalities targeted by the Strategy. In addition, SpD's municipal management training work and PROSALUD's contraceptive distribution activities contributed to the aims of the Rural Health Strategy, even though they were not formally part of the strategy. Because of the disruptions caused by the change in geographic focus of the Rural Health Strategy, USAID dropped it as an organizing and coordinating mechanism for their health activities since the beginning of 2008. The Health Team has also made an effort to move beyond a segmented and isolated approach, as driven by the original design of the Strategy, to a more integrated focus on strengthening health networks in underserved municipalities, a purpose that was interrupted when the original implementing organizations of the RH were not able to either completely relocate in the same municipalities or to coordinate their efforts in the ones they did overlap in.[40]

In 2010, USAID attempted to integrate across health elements (MH, FP, and NH) as well as across different levels of the health system through the ENLACE Program. The program was an interim step to redress the set of circumstances related to ACQUIRE's failure to contribute adequately to the objectives of the Strategy, which had a major impact on the provision of quality SRH and maternal health services in Bolivia. USAID has been the largest bilateral supporter of public and private SRH services in Bolivia for the last 20 years. The confluence of factors which include ACQUIRE's poor performance, lack of strong political support for SRH, and the absence of an IEC and social marketing program has affected the provision and quality of SRH services. Preliminary and unofficial results of the Demographic and Health Survey (DHS) indicate a slight decline in CPR. Neonatal and Maternal mortality appear to have stagnated in five years. Interviews conducted during the evaluation with providers, healthcare administrators, program managers, and technical experts, reveal a consensus opinion that there is a less varied supply of contraceptives (particularly of IUDs, pills, and surgical contraception) offered by healthcare services as a consequence of a decline in providers skills and shortages of supplies. Some of the most notable changes during this Strategy as compared with earlier USAID Strategies are:

- No dedicated program of IEC/BCC and social marketing
- No institutionalized national training capacity as there had been when there were regional training centers located in Departmental teaching hospitals
- Health services do not prioritize contraceptive supplies and do not articulate their importance to municipal governments charged with purchasing them
- Few effective communication and advocacy channels for women and men to communicate their interest in SRH to policy makers
- Less active and vocal champions of reproductive rights within the government and in civil society
- Funding cuts for important elements of the strategy (e.g. infectious diseases and HIV/AIDS) midway through the Strategy
- Overemphasis on medicalized models for family planning to the detriment of other distribution models (e.g., community based distribution, better advertised social marketing, and more robust peer education on SRH)

[40] In September 2009, the Mission funded a one year project called ENLACE to try to recapture the health network focus in order to better address maternal and neonatal mortality, which are among the health indicators that have not improved in the last 5 years. Coordination among numerous organizations continues to be a significant challenge.

- Premature emphasis on sustainability and self-sufficiency (i.e. , cessation of importation of donated contraceptives for the public sector; pressures for financial sustainability on private providers who are forced to achieve that by diversifying their health services instead of more vigorously promoting SRH services).

The misdirected focus of ACQUIRE on theoretical SRH training rather than on providing T.A. on SRH, which resulted in its early termination, also affected the possibility of improving availability, access, and quality of maternal and neonatal health services, particularly of the interventions that contribute to saving lives, such as active management of the third stage of labor, treatment of hemorrhage during the first half of pregnancy, provision of quality EmONC paired with effective community mobilization, access to post-partum FP, and proven Neonatal practices, such as early initiation of breastfeeding, delayed cutting of the umbilical cord, Kangaroo care for premature and underweight babies, and good antenatal care.

COORDINATION AND LINKAGES TO NATIONAL HEALTH POLICIES

The contribution of several projects to improve technical and management practices was achieved through close coordination with SEDES and joint planning in some regions.
In all the three Departments visited, the evaluation team found evidence of good working relationships among PROCOSI CHP implementing organizations, GCS, and the SEDES. In Tarija, CARE and ADRA were part of an IMCI-Nut coordinating and implementation committee, convened by the SEDES, which jointly planned and monitored IMCI-Nut activities in the Department. JSI (Gestion y Calidad) and PLAN International also participated along with the CHP coordinator[41] and the Director of Child Health for the SEDES. In Chuquisaca, CHP organizations and GCS coordinated and collaborated closely with the SEDES in support of implementation of Zero Malnutrition. The SEDES also had recently convened all implementing organizations in the Department to coordinate future actions. The Director of SEDES emphasized the important contribution that PROCOSI organizations and other USAID funded programs make to improving health in Chuquisaca. In Santa Cruz, it was evident that the CHP implementers also had close working relationships with the SEDES, particularly with the directors of health networks. In all three Departments, the SEDES directors made direct pleas for continued technical assistance (Tarija, Chuquisaca, and Santa Cruz) and funding (Chuquisaca) from USAID.

CHP also collaborated with the MSD on developing informational and training materials for the ALSs. Although the MSD clearly specified the role of the ALS in the SAFCI, there was little attention to how to operationalize the approach in the policy document. By developing a community handbook to inform the community about the responsibilities and election of the ALS as well as a manual for the ALS to guide them through their management and oversight roles, CHP assisted the MSD in translating policy into action.

Until very recently, there was no clear strategy on how to distribute the feeding bowls and ACS educational materials beyond the reach of CHP communities. The Project printed barely enough to cover the ACS and households in the project area. There were no materials available to distribute to the health services in project municipalities. Consequently, there was little effective coordination between the ACS and the health services in many project areas due to changes in the USAID Strategy and differences in timing and sequencing between GCS and CHP activities. For the most part, healthcare providers did not participate in training sessions for the ACS and had limited access to materials. Nevertheless, there were some rare exceptions, such as in San

[41] The CHP Coordinator participated up until a reduction in funding terminated his position.

Ignacio de Velasco where the Auxiliary Nurse Training School incorporated the ASC training course and materials into their standard curriculum so that it would form part of all auxiliary nurses training. In other areas, CHP implementing partners photocopied materials for healthcare providers but as they were designed graphically to be used by people with limited literacy, the materials lost much of their educational value when reduced to black and white.

This problem had been overcome by the end of July 2009, with changes in personnel in the MSD Social Promotion Unit, CHP's primary partner in the MSD had shifted to the Zero Malnutrition Unit in the MSD which revised some of the materials to make them more user-friendly and replicated them in greater quantities for distribution to ACS and healthcare providers. In addition, the MSD developed a new module on early childhood development and stimulation. The MSD has engaged the wider PROCOSI network, in addition to the CHP implementing partners, in the distribution and training of local healthcare providers on how to train ACS in other regions. This effort promises to address one of the major constraints of the CHP project, which was not supposed to train healthcare personnel. It is also a strong acknowledgement on the part of the MSD of the PROCOSI network as strategic partner in expanding access to healthcare in the country.[42]

[42] This finding came to the attention of the team as a result of two team members' (Marcia Ramirez and Deborah Caro) participation in the launch workshop on July 24th at PROCOSI.

LESSONS LEARNED AND RECOMMENDATIONS FOR NEXT STRATEGY

1. The new strategy should have a more explicit focus on the reduction of social exclusion from healthcare. The orientation of the 1998-2004 strategy prior to the 2005-2010 strategy focused on areas of greatest need and were able to demonstrate greater impact on health indicators, especially in areas targeted by USAID programs (see PROSIN final report) such as neonatal mortality rate, malnutrition, maternal mortality ratio, infant mortality, and contraceptive prevalence rate, than is evidenced by the latest 2008 DHS. There is increasing evidence that in Bolivia, the poor and indigenous populations, especially in rural areas, suffer disproportionally from health problems and are least likely to access health services.

2. Strengthen articulation of levels, processes, and different social actors in the health system:
    - Among households, communities, municipalities, departments, and the national level
    - Across different levels of care (household, ACS, primary, secondary, tertiary healthcare facilities)
    - Across different sectors
    - Between Rural/Peri-urban/Urban areas (e.g. such as between El Alto and the municipalities from which migrants come)

3. Improve understanding of municipal governments of the importance, and strengthen support, and management of local government for healthcare (both at Prefectural and Municipal levels).

4. Develop more appropriate and effective technical assistance and training models to improve provider technical skills, attitudes, and intercultural and gender competence. Many of the gender and cultural competence materials are oriented toward program managers rather than healthcare providers. It would be worthwhile investing in the development and dissemination of more culturally appropriate and gender sensitive materials for healthcare providers and administrators.[43]

5. The best way for USAID to strengthen the MSD's stewardship role is through collaborative partnerships such as those modeled by GCS and CHP, and now ENLACE. These were efforts where USAID funded programs bring technical and social knowledge to help the MSD develop the tools to effectively implement policies. In the process of working through implementation modalities, weaknesses in the policies often come to light and are more easily addressed when the changes solve particular implementation problems. At this time this is a better approach than USAID taking on a direct role in influencing policy making. Another potential role for USAID funded organizations is in developing grassroots capacity in advocacy (see suggestion 7 below). This builds on other successes, such as GCS work on municipal CAIs and PROCOSI's work on community CAIs.

