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BOLIVIAN HEALTH SECTOR SUPPORT PROGRAM - PASS

End-of-Project Evaluation

FINAL REPORT

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ABBREVIATIONS AND ACRONYMS

ALS	Autoridad Local de Salud (Local Health Authority)
AMUPEI	Articulación de Mujeres por la Equidad y la Igualdad (Women's Alliance for Equity and Equality)
APROSAR	Asociación de Promotores de Salud del Área Rural (Association of Rural Health Promoters)
Bs.	Boliviano (Bolivian currency)
C\$	Canadian Dollar
CAP	Componente de Apoyo Presupuestario (Budget Support Funding)
CEA	Cost-effectiveness analysis
CIDA	Canadian International Development Agency
CIPOAP	Central Indígena de Pueblos Oroginarios de la Amazoni de Pando (Association of Indigenous Peoples of the Pando Department, in the Amazon)
CECI	Center for International Studies and Cooperation
CFB	Child Fund Bolivia
CIES	Centro de Investigación, Educación y Servicios (Centre for Education, Research and Services)
CLS	<i>Comité local de Salud</i> (Local Health Committee)
DGP	Dirección General de Planificación (Directorate General of Planning)
DHS	Demographic and Health Survey (DHS)
DILOS	Directorio Local de Salud (Local Health Board)
FCI	Family Care International
FLASS	Fondo Local de Apoyo al Sector Salud (Local Fund for Health Sector Support)
FLS	Fondo Local de Salud (Local Health Fund)
FPS	Fondo Nacional de Inversión Productiva y Social (National Productive and Social Investment Fund)
HAMN	Hospitales Amigos de la Madre y del Niño
MDG	Millennium Development Goal
M&E	Monitoring and Evaluation
MoU	Memorandum of Understanding
MSD	Ministerio de Salud y Deportes (Bolivian Ministry of Health and Sports)
NGO	Non-governmental organisation
AOP	Annual Operating Plan
PAHO	Pan American Health Organization
PAI	Programa Ampliado de Inmunizaciones (Expanded Immunisation Program)
PASS	Programa de Apoyo al Sector Salud (Bolivian Health Sector Support Program)
PIP	Project Implementation Plan

POA	<i>Plan Operativo Anual</i> (Annual Operating Plan)
PRICCAS	Proyecto de Incremento de Coberturas y de Calidad en Atención en Salud (Project to Improve the Coverage and Quality of Health Care)
RBM	Results-Based Management
REDES	Redes de salud (health networks)
SAFCI	Salud Familiar, Comunitaria e Intercultural (family and community health)
SECI	Sistema Epidemiológico Comunitario Integral (Comprehensive Community Epidemiological System)
SEDES	Servicio Departamental de Salud (Departmental Health Secretariat)
SIGMA	<i>Sistema Integrado de Gestión y Modernización Administrativa</i> (integrated system for management and administrative modernisation)
SNIS	Sistema Nacional de Información en Salud (National Health Information System)
SUMI	Seguro Universal Materno-Infantil (Universal Maternal and Infant Insurance Program)
ToRs	Terms of Reference
UASCC	Unidad de Apoyo de Servicios de la Cooperación Canadiense (Program Support Unit of the Canadian Cooperation)
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
UP	Unidad de Planificación (Planning Unit)
USAID	United States Agency for International Development
VIPFE	Viceministerio de Inversión Pública y Financiamiento Externo (Vice Ministry of Public Investment and External Financing)
VIO	Viceministerio de Igualdad de Oportunidades (Vice Ministry for Equal Opportunities)

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1. INTRODUCTION

This document reports the key findings of the end-of-project evaluation of the *Programa de Apoyo al Sector Salud* (PASS), or Bolivian Health Sector Support Program. Introduced progressively starting in 2005, the latter began winding down its activities in December 2011. The PASS was a joint initiative of the Canadian International Development Agency (CIDA) and the *Ministerio de Salud y Deportes* (MSD) of Bolivia (i.e. Ministry of Health and Sports). Its objective was to improve the health condition of the Bolivian population and to strengthen the capacities of Bolivia's public health sector, especially in three of the country's nine departments: Beni, Pando and Oruro. In support of this objective, a budget of C\$18.4 million was allocated, over a period of five years, to provide for the delivery of six project components:

- the *Componente de Apoyo Presupuestario* (CAP), or Budget Support Funding;
- the *Proyecto de Incremento de Coberturas y de Calidad en Atención en Salud* (PRICCAS), or Project to Improve the Coverage and Quality of Health Care;
- the *Fondo Local de Apoyo al Sector Salud* (FLASS), or Local Fund for Health Sector Support;
- Infrastructure and Equipment handled by the *Fondo Nacional de Inversión Productiva y Social* (FPS), or National Productive and Social Investment Fund;
- Policy Dialogue;
- Monitoring and Evaluation (M&E).

The end-of-project evaluation of the PASS was carried out between January and April 2012 by a private consulting firm, Le Groupe-conseil baastel ltée ("Baastel" for short), on behalf of the CIDA Bolivia Program. The purpose of the evaluation was to assess performance of the PASS in the three years that followed the conduct of a mid-term evaluation of the project carried out between July and November 2009.¹

The report is structured as follows:

- Chapter 2 outlines the key features of the end-of-project evaluation;
- Chapter 3 examines the Bolivian context and provides relevant development assistance information;
- Chapter 4 provides a more detailed description of the PASS;
- Chapter 5 presents the main findings derived from application of the evaluation criteria;
- Chapter 6 discusses the main conclusions of the evaluation;
- Chapter 7 identifies relevant lessons and recommendations.

¹ Coupal, Françoise, Lynn Johnson, and Waldo Gutierrez. *Mid-Term Evaluation of the Bolivian Health Support Programme*. November 2009.

2. OVERVIEW OF THE EVALUATION

This chapter: outlines the rationale and scope of the end-of-project evaluation of the PASS; identifies the objectives of this evaluation; lists key questions and criteria examined by the evaluation team; describes the approach and methodology used to perform the evaluation; and addresses challenges and potential limitations associated with the latter.

2.1 Rationale and Scope

This assignment was carried out to comply with the requirement to conduct an evaluation at the conclusion of the program, as per the PASS Project Implementation Plan (PIP). It followed the completion of all project activities, starting in January 2012, in a bid:

- To help CIDA officials and Bolivian partners appreciate the factors that had a positive or negative effect on progression of the PASS;
- To allow the sharing of lessons learned with the PASS stakeholders and within CIDA;
- To identify results that supported the achievement of CIDA and the Government of Bolivia priorities, particularly those related to children and youth, and the reduction of maternal and child health problems.²

The findings, lessons learned and recommendations will hopefully contribute to the development of further programming in the health sector in Bolivia, with regards more specifically to maternal and child health issues.

The mid-term evaluation of the PASS, had led to the development of valuable recommendations for the continuation of the project (see Appendix 1). Measures taken to implement these recommendations were reviewed in this end-of-project evaluation. More generally, the latter examined the relevance, coherence, effectiveness, efficiency and sustainability of the PASS, along with risks associated with the project.

2.2 Evaluation Objectives

The evaluation encompassed all six PASS components and addressed the following, specific objectives:

- To ascertain the degree to which intermediate results (effects) were achieved and to evaluate the relevance of the model, the coherence of the PASS approach with respect to priorities and policies of the MSD and the effectiveness of methods used to improve access to—and the quality of—health services, and to strengthen management capabilities of the MSD and of the *Servicios Departamental de Salud* (SEDES, i.e. Departmental Health Secretariat), the efficiency of management processes and the sustainability of existing procedures;
- To identify lessons learned and best practices, including the implementation of recommendations made in the mid-term evaluation,³ and to suggest new directions for further CIDA health sector programs.

2.3 Evaluation Criteria and Questions

Table 1 lists the key questions and criteria that were suggested in the Terms of Reference (ToRs) prepared for the end-of-project evaluation. These questions and criteria, which are in accordance with OECD-DAC

² As per the Terms of Reference set out for the end-of-project evaluation.

³ Coupal, *Idem*.

guidelines for project evaluation, were used to develop the evaluation matrix that was applied to conduct the assignment (see Appendix 2).

Table 1
Key Evaluation Questions and Criteria

Criteria	Brief description	Preliminary questions
Development-level results		
Effectiveness (note 1)	The extent to which the development intervention's objectives were or are expected to be achieved, taking into account their relative importance	<ul style="list-style-type: none"> What progress has been made with respect to real results—outputs, effects—and the performance framework of the program? Do these results facilitate the achievement of CIDA priorities, particularly those related to children and youth? Are there any unexpected results—positive and/or negative?
Cost-effectiveness	A measure of how economically resources/inputs (funds, expertise, time, etc.) are converted into results	<ul style="list-style-type: none"> Is the ratio between costs and results reasonable? Do real expenditures match planned expenditures, or is a detailed explanation of discrepancies required?
Relevance (note 1)	<ul style="list-style-type: none"> The extent to which the objectives of the development intervention are consistent with the requirements of beneficiaries, the needs of Bolivia, global priorities, and the policies of partner and donor Appropriateness of development interventions in a given sector, region or country 	<ul style="list-style-type: none"> Are the local partners' initiatives relevant, considering the situation, the needs or the problems that call for a solution? Are these initiatives consistent with the needs and priorities of the beneficiaries, the country or the region?
Sustainability (note 1)	<ul style="list-style-type: none"> The continuation of the benefits from a development intervention after major development assistance has been completed The probability of continued long-term benefits The resilience to risk of net benefit flows over time 	<ul style="list-style-type: none"> What are the chances that the spin-offs/results will be sustainable, once the initiative has ended? Will there be local ownership (i.e. by the MSD or the SEDES) of the approach and strategies used to achieve expected results and maintain the acquired practices? What is the capacity of the MSD to reproduce or adapt the intervention methodology in other Bolivian departments?
Quality of the partnership		
Local ownership	<ul style="list-style-type: none"> Local ownership, harmonisation and alignment Ownership of the program by the MSD (e.g. measures taken by the Ministry to fully exercise its role as leader, regulator and coordinator in the health sector) and by the various beneficiaries at the departmental level—including the SEDES and the <i>redes de salud</i>, or REDES (i.e. health networks)—and at the local level (i.e. target communities) 	<ul style="list-style-type: none"> Do participants have a clear and comprehensive definition and acceptance of their roles and responsibilities in the program? To what degree has the MSD taken ownership of the program?
Joint responsibility for results	Degree of commitment by partners (i.e. the MSD, the SEDES and local communities) to achieve the results and maintain vested interests	<ul style="list-style-type: none"> Is the responsibility for achieving results shared jointly?
Success factors		
Sound concept, relevant model	<ul style="list-style-type: none"> Appropriateness of design, based on a sound understanding of the local context Identification and assessment of risks, and strategies developed for ongoing monitoring Evidence that innovative and creative ideas and approaches are explored to achieve results 	<ul style="list-style-type: none"> Have the goals, objectives, expected results and performance indicators met CIDA's requirements concerning Results-Based Management (RBM), as defined within the framework of a participative approach, and based on a clear understanding of the local context? Are strategies well adapted to the situation (risks in particular), the needs or the problems? What are the strengths and/or weaknesses of the multi-component model that has been implemented?

Criteria	Brief description	Preliminary questions
Community involvement (FLASS projects)		<ul style="list-style-type: none"> To what extent are the projects implemented by non-governmental organisations (NGOs) in the three departments relevant? What is the degree of complementarity with efforts made by major partners of the PASS? To what extent have the departmental partners (i.e. the SEDES, the REDES and the communities) taken ownership of know-how implemented by the NGOs?
Management and coordination mechanisms	Efficient management mechanisms and coordination between major partners of the PASS, including the MSD, the FLASS, the PRICCAS-United Nations Children's Fund (UNICEF), and the FPS	<ul style="list-style-type: none"> What value added are the PASS Management Committee and the PASS Operational Committee bringing to the program's implementation? How can these mechanisms be improved in view of the planning of future CIDA health projects in Bolivia?
Informed and timely interventions (risk management)	<ul style="list-style-type: none"> Anticipation of, and response to, change based on adequate information Adoption of appropriate measures to manage risks 	<ul style="list-style-type: none"> To what extent are the networks effective and do the methods enable the identification and evaluation of mainstream trends and key changes that are likely to affect the program? To what extent are the strategies and practices adapted to the nature and level of inherent and external risks that could affect program funding and assets?
Gender equity	Integration of gender equity principles and practices in the design, planning and execution of the project	<ul style="list-style-type: none"> How relevant is the PASS gender equity strategy? What is the degree of ownership of gender equity by partners in the field (i.e. the SEDES and the REDES)?

Notes:

1. Source: Organisation for Economic Co-operation and Development. *Glossary of Key Terms in Evaluation and Results Based Management*. [n.p.] 2002.

2.4 Evaluation Approach and Methodology

Evaluation Approach

The evaluation followed an approach that emphasised the participation of stakeholders and partners and that focused on the usefulness and application of evaluation results. The following principles guided the evaluation team in its efforts to achieve the objectives of the assignment:

- *Focus on results* – The evaluation team identified expected results, performance indicators and potential risks in order to make a consistent, integrated use of Results-Based Management (RBM) principles throughout the assignment;
- *Participatory approach* – Special attention was paid to improving collaborative processes and ensuring that all key stakeholders could feed the assignment. Data collection methods were designed to promote active involvement on the part of informants (see below);
- *Triangulation of evidence* – Multi-research methods were used to provide for the cross-validation of all evaluation findings.

Evaluation Methodology

Four lines of evidence were deployed to cover and assess key evaluation issues:

- *Comprehensive document review* – To develop a thorough understanding of the project, the evaluation team conducted an in-depth analysis of the documentation on hand (see Appendix 3). This line of evidence focussed on:
 - ❖ CIDA project documents, including contribution agreements, project approval documents, monitoring reports, annual project progress reviews, past project evaluation, annual and semi-annual reports, and general correspondence;
 - ❖ major studies, including country reports or sector studies, as well as other credible international studies about Bolivia;
 - ❖ other documents, including reports, baseline surveys, statistics and data from credible sources regarding Bolivia, more specifically this country’s health sector.

In addition, the evaluation team examined a recent study that was developed to systematise PASS experiences to date.⁴ Specifically, this systematisation effort was “to recover the experience of stakeholders involved directly in the Health Sector Support Program, in a bid to understand the significant purpose of implementation of this program and to provide information to reflect on the experience of the program and its dissemination.”⁵ The systemisation study supplied the evaluation with a wealth of invaluable data and quantitative and qualitative information;

- *Semi-structured interviews with key informants in Canada and in Bolivia* – Interviews took place with representatives from CIDA, the MSD, UNICEF, non-governmental organisations (NGOs), health personnel in the field, and beneficiary within communities (see Appendix 4);
- *Focus groups, roundtables and workshops with various categories of informants* – Focus groups were organised with various groups of participants, including members of beneficiary communities, coordinators of the *redes de salud* (REDES)—i.e. health networks—, trainees, hospital personnel, NGO managers, representatives of municipal authorities, and male or female users of health services. As well, the evaluation team hosted workshops and round tables involving relevant government ministries, the United Nations Children’s Fund (UNICEF), municipalities, the REDES, and communities (see Appendix 4);
- *Expert panel groups* – The evaluation team called upon gender and health sector experts to take part in expert panel groups designed to inform the end-of-project evaluation of the PASS.

The methodology was designed to be as inclusive as possible and to capture the thoughts and suggestions of different categories of informants who actively participated in the project, including decision makers, operational personnel, and beneficiaries.

It should be noted that several key actors in the PASS were no longer involved in the program or were not available at the time of the end-of-project evaluation. In an effort to recover some of the lost “corporate memory” associated with the project, the evaluation team interviewed current members of the PASS personnel, as well as a sample of individuals who had previously worked on the project. To draw up its list of informants, the evaluation team consulted organisations like CIDA, the MSD and UNICEF, and members of the team who had developed the aforementioned systematisation study.

⁴ PASS. *Sistematización de la Experiencia de Implementación del Programa de Apoyo al Sector Salud*. Page4, 2012.

⁵ Original Spanish version: “Esta sistematización pretende recuperar la experiencia de los actores que de una u otra forma intervinieron de manera directa en el Programa de Apoyo al Sector Salud, para entender el propósito significativo de la aplicación del programa ha tenido en ellos. Además extraer las experiencias y conocimiento generado en la aplicación del programa. Con ello se busca proporcionar información que permita reflexionar de manera crítica que la experiencia del programa y su posterior socialización.”

The following criteria inspired the selection of regions, sub-regions, and communities, as well as the identification of categories of respondents:

- Representativeness of the regions, sub-regions and communities;
- Representativeness of the categories of respondents;
- Representativeness of the number of respondents within each category;
- Adequate coverage of issues and questions, for triangulation purposes;
- Time limitations;
- Underlying methodology of the mid-term evaluation;
- Underlying methodology of the systematisation study;
- Adequate number of participants in each relevant line of evidence.

2.5 Evaluation Challenges and Potential Limitations

- One major limitation relates to the fact that the development of a results framework for the PASS occurred in a context that was evolving both for CIDA and its counterparts and for the MSD authorities. Modifications had to be made at the design stage, and even during the implementation period. As a result, indicators were not always clearly defined for the project's expected results.
- Reports were routinely produced and presented by partners responsible for the various components of the project. However, regular consolidated reports were not issued by the MSD.
- Due to time restraints, and because some project sites were hardly accessible, field visits could not be made in the full range of project sites associated with the various components of the PASS. For this reason, the evaluation team had to select a representative sample of projects involving different geographic areas and implementation partners associated with the FLASS, the PRICCAS and the FPS.
- All field work, interviews and observations in the three targeted departments had to be completed over a period of 10 days. This constraint justified the decision to call group meetings with similar audiences and to resort to participatory qualitative models involving focus groups, group discussions, and expert panel groups, in an effort to rapidly assess new ideas and identify relevant gaps and barriers. The richness of information provided by the CIDA program team, by counterparts and by informants participating in the interviews and focus groups compensated for restrictions associated with the tight evaluation schedule.

