
Mid-Term Evaluation of the Bolivian Health Support Programme (PASS)

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ACRONYMS

Aguayo	Woven cloth of cotton or wool traditionally used to carry babies and/or other loads.
Altiplano	High plains region of Bolivia, at an altitude of approximately 14,000 feet
AOP	Annual Operation Plan
Aymara	Indigenous race of people who have inhabited the Bolivian Altiplano and La Paz region since pre-Colombian times
CAI	Health Information Analysis Committee (Comité de Análisis de Información)
Chacana	The Southern Cross constellation is referred to the Andean Cross or the Chacana among the Aymara people. It is considered to have four dimensions: 1) cosmic vision, energy, spirituality; 2) public life, community; 3) ecology, production; and 4) art and esthetics.
CIDA	Canadian International Development Agency
CEDAW	UN Committee for the Elimination of Discrimination Against Women
Cosmo-Vision	The cosmo-vision refers to a micro-cosmos that emanates from the mother earth (pacha) and is a representation of the cosmos at large. It is animated, sacred, consubstantial, immanent, diverse, variable, and harmonious. Withn the local pacha, there is the Aiayu (community), which is comprised of three communities: people, nature, spirits.
DILOS	Local Health Directorate (Dirección Local de Salud)
DUF	Single Funds Directorate (<i>Directorio Único de Fondos</i>)
EmOC	Emergency Obstetric Care
ENDSA	National Population and Health Survey (<i>Encuesta Nacional de Demografía y Salud</i>)
FLASS	Local Fund for Health Sector Support (Fondo Local de Apoyo al Sector Salud)
FPS	National Productive and Social Investment Fund (Fondo Nacional de Inversión Productiva y Social)
MC	Management Committee

MDG	Millennium Development Goals
M&E	Monitoring and Evaluation
MEFP	Ministry of Economy and Public Finance <i>(Ministerio de Economía y Finanzas Públicas)</i>
MSD	Ministry of Health and Sports <i>(Ministerio de Salud y Deportes)</i>
NGO	Non Governmental Organization
Nutri-Bebe	Cereal of high nutritious value used as a supplement for complementary feeding for children age 6-23 months
OC	Operations Committee
PAHO	Pan American Health Organization
PASS	Program Support to the Bolivian Health Sector (Programa de Apoyo al Sector Salud)
PND	National Development Plan of Bolivia (<i>Plan Nacional de Desarrollo</i>)
PRICCAS	Project to Improve Coverage and Quality of Health Care (Proyecto de Incremento de Coberturas y de Calidad en Atención en Salud)
SAFCI	Intercultural Family and Community Health System (Sistema de Salud Familiar Comunitaria Intercultural)
SEDES	Departmental Health Secretariat (Servicio Departamental de Salud)
SNIS	National Health Information System (<i>Sistema Nacional de Información en Salud</i>)
SUMI	Universal Maternal-Infant Insurance (Seguro Universal Materno-Infantil)
TBA	Traditional Birth Attendant
TGN	General Treasury of the Nation (<i>Tesoro General de la Nación</i>)
UNICEF	United Nations Children's Fund
UP	Planning Unit of the MSD (<i>Unidad de Planificación</i>)
VIPFE	Vice Ministry of Public Investment and External Financing <i>(Viceministerio de Inversión Pública y Financiamiento Externo)</i>

Executive Summary

The report presents the findings of a mid-term evaluation of the Bolivian Health Support Programme (PASS) undertaken in Bolivia from August 10-28, 2009. This \$ 18.4 million. 5 year project commenced in 2006 and is due to end in 2011. The project seeks to improve access to and quality of primary health care services, particularly mother and child care while at the same time strengthening public health sector management capacities at the central departmental and local levels in three of the poorest departments of Bolivia: Oruro, Beni and Pando.

The rationale of the evaluation consists of confirming the relevance of the Programme to the Health Sector in Bolivia and to make recommendations to make its execution more effective in order to meet the Programme's expected results while providing reflections on a possible second phase to the programme. The scope of the evaluation will cover eight topics as per the terms of reference: 1) relevance; 2) coherence; 3) effectiveness; 4) efficiency; 5) sustainability; 6) risks; 7) gender equality and interculturalism and 8) lessons learned and recommendations.

The methodology consists of a mixed method approach that combines quantitative and qualitative methods which includes the : 1) the review of documentation; 2) semi-structured interviews; 3) testimonials; 4) focus groups; 5) workshops and roundtables; 6) PRA/PLA methods; 7) a questionnaire; and, 8) logic model assessment grid. The methods were utilization-based, participatory and innovative for the energy, passion and insight it generated. The diversity of methods and sources of information allowed for the triangulation of the evaluation findings.

In terms of relevance, the report found that the programme is highly relevant to the needs of the population of Oruro, Beni and Pando with regards to primary health care and increasing the demand for access to and quality health care services. The Programme is consistent with the Ministry of Health and CIDA development priorities

Greater coherence between and among the different parts of the programme could be achieved with greater interaction and exchange between the different components so that the Programme is more than the sum of its parts. This is why it is suggested that an advisory council with representation of the different components be set up to meet on a quarterly basis to exchange experiences and innovative practices.

PASS is seen as effective as it responds to the needs for improving the population's access to healthcare services, which is limited due to economic, geographic, cultural and social factors. However, given the lack of a standard reporting format and agreed upon indicators by all components, it has been difficult to track the progress in achieving the outputs, outcomes and impact as per the logic model. The overall perception of programme stakeholders in the workshops given is that the programme is achieving key

results in training and quality care; management and planning, capacity-building and strengthening; improvement of the infrastructure and provision of equipment and the strengthening of local stakeholders. Overall impact indicators (child mortality and chronic malnutrition), service provision for vaccinations and pregnant women, shared management and gender showed notable improvements especially in Oruro and Pando between 2003 and 2008.

Efficiency could be strengthened if the Unit of Planning with the Ministry of Health took more of a leadership role of the Entire programme. The resources disbursed by CIDA to the different Programme implementation entities total 72% of the total allocated amount which are significant. As at June 2009, however, budget execution totals only 54% of the total PASS agreement. The budget execution percentage is not yet satisfactory compared to the resources disbursed for each component, which points to the existence of some difficulties for executing the available resources.

With regards to sustainability, there is limited potential for the Ministry of Health and municipal governments to provide resources after PASS ends in 2011. However, since PASS is well integrated into the Ministry of Health system, primarily through PRICASS, many activities will continue to be implemented, especially those that the Ministry of Health traditionally supports such as vaccination coverage.

No formal mechanism during the programme implementation have been established for identifying, analyzing and proposing risk mitigation measures; only UNICEF has given an overview of risks and risk mitigation strategies in its reports besides the degree of implementation and compliance of the strategies.

Gender and Multiculturalism has become more prominent with the establishment of the Gender Committee. What is needed are practical actions that can be implemented in the components as soon as possible (ie. Multicultural sensitive health posts and centres that are user-friendly, involvement of men in women's pregnancies and in the healthcare of their children; workshops on Gender Equality for Health personnel).

The lessons learned are too numerous to enumerate in the summary and the reader should refer to section 5.8 of the report. The following recommendations have been made targeting the Ministry of Health, UNICEF, FPS and CIDA:

Recommendations

5.8.2.1. SHORT-TERM RECOMMENDATIONS

The Ministry of Health MSD

1. The MSD must assume leadership of the Program and not only of the Budget Support component. The UP must be strengthened by assigning it the hierarchical level

of a General Direction and providing it with human resources paid by the TGN who would gradually replace the PASS consultants; the strengthening effort should also include the facilitation of the administrative procedures under its care and advocacy at the highest level in order to reduce bureaucracy in the budget processes with the VIPFE and the MEFP (section 5.2.3; 5.2.4.; 5.4.1.).

2. The UP has to improve its coordination with the SEDES and assume leadership at the technical and policy levels rather than on the basis of financial control; the UP has to respect the departmental AOPs, verifying whether they are consistent with national and sectoral policies, granting flexibility to the SEDES within the framework of a results-based management approach (section 5.2.3.; 5.2.4.; 5.2.5.; 5.4.2.).

3. The financial controls should be performed afterwards in audits; the SEDES should sign a document regarding automatic debits from their accounts in case the resources are found to be used inadequately so as to refund the money to MSD accounts (section 5.4.2).

To the Project through the MSD and CIDA

4. The format of the semester reports must be defined and uniform so as to give information on attainment of the results and the actions performed (degree of physical progress) and the financial execution in all components; the UP should consolidate the reports in an executive summary that shows the Program contribution to the results of the sector in accordance with the logical framework. To do this, it is critical that the programme, in collaboration with the different components finalize a set of basic indicators to measure progress in achieving results. The reporting format should be simple, show actual vs expected results and indicators and be consulted with CIDA (section 5.3.2.).

5. Create an advisory council that can meet quarterly to address implementation issues and provide inter-institutional coordination, synergy and the exchange of experiences among the PASS components at the national and regional levels. Leadership could be rotational so that no component is overburdened. Of particular importance is improving the coordination with the FPS to link infrastructure and equipment to medical requirements and gender and cultural considerations. (See Section 5. 2.4.).

6. The two national committees should prioritize more far-reaching issues, rather than administrative problems, such as the implications of the PASS programme on public health policy, status of the gender and intercultural components, innovative practices with potential to be scaled-up and sustainability issues. (See Section 5.3.5.)
Components)

SEDES

7. Create a Departmental Operational Committee, led by the SEDES and with participation of the institutions involved and representatives of civil society, with the purpose of linking the components to the supply (healthcare services) and demand (civil society). Advantage must be taken of this entity to promote the Program and its benefits, including the FLASS component (section 5.3.5.).

FPS

8. The FPS currently builds traditional structures without considering state of the art construction practices. It is recommended that FPS receive training and guidance regarding building design such as orientation towards the sun in cold climates, use of thermal mass, light shelves, use of materials to make rooms warmer in the Altiplano, or to cool down spaces in the tropics. (See Section 5.5, Ownership of Programme Activities).

9. Reach a consensus between the central Ministry of Health, SEDES, UNICEF, FPS on infrastructure, with state of the art training for the FPS teams at the departmental level so that new infrastructure is adequate in terms of gender, local cultural needs and customs and financial costs¹. (See Section 5.7.2.)

10. Prioritize infrastructure and equipment taking into consideration the baseline in such a way that the SEDES proposes to each municipality the type and characteristics of the investment increasing the participation of the FPS from the idea of the project to strengthening capacities to ensure the maintenance on the part of the municipality. Infrastructure models should also consider the themes of interculturalism, gender and housing for medical personnel. (See Section 5.7.2.)

PRICCAS

11. Prepare a sustainability plan for transferring key programme activities to the three SEDES, municipal governments and other local institutions, as relevant. The sustainability plan should select 5-10 important activities and include indicators to track these during the next two years. (See Section 5.5.1.).

12. Prioritize the implementation of the gender action plan during the last two years of the project. (See Section 5. 7.1.)

Gender Equality and “Inter-culturalism”

13. Disseminate lessons learned and best practices to the Ministry of Health and larger development community in Bolivia. An example is the use of incentives to increase utilization of services such as the Aguayo Project. This could be done by the National Gender Technical Committee. (See Section 5.7.1.)

5.8.2.2. LONG-TERM RECOMMENDATIONS

FLASS

14. The FLASS must make more efforts to allocate resources to at least one initiative in the department of Pando, as a pilot experience to assess the population’s response to this type of initiatives. It should be clear that this component should not only work with

¹ The Maternal-Perinatal Hospital in Lima could provide cost-effective assistance on linking building plans to efficient service provision. They have given excellent on-site technical assistance to the Prefecture of Tarija for the design of the new maternal referral hospital.

the few NGOs in the department, but also with the municipal governments (section 5.3.2, point 4).

PRICCAS

15. Strengthen the PRICCAS emergency obstetric and neonatal care strategy² over the next two years documenting best practices, and scale-up to other departments of Bolivia during the following program cycle. (See Section 5.5.3.)

16. The capacity for managing the financial administration systems should be strengthened, both at the level of the MSD and in the SEDES and municipalities. In this regard, the suggestion is to hire experts to prepare guides on financial administration systems (budgets and treasury) and train personnel on the basis of practical Program cases; this training should be complemented with technical guidance in order to ensure compliance with budget execution and accountability (section 5.3.2; point 2 PRICCAS).

CIDA and Ministry of Health

17. Since PAHO already has a permanent relationship with the Ministry of Health as a provider of technical assistance, it is recommended that CIDA coordinate with PAHO to determine specific inputs which would strengthen the effectiveness of the Planning Unit as the leader of national and regional health planning and policy guidance. (See Section 5.5.2.)

18. The evaluators specifically recommend that PASS be continued and prioritize the reduction of maternal and neonatal mortality (see Section 5.5.3). This model is a priority of the Ministry of Health as mentioned in the “Plan Estratégico Nacional para Mejorar la Salud Materna, Perinatal y Neonatal en Bolivia 2009-2015”. The evaluators recommend that the FPS and FLASS components support this key to strengthen one comprehensive program approach. A new phase should take into account the limitations of the Ministry of Health and SEDES in executing on their own the overall project components and the lessons learned and best practices from the project to date. Improving management capacity to execute projects like these in the future should also be a priority to improve the effectiveness and efficiency of the Ministry of Health. (See also Lessons Learned under design)

19. Future technical assistance should be used in the future to detect the financial and administrative bottlenecks and recommend solutions that can solve these and build the capacity of staff in the SEDES and the networks especially with regards to the financial administration of the country.

20. Future technical assistance should be used in the future to detect the financial and administrative bottlenecks and recommend solutions that can solve these and build the

² See the National Strategic Plan for Improving Maternal and Neonatal Health 2009-2015.

capacity of staff in the SEDES and the networks especially with regards to the financial administration of the country.

Gender Equality and “Inter-culturalism”

21. Include a men’s health component that includes sexual and reproductive education for men and “men friendly services” at health centers. Training objectives should include: strengthen knowledge and attitudes regarding gender equity, reduce risky behaviors (unprotected sex, alcohol and drug use), enhance self-assessment regarding sexual and family violence, improve actions to prevent of ITS-HIV/SIDA and unwanted pregnancies, promotion of the fathers’ role in nutrition and health of young children, and strengthen self-esteem and decision making. (See Section 5.7.3,; 5.8.1.).

22. Determine which practices can be institutionalized and include these in public policy. The SAFCI calls for gender equity and inclusion of inter cultural practices, however specific actions at the field level are yet to be determined. PASS can have an important role in this regard through the National Gender Technical Committee. (See Section 5.7.1.)

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1. Introduction

This report presents the findings of a mid-term evaluation undertaken of the Bolivian Health Sector Support Programme undertaken in Bolivia August 12-28, 2009. The Bolivian Health Sector Support Programme totals \$ 18,4 million with a duration of five years and consists of five components executed by different actors such as the Ministry of Health, UNICEF, Local NGOs and CIDA.

The document is organized in five parts. The first part consists of the introduction. Part 2 describes the project and its components, the key goals and expected results. Part 3 present the scope and rationale for the evaluation. Part 4 presents the overall findings of this mid-term evaluation paying special attention to the eight topics that are the object of this evaluation. Part 5 presents concluding remarks.

2. Description of the Project

The Support of the Health Sector Programme³ was first designed in 2005 with the participation of the Ministry of Health and Sports and the SEDES of the Departments of Oruro, Beni and Pando. In October 2005, the Agreement between UNICEF and CIDA was agreed upon for the execution of the Project to Increase the Coverage and Quality of Health in Oruro, Beni and PANDO (PRICCAS) which is supporting 12 networks and 57 municipalities. On June 5, 2006, a Memorandum of Understanding between the Government of Canada and Bolivia was signed for the implementation of PASS.

The Support of the Health Sector Programme (Programa de Apoyo al Sector Salud or PASS) is the first comprehensive health programme developed by CIDA's Bolivia Programme. The chief purpose of the PASS is to help improved access to as well as the quality of primary health care services, and particularly mother and child care, in selected departments of Bolivia while at the same time trying to strengthen public health sector management capacities in Bolivia at the central, departmental and local levels. The PASS is rooted in the Bolivian Poverty Reduction Strategy Paper (PRSP, 2001) and Bolivia's National Health Policy and promotes principals of Strengthening Aid Effectiveness such as local ownership and capacity-building, geographic concentration, donor coordination, strengthened partnerships, community participation and RBM. The project combines short-term support with a long term vision and operates at different levels (national, departmental, local) as well as different geographic locations (Oruro, Beni and Pando).

³ . While the support of the Health Sector Programme is called a Programme, it is referred to as a project in the report given CIDA semantics.

2.1. PRICCAS

UNICEF through the Project to Increase the Coverage and Quality of Health in Beni, Pando and Oruro (PRICCAS) is a key implementation partner of the project. Through its country programme, UNICEF is working with the MSD/SEDES to strengthen local service networks and control communicable diseases. UNICEF interventions cover institutional strengthening, social mobilization and communication, and selective delivery of supplies and services. By selecting UNICEF, CIDA ensures that there is no distinct management structure or unit parallel to the public system is established. The SEDES, which are the regional operations of the Ministry of Health was important in defining the priorities of the PASS project.

2.2. The Social and Productive Investment Fund (FPS)

The Social and Productive Investment Fund (FPS). Created in 2000, the FPS finances social and productive investments through conditional budget transfers to municipalities. It operates in a decentralized manner. The selected municipalities identify their own sectoral infrastructure and equipment needs, for which the FPS will then manage the procurement contracts, manage the expenditures, and provide assistance to help improve the capacities of those municipalities. The FPS drafts and approves the request for proposals, sends out the required RFPs and acts as an observer in the evaluation of those proposals. After reviewing the documentation from the municipalities, the FPS will validate the process and confirm that the municipalities can proceed with the various contracts.



To ensure better coordination between the FPS and MSD, an agreement was signed between the FPS and MSD with regards to health projects.

2.3. MSD and SEDES

MSD and three SEDES. Costed Strategic Plans for each Department are the foundation of the institutional strengthening component and articulates the need for technical assistance and capacity-building in strategic planning and financial management needs for example as well as for activities required to promote the establishment of an enabling environment for a PBA in the health sector.

2.4. Local Competitive Health Fund and Support for Local Sectoral Dialogue

Apart from these three components noted above executed by UNICEF, FPS, MSD and SEDES, there are two additional components:

1. A local competitive Health Fund that is reactive, managed by CIDA with a budget of \$ 600,000 which is used to fund Bolivian civil society such as NGOs, universities, reflection groups and civil society groups in order to complement PASS actions. Seven projects funded to date include the following:

- Saving the Lives of Women and Children in the Municipality of San Pedro de Totora, executed by the Municipality of San Pedro de Totora, Oruro;
 - “Constructing Social Networks around Health in Our Communities, Oruro”, Oruro
 - Integrated Community and Child Development: “From My Roots”, Christian Children’s Fund, Oruro;
 - Mobilizing the Community to Build Bridges between Women and Health Services in Indigenous Communities, Save the Children, Oruro.
 - A child’s blanket for child birth without risks in the communities of Aymara without borders, CECI, Oruro.
 - Women in Rural Areas of Beni Promoting their Rights via Strategies of Community Participation, Centro de Investigación, Educación y Servicios (CIES)
 - Strengthening family well-being and community through local health networks, Samaritan Purse, Beni.
2. A budget of \$ 120,000 has been set aside for Health Dialogue in order to provide a favourable environment for the health sector. This fund is administered by CIDA to finance workshops, studies, and consultancies with other donors.

These last two components are foreseen to start in 2008.

Table 1: Components of the PASS Programme and Breakdown

Start and End Date	Components	Amount in CAD
October 2005-July 2010	1. UNICEF-PRICCAS. Strengthening of local networks and services	\$ 10.4 million
Signature of Agreement in March 2007-2010. Reporting until March 2011	2. FPS- Productive and Social Investment Fund to improve the infrastructure and equipment related to health	\$ 4.5 million
Signature of agreement in March 2007 until Dec. 2010. Reporting until	3. MSD and SEDES; Institutional Strengthening; local technical	\$ 1.7 million

March 2011.	assistance transferred to SEDES	
Agreements signed March 2009 and have different end dates	4. Local Health Fund administered by CIDA	\$ 600,000
2005-2011	5. Support for Local Sectoral Dialogue in Health administered by CIDA	\$ 120,000
2005-2011	6. Monitoring, Auditing and Evaluation of the project administered by CIDA	\$ 1.080
		\$ 18.4 million TOTAL

Another salient feature of this project is the flexible and iterative approach. PASS thus combines activities of short duration with those of longer vision and operates at different levels (national, departmental and local) and in distinct geographic zones. Each of the components were initiated at different times. PRICCAS got off the ground in 2005 which enabled the project to start in the three departments. The second phase started in 2007 with the institutional strengthening (MSD/SEDES) and the infrastructure and equipment component managed by FPS.

2.5. Goals and Expected Results

The following section summarizes the goals and expected results of the programme.

Goal: To improve the health situation of the Bolivian population and strengthen capacities in the management of the health sector particularly in the Depts. of Beni, Pando and Oruro.

Purpose: Contribute to improving public services in primary health and in particular in maternal-infant health and the control of transmittable diseases, as well as, the Programme for Vaccinations in order to strengthen the capacity in public health management in the sector especially in the departments selected.

Impact: Increase the life expectancy en the selected departments.

Outcomes: Effective and equitable access of the population to integrated health, cultural adequate and gender sensitive.

Outputs:

1. Integrated health services: fixed, mobile and continuous offered to individuals and families, with emphasis in localities and excluded communities;
2. Organized communities participating actively to execute their rights to health;

-
3. Families, communities and the population assume responsibility for the health self-care and demand qualified health services with respect to cultural diversity and gender equality.

Outcome: Improved integrated health services in terms of capacity-building, quality and intercultural acceptance, gender equality and effectiveness in the control of illnesses.

Outputs:

1. Human resources of the health network has improved its competencies (knowledge, practices and decision-making) in maternal health, AIEP-NUT, PAI and prevalent illnesses.
2. Networks and establishment of health priorities with infrastructure and equipment infant-maternal in line with quality standards by level.
3. Networks and health services organized in line with SAFCI norms and community needs.

Outcome 3: MSD, SEDES, Health Networks and establishments with greater capacity to exercise sanitary authority, in the framework of operative programmes and plans.

Outputs:

1. Norms in management models, decentralized and participatory elaborated and implemented.
2. Health interventions coordinated and co-managed by institutional and social actors and others in socio-economic development which are operating in the Programmes areas;
3. Plans and programmes of SEDES and municipality elaborated, in line with PNDSS and evaluated effectively.
4. Increased Health investments executed with efficiency and effectiveness in SEDES and municipalities with a focused health programme.
5. Staff of MSD, SEDES y DILOS with greater health capacities;
6. Efficient and effective management of PASS in all of its components.

The project really started in 2007 with the holding of the first management committee meeting on October 16, 2007 which approved the Project Implementation Plan (PIP) and the 2007 Workplan.

3. Rationale and Scope for the Evaluation

3.1. Rationale and Scope

CIDA is looking to confirm the relevance of the Programme Support to the Health Sector Project being executed in Bolivia, commonly known as PASS and to make recommendations to make its execution more effective in order to meet the Programme's expected results while providing reflections on a possible second phase to the programme. The evaluation is timed to be a mid-term evaluation coming less than a year from the end of the PRICCAS component and 1.5 years after the approval and execution of PASS with its MSD and FPS component.

The evaluation will focus on two components: 1) Local-departmental level in Beni, Pando and Oruro in order to improve the access and quality of local services in basic maternal and infant health, the renovation of existing equipment and infrastructure and the control of transmittable diseases; 2) Institutional strengthening focusing on the Ministry of Health and the three departmental health services.

The scope of the evaluation will cover the following eight topics as per the terms of reference (See Annex 1) :

- 1. Relevance**
- 2. Coherence**
- 3. Effectiveness**
- 4. Efficiency**
- 5. Sustainability**
- 6. Risks**
- 7. Gender Equality and "Inter-culturalism"**
- 8. Lessons Learned and Recommendations**

3.2. Field Mission and Sampling

A field mission was undertaken to Bolivia which will allow the evaluator to gather the information needed for the evaluation. Field visits were made to three departments: Oruro, Beni and Pando. The country visit to Bolivia will inform the evaluation. Criteria for the selection of communities will include representativeness, distance and size and nature of the intervention.

Whenever possible, the evaluation will seek to interview a wide range of stakeholders to properly inform the evaluation as per the list presented in the next section.

3.3. Limitations

The Consultants travelled to 3 Departments in the Space of 2.5 weeks which made for a very tight schedule. One of the other problems the evaluation team encountered was the lack of a baseline assessment and detailed implementation plans with indicators

and quarterly results per SEDES, on which to base analysis and recommendations. Each SEDES does have targets called (compromisos de gestión), and according to the presentations we saw, these are all being fulfilled. However, the general information presented did not lend itself to an in-depth analysis of which technical aspects were not going well, therefore specific strategies were not recommended, except for the EmOC approach. Too little time was spent at each SEDES to undertake the analysis that CIDA is asking for. This type of detailed analysis would require at least 2 weeks per SEDES and would include the implementation of a rapid assessment of health posts, centers and hospitals, in addition to gathering information from community members.

The accreditation process for health facilities and the EmOc model both require assessments and these would allow the PASS Project to develop concrete indicators for each SEDES. Without these, it is difficult to determine the achievements of each SEDES, since they all implement the national MOH programs to a greater or lesser extent.

4. Methodology

The evaluation corroborated its findings by combining conventional methods of programme evaluation (review of documentation, semi-structured interviewing, survey questionnaire) with more dynamic and participatory methods (focus groups, testimonials, lessons learned workshops/roundtables) with regards to the planning and implementation of the evaluation process.

4.1. Methods

A range of methods were used for this evaluation which together corroborated the findings. The methods consisted of mixed methods that combined both quantitative and qualitative methods. The following is a summary:

- 1. *The review of documentation*** was done at the beginning of the evaluation to provide a solid understanding of the project, its implementation and progress. Key documents reviewed include the project contribution agreement, monitoring reports from the field and headquarters, annual and semi-annual reports, and general correspondence.
- 2. *Semi-structured interviews*** were undertaken both in Canada and in Bolivia with a wide range of both primary and secondary stakeholders such as CIDA, the Ministry of Health, various NGO executing agencies, health personnel in the field and community beneficiaries. An interview guide prepared prior to the mission focused on the key questions related to the terms of reference. See Annex 2.

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- 3. Testimonials** were gathered from the semi-structured interviews and questionnaires and help illuminate key findings in the evaluations.
 - 4. Focus Groups** were used with community members, women and men health service users where key questions were asked.