6. The original intention of the Rural Health Strategy to focus on municipal health services was consistent with MSD policies and good policy overall at the time the strategy was developed. The lack of an integrating mechanism during implementation of the Rural Health

[43]Examples include PROCOSI/Population Council's Gender-friendly Services Accreditation materials, Family Concern International's series on intercultural approaches to SRH and Maternal Health (http://www.familycareintl.org/fr/resources/publications?language_id=3&sort=title), and CARE Peru's and the Peruvian government's gender and intercultural module (and the Bolivian adaptation for ENLACE which is in process).

Strategy, however, meant that there was little synergy or interrelationship among the interventions at different levels of the health system. Both the MSD and USAID have now turned their focus to health networks which will contribute to strengthening integration among different levels of the health system. It is recommended that the new strategy focus on health networks from a health systems approach within the policy framework of SAFCI. The results should be integrated across levels of the health system rather than organized by level as in the 2005-2009 results framework.

7. Develop creative solutions to high turnover of healthcare providers, especially in rural areas. PROSIN offered some interesting possibilities in terms of human resource planning. PROCOSI might be a good interlocutor to reopen discussions with the MSD about a Masters Degree or residency in family and community medicine focused on integrated primary care for doctors and nurses based in health centers, to complement rather than compete with the SAFCI residency.

8. Reactivate and potentially build grassroots support for SRH in order to advocate more effectively at the national level. It is important to build this support among indigenous organizations, to more actively engage men, especially indigenous men, and to build support among municipal and community leaders. Renewing USAID's former leadership in IEC/BCC and community mobilization is key to this effort.

9. Operationalize SAFCI by strengthening social networks/movements and ensure broad and diverse participation in planning, management, and oversight (take advantage of best practices, community census, CAI, social mobilization approaches (e.g., WARMI II, MAC, EAPC, etc).

10. A complex program, like the one undertaken in support of the USAID 2005-2010 strategy requires a strong coordination mechanism, especially when so many interdependent actors and activities are involved. It is neither feasible nor practical for the USAID Health office to play that role. USAID should consider developing a comprehensive bilateral project capable of coordinating an integrated implementation of all health elements at all levels, or have multiple implementers but designate one entity as the coordinating and monitoring mechanism.

APPENDIX A. SCOPE OF WORK

Rapid Assessment of USAID/Bolivia Health Program
Design of a New Health Strategy
(GH Tech Revised: 2009-05-13

I. Objectives and Purpose of Assignment

USAID/Bolivia seeks assistance from GH Tech for a three-month assignment that will accomplish two objectives: (1) assess the current Mission Health Strategy (2005-2009), and (2) design of a new health strategy for the 2010-2015 period. To accomplish the first objective, a GH Tech team will review progress and performance in health over the FY2005-FY2009 period, as well as assess implementation approaches. This task is complicated by a shift in strategic approach in 2006 in response to a changed political landscape and the lack of specific performance expectations in the formal agreements with implementing partners.

Once this process is concluded, USAID will initiate program and activity design activities building on the newly proposed strategy.

II. Performance Period

This assignment is envisioned to begin o/a May 2009 and to be completed by August 2009.

III. Funding Source

The assignment will be funded through field support to GH Tech using a combination of Child Survival and Family Planning/Reproductive Health funds. Illustrative cost estimates for the assignment are in Section IX.

Background

The development context that USAID/Bolivia faces since the formulation of its Health Strategy (originally covering the period 1998-2004 and updated for the years 2005-2009) has changed on several fronts. Within Bolivia, the Morales government has developed a broad National Development Plan to guide development programming and coordination with international donors, and the Ministry of Health (MOH) has developed a national health sector strategy that changes the focus of the health care model to prevention and health promotion at the family and community levels, rather than facilities-based curative care.

The US government (USG) has also redefined its development priorities by introducing a broad Transformational Diplomacy and Foreign Assistance ("F") Framework that requires USAID missions to relate foreign assistance expenditures to specific Program Areas (e.g. Health) and Elements (i.e. technical intervention areas such as maternal-child health, Tuberculosis or reproductive health). *(See USAID's Automated Directives System (ADS) 200 series for additional information.)*

Within this changing context, USAID/Bolivia must now assess the results achieved through its current program and develop a new health strategy so that the Mission's health activities achieve the greatest impact possible, can be measured against USG indicators and contribute to the Government of Bolivia's (GOB) own health sector priorities and policies.

A. <u>Health Indicators and Challenges</u>

Despite impressive health improvements between1997-2003, Bolivia's health statistics continue to reveal large disparities between rural and urban areas and by wealth quintile, and remain among the poorest in the region, with only Haiti performing below Bolivia on key indicators.

Indicator	Total			Urban			Rural		
Survey year	1998	2003	2008	1998	2003	2008	1998	2003	2008
Total fertility rate (TFR)	4.2	3.8	3.5	3.3	3.1	2.8	6.4	5.5	4.9
Modern contraceptive prevalence rate (CPR) (%)[1]	25	35	34.6	32	40	40.2	11	25	25.7
Infant mortality rate[2]	67	54	50	50	44	36	90	67	67

[1] currently married women

[2] deaths/1,000 live births

Source: Encuesta Nacional de Demografia y Salud, 1997, 2003, and preliminary report for 2008.

It was expected that the 2008 Demographic and Health Survey (DHS) would demonstrate significant reductions in maternal and child mortality as a result of the Government of Bolivia's (GOB) implementation of an expanded insurance system. Preliminary 2008 DHS data does, in fact, indicate overall progress in reducing total fertility and infant mortality since 2003, but gains are much stronger in urban than rural areas, and there are some inconsistencies in data that have yet to be explained. For example, TFR in rural areas has reportedly decreased from 5.5 to 4.9 in rural areas, but CPR has only increased from 25 to 25.7, and the reported infant mortality rate in rural areas hasn't improved at all since 2003. In addition, the national rate for chronic malnutrition has remained stagnant (at about 26.5) since 1998. However, the reality is that widespread poverty, limited infrastructure, socioeconomic inequity, geographic isolation, strong cultural preferences with respect to health practices, excessive turnover of public sector staff, chronic government resource shortages and a highly complex political situation combine to create a challenging environment in which to design effective programs and achieve sustainable results.

B. Country Strategic Plan

USAID/B's Country Strategic Plan (CSP) for the FY2005-FY2009 period was approved in September 2004. In support of an overall goal of sustained and equitable development under democratic rule of law, the Plan includes strategic programs in the areas of economic opportunities, health, environment, integrated development, and democracy. The health section of the CSP was developed in consultation with the Ministry of Health. The overall approved funding level for the Health Strategic Objective approved under the plan was $71.518 million.

In 2007, USAID initiated the "F" framework and shifted the focus from CSPs -- which are based on Results Frameworks including Strategic Objectives (SOs) and Intermediate Results (IRs) -- to Program Areas and Elements.

The original planned annual budget levels for the 2005-2009 planning period were:

FY2005	FY2006	FY2007	FY2008	FY2009*	TOTAL
$16.495m	$17.334m	$14.689m	$11.5m	$11.5m	$71.518m

Actual budget levels have been:

FY2005	FY2006	FY2007	FY2008	FY2009*	TOTAL
$16.495m	$17.334m	$16.885m	$16.236m	TBD	TBD

At the time of the writing of this document, the budget projection for FY09 was $10.251 million and $19 million for FY2010. No estimates are available for FY2011-2015. Additional details concerning projected levels for the various funding "elements" (i.e. technical intervention areas) will be made available to the consultants upon initiation of the assignment.

The Health Office bases its planning and coordination activities around it's SO and IRs, as they are helpful in defining with the GOB and its implementing partners what the Mission is trying to achieve in the health sector in Bolivia.

1. Health Strategic Objective

The 2005-2009 health strategy was considered a follow-on to the 1998-2004 strategy rather than a fundamentally new approach. However, as a result of GOB health sector policy shifts in 2003, a larger percentage of resources for the 2005-2009 strategy were to be invested at the local level than in previous strategies; activities were to be concentrated in a smaller number of municipalities characterized by the lowest economic and health indicators; a more systematic approach was to be taken to promote local coordination and partnerships between the public sector and NGOs that provide health services; and activities were to focus on implementation of a basic package of services in communities and health facilities. In addition, all activities – whether implemented through the public or private sectors – were intended to support national health sector priorities and policies, as well as the GOB's National Development Plan.