3. COUNTRY CONTEXT AND DEVELOPMENT ASSISTANCE INFORMATION

This chapter discusses the context in which the PASS was implemented in Bolivia, outlines development assistance supplied by donors at large in Bolivia's health sector, and examines specifically CIDA's aid program and strategy in this sector.

3.1 Country context – National Development Plan and Health Sector Strategy

According to the latest census data, Bolivia, with an estimated population of 9.1 million and an annual growth rate of 2.7% between censuses, is the poorest country in South America and the most inequitable country in Latin America. Of all countries in the world, Bolivia has the sixth lowest Gini Index score for household income distribution. In Bolivia, 62% of the population lives in urban settlements, and 51% of urban residents are female. Approximately 60% of the population self-identifies as being indigenous and as belonging to one of the country's 37 recognised ethnic groups. Jointly, the Aymara and Quechua ethnic groups make up over half of the Bolivian population.⁶

In Bolivia, life expectancy at birth is 64 years, 39% of the population is under the age of 15, and 7% of the population is 60 or older. At the national level, the fertility rate is 3.8 children per woman. Bolivia is experiencing a demographic and epidemiological transition that is characterised by a growing urban population, an aging overall population, and high levels of transmissible diseases combined with a progressive increase in the prevalence of chronic diseases. The maternal mortality rate is 230 per 100,000 live births,⁷ and the infant mortality rate is 50 per 1,000 live births.⁸

With respect to the Human Development Index computed by the United Nations Development Programme (UNDP), Bolivia ranked 108 out of 187 countries in 2011. However, according to the UNDP, Bolivia is one of the lowest-scoring countries in the Americas with respect to health indicators.⁹ The critically poor health of Bolivians is closely tied to: poverty, social exclusion in the health sector, the system's segmented and fragmented character, the low level of budget allocation and the inadequate nature (or lack) of infrastructures, equipment and allocation of human resources. More than 25% of Bolivians do not have access to safe drinking water, while 44% have no access to basic sanitation services. The MSD plays his leadership role in addressing these challenges, but needs to improve its technical capacity in order to properly fulfill its direction role.

Although Bolivia has achieved significant progress overall, 58% of its population is still regarded as poor (i.e. living under the national poverty line), including 32% who live in extreme poverty—a proportion that has been declining in recent years. Geographical and ethnic features account for striking differences in the distribution of poverty. In Bolivia, poverty is more commonly seen in rural households than urban households (76% vs. 47%), and it is especially prevalent among indigenous households (78%). One fourth of the country's population is made up of female heads of household.¹⁰

Between 2000 and 2005, Bolivia experienced a major period of political and social instability.¹¹ Evo Morales' rise to power, in January 2006, significantly altered the country's political context. The new Government proposed a new, more equitable economic and social model that sought to include indigenous populations and that contemplated measures such as the reintroduction of traditional forms of community justice and political organisation, coupled with regional decentralisation. A framework to this effect was included in the Constituent Assembly that enacted the new political constitution of the Plurinational State of Bolivia, in

⁶ According to a national census of Bolivia's population and households conducted by the *Instituto Nacional de Estadística de Bolivia* (i.e. National Institute of Bolivia Statistics) in 2001.

⁷ According to a maternal post-census survey conducted by the *Instituto Nacional de Estadística de Bolivia* in 2001.

⁸ According to a national survey of demography and health conducted by the *Instituto Nacional de Estadística de Bolivia* in 2008.

⁹ For instance, in Bolivia, one child out of 16 dies before the age of 5, and one woman out of 89 die during pregnancy or child birth.

¹⁰ According to the sixth national progress report on the achievement of Millennium Development Goals (MDGs) prepared in 2010 by the *Unidad de Análisis de Políticas Sociales y Económicas*, or Economic Policies Analysis Unit.

¹¹ The country had six presidents during this period.

January 2007. Shortly after, the president tabled a new National Development Plan called *Bolivia Digna, Soberana, Productiva y Democrática para Vivir Bien 2006-2011*, which was approved in September 2007.¹² This plan lays out a social paradigm focused on “well-being,” as a basis for developing a “new, harmonious and just society” that embraces gender and social equality, as well as ethnic, sexual and generational diversity. The Morales administration is committed to achieving better alignment and harmonisation of development efforts, as per the Paris Declaration on Aid Effectiveness.

While these social and political changes were occurring, Bolivia saw its economic indicators stabilise following an increase in its fiscal surpluses in 2006. According to the World Bank, in 2010, Bolivia’s gross national income per capita, Atlas method, was US\$1,810, whereas the country’s gross domestic product scored a moderate increase of 4.5%. In 2009, on a per capita basis, public expenditures in the Bolivian health sector were US\$85, compared to private expenditures of US\$1.80.¹³

Under the umbrella of the Plurinational State Constitution and the National Development Plan for 2006-2011, the Government of Bolivia approved the sectorial plan “Movilizados por el derecho a la salud y la vida” (Mobilized for the right to health and life) 2006-2011), a Development Plan for the Healthcare Sector for 2010-2015. The main goal of this plan is to eliminate discrimination and social exclusion from the healthcare sector with the determination to guarantee universal access to healthcare services and to eliminate discrimination and exclusion of the poorest, especially indigenous people. To this end, the plan puts forward three priorities:

- Universal access to quality health services and gender and intercultural equity, to be achieved through an extension of health coverage, the development of a universal health insurance service, the strengthening of networks, the promotion of traditional medicine, and monitoring and improvement of health management efforts;
- Social mobilisation and promotion of health, to be achieved through a healthy environment, healthy nutrition and food, the reduction of violence, integration of the handicapped, the management of environmental risks, and community mobilisation, education and communication;
- The recovery of health sovereignty, to be achieved through management and financial coordination.

The Health Sector Development Plan is supported by the *Salud Familiar, Comunitaria e Intercultural* (SAFCI) Policy—. The latter features management and services models that seek to integrate community and intersectorial efforts in actions taken by health institutions (see Box 1). Though the SAFCI Policy is in force, its implementation to this day remains insufficient.

Specific health plans have also been developed for the 2009-2015 period, to support implementation of the Health Sector Development Plan. These include national strategies for adolescent health, reproductive and sexual health, safe birth and motherhood, and breast and cervix cancer.

Box 1
Health Management Model of the SAFCI

- At the national level: the MSD.
- At the departmental Level: the SEDES.
- At the municipal level: a *Directorio Local de Salud* (DILOS) (i.e. Local Health Board), along with a *Red Municipal* (municipal network) and a social structure involving the *Autoridad Local de Salud* (ALS) (i.e. Local Health Authority), a *Comité local de Salud* (CLS) (i.e. Local Health Committee) and a *Consejo Social Municipal de Salud* (Municipal Social Health Council).

¹² *Bolivia Digna, Soberana, Productiva y Democrática para Vivir Bien, Decreto Supremo No. 29272*. Website found at <<http://www.sns.gob.bo/planificacion/documentos>>, accessed April 15, 2012.

¹³ The World Bank. *GDP per Capita (Current US\$)*. Website found at <<http://data.worldbank.org/indicator/NY.GDP.PCAP.CD>>, accessed April 15, 2012.

3.2 Development Assistance by Donors in the Health Sector

Bolivia is one of the signatories of the Paris Declaration on Aid Effectiveness. As shown in Table 2, Canada ranked 8th among all bilateral donors in Bolivia, with average annual disbursements of approximately US\$20 million. In recent years, Canada's assistance in this country has been geared towards the public health sector (see Table 3), sustainable economic growth, and support to democratic institutions.

Table 2
Top ten Donors of Official Development Assistance to Bolivia (5-year average, 2006-2010)

Country	Disbursements (US\$)
United States	128.59
Spain	79.88
Japan	58.10
Germany	47.49
Netherlands	44.79
Denmark	35.48
Sweden	24.60
Canada	20.09
Belgium	18.34
France	18.12

Source: Organisation for Economic Co-operation and Development. *Aidflows*. Website found at <<http://www.aidflows.org/>>, accessed April 2012.

Table 3
Top five Donors of Official Development Assistance in the Health Sector to Bolivia (5-year average, 2006-2010)

Country	Disbursements (US\$)
United States	7,15
Spain	6,19
Canada	4,95
Japan	4,61
Belgium	3,75

Source: Organisation for Economic Co-operation and Development. Stats found at <<http://stats.oecd.org/>>, accessed July 2012.

Bolivia is currently leading the planning process to associate development cooperation work with its National Development Plan for 2006-2011. Donors have aligned with this plan and have focused their program on a reduced number of sectors. As of 2009, joint assistance strategic agreements had been established in the health and governance sectors. Moreover, regular meetings between the Bolivian minister responsible for planning and in-country representatives have strengthened the coordination of aid efforts.

3.3 CIDA's Aid Program and Strategy in the Health Sector in Bolivia

In 2009, as part of Canada's new Aid Effectiveness Agenda, CIDA identified Bolivia as one of its "countries of focus." CIDA's programming in Bolivia is closely aligned with the guiding principles of Bolivia's National Development Plan for 2006-2011, which supports and promotes the Government of Bolivia's goals of

constructing a new, equitable, more just, and economically vigorous society by addressing the social, democratic, and economic dimensions of development.

The overall goal of CIDA's program in Bolivia is to support the establishment of a more equitable society in which poverty is reduced and the quality of life of vulnerable and marginalised populations is improved. More specifically, CIDA focuses on providing the means for a better future for children and youth, and on creating the conditions for sustainable economic growth. CIDA also continues to maintain support for key democratic and oversight institutions, such as the *Tribunal Supremo Electoral* (i.e. Supreme Electoral Tribunal) and the Bolivian *Contraloría General del Estado* (i.e. Auditor General's Office), to help strengthen democratic processes, accountability and transparency. In addition, environmental challenges are addressed through an emphasis on corporate social responsibility initiatives.

According to the Logic Model of CIDA's program in Bolivia (dated May 27, 2011), the ultimate outcome of this program is "Improved sustainable economic, social and cultural well-being of vulnerable populations in a democratic, inclusive, and decentralised Bolivia." The program features three intermediate outcomes, including one that is health-related, i.e. "Increased effectiveness of health sector actors in the implementation of the national health policies in a manner that responds to the needs of vulnerable populations."¹⁴ Three related immediate outcomes have been identified, aligned to the Bolivian Health Sector Development Plan, namely:

- "Improved capacity of all health actors, in targeted departments to deliver health services to vulnerable populations, in the context of decentralisation;"
- "Improved knowledge of preventative health practices by targeted populations;"
- "Improved management capacities (especially technical and financial) of selected health sector actors in the context of decentralisation."

CIDA has been supporting Bolivia's health sector since 1997-1998, through various programs implemented notably by the Pan American Health Organization (PAHO), the Canadian Society for International Health or the FPS. Health was identified as one of the three priority sectors in CIDA's Bolivia program for 2003-2007, which primarily sought to "reduce poverty and improve the standard and quality of life of the poorest Bolivians."¹⁵

CIDA's current program for Bolivia focuses on economic growth, and on children and youth. Regarding the latter theme, CIDA aims to improve maternal health and reduce child mortality by enhancing quality of access to essential health care, fighting malnutrition, and increasing sustainable access to safe drinking water and basic sanitation services. Two key anticipated results have been identified, namely:¹⁶

- Reduced malnutrition by increasing vitamin A coverage among children under 5;
- Reduced neonatal, child, and maternal mortality by increasing the percentage of deliveries in health centres.

¹⁴ The other two intermediate outcomes read as follows: "Increased participation of vulnerable populations in new and existing environmentally-sustainable value chains, in targeted sectors," and "Improved implementation of the decentralisation agenda by selected national and subnational entities."

¹⁵ According to the CIDA programming framework for Bolivia (2003-2007). The other two priority sectors were water and governance.

¹⁶ CIDA. *Bolivia*. Website found at <<http://www.acdi-cida.gc.ca/acdi-cida/ACDI-CIDA.nsf/eng/JUD-129112821-MBV>>, accessed April 2012.

4. DESCRIPTION OF THE PASS

This chapter provides a description of key features of the PASS. The goal, purpose and expected outcomes are discussed, along with key components of the project, and the latter's scope and reach.

4.1 Goal, Purpose and Expected Outcomes

The PASS is CIDA's first integrated health program in Bolivia. It provides technical and financial support to the MSD and health authorities in three Bolivian departments (i.e. Beni, Pando and Oruro) so they may implement policies, strategies, programs and projects that tie into Bolivia's Health Sector Development Plan for 2010-2020 and Bolivia's SAFCI Policy.

As indicated in the project's Logic Model, featured in Appendix 5, the goal of the PASS is to improve the health situation of the Bolivian population, especially in the departments of Beni, Pando and Oruro. The purpose of the PASS is to help improve primary health care public services and to reinforce public management capacities in this area, especially in the targeted departments. There are three series of outcomes and outputs associated with the project's expected results, as follows:

- *Outcome level result 1* – Effective and equitable access of the population to comprehensive, culturally-appropriate and gender-equitable health services:
 - ❖ Integrated fixed or mobile health services that are regularly delivered to populations and families, with an emphasis on marginalised towns and communities;
 - ❖ Organised communities that actively exercise their right to health care and that participate in the social monitoring of health care delivery;
 - ❖ Families, communities and populations that look over their own health and demand quality health services, taking into account cultural diversity and gender equity;

- *Outcome level result 2* – Improved quality of integrated health services, in terms of resolution capacity, quality, intercultural appropriateness, gender equity, and effectiveness of the control of communicable diseases:
 - ❖ Human resources within the REDES who have improved skills (knowledge, practices and judgment) in maternal and child care, comprehensive care for nutritional childhood diseases, expanded immunisation programs, and communicable diseases;
 - ❖ Networks and priority health facilities with infrastructures and maternal and child care equipment that meet quality standards appropriate to their level;
 - ❖ Networks and health services that are set up to meet the SAFCI standard and address the needs of communities;

- *Outcome level result 3* – Increased capacity within the MSD, the SEDES, the REDES and health institutions to exercise leadership in the health sector, following the operational plans and program frameworks:
 - ❖ Decentralised and participative management model standards, developed and implemented;
 - ❖ Health interventions that are coordinated and jointly managed by health sector institutional and social stakeholders and by other socio-economic development partners involved in the targeted departments;
 - ❖ SEDES/municipal plans and programs that align with the Health Sector Development Plan for 2010-2020 and that are duly evaluated;
 - ❖ Increased health sector investments that are managed efficiently within the SEDES and the municipalities and that support a program approach to health care;
 - ❖ MSD, SEDES and *Directorio Local de Salud* (DILOS)—i.e. Local Health Board—officials who strengthen their management capacity within the health sector;
 - ❖ Effective and efficient management of all PASS components.

4.2 Key Components of the PASS

Table 4 briefly describes the main components of the PASS, namely: the CAP; the PRICCAS; the FLASS; Infrastructure and Equipment; Policy Dialogue; and M&E.

Table 4
Components of the PASS

Component: CAP			
Executing agency:	MSD	Date of signature of agreement:	March 9, 2007
Budget (2011):	C\$1.7 million	End date (actual or planned):	September 30, 2012
Description:			
<ul style="list-style-type: none"> MSD and its intermediaries (i.e. the three SEDES of the targeted departments) – Contribution agreement up to C\$1.7 million for budgetary support. Along with development plans of the targeted departments, the development plan of the MSD-DGF is at the heart of this component, which is dedicated to institutional building. The MSD (via the DGF), UNICEF and the FPS are regarded as partners in the delivery of the PASS, in so far as they have signed individual contribution agreements with CIDA. The SEDES are strategic stakeholders of the PASS because they are the primary beneficiaries of three PASS components, and because they are responsible for strategic implementation within the three departments. 			
Component: PRICCAS			
Executing agency:	UNICEF	Date of signature of agreement:	October 17, 2005
Budget (2011):	C\$10.4 million	End date (actual or planned):	December 31, 2010
Description:			
<ul style="list-style-type: none"> Through the PRICCAS, which was designed to improve the coverage and quality of health care in the departments of Beni, Pando and Oruro, UNICEF cooperates with the MSD and the SEDES in the targeted three departments, in order to strengthen local health service networks and improve the control of communicable diseases and maternal and child health. Action by UNICEF focuses on three major strategic areas: institution building; communication and social mobilisation; and delivery and storing of material and equipment. By choosing UNICEF as executing agency for the PRICCAS component, the PASS avoids having to set up a structure or a distinct administrative unit working in parallel to the public system. This facilitates the adoption of a sector-wide approach to health. 			
Component: FLASS			
Executing agency:	NGOs	Date of signature of agreement:	N/A
Budget (2011):	C\$0.84 million	End date (actual or planned):	December 31, 2011
Description:			
<ul style="list-style-type: none"> The FLASS is a responsive and competitive fund valued at approximately C\$840,000. Launched in 2009, the FLASS is used to finance Bolivian and international civil society organisations (i.e. NGOs, universities, think-tanks, civil society groups), with a view to supplementing PASS activities in the three targeted departments by supporting community participation in health management. 			
Component: Infrastructure and Equipment			
Executing agency:	FPS	Date of signature of agreement:	March 22, 2007
Budget (2011):	C\$4.5 million	End date (actual or planned):	December 31, 2011
Description:			
<ul style="list-style-type: none"> This component is managed by the FPS, a paragonovernmental agency. It involves extensions and renovations to existing infrastructures in the three targeted departments, as well as the purchase of medical equipment for selected health centers. Follow up of administrative procedures and implementation work is achieved using SIGMA (<i>Sistema Integrado de Gestión y Modernización Administrativa</i>), the Bolivian Government's integrated system for management and administrative modernisation. 			
Component: Policy Dialogue			
Executing agency:	Not applicable	Date of signature of agreement:	Not applicable
Budget (2011):	C\$0.12 million	End date (actual or planned):	December 31, 2011
Description:			
<ul style="list-style-type: none"> The Policy Dialogue component is managed by CIDA. This component is earmarked for sector dialogue and seeks to foster an environment that is conducive to the adoption of a sectorial approach to health. This component should allow joint financing of workshops, studies and consultations with other donors. 			