- 5. Workshop and round tables** were a reflective exercise on the project's implementation to date. The ½ day roundtables involve four workshops of up to 35 persons each in the departments of Oruro, Beni, Pando and La Paz. Participants were drawn from the relevant Government ministries; UNICEF, Municipalities, Health Networks and



Prioritizing Key Findings with Dot Democracy, La Paz

- Communities. The evaluators used a very effective method called World Café whereby four tables discuss 4 different topics (i.e. Strengths and Weaknesses of the project; Challenges Facing Project Execution and Strategies to Overcome Challenges; Recommendations to Strengthen Management and Improve Project Implementation in the next 3 years; Recommendations to Achieve Sustainable Results, Respond to a survey questionnaire, etc) with workshop participants discussing the table topic for 20 minutes before moving on to a new table and theme deepening the conversations and insights of the last group. In little time, a thorough discussion takes place and workshop participants have the opportunity to dialogue, exchange ideas and experiences; a very enriching experience that builds energy, passion and insight. This method was used with other participatory methods to inform the evaluation and future project implementation.
- 6. The PRA/PLA methods** are described under section 5.3 and will be used to gather qualitative and quantitative feedback about the project. Post-its, fishes and boulders (resources and obstacles to meeting the project impact), venn diagrams (fleshes out key stakeholders and their importance to the project), matrices for ranking and prioritizing project results and achievements were used.
 - 7. Questionnaire** was distributed during the workshops and completed by 128 workshop participants. (See Annex 3).
 - 8. Logic Model Assessment Grid.** The projects expected results were summarized on two pages and 57 interviewees were asked to assess the achievement of results on a scale of 1-5. (See Annex 4)

4.2. Salient Features of the Methodology

There were three salient features of the methodology to be used in this evaluation:

4.2.1. A utilization focus. Utilization focused evaluation is intended to make a shift away from more classical, extractive methods that are often seen as separate ('apart from') donor exercises aimed at gathering results documentation and lessons learned for higher level reporting purposes. With this utilization focus, the intent is to create a value-added exercise that, while collecting important evaluation data for the donor, engages the stakeholders in their own reflection and analysis of the impact and experience of the programme, while offering them an opportunity to move forward with more informed decision-making to consolidate the achievements to date for the remaining period of project execution.

4.2.2. A participatory approach fostered the active involvement of the programme throughout the evaluation: designing, implementation and debriefing the evaluation. The participatory nature of the evaluation involved the project at critical stages of the evaluation particularly in the design and planning stages, interviewing phase and presentation of findings. The participation of programme stakeholders in a workshop setting to reflect and analyze information and exploring the impact of their work can help foster deeper understanding of the achievements and limitations of the Programme. This complemented the participatory dimensions of the programme and were positive and constructive processes to the evaluation.

4.2.3. Innovative methods for gathering qualitative information such as Appreciative Inquiry and Participatory, Learning and Action techniques were used because they go beyond traditional interview and questionnaire methods by fostering an exchange among stakeholders, deepening knowledge and understanding of the Project and generating lessons-learned and recommendations steeped in first-hand experience of the Project. For example, Participatory, Learning and Action methods included a number of appraisal tools such as semi-structured interviewing, focus groups, mapping, ranking and sorting, stakeholder analysis, force-field analysis or trend analysis which shed light on performance and results relating to the objectives of the organization and programme or identified the lessons learned, best practices and insights from the organization and its partners.

These were positive and constructive assessment methods that lent itself well to the type of evaluation process proposed by the project and programme partners. The benefit of using these methods over more traditional evaluation methods is that they involved stakeholders in the process of reflection and also provided valuable input into the evaluation work. These shared learning opportunities can contribute to moving forward with the programme by responding to what is learned from the evaluation.

These methods were constructive, interactive, reflective and forward looking.

5. Findings

5.1. Relevance

5.1.1. Objectives and Scope of the Programme

Among the Millennium Development Goals adopted by the international community in 2000, goal number 5 is to improve maternal health, with specific targets of reducing the maternal mortality ratio by three-quarters (between 1990 and 2015) and achieving universal access to reproductive health. For Bolivia, that means cutting maternal mortality from 229 to 98 deaths per 100,000 live births.

The primary objective of the programme is to improve the quality of life of the Bolivian people through the reduction of the burden of disease and decreasing maternal and infant mortality. Intermediate results are to strengthen the institutional capacity of the Ministry of Health with a focus on the Millennium Development Goals, improve access to and quality of health services, provide technical assistance to local health networks and improve health infrastructure and equipment. Cross-cutting themes

include gender equity, cultural competency, community mobilization, and capacity building.

The objectives of the programme address key challenges facing the public health system in Bolivia: over half of the population suffers from poverty (59%)⁴, over two thirds are excluded from the health system (77%)⁵, and Bolivia has one of the highest infant and maternal mortality rates⁶ in Latin America. In rural areas only 4 out of 10 deliveries are attended by qualified medical personnel, while only 3 out of every 10 women receive medical care during pregnancy.⁷

“CIDA is the first agency to support the new Ministry of Health programme under the Evo Morales government. We received support in nutrition and our first basket fund thanks to Belgians and the Canadians. This set s an example for the other cooperation agencies.”
Nila Heredia,

Minister of Health, 2006-2008

The geographic scope of the programme targets municipalities in three departments which were selected by the Plan Vida⁸ in phases for interventions to reduce extreme poverty: Pando (Phase I, 2009-2011) with 15 municipalities, and Oruro and Beni

⁴ According to the 2002 Poverty Map with information from the National Census (2001), 59 per cent of the population of over 8,274,325 inhabitants live in conditions of poverty and 24,4 per cent live in conditions of extreme poverty.

⁵ Caracterización de La Exclusión en Salud en Bolivia, the Social and Economic Policy Analysis Unit (UDAPE) and OPS/OMS, October 2004, La Paz, Bolivia.

⁶ Maternal mortality is estimated at 229 per 100,000 live births, while infant mortality is estimated at 50 per 1,000 live births, INE, Bolivia Encuesta Nacional de Demografía y Salud, Informe Preliminar, ENDSA 2008

⁷ ENDSA, 2008.

⁸ Plan Vida, Para la Erradicación de la Extrema Pobreza.

(Phase II, 2010-2012) with 10 and 6 municipalities respectively. The technical scope of the programme includes an effective mix of interventions to address the needs of rural, indigenous, and/or dispersed population groups with limited access to health services.

The presence of CIDA is relevant as the only international cooperation agency supporting the Ministry of Health in the departments of Oruro, Beni and Pando; and the only donor that provides budgetary support to the central Ministry Planning Unit.

5.1.2. Consistency with the Needs of the Target Population

The needs of the target population center on maternal-child health issues and communicable disease prevention. Children suffer from malnutrition and infectious diseases, primarily diarrhea and pneumonia associated with poverty and poor access to potable water and basic sanitation. Many women do not seek prenatal care, nor go to a health facility for delivery⁹, resulting in a potential risk of incapacity and death due to obstetric complications. Pregnant women have limited access to emergency obstetric care, and insufficient knowledge of danger signs to make timely choices to seek medical attention. Not all women know about the Health Insurance Plan (SUMI), and therefore do not use health services¹⁰. Knowledge of communicable diseases is limited; hence protective measures are not taken. In Oruro, Beni, and Pando, only half of the women surveyed in UNICEF's Baseline Study¹¹ knew about Tuberculosis, Dengue and Leishmaniasis; and in Oruro and Pando, only 20% and 40% of women respectively, knew about HIV/AIDS.

PASS components PRICCAS and FPS are particularly relevant to addressing the above needs in the three departments, especially regarding the expansion of coverage and focus on quality medical standards. Programme interventions include emergency obstetric and neonatal care to reduce maternal and neonatal mortality. Nutrition improvement and vaccination coverage prevent deaths in children under five years of age, while control of communicable diseases protects the population from morbidity and mortality. The PRICASS information, education and communication component provides key messages to local populations to increase knowledge and care seeking behavior.

The combination of strategies to improve coverage and quality of health care; remodel, equip and supply health centers; train health care providers in appropriate case management; and strengthen management systems are making inroads to improve geographic, economic and cultural access to services. The performance of health care providers has been improved through training in protocols to treat key health problems,

⁹ Encuesta Línea de Base PRICCAS 2006. Only 5 out of 10 women in Oruro and 6 out of 10 in Pando have the required 4 prenatal checkups, and only 4 out of 10 women in Oruro have their delivery at a health facility, while in Beni and Pando the number rises to 7 out of 10.

¹⁰ IBID. Four out of 10 women in Oruro, 5 out of 10 in Pando and 8 out of 10 in Beni are aware that there are free health services available under the SUMI Health Insurance Plan.

¹¹ IBID.

and community demand has been increased through mobilization and community participation activities.

5.1.3. Consistency with the National Health Strategy

The PASS programme is consistent with the Paris Declaration which calls for the alignment of international cooperation agencies with the policies of the Bolivian Government and Health Sector Plans, stipulating that all agencies work together to enhance effective cooperation efforts.

A key component of the National Development Plan¹² is the Health Sector Plan, which is based on the transformation of an inequitable and inefficient health system into one that is responsive to the real needs of the population, eliminating social exclusion. The “*Sistema Unico, Intercultural y Comunitario de Salud*” (SAFCl)¹³ proposes to increase access to basic services, reduce maternal and infant mortality, combat infectious diseases, and eradicate extreme poverty and hunger. A health insurance program (SUMI) provides free services and food supplements are provided to reduce malnutrition in young children to zero.

5.1.4. Consistency with the Ministry of Health and Development

The National Strategic Plan to Improve Maternal, Neonatal, and Child Health (2009-2015)¹⁴ calls for the reduction of maternal and infant mortality through strengthening the capacity of municipal health networks to provide quality of care, adequate response to emergencies and the promotion of healthy practices at the community level. PRICCAS is supporting regional clinical training centers and is spearheading the organization of obstetrical and neonatal networks, while FPS is providing health infrastructure and equipment to respond to these emergencies.

The chart below shows how PASS contributes to the National Health Plan.

Table 2: PASS Contribution to the National Health Plan

National Health Plan	PASS
Mandate: <ul style="list-style-type: none"> • Access to a universal, intercultural family and community based health system Strategies <ul style="list-style-type: none"> • Strengthen health networks • Quality improvement • Services cater to inter-generational families and a gender and intercultural approach is fostered 	<ul style="list-style-type: none"> • Improve service delivery • Strengthen management systems • Improve access and quality • Foster a gender and intercultural approach • Expand coverage through mobile brigades

¹² Plan Nacional de Desarrollo: Bolivia Digna, Soberana, Productiva y Democrática para Vivir Bien, 2006.

¹³ Intercultural Family and Community Health System

¹⁴ Plan Estratégico Nacional para Mejorar la Salud Materna, Perinatal y Neonatal en Bolivia 2009-2015, Resumen Ejecutivo, Ministerio de Salud y Deportes, La Paz, Bolivia.

<ul style="list-style-type: none"> • Expand coverage of health services 	
<p>Mandate:</p> <ul style="list-style-type: none"> • Recuperate and consolidate public health leadership <p>Strategies:</p> <ul style="list-style-type: none"> • Regulation and control of health financing • Strengthen management capacity • Oversee the quality of the provision of goods and services • Implement the Universal Health Insurance Plan • Plan and implement research • Expanded use of technology for health management 	<ul style="list-style-type: none"> • Capacity building to strengthen public health leadership and authority for the Ministry of Health Planning Unit, 3 SEDES and respective health networks • Improvement in infrastructure for health centers and posts • Purchase of equipment and supplies • Research: PRICCAS Baseline Survey • Provision of computer equipment to health networks

It is also important to underscore the Program’s support for strengthening the UP of the MSD, with the purpose of having an institutional body that goes beyond the operational sphere of the MSD and that engages in building the strategic vision required for the health sector.

5.1. 5. Consistency with CIDA’s Development Priorities

The programme falls within CIDA’s Social Development Priorities¹⁵ namely reduction of child and maternal mortality, promotion of gender equity, and improved access to health services. PASS supports Canada’s International Policy Statement on Development¹⁶ as regards a sector approach in health, with a focus on strengthening the capacity of local health systems, improving infant and child health, and strengthening sexual and reproductive health—all linked to the cross-cutting theme of ensuring gender equality. Bolivia is one of Canada’s enhanced partnership countries, and the PASS strategies promote local ownership and a results-based approach as articulated in Canada’s Policy Statement on Strengthening Aid Effectiveness¹⁷.

Gender equality is addressed through the PRICASS and FLASS components. Participation of women in training events, and the promotion of women as traditional birth attendants and health promoters empowers them to realize their potential as partners in community development, along with the men. PASS has improved physical access to maternal and child health services through the improvement of health posts and centers.

¹⁵ “Social Development Priorities”: A Framework for Action, September 2000, Canada.

¹⁶ “Canada’s International Policy Statement, A Role of Pride and Influence in the World: DEVELOPMENT”, CIDA, Quebec, 2005.

¹⁷ “Canada Making a Difference in the World: A Policy Statement on Strengthening Aid Effectiveness”, Canadian International Development Agency, Quebec, 2002.

5.2. Coherence

5.2.1. Internal Coherence

Attainment of coherence between the diverse components of PASS posed a series of challenges. Although the PASS was planned as a programmeduring 2006 unifying various components towards a common objective, attainment of coherence between the diverse components of the PASS posed a series of challenges. This coincided with the election of President Evo Morales in December 2005 and the subsequent reorganization of the central government around a new ideology which had implications for the public health system. Due to these fundamental changes during 2006, CIDA had difficulty getting consensus with the new government and with the initiation of project activities. Although an initial Memorandum of Understanding was drafted in 2006, it was not signed until a year later.

5.2.2. Partnering

The choice of partners is a good one. The central Ministry of Health Planning Unit is the official liaison between the Ministry and international cooperation agencies. UNICEF is competent in its role as a provider of technical assistance and accompaniment to the Ministry of Health, especially at the Departmental and Health Network levels. The FPS has an organized structure that facilitates the entire building process from project design to completion in an efficient timely manner. The NGOs implementing the FLASS component have experience in community education, mobilization, and are innovative and committed. The three SEDES are appropriate partners and will be key participants in the sustainability of PASS activities. Field implementation got off the ground in 2007 in Oruro and has been consistent with national health and development plans at the regional and local level. In contrast, social conflict and political tension and severe flooding affected the Beni and Pando Departments, therefore programme activities did not gain momentum until August of 2008

The program does link the supply (improvement of healthcare services by means of training and infrastructure) and demand (community empowerment) sides of the health sector; in addition, it strengthens the governing bodies at the national and departmental levels so as to improve monitoring of the healthcare system.

5.2.3. Development Hypothesis

Regarding the relevance of the initial development hypothesis and geographic focus, CIDA selected its target area based on recommendations from the Ministry of Health and included departments with high levels of poverty and geographic dispersion. The premise that UNICEF has the appropriate mix of skills to be the leading technical partner is well-founded. Conversely, the hypothesis that the Planning Unit would provide an important leadership role has not been fulfilled. The Ministry is highly politicized and lacks a strong technical agenda to make it an effective policy lead at this

time. Nonetheless, the assignation of funds to the Planning Unit has gained support for PASS and facilitated coordination with the SEDES.

5.2.4. Integration of Programme Components

PRICCAS and FPS, with their respective interventions, are making progress towards PASS objectives. The FLASS component provides a laboratory for small innovative community projects with the potential to be scaled up and adopted by their respective SEDES or municipal government structures. There have been some difficulties with the Planning Unit, as regards its integration into PASS in the intended leadership role.

Although the Ministry of Health Planning Unit greatly appreciates the donation of unrestricted funds, the results in terms of policy development, guidance and sector leadership has not met the initial expectations of PASS. The head of the Planning Unit has been changed several times since the programme began, and the Unit has not been able to hire and retain the 7 consultants that PASS initially budgeted for. The Planning Unit only has 2 staff funded by the Ministry of Health, resulting in minimal potential for sustainability when PASS ends. Administrative bottlenecks at the Central Ministry have rendered disbursements to SEDES untimely. For example the funds arrive during the second semester and coincide with the rainy season in Beni and Pando, when few activities can be implemented due to inaccessibility.

Dr. Nila Heredia, the first Minister of Health under the new administration, played a significant role in the building of the new health strategy and was an active participant in the development of the Planning Unit and supported its leadership role. However, there have been three health ministers since and they have not participated, adversely affecting the full integration of the Planning Unit in the PASS programme. For example, PASS supported the Planning Unit to develop an institutional plan, which has undergone several revisions over the past several months and has yet to be launched.

There is no official mechanism to ensure the integration of programme components except for two national committees (managerial and technical) that meet twice a year at the national level. General themes are analyzed including administrative problems facing the Planning Unit rather than strategic analysis of progress towards results. At both the national and regional levels insufficient analysis is undertaken by the group of stakeholders to determine how actions could be streamlined in terms of cost and level of effort to achieve results. From interviews during the evaluation, several FPS staff did not understand the big picture, nor were aware of the objectives and expected results of the PASS programme. Therefore there was no awareness of the need to provide value added in terms of innovation on design and other structural issues that would have a positive impact on gender and intercultural aspects in addition to medical requirements, such as the installation of more electrical outlets in operating and laboratory rooms.

Although there is a potential synergy among the partners and their contributions to PASS, this has not been capitalized upon. It is important to determine what needs to happen so that “the whole is greater than the sum of the parts”. Objectives would be

better met if the different partners “talked to each other” regularly at the operational level and worked to turn PASS into a programme rather than a set of independent projects. It has been suggested that an advisory group be formed with the participation of the different components to exchange experiences and coordinate actions on a quarterly basis as appropriate. Leadership and organization of this advisory group could be rotational to foster shared vision, commitment and team learning; and not to overburden any one component.

5.2.5. Consistency with Key Stakeholders

Consistency with the key stakeholders including the central Ministry of Health, the three SEDES, and their respective municipal health networks has developed gradually since the start of the programme. CIDA determined that PRICASS should lead the health component in the PASS programme, and activities started in 2006. PRICASS did a baseline study and integrated the results into the annual operating plans for the three SEDES. These plans provided a united vision about where to go and how to get there. The integration of PASS into the Ministry of Health, through support to the Planning Unit was an appropriate approach to institutional strengthening and helped build consistency between levels.

The SEDES Planning Units have received funds from the central Ministry several months after the activities were to take place. However, the support to the SEDES is serving a purpose. In Oruro, for example, the SEDES used the funds to: prepare a Departmental Development Plan, hire two experts in planning and health economics, improve the health information system and decision making through the data analysis committees (CAI), and implement monitoring, supervision and evaluation with the health networks.

Coherence between the central Planning Unit and the regional SEDES needs to be strengthened, especially in terms of policy guidance to the lower levels of the system. Even though all the levels of the Ministry of Health respond to the National Development and Health Sector Plans, administrative and financial weaknesses along with political differences between the central government and the Beni and Pando Departments have adversely affected the continuity of programme activities.

5.3. Effectiveness

It is interesting to note that the questionnaire revealed that 82.17% of the respondents were highly committed to the results of the programme. When asked what were the most important results, survey respondents noted:

- Increased coverage to far away places
- Decrease in maternal and neonatal deaths
- Renovation of infrastructure
- Training in Institutional strengthening
- Nutritional assistance to children
- Getting commitment of community integrated health

-
- Big commitment to arrive at isolated and far away places
 - Improved technical capacity of staff
 - Economic Support to SEDES

When asked what were their satisfaction with the implementation of the programme, 68% were very satisfied followed by 30.4% to some extent and 1.6% very little.

Overall, these findings are impressive and were corroborated with the findings of the workshop.

5.3.1. Nature and Modalities for Program implementation

The nature of the PASS is effective as it responds to the need for improving the population's access to healthcare services, which is limited due to economic, geographical, cultural and social factors.

Project implementation includes different public entities (MSD, SEDES and FPS), one international organization (UNICEF) and several private organizations (foundations and NGOs). Being a new experience in the country, this form of support of the international donor community is effective as it joins and integrates institutional expertise and efforts with the risks being distributed over more than one institution.

5.3.2. Scope of Achievement of the Activities and Expected Outcomes

a) Programmed and Performed Actions

The actions programmed in each component are included in the different Annual Operational Plans (AOPs), which link each impact and output of the Program logical framework to the specific activities and tasks to be carried out on an annual basis.

However, as there is no Program baseline, it is not possible to quantify each implementing entity's contribution to the outputs defined in the logical framework. Moreover, indicators have changed over time making it difficult to track results in a consistent manner.

Each implementing entity provides six-monthly reports on physical and financial progress in implementation of the activities. Nonetheless, there is no consolidated report on the degree of progress of the Program, which should be connected to the logframe.

Below, an explanation is provided of the situation of each component:

“It is the first experience of budget support in the MSD and it will be helpful to define future modalities for support from the international donor community”.

Leslie La Torre

PASS consultant

Planning Unit - MSD

1) Institutional Strengthening (MSD and SEDES)

MSD: the National Health Plan is aligned to the National Development Plan, with the purpose of eliminating social exclusion in health (to some extent, 77% of the population has no access to healthcare services) through the following policies: 1) a Single, Intercultural and Community-based Healthcare System; 2) Leadership; 3) Social Mobilization; 4) Health Promotion; and 5) Solidarity.

The budget support for the PASS is aimed at strengthening the UP of the MSD and the SEDES, prioritizing activities regarding leadership policies and social mobilization, contained in the Sectoral Development Plan. This way, the activities of the MSD are covered under strategy 3 of the Program logical framework: “MSD, SEDES, network and healthcare facilities with enhanced capacity to act as the leading health authorities within the framework of operational plans and programs”.

The budget support for the planning entities in the MSD and SEDES is vitally important for the institutional structures to acquire the technical capacity required for drafting public policies for the benefit of the population.

The AOP of the UP at the MSD includes activities to: a) draft regulations for the decentralized and participatory management model; b) improve communication for coordination and joint management of health actions by institutional and social stakeholders; c) align and evaluate the plans and programs of SEDES and the municipalities; d) increase the volume and execution of investments in health; e) build the capacity of human resources of the MSD, SEDES and DILOS; and f) improve management, supervision and monitoring in the MSD and SEDES.

However, these activities have not been fully developed as many tasks could not be concretized, e.g. the selection and procurement of online technical assistance. In this activity, the plan was to hire 7 consultants but only four consultants were employed in 2008 and two in 2009.

It is not possible to measure the degree of physical progress, as no data are reported on this, but in its six-monthly reports the MSD points out that “physical and financial execution have not been as expected”, due to many constraints, particularly the following ones:

- The MSD has not internalized the importance of the PASS support for strengthening and empowering the Planning Unit (UP) as an entity with capacity to coordinate and articulate the strategic planning processes. Hence, the UP was not granted the hierarchical level of a General Direction, as provided for in Supreme Decree N° 29894 dated 7 February 2009 on Organization of the Executive Branch. Therefore, an opportunity was missed to create an internal

structure to improve planning, programming and management and to institutionalize some key positions with funding from the TGN.

- Because of an overload of responsibilities and tasks in the UP, only “urgent” matters were dealt with and planning was ignored. A large part of its work is therefore not mentioned in the PASS reports. We should underline that this is an implicit recognition of this unit’s response capacity to address the matters entrusted to it.
- Constant turnover of the supreme authority of the MSD (from 2006 to date there have been 3 Ministers), with repercussions at the level of General Directors and personnel in general (from 2006 to date there have been 5 Directors General of Administrative Affairs). This situation gives rise to employment instability, which hampers development of a firm commitment to the institution and which affects the employees’ productivity.
- Low staff morale in the MSD and particularly among the PASS consultants due to the low salaries and the lack of continuity in their consulting contracts.

SEDES: as in the case of the MSD, the activities of the 3 SEDES are also part of strategy 3 of the Program logical framework. In this sense, the 3 SEDES have prepared their respective AOPs, including activities aimed at building a greater capacity to assume technical, administrative and management leadership and act as the health sector authorities in their departments, within the framework of the national health policies and strategies in force.

Their activities cannot be measured either in terms of physical progress as there is no reported information. Even though the MSD developed a reporting format for the Ministry and the SEDES, which includes data on programming of the activities and tasks as well as the expected outcomes, it does not include the most important aspects, i.e. the attained results, and so the reports are simply narrative documents, which cannot be consolidated in progress reports of the component.

The SEDES have information on progress of their activities, which is, however, not included in the six-monthly reports, as shown in the following example of SEDES Pando for a concrete example. In this example, the columns on Activities, Tasks and Expected Outcomes come from the Year Report 2008 and the last column contains information collected in field visits of the evaluation team.

Table Nº 3
COMPARISON YEAR REPORT 2008
AND AVAILABLE INFORMATION
SEDES PANDO

Output 3. Regulations for the decentralized and participatory management model developed and implemented.			
Activities	Tasks	Expected Outcomes	Achieved Outcomes
Development and implementation of the information system to track and monitor activities of the second phase	Implement the integrated system in the Planning and Administration Units	The SEDES Pando has an integrated information system for inventory control, follow-up of the activities and supervision of the facilities	<ul style="list-style-type: none"> • Implementation of the information system on fixed assets (90% progress) • Implementation of the information system for Follow-up and Monitoring of Trainings (80%) • Financial progress of 98.9%

Source: Year Report 2008 and Power Point Presentation PASS report 2008, SEDES Pando

Hence, valuable information is being lost for tracking and measuring the Program contributions to the PASS goals.

Historically, the SEDES have had an important role in the implementation of sector health policies in each of their departments, evolving as awareness at an institutional level increased to resolve health matters. Nevertheless, the limitations have revolved around the designation of funds and capacity-strengthening. In the case of PASS, budgetary support overlooks the lack of resources by becoming an important support, although it is not sufficient to fulfill all of its roles.

In terms of the strengthening of capacities related to human resources, the SEDES reflect the lack of decentralization in terms of capacity which could improve to the degree that decentralization and autonomy is deepened in the future.

The low level of budget execution demonstrated in the three SEDES with relation to PASS is due to the lack of an efficient administrative and financial system established to facilitate project execution for PASS which affects the SEDES, administration at the Prefecture level, MSD which creates delays. In addition employment instability within the SEDES requires a capacity building policy at all times to keep staff abreast of developments.

In the case of Oruro, one can distinguish in a positive manner the institutional management of the SEDES despite the difficulties noted below. Nevertheless, it has consolidated its departmental management. In Beni and Pando, the lack of professionals in the region or from other regions that are willing to work in the department is more limited and has influenced in a negative manner the strengthening of capacities.

Similar to the MSD, the SEDES have had difficulties regarding the physical and financial execution of their AOPs, which are detailed below by SEDES:

SEDES Beni:

- The limited geographical accessibility and the lack of roads to the communities give rise to high costs and hamper the implementation of some activities.
- No respect for the deadlines for implementing the activities as the resources are disbursed late.
- Little commitment of some local authorities to allocate resources for investments and operating expenses in health (they prefer to make investments in cement works instead of in hospital inputs).

SEDES Oruro:

- Excessively slow administrative processes in SEDES.
- Instability on different levels: the municipal authorities due to poor governance, on the level of the SEDES Direction (3 changes since 2006), the Network Managers and the human resources in general.
- An overload of responsibilities and tasks for the technical team, which reduces the possibilities of an adequate management and supervision in the rural areas for an adequate control and monitoring of compliance with technical-administrative regulations.
- Low morale in the team of the Network Managements, because of the annual calls for filling their positions, which means that the first three months of every year are without leadership.

SEDES Pando:

- The social conflicts in September 2008 paralyzed public and private activities in the department.
- The change of departmental authorities gave rise to a change of authorities and personnel in the health sector.
- The management model of the departmental authorities eliminates the administrative and financial management autonomy of the SEDES, concentrating all financial and administrative authorizations in the hands of the Prefecture (departmental government), and generating considerable delays. In addition, there are delays in registration of the budget and subsequent modifications by the VIPFE and the MEFP.
- There are difficulties to hire consultants because the national regulations are bureaucratic and inadequate for the conditions of the department (the Basic Regulations for the Procurement of Goods and Services); consultants refuse to work in the departments as they have no fixed-term commitments and as the cost of living in Pando is high compared to other departments.
- The health personnel's morale is low, particularly in the rural areas, as there are no good living conditions (there is a shortage of houses and other incentives in the rural area).

2) PRICCAS (UNICEF)

UNICEF has a Country Program Action Plan, which is fully aligned to the National Development Plan and the Sectoral Development Plan 2006-2010 of the MSD.

The Country Program strategies are: a) comprehensiveness of the actions in life cycles, putting the child at the center of the actions; b) capacity-building for the communities, households and individuals, as well as for public institutions and civil society on all levels, and; c) a reduction of the gender and geographical gaps and the gaps affecting the indigenous population and other vulnerable population groups.