Technical focus areas of the SO originally included family planning/reproductive health, maternal and child health, Chagas, and infectious diseases, including HIV/AIDS, TB, and malaria. In FYs 08 and 09, however, no funding was provided/is planned for Chagas or infectious diseases, including HIV/AIDS or malaria.

The Mission's strategic objective (SO) in health is: Improved health of Bolivians, Contributing to Their Quality of Life. Three intermediate results (IRs) contribute to the SO:

1. Increased ability of individuals, families, and communities to take action to improve health.
2. Expanded delivery of quality, high-impact services through health networks.
3. Strengthened institutional capacity for health care management and sustainability.

The intent of activities under these IRs is to promote behavior change and community empowerment; expand the delivery of high-impact, cost-effective interventions that address key public health problems; and build a sustainable service delivery platform in both the public and NGO sectors.

In addition to the activities implemented with the Health Office's budget in support of the SO and IRs above, USAID/B's PL 480/Title II program, worth $125 million over seven years and scheduled to close by April 2009, also supported achievement of the Mission's objectives in maternal and child health (MCH). The Mission's Title II activities contribute to achievement of MCH targets for the Health SO's performance monitoring plan and the Mission's Annual Results Report to USAID/Washington. A separate evaluation has been undertaken for Title II activities, which will be made available to the consultant team.

2. Adjustments to the Health Strategy

Until July 2006, activities were implemented in approximately 150 municipalities across Bolivia, predominantly in the Altiplano. Responding to the priorities of the newly-elected Morales government, USAID, in consultation with the MOH and departmental (i.e. sub-national) health authorities (called SEDES), revised its health strategy to include a new Rural Health Component (RHC) for the 2006-2009 period. The SO and IRs articulated in the CSP remained unchanged.

RHC activities, which were intended to take an integrated, comprehensive approach to family and community health, are concentrated in approximately 48 underserved municipalities in the departments of Beni, Chuquisaca, Tarija, and Santa Cruz. The emphasis of activities is on reaching indigenous and socially excluded populations. Part of the stated rationale for selection of municipalities for the RHC was to avoid overlap with the 148 municipalities across the country targeted by the MOH for its Zero-malnutrition program, an integrated, multi-sectoral program that was the centerpiece of the MOH's strategy. While the Zero-malnutrition program is still a government-wide priority, the MOH has developed a new Family and Community Health Model (known as *SAFCI* in Spanish), which is now the foundation of its health strategy. After the initiation of the RHC, a number of USAID implementing partners continued implementing selected activities in other departments as well.

A. Implementing Partners

Implementing partners currently include three local entities that USAID/B has supported for many years: PROCOSI, an umbrella organization of local NGOs; PROSALUD, Bolivia's largest health NGO; and CIES/Salud Sexual y Reproductiva, an NGO focused on sexual and reproductive health – and two international partners: John Snow, Inc. and Save the Children, each with their respective sub-partners. In addition, EngenderHealth implemented the mission's flagship reproductive health project, ACQUIRE, until approximately June 2008.

PROSIN, a technical and administrative support unit to the Ministry of Health that also played an important role in coordinating the activities of all the implementing partners was funded until 2006, when USAID made adjustments to its strategy. The JSI activity, known as *Gestion Y Calidad en Salud*, is a contract implemented under a Strategic Objective Agreement (SOAG) with the GOB. All the other mechanisms are cooperative agreements that are funded and implemented outside of the SOAG. Contraceptive commodities are procured through USAID's Central Commodity Procurement program, and a number of other field support projects, which are based in USAID/Washington, have been used for program support and implementation over the years *(see Annex C for more details on activities funded during the strategy period).*

C. Other Donors In the Health Sector

Several bilateral and multi-lateral donors are supporting health activities in Bolivia. Canada, Belgium, Japan, the European Union and France support various regional health programs and/or national institutional strengthening activities. Venezuela also supports the MOH's community health strategy by funding Cuban doctors who are providing services around the country.

UNICEF supports activities for maternal and child health, UNFPA supports safe motherhood and reproductive health, and the Pan-American Health Organization (PAHO) provides technical assistance to the MOH at the national and regional levels in a wide-range of technical areas, a portion of which is financed through USAID/Washington. Currently, the Global Fund for HIV/AIDS, Tuberculosis and Malaria (GF) is supporting HIV/AIDS and Tuberculosis activities; the second phase of the Malaria program was suspended due to poor performance.

USAID coordinates with the Ministry of Health and other donors through a number of mechanisms, including MOH-led "Interagency" sector-wide meetings and the *Mesa Tecnica de Cooperantes en Salud*, which includes all donors providing significant support to the health sector, as well as through MOH-led technical working groups, such as the *Mesa por una Maternidad y Nacimiento Seguro* and the *Comité Disponibilidad Asegurada de Insumos Anticonceptivos* (DAIA).

V. SCOPE OF WORK

The contractor will prepare: (1) a qualitative assessment of the Health program from 2005-2009, and (2) a strategy design for 2010-2015 that takes into account current development opportunities and challenges in Bolivia and that fall within the USG's "F" Framework. The strategy design shall include a new or revised Area Objective statement (formerly known as a Strategic Objective Statement) and a supporting results framework that is consistent with the "F" framework, the ADS and USAID/Bolivia Mission Orders.

The task for the consultant team is to:

- Collect information on the results and contributions of USAID's health assistance in the technical areas mentioned above over the FY2005-FY2009 period using existing data to the extent possible, and through the gathering of additional information through interviews and site visits, as needed;
- Complete a rapid assessment of what has worked in implementing the USAID health program over the period;
- Design and implement a participatory process for development of the new health strategy;

- Using the "F" framework (including technical elements and sub-elements) as a basis, develop an Area Objective Statement and accompanying results framework for the 2010-2015 strategy, along with supporting information on the development hypothesis underlying the proposal;
- Document the rapid assessment and strategy development processes and findings.

Specifically, the team should address the following issues and questions. This list should be considered preliminary and illustrative and, with USAID/B's agreement, may be adjusted by the team.

Part 1: Rapid Assessment

Assess the strengths, weaknesses and challenges of the current Health Program activities, including:

Technical Achievements:

1. What were the most significant results achieved through the USAID/Bolivia Health Program from 2005 to the present?
2. What were the Health Program's main contributions to achieving the specific goals of the Ministry of Health and USAID goals?
3. To what extent was the program successful in translating national policies into implementation at the service delivery level in both the public and private sectors?
4. What were the key results achieved through USAID-supported activities in each of the program's technical focus areas:
    - family planning/reproductive health
    - maternal and child health
    - infectious diseases (ID) (including HIV/AIDS, TB, avian influenza and malaria)
    - Chagas
    - municipal management of health
    - social marketing
5. Did the program have more impact in some technical areas than others? If yes, what accounts for the differences?
6. What were the strengths and weaknesses of activities in the technical areas listed above?
7. What, if any, impact did USAID-supported activities have on:
    - the reach and quality of public health services available at the municipal and department levels?
    - the reach and quality of services offered through USAID-supported private sector health service providers?
    - the institutional capacity for public health care management and sustainability at the municipal, department, and central levels?
    - the institutional capacity and sustainability of private sector service providers?
8. Did USAID support to NGOs (PROSALUD, CIES, PROCOSI and Save the Children) effectively contribute to national health programs and priorities?

Approaches:

9. What activities and/or approaches are most appreciated by the target populations? By service providers? By government counterparts at the regional and national levels?
10. What approaches worked well and should be preserved? What could be done more effectively in the new strategy period?
11. What accounts for some activities/approaches being more or less effective than others? Are there common underlying determinants that made these activities/approaches successful? (include a comparison of the approaches and impact of infectious disease activities in the Yungas funded by the Alternative Development program with ID activities funded under the Health program.)
12. Were the program's implementing mechanisms (including PROSIN) effective – both in terms of results achievement and cost-effectiveness -- for reaching target populations and achieving desired objectives?

13. To what extent did USAID/Washington-based field support projects contribute to achievement of results?
14. What are the prospects for sustainability of activities within the current health strategy?