Component: M&E			
Executing agency:	Not applicable	Date of signature of agreement:	Not applicable
Budget (2011):	C\$0.84 million	End date (actual or planned):	March 31, 2012
Description:			
<ul style="list-style-type: none"> This component is used to finance: the conduct of an evaluation by a Canadian M&E consultant who specialises in RBM; the work of a Bolivian M&E consultant (from 2006 to 2008); the work of a health specialist; the conduct of the mid-term and end-of-project evaluations; and systematisation and other related activities. 			

4.3 Scope and Reach of the PASS

General Approach

The PASS was implemented through an innovative and unique combination of both bilateral (CIDA/MSD) and multilateral (CIDA/UNICEF) assistance, with participation from other partners such as NGOs and Bolivian departments and municipalities. The general approach of the project reflects the following realities:

- Bolivia's population has limited access to quality health services. Response capacity is insufficient, and services that do not take into account ethnic and cultural diversity, or traditional medicine;
- First- and second-tier health facilities lack the qualified human resources, the infrastructures and adequate equipment, and the administrative systems and procedures they would need to deliver efficient health services;
- There is a need for normative regulation dealing with change in Bolivia's health sector;
- Autonomy, decentralisation and community participation are critical nodes to initiate an institutional strengthening process within the health sector, so that Bolivia may reach the objectives set out in the Paris Declaration;
- For both Bolivia and Canada, the PASS—more specifically the CAP—provides an opportunity to implement the determinants of alignment, harmonisation and effectiveness in development cooperation between the two countries.

Justification and Underlying Principles

The PASS is aimed at implementing an integrated health program in Bolivia. It focuses on strengthening the country's health institutions to ensure efficient implementation of policies, strategies, programs and projects that support the SAFCI Policy, particularly with regards to maternal and child health issues.

The project was inspired by several justifications. Prior to implementation of the PASS, Bolivia's health sector suffered a number of structural, systemic problems:

- 57% of the Bolivian population between 6 and 59 years had no access at all to health services, and 87% of the population was excluded to various degrees from access to adequate health services;
- Health systems were segmented and fragmented, and delivery involved multiple vendors or service providers;
- Insufficient financial resources were dedicated to sustainable health systems and operations;

- The training of health professionals was not adequately carried out;
- The Bolivian population was generally unsatisfied with the quality, equity and treatment supplied by public health services and social security;
- Health services networks established on the basis of “administrative discretion” could not respond to the needs and demands of the population.

The PASS is based on the core principles of sustainability, participation and RBM, as exemplified by:

- Consultation and coordination with all partners, particularly Directorates of the MSD and Departmental Headquarters in Beni, Pando and Oruro, in order to select a joint programming approach that reflects the needs and priorities identified to implement activities associated with the CAP;
- Participation, support, commitment and ownership on the part of institutional officials of the MSD and Departmental Headquarters, through active participation in all meetings of the PASS Operational Committee and in supervision sessions carried out at Headquarters;
- The participation of women in the planning and implementation of various activities, especially training.

The PASS is designed to help Bolivia progress towards the achievement of four Millennium Development Goals (MDGs):

- MDG 1 – “Eradicate extreme poverty and hunger;”
- MDG 4 – “Reduce child mortality;”
- MDG 5 – “Improve maternal health;”
- MDG 6 – “Combat HIV/aids, malaria and other diseases.”

Coverage and Resourcing

The PASS spans across all three levels of Bolivia’s public health system (i.e. national, departmental and local). This is particularly true for maternal and child health issue (via the PRICCAS-UNICEF component). Geographically, the project targets three of the nine departments of the country: Beni and Pando, in the Amazon region; and Oruro, in the Altiplano. Furthermore, the PASS pursues an objective associated with governance, as it seeks to strengthen the leadership and management capacity of both the MSD and the three concerned SEDES.

The PASS focuses on the delivery of technical assistance to improve the local REDES. It supports the implementation of national priority programs in 17 such networks and 57 municipalities located in the three targeted departments, with a view to addressing maternal and child health problems.

CIDA and the MSD are the organisations responsible for implementing the PASS. To this end, a budget of C\$18.4 million was allocated, for a period of five years. As per the Memorandum of Understanding (MoU) signed between the two countries, this includes:

- CAP – A C\$1.7 million contribution for budgetary support to the MSD;
- PRICCAS – A C\$10.4 million grant to UNICEF, as approved in 2005;
- FLASS – C\$600,000 (increased to C\$840,000 in 2009) to support civil society organisations;
- Infrastructure and Equipment – A C\$4.5 million contribution to the FPS;
- Policy Dialogue: C\$120,000;
- M&E: C\$1 million (decreased to \$840,000 in 2009).

Highlights of PASS Implementation

Several key changes have occurred in Bolivia—more specifically in the health sector—since the day development policies were designed and implemented in 2006.¹⁷ Structural transformations have been carried out to build an institutional framework that supports the operation of the new Plurinational State of Bolivia and the achievement of objectives spelled out in the National Development Plan for 2006-2011. The design and implementation of the PASS also occurred in the midst of major policy changes in Canada. The context in which the project was carried out was therefore not optimal. Nevertheless, the joint efforts of CIDA, MSD and other implementing partners helped overcome the constraints associated with policy changes. In addition, decision makers in Canada and personnel in Bolivia worked arduously to unlock administrative barriers faced by the project. UNICEF's involvement was useful to mitigate risks and ensure continuity of the PRICCAS, which constitutes the largest component of the PASS.

In essence, the PASS was developed and executed in two four-year phases:

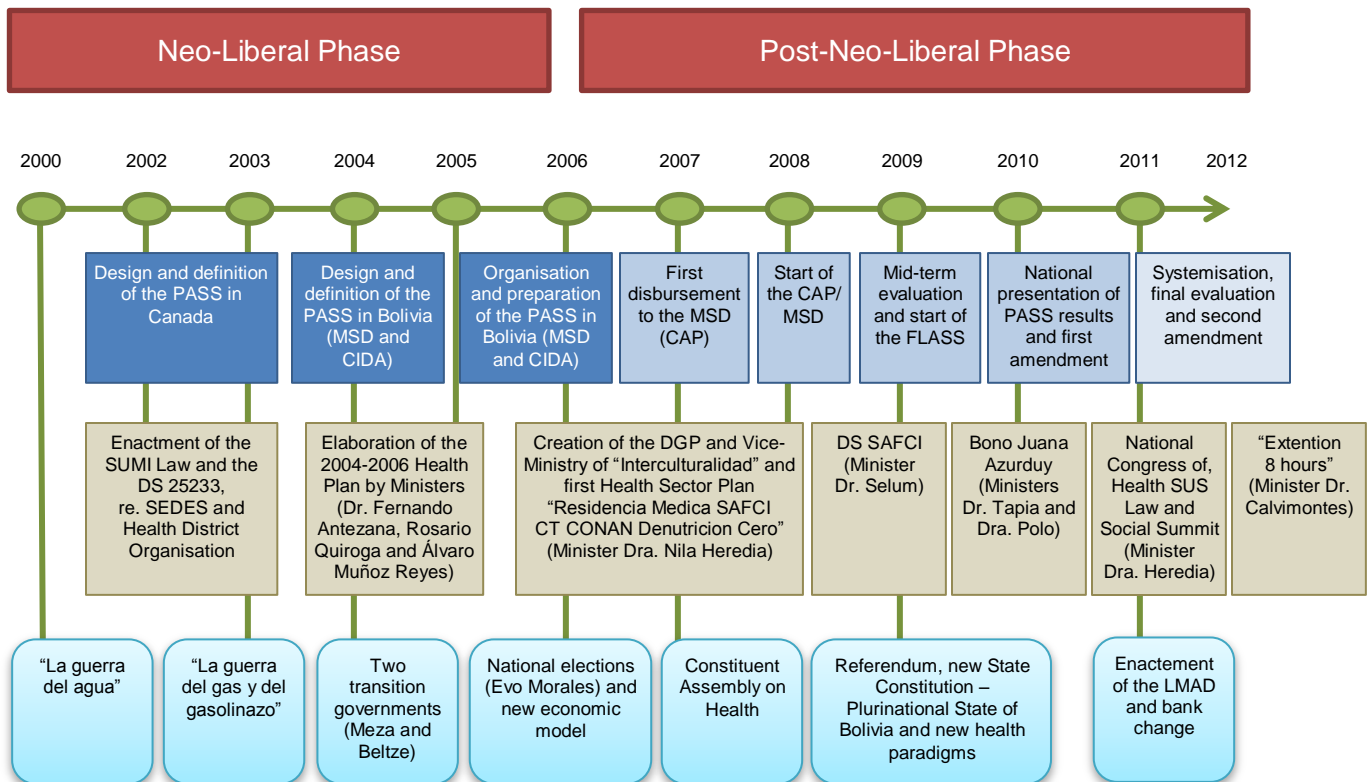
- *Design and organisation (2002-2006)* – During this phase, the strategic objectives and the scope of interventions in the departments of Beni, Pando and Oruro were set out. Negotiations took place with four MSD administrations to finalise definition of the PASS. Approval from the Canadian Minister responsible for CIDA was obtained in September 2005, and one month later a funding agreement was signed by CIDA and UNICEF. Finally, in June 2006, a Memorandum of Understanding was signed by the Canadian and Bolivian governments, in view of implementation of the PASS;
- *Implementation (2007-2011)* – The project was carried out with five different Ministers at the MSD. During this period, extensive technical, political and administrative management work was needed to implement the PASS within the MSD and the three targeted departments. The components were implemented gradually, beginning with the PRICCAS in 2005, then the CAP and the Infrastructure and Equipment component (managed by the FPS). As for the FLASS, it did not start before 2009.

In 2010, an amendment to extend the PASS had to be signed, as a result of delays in initial implementation and difficulties in achieving some key activities. In 2011, the Management Committee of the PASS approved a closure plan. Although PRICCASS, FLASS and FPS components are basically finished, closure activities will extend during 2012.

¹⁷ Diagram 1 summarises the relevant context and timeline of the project for the 2000-2012 period.

Diagram 1
Project/Context Timeline, 2000-2012

The following diagram maps a number of landmark events of the PASS against key points in the recent evolution of Bolivia, both at the national level and within the health sector.



Inspired by, and translated from: Crespo, Dr. G. *Hitos Históricos en las Principales Etapas del PASS*. [n.p.] 2012.

5. KEY FINDINGS

This chapter presents the evaluation's key findings regarding the development-level results associated with effectiveness, cost-effectiveness, relevance and sustainability of the PASS. Quality of the program is also addressed, along with success factors pertaining to soundness of concept and relevance of model, community involvement, management and coordination mechanisms, informed and timely interventions, and gender equity. Observations and findings reported in this chapter are derived from an analysis of key components of the project and their contribution to improving the Bolivian population's health condition and strengthening the public health sector's capacities, particularly in the departments of Beni, Pando and Oruro.

5.1 Development-Level Results

5.1.1 Effectiveness

5.1.1.1 Degree of Achievement of Outcomes

Outcome 1: To what extent has the PASS contributed to effective and equitable access of the population to comprehensive, culturally-appropriate and gender-equitable health services?

In order to achieve this first outcome, the PASS had planned the three following outputs:

- Integrated fixed or mobile health services that are regularly delivered to populations and families, with an emphasis on marginalised towns and communities;
- Organised communities that actively exercise their right to health care and that participate in the social monitoring of health care delivery;
- Families, communities and populations that look over their own health and demand quality health services, taking into account cultural diversity and gender equity.

The Logic Model of the project, shown in Appendix 5, identifies a series of indicators to measure the degree of achievement of such outputs. As mentioned earlier, the monitoring of these indicators was not carried out systematically, and not all indicators were subject to an ongoing evaluation process. Despite this limitation, the lines of evidence tend to indicate that Outcome 1 was achieved to a large extent. As suggested by a majority of sources, the Bolivian population now has fairer, more effective access to comprehensive health services that are culturally appropriate and that focus on gender equity. A selection of progress indicators monitored by UNICEF¹⁸ for selected years (2005, 2008 and 2010), which are found in the PASS Results Framework, are presented in the Table 5. While more recent data than 2011 is not yet available, and that these results cannot be all attributed to the PASS initiative, they suggest that fair progress has been achieved regarding various results and that significant changes will take place in the future. The next census or Demographic and Health Survey will constitute an important milestone providing the data that will allow a sufficient number of years to analyse results progress. In addition the exercise organised by CIDA in next September 2012 consisting in consolidating the systematisation and evaluation exercises results, as well as the outcome of the PASS Final report (produced by MSD) and the "Linea de Salida" study carried out by PRICASS, will complete the process and significantly contribute to forging a much more accurate picture of the PASS results.

The following comments should be taken into consideration:

¹⁸ These indicators have been drawn from the sixth and last available PRICASS – UNICEF report produced in March 2011.

- Regarding Product 1 and the indicator “Iron Supplement,” there have been various circumstances explaining the yearly variations in percentages. One of them is linked to the iron intolerance presented by the infants that forced the Ministry into presenting again the product named “Las Chispitas,” which is now being provided. The other problem relates to the temporary shortage in product distribution that led to a decline in coverage, especially in Oruro. Finally, a lesson learned is the need for a sustained community campaigning about the importance of this supplement. There is some resistance within the population regarding the administration of iron, not only for children, but also for pregnant women.
- Output 2 defined the following indicators: “Number of Community Health Services that carry out health care activities” and “Number of women that take part in Health Committees and Councils.” These activities were sometimes carried out with the health institutions that coordinated with the social organisations and the social structure of the SAFCI as well as with the “local health authorities.” In order to guarantee an increase in women’s participation in the SAFCI’s social structure, an agreement was reached with ACOBOL (Asociacion de Concejalas de Bolivia, i.e. Bolivia’s Councilwomen Association) to strengthen women’s participation and coordinate with municipalities. In the case of Beni, participation was greater due to the work realised with CEMIP and its branches. In the case of Oruro, work was realised in coordination with AMUPEI and its networks.
- It is interesting to notice that Pando has low results, while activities were realised with traditional doctors, indigenous leaders and traditional midwives, along with SEDES Oruro’s Red 3 and Family Care International through the FLASS. According to FLASS reports, up to 100 people were gathered through this activity.
- Once again, there is evidence that the PRICASS indicators only take into account the progresses achieved through the SEDES and UNICEF, while failing to integrate the FLASS projects.
- Regarding Product 3, the information was provided through surveys. In reality, PRICASS did not realise direct interventions, as it was considered that they corresponded to activities of the Global Fund and duplication was not desirable.

Table 5
PRICASS Progress Indicators – Outcome 1

Indicators	Description	2005		2008		2010	
		SEDES	Result	SEDES	Result	SEDES	Result
Output 1: Integrated fixed or mobile health services that are regularly delivered to populations and families, with an emphasis on marginalised towns and communities							
Pentavalent vaccine coverage	Number of children under 1 year of age with third dose of pentavalent over the total number of children under 1 year of age times 100	Beni Pando Oruro	86% 40% 90%	Beni Pando Oruro	90% 100% 94%	Beni Pando Oruro	93% 95% 100%
Iron supplement (0.5 to 2 years)	Number of children aged 6 months to 2 years with iron supplements over the total number of children aged 6 months to 2 years times 100	Beni Pando Oruro	N/A N/A N/A	Beni Pando Oruro	81% 100% 77%	Beni Pando Oruro	83% 100% 90%
Iron supplement (2 to 5 years)	Number of children aged 2 to five years of age over the total number of children aged 2 to 5 times 100	Beni Pando Oruro	61% 56% 34%	Beni Pando Oruro	52% 86% 52%	Beni Pando Oruro	61% 80% 48%
Institutional child birth coverage	Number of in-service childbirths service plus births attended to by trained health care professionals over the total number of births times 100	Beni Pando Oruro	71.4% 60.3% 64%	Beni Pando Oruro	77% 100% 73%	Beni Pando Oruro	82% 76% 80%

Indicators	Description	2005		2008		2010	
		SEDES	Result	SEDES	Result	SEDES	Result
Output 2: Organised communities that actively exercise their right to health care and that participate in the social monitoring of health care delivery							
Number of community health services that carry out health care activities	Number of CHAs trained that carry out maternal/infant health actions	Beni Pando Oruro	ND ND ND	Beni Pando Oruro	340 30 153	Beni Pando Oruro	336 30 184
Number of women's organisations that work on health-related issues	Number of Women's Organisations per municipality that participate in the drafting and evaluation of health APOs.	Beni Pando Oruro	ND ND ND	Beni Pando Oruro	56 12 40	Beni Pando Oruro	62 7 74
Number of women participants in Health Committees and Councils	Number of municipal social councils that have women participating in them over the total number of municipal special councils times 100	Beni Pando Oruro	ND ND ND	Beni Pando Oruro	19 15 35	Beni Pando Oruro	43 35 104
Output 3: Families, communities and populations that look over their own health and demand quality health services, taking into account cultural diversity and gender equity							
Percentage of people who are familiar with the mechanism for vertical transmission of HIV	Number of people who know the mechanisms for vertical HIV transmission over the total number of women interviewed times 100	Beni Pando Oruro	ND ¹⁹ 57.7% 48.8%	Beni Pando Oruro	68.8% 67.5% 46.7%	Beni Pando Oruro	NAND ²⁰ NAND NAND
Percentage of children under 2 with full sets of vaccines	Number of children under 2 with full sets of vaccines over the total number of children under 2 times 100	Beni Pando Oruro	51.5% 51.5% 47.7%	Beni Pando Oruro	87% 76.9% 80%	Beni Pando Oruro	ND ND ND

Comprehensive Model

The PASS comprehensive health care model makes an important contribution to public health, mainly because it rests on a broad vision that extends far beyond the mere handling and curing of prevalent diseases coordinating multiple partners that include MOH, community leaders, NGOs and municipal authorities. The model has set the foundations for enhanced teamwork and improved quality of health care, in support of greater access to services for the general population targeted by the PASS.

Current evidence points to a significant degree of appropriation of the integrated, comprehensive concept of care. Improvements in the response and resolution capacity of services are mainly linked to:

- Increased professional skills and competency;
- The use of proper standards to ensure that medical processes are reliably, accurately and consistently carried out;
- Application of effective case practices and enhanced performance monitoring;
- Greater availability of equipment drugs and supplies;
- Community involvement to assure social sustainability;
- Departmental and Municipal authorities involvement to ensure institutional sustainability.