“PRICCAS is not an isolated project for UNICEF, but it is part of a cooperation project agreed upon with the government of Bolivia; we have gone beyond the project approach to work from a country policy perspective”.

Fátima Ivette Sandino, Nutrition and Health Director

UNICEF

The PRICCAS component is part of this conceptual model, the activities of which focus on expanding the access to and improving the quality of primary healthcare services, particularly in mother-child health, as well as strengthening the capacity of healthcare institutions on the national, (MSD), departmental (SEDES and Network Managements) and municipal (DILOS, Municipal networks and health facilities) levels.

The PRICCAS activities focus on achieving the three strategies of the PASS program logical framework: E.1) Effective and equitable access of the population to integrated, culturally adequate healthcare services with gender equity; E.2) Improve the quality of integrated healthcare services in terms of problem-solving capacity, warmth, intercultural adaptation, gender equity and effective disease control; and E.3) the MSD, SEDES, networks and health facilities have more capacity to act as the leading health sector authorities, within the framework of operational plans and programs.

In order to ensure implementation of the priority national programs, improve the access to and quality of the municipal primary services, particularly regarding mother-child health, the PRICCAS has its own strategies: 1) Institutional strengthening, through support for the healthcare policies, human resources training, and the construction and consolidation of strategic alliances at the local level; 2) Social mobilization and communication, for promoting health and nutrition with a rights-based approach; and 3) The selective distribution of services and supplies, based on the epidemiological reality and situation.

The reports on physical execution of the PRICCAS include the degree of progress in the expected outcomes and conclude that 71% of the goals are achieved (46% achieved

and 25% overachieved) and 29% are partially achieved. There is not one goal that was not achieved to some extent (see Annex N° 7 and 9).

Due to the management model of UNICEF, there are no internal difficulties hindering Project implementation. On the contrary, in some cases the typical difficulties of the state bureaucracy are overcome, for example in the direct procurement of goods and supplies by UNICEF without taking into account national regulations that cause delays in procurement processes. Hence, using UNICEF processes is an advantage, not only to speed up procurement but also in terms of price reductions.

Most obstacles are related to the state administration on the different government levels:

- The lack of local management capacity causes delays in the reports to account for the resources.
- Registration of the budgets of the SEDES and the municipalities in the VIPFE and the MEFP.
- Turnover of authorities and personnel of the health sector, at the national, departmental and municipal levels.
- Bureaucratic administrative processes in the MSD and SEDES, due to situations derived from national regulations on the financial management systems and management models.
- The lack of technical capacities hampers the operational implementation of public policies in the health sector.

The capacity for managing the financial administration systems should be strengthened, both at the level of the MSD and in the SEDES and municipalities. In this regard, the suggestion is to hire experts to prepare guides on financial administration systems (budgets and treasury) and train personnel on the basis of practical Program cases; this training should be complemented with technical guidance in order to ensure compliance with budget execution and accountability.

3) Infrastructure and equipment (FPS).

Within the framework of the National Development Plan, the FPS is an operational entity in charge of linking national policies to social and productive investments and investments in intangible assets in the communities, municipalities, departments and regions.

Since its creation in 2000, the FPS has developed expertise in the development of infrastructure and equipment in education, health, basic sanitation and production through conditional financial transfers for implementing projects in a decentralized manner.

The projects implemented through the FPS must be linked necessarily to specific sectoral policies, based on guidelines of the PND and sectoral strategies. Thus, the PASS projects contribute to the achievement of strategy 3 of the Program logical framework and concretely to output 5: Investments in health increased and executed with efficiency and effectiveness in SEDES and the municipalities, advancing towards a program approach in health.

The PASS finances projects in infrastructure and equipment, including the required supervision; moreover, the FPS collects an administration fee equivalent to 10% of the amount of the funding.

The data on execution show us that there are projects on the three healthcare levels, but with an emphasis on Level 1 (87.80%), basically in the Healthcare Centers (68.29%), and so there is consistency with the strategy to improve the access to and quality of the primary healthcare level.

Table N°4

PROJECTS BY TYPE OF INVESTMENT

Classification of the Investment	Beni	Oruro	Pando	Total	%
Level 1	5	28	3	36	87.80%
- Healthcare Posts	2	6	0	8	19.51%
Equipment of the Healthcare Posts	0	1	0	1	2.44%
Extension and Equipment of the Healthcare Posts	2	5	0	7	17.07%
- Healthcare Centers	3	22	3	28	68.29%
Equipment of the Healthcare Centers	0	7	0	7	17.07%
Extension of the Healthcare Centers	0	1	0	1	2.44%
Extension and Equipment of the Healthcare Centers	3	14	3	20	48.78%
Level 2	3	0	1	4	9.76%
Equipment Hospital	1	0	0	1	2.44%
Extension and Equipment Hospitals	2	0	1	3	7.32%
Level 3	1	0	0	1	2.44%
Extension and Equipment Mother-Child Hospital	1	0	0	1	2.44%

TOTAL	9	28	4	41	100.00%
% of projects by Department	21.95%	68.29%	9.76%	100.00%	
Budget Allocation by Department	\$ USD 992,264 or 33.33%	\$ USD 1,479,25 5 or 44.44%	\$ USD 457,168 or 22.22%	\$ USD 2,928,686 or 100%	

Source: Six-monthly report as at June 2009, FPS

Likewise, as regards the number of projects, it is clear that at the moment the department of Oruro has the highest number of projects in the portfolio (68.29%), followed by Beni (21.95%) and Pando (9.76%); in the three departments there is consistency as regards the priority given to the primary healthcare level. Budget allocations also varied. Although, Oruro was allocated 44.44% of the budget, Pando with far fewer projects received, nevertheless, 22.22% of the budget allocation.

The FPS activities were set within the framework of the Project Cycle, which is made up of the following phases: application; evaluation; approval; invitation, tender and award; implementation; and close.

The reports show the degree of progress in all approved projects (41), 24% of which are concluded and the rest is in different phases of the project cycles, as detailed below:

Table N° 5

PROGRESS OF PROJECT

Department	Number of Projects	Project Phase					
		In Evaluation	Approved	Tendered	Awarded	In implementation	Concluded
Beni	9	0	0	2	0	1	6
Oruro	28	1	8	7	0	8	4
Pando	4	0	0	0	1	3	0
Total	41	1	8	9	1	12	10
%	100%	2%	20%	22%	2%	29%	24%

Source: Six-monthly report as at June 2009, FPS

During project implementation, some difficulties delayed the projects:

- The tender processes under the responsibility of the municipal governments took more time than needed.
- The projects were subject to observations in the evaluation phase and so more time was needed to adjust the items.
- The coordination with the SEDES depends on personal will as there is no formal relationship, though this has recently improved. The change of authorities in SEDES has given rise to changes in some projects.
- The national regulations and the procedures with the VIPFE and the MEFP cause delays in budget modifications.
- The DUF does not delegate the approval of budget modifications to the Managing Director, which delays the processes.
- The depreciation of the North American dollar in relation to the Canadian dollar has given rise to a higher amount of resources to be allocated.
- The sectoral regulations are not updated so as to consider the gender and interculturality perspectives.
- In Beni and Pando, the rainy season has a negative impact on the implementing rhythm. This aspect must be considered when defining implementing timeframes.
- In Pando, the events of September 2008 caused delays in all programs.
- In Pando, there was a change in the priority given to the Hospital del Sena, with which an agreement had already been signed. At the moment, the activities have been paralyzed, which affects 65% of the resources allocated to the department.

4) Local Fund in Support of the Health Sector (FLASS).

The objective of the FLASS is to “support integrated actions on the communal level, particularly for the promotion and education in health in order to improve the demand for health services, prevent diseases and develop community-based surveillance activities”.

“I went to the healthcare center to avoid risks; women should go there not only for the aguayo cloth they receive, but thinking of themselves and of their children”.

María Elena Cruz

Beneficiary of the project “An Aguayo Cloth for Safe Childbirth”.

Curahuara de Carangas, Oruro

The FLASS funds are executed through concrete projects for the benefit of the population and for compliance of the logical framework outputs: 1.b “the organized community participates actively for exercising its right to health and in social control” and 1.c “families, communities and the population in general assume responsibility for the self-care of their health and they demand quality health services with respect for their cultural diversity and with gender equity”.

In this sense, in coordination with the SEDES, CIDA launched calls in the three departments. For example, all three SEDES were informed about the call for proposal, which were published in La Razon newspaper for two weeks, published on the UASCC’s website,

and an email was sent to all the Canadian NGOs, all members of the Health table, as well as to the Ministry of Health and the three SEDES. As a result, 7 projects were approved (3 in Beni and 4 in Oruro), benefiting a population of 99,128 persons (33,304 direct beneficiaries and 65,824 indirect beneficiaries) (see Annex N° 8) out of a total of 31 proposals received.

No concrete results have been reported as yet, as the start of FLASS was programmed to take place in the last two years of the Program. Hence, the activities started only in 2008 and the first disbursements for the projects were made in the first half of 2009.

In the field visits, it was clear that the activities carried out by the Project implementing institutions have given rise to a change of behavior in the beneficiary population. The activities focus on female empowerment as a guarantee to achieve sustainability of the first Program strategy: the population's effective and equitable access to integrated, culturally adequate healthcare services with gender equity.

Departments like Pando may require special support for the dissemination of the component and help in preparing project proposals. Nonetheless, the percentage of allocation was 91% in relation to the available resources. 31 projects were submitted in the selected departments, 26% of which were approved; in the case of Pando, no projects were approved. Four proposals were not assessed as they were not received in time and fell outside of the criteria established for the Programme.

Table N° 6

FLASS: PROJECTS PRESENTED AND APPROVED¹⁸

Department	Projects Presented	Projects Approved	% of Approval by Projects Presented by Department
Beni	9	3	33.33%
Oruro	14	4	28.57%
Pando	4	0	0.00%
Total	27	7	26%

Source: CIDA

¹⁸ . It should be noted that 31 proposals had been received by CIDA but, four of these did not fall within the criteria of the programme and thus were not formally presented for evaluation.

b) Program Outputs

The achievement of the Program outputs is reported in the Year Reports, which compare the goals of each output to the achieved outcomes (see Annex N° 1). Twenty-nine percent (29%) of the results have been partially met, 46% was complied and 25% was overachieved, which shows that the actions under the different Program components were effective.

On the other hand, techniques were used to collect data on the perception of the Program stakeholders with regards to the major results of the Project to date through Workshops at the departmental and national levels. Participants were asked to define the key results of the programmes using post-its and then, after discussion, to prioritize the most important results using dots. The results are summarized in the table below:

Table N° 7

PERCEPTION OF PROGRAM RESULTS

RESULTS	NATIONAL	BENI	ORURO	PANDO	TOTAL
Training and Quality care ¹⁹	26.19%	23.08%	14.10%	21.67%	20.41%
Management and planning capacity-building and strengthening	9.52%	16.92%	23.08%	25.00%	19.59%
Improvement of the infrastructure and provision of equipment	11.90%	3.08%	16.67%	35.00%	16.73%
Strengthening of Local Stakeholders	23.81%	23.08%	1.28%	16.67%	14.69%
Access and Coverage	14.29%	0.00%	20.51%	1.67%	9.39%
Impacts	14.29%	0.00%	14.10%	0.00%	6.94%
	0.00%	7.69%	10.26%	0.00%	5.31%

¹⁹. Training was highly regarded in the survey results. Of survey respondents who received training 78.2% were highly satisfied followed by 20% who had a medium level of satisfaction. The most sited courses were: nutrition and neo-natal care, gender and violence, strategic management, administrative management, and malnutrition.

Interculturalism and Gender					
Institutional Strengthening	0.00%	20.00%	0.00%	0.00%	5.31%
Intersectoral Approach	0.00%	6.15%	0.00%	0.00%	1.63%
TOTAL	100.00%	100.00%	100.00%	100.00%	100.00%

Source: Prepared by author based on the Workshops

The achievement of Program results is acknowledged, specifically in the following fields: Training and Quality care (20.41%), Management and planning capacity-building and strengthening (19.59%), Improvement of the infrastructure and provision of equipment (16.73%) and Strengthening of Local Stakeholders (14.69%). However, these results have different connotations in the departmental analysis: in Beni, the most important result is in the field of human resources and integration of the communities into the health sector; in Oruro and in Pando, the most important result is related to management and planning capacity-building.

The stakeholders also have assessed the importance of key results, though to a lower extent, of the Program contribution to improvement of the Access and Coverage, the Impact and Institutional Strengthening, which are part of the Program aim. In this sense, we can conclude that there is not only a perception on the achievement of concrete results that are visible in the short term, but also on the desired impacts that can be measured only in the medium and long-term.

Some crosscutting topics are influenced by cultural differences in the departments; for example, Gender is important, but it does not stand out in Pando with the same emphasis as in Beni and particularly Oruro.

The topic of interculturalism does not have the same specific weight in the east as it has in the west, as the eastern natives are rooted less in ancient cultures than the western natives. Exclusion is therefore less related to intercultural factors and more to the cost of the interventions and the lack of access by roads.

Likewise, the stakeholders' perception was measured on the achievements in terms of outputs, impacts and expected outcomes of the PASS, which are contained in the Program logical model. A scale of 1 to 5 was used, obtaining the ratings shown in Annex N° 9.

The rating for the different outputs, impacts and expected outcomes is between 3 and 4, which shows the positive perception the implementers and beneficiaries have of the Program achievements. These ratings should be viewed with caution as they are not backed by indicators, though they are helpful to compare the degrees of progress of the different outputs. Thus, the conclusion is that more emphasis is needed on the perceptions with the lowest rating, for example the ones related to the access to healthcare services (E.1), organization of the communities (1.b) and the responsibility to be assumed by the families and communities (1.c).

5.3.3. Level of Advancement of the Program Objectives

The logical framework of the Project contained the following goal, which is the desired impact: “Contribute to an improvement of the health situation of the Bolivian population and strengthen management capacities in the public health sector, particularly in the departments of Beni, Pando and Oruro”.

The Project has been effective in contributing to an improvement of the health situation of the target population in the three departments: Beni, Oruro and Pando.

The measurement of this contribution is based on a series of indicators shown by department in the following tables:

Table Nº 8

INDICATORS OF THE IMPROVEMENT OF THE HEALTH SITUATION - ORURO

Impact indicators	ENDSA 2003	ENDSA 2008	Progress
Newborn mortality ²⁰	43	23	20
Infant mortality ²¹	88	56	32
Child mortality ²²	113	69	44
Chronic malnutrition ²³	32	27	5
Service Provision	SNIS 2004	SNIS 2008	Progress
% of children with the third dose of the pentavalent vaccine	90%	94%	4%

²⁰ Deaths before the first month of life x 1,000 life births.

²¹ Deaths before the first year of life

²² Deaths before the fifth year of life

²³ Percentage of children under 5 with a low height for age

% of pregnant women with 4 prenatal controls	51%	64%	13%
% of pregnant women with institutional delivery	56%	73%	17%
Shared Management and Gender	UNICEF²⁴ 2005	UNICEF 2008	Progress
Health committees in operation	25	123	98
Social municipal councils in operation	0	32	8
% of female participation in committees and councils	25%	45%	20%
# of women's organizations in health	5	78	73

The impact indicators are measured every 5 to 10 years in the National Population and Health Survey²⁵. Although the results of these five-year studies reflect various factors, it is probable that the PASS has made a contribution as it is the only donor agency in the department of Oruro. As regards newborn, infant and child mortality, the rates decreased significantly in Oruro and at the same time, the healthcare for children under the age of 2 improved, as is clear from the coverage of 94% of the children with the third dose of the pentavalent vaccine in 2008.

The increase in the number of women with prenatal controls and institutionalized childbirth, from 51% to 64% and from 56% to 73%, respectively, is significant and will contribute to a reduction of maternal mortality, which at the moment is estimated at 234 per 100,000 live births. (ENDSA 2003)

With regard to joint municipal management in health, there is a significant increase in the number of health committees (from 25 to 123) and municipal social councils (from 0 to 8), which have been set up and are operating. This achievement is an important contribution of the PASS that, together with local initiatives and inputs of the central government, turns Oruro into a model department in terms of healthcare management.

The participation of women in Oruro is noteworthy. The percentage of women participating in the committees and/or councils increased from 25% in 2005 to 45% in 2008. The women's organizations working in health also increased from 5 in 2005 to 78 in 2008.

²⁴ Information from reports submitted by the UNICEF PRICCAS program to CIDA

²⁵ National Population and Health Survey (ENDSA), National Statistics Bureau (INE), La Paz, Bolivia, 2003, 2008

Table N° 9

INDICATORS ON IMPROVEMENT OF THE HEALTH SITUATION - BENI

Impact indicators	ENDSA 2003²⁶	ENDSA 2008	Progress
Newborn mortality	16	22	-6
Infant mortality	33	34	1
Child mortality	52	56	4
Chronic malnutrition in children under 5	32	27	5
Service Provision	SNIS 2004	SNIS 2008	Progress
% of children with the third dose of the pentavalent vaccine	77%	90%	13%
% of pregnant women with 4 prenatal controls	41%	53%	12%
% of pregnant women with institutional delivery	57%	77%	20%
Shared Management and Gender	UNICEF 2005	UNICEF 2008	Progress
Health committees in operation	0	87	87
Social municipal councils in operation	0	8	8
% of female participation in committees and councils	45%	60%	15%
# of women's organizations in health	2	12	10

Compared to Oruro, the impact indicators in Beni are not encouraging. Between 2003 and 2008, newborn, infant and child mortality rates increased and only the chronic malnutrition rate improved slightly. The dispersion of the rural population is a factor that determines the exclusion of children and mothers from the healthcare system, which is clear in the high maternal mortality rate of 229 deaths per 100,000 life births and the increase in newborn mortality.

²⁶ The ENDSA 2003 grouped the departments of Beni and Pando, so no separate information is available

As regards the provision of services by the healthcare system, there is a significant growth in the coverage of vaccinations, prenatal controls and institutional delivery. The provision of technical assistance and logistical support, together with the medical brigades, is a significant contribution to these achievements.

With regard to joint management in health, the 87 health committees and the 8 municipal social councils were set up with support from the PASS. The percentage of women participating in the committees and councils increased by 15% between 2005 and 2008, as well as the number of women's health organizations, which grew from 2 to 12 groups over the same period.

Table N° 10

INDICATORS ON IMPROVEMENT OF THE HEALTH SITUATION - PANDO

Impact indicators	ENDSA 2003²⁷	ENDSA 2008	Progress
Newborn mortality	16	8	8
Infant mortality	33	16	17
Child mortality	52	47	5
Chronic malnutrition in children under 5	32	10	22
Service Provision	SNIS 2007	SNIS 2008	Progress
% of children with the third dose of the pentavalent vaccine	92	100	8
% of pregnant women with 4 prenatal controls	65	66	1
% of pregnant women with institutional delivery	75	79	4
Shared Management and Gender	UNICEF 2007	UNICEF 2007	
Health committees in operation		1	Departmental Committee
Social municipal councils in operation		11	Committees reactivated

²⁷ The ENDSA 2003 grouped the departments of Beni and Pando, so no separate information is available

% of female participation in committees and councils		30%	Preparation of the AOPs
# of women's organizations in health			No data available

Taking into account that the ENDSA 2003 grouped Beni and Pando, and there is separate information as from 2008, the infant mortality and chronic malnutrition rates decreased by 17% and 22%, respectively. As regards data of the SNIS and UNICEF, there is comparative information as from 2007. The 100% coverage in immunization can be questioned, as the year 2008 was characterized by social conflicts, and a weak institutional and social commitment of the SEDES. Besides, it is important to take into account the geographical characteristics of the region and the deficient access roads²⁸. According to UNICEF²⁹, the information provided by the SNIS is neither appropriate nor accurate. The information on joint management and gender is limited and we can conclude that no significant progress has been made in this component.

In addition, the reports prepared by UNICEF for the PRICCAS component show a series of indicators that measure the achievement of results in terms of their contribution to the improvement of health (see Annex N° 10). However, the final indicators to measure the changes in health over time are still being defined.

On the other hand, although the Project logframe is consistent in terms of the contribution of the PASS to the outcomes in the health sector and although it is the only donor program in the departments of Beni, Oruro and Pando, we cannot conclude that there is a direct one-to-one relationship between the improvement in the state of health and the Project interventions, as there is no baseline to measure the achieved results.

5.3.4. Supervision

Implementation of the PASS is linked to the state structure (MSD, SEDES and FPS) as well as to international donor efforts (UNICEF and CIDA).

The state institutions governing the sector (MSD and SEDES) have sufficient experience to implement the technical work, though there continue to be weaknesses in the management part, both in terms of human resources capacities and in terms of equipment.

²⁸ Idem

²⁹Health Sector Support Program (PASS, *Programa de Apoyo al Sector Salud*) UNICEF PASS/PRICCAS, Annual Report – Department of Pando, year 2008.

As regards the FPS, the accumulated expertise ensures an adequate supervision. Besides, the Project Administration System is constantly improved and now covers all phases of the project cycle with a high level of efficiency.

UNICEF has its own tracking systems that ensure implementation of the PRICCAS actions, based on teams with high levels of technical experience and strategic alliances with other organizations supporting this effort. Both the FPS and UNICEF have supervision systems in place to track their activities. CIDA does not need to supervise the technical component, but rather provide technical and financial oversight.

The type of modality for execution, places an important role on the Government. Nevertheless, CIDA has played an important role in prodding those responsible for project implementation in the various components. In the future, given the weaknesses in project execution, CIDA will most likely need to continue this role to ensure the objectives of the project are achieved and to ensure that there is greater ownership by local authorities and the strengthening of its technical team.

In this case, it is recommended that future technical assistance be used in the future to detect the financial and administrative bottlenecks and recommend solutions that can solve these and build the capacity of staff in the SEDES and the networks especially with regards to the financial administration of the country.

5.3.5. Monitoring

The Program monitoring mechanisms have been defined through the Management Committee (MC) that provides for strategic orientation of the Program and the Operational Committee (OC) that provides mechanisms for communication between the different stakeholders. The Committees are adequate for the different levels of coordination. Still, there are no formal coordination mechanisms at the departmental level, which only depend on each stakeholder's management model.

In the MC, the analysis of information has suffered delays (the reports as at December 2008 are analyzed in June 2009), because there are only two yearly meetings, when there are issues that must be resolved promptly.

The content of the six-monthly reports is not adequate for the MC to take the decisions required to adjust the Program implementation rhythm. The reports guide the agenda of the meetings, which are related more to administrative difficulties and much less to Program impacts.

5.3.6. CIDA's Support for the Program

CIDA considers this programme labour-intensive as it requires much attention from the CIDA officer in La Paz along with one person from the CIDA Support Unit who devotes herself full time to the project. Field monitoring has been significant. In 2008, 30 days were spent visiting various projects compared to 16 days in 2009. The objective of the visits varied from visiting: potential FPS projects, SEDES, infrastructure projects, participate in PRICCAS workshops and projects, provision of equipment, etc. CIDA has played an important role in Program guidance. At the same time, the participation of CIDA is very prudent, as it has not interfered in the MSD's powers though it used sufficient authority to insist on the implementation of all Program components.

The MSD referred to CIDA as “the small train engine”, precisely because of its ongoing and intensive support for the Program activities, maintaining a highly positive and constructive relationship with the Program components, but avoiding the imposition of ideas.

5.4. Efficiency

5.4.1. MSD Capacity for Coordination and Supervision

The UP of the MSD has not fully assumed leadership of the entire Program as it has to divide its time between the Program activities and the daily tasks assigned by MSD authorities. This situation has given rise to a deficient incorporation of the committed results of the SEDES into the Sectoral Plan of the MSD, a lack of clear and uniform instructions for preparing reports on all PASS components and the lack of a consolidated Program report.

The financial controls should also be performed afterwards in audits; the SEDES should sign a document regarding automatic debits from their accounts in case the resources are found to be used inadequately so as to refund the money to MSD accounts.

5.4.2. Financial execution

a) Preparation of AOPs and Budgets

The AOPs, including activities and financial overviews, were prepared by each implementing entity in accordance with its own procedures and national regulations in force.

In general, the communities' demands are included in the municipal AOPs, and in turn, these demands are included in the AOPs of the SEDES. This process is supported by

UNICEF, which also includes the demands of the communities, municipalities, SEDES and the MSD in its AOP.

On the other hand, the MSD prepares its own AOP, which does not include demands from the other levels: SEDES, municipalities, communities.

The FPS prepares a general AOP and when it has to include project portfolios, it makes the necessary modifications in its budget so as to concretely register every project.

The SEDES had to adjust their initial AOPs to the scheduled disbursements, with a significant impact on their levels of execution as there were not only delays in this adjustment process but they also had to postpone important activities until the following years. Besides, with this programming modality it is not possible to have action margins, because when a certain activity cannot be carried out due to technical difficulties, the AOP and the budget have to be modified once again for replacement with another activity.

Thus, for example, in Beni the AOP was prepared for an amount of BOB 852,202, which then had to be adjusted to the scheduled disbursement of BOB 416,140, i.e. a reduction of 48.83%. Likewise, in Pando the initial AOP of BOB 832,256 was adjusted by 50% to the scheduled disbursement of BOB 416,140.

The SEDES are unclear as regards the difference between the AOPs and the disbursements, as their programming is subject to disbursements.

b) Disbursements

The resources disbursed by CIDA to the different Program implementation entities total 72% of the total allocated amount, as per the following detailed overview:

Table N° 11
AMOUNTS DISBURSED BY CIDA
(In Canadian Dollars – CDN\$)

DETAIL	UNICEF	MSD	FPS	Local Fund	Political Dialogue	M&E	TOTAL
Allocated	10,400,000	1,700,000	4,500,000	680,000	120,000	1,000,000	18,400,000
Disbursed	8,860,000	628,112	2,906,660	264,475	34,604	249,984	12, 943,835
% of Disbursement	85%	37%	65%	38%	29%	25%	72%

Source: CIDA

The percentage of disbursements is significant, and so we can conclude that there are no difficulties with the disbursements made by CIDA to the different Program components in terms of amount and timeliness.

Nonetheless, there were delays in the transfers of the disbursed money from the MSD to the SEDES, which led to considerable delays in physical implementation of the AOPs.

The MSD received the first disbursement from CIDA in March 2007 and transferred the money to the SEDES of Beni and Oruro in November 2007 and to the SEDES of Pando in August 2008 (i.e. 8 and 17 months later, respectively).