Part Two: Design of Health Strategy 2010-2015

USAID's Health Office seeks a strategy that is clearly linked to Bolivia's National Health Sector Strategy and directly supports MOH goals and priorities. In addition, the strategy must be flexible enough to be scaled up or down based on changing budget levels, with recommendations for prioritized interventions based on probable funding sources. In addition, the strategy must have the potential to produce visible and timely results that will help improve the health status of Bolivians by the end of the strategy period.

The following questions/issues should be considered in weighing strategic options:

Technical Focus:

1. What are the short- and long-term GOB's priorities in the health sector?
2. What are the synergies between USG development objectives for Bolivia/LAC region and GOB priorities and objectives, focusing on framing potential opportunities in the context of the "F" Framework?
3. How has the profile of need changed since the 2003 DHS survey, and given the preliminary results from the 2008 DHS survey?
4. What are the MOH's priorities in the technical element areas that are most likely to receive funding? To what extend do they coincide with sub-elements under the "F" framework?
5. In what technical areas are other donors and the private sector (both for-profit and NGO) contributing?
6. In light of #4 & 5 above, what are USAID's comparative advantages in terms of technical focus areas? (taking into account "F framework" sub-elements)
7. What types of specific interventions would you recommend within the key technical focus areas?
8. At which levels of the health system (national, regional, municipal, community) should interventions be focused?
9. What are the prospects for sustainability of any given intervention?
10. Based on the outcome of the rapid assessment, should USAID attempt to maintain some involvement in areas such as Other Public Health Threats (Chagas) or Infectious Diseases (HIV, malaria, dengue, leishmaniasis) indirectly, even if we receive no funding in those elements?
11. If contraceptive security is identified as an issue that requires support, should social marketing of contraceptives be part of the strategy?
12. What are appropriate indicators by which to judge the success of the new strategy?

Geographic Focus:

13. What criteria should be used to determine where to work at the sub-national level (e.g., need, opportunity for integrated health programming, likelihood of public health impact, possibility of scaling up, sustainability, cost-effectiveness, location of other USAID programs, political factors, etc.)?
14. Where are other donors working? What are the advantages and disadvantages of focusing USAID activities in these same areas? in other areas?
15. What are the costs/benefits of focusing activities in sparsely populated rural areas vs. more densely populated urban/peri-urban areas?
16. What are your recommendations for the geographic focus for the strategy?

Assumptions Underlying the New Strategy:

17. What critical assumptions underlie the strategy? What are the likely consequences if one or more of the critical assumptions does not hold true?
18. What "safety valves" could be designed into the strategy to protect against uncertainty?

19. If the health program is designed in an integrated way with other USAID programs (e.g., pop-health-environment activities, co-location of health and democracy interventions), is it likely to be more or less effective?

Cross-cutting Themes:

20. What are the costs/benefits (in terms of economic cost and likelihood of impact) of pursuing a strategy that targets the "poorest of the poor" vs. other marginalized, poor populations?
21. How can the Health Office best integrate gender/intercultural issues into its program?
22. How can/should support for municipal governance and transparency be integrated into the Health program?
23. What are the advantages/disadvantages of pursuing short-term interventions with more immediate results (e.g. the Yungas infectious disease model) vs. longer-term, systems strengthening approaches?
24. What opportunities for synergies exist between USAID/Bolivia's health program and other USAID programs?

Possible Implementation Mechanisms:

25. Based on the findings of the assessment, what implementation models show promise for successful replication, scale-up and sustainability (e.g., PROSIN, small grants, municipal matching funds, mobile clinics)?
26. If at all, how should promising models differ from their prior structures?
27. What experience has Bolivia had with basket funds in the health sector? Have health sector basket funds been successful in achieving measurable results?
28. Are there opportunities for public–private or Global Development Alliance (GDA) partnerships?

Other:

29. What are the implications of the new strategic recommendations on Health Office staffing, if any?

A. Methodology

The methodology will be finalized by the GH Tech consultant team after its arrival in Bolivia, but it is expected to involve a combination of document review, data analysis, and participatory data collection processes in Washington, DC and Bolivia. Potential activities include:

Document Review

- USAID/Bolivia will provide the team with the key documents prior to the start of the assignment. All team members will review these documents in preparation for the initial team planning meeting.
- Collect and review relevant GOB/MOH documents including national policies, guidelines, and strategies as well as strategy documents of other donors in health in order to understand the political environment within which activities will be implemented, the roles of other actors, and the organizational focus of partner organizations roles.
- Review USAID/B Country Strategic Plans (1998-2002, 2005-2009), the Health Program's Performance Monitoring Plan and related reports/analyses, Annual Performance Reports (FY05-FY07), and selected project documents and materials in order to gain familiarity with the program vision, structure, and activities.
- Review the draft report from Part One of the previous GH Tech team's assessment effort to gain insight into preliminary findings and recommendations on USAID involvement in the health sector in Bolivia.
- Review the draft reports from the USAID/Bolivia series of health project "mini-assessments" that were to be carried out o/a April - June 2009.

- Analyze available data from DHS reports (including preliminary results from the 2008 DHS), project baseline and end-line studies, routine performance monitoring reporting, and GOB sources in order to quantitatively evaluate program impact.

Team Planning Meeting--TPM (US-based for international consultants)
A two-day team planning meeting for the international consultants will be held in Washington, DC before the work begins in Bolivia. This meeting will allow the international team members to:

- develop draft workplan, data collection methods, instruments, tools and guidelines;
- develop a draft key informant guide; and
- design and implement a participatory process for developing the strategy including identifying ways to gather input through workshops, roundtables and key informant interviews with broad range of stakeholders. (Stakeholder groups include appropriate staff from the Global Health and Latin America Bureaus of USAID/Washington, home office representatives of implementing organizations, and other donors such as PAHO. The purpose of implementing a participatory process is to enable the strategy design to benefit from a range of experience and perspectives, to reinforce USAID's commitment to being collaborative and transparent, and to build ownership of the final strategy).
- Propose an in country timeline for USAID Bolivia and consultant team review and approval.

Team Planning Meeting--TPM (Bolivia-based)
A three-day team planning meeting will be held in Bolivia before the assessment/design begins. This meeting will allow USAID to present the team with the purpose, expectations, and agenda of the assignment. The USAID Health Team will participate in portions of the team planning meeting, as appropriate, and its outcomes will be shared with USAID/B. The proposed participatory approach will be vetted with and approved by USAID/B. In addition, the team will:

- clarify team members' roles and responsibilities;
- establish a team atmosphere, share individual working styles, and agree on procedures for resolving differences of opinion;
- develop data collection methods, instruments, tools and guidelines and review with USAID;
- finalize data collection methods, instruments, tools and guidelines;
- develop key informant guide and review with USAID;
- finalize key informant guide;
- review and finalize the participatory process for developing the strategy including identifying ways to gather input through workshops, roundtables and key informant interviews with broad range of stakeholders;
- review and finalize final assessment and design questions;
- review and finalize the assignment timeline and share with USAID;
- review and clarify any logistical and administrative procedures for the assignment;
- discuss and agree on report content and organization (and whether there should be one or two final documents);
- develop a preliminary draft outline of the team's report; and
- assign drafting responsibilities for the final report.

Interviews/Facilitated Meetings/Workshops

- Interview key informants including, but not limited to, Mission and Embassy leadership, the Director of the Mission Health Office and Health Team members (including some past team members, to the extent possible), Mission support office staff, appropriate GOB and MOH staff, selected regional and municipal health authorities, leadership and staff at the La Paz headquarters of implementing partners, partner staff at program sites, other donor agency representatives,

public and private sector service delivery staff and representatives of community organizations at program sites, clients, and community members. The purpose of the interviews is to gather information, impressions, and opinions about the USAID/B health program from a range of stakeholders, implementers, and beneficiaries.

- Organize round tables and/or workshops to gain perspectives on the USAID program and strategy from groups of individuals involved in the health sector and/or familiar with USAID's program.
- Visit selected program sites in order to better understand the local circumstances that influence program implementation and to see project activities. The site visits will include interviews with Bolivian government staff, regional and local health authorities, health workers, implementing partners, donors, community representatives and beneficiaries. The team would split into 2 sub-teams, with each sub-team visiting 3 departments.
- Facilitate at least one session each with a subset of Mission health staff and, separately, with a subset of stakeholders to develop and agree on one or more possible results frameworks for USAID/B's health portfolio.
- Vet the resulting framework(s) with a broader group of mission staff and external stakeholders for their feedback, suggestions, and reactions.

The Team Leader will meet and/or communicate with the USAID/B Health Office Director on a regular basis (to be defined when the Team is in country) throughout the assignment to discuss the progress of the assignment and confirm that the draft strategy is evolving within the parameters discussed at the initial TPM.