Benefits of Training

The PRICASS provided technical assistance to develop a three level competency-based training model.

¹⁹ The survey was not made in this Department.

²⁰ The survey does not occur every year and the SNIS does not collect this information.

- Clinical training that increased the motivation of health staff working in the regions.
- Management training, including the development of three curricula, namely:
 - ❖ a strategic communication diploma in nutrition delivered by the *Universidad Mayor de San Andrés*;
 - ❖ a diploma in basic management and public health delivered by the *Universidad Mayor de San Simón*;
 - ❖ a master's degree in public health delivered by the *Universidad NUR*;
- Epidemiology training by means of a curricula inspired by the *Módulo de Principios de Epidemiología para el Control de Enfermedades* (module on the principles of epidemiology for the control of diseases) of the PAHO/World Health Organisation, which helped improve management and effectiveness of the system of indicators used for surveillance and epidemic control. The diploma is delivered by the *Universidad Mayor de San Andrés*.

These diplomas were characterised by the following: 1) The universities discussed the program contents with the MSD, with technical assistance on the part of UNICEF; 2) The universities penetrated the departmental level; 3) The programs included gender equity modules as well as the SAFCI policy.

Clinical training activities generated motivation, promoted safer practices, and increased the self-esteem of participants. In addition, it encouraged health personnel to develop a culture and practices based on “reading and research” while restoring their professional status and scientific capacity, which increased the personnel’s ability to better solve health problems. This was reported in all three departments targeted by the PASS and confirmed by the MSD.

Managerial training assisted in building stronger planning capacities regarding “what needs to be done, how and why.” Consequently, under the leadership of the MSD and the SEDES in Beni, Pando and Oruro, the PRICASS developed a structure to help the REDES operate with financial resources from the municipalities, the departmental governors, the MSD itself, the PRICCAS and other alliances generated through the PASS.

Epidemiological training was well structured and assisted in enhancing the capacity to manage indicators used for the monitoring and epidemiological control of prevalent diseases. Training in food preparation, in support of health personnel competencies in advising the population regarding adequate child nutrition and feeding.

Information, Education and Communication Strategy

An Information, Education and Communication Strategy—involving the use of radio spots, posters and various promotional materials—was implemented in the three targeted departments. The Strategy had an impact on the population, as it encouraged people to assimilate health themes and facilitated their active participation. In addition to promoting health services, the Strategy also made the population, the municipalities and departmental governors more aware to their respective roles and responsibilities in health issues. A significant change in attitude has been observed and reported in this area.

Shared Management and Community Participation

Community participation was inspired by the principle of complementarity and established a “shared management model” concept that transcends the antagonistic, co-management approach of the past. This component has become a key factor to promote intermediation between the health sector, municipal and provincial governments, and the community itself.

Health personnel in the departments recognise and appreciate community involvement, and they relate more strongly to the SAFCI Policy. It is now acknowledged that community participation contributes to ensure sustainability of health care and facilitates access to health services by the population.

At the level of health facilities, communities not only participate in approval of the *Plan Operativo Anual* (POA)—i.e. Annual Operating Plan—, but also in the identification of health-related activities as well as the subsequent execution, monitoring, follow-up and control of implementation of the said activities.

Empowerment

Partly due to Bolivia's recent and current political processes, the notion of a community's right to health has become more prevalent—a sign of empowerment within communities. The views of community leaders have become important and are increasingly heard and taken into account in the decision-making process.

At the local level, the exercise of community rights has become a capacitating, strengthening factor in the health sector. Community organisations are being increasingly vocal with municipal governments, and this has been instrumental in establishing the type of planning process that helps allocate much-needed financial resources to implement health-related POAs.

Social Control and Monitoring

Social control is also a part of the SAFCI Policy. This approach has facilitated the approval of health sector POAs, and has allowed for better monitoring and control of the implementation of activities. Monitoring and control were performed from the planning phase. Programming processes were realized with participation from the social organizations. Monitoring was part of the systematic meetings of the Information Analysis Committees (CAIs) which took place every trimester at the departmental levels. In Oruro, the Institutional Strategic Plan (PEI) was realized through the “muytas” methodology which implied touring the municipalities to collect requests and incorporating them in the plan.

Self-Health Care

Prior to the PRICCAS, self-care was contingent on the *Responsable Popular en Salud* and the *Agentes Comunitarios de Salud*. With the SAFCI Policy, customs and ancestral practices have become a part of health education and are being recognised and integrated in the health system, which increasingly values *Saber Popular* (popular health knowledge and wisdom). The *Autoridad Local de Salud* (ALS)—i.e. Local Health Authority—now acts as the mediator between local health institutions or facilities and the community.

A Health Self-Care Strategy was developed to educate communities in personal, family and community health care, and this has had a positive effect on access to, and demand for, quality community health services. The Strategy has led people to assimilate the importance of healthy lifestyles (e.g. drinking filtered water, washing hands, changing nutritional habits, etc.). This was reinforced by the FLASS projects.

Adjustments to Meet Demand for Health Services

To adjust health services to adequately meet demand, issues like *interculturalidad* (i.e. interculturality), gender (i.e. needs of women and men) and rights were to some extent taken into account, thus underlining the comprehensive, integrated and horizontal nature of health care. Areas for improvement still need to be addressed and are discussed further in the report.

Issues for Consideration

Trained personnel do not yet always have the knowledge and skills required to adequately manage health care services, in part because they have not fully internalised the health care system. A rigorous selection of trainers and trainees is essential to ensure the proper transfer of knowledge regarding health policies and treatment protocols.

In general terms, medical personnel needs to better develop their vision of the concept of *interculturalidad*, and how to incorporate it in the activities of their respective services.

The introduction of gender issues in health care for women and men is not yet fully understood by health personnel, who have a tendency to interpret and manage this concept strictly from the angle of women's health.

Outcome 2: To what extent has the project contributed to improved quality of integrated health services, in terms of resolution capacity, quality, intercultural appropriateness, gender equity, and effectiveness of the control of communicable diseases?

This second outcome involved following outputs:

- Human resources within the REDES who have improved skills (knowledge, practices and judgment) in maternal and child care, comprehensive care for nutritional childhood diseases, expanded immunisation programs, and communicable diseases;
- Networks and priority health facilities with infrastructures and maternal and child care equipment that meet quality standards appropriate to their level;
- Networks and health services that are set up to meet the SAFCI standard and address the needs of communities.

Table 6
PRICASS Progress Indicators – Outcome 2

Indicators	Description	2005		2008		2010	
		SEDES	Result	SEDES	Result	SEDES	Result
Output 1: Human resources within the REDES who have improved skills (knowledge, practices and judgment) in maternal and child care, comprehensive care for nutritional childhood diseases, expanded immunisation programs, and communicable diseases							
Percentage of trained human resources who apply maternal-infant care/nutrition standards	Number of trained human resources that apply norms over the total number trained on norms (sample) times 100	Beni Pando Oruro	ND0 0 0	Beni Pando Oruro	11% 17% ND	Beni Pando Oruro	60% 67% 86%
Output 2: Networks and priority health facilities with infrastructures and maternal and child care equipment that meet quality standards appropriate to their level							
Percentage of infrastructure projects completed-delivered after six months	Number of infrastructure projects satisfactorily completed/delivered to the establishment authorities after 6 months over the total number of projects delivered times 100	Beni Pando Oruro	Building projects not delivered Not delivered Infrastructure not delivered	Beni Pando Oruro	100%(3) 0% Infrastructure not delivered	Beni Pando Oruro	100% 50% (2/4) 100%
Percentage of equipment projects completed-delivered after six months	Number of equipment projects satisfactorily completed/delivered to the establishment after 6 months over the total number of equipment projects delivered times 100	Beni Pando Oruro	Equipment not delivered Equipment not delivered Equipment not delivered	Beni Pando Oruro	100% 0% 100%	Beni Pando Oruro	100% 50% 100%
Percentage of institutions with updated equipment	Number of establishments with updated equipment over the total number of establishments times 100	Beni Pando Oruro	0% 0% 0%	Beni Pando Oruro	70% 60% 100%	Beni Pando Oruro	ND ND 71%
Output 3: Networks and health services that are set up to meet the SAFCI standard and address the needs of communities							
Percentage of emergency and obstetric and neonatal care institutions with equipment	Number of CONE establishments with complete equipment over the total number of CONE establishments times 100	Beni Pando Oruro	ND ND ND	Beni Pando Oruro	ND ND ND	Beni Pando Oruro	40% ND 55%

Some of the lines of evidence used over the course of the evaluation suggest that the PASS was instrumental in improving the overall quality of integrated, comprehensive health care services, taking into consideration

factors such as response capacity, competence, intercultural adaptation, and gender and equity in the effective control of communicable diseases. REDES coordinators recognised improvements in skills in second health facilities personnel who were able to solve health problems, which, in the past, had to be referred to third level hospitals. Unfortunately the figures in Table 6 are not complete as some data are either not available or indicate partial achievement of some key indicators.

Once again, there is evidence of the difficulty to respond to the indicators, as they are numerous and lack an operational definition on their conception and sources of information. As an example, the following can be highlighted:

- The percentage of the personnel in the services applying their skills was measured through a checklist designed by SEDES Oruro with PRICASS support. This checklist is related to knowledge, and not to the verification of skills. Within the instruments of the “Rapid Cycle” model, information exists that could be used to verify the participant’s progress in regards to the use made of their skills. It would be important to update this for the final evaluation.
- Regarding Output 2, the information indicated that only SEDES Oruro has an equipment maintenance operating system for which the equipment inventory is up to date. It could not be transferred to SEDES Beni and SEDES Pando. In the latter, the administrative processes required between SEDES and the authorities caused many delays in equipment and furniture purchases and in infrastructure adaptation.
- Regarding Output 3, during the implementation of the PRICASS, the Ministry of Health, through its Service and Quality Unit (Unidad de Servicios y Calidad), realised a diagnosis of REDES that did not include SEDES Pando and did not prioritise the maternal and neonatal component. This diagnosis was used for the table’s information, but it is worth highlighting that, since this indicator accounts for two healthcare areas, it should have been conceived as two separate indicators.

Infrastructure and Equipment (FPS)

Observations regarding the adequacy and management of infrastructure and equipment vary across regions and reflect specific circumstances. The design and planning of infrastructures did not always systematically take into account the participation or the opinion of health personnel and members of the community. Complaints regarding inadequate or improper infrastructure performance were noted. In some cases, where health personnel were involved in the definition of administrative procedures associated with approval and acquisition of equipment, improved maternal and child health care was observed. To ensure proper quality, comply with relevant standards, and deliver appropriate infrastructure and equipment, the establishment of a specialised office, in charge of these matters within the MSD, would be advisable in the future.

PRICASS provided technical assistance for the standardisation of the mother-child basic equipment in the first and second care level institutions. This partially contributed to the improvement of the technical specifications on the requested equipment.

SAFCI Standards

With respect to implementation of the SAFCI Policy, the PASS served as laboratory, a testing ground. Within the MSD, the UP was responsible for this aspect of the project. As such, it had the merit of steering the implementation process, which succeeded at developing and implementing the Bolivian National Health Policy. At the departmental level, Beni and Oruro succeeded at internalising the SAFCI principles and spirit. The same was not achieved to a similar extent in Pando, however.

Issues for Consideration

Ideally, the construction of infrastructure must directly involve personnel at all stages, from design to delivery.

There is a lack of knowledge regarding the standards and services associated with the *Sistema de Información de Contrataciones Estatales* (information system on State contracts). For instance, as part of the process, the personnel should play a leading role—e.g. to approve the design, attend to and jointly certify the proper execution of work, and certify subsequent acceptance.

Outcome 3: To what extent is there increased capacity within the MSD, the SEDES, the REDES and health institutions to exercise leadership in the health sector, following the operational plans and program frameworks?

The following outputs had been designed to support achievement of Outcome 3:

- Decentralised and participative management model standards, developed and implemented;
- Health interventions that are coordinated and jointly managed by health sector institutional and social stakeholders and by other socio-economic development partners involved in the targeted departments;
- SEDES/municipal plans and programs that align with the Health Sector Development Plan for 2010-2020 and that are duly evaluated;
- Increased health sector investments that are managed efficiently within the SEDES and the municipalities and that support a program approach to health care;
- MSD, SEDES and DILOS officials who strengthen their management capacity within the health sector;
- Generally effective and efficient management of PASS components, thanks in part to the active participation and continuous accompaniment of CIDA representatives during the course of the project.

Table 7
PRICASS Progress Indicators – Outcome 3

Indicators	Description	2005		2008		2010	
		SEDES	Result	SEDES	Result	SEDES	Result
Output 1: Institutional health management standards, applied by the MSD and the SEDES							
Percentage of the SEDES that implement planning and programming standards	Number of SEDES that implement planning and programming norms over the total number of SEDES times 100	Beni Pando Oruro	ND 0% ND	Beni Pando Oruro	100% ND ND	Beni Pando Oruro	100% ND ND
Investment and spending standards implemented within the MSD and the SEDES	Investment and spending norms implementing over the total number of norms times 100 (within MSD and SEDES)	Beni Pando Oruro	ND ND ND	Beni Pando Oruro	ND ND 100%	Beni Pando Oruro	ND 100% 100%
Percentage of the SEDES that implement specific MSD provisions	% of SEDES that implement specific provisions and norms issued by MSD	Beni Pando Oruro	100% ND ND	Beni Pando Oruro	100% ND ND	Beni Pando Oruro	100% ND ND
Output 2: Increased health sector investments that are managed efficiently within the SEDES and the municipalities and that support a program approach to health care							
Percentage of execution of MSD programs and projects		Beni Pando Oruro	100% 100% 80%	Beni Pando Oruro	100% 100% 83%	Beni Pando Oruro	100% 100% 100%
Output 3: Strengthened information analysis and planning capacity with the MSD, the SEDES and management							

Indicators	Description	2005		2008		2010	
		SEDES	Result	SEDES	Result	SEDES	Result
Percentage of national, departmental and municipal IACs that analyse information on inequalities in healthcare, including gender	Number of departmental IACs that analyse information on inequalities in healthcare, including gender, over the total number of IACs times 100	Beni Pando Oruro	0% 0% 0%	Beni Pando Oruro	25% 25% 25%	Beni Pando Oruro	100% 100% 100%
	Number of municipal IACs that analyse information on inequalities in healthcare, including gender, over the total number of IACs times 100	Beni Pando Oruro	0% 0% 0%	Beni Pando Oruro	0% 0% 0%	Beni Pando Oruro	50% 25% 50%
	Number of IAC networks that analyse information on inequalities in healthcare, including gender, over the total number of IACs times 100	Beni Pando Oruro	0% 0% 0%	Beni Pando Oruro	0% 0% 0%	Beni Pando Oruro	50% 40% 70%
% of SEDES and Health Networks that fulfill at least 80% of their yearly commitments	Number of SEDES that fulfill at least of their yearly commitments over the total number of SEDES times 100	Beni Pando Oruro	No No=0% No	Beni Pando Oruro	Yes Yes Yes	Beni Pando Oruro	No= 33% No=33% Yes=81%
	Number of Health Networks that fulfil at least 80% of their yearly commitments over the total number of SEDES times 100	Beni Pando Oruro	40% 50% 50%	Beni Pando Oruro	80% 60% 80%	Beni Pando Oruro	50% 33% 68%
% of results from MSD, SEDES and Network Management APOs	Number of results achieved by SEDES over the total number of expected results times 100	Beni Pando Oruro	ND ND ND	Beni Pando Oruro	ND ND ND	Beni Pando Oruro	72% 33% 69%
	Number of results achieved by Health Networks over the total number of expected results times 100	Beni Pando Oruro	ND ND ND	Beni Pando Oruro	ND ND ND	Beni Pando Oruro	60% 50%
% of SEDES and municipal APOs that allocate resources to gender-based interventions	Number of Municipal APOs that allocate resources to gender-based interventions over the total number of municipalities times 100	Beni Pando Oruro	ND ND ND	Beni Pando Oruro	ND ND ND	Beni Pando Oruro	100% 100% 100%
	Number of SEDES APOs that allocate resources to gender-based interventions over the total number of municipalities times 100	Beni Pando Oruro	ND ND ND	Beni Pando Oruro	ND ND ND	Beni Pando Oruro	100% 27% 100% ²¹

Role of the DGP

The MSD-DGP played a critical role in implementation of the PASS—a noteworthy achievement on two accounts. First, working jointly with CIDA, the DGP was successful at carrying out the PASS, which was efficiently managed overall, and at rising up to the challenge of having multiple institutional and social actors team up to support a common cause. Second, the DGP was successful at validating the SAFCI Policy and other instruments and strategies entailed in the implementation process, thus exerting significant influence on the development of Bolivia's health system as a whole.

Nonetheless, during the implementation of the PASS, more support than initially planned was required from the UASCC through the healthcare official and the coordinator of the PRICASS in order to accompany the implementation processes. Additionally, the DGP employee that took part in the Program was contractual, which meant that once this contract ended, they did not work anymore in this Direction. This loss in qualified human resources caused a weakening of the team's management capacity and of its institutional memory.

²¹ Some of data found in the table is not totally aligned with the answers of respondents on some of the issues, notably regarding gender-based interventions.

Knowledge of the Legal Framework

Personnel at the MSD gained sound knowledge of the Health Sector's legal framework. Work achieved by the DGP led to the design and validation of legal instruments that supported the PASS implementation process.

Involvement of Municipalities

The PASS, through the PRICASS component, was successful in getting municipalities²² on board, to influence budget allocations for health, and to devise funding strategies with high-impact content on health issues, such as multi-program campaigns. Strong municipal participation acts as the foundation of future program sustainability.

Leadership

The MSD-DGP exercised specific administrative and technical leadership to articulate and supplement the various components of the PASS (i.e. CAP, FPS, PRICCAS and FLASS). Although it had to deal with multiple public institutional actors, NGOs and others social actors, the DGP exercised enough leadership to bring them around to perform all of the activities associated with this complex undertaking.