The causes underlying these delays are of an administrative nature, e.g. approval and registration of the AOPs, the budget and opening of the respective fiscal accounts. These procedures show the limited management capacity in the SEDES, the Prefectures, the MSD and the national levels of the VIPFE and the MEFP.

c) Budget Execution

The budget execution as at June 2009 for the Program totals 54.09% of the total amount of the PASS Agreement, as per the following table:

**Table N° 12
BUDGET EXECUTION BY COMPONENT**

COMPONENTS	AMOUNT OF THE AGREEMENT	AMOUNT OF THE AGREEMENT	TOTAL EXECUTION AS AT JUNE 2009	
	CDN\$	USD	USD	%
MDS (Budget Support)	1,700,000	1,682,335	253,078	15.04%
FPS (Infrastructure and Equipment)	4,500,000	4,453,241	1,792,937	40.26%
UNICEF (PRICCAS)	10,400,000	10,291,935	7,405,416	71.95%
Local Health Fund (FLASS)	680,000	672,934	116,468	17.31%
Monitoring and Evaluation	1,120,000	1,108,362	281,631	25.41%
TOTAL	18,400,000	18,208,808	9,849,529	54.09%

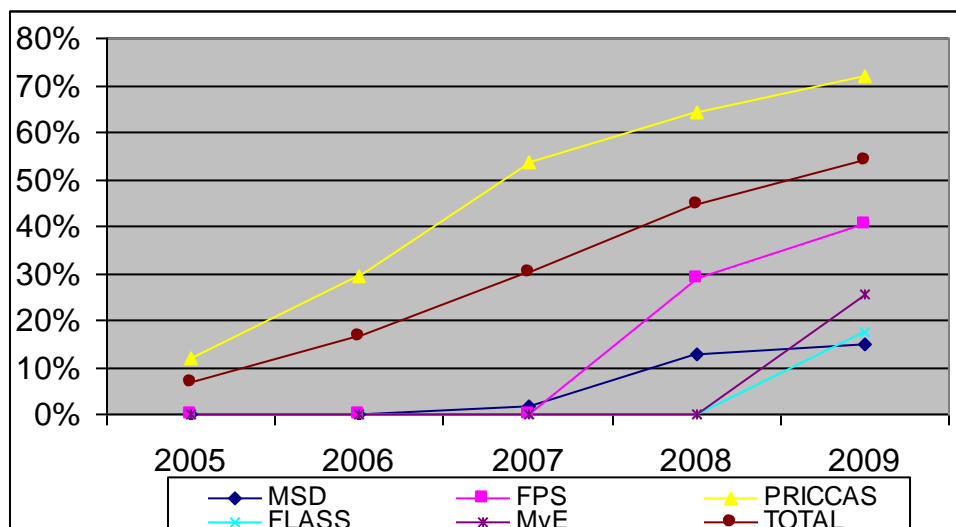
Source: Six-monthly reports by component

1/ Exchange rate CDN\$ 1.010499987 USD

2/ UNICEF: the budget execution includes the Cost Recovery of 11% that stays in its Headquarters

The evolution in financial execution as at the first half of 2009 has been slow, with annual percentages of maximum 15% and an annual average growth rate of 9%, which is insufficient for achieving the expected execution.

Graph N° 13
EVOLUTION OF BUDGET EXECUTION



Source: Six-monthly reports by component

The budget execution percentage is not yet satisfactory compared to the resources disbursed for each component, which points to the existence of some difficulties for executing the available resources.

However, in the individual analysis we must underscore that the budget execution of UNICEF is 71.95%. This is in part because the organization has its own procurement and payment systems that help to avoid much of the state bureaucracy. Nevertheless, there are also some problems related to the rendering of accounts by the municipalities and other beneficiaries that receive resources for specific activities.

UNICEF is followed by the FPS with a budget execution of 40.26%, which is concentrated in one and a half year of implementation. At the moment, considering that 76% of the projects are in the implementation phase, a higher rate of payments is expected, which would help to reach the programmed goal.

Budget execution in Monitoring and Evaluation is 25.41%, with a commitment to reach 57%. Unused funds could be reallocated to other components in need like FLASS before the end of the project.

The FLASS budget execution is 17.31% and there is a commitment to reach 89.94%. Here, it is important to take into account that the FLASS was programmed for the last

two years of the Program. Hence, expectations are that all committed resources will be used.

Finally, accumulated budget execution in Budget Support is 15.04%, i.e. 10.29% in the MSD and 21.74% in the SEDES, as per the following detailed overview:

**Table N° 14
BUDGET EXECUTION**

COMPONENT: BUDGET SUPPORT

COMPONENTS	AMOUNT OF THE AGREEMENT	AMOUNT OF THE AGREEMENT	EXECUTION AS AT JUNE 2009	
	CDN\$	USD	USD	%
MIN. OF HEALTH AND SPORTS	995,000	984,661	101,369	10.29%
SEDES	705,000	697,674	151,708	21.74%
SEDES BENI	235,000	232,558	53,230	22.89%
SEDES ORURO	235,000	232,558	50,144	21.56%
SEDES PANDO	235,000	232,558	48,335	20.78%
TOTAL	1,700,000	1,682,335	253,078	15.04%

Source: Six-monthly reports by component. The table identifies clearly that the agreements are in Canadian dollars only, and that the US dollar figures are converted values at a given exchange rate.

The financial execution mirrors the problems affecting physical execution, besides the following specific causes:

- Bureaucracy on different levels: a) the supreme authority of the MSD gives rise to an excessive concentration of operational decisions; in the General Direction of Administrative Affairs, there are delays in procurement processes and disbursements; in the General Direction of Legal Affairs, there are delays in the consultancy agreements; in the MEFP (Vice Ministry of the Budget) and the VIPFE, there are delays in budget registration and modifications.
- The joint consideration of the 3 SEDES is negative for the ones with quicker implementation rhythms, as they have to wait for all SEDES to account for their funds before they can access new disbursements.
- Because of delays in disbursements, which are made only in the second half of the year, the activities are concentrated in just a few months, when the activities are affected by the rainy season and the impossibility to access some municipalities (Beni and Pando). UNICEF's disbursements face the same problem.

-
- There are still insufficient resources to strengthen the teams of the Network Managements with personnel, transportation, communication, infrastructure and administrative expenses.

5.4.2. Agenda and Work Schedule

As a result of the mentioned obstacles, the agenda and work schedule have suffered delays in virtually all components, particularly in the start-up phases, except for the FLASS that was scheduled for the final Program phase.

This situation is confirmed when making an analysis of financial execution of the Program (Graph N° 12 and 13), the rhythm of which was inappropriate at the beginning; however, some components (e.g. UNICEF and FPS) have made an effort to implement all activities on time.

Only in case of the MSD and the SEDES, there is a need for important adjustments so as to carry out all activities on time.

5.4.3. Effectiveness in Terms of Cost and Timeliness

Health interventions are costly and sometimes late, particularly in Beni and Pando because of access issues. However, they are effective interventions in terms of human rights, as no interventions would have serious consequences for the population in general. In this sense, planning is very important to help lower costs, especially if we consider that many health issues can be solved based on an interrelation with other sectors.

5.5. Sustainability

5.5.1. Sustainability of Programme Interventions

Sustainability has three interrelated components: programmatic, institutional, and financial. Within these components each actor (SEDES, Municipal Governments, the National Ministry of Health) has certain capabilities for continuing activities after PASS ends. The evaluation team made an assessment of sustainability potential based on document review, key informant interviews, and discussions generated during the workshop activities. This methodology represents a snapshot of what the evaluators perceived during their interaction with the different actors. It is recommended that PASS develop a sustainability Plan with specific objectives, activities and indicators to guide the program components towards sustainability during the last 2 years of the project.

There is limited potential for the Ministry of Health and municipal governments to provide resources after PASS ends in 2011. However, since PASS is well integrated into the Ministry of Health system, primarily through PRICCAS, many activities will continue to be implemented, especially those that the Ministry of Health traditionally supports, such as vaccination coverage.

Below is a summary of key activities based on their sustainability potential after PASS funding ends.

High Sustainability Potential

- ❖ Formulation of national plans for maternal, neonatal and infant health
- ❖ Continued public sector funding for national health programs:
 - Immunization program linked with nutrition and integrated management of childhood illnesses (AIEPI-Nut)
 - Continuation of the anti-rotavirus vaccine within the vaccination program³⁰
 - Maternal and reproductive health
 - Micronutrient and Food fortification
 - Control of communicable diseases: Tuberculosis, Malaria, Dengue, HIV/AIDS
- ❖ Functioning of the committees for health data analysis and decision making
- ❖ Repair and maintenance of health posts and centers

Moderate Sustainability Potential

- ❖ National Management and Technical Committees
- ❖ Build strategic inter-sector alliances in health
- ❖ Implementation of joint municipal and community public health governance councils, committees and activities

Low Sustainability Potential

- ❖ Implementation and monitoring of the 52 Integral Nutrition Units (UNI)
- ❖ Strengthen the leadership role of the Health Ministry aligning the annual operating programming for sector policies, to implement national programs
- ❖ Friendly Hospital Initiative for Mothers and Children
- ❖ Technical assistance for food fortification
- ❖ Improvement for health care quality for mother-child continuum in hospitals
- ❖ Mobile brigades
- ❖ Prevention of HIV vertical transmission (the risk of *HIV transmission* from mother to unborn child is about 26% without any treatment or intervention).
- ❖ Human resource development with the local level with post-graduate training in Epidemiology and Strategic Communications in Public Health,

No hemos participado como queríamos por falta de tiempo y personal. El funcionamiento de la UP será factible si se institucionaliza el PASS, asumiendo el liderazgo sectorial. El MSD debe proveer los recursos humanos y financieros necesarios.

Rogel Matos,

Ministry of Health Planning Unit

³⁰ Rotavirus is the most common cause of severe, dehydrating diarrhea among children worldwide, and it is the leading culprit of the nearly two million unnecessary and preventable deaths caused by diarrheal disease each year.

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- ❖ Train leaders in municipal level to improve their public governance such as municipal councilors.
 - ❖ Provision of equipment for health posts and centers
 - ❖ Infrastructure projects to improve and expand health posts and centers

In order to improve the sustainability potential of key programme activities, PASS needs to focus on how to increase financial commitments by the Ministry of Health, Departmental governments (prefectures) and municipal governments. Information regarding the financial contributions has not been collected or analyzed by PASS. Ideally over the next two years, PASS can set targets for increasing financial support for health, hence improving the sustainability of important programme interventions after funding ends. UNICEF should prepare a sustainability plan for transferring key programme activities to the three SEDES, municipal governments and other local institutions, as relevant. The sustainability plan should select 5-10 important activities and include indicators to track these during the next two years.

5.5.2. Institutional Responsibility

The Planning Unit at the central Ministry of Health and the three SEDES are committed to PASS; however each has its own set of constraints. The Planning Unit is dependent on the priorities of the Minister of Health and does not have authority to set its own agenda as the lead for national policies and the official link between the Ministry of Health and the international cooperation agencies. Budgetary support to the Planning Unit was spent on consultant salaries, workshops, and the development of an institutional plan. Unfortunately the consultants and permanent staff are constantly called upon to respond to other Ministry of Health needs, such as launching the

There is a good relationship between the Planning Unit and CIDA. We have frank discussions about difficult topics, we deal with issues head-on and we solve problems together.

Rogel Matos, Ministry of Health
Planning Unit

Juana Azurduy Bonus Package. To further compound matters the Planning Unit has had four different directors since PASS started, travel has been restricted since September 2008 preventing monitoring visits to the field, and the program approach changed from global health planning to micro-planning for specific topics. The interaction between the Planning Unit and the SEDES functions primarily by e-mail and telephone. Important events and meetings are held in La Paz because UNICEF provides the funding for staff travel from the three SEDES.

The work of the Planning Unit is a priority for CIDA, because it is the Planning Unit that must provide leadership for country-wide health goals, objectives and priorities. In order for the Planning Unit to be viable after PASS funding ends, the Ministry of Health needs to buy into supporting the Unit. This would mean creating and funding permanent positions within the Ministry of Health.

PAHO provides technical assistance to the Ministry of Health on a regular basis and could provide specific technical assistance to the Planning Unit, in coordination with CIDA. The PAHO Representative, Christian Daras, mentioned that this would be consistent with PAHO's institutional objectives. Since PAHO is a permanent structure vis-à-vis the Ministry of Health, their participation could continue over time enhancing the sustainability potential of the Planning Unit, including ownership of its leadership role.

There is more sustainability potential and responsibility at the regional level. SEDES can obtain support and resources from prefectures and municipal governments. In fact the Popular Participation Law requires that both institutions include funding in the annual operating plans for health. This includes management of the health insurance system (SUMI), payment of utilities, maintenance and repair of health facilities, and other activities. Examples of municipal support to PASS include: purchase of Nutri-bebe supplement for the complementary feeding program and gasoline and maintenance for ambulances and other vehicles. However, if significant actions are to be continued, municipal governments will need to make greater commitments.

5.5.3. Scale-up in Other Departments of Bolivia

The work that UNICEF has initiated with the establishment of emergency obstetric (EmOC) care and neonatal services has excellent potential for expansion to other departments of Bolivia. Interventions could be streamlined under an overall objective to decrease case fatality rates in women and newborns, based on the National Strategic Plan for Improving Maternal and Neonatal Health 2009-2015. Two factors provide rationale for targeting these two groups with specific interventions: concordance with Ministry of Health policies and 2015 MDG goals to reduce infant mortality (MDG 4) and improve maternal health (MDG 5), especially considering that Bolivia is still far from reaching its MDG targets.

The evaluators consider that a focus on the reduction of maternal and neonatal mortality in concert with the work already done in the three Departments by PRICASS and the Ministry of Health, which collected data on the below indicators, should be strengthened.

- Total Regional/District Population
- Number and geographic distribution of health facilities that provide: 1) Comprehensive EmOC, 2) Basic EmOC
- Expected number of births
- Proportion of all Births in EmOC facilities
- Total Numbers of Obstetric Complications

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- Met Need for EmOC
 - Total Number of maternal Deaths
 - C/Section Rates
 - Case Fatality Rates

The results of the assessments on the above indicators undertaken by PRICSS will help the PASS Project determine criteria for the selection of municipalities. The evaluators are in agreement that population density should be a criteria since impact would be greater if a larger number of women were reached. Experience with the FEMME Project in Peru, which used the same methodology, demonstrated a dramatic reduction in mortality over a relatively short period of time. The success was so dramatic that the Peruvian Ministry of Health adopted the model as a national policy. It is the evaluators' perception that CIDA is in a position to have a real influence on health policy in Bolivia. Therefore the evaluators applaud the initial work and recommend its continuation and expansion to other Departments of Bolivia.

Over the past 5 years there has been no reduction in the number of children who die in the first 28 days of life according to the results of the 2003 and 2008 DHS³¹ surveys (27 per 1,000 live births). Neonatal mortality represents 50% of all infant deaths (0-11 months of age) and 40% of all child deaths (12-59 months of age). Although maternal mortality decreased between 1994 and 2003³² from 390 to 229 deaths per 100,000 live births, projections for 2008 show a minimal reduction over the past 5 years.

The recently launched Maternal and Neonatal Health Plan calls for increasing utilization of health services by pregnant women and preventing *Phase III Delays*³³ through expansion of interventions based on the UN process indicators, and initiatives to minimize *Phase I and II Delays* through community education and organization, human rights activities, and improved transportation and communication systems. Following are some considerations for strengthening the current emergency obstetric care (EmOC) strategy implemented by PRICASS during the next two years. Successful implementation strategies and best practices could then be scaled-up and expanded to other departments of Bolivia, during a new programme cycle.

- ❖ Prioritize the municipalities that have the highest rates of infant and maternal mortality. Center efforts and resources at the health network level to improve the quality of care at health facilities, through training, adaptation and implementation of protocols, infrastructure renovation, and equipment procurement.

³¹ DHS – Demographic and Health Survey, Macro Systems and Bolivian Institute of National Statistics, 2003, 2008.

³² DHS

³³ *Phase I Delay*: Delay in deciding to seek care on the part of the individual, the family or both

Phase II Delay: Delay in reaching an adequate health care facility

Phase III Delay: Delay in receiving adequate care at the facilities.

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- ❖ Prioritize the reduction of maternal and infant mortality, and case fatality rates using “Guidelines for Monitoring the Availability and Utilization of Obstetric Services”. These guidelines were distributed by the United Nations (UN), UNICEF, and UNFPA in 1997, and have been useful in the planning and evaluation of programs to reduce maternal and neonatal mortality in many countries.
 - ❖ Link the maternal-child interventions under the concept of the “Continuum of Care” from mother to newborn to child outlined by the National Strategic Plan for Improving Maternal and Neonatal Health 2009-2015.
 - ❖ Use the UN process indicators to track progress, based on baseline assessments, some of which have already been done by PRICCAS³⁴.
 - ❖ Focus the type and location of infrastructure to comply with the UN standards for emergency obstetric and neonatal care that have been adapted for Bolivia, locating one comprehensive health facility and four basic facilities per 50,000 inhabitants. This will need to be done in concert with the Ministry of Health to assure staffing, budgetary resources and concurrent clinical training and supplies for these facilities.
 - ❖ Provide management training for the SEDES linked to the EmOC networks: communication systems, complete and accurate patient registers, regular training and supervision, infection prevention, periodic evaluations.
 - ❖ Develop municipal health management capacity including partnerships and collaborations.
 - ❖ Spearhead human rights initiatives that focus on the development of maternal death and near miss review committees and the initiation of specific activities that promote human rights and dignity of patients served.

Infrastructure and equipment provision by the FPS could be scaled-up in concert with PRICCAS, linked to the need for health centers, equipment and clinical capacity based on the minimum coverage acceptable by UN standards for emergency obstetric and neonatal care. If exclusion from adequate health care is to be reduced, health facilities need to be located strategically so that a woman with an obstetric emergency can get to a basic care center to be evaluated and stabilized, and then transferred to a

³⁴ The indicators are: total population; number and geographic distribution of health facilities that provide comprehensive care and basic care; expected number of births; proportion of all births in EmOC facilities; total numbers of obstetric complications; met need for EmOC; total number of maternal deaths; caesarian section rates; case fatality rates.

comprehensive health facility within a short period of time. (See “*Too Far to Walk: Maternal Mortality in Context*”³⁵.)

Some of the FLASS projects could be scaled-up with potential to reduce maternal and neonatal mortality at the community level including interventions for communication for behavior change, community participation and mobilization and awareness building around human rights issues. A good example is the Aguayo Project in Curahuara, Oruro which increased prenatal care and deliveries at the health center by giving each woman an aguayo (women cloth for carrying an infant) and a set of baby clothes if she complied with four prenatal care visits and had her baby at the health facility. The Aguayo project also helps municipalities to obtain midwives from the SEDES, making sure they speak Aymara to the women and help them out in the hospital, and also helps municipalities to provide HR to its hospital.

5.5.4. Consultants Designated to the Ministry of Health

Regarding the consultants designated to the central Ministry of Health Planning Unit, there are serious limitations to the success of this strategy. The consultants have not been effective because they are assigned routine duties to support other Ministry priorities, their skills are not fully used, and they are overworked. The Planning Unit was not able to provide the required authority to insure that the consultants comply with their intended duties vis-à-vis the PASS programme. To further worsen matters, contracts have to be renewed yearly and each year salaries are lowered, resulting in high turnover. The current problem the Planning Unit is facing is how to attract competent professionals with salaries that are not competitive. A better option would be to have permanent staff rather than consultants, however only 30% of Ministry workers have a long term contract and the easiest way to hire people is on a short-term basis. In spite of the above limitations, the Planning Unit considers that the “consultants are committed and very helpful”.

5.5.5 Ownership of Programme Activities

<p style="text-align: center;">UCUMASI</p> <p style="text-align: center;">Health Center</p> <p>“Local authorities contribute funds. With a little help from internal and external sources things are working.”</p>
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Ownership of PASS activities at the community level has been enhanced by a national health policy launched in 2006 that lays out the strategy for community participation in municipal health management: “Gestión Compartida Municipal en Salud”. The participatory management policy gives municipal governments and social actors an official mechanism to engage in health planning, implementation, administration, evaluation and social control, the end result of which is to “Live Well in a Dignified Bolivia”. Each

³⁵ Maine, Deborah & Thaddeus, Sereen, *Too Far to Walk: Maternal Mortality in Context*, Center for Population and Family Health, Public Health Department, Columbia University, June 1997

community or neighborhood elects a “health authority” who becomes the liaison between the community and the health system. These individuals serve on a health committee which provides stewardship for the health of the population, making sure that local needs are included in municipal planning. A Municipal Social Council if formed by representatives from health committees and other social organizations and serves as a liaison between the health committees and the Local Health Directorate (DILOS). The DILOS is responsible for the implementation of the SAFCI in conjunction with the local health system.

PASS supports these community structures under PRICCAS through specific objectives and activities for local health committees, municipal social councils, the local health directorates and the municipal planning process. Visits to two communities in the Oruro Department, Ucumasi and Curahuara demonstrated strong community support and ownership of programme activities.

5.6. Risks

During Program implementation, no formal mechanisms have been established for identifying, analyzing and proposing risk mitigation measures; only UNICEF has given an overview of risks and risk mitigation strategies in its reports, besides the degree of implementation and compliance of the strategies.

The risks identified by UNICEF are related to financial issues, human resources, maintenance of the infrastructure and planning; the mitigation measures focus on advocacy, monitoring and training.

Despite efforts for identifying the risks, UNICEF does not have an overall Program perspective and so it does not cover all risks, particularly the ones not directly related to health interventions. Likewise, the mitigation measures only focus on the actions UNICEF can take, which limits the results.

There are some risks such as political changes, personnel turnover and bureaucracy that are difficult to mitigate; the decisions on mitigation are beyond the action sphere of UNICEF and even of the MSD. For example, bureaucracy has been identified as a problem in the VIPFE and the MEFP; and the political changes are related to different authorities and institutions that are responsible for leading the country today.

However, the MSD has to assume responsibility for risk analyses and for encouraging mitigation measures and so once again there are doubts as regards the MSD’s capacity to assume leadership for the Program.

Hence, the MSD’s leadership capacity is one of the principal risks for Program continuity because as it does not assume full leadership of the Program, it has no capacity to generate actions for mitigating the risks that arise.

As a result of the interviews with Program stakeholders, we have seen that there are persistent risks that must be dealt with immediately so as to ensure Program continuity.

Table N° 15

RISKS AND MITIGATION MEASURES

RISKS	MITIGATION MEASURES
The political situation and the changes in the country hamper institutional support for the PASS.	Assume measures for advocacy with national authorities, so that the PASS would be fully integrated into the state structure. Condition the following phase to more state participation.
The international donor community suspends its support.	Define indicators and a baseline to show intermediate impacts that encourage the donor community to continue funding the activities. Enter into agreements so that the national, departmental and municipal levels would gradually finance part of the budget. Find other donors who are prepared to give technical assistance and/or join a basket fund in order to deepen the impact with greater investments.
The MSD and the UP do not fully assume the leadership the Program requires.	Give technical assistance to the UP to define a planning, monitoring and follow-up system so as to ensure technical solidness with results-based efforts.
Institutional weaknesses affect achievement of the results.	Reorient the activities so as to strengthen the operational sphere of the Program, with direct support for the Network Managements, improving the management and monitoring capacity. Empower society and mainly women, in order to generate a greater demand for healthcare services.
The administrative and bureaucratic processes delay Program implementation.	Give technical support to the MSD, the SEDES and the municipalities to reformulate their AOPs for the balance of the contribution, prioritizing the activities to be carried out by 2010 and ensuring more flexibility in the administrative processes.
Climatic factors affect the implementation rhythm and increase the costs of the interventions, especially in Beni and Pando.	Transfer a higher amount of resources to the SEDES, so that they could start the year 2010 with no liquidity constraints. In this sense, the rendering of accounts could be made more flexible partially based on expense declarations that would be later subject to audits.

It is also clear that CIDA has shown levels of flexibility that support the needed adjustments so as to give greater momentum to the Program.

5.7. Gender Equality and “Inter-culturalism”

5.7.1. Pertinence and Effectiveness

Gender equality, intercultural health, and traditional medicine are on the national agenda and have received significant political support since early 2006 under the current government administration. The National Development Plan and health sector plans, specifically the SAFCI and the Strategic Plan to Improve Maternal and Neonatal Health en Bolivia, support inclusion of women and indigenous populations in a universal health system.

The Health Sector Development Plan Solidarity Policy calls for
“Zero Violence Against Girls”

A “National Gender Technical Committee” was formed in December 2007 with representatives from the Planning, Gender, Intercultural and Violence Prevention Units of the Ministry of Health, gender specialists from UNICEF and CIDA, and members of the Canadian Embassy. The FPS gender and programme specialists have recently joined the committee.

Since 2008 the committee has meet every two months. Below is a summary of the Committee’s activities.

- ❖ A Gender Equity Strategy was developed and tailored to the PASS logical framework to facilitate integration of gender topics in the results based management plan.
- ❖ In 2009 the Committee designed an implementation plan for the duration of the PASS programme.
- ❖ A decision was made to use PASS resources to strengthen the gender specialists assigned to each SEDES.
- ❖ The Committee was instrumental in the incorporation of a gender and intercultural approach in the strategic plan developed by the Ministry of Health Planning Unit.
- ❖ The Committee assisted the Ministry of Health to adopt indicators for gender equity that will be analyzed through the Health Information Analysis Committees (CAIs) in Beni, Pando and Oruro.
- ❖ The Committee made a formal decision to incorporate gender and intercultural adaptations for all FPS building projects that will be implemented during the second phase of the PASS programme.
- ❖ All educational material and projects developed with PASS funding will be reviewed by the respective gender specialist
- ❖ Pando, Beni, and Oruro will receive technical assistance to improve intercultural maternal health care through training modules for SEDES and health network personnel.



UCUMASI

Health Center

The delivery room is set-up for both traditional and modern deliveries. The physician and the traditional birth attendant work together providing cultural competence, warmth and quality of care to patients.

PRICCAS Gender activities included:

- ❖ Inclusion of gender and intercultural content in graduate courses in Public Health Communication Strategies and Epidemiological Surveillance at the University Mayor de San Andres Schools of Medicine and Communication;
- ❖ Inclusion of gender and intercultural content in the curricula of online and off-line training in the municipalities of Oruro Pando y Beni;
- ❖ Provision of technical assistance for a research project on maternal-infant health and HIV/AIDS, which will include gender and intercultural topics. The objective of the study is to understand the most common family practices in health and sanitation, as well as the roles of women and men in health decisions. Once the study is completed, a communication for behavior change strategy will be developed.



The need for patient-friendly health centres like this one in Ucumasi, Oruro

Although initial activities implemented by PASS are on-track and pertinent to addressing gender and intercultural topics, it is too early to evaluate the effectiveness of PASS strategies, as activities are in the beginning stages in the three Departments.

Implementation at the field level has been confined to awareness building, training, and promotion of women's participation in health committees and social councils. Before measures that favor gender equality can be integrated into on-going programme implementation, the PASS Gender Strategy, action plan, and operational research project, need to be completed and fully implemented at the three SEDES. UNICEF with the SEDES should prioritize the implementation of the gender action plan during the last two years of the project.

It is important for the project to disseminate lessons learned and best practices to the Ministry of Health and larger development community in Bolivia. An example is the use of incentives to increase utilization of services such as the Aguayo Project. This could be done by the National Gender Technical Committee.

The programme should also determine which practices can be institutionalized and include these in public policy. The SAFCI calls for gender equity and inclusion of inter cultural practices, however specific actions at the field level are yet to be determined. PASS can have an important role in this regard through the National Gender Technical Committee.

Doña Gregoria, Partera



First salaried position for a Traditional Birth Attendant in Oruro.

5.7.2 Ownership

Due to inclusion of both gender and intercultural topics in national Health Sector Plans, and the participation of the Ministry of Health, FPS, UNICEF, and FLASS in the “National Gender Technical Committee”, both the Bolivian government and PASS partners have a high level of commitment. The three SEDES have included gender equity and inter-cultural topics in their annual operating plans, as summarized below. (See Section 7.3 for the results of these activities.)

It is also important to reach a consensus between the central Ministry of Health, SEDES, UNICEF, FPS on infrastructure, with state of the art training for the FPS teams at the departmental level so that new infrastructure is adequate in terms of gender, local cultural needs and customs and financial costs³⁶. Infrastructure and equipment should be prioritized taking into consideration the baseline in such a way that the SEDES proposes to each municipality the type and characteristics of the investment increasing the participation of the FPS from the idea of the project to strengthening capacities to ensure the maintenance on the part of the municipality. Infrastructure models should also consider the themes of interculturalism, gender and housing for medical personnel.