B. Team Composition, Skills, and Level of Effort

The GH Tech Rapid Assessment and Design team will consist of five-six people: one international consultant who will serve as the Team Leader, one other international consultant and four Bolivians, including one administrative support person. In addition, an appropriate MOH technical representative will also be member of the team. A staff member from USAID/Washington (either from the Global Health or Latin America bureau) and members of the USAID/B Health Team may participate in parts of the design phase of this exercise, but not in the rapid assessment phase. Mission technical staff may be involved in discussions/trips for identifying key technical aspects of the new strategy but they will not be involved in writing.

As a group, the team should have strong technical background in public health; experience in strategy evaluation and design for USAID health programs; excellent understanding of the Bolivian political context and structure of the Bolivian health system; and demonstrated, effective interpersonal and teamwork skills. Each team member should have an advanced degree (Masters or above) in public health or an applicable social sciences field. The team will include at least one technical expert (local or international) with 5-7 years of experience working in each of the following areas:

- family planning/reproductive health
- maternal and child health
- infectious diseases (including HIV/AIDS and TB, in particular)
- health sector decentralization/municipal management of health

In addition, all team members must be able to speak and read Spanish, and local team members also need to be able to read and understand technical documents in English; Bolivian/local consultants do not need to speak English.

The Team Leader must have prior experience leading design teams for USAID assignments, with a minimum of ten years of experience working on evaluation and design, be fluent in both English and Spanish, and have outstanding English writing skills. S/he will:

- Serve as the team's principal point of contact with the Director of the Mission's Health Office, including clarifying and managing expectations;
- Facilitate the Team Planning Meeting or work with a facilitator to set the agenda and lead the TPM;
- Coordinate workflow and tasks and ensure that team members are working to schedule;
- Assign tasks to team members over the course of the assignment;
- Manage team coordination meetings;
- Facilitate group meeting(s) to draft and vet results framework options for the strategy; and
- Write the draft assessment and strategy document.

GH Tech will also contract the services of an in-country assistant who will provide administrative, clerical, and logistical support to the team. This individual will ensure that field logistics are arranged (e.g., payment is made for services, car/driver hire or other travel and transport is arranged, lodging for site visits is arranged, documents are distributed, etc.). S/he will report to the Team Leader and will work closely with the Administrative Assistant on the USAID Health Team staff.

Work will be performed between May-August 2009. Following is an illustrative LOE table for the GH Tech team, as well as information on the expected LOE outside of La Paz for the MOH team member. LOE for USAID staff (Bolivia and Washington) are not reflected on this table. A six-day work week is authorized in country. The distribution of effort within the overall time frame may be adjusted as necessary based on decisions made at the TPM and in discussion with USAID/B. In the interest of time, the team will split up for site visits.

Activity	**Team Member(s)**	**Individual X Days=total days**
USAID provides documents and prelim. list of key informants to GH Tech by agreed start date of activity	USAID	
Receipt and review of documents May 14-15-16-18-19 = 5 days	5 days/TM	5 X5 =25
Travel to Washington, DC	TL & Int'l TM	--
TPM & key informant/stakeholder interviews in Washington, DC May 20-22 = 3 days	3 days-TL & int'l TM	TPM and interviews: 2X3=6
Travel to La Paz and acclimation to altitude May 23 May 24th will be a day off	1 day each—TL & Int'l TM	2X1=2
TPM in Bolivia –Entire team with USAID Health team May 25-27	3 days/TM	5X3=15
RAPID ASSESSMENT (RA) TASKS – In country		
• Meetings, workshops and interviews with key stakeholders in La Paz May 28-June 3	5 days/TM	5X5=25
• Site visit(s), incl. travel: team splits into 2 sub-teams for internal travel June 4-19	14 days/TM + MOH	5X14=70
• Review of mini evaluations June 20	1 day/TM	5X1= 5

• Data and interview analysis June 22-24	3 days/TM	5X3=15
• Write up of RA findings June 25-27	3 days/TM	5X3=15
• Integration of RA report June 29	1 day/TL	1X1=1
• Mid-term debriefing (with entire USAID health team) of RA findings June 30	1 day/ TM	5X1=5
STRATEGY DESIGN TASKS – In country		
• Design and implement a participatory process for development of the new health strategy July 1-2 & 6-7 • Team Leader to follow-up and finalize design of participatory process implementation July 3-4	4 days/TM 2 days/TL	Design: 5X2=10 Implement: 5X2=10 1X2=2
• Development of results framework (RF) based on workshop outcomes—all team members involved in this analysis July 8 = 1 day	1 days/TM	5X1=5
• Discussion of draft framework(s) with USAID/B and stakeholders July 9-10	2 day/TM	5X2=10
• Write up RF narrative and finalize RF based on feedback from stakeholders July 11&13	2 days/TL 2 days/int'l TM	2x2=4
Three separate debriefs –(1) USAID/B Health team, (2) Mission, and (3) MOH & partners July 14-15	2 days/TM	5X2=10
• Preparation and packaging of supplemental documents July 16-17	2 days/TM	5X2=10
International TM departs Bolivia July 18	1 day/Int'l TM	1x1=1
• Development and preparation of procurement options and discussion with USAID/B (TL to do this after debriefs) July 20	1 day/TL	1X1=1
Finalize draft integrated document (RA and RF) July 18 and 21	2 days/TL	1X2=2
Team Leader departs Bolivia July 22	1 day/TL	1X1=1
USAID/B comments due to GH Tech (USAID has10 days to review & return comments to GH Tech). July 22-Aug 4		--
Team Leader integration of comments Aug 5-7	3 days/TL and GH Tech	1X3=3

Final Report signed off by USAID/Bolivia after review of final draft On/about Aug 10 (GH Tech has 30 days to format and edit final report before submitting final report to USAID Bolivia) Aug 11-Sept 22		
LOE for admin/clerical/logistics support team assistant	12 days	
Total LOE—Adjusted to correspond to illustrative calendar LOE table and Cost Estimate.	**days/TL** **days/int'l TM** **days/B** **12 days/LA**	62/TL 53/int'l TM 46/B 12/LA
Total days LOE for MOH team member (for purposes of calculating travel/per diem ONLY)	10 days/MOH--Tentative	

****A** 6 day work week is authorized for all team members when working in Bolivia.

TL = Team leader
Int'l TM = International team member
B=Bolivian team members (for LOE total purpose only)
LA = Logistics Assistant
MOH = MOH team member

C. Logistics

GH Tech will handle all aspects of the international travel arrangements for international consultants. Travel and per diem expenses for the participation of the MOH team member will be covered by GH Tech based on clear stipend and daily lodging/per diem instructions provided by the Mission. Any USAID/W team members will be either program-funded and covered by USAID/B outside of the GH Tech contract or OE-funded by USAID/W. International travel arrangements for the USAID/W team member will be handled by USAID/W. USAID/B will arrange for country clearances for the international consultants and USAID/W team member as well as transport to and from the airport for international flights. USAID/B will secure hotel reservations in La Paz for the team and arrange for initial meetings with stakeholders in La Paz. USAID/B will also handle arrangements for any meetings that take place at USAID/B. All other in-country logistics will be handled by the contracted logistics assistant, who will communicate directly with the consultant team as well as USAID Bolivia in order to streamline schedules and in country logistics. GH Tech will handle any photocopying and distribution of documents that occurs before the team arrives in country and after they depart.

D. Deliverables and Products

The team will provide the following products and deliverables to USAID/B:

1. In-country workplan: At the conclusion of the TPM in Bolivia, the Team will share with USAID/B its workplan for the assignment -- including individual team member responsibilities; draft data collection methods, instruments, tools and guidelines; the draft key informant guide; the annotated outline for the assessment and design document; and the proposed participatory design process.

2. Mid-term de-briefing: Approximately half-way through the data collection process, all or part of the Team shall brief USAID/B on progress towards achieving the assignment's objectives and any obstacles encountered in an effort to identify actions that USAID/B can take to ensure that work proceeds on schedule.

3. De-briefings: At the conclusion of the assignment, the Consultant Team will conduct a series of debriefings as follows:

a. One for the USAID/B Health Team on the assessment results, new strategic framework and related processes;
b. One for Mission leadership and other USAID offices on the assessment results and new strategic framework; and
c. One for implementing organizations and the MOH on the assessment results and new strategic framework.

In order to avoid conflicts of interest, the Bolivian team members will not participate in the development or presentation of the strategy options.

4. Meeting on Procurement Options: After the debriefings are completed, the Team Leader will meet with the USAID/B Health Team and Contracting Officer to discuss procurement options for implementation of the strategy.