As part of the operational plans and programs, the MSD, the SEDES and the health institutions and facilities enhanced their capacity to take on a leading role in the health sector. To some extent, the PASS succeeded at strengthening the DGPs at the national and departmental level, which led to improve their planning, programming and follow-up of coordinators of the REDES, and to better ensure overall intersectorial and inter-agency coordination. However, it is important to take into account the previous comment about the contractual personnel whose departure weakened the institution's leadership role. In the case of Oruro, 2 new staff members for the Planning Unit were incorporated, which allowed retaining the human resources.

Alignment and Harmonisation

The CAP was successful at disseminating and explaining the new health sectorial approach to international cooperation actors and at fostering appropriation of this approach among these actors. In turn, this strengthened the MSD's capacity to align and harmonise with cooperation efforts while promoting the importance of sound financial management internally, as a means of achieving institutional sustainability. With CIDA's assistance, the MSD is in the process of developing a code of conduct and rules of operation for the Sector-Wide Approach in health, and designed a critical path for future action involving international donors. The recent nomination of a new minister with the various changes this implies has put a halt for now to discussions to this effect.

Results-Based Management

So far, a harmonious development and systematic application of RBM in the health sector have not been fully achieved, although groundwork for future progress in this area has been laid. Though quite a lot of work remains to be carried out in this regard, in particular in the development of monitoring indicators, technical assistance provided by CIDA helped consolidate the RBM system within the MSD. This has increased to some extent the effectiveness and impact of public health policies, made budget allocations more transparent, enhanced the responsibility of MSD officials for results, and improved accountability at different levels, including with civil society.

Other Successes

²² No precise figures on the number and percentage of involved municipalities that have actively participated and allocated earmarked budgets to health activities have been produced and made available as yet.

Via its CAP component, the PASS had several other meaningful and/or promising experiences, such as consolidation of implementation of the *Sistema Integrado de Gestión y Modernización Administrativa* (SIGMA), an integrated system to support management and administrative modernisation. SIGMA acts as primary tool for the management, administration and control of public resources, for the creation of the Sector-Wide Approach, and for consolidating the fight against corruption through the preparation and presentation of quarterly reports addressed at the civil society. Another meaningful achievement has been the accreditation of hospitals with the *Hospitales Amigos de la Madre y del Niño* (HAMN)—an initiative that supports epidemiological surveillance systems, enables service staff to meet the demands of the population, and helps the REDES handle obstetric and neonatal care emergencies.

5.1.1.2 Contribution of the FLASS to Achievement of Outcomes

Generally speaking, all FLASS projects contributed to the development of operational models towards the achievement of results, especially Outcome 1 (i.e. effective and equitable access) and Outcome 3 (i.e. capacity to exercise leadership). Indeed, in complementarity with other components of the PASS, small-scale projects associated with the FLASS primarily focussed on community participation, self-health care, health promotion and education, the extension of health services, the strengthening of grassroots organisations, leaders and municipal authorities, and local co-management in health. Indirectly, the FLASS component also contributed to Outcome 2 (i.e. improved quality of health services), as some of its projects aimed at strengthening the dialogue between users and services, to get more adequate and appropriate answers from health facilities.

Although their individual Logic Models were not necessarily linked to the overall PASS Logic Model, all projects were designed on the basis of a results framework. Each individual Logic Model emphasised various themes that related to the PASS results, such as maternal and child health, access to water, nutrition, community building, and the like. On the whole, FLASS projects consistently achieved all of their expected results.

5.1.1.3 General perception of key respondents regarding results

Generally speaking the vast majority of PASS actors at all levels were very laudatory when asked to identify the main accomplishments derived from project activities, and where they feel the PASS has contributed the most. Table 8 below reports on a sample of key observed results, on the basis of the SEDES, REDES and hospitals representatives' perception, and their own personal and corporate experience with the project. A solid portion of these are shared by all three departments which translates in the capacity of the project to implementing a coherent model of interventions in quite different and distinct political, economic and cultural environments in the said departments.

Table 8
Perception of Respondents (SEDES, REDES and Hospitals) Regarding Key Results

Results	Departments		
	Oruro	Beni	Pando
Quality and coverage of health services			
Reduction in maternal, neonatal and child mortality, and chronic malnutrition	✓	✓	✓
General improvement in program coverage and quality of care	✓	✓	✓
Improvement in the performance of indicators and better capacity to prioritise and reach a consensus on the indicators	✓	✓	✓
Better access to first-tier health care services	✓	✓	✓
General strengthening of health programs and better reach of the target population	✓	✓	
Stronger communication strategies, leading to enhanced promotion of healthy practices		✓	✓
Clinical and professional capacity of health practitioners			

Results	Departments		
	Oruro	Beni	Pando
Strengthening of gender units in Headquarters and in the SEDES, and development of activities pertaining to domestic violence	✓		
Effective epidemiological surveillance systems	✓		
Better-trained personnel who have enhanced their capacity to meet the population's demand, and improved their ability to address the control and monitoring of prevalent diseases	✓	✓	✓
Improved response capacity of second-tier institutions, resulting in a lesser burden for third-tier institutions (i.e. hospitals)	✓	✓	✓
Improved operations of the training centers	✓	✓	

Results	Departments		
	Oruro	Beni	Pando
Management-related results			
Improved intrasectorial coordination and inter-agency support, and more effective departmental and local budget planning	✓	✓	✓
Strengthening of the DGPs at the national and departmental levels (via the CAP)	✓	✓	✓
Strengthened leadership, management and stewardship for health structures, departmental governors, municipalities, NGOs and authorities at the community level	✓	✓	✓
Improved programming activities, and enhanced monitoring of coordinators of the REDES by directors of the SEDES	✓	✓	✓
Improved coordination with municipalities and communities	✓	✓	✓
Improved project design and management, as a result of RBM training	✓	✓	
Economic resources that facilitate coordination meetings and program monitoring	✓	✓	✓
Improved hospital management, and standardisation of supervision the <i>Seguro Universal Materno-Infantil</i> (SUMI), Bolivia's Universal Maternal and Infant Insurance Program	✓	✓	✓
Development of integrated departmental health plans	✓	✓	✓
Multi-program campaigns and improved coordination between programs		✓	✓
Reinforcement of the SAFCI social networks structure, and support to the operations of ALS, Municipal Social Health Councils, and Departmental Health Councils	✓	✓	✓
Other results			
Adolescent population better prepared for the prevention of early pregnancy			✓
Accreditation of hospitals with the HAMN	✓	✓	✓
Participation in networks involved in the fight against violence	✓		✓
Changes in the attitude of health personnel (i.e. increased professionalism)	✓	✓	✓
Strategic links established between nutrition and diseases prevalent in childhood	✓	✓	✓
Improved infrastructure and equipment for institutions, to improve their resolution ability		✓	✓
Intercultural spaces created within health institutions	✓	✓	✓

5.1.2 Cost-Effectiveness

Resources disbursed by CIDA in support of the PASS components accounted for some 97.5% of the total allocated amount, as shown in Table 9.

Table 9
Disbursement and Execution by Component (C\$)

	CAP	PRICASS	FPS	FLASS	Policy Dialogue	M&E	Total
Initial allocation	1,700,000	10,400,000	4,500,000	680,000	120,000	1,120,000	18,400,000
Amended allocation (2011)	1,700,000	10,400,000	4,500,000	840,000	120,000	840,000	18,400,000
Disbursements	1,700,000	10,400,000	4,406,660	834,364	10,200	500,095	17,851,319
Execution as of April 2012							

As indicated in the mid-term evaluation, and as is also currently the case, the percentage of disbursements is significant. Therefore, there appears to be no problem with the amount and timeliness of disbursements made by CIDA, in support of the various PASS components.

However, significant delays in the transfer of disbursements from the MSD to the SEDES were noted over the course of the project, a situation that has led to repeated delays—varying between 6 and 17 months—in

implementation of the POAs. The underlying factors behind these delays are administrative in nature, (i.e. approval and registration of the POAs, opening of relevant fiscal accounts, etc.). This demonstrates the certain limitations regarding management capacity observed among stakeholders, from the SEDES to the *Viceministerio de Inversión Pública y Financiamiento Externo* (VIPFE)—or Vice Ministry of Public Investment and External Financing—, including departmental governor offices and the MSD.

As for budget execution, it has not been up to speed compared to resources disbursed for each component. This points to difficulties associated with the utilisation of resources on hand.

Because it has its own procurement and payment systems that help avoid much government bureaucracy, UNICEF has been able to disburse adequately, more or less as scheduled, despite some problems associated with the rendering of accounts by municipalities and other beneficiaries that received resources for specific activities. The FPS will reach its objective of disbursing 100% of the committed funds. Budget execution for M&E is 60%. Unused funds have been reallocated to other components, such as the FLASS, and could be used for post-project activities. Close to 100 % of budgeted allocations for the FLASS have been executed. Finally, budget execution for the CAP amounts to 100%.

Delays in financial execution during the course of the project have been caused by the following, specific factors:

- Bureaucracy witnessed at various levels, including: excessive concentration of operational decisions within the MSD; delays in the procurement and disbursement process experienced within the branch responsible for the general handling of administrative affairs; delays in consultancy agreements occurring within the branch responsible for legal affairs; and delays associated with budget registration and modifications within the VIPFE and the *Ministerio de Economía y Finanzas Públicas* (Ministry of Economy and Finance).
- The simultaneous consideration of three SEDES as a unit had a negative effect on those that could proceed more rapidly with implementation, as they had to wait for others to account for their funds before accessing new disbursements from MSD
- Disbursements could only be made during the second half of the year. In this context, delays in disbursements resulted in activities taking place over a span of a few months, at a time when some municipalities could hardly be accessed due to the rainy season (i.e. in Beni and Pando). UNICEF initially faced the same problem with its disbursements to departments and municipalities.

Table 10
Overview of Financial Results, by PASS Component

Year	Financial Results			Comments
	Planned ²³	Disbursed	Achieved	
FPS – Total contribution: \$C4,500,000 (approximately US\$3,729,000)				
	US\$	US\$		
2008	1,305,100	1,254,145	96%	Includes three months in 2007, October to December.
2009	1,241,939	1,203,593	97%	
2010	952,920	838,570	88%	
2011	821,906	747,934	91%	

²³ The yearly planned amounts include undisbursed amounts from previous years.

Year	Financial Results			Comments
	Planned ²³	Disbursed	Achieved	
2012	337,316.47	In process	In process	The FPS (like the CAP) has been extended from January to June 2012 to run a balance of \$337,316.47 in the purchase of equipment. The latter has previously been endorsed by a Committee formed for that purpose by the <i>Dirección General de Planificación</i> (DGP)—i.e., Planning Directorate—of the MSD, UNICEF and CIDA. The balance is currently being implemented.
General remarks:				
<ul style="list-style-type: none"> The annual reporting of FPS financial information is aggregated on a yearly basis, although this component is not designed or implemented following such a schedule. Several cross-checks had to be made by CIDA to come up with these figures. In addition to CIDA's contribution (\$C4,500,000 or its equivalent, estimated at US\$3,729,602), 45 infrastructure and equipment projects received counterpart contributions through a local partner (a mandatory requirement), beginning with a 21.7% of CIDA that subsequently increased to 54% (especially in Pando). 				
PRICCAS – Total contribution: \$C10,000,000 (approximately US\$8,040,000)				
US\$		US\$		
2005	1,095,000	188,270	17%	The agreement with UNICEF was signed on October 17, 2005, and the first disbursement was received on October 25, 2005. Implementation only covers the last two months of 2005. The balance of funds was allocated to programming of the PRICCAS 2006.
2006	2,263,716	1,950,822	86%	
2007	2,490,421	2,467,439	99%	
2008	1,442,441	1,098,827	76%	
2009	1,340,496	1,340,496	100%	
2010	1,574,614	1,215,634	77%	
2011		211,284		The UNICEF component was completed in December 2010, at the same time as PRICCAS programming. A balance of US\$211,284 was used for selected activities in Oruro and Pando, however.
CAP-MSD – Total contribution: \$C1,700,000				
Bs.		Bs.		
2007-2008	2,007,987	1,961,709 (1,248,420 for the SEDES)	98%	<ul style="list-style-type: none"> CAP programming began in March 2007, and the first execution summary table was produced for the March 2007-December 2008 period. Percentage of achievement excluding transfers to the SEDES = 36%.
2009	2,245,325	1,543,528 (1,016,865 for the SEDES)	69%	<ul style="list-style-type: none"> Percentage of achievement excluding transfers to the SEDES = 23%.
2010	2,873,250	1,426,443 (900,000 for the SEDES)	50%	<ul style="list-style-type: none"> Percentage of achievement excluding transfers to the SEDES = 18%.
2011	6,883,059	5,547,051 (2,000,044 for the SEDES)	81%	<ul style="list-style-type: none"> Percentage of achievement excluding transfers to the SEDES = 52%.
2012	1,974,598	In process	In process	<ul style="list-style-type: none"> The DGP (like the FPS) has been extended from January to June 2012 to run a balance of Bs.1,974,598 in the closure plan of the PASS (audit, final reports, systematisation, closing shop, etc.). This balance is currently being implemented.
General remarks:				
It should be noted that the DGP includes transfers made to the SEDES in its schedule (as if they were an activity). Excluding the share for transfers would result in lower annual implementation figures for the DGP's own planned activities.				
SEDES				
Bs.		Bs.		
Oruro				
2008	416,140	350,148	84%	
2009	-	-	-	No reports were made available for the three SEDES for 2009. Therefore, no information on budget execution was found for the three departments.
2010	1,644,012	890,911	54 %	
2011	600,044	561,140	94%	

Year	Financial Results			Comments
	Planned ²³	Disbursed	Achieved	
Beni				
2008	509,648	228,077	45%	
2009	-	-	-	
2010	380,068	291,235	77%	
2011	821,209	797,493	97%	
Pando				
2008	416,140	287,530	69%	
2009	-	-	-	
2010	937,029	108,630	12%	
2011	750,000	725,344	97%	

Source: Informe Final, Programa de Apoyo al Sector Salud (PASS) Componente, Fondos Locales de Apoyo al Sector Salud (FLASS), ACIDI Bolivia, Abril 2012

Reasonable Ratio between Costs and Outcome Results

Cost-effectiveness analysis (CEA), which was developed in the 1970s as a tool for healthcare decision-making, is a form of economic analysis that compares the relative costs and outcomes of two or more courses of action, which is distinct from cost-benefit analysis, which assigns a monetary value to the measure of effect. CEA is often used in the field of health services, where it may be inappropriate to monetise health effect. The CEA is usually expressed in terms of a ratio where the denominator is a gain in health from a measure (years of life, premature births averted, sight-years gained) and the numerator is the cost associated with the health gain. CEA was initially applied in the clinical arena but has recently been used to evaluate health policies, programs, and interventions. It is therefore generally used to either compare alternative programs with a common health outcome, or assess the consequences of expanding an existing program.

This evaluation exercise did not plan for this type of analysis which would obviously require a much more rigorous and sophisticated (and costly) approach and apparatus to gather and analyse such information and data. In addition, a CEA draws its value from the comparative dimension, which is not part of this mandate.

Can one risk assessing the value of the PASS, the relation between the cost and effects, based solely on the observations collated in the course of this evaluation, with a sufficient degree of assurance? Probably not. Instinctively however, the project provides evidence and demonstrates signs that significant results have been achieved in a complex environment, on a very significant geographical area, with a vast array of inputs, and the involvement of an impressive number of actors and stakeholders, within an important, but all things considered, reasonable budget for a project of such amplitude and (potentially) sustainable results.

5.1.3 Relevance

5.1.3.1 Relevance of the PASS with regards to the Health Sector Development Plan

Upon coming into power in 2006, the Bolivian authorities identified four main problems that negatively affected the high mortality and morbidity rates for new mothers and infants, children's health, and nutritional issues:

- The first problem concerns the difficulties faced by the Bolivian population, especially those in rural areas, in accessing services with quality, equity, and respectful care;
- Second, first- and second-tier health facilities focus mainly on clinical activities and lack well-trained human resources and supplies to improve their health services response capacity;

- Third, the composition of the staff employed at health facilities does not reflect the country's ethnic diversity, nor are the communities participating in the development, management, and supervision of local health plans;
- Lastly, health personnel at the local, departmental, and national levels have limited managerial (both technical and financial) and planning capacities for implementing programs.

Partners at the local, departmental, and national levels, MSD authorities and project implementers all agreed that the PASS was “very relevant and crucial to improve Bolivia’s health indicators.” Table 11 lists evidence of alignment of the PASS logic model with the Health Sector Development Plan of Bolivia. This alignment is believed to be the product of a participatory project design process, and CIDA’s readiness to incorporate MSD demands when defining the purpose and expected outcomes of the project.

Coordinators of the REDES in all three targeted regions recognised that the PASS gave them an opportunity to incorporate innovative programming methodologies and supervision systems to improve their performance. Community leaders interviewed during the field visits declared that “coordination between health personnel and communities has improved,” “now they listen to us,” and “we can bring in our ideas.”

Table 11
Evidence of Alignment between the Health Sector Development Plan and the PASS

Health Sector Development Plan 2010-2020	PASS
Strive towards universal health	Improve primary health care public services and strengthen public management capacities in this area, especially in the targeted departments
Eliminate social exclusion in health through coverage extension and strengthening of the REDES	Effective and equitable access of the population to comprehensive, culturally-appropriate and gender-equitable health care services
Promote health by developing healthy environments, improving nutrition and food, reducing violence, integrating disabled people, managing environmental risks, and encouraging community mobilisation, education, and communication	Improved quality of comprehensive health services, especially with respect to health resolution capacities, quality, intercultural appropriateness, and effectiveness in controlling illnesses
Re-establish the MSD’s sovereignty and leadership role through management and financial coordination measures	The MSD, the SEDES, the REDES and health care institutions all have an increased capacity to exert authority in sanitary matters within operational plans and programs

5.1.3.2 Relevance of the PASS with regards to the targeted populations’ needs

At the moment of the design of the project, the baseline study carried out by UNICEF highlighted the following:

- Not all women know about the Universal Maternal and Infant Insurance Program (SUMI), and hence do not use health services;
- Limited knowledge of communicable diseases – therefore protective measures are not always taken;

- In Oruro, Beni, and Pando, only 50% of the women surveyed knew about Tuberculosis, Dengue and Leishmaniasis;
- In Oruro and Pando, only 20% and 40% of women respectively, knew about HIV/AIDS;
- 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 delivery, 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.