Objectives:

- 1) Strengthen women’s participation in health decision making at both the institutional and community level
- 2) Include gender and intercultural activities in municipal annual operating plans
- 3) Incorporate knowledge and wisdom of indigenous groups in community health services and include these in social mobilization activities

Key Planned Activities:

- ❖ Train men and women in human rights, gender and cultural topics, prevention of domestic violence, providing opportunities for self-evaluation regarding prejudice and discrimination
- ❖ Train health personnel, community leaders and representatives of indigenous groups
- ❖ Establish community counseling units
- ❖ Promote the inclusion of women as members of health committees
- ❖ Coordinate with the Prefecture’s Social Justice Department, the nursing schools, legal services, Public Defender for Minors, Police Family Protection Unit, and the Ministry of Health Planning Unit

High Risk Pregnancies

In Oruro, 28% (25,553) of pregnant women are age 45-64. Over half (54%) gave birth at home.

Plan Estrategico Institucional

SEDES, Oruro

³⁶ The Maternal-Perinatal Hospital in Lima could provide cost-effective assistance on linking building plans to efficient service provision. They have given excellent on-site technical assistance to the Prefecture of Tarija for the design of the new maternal referral hospital.

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- ❖ Distribute materials: Gender Approach, Law 1674/95³⁷, Legal and Forensic Medicine Guide, Manual for Health and Family Violence, Manual for Family, Community and Intercultural Health, inter-institutional form for reporting cases of domestic violence.
 - ❖ Inform, educate and train women's organizations about women's rights based on the guidance provided by the UN Committee on the Elimination of Discrimination Against Women (CEDAW/Bolivia)

5.7.3. Relevance and Quality of Response

The measures taken by PASS are relevant to the needs of women and indigenous groups, and the promotion of their strategic interests. However, the work is still in its initial stages. Planning has taken place at the national and departmental levels and topics have been included in annual operating plans at the three SEDES and their respective municipal governments. However, the response by regional and local authorities, the majority of who are men, has been lukewarm.

Round table discussions and interviews during the evaluation indicated that both men and adolescents should be targeted as a means of bridging the gap between men and women and increasing gender equity. Work with adolescents was viewed as important because young people are more open to changing attitudes and behavior than older people. Participants in the round tables cited "machismo" as a deterrent to better treatment of women and decreased gender based violence.

Of the three departments, Oruro has made the most progress with use of Aymara concepts, intercultural birthing practices, and women's participation. Below is a summary of results from the three SEDES.

Oruro

- ❖ The SEDES used the Chakana (Andean Cross) to develop their Strategic Health Plan (2007-2011) and the Aymara concept of "Muyta" (field visit) to identify local health needs and priorities for the strategic plan
- ❖ Health planning includes intercultural birthing options and gender equity
- ❖ 50% of health personnel have been trained in the Ministry of Health norms for management of cases of domestic violence
- ❖ In 7 municipalities 22 health care providers, 44 traditional birth attendants and 17 health promoters were trained intercultural birthing practices using traditional medicine

³⁷ Law 1674 provides for legal recourse for those who have suffered domestic violence and sanctions against perpetrators. The law was passed in 1995 and norms and procedures were approved in 1998, but not applied until 2002.

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- ❖ In 3 municipalities³⁸ the demand for birthing services at hospitals and health centers increased by 5%, and demand for birth with a trained traditional birth attendant by 10%
 - ❖ Mass media campaigns on gender rights and domestic violence reporting have been implemented to reach all families in the Department of Oruro.
 - ❖ Notification of cases of domestic violence improved by 30% in 2008.
 - ❖ Leaders in municipalities with the highest incidence of domestic violence received training on how to manage cases in coordination with the health system
 - ❖ Thirty councilwomen were trained in women's empowerment, including the President of the Oruro City Council, Ms. Santusa Humeres.

Unexpected Results:

- ❖ Project Aguayo in Curahuara has increased prenatal care and births at the hospital and lowered neonatal and maternal mortality
- ❖ Women learned to make herbal medicines and package them to be sold in the community
- ❖ The Curahuara health center is certified and accredited³⁹
- ❖ The credibility of the Curahuara health center has increased and more people are using the services as their degree of trust grows. Before women would not come for a PAP smear, now they do.

Beni

- ❖ In San Ignacio, Riberalta and Guayaramerin three workshops were held on gender, violence and responsibilities of health facilities to refer cases to the authorities.
- ❖ 35 health personnel received training in gender based violence, registration of cases using official medical certificates, and notification to police departments.
- ❖ On-going training is provided in family and intercultural medicine, to support implementation of the norms outlined in the Family and Community Health System (SAFCI).
- ❖ Five representatives of the police department, and 20 leaders from the Indigenous Peoples Council and the Tacana Council received training in gender based violence.

³⁸ , Caracollo (La joya), Huayllamarca, Curahuara de Carangas.

³⁹ . In January, 2007, the Ministry of Health began a process of accreditation for clinics and hospitals, using the "Manual de Acreditación de Establecimientos de Atención Médica del Sistema Nacional de Salud". The manual was developed in 2005 by the "Instituto Nacional de Seguros de Salud (Inases)". The purpose of the accreditation process is to determine which health facilities fulfill the minimum conditions required to provide safe and effective care to patients.

Pando

- ❖ 50% of health personnel have received training on gender based violence, surveillance and referral of cases in coordination with the Prefecture.
- ❖ Approximately 30% of the participants in local health committees and DILOS are women and these have participated in the development of municipal annual operating plans.
- ❖ 40 women attended a forum on reproductive rights and HIV/SIDA.
- ❖ Three women's groups interface with the SEDES: Bartolina Sisa, CIMAP, AMUPEI
- ❖ Youth and parents participated in sexual health education including ITS-HIV/AIDS at 8 schools.
- ❖ The SEDES is promoting the use of the feminine condom for use by professional sex workers.
- ❖ The SEDES is working with the Roberto Galindo Terán Hospital to provide intercultural birthing options.

Following are some of the constraints mentioned by participants in the round table discussions and interviews held in the three departments with SEDES, FPS and FLASS. Although training and coordination have taken place, and informational materials have been distributed, there is a long way to go before the gender strategy shows concrete results.

Municipal authorities do not view gender based violence as a problem, rather it is accepted as natural behavior.

Interview with SEDES

- ❖ In Curahuara, Oruro, the hospital and the traditional birth attendant's quarters are freezing cold and many women have complained. This is a new facility; however the FPS did not consider orientation of the building to increase warmth through sunlight nor use of solar energy for heating rooms and water.
- ❖ The traditional birth attendant in Curahuara is not located in the obstetric area of the hospital but outside in separate quarters. Curahuara could follow the lead of Ucumasi and have one birthing room that combines modern and traditional medicine.
- ❖ Despite training efforts, many health personnel are not committed to working with gender based violence and providing services for referral and follow-up of cases with other institutions. Many do not accept and/or practice what they have learned. The SEDES does not have interdisciplinary teams to provide adequate care for victims.
- ❖ Women victims do not register their cases with the police department due to poor treatment characterized by discrimination and indifference. When cases

have been referred by health staff to police departments, no action has been taken and health personnel have lost credibility.

- ❖ In the Pando there were several constraints: no follow-up was provided after the training events; due to poor road infrastructure, it was not possible to reach all the health networks; and there is no mass media system for rural communities limiting the dissemination of health education and information.

5.8. Lessons Learned and Recommendations

5.8.1. Lessons Learned

The PASS Programme has generated a number of lessons learned. They include:

Design:

- The integrated design of the PASS requires a good coordination between the different components, the local environment and the international donor community in order to be able to achieve the objectives and optimize the efforts and resources: the MSD and the SEDES by assuming leadership and national and departmental coordination, respectively; the Prefectures and Municipalities by contributing resources and assuming ownership of the healthcare services; the community by participating in the definition of needs and being empowered in its rights to health; and the international donor community with technical and financial assistance.
- The support for human resources has enhanced the commitment for improving healthcare services.
- The improvement of infrastructure and the provision of equipment have improved the quality of the service.
- The support from the international donor community has been fundamental to improve sectoral indicators.
- Incentives have been effective in increasing coverage: mobile brigades to remote areas, giving formula to mothers who bring their children to growth monitoring and vaccination services, combination of traditional and modern birth attendants has increased coverage.
- If CIDA's future contributions are to have an impact on the Bolivian Health system, the evaluators recommend that CIDA focus on one ultimate outcome with its underlying intermediate outcomes and respective activities, using the Logic Model Framework. A study of the most important health concerns in Bolivia coupled with a review of the national plans and priorities has lead the evaluation team to recommend that CIDA focus on the following ultimate outcome: "Reduction of Maternal and Neonatal Mortality" (see Section 5.5.3 of the report for more details). This model is a priority of the Ministry of Health as articulated in the "Plan Estratégico Nacional para Mejorar la Salud Materna, Perinatal y Neonatal en Bolivia 2009-2015". The list of Effects and Products above could be fine-tuned to address this particular outcome. Having a specific focus

would give PRICASS concrete intermediate outcomes and activities with measurable indicators.

The evaluators recommend that the FPS, FLASS, and budgetary support components support this ultimate outcome, which includes: improvement of provider performance, improvement in equipment and infrastructure, development of logistics, information and referral systems, community participation and mobilization, intercultural aspects and gender and human rights, approach. The accreditation process for health facilities and the EmOc model, based on the UN process indicators, both require assessments and these would allow the PASS Project to develop concrete indicators for each SEDES. Different types of indicators should be considered for the new project cycle to facilitate the monitoring and evaluation process.

- Design indicators are based on key elements of quality (eg. existence of clearly defined goals and objectives, involvement of local stakeholders in program planning, etc.)
- Systems development and functioning indicators include organizational structure, functioning partnerships, networks, and collaboration.
- Implementation Indicators: measure whether and how planned activities have been conducted, and the quality of the implementation of these activities (for example: people trained, communication products developed, involvement of stakeholders, etc.).
- Outcome indicators state results in terms of the program participants and are measurable statements of the outcomes the project hopes to achieve in the target population (vaccination coverage, pre and post natal care coverage, incidence of infectious diseases, etc.).

It seems appropriate that donor funding be used to implement an evidence based model, have the SEDES present results to the Central Ministry, then take it to scale in the whole country and advocate for better policies to prevent maternal and neonatal deaths.

Management Model

- Activity planning and programming improve local management, which is why it is important to strengthen leadership and build management capacities. The departmental AOPs must be participatory and comprehensive, and respect the demands and needs in health.
- The AOP is drafted on the basis of needs of the department, but on the moment of review and approval, the MSD adjusts the activities to new financial ceilings, which leads to an unbalanced relationship between the budget items (e.g. the relationship between tickets and per diems).
- Late disbursements affect physical and financial execution.

-
- Health network managers are motivated because they have the means to fulfill their duties: logistical support (vehicles, gasoline), knowledge (post graduate courses, clinical training), and equipment.

Implementation in the Field:

- In the health networks of Riberalta and Guyaramerin in the Beni, a family census took place with data collected and regularly updated to track children under 5 years of age and pregnant and lactating women for interventions. This should be done in all regions.
- In Oruro an inventory of communities was done to determine which ones were located over 2 hours by foot from a health post or center, and actions undertaken to reach these communities with mobile units.
- Natural disasters in the Beni with flooding during the rainy season resulted in improved inter-institutional coordination and disaster relief measures, including prevention of the spread of Dengue and Malaria.
- The impact of monetary and tangible incentives has been significant. Women who are given a financial bonus by the government (Bono Juana Azurduy) are coming to health centers for child and maternal care and coverage has dramatically increased. Pregnant women who receive an agauyo (cloth to carry a newborn in) and a set of baby clothes now come to the health center for deliveries and comply with the required prenatal check-ups. The free Nutri-bebe is also motivating more mothers to seek child care services.
- Coordination between institutions and sectors at the municipal level is the key for improving health services and community demand and use of services.
- Training of human resources through formal courses at the university is an important motivation for health personnel.
- Incentives such as Proyecto Aguayo in Oruro, and Nutri-bebe nutritional supplements are a key factor in increasing demand and use of health facilities.

Gender and Interculturalism:

- A focus on gender issues and decreasing gender based violence has helped to institutionalize gender in health services.
- If gender equity and quality of life for families is to be improved, men need to be included in reproductive health education.
- Cross-cutting themes such as gender and interculturalism need to be more fully integrated into annual operating plans, if results are to be forthcoming.
- Use of mass communication strategies is vital, if the general population is to be educated and informed about gender and intercultural issues.
- If women's groups do not receive motivation and follow-up, they often become inactive, as in the case of Pando, where mothers in Cobija and Puerto Rico need to be reactivated.
- Priority interventions are required both gender and inter-cultural aspects, if these components are to be fully developed by the end of the programme.
- It was not expected that the SAFCI model would be so fully embraced and garner the full participation of a host of local actors, becoming the cornerstone of local health management. As the model matured in Oruro, UNICEF played a key role in the support of the Chacana, a conceptual framework linked to the SAFCI model that bases

participatory planning on the spiritual wellbeing of communities and individuals. The Chacana stems from the Aymara and Quechua cosmo-vision based on living in harmony with the world around us in its myriad aspects.

CIDA:

- CIDA has worked hard so that the programme moves forward vis-à-vis the Planning Unit. Good relationships have been established with the different actors at the Ministry and the members of the Planning Units have developed a close working relationship with CIDA staff.

5.8.2. Recommendations

5.8.2.1. SHORT-TERM RECOMMENDATIONS

The Ministry of Health MSD

1. The MSD must assume leadership of the Program and not only of the Budget Support component. The UP must be strengthened by assigning it the hierarchical level of a General Direction and providing it with human resources paid by the TGN who would gradually replace the PASS consultants; the strengthening effort should also include the facilitation of the administrative procedures under its care and advocacy at the highest level in order to reduce bureaucracy in the budget processes with the VIPFE and the MEFP (section 5.2.3; 5.2.4.; 5.4.1.).
2. The UP has to improve its coordination with the SEDES and assume leadership at the technical and policy levels rather than on the basis of financial control; the UP has to respect the departmental AOPs, verifying whether they are consistent with national and sectoral policies, granting flexibility to the SEDES within the framework of a results-based management approach (section 5.2.3.; 5.2.4.; 5.2.5.; 5.4.2.).
3. The financial controls should be performed afterwards in audits; the SEDES should sign a document regarding automatic debits from their accounts in case the resources are found to be used inadequately so as to refund the money to MSD accounts (section 5.4.2).

To the Project through the MSD and CIDA

4. The format of the semester reports must be defined and uniform so as to give information on attainment of the results and the actions performed (degree of physical progress) and the financial execution in all components; the UP should consolidate the reports in an executive summary that shows the Program contribution to the results of the sector in accordance with the logical framework. To do this, it is critical that the programme, in collaboration with the different components finalize a set of basic indicators to measure progress in achieving results. The reporting format should be simple, show actual vs expected results and indicators and be consulted with CIDA (section 5.3.2.).
5. Create an advisory council that can meet quarterly to address implementation issues and provide inter-institutional coordination, synergy and the exchange of experiences

among the PASS components at the national and regional levels. Leadership could be rotational so that no component is overburdened. Of particular importance is improving the coordination with the FPS to link infrastructure and equipment to medical requirements and gender and cultural considerations. (See Section 5. 2.4.).

6. The two national committees should prioritize more far-reaching issues, rather than administrative problems, such as the implications of the PASS programme on public health policy, status of the gender and intercultural components, innovative practices with potential to be scaled-up and sustainability issues. (See Section 5.3.5.)
Components)

SEDES

7. Create a Departmental Operational Committee, led by the SEDES and with participation of the institutions involved and representatives of civil society, with the purpose of linking the components to the supply (healthcare services) and demand (civil society). Advantage must be taken of this entity to promote the Program and its benefits, including the FLASS component (section 5.3.5.).

FPS

8. The FPS currently builds traditional structures without considering state of the art construction practices. It is recommended that FPS receive training and guidance regarding building design such as orientation towards the sun in cold climates, use of thermal mass, light shelves, use of materials to make rooms warmer in the Altiplano, or to cool down spaces in the tropics. (See Section 5.5, Ownership of Programme Activities).

9. Reach a consensus between the central Ministry of Health, SEDES, UNICEF, FPS on infrastructure, with state of the art training for the FPS teams at the departmental level so that new infrastructure is adequate in terms of gender, local cultural needs and customs and financial costs⁴⁰. (See Section 5.7.2.)

10. Prioritize infrastructure and equipment taking into consideration the baseline in such a way that the SEDES proposes to each municipality the type and characteristics of the investment increasing the participation of the FPS from the idea of the project to strengthening capacities to ensure the maintenance on the part of the municipality. Infrastructure models should also consider the themes of interculturalism, gender and housing for medical personnel. (See Section 5.7.2.)

PRICCAS

11. Prepare a sustainability plan for transferring key programme activities to the three SEDES, municipal governments and other local institutions, as relevant. The sustainability plan should select 5-10 important activities and include indicators to track these during the next two years. (See Section 5.5.1.).

⁴⁰ The Maternal-Perinatal Hospital in Lima could provide cost-effective assistance on linking building plans to efficient service provision. They have given excellent on-site technical assistance to the Prefecture of Tarija for the design of the new maternal referral hospital.

12. Prioritize the implementation of the gender action plan during the last two years of the project. (See Section 5. 7.1.)

Gender Equality and “Inter-culturalism”

13. Disseminate lessons learned and best practices to the Ministry of Health and larger development community in Bolivia. An example is the use of incentives to increase utilization of services such as the Aguayo Project. This could be done by the National Gender Technical Committee. (See Section 5.7.1.)

5.8.2.2. Long-term Recommendations

FLASS

14. The FLASS must make more efforts to allocate resources to at least one initiative in the department of Pando, as a pilot experience to assess the population’s response to this type of initiatives. It should be clear that this component should not only work with the few NGOs in the department, but also with the municipal governments (section 5.3.2, point 4).

PRICCAS

15. Strengthen the PRICCAS emergency obstetric and neonatal care strategy⁴¹ over the next two years documenting best practices, and scale-up to other departments of Bolivia during the following program cycle. (See Section 5.5.3.)

16. The capacity for managing the financial administration systems should be strengthened, both at the level of the MSD and in the SEDES and municipalities. In this regard, the suggestion is to hire experts to prepare guides on financial administration systems (budgets and treasury) and train personnel on the basis of practical Program cases; this training should be complemented with technical guidance in order to ensure compliance with budget execution and accountability (section 5.3.2; point 2 PRICCAS).

CIDA and Ministry of Health

17. Since PAHO already has a permanent relationship with the Ministry of Health as a provider of technical assistance, it is recommended that CIDA coordinate with PAHO to determine specific inputs which would strengthen the effectiveness of the Planning Unit as the leader of national and regional health planning and policy guidance. (See Section 5.5.2.)

18. The evaluators specifically recommend that PASS be continued and prioritize the reduction of maternal and neonatal mortality (see Section 5.5.3). This model is a priority of the Ministry of Health as mentioned in the “Plan Estratégico Nacional para Mejorar la Salud Materna, Perinatal y Neonatal en Bolivia 2009-2015”. The evaluators recommend that the FPS and FLASS components support this key to strengthen one

⁴¹ See the National Strategic Plan for Improving Maternal and Neonatal Health 2009-2015.

comprehensive program approach. A new phase should take into account the limitations of the Ministry of Health and SEDES in executing on their own the overall project components and the lessons learned and best practices from the project to date. Improving management capacity to execute projects like these in the future should also be a priority to improve the effectiveness and efficiency of the Ministry of Health. (See also Lessons Learned under design).

Gender Equality and “Inter-culturalism”

19. Include a men’s health component that includes sexual and reproductive education for men and “men friendly services” at health centers. Training objectives should include: strengthen knowledge and attitudes regarding gender equity, reduce risky behaviors (unprotected sex, alcohol and drug use), enhance self-assessment regarding sexual and family violence, improve actions to prevent of ITS-HIV/SIDA and unwanted pregnancies, promotion of the fathers’ role in nutrition and health of young children, and strengthen self-esteem and decision making. (See Section 5.7.3,; 5.8.1.).

20. Determine which practices can be institutionalized and include these in public policy. The SAFCI calls for gender equity and inclusion of inter cultural practices, however specific actions at the field level are yet to be determined. PASS can have an important role in this regard through the National Gender Technical Committee. (See Section 5.7.1.)

6.0. Concluding Remarks

The report presents findings of a three person mission to Bolivia undertaken between August 12-28, 2009. During this time, three departments were visited: Oruro, Beni and Pando. Close to two hundred persons were interviewed using a mixed method approach.

The concept of the PASS Program is viable as it integrates and centers the efforts and expertise of public, private and donor institutions with the need to improve the population's access to healthcare services. The geographic scope targets the poorest municipalities in Oruro, Beni and Pando, all of which are part of the National Plan Vida to reduce extreme poverty.

The Program centers its actions on the improved provision of healthcare services, training, improvement of the infrastructure and the empowerment of civil society. In addition, the idea is to strengthen the strategic health vision through the UP of the MSD and build the capacity to monitor the implementation of sectoral policies based on activities to strengthen the SEDES. The choice of partners is relevant with the Planning Unit functioning as the official Ministry of Health with CIDA, UNICEF as provider of public health technical assistance, FPS responsible for health infrastructure and equipment, and FLASS generating innovate projects at the community level.

Although there is a potential synergy among the partners and their contributions to PASS, this has not been capitalized upon. There is no official mechanism to ensure the integration of programme components except for two national committees (managerial and technical) that meet twice a year at the national level. For this reason, an advisory council composed of the different components is suggested that could meet on a quarterly basis and exchange experiences and innovations in the field.

The difficulties in Program implementation can be summarized in three big groups:

- a) Ownership and leadership. The MSD has not assumed the importance of the international donor support, not only in financial terms but also in terms of the need to strengthen the UP as the basis to build a strategic vision and its leadership as the governing entity in the sector. This is a consequence of the lack of clear indicators that show the direction in which the Program should advance and the inexistence of a baseline to measure sectoral achievements.
- b) Bureaucracy on different levels. There are important difficulties in drafting of the AOPs, budget registration and modification, the opening of fiscal accounts, the hiring of consultants, the procurement of input etc.; these difficulties do not only appear in the different implementing entities that create their own bureaucracies (except for UNICEF), but they also refer to national entities, such as the VIPFE and the MEFP.

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- c) External problems such as the agenda of change at the central level (MSD) and in some departments like Beni and Pando, the political events in Pando in 2008 and the limited geographical access in Beni and Pando.

Because of these difficulties, the levels of financial execution is not yet satisfactory even though CIDA has made the disbursements in order to avoid suspensions of the project and has also made major efforts to advance the Program.

The principal difficulty is found in the institutional strengthening component, in which the MSD is the leader through financial control of the SEDES rather than overseeing the orientation of public health policies.

On the other hand, the monitoring mechanisms have not been able to have an impact on resolving difficulties as they are part of the public sector structure. Rather on the contrary, the MC has spent considerable time on administrative matters, to the detriment of technical proposals.

It is therefore necessary to reinforce the decision-making level of the MC with a team of experts that have sufficient authority in order to provide technical solutions for the difficulties; at the same time, it is necessary to strengthen the UP, the lack of leadership of which in the program is the principal risk for Program continuity. This strengthening effort should also be made in the SEDES, which also have serious management difficulties.

A key strategy to be scaled-up in other parts of Bolivia is the establishment of an emergency obstetric (EmOC) and neonatal care system within existing rural health networks, in alignment with the National Strategic Plan for Improving Maternal and Neonatal Health 2009-2015. Although ownership of PASS activities has been enhanced, especially through PRICASS's support of the SAFCI model, full community empowerment will be a much longer process. There is limited potential for the Ministry of Health and municipal governments to provide resources after PASS ends; the health system will continue to implement their programs, but not at the same level of effort.

Together with programme partners, a National Gender Technical Committee was formed and has developed a Gender Equity Strategy for the duration of the PASS programme. The implementation plan was launched in 2009 and will insure a more intensive gender approach and analysis of indicators at the three SEDES. Due to inclusion of both gender and intercultural topics in national Health Sector Plans, PASS partners have included activities and indicators in their annual operating plans, however many municipal government and SEDES staff have yet to buy-in to inclusion and equity for women and indigenous populations.

Finally, it is essential for the international donor community to continue supporting the sector, as the desired results have not yet been achieved; however, this support should be conditional on a greater commitment at the national, departmental and local levels, not only in terms of Program guidance but also in terms of resources in order to

institutionalize the Program in the state structures, by means of hiring permanent staff for the PASS, the purchase of inputs, and maintenance of the infrastructure, etc.

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Annex 1: Terms of Reference for the Consultant Specializing in Health and/or Public Financial Management

1. Description of the Project

This project forms part of a large-scale program, the Health Sector Support Program (PASS). In general, PASS seeks to improve the quality of life in Bolivia by establishing a more effective, equitable, and accountable public health care system. The project helps to improve the quality and availability of public health care services, to better the health of Bolivians, and to reduce the incidence of communicable diseases. Through this project with the Ministry of Health and Sports, activities serve to strengthen the planning unit of the Ministry and the three departmental health services (SEDES) in Beni, Pando, and Oruro.

The activities with UNICEF provide support for strengthening local health care networks in Beni, Pando, and Oruro. They also support the implementation of communicable disease control programs.

2. Rationale and Scope for the Evaluation

CIDA is looking to confirm the relevance of the Programme Support to the Health Sector Project being executed in Bolivia, commonly known as PASS and to make recommendations to make its execution more effective in order to meet the Programme's expected results while providing reflections on a possible second phase to the programme.

The evaluation will focus on two components: 1) Local-departmental level in Beni, Pando and Oruro in order to improve the access and quality of local services in basic maternal and infant health, the renovation of existing equipment and infrastructure and the control of transmittable diseases; 2) Institutional strengthening focusing on the Ministry of Health and the three departmental health services.

The scope of the evaluation will cover the following topics as per the terms of reference:

3. Findings

3.1. Relevance

Was the project well-founded in terms of the objectives and scope determined in the beginning?

What is the degree of consistency with the National Bolivian Strategy in Health?

What is the degree of consistency with the key stakeholders (MSD, SEDES, municipalities)?

What is the consistency with the needs of the target population in the three departments: Beni, Pando and Oruro?

Is the project consistent with the orientations of the Ministry of Health and Development (ie. sectoral strategies, etc)?

What is the degree of integration of the three components of PASS and one unique programme?

3.2. Coherence (the relationship between the different parts constitute a programme. The following questions will be examined:

What is the degree of internal coherence: coherence between the diverse components in order to meet expected objectives and results given the design of PASS and the methods for its implementation, choice of partners of PASS, relevance of initial hypothesis and geographic focus in three departments)?

3.3. Effectiveness. Effectiveness and the degree of realization of actions, the state of implementation of each component. The following questions will be examined:

Is the nature and modalities of implementation of PASS effective?

What is the degree of achievement of expected activities and results?

Is there a relationship between expected and actual results?

Are there unexpected results (negative or positive) and what are they?

What is the meaning of any differences between expected and actual results?

Has the calendar and timetable been respected?

Is the monitoring adequate?

Are the mechanism for piloting the project (management committee, operational and PRICCAS committee) effective?

3.4. Efficiency. What is the relationship between costs (financial, temporal and human) and the advantages, between the results achieved and the resources utilized. The following questions will be examined:

What is the degree of financial execution?

Are the capacities of the MSD (Planning Unit) adequate to ensure the coordination of PASS activities and the monitoring of the results and to produce consolidated annual plans and reports?

Is the level of strengthening of management capacity of MSD and SEDES with the institutional support component sufficient?

Are the modalities of mobilization of financial, technical, organizations and human resources use in a timely and cost-effective manner?

How can one explain possible cost overruns and delays?

Is the process of project approval and monitoring of FPS component efficient?

3.5. Sustainability. What is the duration and sustainability of the intervention after funding? The following questions will be examined:

What is the degree of financial and operational viability of the structures and mechanisms put into place?