5. Initial Draft(s) of Rapid Assessment and New Strategy: Following the series of debriefings and prior to team departure the draft assessment and strategy design report will be presented at the end of the team's in-country work for Mission review. During the Bolivia-based TPM, there will be discussion with USAID over the document's content and organization (and whether there should be one or two final documents), The document(s) will be in English and should not exceed 20-30 pages in length total (single-spaced), not counting annexes. (Final decisions on page limits and whether the assessment and strategy should be presented in the same or separate documents will be made during the Team Planning Meeting in Bolivia). One electronic copy (in Microsoft Word on CD) and four hard copies (of each?) shall be provided.

While the body of the document(s) need not specifically address all of the (currently draft, illustrative) questions reflected in Section V. Scope of Work, above – the supplementary materials should include a report with information on each of these questions to allow USAID to understand what the team discovered during its field work.

4. 2nd Draft(s) of Document: USAID/B will provide notes/comments to GH Tech within 10 business days of receiving the initial draft(s). The TL will make edits and resubmit the final report to USAID/B through GH Tech within 10 business days of receipt of USAID/B's comments. GH Tech is not responsible for preparing the final strategy; USAID/B will finalize the strategy. No GH Tech editing of the draft strategy is expected beyond integration of final comments by the TL. The Mission shall receive an electronic version (Microsoft Word format on CD) and four hardcopies of the document.

E. Suggested Strategy Outline (based on ADS 201.3.8)
   I. Bolivian Development Context
      a. Background
      b. Rationale for Assistance in Health
      c. Bolivian Assistance Environment
      d. Socio-Political Context
      e. Role of Other USG Agencies/Other Donors in Health

   II. 2005-2009 Health Program Rapid Assessment

   III. Strategic Plan
      a. Development Hypothesis
      b. Recommended Results Framework (including graphic)
         i. Assistance Objective Start and End Dates
         ii. Assistance Objective
         iii. Intermediate Results and Illustrative Activities
         iv. Critical Assumptions
         v. Resource Requirements
      c. Linkages to Key Bolivian Policies or Strategies
      d. Preliminary Performance Monitoring Plan
      e. Donor Coordination

f. Strategy Development Process

F. **Supplemental materials**

At the conclusion of the in-country portion of the assignment, the Team Leader will also provide USAID/B with the following supplemental documents:

- all the results frameworks that were developed, as well as the rationale underlying the team's recommend option;
- information on specific responses to questions in the SOW presented in Memo form;
- suggested procurement options;
- the in-country workplan;
- a list of individuals involved in the assessment strategy design processes and their contact information (if available); and
- a list of the documents reviewed for the assignment.

GH Tech will edit and format these items and compile them into a single document, which will be provided to USAID/B in electronic (MS Word) format along with the last draft of the assessment and strategy design document. Supplemental documents such as the SOW response Memo and suggested procurement options document should also be edited and formatted before final submission.

G. Relationships and Responsibilities

GH Tech is responsible for identifying GH Tech-funded team members with the skills and experience described above, negotiating the final team composition with USAID/B, and entering into contracts with the team members. GH Tech will also identify and contract with an in-country individual to provide support services to the team. GH Tech will assist with development of the agenda for the DC based TPM. As noted above, GH Tech will edit and compile the Supplemental Materials document and provide it to USAID/B in conjunction with or after the final report has been formatted/edited. Other GH Tech responsibilities are included under VI.D. Logistics, above.

USAID/B will identify the Mission Team member who will participate as a core member of the strategy design team and, in coordination with USAID/W, will identify the USAID/W team member. To the best of its ability, USAID/B will provide names and contact information for key contacts as well as relevant USAID, GOB, and partner documents to GH Tech for copying and distribution to the team prior to the start of the assignment. To the extent possible, documents will be provided electronically. Other USAID/B responsibilities are included under VI.D. Logistics, above.

The Ministry of Health will be responsible for identifying a representative to participate in the strategy design process. This individual will be responsible for coordinating/organizing meetings with national level Ministry of Health personnel and for participating in data collection (including site visits) and analysis activities as a member of the assessment and design team. The MOH representative will not be involved in drafting the strategy document. Who will this individual report to? Will he/she be under the direct supervision of the Team Leader?
If MOH does not designate a MOH representative in a timely manner, USAID/Bolivia will make the executive decision to move forward with or without this person? Questions above are to be decided and confirmed with Mission during Team Planning Meeting in La Paz, Bolivia.

VII. Points of Contact

The principal point of contact on technical issues for GH Tech and for the Team Leaders will be the Director of USAID/B's Health Office, Alicia Dinerstein. The principal point of contact for administrative matters and for the Team's support person is Amparo Antelo.

VIII. References

Among others, the following documents will be made available to team.

GOB health policies, strategies, and guidelines
USAID strategy development guidelines (ADS 201.3.8) and PMP guidelines (201.3.8.6)
USAID/B Strategic Plan 1998-2002
USAID/B Strategic Plan 2005-2009
Health Program PMP -- approved 2007, updated 2009
Rural Health Strategy Document
Technical Assessment Reports
Key partner reports

IX. Annexes

A. Brief summary of partner roles and activities
B. Preliminary list of key contacts— (Mission to provide list of key contacts)
C. Illustrative budget

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APPENDIX C: LEVELS AND FUNCTIONS OF THE BOLIVIAN HEALTH SYSTEM

FUNCIONES Y ATRIBUCIONES DE LOS NIVELES

1. **Nivel Central**:

El Ministerio de Salud y Deportes es el órgano rector y normativo de la gestión en salud a nivel nacional.
Dicta las normas para el Sistema Nacional de Salud
Formula estrategias, políticas, planes y programas nacionales
Reglamentar, supervisar y fiscalizar el funcionamiento de los SEDES para el cumplimiento de las políticas nacionales (de ésta responsabilidad vienen los "Performance Agreements")
Coordinar, apoyar y orientar técnicamente a los Municipios en el desarrollo y mantenimiento de la infraestructura y equipamiento en salud
Coordinar acciones técnicas y económicas con la cooperación internacional
Formular políticas y ejecutar programas de alimentos y nutrición
Formular políticas y ejecutar programas de promoción de la salud con participación activa de la población
Formular políticas, supervisar y evaluar la ejecución de programas de prevención y control de enfermedades

2. **Nivel Departamental**:

El SEDES es el articulador de las políticas nacionales y de la gestión municipal.

- Es el máximo nivel de gestión técnica del Departamento.
- Coordina y supervisa la gestión de salud en el Departamento
- Articula políticas nacionales y la gestión municipal.
- Es el encargado de cumplir y hacer cumplir las políticas de salud y las normas de orden público en su jurisdicción territorial en el sector público, el Seguro Social de corto plazo, Iglesias, Privados con y sin fines de lucro y la Medicina Tradicional
- Junto al Municipio, es el responsable de identificar los niveles de atención de los múltiples prestadores, de organizar redes y de articular éstas con el tercer nivel de atención.

3. **Nivel Municipio**:

El Gobierno Municipal es el:

- Responsable de la Gestión Municipal de Salud en su competencia y obligaciones, dadas por normas vigentes
- Responsable de la administración de la Cuentas Municipales de Salud/SUMI a través de la gestión compartida del DILOS.
- Financia y fiscaliza los gastos operativos y de ejecución del SUMI
- Controla la afiliación
- Es co-responsable de la gestión de medicamentos, insumos y reactivos
- Contrata con cargo a sus propios recursos personal administrativo y de apoyo

3.2. Comité de Vigilancia (Instancia de articulación entre la sociedad civil y el Gobierno Municipal)

- Asume la gestión compartida con participación popular en salud
- Apoya la organización de redes sociales basada en a cultura organizativa de los pueblos con énfasis en las poblaciones campesinas, indígenas y originarias para lograr su activa participación en la planificación y el control social
- Ejerce el control social de la gestión del SUMI
- Informa periódicamente a las organizaciones de base de su municipio los avances en salud y canaliza sus iniciativas y demandas