PRICCAS and FPS are quite relevant to addressing the needs and realities in the three departments regarding the expansion of coverage and focus on quality medical standards. The PRICASS information, education and communication component disseminates key messages to local populations with a view to improving their knowledge and enhancing their capacity to seek proper and adequate health care.

The combination of strategies to improve coverage and quality of health care (infrastructure construction or remodelling, adequate equipment, training of health care providers and practitioners; management strengthening), are collectively contributing to improve geographic, economic and cultural access to services. A striking result of this is that community demand has been consistently increasing through mobilisation and community participation strategies and activities.

5.1.3.3 Relevance of the PASS with regards to CIDA's priorities and MDGs

The PASS is in line with CIDA's priorities namely reduction of child and maternal mortality, promotion of gender equity, and improved access to health services. Bolivia is one of CIDA's concentration countries, and the PASS approach and strategies promote local ownership and an RBM approach—as articulated in Canada's Policy Statement on Strengthening Aid Effectiveness.

Gender equality is addressed mainly through the PRICASS and FLASS components. Participation of women in training events and the promotion of women as traditional birth attendants and health promoters empower them to realise 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 establishments.

The PASS is based on the core principles of sustainability, participation, RBM and gender equity, i.e.: consultation and coordination with all partners; participation, support, commitment and ownership on the part of institutional officials of the MSD and Departmental Headquarters; participation of women in the planning and implementation of various activities, in particular training.

Finally, the PASS is designed to help Bolivia progress towards the achievement of four Millennium Development Goals (MDGs): MDG 1 – “Eradicate extreme poverty and hunger;” MDG 4 – “Reduce child mortality;” MDG 5 – “Improve maternal health;” MDG 6 – “Combat HIV/aids, malaria and other diseases.”

5.1.4 Sustainability

The notion of “sustainability” is analysed from a broad perspective that encompasses its technical, social, institutional, and financial dimensions. Technical sustainability relates to the skills and inputs of the personnel trained by the PASS, including their capacity to maintain or expand interventions, software, and practices as well as their leadership skills. Institutional sustainability is related to the capacity of central and departmental

levels to maintain assets gained through the project. Financial sustainability is linked to the ability to leverage funds or access new funding sources, be they international or national. Social sustainability is understood as the partnerships, networks, and communities that sustain project results that improve the quality of life for communities targeted by the project, and that ensure that such improvements are maintained.

Both the PIP (2007) and Outcome 3 of the logic model state that there is “increased capacity within the MSD, the SEDES, the REDES and health institutions to exercise leadership in the health sector, following the operational plans and program frameworks” (2009) and that that to accomplish this result, the PASS must “reinforce the financing capacity at every level”—thus sustainability was addressed explicitly. Some indicators that refer to municipal budgets were also identified. However, fewer systematic efforts were developed, especially during the last few months of the project, to ensure that a Sustainability Plan would be put into practice. In spite of this situation, some promising sustainable interventions and components of the PASS deserve to be highlighted, alongside challenges that lay ahead.

Technical Sustainability

Skills developed during the training sessions were identified as an asset that enables practitioners to enhance sustainability regarding improved capacity to solve health problems, and to enhance quality of care and interaction with clients to maintain the coverage of newborn, maternal, children’s and nutritional interventions observed during PASS implementation, especially with the PRICCAS. Examples of practices were given, such as attention to birth, neonatal resuscitation expertise, attention to cases of malnutrition, tuberculosis detection and treatment, and the HIV rapid test, showing that second-tier health institutions personnel are in fact solving rather than referring cases on to the third-tier hospitals, which used to be common practice.

Ownership of adopted methodologies, such as “RBM approaches,” “short cycles towards continuous improvement of quality attention,” “referral and return of cases” and “multi-program supervision visits,” were also identified as practices that have been continued following the termination of project activities.

The participatory process used by the SEDES to prepare their departmental plans allowed other projects and donors to share methodologies, which they then implemented in other geographic areas. These methodologies have also been instrumental in ensuring sustainability. The SEDES and REDES have acknowledged that they have the political will, commitment, and technical expertise to maintain and disseminate these methodologies.

As mentioned previously, another element to reflect on is how to ensure experience sharing between components, in this case, between PRICASS and FLASS, and how these exchanges strengthen the social structure of SAFCI and of the healthcare services. It is worthy noting that most of the projects approved by FLASS were from international organizations, due to the fact that their proposals were better structured and more innovative. Even if most FLASS projects were realized with the municipalities²⁴ and the social organizations, so that the social structures of the SAFCI were reinforced, the challenge remains to find mechanisms to generate incentives for local social organizations to participate directly in these financing opportunities and to guarantee that they can appropriate the technical experience to replicate it.

Social Sustainability

The strengthening of social networks and bridging of the latter with health services are practices that are still in use in most of the REDES. This will ensure that communities, mothers, and local authorities request and will expect quality services in the future.

²⁴ Municipalities : San Pedro de Totora, Eucaliptus, Corque, Huayllamarca, Belen de Andamarca, among others; base women organizations in Eucaliptus and el Choro; Local Healthcare Agents and Municipal Health Councils in Reyes, Rurrenabaque, Santa Rosa, San Borja, Action Plans in Trinidad Rural and San Ignacio, Networks of traditional doctors in Red 3 de Pando (see table 12).

The recognition of intercultural practices and gender approaches as quality assurance elements is still in process. However, these have been incorporated to a certain extent in the discourse of health facilities personnel. Although reinforcement will be needed, a first significant step has already been made.

Financial Sustainability

All of the people contacted from the three SEDES identified departmental governments and municipalities as potential, concrete sources of funding for some interventions, such as multi-program supervisions, the purchasing of supplies, the maintenance of equipment, and the construction or adaptation of health infrastructures using an intercultural approach. This practice is already in place, but faces some limitations due to limited budgets. However, including local and departmental governments as partners has contributed to the development of a sense of ownership of, and responsibility in, their role within the MSD to support the health of constituents.

During the implementation of the program, the coordinators of the REDES of Beni actively conferred with other projects developed by other donors—such as the *Gestión y Calidad* project by JHPIEGO and the United States Agency for International Development (USAID)—to leverage funds to develop activities or to scale them up.

There is more sustainability potential and responsibility at the regional level. The SEDES can obtain support and resources from departmental and municipal governments. In fact, the Bolivia's *Ley de Participación Popular* (Popular Participation Law) requires that both levels include funding for health in their annual operating plans. This includes management of the *Seguro Universal Materno-Infantil* (SUMI)—Bolivia's Universal Maternal and Infant Insurance Program—, the payment of utilities, the maintenance and repair of health facilities, and other activities. Examples of municipal support to the PASS include the formulation of Nutribebé® supplements for the complementary feeding program, included in the SUMI (purchase of zinc, formula 100, rehydration salts of low osmolarity which then became part of the zinc) and to cover expenses for gasoline and maintenance for ambulances and other vehicles. However, if significant actions are to be continued, municipal governments will need to make greater commitments.

In order to improve the sustainability potential of key program activities, the PASS needs to focus on how to increase financial commitments by the MSD, departmental governments, and municipal governments. Information regarding financial contributions has not been collected or analysed by the PASS.

Institutional Sustainability

Managing interactions between MSD/municipalities and community elements has proven to be a condition for maintaining results.

There is limited potential for the MSD and municipal governments to provide resources on a constant and continuous basis, and to maintain some assets of the PASS. However, since the PASS is well integrated into the MSD system, primarily through the PRICCAS, many activities will continue to be implemented, especially those that the MSD traditionally supports.

Based on interviews and discussions, the authorities at different levels have the potential to carry out several activities that were launched by the PASS. Among these are: the development and formulation of national plans for maternal, neonatal, and infant health; continued public sector funding for national health programs (i.e. immunisation programs linked with nutrition and integrated management of childhood illnesses; maternal and reproductive health; micronutrient and food fortification; or communicable disease control such as tuberculosis, malaria, dengue, HIV/aids); functioning of Committees in charge of health data analysis and decision-making; repair and maintenance of health posts and centres; national Management and Technical Committees; and the implementation of joint municipal and community public health Governance Councils, Committees, and activities.

However, some actions are less likely to be pursued on a sustained basis. Among these are: promoting the leadership role of the MSD in aligning the annual operating programming for sector policies and in implementing national programs; the setting up of mobile brigades; human resources development at the local level, in particular with post-graduate training in epidemiology and strategic communications in public health; training of leaders at the municipal level to improve their public governance; provision of equipment for health posts and centres; and the implementation of infrastructure projects to improve and expand health posts and centres.

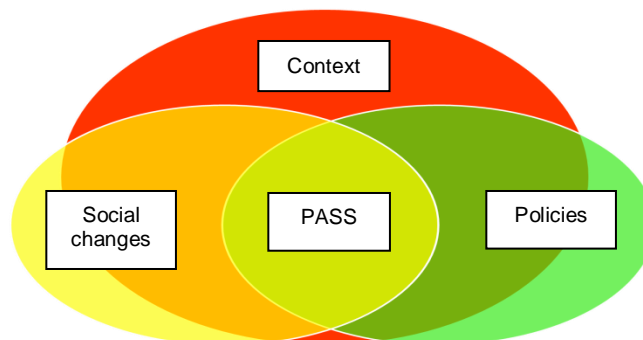
The DGP is an important element within the MSD and a priority for the donors, namely because this unit is responsible for providing leadership in achieving country-wide health goals, objectives, and priorities. In order for the DGP to be viable after PASS funding ends, the MSD needs to buy into supporting it. This would mean creating and funding permanent positions within the MSD.

5.2 Quality of Partnership

5.2.1 Local Ownership, Harmonisation and Alignment

The PASS began its design in 2002 and was implemented in 2007. The complexity of the international and national context resulted in some design difficulties, as the project had to reflect major transformations occurring in Bolivia. The PASS also had to be implemented in a “special” manner, given that the planning process occurred in evolving political environments. The developers of the program emphasised the importance of analysing the PASS by considering three dimensions, pictured in Diagram 2.

Diagram 2
Dimensions of the PASS



At the global level, in 2006, the Paris Declaration introduced the need to address the complex bureaucratic and fragmented international support mechanisms, as part of the debate about the international aid system. It also recognised that aligning and harmonising national policies would create ownership and enhance programs geared towards results and accountability of partners. At the national level, the new government of Bolivia was encountering significant changes while developing a new economic and social model where State sovereignty and stewardship were central issues. For example, the *Plan Nacional de Desarrollo 2006-2011* emphasises the importance of stewardship by the MSD, and policies and standards were developed to support this new paradigm. Jointly with the DGP, representatives of UNICEF and the *Unidad de Apoyo de Servicios de la Cooperación Canadiense* (UASCC), or Program Support Unit of the Canadian Cooperation, have identified that the spirit of these new policies and the Health Sector Plan 2006-2011 was first implemented by the PASS.

Alignment and harmonisation with national health policies was the backbone of the PASS components. Numerous meetings between the MSD and CIDA representatives set the stage for overcoming contextual barriers. For this reason, one of the focus areas was the mechanism to strengthen MSD governance through

the CAP component. The PRICCAS was designed to support SAFCI and “Zero Malnutrition” Policies and other maternal, newborn, and children’s program interventions, along with reinforcing departmental and local SEDES and REDES leadership. Finally, the FLASS was designed to bridge health centers’ interventions with communities. Another crucial element for coordination was the joint-management approach taken in the different stages of the project: design, implementation, and evaluation. The results framework developed helped to define joint responsibilities between partners and to hold them accountable for interventions.

Technical assistance given to MSD personnel was recognised as empowering, since the project was accompanied by Canadian experts in different areas such as project design based on results, M&E frameworks, and gender. The PASS was recognised as the new model for external aid to be adopted by other cooperation agencies.

Although methodologies, administrative standards, and planning tools are still in place, and although the MSD claims ownership, there is still a need to reinforce and scale them up as national health tools, including the results framework, M&E skills, and crosscutting issues such as gender. UNICEF and the UASCC have played a major role in producing quarterly reports that sustain the technical and administrative abilities of national and departmental counterparts.

5.2.2 Joint Responsibility for Results

A management mechanism put in place during the project gave the MSD the option to exercise leadership. Joint management offered solid opportunities for making decisions and taking responsibility for results. The M&E system helped to keep track of indicators designed for the products and activities, through periodical Management and Steering Committees of the PASS and the PRICCAS Technical Committee. The latter was in charge of developing quarterly reports with the MSD-DGP and with coordinators of the REDES in the three departments.

5.3 Success Factors

5.3.1 Sound Concept, Relevant Model

CIDA leadership in the health sector is recognised by the donor community. At a time in which the political and social structure of Bolivia was undergoing significant changes, the Canadian Cooperation was regarded as a valid speaker by the MSD and as a mediator by some donors, such as USAID, which encountered political issues that preventing them from implementing their program in the flexible and “free” manner in which Canada carried out its own aid program. Alignment with Bolivian health policies and joint management of the PASS were considered relevant enough to be used as a model for other donors, such as the FORTALESSA initiative, which is being implemented by PAHO and UNICEF with bilateral funds from USAID.

Another issue that emerged during the interviews with the MSD, UNICEF, and NGOs was the flexibility displayed to respond to health demands and make changes while developing the PASS components. Project implementation was identified as an important learning process that has allowed the strengthening of local expertise.

The comprehensive approach that the PASS incorporated to respond to maternal, neonatal, and child mortality and morbidity reduction reinforces a model that integrates health facilities with communities and municipal authorities working together.

The PASS was presented with a comprehensive approach involving complementary components. Each piece of the project was designed to create synergies with the others, but the fact that each component had complementary and specific activities, that the FLASS started late, and that reports on results were presented separately affected the efficiency of interventions. Coordination issues, highlighted in the mid-term evaluation, persisted even though efforts were made to improve the situation. One of the issues identified included

coordination problems between the FPS infrastructure and the MSD or the SEDES, and also between the FLASS and the PRICCAS.

The PASS was developed in a changing and moving environment to respond to, and align with, the local context through a participative process. This also brought some limitations to the Results Framework, in turn providing clear indicators for measuring results and following up and for identifying sources of information and responsibilities. The mid-term evaluation recognised this gap and tried to amend it. For example, gender indicators were included in the updated version of the Results Framework, and a follow-up M&E matrix was added.

5.3.2 Community Involvement

One of the PASS commitments is to improve community participation, since quality issues and cultural barriers were identified as important factors in impeding access for women and families to health services. The SAFCI Policy was designed to take action to overcome this health gap. The FLASS component basically responded to addressing the PASS Results Framework with measures such as: improvements to the coverage and quality of interventions, and implementation of the SAFCI Policy. When the ToRs were designed for the approval of proposals, community participation, self-care practices, intercultural approaches, and empowering community and women's methodologies were given priority. With 10 projects, the FLASS component began in 2009, two years after the PRICCAS component. It had a short duration of no more than 29 months and benefited nearly 40,000 people (see Table 12).

The end-of-project evaluation of the PASS recognises that the products and activities identified in the projects were generally accomplished, alongside other unexpected results.

Table 12
Beneficiaries and Main Results of the FLASS Component

NGO	Health areas	Months	Beneficiaries	Geographic area	Results
Child Fund Bolivia (CFB)	Child and prenatal care, including nutrition	2-9 months	• 1,381 people	• San Pedro de Totora, Oruro	• Final Report not made available
Center for International Studies and Cooperation (CECI)	Maternal health: prenatal, deliveries, and postnatal care with an intercultural approach	19 months	• 2,203 people	• Curahuara de Carangas • San Pedro de Totora • Santiago de Huayllamarca • Corque, Belén de Andamarca, Oruro	<ul style="list-style-type: none"> • Increase by 80% of the coverage in prenatal care, delivery and detection of danger signals • Experience exchange workshops between traditional and occidental doctors have been realised in the municipalities of Curahuara de Carangas, San Pedro de Totora, Santiago de Huayllamarca, Belén de Andamarca and Corque • 125 trained ACS • 5 intercultural delivery rooms implemented

NGO	Health areas	Months	Beneficiaries	Geographic area	Results
Municipality of Totora	Home gardens to solve nutrition issues for mothers and children	19 months	<ul style="list-style-type: none"> • 1,260 people • (152 families) 	<ul style="list-style-type: none"> • San Pedro de Totora, Oruro 	<ul style="list-style-type: none"> • 150 families with children under age 5 have family production systems (rabbits, guinea pigs and vegetable gardens) • 150 families with children under age 5 have improved knowledge and good practices in nutrition, healthy feeding and food combination • 15 educative institutions have a productive egg-laying hens system • Implementation of a Child Nutrition Unit (Unidad Nutricional Infantil) in the community of Totora • Strengthening of the social healthcare networks for community surveillance • Equipment with healthcare services OR Healthcare services equipment
Save the Children	Empowering women's indigenous groups to respond to maternal and reproductive health	24 months	<ul style="list-style-type: none"> • 3,698 people • 7 women's organisations • 43 community health workers trained 	<ul style="list-style-type: none"> • El Choro • Eucalptos, Oruro 	<ul style="list-style-type: none"> • 7 Basic Community Organisations (30 communities) from the El Choro and Eucalptos municipalities implement projects that improve healthcare services • 6 interventions from the Municipality of El Choro and 3 from the Municipality of Eucalptos to improve health care services have been implemented • 90% increase in the knowledge of sexual and reproductive health of the workshop attendants
<i>Asociación de Promotores de Salud del Area Rural</i> (APROSAR)	Community surveillance networks	22 months	<ul style="list-style-type: none"> • 8,554 people • 47 community health workers • 27 local community authorities (ALS) 	<ul style="list-style-type: none"> • Reyes • Santa Rosa • San Borja • Rurrenabaque, Beni 	<ul style="list-style-type: none"> • 47 ACS trained and working in social networks with a Maternal and Neonatal Health Surveillance System • ALS and CMS selected and functional (5 in Rurrenabaque, 6 in Reyes, 3 in Santa Rosa and 11 in San Borja)
<i>Centro de Investigación, Educación y Servicios</i> (CIES)	Maternal and reproductive health	15 months	<ul style="list-style-type: none"> • 3,622 people • 100 community health workers trained 	<ul style="list-style-type: none"> • San Ignacio, Trinidad Rural, Beni 	<ul style="list-style-type: none"> • 6 self-diagnosis and 8 sub-projects are elaborated and executed • 30 women are trained in project management and administration • 123 promoters trained in SSR • 120 out of 130 women make usage of the healthcare services two times or more • 87% of women participating in the project know 3 signs of risk in pregnancy, delivery and postpartum • 84% of women participating in the project know 3 signs of Sexually Transmissible Infections • 12% of women with 4 prenatal controls (it increased with the project) • 25% of women participating in the project realise and know the results of the PAP • 2 joint action plans—1 in Trinidad rural and 1 in San Ignacio—have been negotiated, signed, realised and evaluated