Is the institutional responsibility by the MSD and SEDES, approaches and strategies put into place for PASS viable?

Is it possible to reproduce and generalize the intervention in other departments of Bolivia?

What is the benefit of consultants designated to MSD and engaged thanks to the project?

What is the degree of ownership of programme activities by the beneficiary population?

3.6. Risks

What are the real risks confronting the PASS programme, their nature, their magnitude and potential perturbation?

What are measures of mitigation put into place to reduce the incidence of anticipated risks and are they assumed?

Does CIDA have the capacity to react given the environment for implementation?

3.7. Gender Equality and “Inter-culturalism”. Are gender equality and interculturalism pertinent and effective? The following questions will be examined:

What is the degree of integration of measures favor gender equality at the level of programme activities and the degree of internalization in the implementation of the programme?

What is the degree of ownership by programme partners of the strategies for reaching gender equality and inter-culturalism?

What is the degree of ownership by SEDES of gender equality and interculturalism strategies?

Are the preconceived measures taken by the Programme adequate in terms of relevance and quality of response with regards to the needs of women and cultural community and their promotion of their strategic interests as a social group?

3.8. Lessons Learned and Recommendations

Formulation of lessons learned and recommendations that can improve the follow-up to the project and a possible second phase in order to achieve sustainable results and the optimal use of CIDA’s contribution.

4. Field Mission and Sampling

A field mission will be undertaken to Bolivia which will allow the evaluator to gather the information needed for the evaluation. Field visits will be made to two of three departments: Oruro, Beni or Pando. The country visit will inform the evaluation. Criteria for the selection of communities will include representativeness, distance and size and nature of the intervention.

Whenever possible, the evaluation will seek to interview a wide range of stakeholders to properly inform the evaluation as per the list presented in the next section.

5. Timetable and Deliverables:

May 2009	Selection of the Consultant, Contract signed
May/June	Review of documentation
August 10, 2009	Meet with Lead Consultant and undertake field interviews
October 15, 2009	Submission of report
November 15, 2009	Revision and input into final report

6. Local Evaluators

Two local intermediate evaluators will be part of the Evaluation Team and will be part of the field travel and interviews. The local Evaluators will participate in all meetings and in some cases help to arrange meetings that are critical for responding to his/her mandate. He/she will provide input into the final powerpoint presentation based on their findings to date. He/she will prepare a succinct and analytical report that systematically provides input into each of the nine topic areas and responds directly to each of the questions in an organized fashion. The Consultant will also review the final report and provide any suggestions. He/she should have expertise in 1) health and/ or 2) public financial management. 24 days should be sufficient for each evaluator to review documentation (3 days), conduct field work (13 days), prepare input into the report (5 days) as per each of the topics and sub-questions and read and provide suggestions/comments to the final report (3 days). Spanish is essential. English is an asset.

The **local evaluators will be under the direction of the Lead Evaluator** although the CIDA Project Support Unit will be responsible for the administrative aspects of their contract and payment based upon approval by the lead Evaluator. All communication should be with the Lead Evaluator except for administrative and contractual matters.

Annex: 2 List of Semi Structured Interviews

Date	Activity	Participants	Objectives/Comments
Wednesday 12-Aug-09			
8:00	Departure to Canadian Embassy	FC	
8:30 – 11:30	Internal meeting with the Evaluation Team Place: PSU office – Plaza España, Edificio Barcelona, Piso 2 Contact person: Gilda Portocarrero. Tel. 2411511 Ext. 24	FC, LJ, WG	Evaluation Team coordination
11:30 – 13:00	Interview with Mr. Alberto Palacios-Hardy (Counsellor and Head of Aid – Embassy of Canada), Mrs. Anne-Marie Hodgson (1 st . Secretary – Embassy of Canada and Mrs. Erika Silva (Health Consultant – PSU office) Place: Embassy of Canada – Plaza España, Edificio Barcelona, Piso 2 Contact person: Gilda Portocarrero. Tel. 2411511 Ext. 24	FC, LJ, WG, APH, AMH, ES	Obtención de información adicional coordinación general. Estado Actual del proyecto.
13:00 – 14:00	Lunch time	FC, LJ, WG	
14:30 – 15:30	Group interviews with Mrs. Ivette Sandino (Manager of Health and Nutrition - UNICEF), Mrs. Rosario Quiroga (Health Specialist - UNICEF), Mrs. Leda Azad (Health Communal Officer - UNICEF), Mrs. Ivana Calle (Gender Officer – UNICEF), Carmen Luca (UNICEF) and administrative staff. Place: UNICEF Calle 20, esq. Av. Fuerza Naval N° 7720 – Calacoto.	FC, LJ, WG	Comprensión de la Implementación de PRICCAS y su alcance y resultados Revisión de Documentación en UNICEF

Date	Activity	Participants	Objectives/Comments
	Contact person at UNICEF: Gretel Bedregal. Tel. 2770222 int. 262		
15:30 – 16:15	Individual interview with Mrs. Rosario Quiroga (Health Specialist - UNICEF) Place: UNICEF Calle 20, esq. Av. Fuerza Naval N° 7720 – Calacoto. Contact person at UNICEF: Gretel Bedregal. Tel. 2770222 int. 262	FC, LJ	
16:15 – 17:00	Individual interview with Mrs. Leda Azad (Health Communal Officer - UNICEF) Place: UNICEF Calle 20, esq. Av. Fuerza Naval N° 7720 – Calacoto. Contact person at UNICEF: Gretel Bedregal. Tel. 2770222 int. 262	FC, LJ	
17:00 – 18:00	Individual interview with Mrs. Ivana Calle (Gender Officer – UNICEF) Place: UNICEF Calle 20, esq. Av. Fuerza Naval N° 7720 – Calacoto. Contact person at UNICEF: Gretel Bedregal. Tel. 2770222 int. 262	FC, LJ	
15:30 – 17:00	Individual interview with Mr. Edgar Donoso (Oficial de Programa – Presupuesto) Place: UNICEF Calle 20, esq. Av. Fuerza Naval N° 7720 – Calacoto. Contact person at UNICEF: Gretel Bedregal. Tel. 2770222 int. 262	WG	Análisis de aspectos presupuestarios y financieros del PRICCAS
Thursday			

Date	Activity	Participants	Objectives/Comments
13-Aug-09			
8:00	Departure to Health Ministry	FC, LJ, WG	
8:30 – 10:30	<p>Group interviews to the planning team of the Planning Unit - Ministry of Health:</p> <p>Mr. Rogel Mattos (General Advisor of Programs and Projects PASS), Mr. Freddy Sanabria (Manager of Planning Unit – Ministry of Health), Ms. Leslie La Torre (Consultant PASS funding), Mr. Jhonny Sánchez (Consultant PASS funding), Mr. Steven Sanjines (Consultant) and Mr. Antonio Ramos de Mattos (Consultant of French Cooperation)</p> <p>Place: Ministerio de Salud – Calle Capitán Ravelo N° 2199, Piso 4</p> <p>Contact: Carmen de la Barra. Tel. 2444652</p> <p>Natalia Guarachi (Asistente F.Sanabria). Tel. 2444652</p> <p>Contact: Antonio de Mattos. Cel. 706-37870</p>	FC, LJ, WG	Comprensión del Rol de la Unidad de Planificación, los alcances y resultados del apoyo presupuestario del PASS
10:30 – 11:00	<p>Individual interview with Mr. Rogel Mattos (General Advisor of Programs and Projects PASS)</p> <p>Place: Ministerio de Salud – Calle Capitán Ravelo N° 2199, Piso 4</p> <p>Contact: Carmen de la Barra. Tel. 2444652</p>	FC, LJ, WG	<p>Revisión de Documentación en la Unidad de planificación</p> <p>Objetivo: Ampliar información</p>
11:00 – 11:30	<p>Individual interview with Mr. Jhonny Sánchez (Consultant PASS funding)</p> <p>Place: Ministerio de Salud – Calle Capitán Ravelo N° 2199, Piso 4</p>	FC, LJ, WG	

Date	Activity	Participants	Objectives/Comments
	Contact: Carmen de la Barra. Tel. 2444652		
11:30 – 12:00	Individual interview with Mrs. Leslie La Torre (Consultant PASS funding) Place: Ministerio de Salud – Calle Capitán Ravelo N° 2199, Piso 4 Contact: Carmen de la Barra. Tel. 2444652	FC, LJ	
11:30 – 12:30	Individual interview with Mr. Máximo Huaywa (Administrator) Place: Ministerio de Salud – Calle Capitán Ravelo N° 2199, Piso 4 Contact: Carmen de la Barra. Tel. 2444652	WG	Análisis de aspectos administrativos financieros y presupuestarios del MSD
12:00 – 12:30	Individual interview with Mr. Antonio Ramos de Mattos (Consultant of French Cooperation) Place: Ministerio de Salud – Calle Capitán Ravelo N° 2199, Piso 4 Contact: Antonio de Mattos. Cel. 706-37870	FC, LJ	
12:30 – 13:30	Review of files and documentation Place: Ministerio de Salud – Calle Capitán Ravelo N° 2199, Piso 4	FC, LJ, WG	
13:30 – 14:30	Lunch time	FC, LJ, WG	
14:45 – 15:45	Interview to Dr. Igor Pardo (General Director of Health – Ministry of Health)	FC, LJ, WG	Conocer las políticas nacionales de salud y cómo éstas se implementa

Date	Activity	Participants	Objectives/Comments
	Place: Ministerio de Salud – Calle Capitán Ravelo N° 2199, Piso 4 Contact Person: Jackeline Zúñiga. Tel. 2440591 / 2442572		a través de PRICCAS en los Departamentos de Oruro, Pando y Beni. ¿Cómo PRICCAS/UNICEF es apoyando al MSD a nivel central?
16:00 – 16:45	Interview with Mrs. Alba Mora (Former consultant of Ministry of Health) Place: Ritz Apart Hotel Av. Arce – Plaza Isabela Católica Contact Person: Alba Mora. Tel. 2797398. Cel. 720-92995	FC, LJ, WG	Conocer las políticas nacionales de salud y cómo éstas se implementa a través de PRICCAS en los Departamentos de Oruro, Pando y Beni. ¿Cómo PRICCAS/UNICEF es apoyando al MSD a nivel central?
17:00 – 18:00	Interview with Dr. Christian Darras (Representative of OPS-OMS) Place: Plaza España, Edificio Barcelona, Piso 6 Contact person: Ximena Carrión 2412303 / 2412313 / 2412465 Ext. 610	FC, LJ, WG	Miembro del Comité de Gestión del PASS y de la Cooperación Internacional en Salud
Friday 14-Aug-09			
8:00	Departure to FPS	FC, LJ, WG	
8:30 – 10:30	Group interview with FPS team: Rocio Ticona (Infrastructure Manager)	FC, LJ, WG	Comprensión de la Implementación del componente de infraestructura y equipamiento de FPS, su alcance y resultados

Date	Activity	Participants	Objectives/Comments
	<p>Roxana Encinas (Financial Manager)</p> <p>Frida Martínez (Responsible of Agreements)</p> <p>Ariel Cortez (Operations Manager)</p> <p>Ana Quiroga (Coordinator of PAAF - Programa de Apoyo, Asesoramiento y Fortalecimiento a los Municipios)</p> <p>Place: Belisario Salinas esq. Presbítero Medina N° 354, Piso 7.</p> <p>Contact Person: Rocío Ticona Tel. 2412474 Cel. 706-55655</p>		Revisión de Documentación en FPS
10:30 – 11:30	File and documentation review at FPS	FC, LJ, WG	
11:30 – 12:30	Individual interviews with Mrs. Rocío Ticona and Mrs. Ana Quiroga	FC, LJ	
11:30 – 12:30	Individual interviews with Mrs. Roxana Encinas	WG	Análisis de temas administrativos, financieros y presupuestarios
13:00 – 14:30	Lunch time	FC, LJ, WG	
14:30 – 16:00	<p>Individual interviews with former authorities in charge of PASS:</p> <p>Mr. Herland Tejerina (Former consultant of CIDA)</p> <p>Place: Ritz Apart Hotel – Av. Arce, Plaza Isabela Católica</p> <p>Contact Person: Herland Tejerina Cel. 730-22709</p>	FC, LJ, WG	Conocer como se gestó el PASS y ejecución inicial

Date	Activity	Participants	Objectives/Comments
16:00 – 17:30	Interview with Dr. Germán Crespo (Former Planning Advisor) and Dr. Nila Heredia (Former Minister of Health) Place: Ritz Apart Hotel – Av. Arce, Plaza Isabela Católica Contact Person: Germán Crespo. Tel. 2486891 Cel. 720-38544 Nila Heredia. Tel. 715-85410	FC, LJ, WG	Conocer como se gestó el PASS y ejecución inicial
Saturday 15-Aug-09			
8:00 – 18:00	Flexible work time to organize activities with the consultants's team	FC, LJ, WG	
Sunday 16-Aug-09			
8:00 – 18:00	Flexible work time to organize activities with the consultants's team	FC, LJ, WG	
Monday 17-Aug-09			
7:30 – 10:30	Trip to Oruro	FC, LJ, WG	PSU driver will take the evaluation team to the city of Oruro. José Luis Sánchez. Cel. 762-05952
10:45	Arrival to Hotel "Villa Real San Felipe"	FC, LJ, WG	Bookings are confirmed.

Date	Activity	Participants	Objectives/Comments
	Place: Calle San Felipe N° 678 entre La Plata y Soria Galvarro. Contact Person: Hector Gómez. Tel. 2-5254993		
11:00 – 13:00	Preparation for the discussion round table	FC, LJ, WG	
13:00 – 14:00	Lunch time	FC, LJ, WG	
14:00 – 18:00	<p>DISCUSSION ROUND TABLE IN THE CITY OF ORURO</p> <p>SEDES ORURO:</p> <p>Dr. Johnny Vedia (Director of SEDES)</p> <p>Dr. David Choque (Planning Unit – SEDES)</p> <p>Lic. Gonzalo Pozo (Plannit Unit - SEDES)</p> <p>Lic. René Mollinedo (Planificador – SEDES)</p> <p>Dr. Rodolfo Martínez (Responsible of Health Networks - SEDES):</p> <p>Lic. Margot Gutiérrez (Responsible of Gender and Violence - SEDES)</p> <p>Program Managers:</p> <p>Dra. Carmen Huanca (Responsible of Zero Malnutrition)</p> <p>Dra. Ana Beatriz Cuellar (Responsible of PAI – Programa Ampliado de Inmunización)</p> <p>Dra. Gladys Colque Cárdenas (Responsible of SUMI)</p> <p>Lic. Nancy Solíz (Responsible of Salud Sexual y Reproductiva)</p>	FC, LJ, WG	

Date	Activity	Participants	Objectives/Comments
	<p data-bbox="394 256 1125 285">Dra. Ruth Frías (PAI II - Programa Ampliado de Inmunización)</p> <p data-bbox="394 380 642 409">Network Managers:</p> <p data-bbox="394 441 823 470">Red Urbana: Dr. Mario Coro alvarez</p> <p data-bbox="394 503 877 532">Red Asanaque :Dr. Abundio Taquimallcu</p> <p data-bbox="394 565 877 594">Red Cuenca Pooopó: Dr. Ladislao Iñiguez</p> <p data-bbox="394 626 793 656">Red Occidente. Dr. Reino Alvarez</p> <p data-bbox="394 688 789 717">Red Norte: Dr. Hermes Achacollo</p> <p data-bbox="394 750 793 779">Red Minera: Dr. Jorge Viracochea</p> <p data-bbox="394 873 680 902">Local Staff of UNICEF:</p> <p data-bbox="394 935 869 964">Rosario Quiroga (Especialista en Salud)</p> <p data-bbox="394 997 819 1026">Gustavo Tapia (Consultor en Salud)</p> <p data-bbox="394 1120 634 1149">Local Staff of FPS:</p> <p data-bbox="394 1182 1075 1211">Gerente Departamental FPS : Sr. Rosendo Copa Mamani</p> <p data-bbox="394 1243 768 1273">Jefe Técnico: Ing. Milton Claros</p> <p data-bbox="394 1305 882 1334">Profesional Técnico: Ing. Gonzalo Llanos</p> <p data-bbox="394 1367 890 1396">Profesional Técnico: Ing. Simeon Huallata</p>		

Date	Activity	Participants	Objectives/Comments
	<p>Alcaldes Municipales:</p> <p>Gerardo Loayza Chinche (Alcalde Municipal - El Choro)</p> <p>Ruth Sanchez (Alcalde Municipal – Huanuni)</p> <p>Nicanor Lopez Choque (Alcalde Municipal – Poopo)</p> <p>Rómulo (Alcalde Municipal – Curahuara de Carangas)</p> <p>Health Local Commitees</p> <p>2 persons</p> <p>Health Personnel</p> <p>2 persons</p> <p>Place: Hotel “Villa Real San Felipe”. Calle San Felipe N° 678 entre La Plata y Soria Galvarro. Tel. 2-5254993</p> <p>Contact Person: At SEDES Oruro: Jenny Choque. Tel. 252-77001 Cel. 718-43550 (J.Vedia)</p> <p>Contact Person: At FPS Oruro: Milton Claros. Tel. 252-55770. Cel: 722-65917</p>		

Tuesday 18-Aug-09			
8:20	Departure to SEDES Oruro		
8:30 – 9:30	<p>Interviews with SEDES team (Director and personnel of Planning Unit)</p> <p>Dr. Johnny Vedia (Director of SEDES)</p> <p>Dr. David Choque (Planning Unit – SEDES)</p> <p>Mr. Gonzalo Pozo (Planning Unit – SEDES)</p> <p>Dr. Rodolfo Martínez (Responsible of Health Networks)</p> <p>Mr. René Mollinedo (Budget Support Consultant)</p> <p>Responsible of Administration SEDES</p> <p>Place: Calle 6 de Octubre N° 7625 entre San Felipe y Arce.</p> <p>Contact Person: At SEDES Oruro: Jenny Choque. Tel. 25277001 Cel. 718-43550 (J.Vedia)</p>	FC, LJ	
9:30 – 10:00	Individual interview with Dr. Rodolfo Martínez (Responsible of Health Networks)	FC, LJ	
10:00 – 10:30	Individual interview with Mr. René Mollinedo (Budget Support Consultant)	FC, LJ	
8:30 – 10:30	<p>Interviews with FPS staff.</p> <p>Sr. Rosendo Copa (Regional Manager of FPS Oruro)</p> <p>Ing. Milton Claros (Technical Manager)</p> <p>Ing. Gonzalo Llanos</p>	WG	

	<p>Ing. Simeon Huallata</p> <p>Place: Calle 1° de Noviembre entre Pagador y Velasco Galvarro N° 285</p> <p>Contact person: Milton Claros. Tel. 25255770. Cel: 722-65917</p>		
9:30 – 10:30	Interview with Mrs. Modesta Janco (Administrative responsible of FPS Oruro)	WG	
10:30 – 11:00	<p>Meeting with Mrs. Margot Gutiérrez (Responsible of Gender and Violence – SEDES ORURO)</p> <p>Contact Person: At SEDES Oruro: Jenny Choque. Tel. 25277001 Cel. 718-43550 (J.Vedia)</p>	FC	
11:00 – 11:30	Interview and review of documentation with Mr. Gonzalo Pozo (Budget Support Consultant in the Planning Unit – SEDES) and SEDES Administrator	FC, LJ	
10:30 – 11:30	<p>Review of files and documentation at FPS</p> <p>Place: Calle 1° de Noviembre entre Pagador y Velasco Galvarro N° 285</p> <p>Contact person: Milton Claros. Tel. 25255770. Cel: 722-65917</p>	LJ, WG	
11:45 – 14:30	Terrestrial trip to UCUMASI and lunch	FC, LJ, WG	<p>PSU driver will take the evaluation team to the community of Ucumasi.</p> <p>José Luis Sánchez. Cel. 762-05952</p>

14:30 – 16:30	Visit to “Centro de Salud” and interviews with the community.	FC, LJ, WG	
16:30 – 19:00	Return to Oruro	FC, LJ, WG	
Wednesday 19-Aug-09			
7:30 – 11:00	Terrestrial trip to Curahuara de Carangas with Mrs. Ruth Bolaños(CECI) Contact Person: Ruth Bolaños. Cel. 717-60728	FC, LJ, WG	PSU driver will take the evaluation team to the community of Curahuara de Carangas. José Luis Sánchez. Cel. 762-05952
11:00 – 13:00	Visit to CECI’s Project (with local funds): “Un aguayo para un parto sin riesgos en los municipios de Mancomunidad Aymaras sin fronteras del departamento de Oruro” Place: Alcaldía de Curahuara de Carangas	FC, LJ, WG	
13:00 – 14:00	Lunch time	FC, LJ, WG	
14:00 – 15:30	Visit to “Centro de Salud” and interviews with authorities and people of the community.	FC, LJ, WG	

15:30 – 18:30	Return to La Paz with Mrs. Ximena Valdivia (CECI)	FC, LJ, WG	
19:00	Arrival to Ritz Apart Hotel Place: Av. Arce N° 2478 - Plaza Isabela Católica. Tel. 2433131	FC	Reservation confirmed
Thursday 20-Aug-09			
05:00	Departure to the airport	FC, LJ, WG	Ritz Apart Hotel's vehicle will take Mrs. Coupal to the airport. We recommend to check and verify the flight is on time.
06:35 – 07:40	Flight N° 71 La Paz – Trinidad AMASZONAS/AEROCON	FC, LJ, WG	
8:15	Arrival to Hotel AGUAHI Place: Av. Bolivar Esquina Santa Cruz. Tel. 462-5569	FC, LJ, WG	Reservations confirmed

9:00 – 13:00	DISCUSSION ROUND TABLE IN THE CITY OF TRINIDAD SEDES BENI: Dr. Ernesto Moisés Yabeta (Director de SEDES BENI) Dr. Jesús Justiniano Méndez (Jefe Unidad de Planificación)	FC, LJ, WG	
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<p>Lic. Juan Antonio Castedo (Consultor PASS Canadá)</p> <p>Lic. Aracy Pérez Chávez (Encargada de Género)</p> <p>Dra. Rocio Cardozo (Jefa Unidad de Redes de Salud)</p> <p>Program Managers</p> <p>Lic. Rosemary Baltazar (Desnutrición Cero)</p> <p>Dr. Florencio Hoyos (PAI)</p> <p>Dr. René Mercado (SPS-SUMI)</p> <p>Network Managers</p> <p>Red 1 Trinidad: Dr. Luís Suárez Pova</p> <p>Red 2 Moxos: Dr. Miguel Ángel Melgar</p> <p>Red 3 Iténez. Dr. Julio Cesar Franco</p> <p>Red 6 Ballivian: Dr. Pedro Chávez Sorioco</p> <p>Red 7 Riberalta: Dr. Edgar Suárez Gonzales</p> <p>Local Staff of UNICEF:</p> <p>Dra. Leda Azad (Oficial en Salud Comunitaria)</p> <p>Lic. Virginia Castro (Responsable del Equipo local)</p> <p>Lic. Magaly Velíz (Responsable del Equipo local)</p>		
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<p>Local Staff of FPS:</p> <p>Gerente Departamental : Lic. Carlos Gomez Añez</p> <p>Ing. Oscar Ávila Chávez (Jefe de Evaluación Departamental del FPS)</p> <p>Profesional Técnica : Ing. Roberto Seoane</p> <p>Alcaldes Municipales</p> <p>Municipio de Trinidad</p> <p>Municipio de San Andrés</p> <p>Municipio de San Javier</p> <p>Municipio de Huacaraje</p> <p>Health Local Commitees</p> <p>2 persons</p> <p>Health Personnel</p> <p>2 persons</p> <p>Place: Hotel AGUAHI - Av. Bolivar Esquina Santa Cruz. Tel. 462-5569</p> <p>Contact person at SEDES Beni: Juan Antonio Castedo. Tel. 34621199.</p>		
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	Cel. 722-90780		
13:00 – 14:00	Lunch time	FC, LJ, WG	
14:00 – 18:00	Flexible work time to organize activities with the consultants's team or visit to near communities.	FC, LJ, WG	
Friday 21-Aug-09			
8:20	Departure to SEDES Beni		
8:30 – 10:00	Interviews with SEDES Beni team (Director and personnel of Planning Unit) Dr. Ernesto Moisés Yabeta (Director de SEDES BENI) Dr. Jesús Justiniano Méndez (Jefe Unidad de Planificación) Mr. Juan Antonio Castedo (Budget Support Consultant) SEDES Administrator Contact person at SEDES Beni: Juan Antonio Castedo. Tel. 34621199. Cel. 722-90780	FC, LJ, WG	
10:00 – 10:30	Interview with Mr. Juan Antonio Castedo (Budget Support Consultant)	FC, LJ, WG	
10:30 – 11:30	Interview to Mrs. Aracy Pérez Chávez (Gender Responsible – SEDES Beni) Contact person at SEDES Beni: Juan Antonio Castedo. Tel. 34621199.	FC, LJ	

	Cel. 722-90780		
10:30 – 11:30	Interview with SEDES Mr. Juan Antonio Castedo (Budget Support Consultant)	WG	Análisis de temas administrativos, financieros y presupuestarios
11:30 – 13:00	Interview and visit to Red Urbana (Trinidad)	FC, LJ, WG	
13:00 – 14:30	Lunch time	FC, LJ, WG	
14:30 – 15:30	Interviews with FPS Beni staff Lic. Carlos Gomez Añez (Regional Manager) Ing. Oscar Ávila Chávez (Jefe de Evaluación Departamental) Ing. Roberto Seoane (Technician) FPS Administrator Place: Av. 27 de Mayo Esquina Laureano Villar S/N Contact person: Cel. 711-30464 Tel. 34624276	FC, LJ, WG	
15:30 – 16:30	Interview to Mr. River Guardia (Financial Administrator - FPS Beni) Place: Av. 27 de Mayo Esquina Laureano Villar S/N Contact person: Cel. 711-30464 Tel. 34624276	WG	
16:30 – 17:15	Review of files and documentation at FPS Beni	LJ, WG	

	Place: Av. 27 de Mayo Esquina Laureano Villar S/N Contact person: Cel. 711-30464 Tel. 34624276		
17:15 – 18:30	Visit to buildings of FPS (Hospital Materno Infantil y Laboratorio)	FC, LJ, WG	
Saturday 22-Aug-09			
9:00 – 12:00	Visit to CIES in Trinidad: Local fund projects Contact person: Roxana Ríos	FC, LJ, WG	
12:00 – 13:00	Visit to APROSAR in Trinidad: Local fund projects	FC, LJ, WG	
13:00 – 13:30	Meeting with Mr. Eduardo Solares (former employee of Planning Unit SEDES Beni) Place: Hotel AGUAHI - Av. Bolivar Esquina Santa Cruz	FC, LJ, WG	
13:30 – 14:30	Lunch time	FC, LJ, WG	
14:30 – 15:30	Flexible work time to organize activities with the consultants's team. Or visit to nearby communities	FC, LJ, WG	

Sunday 23-Aug-09			
7:00	Departure to the airport	FC, LJ, WG	
8:15 – 9:45	Flight N° 11 Trinidad – Cobija AMASZONAS/AEROCON	FC, LJ, WG	Ritz Apart Hotel's vehicle will take Mrs. Coupal to the airport. We recommend to check and verify the flight is on time.
10:15	Arrival to Hotel DIANA Place: Av. 9 de Febrero N° 123. Tel. 3-8422073	FC, LJ, WG	Reservations confirmed
10:15 – 18:00	Flexible work time to organize activities with the consultants's team.	FC, LJ, WG	