3.3. DILOS

- Ejecuta la gestión compartida con participación popular. Asegura la armonización de la planificación participativa municipal con la sectorial en salud
- Promueve y gestiona programas y proyectos de cooperación técnica y financiera
- Elabora, suscribe y evalúa compromisos de gestión con el Gerente de Red
- Evalúa la situación de salud, la red de servicios, y la ejecución de programas, el SUMI y la calidad de atención
- Instruye la realización de auditorias financiero-contables, administrativas, médicas y de medicamentos en la red de servicios
- Apoya, controla y atienda los procesos de fiscalización en el uso de las Cuentas Municipales de Salud
- Gestiona los recursos físicos, financieros y humanos de la red de servicios, promoviendo en los establecimientos y brigadas móviles la aplicación de modelos de gestión para mejorar la calidad y eficiencia en la producción de servicios. Aprueba procedimientos para reembolso a los establecimientos por concepto de prestaciones, medicamentos, insumos y reactivos del SUMI, al Gobierno Municipal
- Conforma mesas de negociación municipal
- Conforma la Red Social con participación de representantes de los pueblos y juntas vecinales y de todas las instituciones vinculadas a la salud asentadas en el municipio
- Generar procesos de planificación participativa sectorial cuyos resultados se constituirán en el POA del DILOS, el cual es el compromiso de gestión del DILOS con el SEDES. El POA del DILOS es compromiso de gestión de los establecimientos de salud y del DILOS y como tal debe ser incorporado en los procesos de planificación participativa del municipio.
- Evaluar la situación de salud, la red de servicios, red social, la ejecución de programas, el SUMI y la calidad de atención. Capta mensualmente de los establecimientos un reporte sobre los asegurados del SUMI.
- Recibe y registra los reclamos y denuncias verbales y escritas. Responsable del seguimiento al cumplimiento de las acciones correctivas y la comunicación respectiva al denunciante, con copia al SEDES y al Gobierno Municipal.
- El DILOS selecciona un **Gerente de RED** quien es la autoridad ejecutiva y responsable técnico del funcionamiento de la red de salud. Suscribe compromisos de gestión con los establecimientos de la Red de acuerdo a la normativa del Ministerio. El Gerente tiene funciones de planificación, supervisión, facilitación, etc. Es responsable para la consolidación, análisis y generación de información agregada bajo normativa del SNIS.

4. **Nivel Local**

La comunidad; establecimientos o RRHH que trabajan en la comunidad (puestos, brigadistas, etc) y Organizaciones Territoriales de Base que conforman una Red Social. Las atribuciones de una Red Social son:

- Ejercer el control social comunitario para que las prestaciones de todos los programas y el SUMI sean ejecutadas adecuadamente
- Identifica las barreras de acceso de la población
- Participa en la mesa de negociación del DILOS y en la elaboración de planes y proyectos de salud
- Promueve la movilización social en defensa de la salud

APPENDIX D: USAID ACTIVITIES FOR HEALTH STRATEGY 2005-2010

Type of Funding	Project Name	Implementing Partner	Start	End	Description	Budget for Strategy[44]
Bilateral	Gestión y Calidad en Salud	John Snow International (JSI)	05/01/05	12/31/09	The objectives of the project include: (1) improve the management capacities of local health clinics and hospitals; (2) increase the quality of services provided in the public health sector; and (3) provide municipalities with opportunities to address local health priorities through matching funds to develop initiatives that improve infrastructure and quality of care. The project provides 'ongoing staff training and technical assistance to public health facilities' staff to facilitate the application of IMCI (AIEPI in Spanish), with a focus on nutrition; improves epidemiological surveillance of infectious diseases; improves the pharmaceutical logistics system to ensure the adequacy of supplies; and trains lab technicians and provides basic supplies to strengthen the capacities of local laboratory networks. The project helps the MSD respond to epidemics and outbreaks, and promotes community participation in prevention activities. In areas that do not have access to health facilities, JSI supports mobile health units to deliver services on an intermittent basis. The project also promotes increased municipal investments in health through municipal matching funds.	$15,190,000
	Asistencia Técnica al Programa de Salud Comunitaria (PS)	Manoff	07/01/04	09/30/09	The Project provides technical assistance to the PROCOSI NGO network in the areas of reproductive health 1 · 2,662,000 (maternal health and family planning); integrated health care for children under five (including nutrition and newborn care); infectious diseases (tuberculosis. malaria. Chagas, leishmaniasis. STIs); and institutional capacity building to strengthen PROCOSI members' technical and administrative capacities to implement activities under the Community Health Project.	$2662,000

[44] These dollar amounts represent the amount budgeted. Some of these have changed over the course of the 5 years and have not been fully expended.

	Integrated Health Project	PROSIN	09/30/98	07/31/06	The Integrated Health Project (PROSIN) was a technical and normative unit integrated within the MSD and its 1 2,261,000 departmental entities. PROSIN focused on capacity-building at the central (MSD), departmental (SEDES) and regional (health network) management levels, providing technical assistance in the areas of IMCI, sexual and reproductive health, malaria, tuberculosis and other infectious diseases. PROSIN also assisted the MSD, SEDES and health networks to fulfill their roles and responsibilities in supporting the development, negotiation, implementation and monitoring of local health plans integrated municipalities. These plans served as a basis for the implementation of JSI's Gestion y Calidad en Salud project and were linked to community-based services supported through the Community Health Project implemented by PROCOSI. PROSIN facilitated coordination between USAID and the MSD, and among USAID's implementing partners in the health sector	$7,990,000
Type of Funding	**Project Name**	**Implementing Partner**	**Start**	**End**	**Description**	**Budget for Strategy[45]**
Bilateral Type of Funding Global	Partners for Development (SpD)	PROSALUD	09/30/02	09/30/09	*Socios para* el d*esarrollo (SpD))* aims to improve the health of Bolivians through a variety of interventions: (1) provide small grants and technical assistance to NGOs and community-based organizations to increase access and coverage of quality culturally appropriate health services in underserved areas; (2) provide assistance on a range of technical and management issues (maternal and child health, reproductive health, infectious diseases, performance monitoring, financial management, etc.) to USAID partner organizations, including the Ministry of Health; (3) manage specific projects to address critical intervention areas or gaps, e.g. support f<.\r voluntary counseling and HIV testing services and support to the National HIV/AIDS program; extension of basic health services in El Alto through use of mobile units; and support for Family and Community Health through a training program with the	$15,796,000

[45] These dollar amounts represent the amount budgeted. Some of these have changed over the course of the 5 years and have not been fully expended.

					Colegio Medico.	
	Community Health Project Proyecto de Salud Comunitaria (CHP)	PROCOSI	06/01/05	05/31/10	PROCOSI *(Programa de Coordinaci6n en Salud Integral)* is a network of 32 NGOs working to improve the health of mostly rural low-income populations. The USAID-financed *Community Health Project* (CHP) is implemented by PROCOSI and its members. The project's purpose is to extend community health services to underserved families, especially in rural municipalities. CHP trains community health workers in the fields of reproductive health, integrated health care and nutrition for children under 5and infectious diseases (tuberculosis, malaria, Chagas, and STIs). The project also includes a housing improvement component to reduce the incidence of Chagas' disease.	$18,000,000
	Reproductive Health Project	CIES	10/01/04	09/30/09	USAID supports CIES a Bolivian NGO in its efforts to increase access to quality health services for women and men and adolescent through support for (1) the direct provision of health services, (2) educational activities targeting urban populations in 8 departments of Bolivia, (3) educational activities targeting rural, indigenous populations in Chuquisaca and Beni, and (4) training and technical assistance in management in order to improve CIES' sustainability	$8,991,980
	Integrated Health Services	PROSALUD	9/30/02	9/30/09	USAID supports the operational costs of PROSALUD's network of 27 primary and secondary health care facilities, which currently serve a population of about 600,000 in six departments in peri-urban areas of Bolivia. PROSALUD also manages a social marketing program, which distributes condoms, oral contraceptives, injectables, and multivitamins nationwide. These products are dispensed to the public through PROSALUD's clinic network, private pharmacies, non-traditional outlets, and other NGO's.	$7,990,000

Type of Funding	Project Name	Implementing Partner	Start	End	Description	Budget for Strategy[46]
Bilateral	Making Decisions Project	Save the Children	09/01/06	08/31/09	The overall objective of the Project is to increase quality and access to health services for adolescents and youth through youth-defined and youth-led initiatives that promote responsible behavior and engage youth in public advocacy. The Project emphasizes delayed onset of sexual debut and developing life-skills among teens. Project activities primarily focus on adolescent peer communications programs on reproductive health and on increasing knowledge of healthcare providers about adolescent health and how to deliver adolescent-friendly services.	$2,108,854
	Improving Our Lives	Save the Children	10/01//07	09/30/10	This Project is based on a partnership between USAID, Glaxo Smith Kline (GSK), Vitamin Angels Alliance (VAA), Save the Children (SC) and municipal governments. Its objective is to improve the health of the poorest children of La Paz, Oruro, El Alto, Cochabamba and Santa Cruz by strengthening the capacity of local governments, schools and communities to deliver nutrition-related services through school-based interventions. The project trains and educates teachers on nutrition-related issues to enhance their knowledge and to enable them to reach 65,000 children under five years, as well as their mothers, caretakers and older siblings with messages concerning nutrition.	$799,944
Global	Access Quality and Use in Reproductive Health (ACQUIRE)	EngenderHealth	09/30/06	09/30/09	This Project improves and expands quality reproductive health/family planning service delivery (with a focus on maternal health and post-abortion care) by providing training and technical assistance to public and private health care workers. The Project focuses on in-service training, and developing tools and procedures to support improved supervision and management.	$4,112,000

[46] These dollar amounts represent the amount budgeted. Some of these have changed over the course of the 5 years and have not been fully expended.