NGO	Health areas	Months	Beneficiaries	Geographic area	Results
Samaritan's Purse	Water and sanitation, nutrition, and health education	27 months	<ul style="list-style-type: none"> • 4,680 people • 133 community health workers trained • 30 family support groups • 400 mothers in nutrition interventions 	<ul style="list-style-type: none"> • Loreto • San Andrés • Eucaliptos, Beni 	<ul style="list-style-type: none"> • 100% of the staff of the Municipality of Loreto (11 communities) and San Andrés (19 communities) trained • 30 Family Support Groups formed • 133 ACS trained • 410 mothers taking part in monthly meetings • 8 Healthcare Centers with safe drinking water • 65% of municipal authorities with intervention (97) trained
Family Care International (FCI)	Intercultural maternal health	15 months	<ul style="list-style-type: none"> • 10,883 people • 50 community leaders and 40 trainees • 6 CLS 	<ul style="list-style-type: none"> • Puerto Gonzalo Moreno, San Lorenzo, San Pedro, Pando 	<ul style="list-style-type: none"> • Intercultural dialogues with CIPOAP and CIMAP (60 healthcare providers, 50 community officials and captainties, 40 empiric midwives) • Plans for modification of short cycles to incorporate interculturalism/CONE • Health Committees working in RED 3 • Captains of the villages Tacana, Esse, Eija and Canineño sensitised • Maternal shelters for Gonzalo Moreno and San Lorenzo
CARE International	Water systems	14 months	<ul style="list-style-type: none"> • 1,080 people • 5 water committees 	<ul style="list-style-type: none"> • San Lorenzo, El Sena, Puerto Gonzalo Moreno, Bella Flor, Santa Rosa, Pando 	<ul style="list-style-type: none"> • Project not yet finished
Samaritan's Purse	Water and sanitation, nutrition, and health education	9 months	<ul style="list-style-type: none"> • 237 people • 40 family groups 	<ul style="list-style-type: none"> • San Pedro, Villa Nueva, Pando 	<ul style="list-style-type: none"> • Project not yet finished

Source: Adaptation of a table found in the Final FLASS Report, April 2012.

Child Fund Bolivia (CFB) and the Center for International Studies and Cooperation (CECI) worked with the health centre in Totora and surrounding communities—CFB worked on resolving children's and nutrition issues, and the CECI took an intercultural approach to women's health at the prenatal, delivery, and postnatal stages. Both managed to incorporate activities in the municipal budget of San Pedro de Totora after the project had finished. On the other hand, the same municipality received a sub-grant to develop family vegetable gardens for nutritional purposes. Samaritan's Purse, the *Centro de Investigación, Educación y Servicios* (CIES)—i.e. Centre for Education, Research and Services—, and Save the Children worked in different geographic areas and with different interventions, but specifically with organised groups to empower them, develop action plans, and do the follow-up. The latter two NGOs worked with women's groups (following a "WARMI" (women in Aymara) inspired methodology). Family Care International (FCI) worked with indigenous leaders and organisations, such as the *Central Indígena de Pueblos Orogénarios de la Amazonia de Pando* (CIPOAP), or Association of Indigenous Peoples of the Pando Department, in the Amazon, and the *Central Indígena de Mujeres de la Amazonia de Pando*, or Association of Indigenous Women of the Pando Department, in the Amazon.

All of the projects liaised with MSD local health centres and with coordinators of the REDES, to support the implementation or strengthening of the SAFCI social structure. At the departmental level, the SEDES in Oruro and Pando recognised the complementary approach of the FLASS and PRICCAS components. The DGP of the SEDES in Beni declared that there had been no coordination with FLASS projects. During the quarterly meetings of the PASS Management Committee, NGOs had the opportunity to present their methodologies and results to each other and the other partners, namely the MSD, the FPS, and UNICEF.

Although this was supposed to be an opportunity to create ownership and to scale up these experiences at the national level, this did not happen. Nevertheless, valuable experiences were made at the local level. In most cases, the budget was used to adopt methodologies and tools within the REDES and the municipalities and communities, to ensure continued implementation. The fact that community leaders were involved contributed to this result. It is important to point out that coordinated actions did not always work well. For example, the intercultural adaptation of health centres in the Gonzalo Moreno Network of Pando was in need of supplies and inputs from the PRICCAS, which had already finished. Now UNICEF is bridging this gap using its own funds. Overlapping has not been an important issue except for interventions in the municipality of San Pedro de Totorá, in which three projects of the FLASS took place. While interventions were supposed to be complementary, children's, nutrition, and maternal health had overlapping activities. Since the population of San Pedro de Totorá is small, it is difficult to define whom the results should be attributed to. Perhaps close coordination at the beginning of the three interventions would have ensured a more synergetic and harmonised impact.

5.3.3 Management and Coordination Mechanisms

Management and coordination instruments were developed for different roles and responsibilities, in keeping with the design of the project and the PIP. Table 13 lists the objectives and participants of each mechanism.

Table 13
Overview of Management and Coordination Mechanisms

Mechanism	Objective/Responsibilities	Participants	Meetings
Management Committee	<ul style="list-style-type: none"> Evaluate and approve annual work plans and budgets Evaluate and approve annual technical and financial reports recommended by the Operational Committee Follow up on recommendations of the external audit Oversee the achievement of results of the program, including those regarding gender equity Approve the mid-term and end-of-project evaluation Provide strategic guidelines 	<ul style="list-style-type: none"> Government of Bolivia, represented by the MSD Head of Canadian Cooperation VIPFE, as an observer PAHO, as an observer 	Twice a year, preferably in February and July
Operational Committee	<ul style="list-style-type: none"> Promote communication and exchange between partners Facilitate training workshops for key implementers using a gender, strategic planning, and intercultural approach Create a space for dialogue among partners to improve implementation Coordinate actions to better integrate the three components and achieve greater impact with interventions Analyse each partner's reports and plans Prepare recommendations for the Management Committee Prepare a contingency plan 	<ul style="list-style-type: none"> MSD-UP FPS UNICEF Director and UPs SEDES representatives CIDA PASS monitor 	Twice a year, two weeks before the Management Committee
PRICCAS Technical Committee	<ul style="list-style-type: none"> Conduct follow-up of PRICCAS indicators Conduct follow-up of activities and budget and propose measures to improve impact Identify risk/weaknesses/barriers for PRICCAS implementation Promote coordination and communication among departmental partners Promote operations of the Interagency Coordinating Committee Elaborate, review/adjust operational plans and budgets for MSD/SEDES/coordinators of the REDES Implement recommendations of the Operational Committee and the Management Committee Issue technical updates on matters concerning maternal health, children's health, nutrition, and transmissible diseases 	<ul style="list-style-type: none"> Representative of the MSD-UP UNICEF representative Representatives from the Oruro, Beni, and Pando SEDES Director of the SEDES Planner Technicians: epidemiologist, maternal and children's health specialist, depending on the technical issue to be dealt with Network managers CIDA representative and local CIDA health monitor (observers/presenters) Beneficiaries/users, depending on the agenda and needs 	Three times a year
Gender Technical Committee		<ul style="list-style-type: none"> Canadian Cooperation Service Support Unit gender specialist UNICEF gender specialist MSD gender specialist 	

Source:
Adapted from the Program Implementation Plan (PIP) 2007.

These mechanisms were recognised by the implementing partners—especially the MSD—as “good practice” and as a model to be followed. In fact, the FORTALESSA USAID initiative has incorporated the same levels of coordination in its ongoing project.

After its first meeting in October 2007, during which it approved the PIP, the Management Committee met at least once a year to approve plans and reports. Although the Management Committee was responsible for

identifying strategic orientations for the PASS, most of its meetings were spent addressing administrative issues. This issue had already been raised in the mid-term evaluation, which recommended that a meeting be held each February to ensure that annual plans be approved in a timely manner. However, the second meeting of the Management Committee meeting did not take place until June 2008, at which time a consensus was reached on 2007 activities. A similar situation occurred in 2009.

Another issue was the follow-up of recommendations, as suggested by a review of Operational Committee reports and the mid-term evaluation. In March 2009, CIDA expressed concern about the MSD's compliance with the rule preventing personnel paid by the project to be integrated the Ministry's its regular budget. To this day, the MSD still has to comply with this requirement, except for a few instances seen in the SEDES in Oruro. It was also recommended to review the administrative processes that delayed activities—especially in the SEDES in Beni and Pando, which did not receive their yearly implementation budgets before July. This situation persisted in 2009 and 2010.

The Operational Committee usually met two weeks before the Management Committee, in order to finalise its report for the previous year and prepare suggestions to reorient PASS components. The practical need to involve technical staff from the SEDES implied that they took part in Operational Committee meetings, along with any NGOs that were invited. The inclusion of all these partners, coupled to the fact that at times the Operational Committee also doubled as the PRICCAS Technical Committee, created a general misunderstanding of the mandate of this body. Moreover, as nearly 50 people participated in these meetings, it was difficult to come to strategic technical agreements.

Despite these difficulties, the possibility of convening such coordination forums gave partners an opportunity to participate and build ownership. However, the issues on the agenda, the quality of strategic decisions, and the redefining of roles should be improved in order to make meetings more efficient in future.

In parallel to these initiatives, since 2006, donors have been sitting on the group *Socios para el Desarrollo de Bolivia* (Partners for the Development of Bolivia). This group has 12 sub-committees, including a Health Technical Committee whose role is to share experiences, coordinate alignment to Bolivia's health policies, and harmonise interventions. The president of this Technical Committee declared that “this space has helped coordination issues, especially between USAID, Belgium and Canada,” and that the committee has also improved coordination with the MSD. CIDA representatives have played an active role advocating for direct support from the MSD. At these meetings, the PASS has presented its results, and field visits were organised to exchange methodologies and tools.

5.3.4 Informed and Timely Interventions

Timely management implies various key elements and ingredients:

- The capacity of projects/program teams to anticipate and respond to changes based on adequate and opportune information;
- The identification and adoption of appropriate actions to manage risks;
- Effective networks and methods for facilitating the identification and evaluation of events and trends as well as important changes likely to affect the project/program.

The effective implementation of the PASS, for its part, relies on several tools: reporting, monitoring, risk mitigation strategies and sufficient capacities of the key players.

Reporting

The nature of the PASS project is such that its various components, albeit integrated, operate in distinct and separate manners, which makes for a rather complex reporting scheme. Reports are produced by the “executing agencies” of each component, each with their own parameters and reporting structure. In addition, each of the three SEDES issue two reports—one for the CAP and one for the PRICASS. The Operational Committee hence has to review at least 10 reports at each meeting. If we add to those the numerous POAs that also require review and approval, little time remains to address systemic, institutional, organisational, or political issues.

The PASS Project Implementation Plan (PIP) had also established that a consolidated annual report was to be produced, which was to include a results-oriented progress update based on the indicators listed in the performance measurement framework. The annual report should also include a risk analysis and lessons learned for the reporting period. The MSD was assigned to produce this report, but has not been able to accomplish this task so far. Thus, the Committee has not received a consolidated annual report during the course of the project.

Risk Management

Unlike UNICEF, the PASS has not yet established any formal mechanisms for identifying, analysing and proposing risk mitigation measures. It has, however, reported on the degree of implementation and has complied with the strategies.

The risks identified by UNICEF are related to financial issues, human resources and the maintenance of infrastructure and planning; and its recommended mitigation measures focus on advocacy, monitoring and training. Despite efforts for identifying risks, UNICEF does not have an overall PASS perspective, and so it does not cover all risks, especially not those that are not directly related to health interventions. Likewise, the mitigation measures only focus on actions that UNICEF is able to or in the position to take, which limits the results.

There are some risks, such as political changes, personnel turnover and bureaucracy, that are difficult to mitigate. In fact, decisions on mitigation are beyond the action sphere of UNICEF and even of the MSD. Bureaucracy, for example has been identified as a challenge within the VIPFE and the MEFP. However, the MSD had to assume responsibility for risk analyses and for encouraging the identification and adoption of mitigation measures. Ensuring constant leadership and taking actions in this difficult context constituted a significant challenge for the MSD.

Timely Control and Supervision

Implementation of the PASS falls in the hands of the governing institutions at the state level and structure (MSD, SEDES and FPS) as well as international donor efforts (UNICEF and CIDA). Despite weaknesses and limitations on the management dimension, alongside often limited equipment, the MSD and the SEDES have the necessary experience and expertise to implement the technical tasks and to achieve substantial results. As for the FPS, it provides adequate supervision thanks notably to its long-lasting experience and accumulated expertise. UNICEF has its own institutional systems that ensure implementation and supervision of PRICASS actions, as well as utilising institutional spaces such as the CAIs, and the promotion of an integrated monitoring multi-program strategy to strengthen the capacities at the department level. Given this structure, CIDA, which operates at arm’s length, is not required to provide technical supervision and limits its involvement in technical and financial oversight.

The execution model for the PASS assigns an important role to the government, namely through the MSD. However, CIDA has played a more active role than planned, in particular in guiding the various key actors of each component. Given the shortcomings regarding project execution, CIDA will most likely need to

continue fulfilling this role—more appropriately via an independent executing agency—to ensure that project results are adequately achieved, that there is greater ownership by local authorities, and that the technical team is strengthened. Future technical assistance in an eventual subsequent project could in particular be useful to detect and solve financial and administrative bottlenecks and to assist in building the capacity of SEDES staff and REDES especially with regard to the financial administration.

Monitoring

The program monitoring mechanisms have been defined through the Management Committee (MC) that provides for the strategic orientation of the Program and the Operational Committee (OC), which develop 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 currently depend exclusively on each stakeholder's management model. In the MC, the analysis of information has suffered delays (e.g., the reports as at December 2008 were not analysed until June 2009). This is because there are only two annual meetings, unless issues arise that call for prompt action. The six-monthly reports do not provide the MC with sufficient content for making optimal decisions regarding the program implementation rhythm. The reports serve to establish the meeting agendas, and are thus related more to administrative matters and less to project impacts.

The PASS has proven to be much more labour-intensive than expected, as it required significant attention and input on the part of the CIDA team in La Paz, with almost daily interventions and intense field monitoring for various mobiles. (The activities included visiting active and potential FPS, SEDES and other infrastructure projects, participating in PRICCAS workshops and projects, and ensuring the supply of equipment.) CIDA has played an important role in guidance and provided ongoing counsel to the MSD throughout the process. Its involvement remained discrete and, applying a constructive and positive approach, it has refrained from interfering with the work of MSD authorities while managing to bring all key actors to implement project components.

5.3.5 Gender Equity

Integration of Gender Equity Principles and Practices in Project Design, Planning and Execution

“CIDA's gender approach is to [...] advance women's equal participation [...] as decision makers [...] and] reduce gender inequalities in access to and control over resources and benefits of development.”

— CIDA's Policy on Gender Equality, March 1999.

During the last decade, national policies in Bolivia have been supporting the inclusion of gender as a crosscutting issue to respond to the social exclusion of women, and major efforts have been made to support the political participation of women. Numerous laws have been developed to address the types of changes needed in various sectors to ensure that women and men have equal opportunities to participate fully in all aspects of the Bolivian society. The most comprehensive framework to date is supplied by the Bolivian Constitution, which was approved in 2009, and the *Plan Nacional para la Igualdad de Oportunidades* (National Plan for Equal Opportunities) that was issued in 2008 by the *Viceministerio de Igualdad de Oportunidades* (VIO)—i.e. Vice Ministry for Equal Opportunities—within the Ministry of Justice. The latter establishes a coordinating role for the VIO, along with other Ministries, to promote gender equity and respect for cultural diversity. The National Plan for Equal Opportunity also references Bolivia's previous international and national legal commitment to promote gender equity, as per MDG 3.

The Bolivian National Development Plan also prioritises social equity and respect for cultural diversity and autonomy of action as key principles of national development, within the laws of the country. Prevention of, and the fight against, domestic violence was identified as a priority program for the health sector.

Two new concepts have been included in the discussion on gender issues, namely “de-colonisation,” which refers to the dismantling of a number of institutions and cultural practices that support the domination of one culture over another, and “de-patriarchism,” which refers to men’s domination over women. These concepts are central to understanding how gender is being addressed in Bolivia, since the Aymara and Quechua culture have developed a conceptualisation of Chachawarmi (Aymara) or Qariwarmi (Quechua)—i.e. man and woman—that describes the roles of both sexes as being complementary. Indigenous women, particularly those affiliated with women’s groups within indigenous social organisations, argue that the division of labour in rural communities is complementary, but not equal.

As mentioned above, this debate has affected the interpretation of gender policies, especially at the departmental and municipal levels, since cultural issues are stronger than gender issues—as illustrated by the SEDES in Oruro, which developed a “Chacana planning model” in which gender is absent.

The SAFCI Policy provides little guidance on how to address gender inequalities within the context of family and community intercultural health care. It is also silent on how to ensure equal opportunities for men and women to participate in decision-making at different administrative levels (e.g. community, municipal, departmental, national). Within the framework supplied by CIDA’s gender policies, a Gender Strategy for the PASS was designed in 2008, and critical areas to be addressed during implementation of the PASS were identified, such as:

- Gender-related health problems that affect high maternal mortality rates and create barriers for women’s access to health services;
- National health policies that are geared towards mother-child interventions, and not women as the subjects of rights;
- Weakness in the MSD Gender Unit’s capacity to mainstream gender in health policies, programs and health units;
- Weakness in the health personnel’s capacity to understand and address the impact of gender equity on health issues;
- Limited access of women to information about health issues, and limited participation of women in social structures;
- Lack of autonomy of women to make their own decisions regarding their sexual and reproductive health;
- Limited disaggregated information by sex within the *Sistema Nacional de Información en Salud* (SNIS), or National Health Information System, and lack of skills to make gender analysis.