Monday 24-Aug-09			
8:30 – 12:30	DISCUSSION ROUND TABLE IN THE CITY OF COBIJA SEDES PANDO: Dirección de SEDES: Dr. Andrés Antezana Lic Sandra Shimokawa (Jefa de la Unidad de Planificación) Dra. Paula Mejía Morales (Responsable de Salud Sexual-Reproductiva y Género).	FC, LJ, WG	

<p>Health Networks:</p> <p>Diego Cáceres (Responsable de Redes de Salud)</p> <p>Red 1: Dr. Alfredo Ossio Campos</p> <p>Red 2: Dr. Abraham Tubé (interino)</p> <p>Red 3: Dr. Alfredo Roda Gonzáles</p> <p>Program Managers:</p> <p>VIH/SIDA: Dra. Gaby Fabiola Mamani Vega</p> <p>PAI: Lic. Isabel Montaña Rocabado</p> <p>Malaria: Dr. Johnny Velarde</p> <p>Desnutrición Cero: Lic. Mónica Antezana Guerrero</p> <p>SUMI: Dr. Angel Daniel Cáceres Méndez</p> <p>Dengue: Javier Noto Nignana</p> <p>Local staff of UNICEF:</p> <p>Dra. Leda Azad (Oficial en Salud Comunitaria)</p> <p>Dra. Carmen Luca (Oficial de VIH-SIDA)</p> <p>Lic. Marylin Higa (Responsable del Equipo local)</p>		
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	<p>Local Staff of FPS:</p> <p>Gerente Departamental: Arq. Limberg Menacho Hurtado</p> <p>Jefe Técnico: Arq. Armando Alcazar</p> <p>Alcaldes Municipales:</p> <p>Sr. Mariano Aparicio (Municipio de Gonzalo Moreno)</p> <p>Sr. Mamerto Robleda (Municipio de San Lorenzo)</p> <p>Sra. Nilma Becerra (Municipio de Porvenir)</p> <p>Municipio de Cobija</p> <p>Health Local Commitees</p> <p>2 persons</p> <p>Health Personnel</p> <p>2 persons</p> <p>Place: "El Curichi del Cocodrilo". Av. 16 de Julio N° 181. Tel. 3-8422656</p> <p>Contact person: Artemia Céspedes. Tel. 38423473</p>		
13:00 – 14:30	Lunch time	FC, LJ, WG	

14:30 – 18:00	Flexible work time to organize activities with the consultants's team. Or visit to nearby communities.	FC, LJ, WG	
Tuesday 25-Aug-09			
8:30 – 9:30	<p>Interviews with SEDES Pando team (Director and personnel of Planning Unit)</p> <p>Mr. Andrés Antezana (SEDES Director)</p> <p>Lic Sandra Shimokawa (Manager of Planning Unit)</p> <p>SEDES Administrator</p> <p>PASS consultants</p> <p>Place: Av. 9 de Febrero S/N al lado de la plazuela Humbert Terrazas</p> <p>Contact person: Artemia Céspedes. Tel. 38423473. Cel. 728-89263 (Karen)</p>	FC, LJ, WG	
9:30 – 10:30	Interview with Mr. Andrés Antezana (SEDES Director)	FC, LJ	
9:30 – 10:30	Interview with Mrs. Sandra Shimokawa (SEDES Administrator)	WG	Análisis de temas administrativos, financieros y presupuestarios
10:30 – 11:30	Interview with Dra. Paula Mejía Morales (Responsible of Salud Sexual-Reproductiva y Género – SEDES Pando).	FC, LJ	

	Place: Av. 9 de Febrero S/N al lado de la plazuela Humbert Terrazas Contact person: Artemia Céspedes. Tel. 38423473. Cel. 728-89263 (Karen)		
10:30 – 11:30	Review of files and documentation at SEDES Pando Place: Av. 27 de Mayo Esquina Laureano Villar S/N Contact person: Cel. 702-65013 Tel. 34622736	LJ, WG	
11:30 – 13:00	Interview and visit to a Health Network	FC, LJ, WG	
13:00 – 14:30	Lunch time	FC, LJ, WG	
14:30 – 15:30	Interviews with FPS Pando Staff Arq. Limberg Menacho Hurtado (Regional Manager) Arq. Armando Alcazar (Technical Manager) FPS Administrator Municipal Supervisor Place: Av. 27 de Mayo Esquina Laureano Villar S/N Contact person: Cel. 702-65013 Tel. 34622736	FC, LJ, WG	
15:30 – 16:30	Interview with Arq. Limberg Menacho Hurtado (Regional Manager)	FC, LJ,	
15:30 – 16:30		WG	

	<p>Interview with Mrs. Cintia Rodríguez (Financial Administrator– FPS Pando)</p> <p>Place: Calle Cívica N° 42 (detrás de COTECO)</p> <p>Contact person: Hilda Dominguez. Tel. 38423344</p>		
16:30 – 17:15	<p>Review of files and documentation at FPS Pando</p> <p>Place: Av. 27 de Mayo Esquina Laureano Villar S/N</p> <p>Contact person: Cel. 702-65013 Tel. 34622736</p>	FC, LJ, WG	
17:15 – 18:30	<p>Visit to FPS Pando staff (Interviews at FPS)</p> <p>Visit to FPS buildings</p>	FC, LJ, WG	
Wednesday 26-Aug-09			
5:15	Departure to the airport	FC, LJ, WG	
7:00 – 10:15	Flight AMASZONAS/AEROCON N° 10 and N° 70 Cobija – La Paz	FC, LJ, WG	
11:00	<p>Arrival to Ritz Apart Hotel</p> <p>Place: Av. Arce N° 2478 - Plaza Isabela Católica</p> <p>Contact: Telf. 2433131</p>	FC	Reservation confirmed

14:00 – 16:00	<p>Flexible work time to organize activities with the consultants's team.</p> <p>Reunión con ONGs locales (Save the Children, Aprosar, Samaritan's Purse, CIES, CCF, CECI, Municipio de Totora.</p> <p>Place: Ritz Apart Hotel</p>	FC, LJ, WG	
Thursday 27-Aug-09			
9:00 – 13:00	<p>DISCUSSION ROUND TABLE IN THE CITY OF LA PAZ</p> <p>Planning Unit - Ministry of Health:</p> <p>Mr. Rogel Mattos (General Advisor of Programs and Projects PASS)</p> <p>Ms. Leslie La Torre (Consultant PASS funding)</p> <p>Mr. Jhonny Sánchez (Consultant PASS funding)</p> <p>Mr. Máximo Huaywa (Responsible of Administration)</p> <p>Program Managers:</p> <p>Dra. Jackeline Reyes (Jefe de Unidad de Servicios de Salud)</p> <p>Dr. Renato Yucra (Salud Materna Perinatal)</p>	FC, LJ, WG	

	<p>Dr. Oscar Velasquez (Salud Neonatal Infantil Escolar y Adolescente)</p> <p>Dra. Ana María Aguilar (National Coordinator of Zero Malnutrition – CONAN)</p> <p>Dra. María Julia Cabrerizo (Nutrition Manager)</p> <p>Dr. Jimmy Frías (PAI)</p> <p>Dra. Gladis Crespo (PAI)</p> <p>Dr. Juan Carlos Arraya (Malaria)</p> <p>Dra. Carola Valencia (VIH/SIDA)</p> <p>Dra. Ana Suxo (SNIS)</p> <p>Mrs. Eulogia Tapia (Responsable de Género)</p> <p>Mrs. Ruth Barral (Responsable of Violence)</p> <p>Personnel of FPS:</p> <p>Rocio Ticona (Infrastructure Manager)</p> <p>Roxana Encinas (Financial Manager)</p> <p>Frida Martínez (Responsible of Agreements)</p> <p>Ariel Cortez (Operations Manager)</p> <p>Ana Quiroga (Coordinator of PAAF - Programa de Apoyo, Asesoramiento y Fortalecimiento a los Municipios)</p>		
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	<p>Personnel of UNICEF:</p> <p>Ivette Sandino (Oficial de Salud)</p> <p>Rosario Quiroga (Especialista en Salud)</p> <p>Dra. Carmen Luca (Oficial de VIH-SIDA)</p> <p>Dra. Leda Azad (Oficial en Salud Comunitaria)</p> <p>Personnel of ACOBOL:</p> <p>María Eugenia Rojas and her team</p> <p>Personnel of CIDA:</p> <p>Anne-Marie Hodgson (1st. Secretary – Embassy of Canada)</p> <p>Erika Silva (Consultora de Salud - UASCC)</p> <p>Place: Rey Palace Hotel. Av. 20 de Octubre N° 1947 entre calles Landaeta y J.J.Pérez. Tel. 2418541</p> <p>Contact Person: Gilda Portocarrero. Tel. 2411511 Ext. 24</p>		
13:00 – 14:30	Lunch time	FC, LJ, WG	
14:30 – 15:30	Meeting debriefing with Mr. Alberto Palacios-Hardy (Counsellor and Head of Aid – Embassy of Canada)	APH, FC, LJ, WG	

	Place: Embassy of Canada – Plaza España, Edificio Barcelona, Piso 2		
15:30 – 18:00	Flexible work time to organize activities with the consultants's team.	FC, LJ, WG	
Friday 28-Aug-09			
8:30 – 10:00	Meeting debriefing with Mrs. Anne-Marie Hodgson (1 st . Secretary – Embassy of Canada) and Mrs. Erika Silva (PSU Health Consultant) Place: PSU office - Plaza España, Edificio Barcelona, Piso 2 Tel. 2411511. Ext. 24	AMF, ES, FC, LJ, WG	
9:30 – 11:00	Meeting debriefing with OPS, MDS, Unicef, FPS, Local ONG's Place: PSU Office		
10:00 – 18:00	Flexible work time to organize activities with the consultants's team.	FC, LJ, WG	
18:00	END OF MISSION	FC, LJ, WG	

FC = Francoise Coupal

LJ = Linn Johnson

APH = Alberto Palacios-Hardy

WG = Waldo Gutiérrez

AMH = Anne-Marie Hodgson

ES = Erika Silva

Annex 3 : Workshop Exercises and Questionnaire

Cuadro 1: Fortalezas y Debilidades del Proyecto y Estrategias para Convertir las Debilidades en Fortalezas

- Seleccione su facilitador
- Seleccione su tomador de apuntes en el rotfolio

1) Mesa 1: ¿Cuáles son las fortalezas y debilidades más importantes del proyecto? ¿Qué estrategias prácticas recomienda para convertir las debilidades en fortalezas?

Fortalezas	Debilidades
Estrategias Prácticas para Convertir las Debilidades en Fortalezas:	

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Mesa 2 : Retos y Estrategias para enfrentar estos retos

- Seleccione su facilitador
- Seleccione su tomador de apuntes en el rotfolio

Mesa 2:

- 1) 1) **¿Cuáles son los retos principales que ha enfrentado el programa durante su implementación?**
- 2) **¿ Cuáles serían sus estrategias para enfrentar estos retos? Siempre que sea posible, indique a qué organización va dirigida su estrategia/recomendación (UNICEF, MSD, FPS, SEDES, ACDI).**

Retos	Estrategias para enfrentar estos retos

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Cuadro 3: Lecciones Aprendidas y Recomendaciones

- Seleccione su facilitador
- Seleccione su tomador de apuntes en el rotfolio

Mesa 3: Lecciones Aprendidas y Recomendaciones

¿Cuáles son las lecciones aprendidas a la fecha?

Lecciones Aprendidas	Recomendaciones con el fin de alcanzar resultados sostenibles y un uso óptimo de la contribución de ACDI.

Cuestionario:

Agradeceríamos que con sus respuestas a las preguntas de este cuestionario, nos diera su amable opinión y evaluación del proyecto PASS

Sexo: ____H o ____M.

Institución/Organización:_____ Puesto:_____

¿Cuánto tiempo hace que participa en el proyecto PASS/PRICCAS?_____

Por favor, responda a las siguientes preguntas:

1. ¿Qué es lo que más le gusta acerca del proyecto PASS/PRICCAS?

2. ¿Existe algo que le guste menos del proyecto?

3. ¿Los mecanismos para pilotear el proyecto (el comité de gestión, el comité operativo y el comité de PRICCAS) y le parecen efectivos?

Muy bien Satisfactorio Pobre Malo

Por favor explique:

4. ¿Existe un fuerte compromiso para generar resultados con el proyecto?

En gran medida En cierta medida Muy poco En ninguna medida

5. ¿Cuáles han sido los resultados más importantes del proyecto?

Por favor explique:

6. ¿Ha notado usted resultados negativos o positivos que no estaban esperados?

En gran medida En cierta medida Muy poco En ninguna medida

¿Puede dar ejemplos de estos resultados inesperados?

7. ¿Ha recibido usted alguna capacitación que tenga el apoyo de o sea ofrecido por el proyecto? _____sí o _____no.

De ser éste el caso, ¿Se siente usted satisfecho con la capacitación?

Alto nivel de satisfacción Nivel medio de satisfacción

Bajo nivel de satisfacción No satisfecho(a)

Enumere los talleres o capacitaciones que ha recibido:

8. ¿Se siente usted satisfecho con la forma como se está desarrollando el programa?

En gran medida En cierta medida Muy poco En ninguna medida

Por favor explique:

9. ¿Tiene usted sugerencia o recomendaciones que puedan ayudar a mejorar la aplicación, la efectividad y la sostenibilidad del proyecto en el futuro?

Annex 4: Informe de las mesas redondas, Oruro

Departamento: Oruro

Fecha: Agosto 17,2009

Ejercicio: Grandes Resultados del Proyecto

Gestión y planificación	Coberturas	Interculturalidad	Equipamiento y Infraestructura	Calidad de atención	Movilización Social	Impacto	Capacitación
18	16	Genero 8	13	9	1	11	2
Elaboración del plan estratégico de salud departamental participativamente con organizaciones sociales	Aumento de coberturas mejoró la calidad de vida Hay mejor acceso	Personal de Salud fortalecido en genero y igualdad Fortalecido a través de leyes y normativas para brindar una atención integral y con enfoque de genero en Oruro	Fortalecimiento institucional a través de equipo y equipamiento para centros y postas de salud La atención se realiza con mayor comodidad	Mejoramiento de la calidad usando estándares y monitoreo	Comunidad que participa en la gestión de salud, ACS, comités local de salud ALS, CLS, CSMS	Descenso de la tasa de TB en Oruro	Capacitaciones al personal de salud Capacitación en AIEPI – Nut 97%
Evaluación y gestión mediante el CAI departamental, red de salud,	Incremento de cobertura 1)en partos institucionales con el Proyecto	Planes de salud que incorporan la inter-culturalidad (Partos) con equidad de	Mejorado la credibilidad de la prestación de servicios a través de la	Mejora en la calidad de atención del control prenatal, atención del parto, recién	PASS apoyo movilización social con Ferias	Disminuzación de mortalidad infantil y neonatal	16 personas del grupo capacitadas

municipal	Aguayo 2)atención materno infantil y nutrición	genero, inter-cultural (esposo, curandero, personal de salud) vienen las mamás más	infraestructura La gente acude con mayor confianza	nacido y del desnutrido agudo-severo			con PASS
Contraparte institucional: Vacuna Nutri-bebe		Contribuir a mejorar la calidad de vida de la población en el marco de equidad de género	Apoyo en equipamiento a puestos de salud UNI – (unidad de nutricional integral)	Mejoramiento de la capacidad resolutoria de los establecimientos de salud	Mejores niveles de coordinación del sector salud con autoridades municipales y originarias	Erradicación de la enfermedades prevenibles por vacunas	
Coordinación inter-institucional y inter sectorial para la planificación de salud	Nutri Bebe a 100% de las comunidades	Fortalecimiento de medicina tradicional – primer ítem de partera y de medicina tradicional	Si no hay los medios y la parte física, la capacitación no sirve de nada	Inter-culturalidad Proyecto Aguayo Parto seguro Interacción social y seguridad		Cobertura de vacunas mayor de 90%	
Fortalecida la planificación, la		Mejorar la infraestructura y equipamiento	Apoyo a la infraestructura y equipamiento			Mejores en los indicadores de	

cobertura, el elemento humano y la infraestructura		con enfoque inter-culturalidad	para brindar mejor calidad de atención con reconocimiento de la inter-culturalidad.			salud	
Todos alienados con el mismo fin para una salud mejor		Mejoramiento de calidad y genero con la gestión del primer ítem de partera tradicional "Proyecto Agulló"					
Seguimiento y monitoreo a los programas y servicios de salud incorporando la inter culturalidad y equidad de genero (binomio madre niño)		Hombres y mujeres mayor participación en planificación, organización, análisis y valoración de salud					

		Fortalecimiento y consolidación de la medicina tradicional					

Cuadro 1: Fortalezas y Debilidades del Proyecto y Estrategias para Convertir las Debilidades en Fortalezas

1) Mesa 1: ¿Cuáles son las fortalezas y debilidades más importantes del proyecto? ¿Qué estrategias prácticas recomienda para convertir las debilidades en fortalezas?

Fortalezas	Debilidades
<ul style="list-style-type: none"> ● Fortalecimiento del modelo de atención y gestión ● Gestión institucional del SEDES (1verde) ● Incentivos, por iniciativa de gobierno municipal (1 verde) ● Fortalecimiento de infraestructura y equipamiento en las redes de salud 50% (9 verde) ● Unidades móviles para la atención integral ● 5 camionetas para realizar supervisión y seguimiento a las gerencias de Red ● 100% de los municipios tienen ambulancias ● Apoyo técnico y financiero (3 verde) ● Alineamiento a políticas de salud y planes ● Definición de intervención por efectos, productos y resultados ● Apoyo quinquenal a través de convenios (1 rojo) ● Apoyo integral – innovación de los equipos médicos 	<ul style="list-style-type: none"> ● Alta rotación de los RRHH que influyen en el alcance de las metas ● Inestabilidad de autoridades municipales por ingobernabilidad ● No existe apoyo a las personas con discapacidad y a la tercera edad. ● Procesos gerenciales prolongados poco fluidos ● Calidad de atención con interculturalidad débil ● Infraestructura y equipamiento insuficiente (falta 50%) ● Actitud de personal de salud poco comprometida al enfoque de genero (2 verde) ● Contraparte municipal insuficiente (1 verde) ● Inestabilidad de los gerentes de red
<p>Estrategias Prácticas para Convertir las Debilidades en Fortalezas:</p>	
<ul style="list-style-type: none"> ● Planificación de la rotación de los RRHH a inicio de año (2 verde) ● Promover intercambio de experiencias para que los gobiernos municipales priorizan la salud (1 verde) ● Cumplir la normativa legal vigente para mejorar la planificación del gobiernos municipales ● Evaluación de desempeño de RRHH para cualificar e incidir las rotaciones plenamente justificadas (3 verde) ● Aplicación del Sistema de Administración de Bienes y Servicios (SASS) y aplicación del manual del funcionario publico ● Dotación de ítem regular de los equipos gerenciales de Red (2 verde) ● Gestionar para la continuidad del apoyo PASS ● Fortalecer con RRHH calificado (antropólogo, sociólogo, etc.) en el área de medicina tradicional ● Implementación del nuevo modelo de salud (SuSalud) con mayor compromiso hacia la comunidad 	



Cuadro 2: Retos y Estrategias para enfrentar estos retos

Mesa 2:

- 3) 1) ¿Cuáles son los retos principales que ha enfrentado el programa durante su implementación?
 4) ¿Cuáles serían sus estrategias para enfrentar estos retos? Siempre que sea posible, indique a qué organización va dirigida su estrategia/recomendación (UNICEF, MSD, FPS, SEDES, ACDI).

Retos	Estrategias para enfrentar estos retos
<ul style="list-style-type: none"> ● Alcanzar un nivel de gestión eficaz para implementar objetivos y metas en SEDES-Oruro enmarcadas en las políticas nacionales (1 verde) ● Extender por otro periodo la participación del PASS en el departamento de Oruro para alcanzar los objetivos el milenio, de acuerdo a las necesidad de cada región (1 verde) ● Elaborar un diagnostico situacional y linease de base para determinar metas, objetivos y planes de medio y corto plazo ● Buscar la sostenibilidad de los logros alcanzados ● Completar la sostenibilidad del proyecto en forma integral (infraestructura, equipamiento, capacitación) (7 verde) ● Ampliar la cobertura del proyecto de infraestructura al total de lo requerido (2 verde) ● Implementación de la gestión compartida al 100% entre SEDES y Municipio ● Transersvalizar el proyecto con educación (adolescente, ITS/SIDA, salud oral, nutrición, PAI) (1 rojo, 3 verde) ● 	<ul style="list-style-type: none"> ● RRHH del SEDES capacitados y comprometidos con involucramiento social ● Gestión y planificación participativa ● Compromisos y convenios inter-institucionales. ● Profundizar procesos de capacitación en gestión de salud (1 rojo) ● Mayor compromiso en salud por parte de las autoridades naciones, departamentales y municipales ● Demostrar el manejo eficiente de los RRHH asignados ● Aplicación de metodologías creativas que motiven el cumplimiento (e.g dilometro (en pagina Web-metodología para medir al los DILOS-Dirección Local de Salud) ● Ampliación del proyecto para lograr las metas del milenio. (1 rojo, 8 verde) ● El convenio se amplíe con otras instancias (educación, agropecuaria, etc.)

Cuadro 3: Lecciones Aprendidas y Recomendaciones

Mesa 3: Lecciones Aprendidas y Recomendaciones

¿Cuáles son las lecciones aprendidas a la fecha?

Lecciones Aprendidas	Recomendaciones con el fin de alcanzar resultados sostenibles y un uso óptimo de la contribución de ACDI.
<ul style="list-style-type: none"> ● Mejoramiento de cobertura en el ultimo quinquenio con sostenibilidad en 4to control prenatal, parto, PAI, nutrición, disminución de la morbi-mortalidad, con articulación inter-cultural (8 verde, 7 rojo) ● Mejoramiento de la infraestructura y dotación de equipamiento, para mejorar la calidad de atención con coordinación inter-sectorial (gobierno municipal, FPS, SEDES) ● Desarrollo de SAFCI inter-sectorial con enfoque inter-cultural, equidad y genero ● Planificación participativa con compromisos de gestión (2 verde) ● Apropiación de la sociedad civil y autoridades municipales de los programas de salud ● Recuperación de la medicina tradicional de acuerdo a los usos y costumbres de cada región, tendiendo al fortalecimiento del sistema de salud ● Trabajo multi-programático, integral genera incremento de alianzas estratégicas. (1 verde) ● Que potencian los resultados alcanzados (1 verde) ● Monitoreo, sistemático y sostenible contribuye al logro de los resultados ● Súper-posición de actividades en nacional, departamental y local dificultan la ejecución de POAS. 	<ul style="list-style-type: none"> ● La sostenibilidad del proyecto PASS para llegar a las metas del milenio, con contrapartes municipales y prefectural. (18 rojo, 4 verde) ● Compromiso interinstitucional para continuar con los proyectos ● Mayor socialización inter-institucional de los POAS prefectural y municipal a la población ● Evaluación, seguimiento y cumplimiento de recomendaciones de los CAI's (municipales, gerenciales, departamentales) ● Continuar la sensibilización a la población socializando de manera permanente con la participación de autoridades y líderes sociales – rompiendo las barreras culturales , respetando l'identidad cultural. ● Generar alianzas estratégicas (1 rojo) ● Mantener seguimiento y monitoreo de actividades (1 verde) ● Programar adecuadamente las actividades.

Informe de las mesas redondas

Departamento: Beni

Fecha: 20 agosto 2009

Ejercicio: Grandes Resultados del Proyecto

Participación Comunitario 15 puntos	Capacitación 15 puntos	Fortalecimiento Institucional 13 puntos	Cobertura	Intersectorialidad 4 puntos	Gestión en salud 11 puntos	Genero 5 puntos	Infraestructura y equipamiento 2 puntos
Integralidad en la atención a comunidades sin servicios de salud	Un buen equipo médico y para medico con apoyo y capacitación con el PASS lo cual permite un buen servicio en los diferentes comunidades con resultados favorables.	Fortalecimiento institucional (incremento coberturas), equipamiento o PASS.	Cobertura del PAI cerca de 86%	Alianzas estratégicas A otros sectores (educación y sectores sociales)	Gestión en salud mejorada.	Mayor participación de pareja en problemas de salud.	Equipamiento Nutrición: UNIS (talleres); Capacitación; Micronutrientes.
Integración de la comunidad en el sector salud	Capacitación de los recursos humanos, desnutrición, UNI-AIEPY; nutrición, lactancia materna.	Promoción de PAR en la comunidad	Ascenso sostenido de coberturas de atención materna e infantil.	Mejoramiento de los niveles de coordinación e interrelación entre SEDES, Municipios, Redes de salud y comunidad.		Participación para lograr la participación de la mujer en cargos jerárquicos en salud en las comunidades.	Mejoramiento de la calidad de atención a través del equipamiento o en el 1er nivel de atención.
Incorporación actores sociales, lactancia materna, desnutrición, micronutrientes	Mejora de los capacidades del personal institucional en áreas como adm. Financiera,	Fortalecimiento del PAI	Aumentos de las coberturas de atención en los distintos				Mejoramiento de las infraestructuras en salud.

ntes	atención en salud, y mejora del conocimiento de la población y su involucramiento.		programas.				
Participación activa de la comunidad	Personal de salud de los servicios y establecimientos con capacidad de manejo administrativo mejorado.	Accesibilidad a los servicios de salud.					Mejora de infraestructura.
Participación comunitaria en el programa de salud	Capacitación a las parteras empíricas.	Fortalecer los diferentes programas: niño, género, salud.					
Coberturas (Programa integrado Salud)	Formación a brigadas móviles y detección de embarazo de mujeres con edad temprana.	Aceptación del sector salud en las comunidades, respetando interculturalidad y género.					
Aplicación interculturalidad programa de salud							

Comunicad organizada participando activamente para ejercer su derecho a la salud y contra social							

Cuadro 1: Fortalezas y Debilidades del Proyecto y Estrategias para Convertir las Debilidades en Fortalezas

1) Mesa 1: ¿Cuáles son las fortalezas y debilidades más importantes del proyecto? ¿Qué estrategias prácticas recomienda para convertir las debilidades en fortalezas?

Fortalezas	Debilidades
<ul style="list-style-type: none"> -Recursos humanos capacitados (3 puntos); -Asignación de recursos económicos por salud por Prefecturas y Gobiernos Municipales; -Mejoramiento de las infraestructuras y dotación del equipamiento, que mejora la calidad de prestación de servicio; -Intersectoralidad (1 punto); -Integralidad de las acciones (1 punto); -Extensión de coberturas; -Participación de la mujer en la toma de decisiones en salud; -Implementación y funcionamiento de Programas de Nutrición; -Articulación o Alineamiento de las Acciones a las políticas nacionales (1 punto); -Apoyo permanente del programa (8 puntos); -Se cuenta con infraestructura; -Personal motivado; -Participación comunitaria en la toma de decisiones (1 punto); -Mejorar capacidad de gestión gerencial. 	<ul style="list-style-type: none"> -Desabastecimiento de suministros e insumos para vacunar durante el trimestre; -Poca accesibilidad geográfica y caminos a las comunidades; -Promover mas la intersectoralidas pero con recursos; -Alta rotación del personal de salud; -Poco compromiso de algunas autoridades locales para la inversión en salud, y dotas de gastos de funcionamiento para potenciar acciones; -desembolsos recursos económicos tardes; -falta de medios de transporte (1 punto rojo, 1 punto verde); -Insuficiente recursos humanos; -falta micronutrientes; -Escasa investigaciones oportunas.
Estrategias Prácticas para Convertir las Debilidades en Fortalezas: <ul style="list-style-type: none"> -Involucramiento efectivo de los autoridades Municipales y Prefecturales ; -Respeto à l'institucionalidad de recursos humanos institucionales ; -Des cargo económico oportuno ; -Mejoras la logistica de insumos y micronutrientes ; -Réalisation de diagnosticas situacionales oportunes. 	