	Access Quality and Use in Reproductive Health (ACQUIRE	EngenderHealth	09/30/03	09/30/08	The project improves and expands quality reproductive health service delivery in public and private sector facilities through training and technical assistance in family planning, maternal health, post abortion care, supervision, continuous quality improvement, infections prevention, and involving men as partners in health.	$2,000,000
	Management and Leadership	Management Sciences for Health (MSH)	09/30/00	09/30/05	The project provided technical assistance to PROSALUD and COMBASE (two Bolivian NGOs) to improve their management and sustainability.	$40,000
	Leadership, Management, and Sustainability	Management Sciences for Health (MSH)	09/01/05	09/30/09	This project provides technical assistance to CIES to improve its management capacity and sustainability	$850,000

Type of Funding	Project Name	Implementing Partner	Start	End	Description	Budget for Strategy[47]
Global	BASICS III	The Partnership for Child Health	09/01/04	09/30/09	The project provided technical assistance to the MSD on issues including: (1) birth spacing; (2) health system strengthening for more effective and efficient child survival interventions; and (3) cost-effective approaches for achieving improved coverage and outcome-level results for child health and nutrition interventions.	$200,000
	DELIVER	JSI	09/30/00	09/30/06	The project provided technical assistance to the MSD Pharmaceutical Unit in developing its logistics system for essential pharmaceuticals and commodities. The project also helped improve PROSALUD's social marketing program by improving their capacity to disseminate health commodities at service delivery points.	$200,000
	Health and Immunization Response Support (UNICEF Umbrella Grant for Polio, EPI, MCH)	UNICEF	06/01/95	09/30/07	Through UNICEF, USAID supported activities designed to improve maternal and child health by: (1) supporting the national working group responsible for reviewing and revising Bolivia's Strategy for Newborn Care and helping to develop the associated Action Plan. The Project also provided technical support to the MSD, UNICEF and NGO partners (Save the	$75,000

[47] These dollar amounts represent the amount budgeted. Some of these have changed over the course of the 5 years and have not been fully expended.

					Children, and PROCOSI) to improve coordination for activities related to newborns in order to help the MSD plan and implement activities to help Bolivia reach Millennium Development Goals 4 and 5.	
	Contraceptive Procurement	USAID/ Washington	09/30/90	09/30/08	USAID uses this mechanism to purchase contraceptive commodities for USAID's social marketing program implemented by PROSALUD	$2,950,000
	Inter-Agency Agreement for Technical Assistance to HIV/AIDS Control Program	CDC	09/30/99	09/30/09	CDC provides assistance to the national STI/HIV/AIDS Control Program in the areas of clinical services, epidemiology, laboratory services, behavioral interventions, and information systems. Main activities include: (1) implementing an HIV sentinel surveillance survey among men who have sex with men (2) technical assistance to help expand STI sentinel and behavioral surveillance and HIV surveillance at voluntary counseling and testing (VCT) sites; (3) reviewing national protocols and guidelines in order to develop an improved HIV testing algorithm , and (4) technical assistance to strengthen diagnostic procedures in CDVIRs and VCT sites.	$250,000
	Private Sector Partnerships One (PSP-One)	Abt Associates	09/01/04	09/30/09	This project provides technical assistance to CIES for development and implementation of their business plan.	$200,000
	Health Systems 2020	Abt Associates	09/30/06	09/30/11	This project provides technical assistance to PROSALUD to improve its management and organizational systems in order to make it more sustainable, while maintaining its mission of providing services to under-served populations.	$800,000
	Health Care Improvement Project (HCI)	University Research Corporation (URC)	10/01/08	9/31/09	In support to the National Tuberculosis Program, and in coordination with the Gesti6n y Cafidad Project, the Project documented the extent of current use of the Tuberculosis CD by public health workers and in universities, and it introduced a "collaborative approach" to improve the implementation of DOTS in USAID target areas through in-service training (based on use of the CD) and the use of team-based continuous improvement methodologies.	$200,000

Type of Funding	Project Name	Implementing Partner	Start	End	Description	Budget for Strategy[48]
Global	Measure Phase II (Demographic and Health Survey-DHS)	ORC Macro	09/30/03	09/30/08	This Project provides technical assistance for the implementation of the National Demographic and Health Survey (DHS 2008), implemented by the Ministry of Health, under a joint agreement with the National Institute of Statistics. Areas of assistance included: survey and sample design (including sample selection); questionnaire design and pre-testing; staff training; data collection; quality control through monitoring of fieldwork; data processing (including data entry, consistency checking, production of survey database and production of tables, calculation of sampling weights); and preparation of reports.	$400,000
	Fertility Awareness Methods (FAM)	Georgetown University Institute for Reproductive Health	10/01/08	9/31/09	The project will provide technical assistance to the MSD and selected NGOs (CIES, PROSALUD) to improve contraceptive choices by expanding access to fertility awareness-based methods (FAMs), the Standard Days Method (SDM) and the Lactational Amenorrhea Method (LAM) in facility-based and community-based settings.	$200,000

[48] These dollar amounts represent the amount budgeted. Some of these have changed over the course of the 5 years and have not been fully expended.

APPENDIX E. IMPLEMENTATION TIMELINE OF RURAL STRATEGY

Implementation Timeline of Rural Strategy

Jun 2005	Start of GCS (JSI) and CHP (PROCOSI); PROSIN (ongoing);
Sept 2005	Acquire Director leaves
Jan 2006	Change in Bolivian Government (Evo Morales assumes Presidency)
Mar 2006	Change in Director of GSC
Jun 2006	Finalization of baseline study in original areas. GSC, CHP, and ACQUIRE told are told to continue on-going activities in parts of the country where they are already working, but to not start new ones. USAID closes PROSIN, and JSI is asked to follow up on PROSIN's pending administrative issues. USAID identifies areas for the rural strategy.
Mar 2006	New Acquire Director begins
May 2006	PROCOSI issues RFA for sub-grants
Aug 2006	USAID instructs PROCOSI to stop its sub-granting process because of the need to change geographic areas
Oct 2006	US direct hire Health Office Director leaves to become Program Office Director; She is replaced by an FSN who is the the SO team member from the Comptroller's Office.
Nov 2006	PROCOSI issues new RFA for sub-grants in lowlands
Dec 2006	EngenderHealth, JSI, and PROCOSI present a new baseline and plan for work in new geographic intervention areas based on the following criteria: (1) places where all three could work, (2) PROCOSI partners already working in the area, (3) PROCOSI partners in the area with experience in housing improvement for Chagas.
Feb 2007	PROCOSI sub-grants awarded
Mar 2007	PROCOSI starts implementation in new areas
Mid- 2007	Problems arise in Chaco of Santa Cruz, purportedly over the FP part of the basic package, but also had to do with the Rural Strategy being strongly associated with USAID, at a time of anti-USAID political sentiment. The compromise was to leave Camiri where opposition was strongest and stay in the Tarija and Chuquisaca parts of the Chaco. GCS, ACQUIRE and CHP move activities to Ñuflo de Chavez and San Ignacio de Velasco. The only Rural Health Strategy Partner to stay in the non-Chaco part of Chuquisaca is GCS which stays in Padilla and Azurduy of Chuquisaca. CIES also works in the area on RH and PF. The Guaranis from Chuquisaca came to USAID and met with the Mission Director to sign new agreement with CIES so it could continue its work in the Guarani area in Chuquisaca.
Nov 2007	New US direct hire Health Office Director arrives
Jun 2008	EngenderHealth/Acquire project terminated in Bolivia by USAID Mission for incapacity to deliver on SOW. Upon announcement of project closure, the Director left the project and an acting Director was left to close it out.
May 2009	Decision to extend implementation of CHP (PROCOSI), GCS (JSI) by one year to September 2010
Jun 2009	Portfolio Review of USAID Health Program

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