Cuadro 2: Retos y Estrategias para enfrentar estos retos

Mesa 2:

- 5) 1) ¿Cuáles son los retos principales que ha enfrentado el programa durante su implementación?
 6) ¿Cuáles serían sus estrategias para enfrentar estos retos? Siempre que sea posible, indique a qué organización va dirigida su estrategia/recomendación (UNICEF, MSD, FPS, SEDES, ACDI).

Retos	Estrategias para enfrentar estos retos
<ul style="list-style-type: none"> -Lograr la sostenibilidad del proyecto (18 puntos rojos ; 5 puntos verdes) ; -Adecuar la sostenibilidad a los cambios politicos nacionales ; -Lograr el cumplimiento de los indicadores del MSD ; -Mejorar la calidad de vida (14 puntos verde) ; -Mejorar la accesibilidad a los servicios de salud ; -Conformacion de equipos multidisciplinarios (1 punto rojo) ; - Llegar a todas las comunidades con atencion integrales ; -Involucrar a los actores sociales de forma efectiva ; -Involucrar a todos los sectores afines sector salud ; -Lograr la estabilidad laboral del personal capacitado ; -Mejorar la logisitica de medicamentos e insumos ; -Atencion integral con PASS o sin PASS ; -Mantener la gestion en salud aun en momentos de emergencias naturales. 	<ul style="list-style-type: none"> -Abogacia con autoridades departamentales y locales ; (1 punto verde) ; -Coordinacion intersectorial con participacion de los sectores sociales ; -Planificacion de las actividades ; -Capacitacion continua de los recursos humanos ; -Abogacia con gobierno municipales, prefecturales para la asignacion para el funcionamiento de equipos multidisciplinarios (3 puntos verde) ; - Medios de transporte adecuados a la region ; -Reuniones ; capacitaciones ; -Convenios inter-institucionales ; -Institucionalizacion de los cargos ; -Decentralizar la distribucion; -Lograr que el nivel central asuma de forma plena su responsibilidad con el sector salud y que la salud de la poblacion sea un prioridad nacional.

Cuadro 3: Lecciones Aprendidas y Recomendaciones

Mesa 3: Lecciones Aprendidas y Recomendaciones

¿Cuáles son las lecciones aprendidas a la fecha?

Lecciones Aprendidas	Recomendaciones con el fin de alcanzar resultados sostenibles y un uso óptimo de la contribución de ACDI.
<ul style="list-style-type: none"> - A coordinar primero con las comunidades de realizar visitas (1 punto rojo y verde) ; - La importancia que tiene la union entre sectores y para un mesofin (salud) ; - Conocer las culturas y el que hacer de nuestras comunidades ; - La importancia del apoyo de los alcaldes y su involucramiento ; - La importancia de la participacion comunitaria para el logro de los objetivos (4 puntos verde y 2 puntos rojos) ; - Al haber inter-relacion, coordinacion e integralidad de acciones, optimiza recursos y esfuerzos ; - A traves del apoyo de los recursos humanos capacitados se han logrado mejorar la gestion en salud ; - Planificacion y programacion de actividades, mejora la gestion local ; - A pesar de los logros alcanzados todavia quede mucho por hacer ; - A mayor empoderamiento de los derechos por la comunidad, existen mayores logros ; - Mejoramiento de temas nutricionales cuando madres y padres participan (2 puntos verde) ; - Recursos humanos institucionales comprometidos con la salud de la poblacion (3 puntos verdes); - Que en la elaboracion de los POAS locales se respecta las demandas y necesidades de salud. 	<ul style="list-style-type: none"> -Mantener siempre presentelas lecciones aprendidas ; -Lograr consolidar los resultados alcanzados y la sostenibilidad de los programas. -Augmentar el nivel de coordinacion entre MSD, SEDES, Municipios, redes de comunidades ; -Que los municipios asumen su responsabilidad con la salud ; -Respetar las programaciones locales (POAS) ; -Readecuar las actividades de salud extrapoas ; -Continuar a los lineamientos nacional, departamentales y municipales ; -Tomar en cuenta las decisiones comunales ; -Que se amplie el PASS para consolidar logros (12 puntos rojos y 11 puntos verde) ; -La participacion debe hacerse con cumplimiento de deberes ; - Que la capacitacion y abogacia se hagan con la participacion de ambos padres ; -Reconocimiento de las instituciones por los logros obtenidos ; -Se continua convocando de manera participativa e efectivos de los directos responsables del equipo de salud (gerentes, jefes de servicio, Directoras hospitales, y otros ; 1 punto verde).

Annex 5: Informe de las mesas redondas

Departamento: **PANDO**

Fecha: 24/08/09

Ejercicio: **Grandes Resultados del Proyecto**

COBERTURA (17)	CALIDAD Y CAPACITACIÓN (13)	INFRAESTRUCTURA Y EQUIPAMIENTO (21)	GESTIÓN (15)	MOVILIZACIÓN SOCIAL (10)
Accesibilidad geográfica y equitativa a servicios de salud	Recursos Humanos capacitados para atención al binomio madre niño (a)	Se mejora la infraestructura y equipamiento de los centros de salud	Fortalecimiento institucional: implementación (informática) del sistema de: -control -monitoreo -supervisión -evaluación En la Unidad de Planificación	Fomento a la participación de las mujeres en los espacios de gestión compartida
Se incrementa la cobertura de atención en salud	Mejora al calidad de servicios de salud pública	La red de salud cuenta con equipamiento básico para la atención materno infantil	Programa de género cuenta con capacidad técnica y tecnológica para su gestión	Mayor participación de las comunidades
Apoyo en el incremento de coberturas con campañas multi programáticas	Recursos humanos con conocimientos y destrezas para la gestión local de la salud	Fortalecimiento institucional en la gestión 2008 en apoyo a laboratorio Vectores SEDES Pando	Apoyo importante para estructurar la red social, garantizando la organización de Consejos o Comités (Ejemplo: COMAN, Consejo de Salud, Mesas Municipales, etc.)	Fortalecimiento de la organización y participación social en el sector salud
Incremento de la cobertura en salud de Puerto Rico gracias a campañas multi programáticas	Adecuación cultural de los servicios de salud	Equipos de atención de parto a los centros de salud de la Red I	Se mejoro las funciones del SEDES como: supervisión, monitoreo y evaluación que permitió alcanzar los resultados	Comité local de salud de Puerto Rico conformado y funcionando

Apoyo en la proyección integral a comunidades sobre atención en salud con regularidad	Capacitación a recursos humanos con varios diplomados y al personal operativo con énfasis en nutrición	Fortalecimiento del 1er. Nivel de atención con equipamiento básico para la atención de la mujeres y menores de 5 años	Apoyo directo a los actores fundamentales del nivel operativo (gerencias, responsables municipales) minimizando los procesos burocráticos	Apoyo a la implementación de la Ley SAFCI
Se incremento la coberturas de atención a la madre y al niño en los 15 municipios del departamento	Mayor capacidad técnica del personal de salud en la ejecución de programas (SNIS, PAI, AIEPI-NUT, ITS/VIH)	Provisión de suministros y equipamiento más dotación de filtros de agua comunidades afectadas por desastres naturales	Apoyo en la socialización del nuevo modelo de atención y gestión en salud (SAFCI)	En Pando se conformo Consejos Locales de Salud en un 60%
Mayor extensión de cobertura en atención integral a la población que tiene difícil acceso a los centros de salud gracias al financiamiento local PRICCAS UNICEF 2006	Mejoramiento de las destrezas y habilidades del personal a través de procesos de capacitación (Ejemplo: maestría en salud pública, diplomado en comunicación social)	Infraestructuras ampliadas para mejorar la atención en salud	Abogacía a los alcaldes municipales para implementación del programa Desnutrición Cero	Socialización del nuevo modelo de salud a autoridades y comunidades
Aumento de atención en comunidades de difícil acceso	Mejora de las capacidades técnicas del personal de salud y la calidad de atención: AIEPI, NUT, Diplomado Nutrición, PED	Establecimientos de salud mejor equipados que permiten mejores coberturas de salud		Conformación y participación social en salud de representantes locales
Incremento de coberturas de micronutrientes y vacunas , CPN	Aumento de la capacidad resolutive de 1er. Nivel de recursos humanos a médicos, licenciados y auxiliares	Fortalecimiento institucional (equipamiento UNI) gobiernos municipales		Comunidad involucrada en salud (CASI comunitario)
Incremento en la cobertura de PR para		Equipamiento de las UNIS en los		

VIH en mujeres embarazadas para la PTMI del VIH		municipios		
85 comunidades de la Red I son atendidas 2-3 veces al año, con atención integral de salud				
Apoyo económico para actividades específicas de salud y que coadyuva a incrementar las coberturas				
Se incremento las coberturas en todos los municipios				
Implementación gradual de PR para VIH en todos los establecimientos de salud de la Red I y cabeceras de Red (Puerto Rico y Gonzalo Moreno)				

Cuadro 1: Fortalezas y Debilidades del Proyecto y Estrategias para Convertir las Debilidades en Fortalezas



Seleccione su facilitador



Seleccione su tomador de apuntes en el rotafolio

1) **Mesa 1: ¿Cuáles son las fortalezas y debilidades más importantes del proyecto? ¿Qué estrategias prácticas recomienda para convertir las debilidades en fortalezas?**

Fortalezas	Debilidades
<p>Recursos humanos capacitados en diferentes niveles (2 R)</p> <p>Se cuenta con recursos económicos para mejorar la infraestructura y equipamiento y, para actividades específicas de salud</p> <p>Comités locales de salud conformados en un 75% (3 V)</p> <p>Se cuenta con equipamiento básico entregados a los establecimientos de salud (material de IEC, equipo UNI, equipo PARTO, cadenas de frío, medios de comunicación)</p> <p>Recursos humanos gerenciales comprometidos</p> <p>Contar con apoyo de la cooperación externa (recursos externos) (1 R)</p> <p>Compromiso Prefectural con recursos económicos y recursos humanos</p> <p>Estructura organizacional del SEDES Pando alineadas alas políticas nacionales</p> <p>Sistema informático financiero, contable funcionando</p> <p>Página WEB SEDES Pando</p> <p>Conocimiento de la situación de salud a nivel local</p> <p>DILOS funcionando (70%)</p>	<p>Cambio de autoridades y personal de salud modifican la planilla establecida</p> <p>Débil seguimiento y funcionalidad de los Consejos Locales de Salud</p> <p>Distribución inadecuada del personal de salud</p> <p>Burocracia en la transferencia de recursos económicos</p> <p>Personal desmotivado, sobre todo del área rural</p> <p>Distribución de recursos humanos no acorde al perfil profesional</p> <p>Falta de infraestructura para recursos humanos en salud (vivienda en el área rural)</p> <p>Falta de incentivos a recursos humanos</p> <p>Falta recursos económicos para gastos administrativos</p> <p>Coordinaciones de red poco fortalecidos con equipamiento (Transporte, comunicación, infraestructura)</p> <p>Red de comunicación deficiente en algunos municipios</p>
<p>Estrategias Prácticas para Convertir las Debilidades en Fortalezas:</p>	
<p>Implementación del SAP con recursos humanos calificados para la conducción del mismo (1 V)</p>	
<p>Extensión del sistema contable financiero a las gerencias (sistematizado)</p>	
<p>Profundizar la planificación participativa a nivel regional y local</p>	
<p>Institucionalizar a recursos humanos (2 V)</p>	
<p>Compromiso a través de firma de convenio para apoyo al sector salud (municipio – SEDES)</p>	

Aplicación de la Ley SAFCI: Nuevo Modelo de Gestión en Salud (1V)

Ver la posibilidad que PRICCAS financie también en el gobierno de Filadelfia (1 V)

Cuadro 1: Retos y Estrategias para enfrentar estos retos



Seleccione su facilitador



Seleccione su tomador de apuntes en el rotafolio

Mesa 2:

- 7) 1) ¿Cuáles son los retos principales que ha enfrentado el programa durante su implementación?
 8) ¿Cuáles serían sus estrategias para enfrentar estos retos? Siempre que sea posible, indique a qué organización va dirigida su estrategia/recomendación (UNICEF, MSD, FPS, SEDES, ACDI).

Retos	Estrategias para enfrentar estos retos
Mantener y mejorar las coberturas logradas (3 R) (9 V)	Implementar la atención integral a comunidades de difícil acceso (3 V)
Asegurar que las intervenciones de salud tengan sostenibilidad por medio de la participación efectiva de Prefecturas, Municipios y Comunidades (20 V)	Dar condiciones de habitabilidad al personal de salud (3 V)
Mejorar y consolidar la participación social	Promover la participación social en la gestión local de salud (1 V)
Lograr la acreditación del 80% de establecimientos de salud y recursos humanos evaluados al 80% por gestión	Gestión para la asignación de recursos económicos por actividades
Implementar el modelo SAFCI en toda la red de servicios (3 R) (1 V)	Profundizar el funcionamiento del modelo SAFCI mejorado la capacidad de gestión a nivel local (1 V)
Lograr la implementación de los POA's individuales para evaluación de desempeño	Fortalecimiento del sistema de referencia y retorno (4 V)
	Desarrollar acciones de comunicación integral y sostenible con participación social
	Asegurar la dotación de : insumos, materiales, equipamiento y medios de transporte adecuados para la atención de las comunidades de difícil acceso y otros (2 V)

	<p>Seguimiento y capacitación periódica a sectores sociales organizados (CLS – Consejos Municipales de Salud y Departamental) ; institucionalizar el funcionamiento de CLS</p> <p>Sensibilizar a la población para la mayor participación en la planificación y toma de decisiones (POA – DILOS – CAI’s, etc.)</p> <p>Dar cumplimiento a la normativa nacional de acreditación</p> <p>Capacitar hasta fin de 2009 al 100% de personal en el modelo SAFCI</p> <p>Implementar Manual de Funciones para todo recurso humano en salud (4 V)</p>
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Anexo N° 7

RESULTADOS DEL PROGRAMA

Gestión 2008

Efecto/Producto	Metas	Alcanzado
<p>Efecto1 Producto 1 Servicios de salud integrales: fijos/ permanentes y móviles/ sistemáticos operando en todas las redes de salud.</p>	<p>a) 85% de las comunidades atendidas integralmente con servicios móviles al menos 4 veces al año</p> <p>b) 120 servicios de salud han incrementado su atención materno infantil; a comunidades rurales</p> <p>c) 2 redes altiplánicas y 2 amazónicas desarrollando acciones de salud comunitaria</p>	<p>1) Parcialmente cumplida el 65% de las comunidades fueron visitadas 4 veces al año a través de campañas multi programáticas y visitas domiciliarias</p> <p>2) Sobre cumplida 323 Servicios de Salud municipales han incrementado su atención integral materno infantil a comunidades rurales</p> <p>3) Cumplida 6 redes desarrollan acciones de salud comunitaria</p> <p>4) 3 municipalidades compran nutri-bebe, en Oruro, inclusive extendieron la compra municipios para niños y niñas hasta los 5 años</p> <p>5) 2 municipios de Oruro compran alimento complementarios para sus embarazadas</p> <p>6) Cumplida: 100% de municipalidades Oruro compran Nutri-bebe, 89% en Beni y 86% en Pando</p>
<p>Efecto 1 producto 2 Comunidad organizada participando activamente para ejercer su derecho a la salud y realizando gestión social</p>	<p>a) 3 comités departamentales constituidos</p> <p>b) 70% de comités municipales de salud activados</p> <p>c) Comités de salud de establecimientos funcionando</p> <p>d) 3 iniciativas municipales</p> <p>e) 40% de mujeres con</p>	<p>1) Cumplida parcialmente 66% dos comités departamentales de salud constituidos</p> <p>2) Parcialmente cumplida, 44% de los comités municipales reactivados y con funcionamiento regular</p> <p>3) 72 % de establecimientos de salud funcionando</p> <p>4) Cumplida: platito medidor de alimento para la embarazada, incentivos al parto</p> <p>5) Sobre cumplida 46% de los POA contaron con la participación de mujeres.</p>

Efecto/Producto	Metas	Alcanzado
	participación en la elaboración de POA's	
Efecto 1 Producto 3 Personas y familias participan en el autocuidado de su salud y demandan servicios de salud	a) estrategias IEC empleadas en Beni, Pando y Oruro b) 3 estrategias empleadas para la introducción de la vacuna antirotavirus c) 50% de respuestas correctas en la encuesta CAP	1) Cumplida 100% Estrategias IEC implementadas en Oruro, Beni y Pando con énfasis en nutrición, PAI y VIH/SIDA 2) Cumplida 100%: introducción exitosa de la vacuna AR 3) Encuesta CAP en proceso
Efecto 2 Producto 1 Recursos humanos de la red de salud han mejorado sus competencias, conocimientos y prácticas en la atención materno infantil.	a) 50% de los recursos humanos capacitados aplican normas técnicas vigentes: CONE, nutrición, PAI, DOTS a través de evaluación de desempeño b) cuatro colaborativos de mejoramiento de la calidad funcionando	1) Sobre cumplida 61% 1482 Recursos humanos capacitados aplican normas vigentes: CONE, PAI, nutrición, DOTS, verificado a través de evaluación de conocimientos 2) Cumplida 100% , cuatro equipos de mejoramiento de la calidad funcionando en 4 hospitales del área PRICCAS, se cuenta con una línea de base y una medición que denota ya mejoramiento en la calidad de atención
Efecto 2 Producto 2 Redes y establecimientos de salud priorizados con infraestructura y equipamiento materno infantil de acuerdo a estándares de calidad por niveles	100% de los equipos entregados están en inventarios de los municipios con verificación en terreno	1) Cumplida parcialmente 50% de los equipos entregados están en inventarios de los municipios con verificación en terreno
Efecto 2 Producto 3 Redes y servicios de salud organizadas de acuerdo a normas SAFCI	Incremento en un 10% de los pacientes referidos y retornados	1) Sobre cumplida 20% de Incremento en el número de pacientes referidos y retornados y tres redes organizadas de acuerdo a SAFCI y a necesidad de la comunidad

Efecto/Producto	Metas	Alcanzado
Efecto 3 Producto 1 Optima gestión sanitaria	100% del personal de las redes conocen la normativa administrativa de administración, planificación y de control	1) Cumplida parcialmente 76% del personal conocen las normas administrativas, de planificación y de control
Efecto 3 producto 2 Intervenciones de salud coordinadas y cogestionadas por los actores institucionales y sociales del sector salud y otros del desarrollo económico que operan en el área de intervención del programa	Estructura social funcionando	1) Cumplida parcialmente, funcionan los municipales y de establecimientos de salud, en tanto que los departamentales son irregulares y de poca convocatoria
Efecto 3 producto 3 Planes y programas de SEDES y municipios elaborados, alineados con el PNDSS y evaluados	El 100% de los planes departamentales, y el 100% de los planes municipales se hallan alineados al plan sectorial de salud	1) Cumplida al 100%, todos los planes se hallan alineados, algunos talleres con ONGs no se concretaron y solo se hizo a través de normativas
Efecto 3 Producto 4 Modulación del financiamiento mejorado	75% de las alcaldías asignan recursos al sector salud	1) Cumplida al 100% a través de acciones de abogacía
Efecto 3 Producto 5 gestión de recursos humanos implementada	50 personas de Beni y Pando capacitadas en comunicación estratégica y 30 personas capacitadas en epidemiología en Oruro	1) Cumplida parcialmente, en curso los diplomados respectivos
Efecto 3 Producto 6 Seguimiento a la ejecución del PASS/PRICCAS	a) Ejecución del 80% de los planes departamentales, de redes y municipales. b) Ejecución financiera del 75% del presupuesto c) tres comités PRICCAS d) 100% de CAI por niveles ejecutados.	1) Cumplida al 100%

Fuente: Programa de Apoyo al Sector Salud PASS/UNICEF-PRICCAS, Informe de Gestión 2008.

Anexo Nº 8

PROYECTOS FLASS

Nº	INSTITUCIÓN EJECUTORA	PROYECTO	UBICACIÓN	MONTO SOLICITADO CND\$	CONTRAPARTE CND\$	TOTAL CND\$
1	Centro de Investigación, Educación y Servicios (CIES)	Mujeres de Áreas Rurales del Beni promueven sus derechos mediante estrategias de participación ciudadana	Departamento: Beni, Municipio: San Ignacio y Trinidad, área rural	99.979,00	42.806,00	142.785,00
2	Samaritan's Purse	Fortaleciendo el bienestar familiar y comunitario a través de Redes Locales de Salud	Departamento: Beni, Municipio: Loreto y San Andrés	99.937,00	103.113,00	203.050,00
3	Asociación de Promotores de Salud de Área Rura - APROSAR	Construyendo redes sociales en torno a la salud de nuestros pueblos	Departamento: Beni, Municipio: Rurrenabaque, Reyes, San Borja y Santa Rosa	94.424,58	23.636,10	118.060,68
4	CHRISTIAN CHILDREN FUND BOLIVIA	Desarrollo Infantil Integral Comunitario: Desde mis raíces	Departamento: Oruro, Municipio: Totora	80.110,22	27.896,78	108.007,00
5	CECI	Un Aguayo para un Parto sin Riesgos en los Municipios de la Mancomunidad Aymaras sin fronteras del departamento de Oruro	Departamento: Oruro, Municipio: Curahuara de Carangas, Corque, Totora, Huayllamarca y Belén de Andamarca	99.956,00	40.777,00	140.733,00
6	Save the Children	Movilizando la comunidad para construir puentes entre las mujeres y los servicios de salud en municipios indígenas	Departamento: Oruro, Municipio: Eucaliptus y El Choro	99.991,17	30.466,56	130.457,73
7	Honorable Alcaldía Municipal de San Pedro de Totora	Salvando vidas de madres y niños en el municipio de San Pedro de Totora	Departamento: Oruro, Municipio: San Pedro de Totora	20.000,00	11.250,00	31.250,00
	TOTAL PROYECTOS			594.397,97	279.945,44	874.343,41

Anexo N° 9

PERCEPCIONES SOBRE CUMPLIMIENTO DEL MARCO LÓGICO DEL PROGRAMA

<p>Objetivo del Proyecto: Mejorar la situación de salud de la población boliviana y fortalecer las capacidades de gestión del sector de la salud pública, especialmente en los departamentos de Beni, Pando y Oruro.</p>		
<p>Propósito del Proyecto: Contribuir a mejorar los servicios públicos de atención primaria salud en particular de atención materno-infantil y control de enfermedades transmisibles, así como del Programa Ampliado de Inmunizaciones (PAI) y fortalecer las capacidades de gestión pública en el sector, especialmente en los departamentos seleccionados</p>		
PRODUCTOS	EFFECTOS	RESULTADOS ESPERADOS
<p>Project stakeholders were asked to measure the achievement of the result on a scale of 1-5 with 5 being high and one low.</p>		
<p>1.a Servicios de salud integrales: fijos, móviles y sistemáticos (continuos) ofertados a personas y familias, con énfasis en localidades y comunidades excluidas</p> <p style="text-align: right;">4</p>	<p>E.1 Acceso efectivo y equitativo de la población a servicios de salud integrales, culturalmente adecuados y con equidad de género</p> <p style="text-align: center;">3</p>	<p>R.E. Aumentar los años de vida saludables en los departamentos seleccionados</p>
<p>1.b Comunidad organizada participando activamente para ejercer su derecho a la salud y realizando control social</p> <p style="text-align: right;">3</p>		
<p>1.c Familia, comunidades y población en general asumen responsablemente por el autocuidado de su salud y demandan calificadamente servicios de salud con respeto a la diversidad cultural y con equidad de género</p> <p style="text-align: right;">3</p>		
<p>2.a Recursos humanos de las redes de salud han mejorado sus competencias (saberes, prácticas y juicios) en la atención materno infantil, AIEPI-NUT, PAI y enfermedades prevalentes</p> <p style="text-align: right;">4</p>	<p>E.2 Mejorada la calidad de los servicios integrales de Salud en términos de capacidad resolutive, calidez, adecuación intercultural, equidad de género y efectividad en el control de enfermedades</p> <p style="text-align: center;">3</p>	<p style="text-align: center;">4</p>
<p>2.b Redes y establecimientos de salud priorizados con infraestructura y equipamiento materno infantil de acuerdo a estándares de calidad por niveles</p> <p style="text-align: right;">4</p>		
<p>2.c Redes y servicios de salud organizados de acuerdo a norma y necesidades de comunidades</p> <p style="text-align: right;">3</p>		

<p>3.a Normativa para el modelo de gestión descentralizada y participativa elaborada e implementada</p> <p style="text-align: right;">3</p>	<p>E.3 MSD, SEDES, redes y Establecimientos de Salud con mayor capacidad para ejercer la autoridad sanitaria, en el marco de planes y programas operativos</p> <p style="text-align: center;">4</p>	
<p>3.b Intervenciones de salud coordinadas y co-gestionadas por los actores institucionales y sociales del sector salud y otros del desarrollo socioeconómico que operan en el área de intervención del Programa</p> <p style="text-align: right;">3</p>		
<p>3.c Planes y programas de SEDES y municipios elaborados, alineados con el PNDSS y evaluados efectivamente</p> <p style="text-align: right;">4</p>		
<p>3.d Inversión en salud incrementada y ejecutada con eficiencia y efectividad en SEDES y municipios en avance hacia un enfoque programático en salud</p> <p style="text-align: right;">4</p>		
<p>3.e Recursos humanos del MSD, SEDES y DILOS con mayores competencias para la gestión en salud</p> <p style="text-align: right;">4</p>		
<p>3.f Gestión eficaz y eficiente del PASS en todos sus componentes</p> <p style="text-align: right;">4</p>		

Fuente: elaboración propia con base a Cuestionario de percepción de cumplimiento del Marco Lógico del PASS.

Anexo Nº 10

INDICADORES TRAZADORES MATERNO INFANTILES

SEDES BENI, PANDO Y ORURO

Años 2007-2008

Indicadores	Oruro		Beni		Pando	
	2007	2008	2007	2008	2007	2008
%Embarazadas con dosis completa de hierro	55	74	70	69	100	100
% 4 CPN	74	72	50,8	67	64,77	66
% Parto en servicio	78	81	76,2	70	74,92	78,55
%puérperas con dosis completas de hierro	40	40	70	69	70	85
% Puérperas con dosis de vitamina A	42	42	79	74	79	83
%Cobertura BCG	95	100	95,2	97,5	93,7	94,1
%1 dosis rotavirus		59		38,3		43,5
%2 dosis rotavirus		28		8,4		26,1
% 1 dosis penta	95	100	94,1	94,4	100	98,2
% 3 dosis penta	89	100	89,5	93	91,7	100
% SRP	95	100	90	95	100	96,1
%Antiamarílica		91		88		86,7
% niños y niñas de 6 a 24 meses con dosis completas de hierro	70	78	65	78	72,32	100
% niños y niñas de 2 a 5 años con dosis completas de hierro	45	52	46	51	70,43	85
niños de 6 a 11 m con vitamina A	80	100	90	95	98	100
%Desnutrición leve en niños y niñas <2 años	46,6	20,5	66	48	66	35,2

%Desnutrición moderada en niños y niñas <2 años	7,8	2,9	13	8	15,7	6,5
%Desnutrición grave en niños y niñas < 2 años	1,1	0,5	3,1	1,5	2,8	1,8
% Mortalidad en desnutridos graves en hospitales de referencia departamental	20	2	14	6,2	0	5

Fuente: Programa de Apoyo al Sector Salud PASS/UNICEF-PRICCAS, Informe de Gestión 2008.