The PASS Gender Strategy was analysed by the Gender Committee in which the MSD, UNICEF and the Canadian Cooperation Service Support Unit participated. In May 2008, the Strategy was presented to the Operational Committee, and three Departmental Plans were approved for implementation. In June 2008, the Management Committee approved the Gender Strategy, which featured commitments, on the part of the directors of all three targeted SEDES, to name a contact for gender issues and have this person sit on their Technical Committee, to develop local plans providing for coordination with the VIO, to train health personnel, and to match the activities of other civil society organisations in order to fight domestic violence. As part of this Strategy, the Logic Model was reviewed, and gender indicators were identified.

Follow-up activities were spearheaded by the Gender Committee, and a workshop on Gender and Health was developed in July 2009. During this workshop, a needs analysis was performed to determine the training requirements of gender contacts and planning heads working in the SEDES in Oruro, Beni and Pando. Since

2010, a National Plan on Gender and Health 2010-2015 has been issued that features a specific training program on gender equity.

Despite these efforts, the mainstreaming of gender interventions remains relatively weak. The MSD has a designated person who looks after gender issues, but this person has limited decision-making power to influence policies, programs and planning processes. The PASS had the opportunity to introduce gender analysis within the SAFCI structure, planning tools and SNIS at the national level, and more specifically at the departmental and municipal levels. Likewise, a review of the impact of gender approaches on health issues would have been a worthy contribution to the ongoing health dialogue with the MSD, and other donors and partners. Of the three SEDES involved in the PASS, the one in Oruro has had the most success overcoming barriers to incorporate gender in PRICCAS activities. This is mainly due to the skills of the gender contact in Oruro, who actively began working with this department's network against domestic violence, and who convinced the SEDES authorities and other programming areas about the need to implement gender approach. As a result, specific budgets were earmarked for gender activities, such as the production of a documentary video and brochures, and the conduct of workshops. Civil society members within the network recognised the importance of having an opportunity to coordinate with the MSD, and that this has strengthened both the network and advocacy activities targeting domestic violence in Oruro.

The FLASS component featured NGOs that implemented specific methodologies to empower women, including "WARMPI" (Save the Children), Community Participation (CIES), "HACAP" (FCI) and others that focused on women's participation in decision-making roles. The PRICCAS component developed a strategy of empowerment of women councillors, and training of local decision makers in gender (graduates).

Overall, the most common approach to gender seen across the PASS has been to start collecting disaggregated data, to include women as participants (sometimes in decision-making positions) and/or to address domestic violence issues. Some components have gone further to ensure that women have tools to participate and select strategic interventions tailored to their needs. A review of the Logic Model reveals that results and indicators do not yet explicitly indicate how to address gender disparities and gaps associated with outcomes.

6. CONCLUSIONS

This chapter discusses the main conclusion and a summary of key findings that transpire from the end-of-project evaluation of the PASS.

6.1 Main Conclusion

Based on multiple lines of evidence, the evaluation comes to the conclusion that the PASS has demonstrated a high level of success and has generated substantial results. Multiple reasons account for the success of the project:

- A design that focussed on the roots of maternal and child health problems;
- The involvement of all relevant structures within the health sector;
- The promotion of shared responsibility and community involvement;
- Alignment with Bolivia's political process;
- A stronger appropriation of the part of the MSD of the planning and monitoring mechanisms of health activities and results;
- A flexible, iterative approach to management on the part of CIDA;
- The development of complementary components of the PASS: CAP, PRICCAS, FLASS and FPS;
- The implementation of the project—a learning process among partners.

6.2 Key Findings

A Highly Relevant Concept and Design

The PASS has devised a comprehensive and integrated vision of health care. The integrated dimension of the project provides for a set of curative, preventive and promotional services, alongside the promotion of community participation, healthier lifestyles and practices traditionally not addressed by the health sector, such as those concerning the importance of adequate water use, hand washing, and nutrition.

In general, the design of the PASS is regarded as innovative, considering that distinct yet relevant components complement each other in improving the management of, and access to, the health system. The program is supported with infrastructure and equipment and collaborates with sound NGOs whose fundamental role it is to promote community participation—a key facet of the PASS as well as a critical sustainability factor. The PASS is a comprehensive technological package that acts on all aspects of the health care system.

Although beset by implementation difficulties which hampered the capacity of the head office to fully and adequately play its role, the financial support component was very much appreciated by the actors at the national and departmental levels. This support assisted in strengthening the leadership and the institutional capacity of the national and departmental players and to reinforce their capacity to plan, coordinate and monitor the management of the health system.

The FPS component—rehabilitation of health facilities and equipment—remains a priority in all departments, and the FLASS, which started only in 2009, has proven relevant and complementary to other actions of the PASS. The initiatives of the FLASS allowed improving health actions at the request of the communities in the

rural areas. Nevertheless, these initiatives being small-scale, they can only address the needs of a limited number of communities. To optimise the potential impact of these interventions, the models tested within the FLASS deserve to be systematised and, if proven worthy and shown to have enough potential impact, be adopted in other regions.

Significant and Important Results

Although hard figures to support this are yet to be available, and that other factors outside the project have no doubt contributed to this, improved access and quality of health services to the population have, to a significant extent, been achieved. The institutionalisation of the regulatory instruments currently in use (the MSD and the SEDES functional structure and Functions Manual) has been prepared for by key officials at the central and departmental levels. Health personnel has appropriated these concepts and perceived them as positive:

- The level of appropriation of the PASS components is very high in Oruro, although less so Beni and Pando, for reasons explained above;
- All three SEDES are driven by strong and dedicated staff and networks of health personnel;
- The project has in practical terms ended a while ago, but the attitudinal changes that occurred and that are still in place within the SEDES and the REDES are striking when compared to the situation during the early stages of the PASS. The current tendency is to gravitate around the importance of achieving genuine and long-lasting results. The majority of staff imparts a strong sense of commitment—if not pride—to achieve and maintain results, notably in terms of coverage and quality. The project clearly demonstrated that the actors within the SEDES and the institutions do not want to fall behind or go back to the former situation;
- SEDES began conducting PASS activities with much enthusiasm and commitment, despite facing several limitations. They have been able to deliver expected outputs in alignment with the 2006-2011 National Development Plan and have applied appropriate procedures for the management of said Plan.

Some activities were performed less successfully than others, among them those related to community participation, *interculturalidad*, gender and to some extent health self-care and the right to health. Socio-cultural, political and historical factors explain the obstacles related to mixed results in these areas. For example, with regard to gender, the PASS strives for equality between men and women with regard to rights, yet differentiates between men and women when it comes to the provision of services. Inducing such a behavioural change takes time, and there are signs in certain areas that this is occurring.

Overall, the FPS mechanism yielded good results, especially in situations where the SEDES effectively played its role as monitor and supervisor of infrastructure work, as was the case in the department of Oruro. In fact, Oruro topped all other departments with regard to prioritising first-tier health centres, in line with PASS guidelines. As well, Oruro managed to complete the largest number of quality infrastructure projects, all within the limited timeframes established by the SEDES.

In the departments of Oruro and Pando, choices often turned out to be more political, which resulted in greater support for larger, second-tier infrastructures. Several infrastructures in Beni and Pando experienced problems with construction. Moreover, basic needs were not always met in these projects, especially in the context of *interculturalidad*. As stated in the “Standards of Recruitment and Services of the MSD” document, the beneficiary is the person who must ultimately approve the design and ensure that communication between the FPS, the SEDES and hospital staff is smooth for the purpose of complying with technical specifications. Considering the difficulties to adapt the infrastructure to the health personnel and community needs, it would be advisable that these types of projects engage an architect with experience in the construction or renovation

of health facilities. Likewise, community and women's participation should be a given when performing renovations that involve culturally appropriate environments. Any consultant hired by the municipality to supervise this kind of work must have the required technical expertise.

A Generally Efficiently Carried-out Project

Despite its complexity, the PASS was generally well handled and managed. From the start, the PASS project was designed to include different components, the synergy of which was to lead to results. Guided by the idea that health services should not be limited to treating diseases but also to implementing preventative interventions that promote healthy behaviour, the project set-up was then able to complement interventions and enhance their impact on certain geographical populations. This has been raised by the partners, all of whom have been invited to the technical and management committees. When analysing the implementation of the project and the agenda of these coordinating units, the quality of the participation could have been improved by emphasising the learning process, and the sharing of methodologies could have been scaled up. For example, the monitoring reports were presented separately. Assessing these synergies and complementarities in the quarterly reports could have helped to create ownership and correlate activities. In brief, consolidated reporting was not achieved to the desired extent, and project reports could have been more results-oriented.

As for the budget, some of the partners interviewed expressed concerns about the percentage of funds allocated to each component, underlining for example that community interventions, the intercultural approach and gender issues received insufficient funds. To increase the efficiency and effectiveness of the program, a needs assessment should be made on the implementation strategies, and a certain percentage of the budget should be allocated according to these elements. The PIP (Project Implementation Plan) was readily embraced and adopted right from the start at the first meeting of the Comité Operativo. However, the plan is not considered to have been integrated properly, and the reasons for this are attributed mainly to the constant changes in the staff offices and networks. While this perception is not shared by all, it is the general sentiment expressed at focus group meetings. During the systematisation exercise, half of those interviewed declared not even knowing the document (with the exception of Pando). Perception or not, lessons can be derived from this experience.

Again, during the systematisation exercise, staff manifested a limited level of knowledge regarding the governing policies of the sector, such as the Health Sector Plan and the SAFCI Policy. Nevertheless, a high level of sensitivity and awareness about the plan and the policy was demonstrated during group discussions.

The level of participation of officials of the MSD-UP and at the SEDES has been generally rated quite satisfactory, despite conflicting priorities and political instability that distracted the attention of key players from the MSD project.

The work carried out by Canadian technical assistants was satisfactory and useful and was recognised as providing a sound balance between management tasks and external technical assistance.

The efforts displayed in terms of developing an initial and final baseline, together with the "global systematisation of the PASS experience," will prove to be very useful for the design and planning of other CIDA-Bolivia sector collaboration projects. This systematisation process aimed at consolidating the experiences made by and with MSD officials and the SEDES constitutes an excellent opportunity for deepening and adjusting the experiences, thereby contributing to their internalisation by key stakeholders.

The absence of a sound internal management mechanism of the program within the MSD represented a significant challenge, especially considering that the PASS was comprised of four important components, each with an institutional partner and a different timeline. This resulted in greater involvement on the part of CIDA in day-to-day activities in order to track the administrative and financial management of each component with technical support by UASCC sectorial specialists.

The only mechanism provided for in the PIP was the Management Committee. Initially, the MSD was supposed to be tasked with ensuring coordination between the different components. However, ultimately the PIP has no provisions that specifically assign this responsibility to anyone. In addition, in view of the frequent changes in the MSD (five ministers in five years) and the UP, the low-capacity management of the MSD, and the ongoing development of new health policies, the MSD experienced difficulties in efficiently and effectively managing the activities of the PASS.

An important obstacle was the difficulty to transfer funds from the national departments through the established mechanisms, which are very slow and red tape-laden. The passage from prefecture to government departments further complicated the problem and caused even greater delays in money transfers between the national government and the departments. As a consequence, the execution of this component has been below expectation at both the national and departmental levels.

Coordination between Key Actors

Coordination between the Departmental Government and Municipalities was addressed during the implementation of the PASS project. Interesting alliances were developed to sustain activities and are still in place. MOH has recognised the importance of these strategic alliances for the sustainability of interventions.

Coordination between the MSD, the FPS and the municipalities was an area of concern. Any shared responsibilities of the latter for the maintenance of infrastructure and equipment deserve to be clearly stated in the agreements signed when remodelling the health infrastructure.

Sustainability Remains a Challenge

The PRICASS developed innovative interventions, among them:

- Training centres with direct sponsorship of third- to second-tier hospitals to follow up and update skills of health personnel;
- Multiprogrammatic supervision rounds that enabled different programs to share experiences, such as immunisation, nutrition and reproductive health and to improve their efficiency in the use of resources to conduct these supervision visits;
- Short-cycle improvement methodology was introduced in third- and second-tier hospitals to follow up on activities of the main maternal and newborn interventions, mainly to identify bottlenecks and design and implement improvements.

These interventions were identified by the SEDES and the REDES to have been crucial for the improvement in the coverage and quality of health services. The question is whether they will continue or be scaled up after the project closes. The people interviewed in the three SEDES identified financial issues as the principal barrier to continuing with these practices. Since December 2011, when the project finished, short cycles have continued to be in use. However, the implementation of training centres and multiprogrammatic supervision was complicated by difficulties, especially in Beni and Pando, where geographical barriers are present.

The long-term success of a project moreover depends on a strategy to ensure its sustainability and longevity. For this, it would be advisable to include in the planned closure workshop in September (Taller de Cierre) discussions on the conditions and future plans to ensure that partners and mechanisms continue with the interventions following project official termination. Departmental and municipal governments have been the main funding sources to maintain certain activities. However, ideally further agreements should be included in the annual budgets of the project to ensure funding for health education, supervision and intercultural adaptation of services, among other activities. In the context of sustainability, it was recommended that the

MSD analyse the possibilities of incorporating training, supervision and promotional activities in the SUMI package.

The PASS worked on improving the technical assistance given to the management side of the project in order to ensure the implementation of transparent and efficient administrative processes and the competent use of financial resources. Administrative and financial software was also developed and used during the implementation of the project, and are still in use by the Planning Unit.

Strong and Relevant Partners and Genuine Community Involvement: Key Success Factors

UNICEF's contribution in the achievement of the results of the PASS was capital. It consisted mainly of the organisation's expertise (a team experienced in maternal-child health), its political neutrality and its ability to respond both to the national plan (support to the development of policies and standards) and to departmental concerns.

The FLASS component was designed to complement the PRICASS component in order to build bridges between health services and communities and to strengthen the social structures of SAFCI. The projects involved the implementation of methodologies that ensured the participation of community authorities, women and indigenous populations. The expectation was that these experiences would be adopted by the SEDES, which would then bring them to scale.

In practice, FLASS interventions have been mainly integrated to the SEDES according the working relationship of the NGOs with the departmental authorities. Coordination has been more efficient at the operational level, for example in Oruro and partly in Pando (RED 3). Sharing lessons learned should be emphasised in order to expand experiences and to use these methodologies in other areas of influence.

Community involvement is essential for improving the coverage and quality of mother and childcare in health facilities. It is recommended that SAFCI improve its strategies to empower the social structure and to encourage participation of the community, especially women, taking into account experiences developed by the MSD and FLASS programs. One participant emphasised that "All with the community and nothing without them."

Insufficient Attention towards Gender Equity and Mainstreaming

Gender issues have been generally weak in the planning and implementation of the project. Attempts to develop different strategies and plans have been made, but with relatively little success. The gender-related activities were focused mainly on addressing family violence, and very little has been done to work with health facilities in this perspective. SEDES Oruro has come a long way in working with networks of women's organisations in their department, but this experience has not been socialised with SEDES Beni and Pando.

Gender mainstreaming should have been considered from the beginning of the planning process and incorporated in the Logic Model with clear indicators in order to identify corresponding results and the allocation of the budget.

It should be pointed out that women's participation in decision-making positions in the social structure of SAFCI or community organisations was one of the indicators of the Logic Model. While this is a good starting point, it does not necessarily mean that the gender perspective is applied. Rather, it merely means that this participation has a correlation with results involving women's demands. The quality of their participation should be assessed. Moreover, there was no baseline for women's participation in the SAFCI social structure that could attest to improvements in women's participation, although there is a widespread appreciation of the fact that more women are now participating in decision-making.

Participants furthermore pointed to the importance of beginning to involve the males of the households in trainings so that these can assume responsibilities for health and home care.

7. LESSONS AND RECOMMENDATIONS

This chapter identifies operational and developmental lessons derived from the PASS experience, as well as recommendations addressed to the various project partners.

7.1 Lessons

Operational Lessons

- The introduction of RBM principles and practices in the project was regarded as a welcome asset by all those who were introduced to this approach. Still, more often than not, the reports produced for each component were mostly activity-oriented, and they failed to adequately measure indicators identified in the Logic Model. This did not facilitate a results-oriented M&E process. Follow up in order to develop and maintain RBM planning skills among the partners of the PASS is essential in this regard.
- The nature of the CIDA-Bolivia partnership promoted a flexible, iterative process of participatory planning and programming that accommodated the beneficiaries' demands, as well as ongoing changes occurring in the project environment. Such an approach is also relevant, in as much as it genuinely involved all stakeholders, regardless of level and hierarchical/institutional importance, and contributed to successful appropriation of the project.
- In the context of a project of this magnitude, which aims at inducing significant organisational and behavioral changes within the health system and amongst its actors, results usually emerge slowly. The patience, constancy and perseverance demonstrated by CIDA representatives in the field emerged as key factors leading to the success of the PASS initiative.
- The strong presence and contribution of an external technical agency such as UNICEF is a significant success factor. The contribution of UNICEF was key to achieving results, due primarily to this partner's specific expertise (i.e. team with experience in maternal-child health), its political neutrality, and its ability to respond both to the National Plan (i.e. support to the development of policies and standards), and to departmental-level needs. UNICEF's contribution was only limited by the fact that—like any other multilateral institution—it had its own agenda, and that its planning and management mechanisms were not always aligned with those of CIDA.
- Profound structural changes occurring in the Bolivian State and in the country's health sector added to the challenge of implementing the CAP. The PIP and the logical framework must be properly disseminated at the beginning of, and during the program, so that all project partners may work their way out of the same bottlenecks, control measures, administrative hurdles and bureaucratic constraints faced by initiatives that begin at different points in time over the course of the project. This should continue during the implementation process to respond to the constant changes of health personnel in SEDES.
- Although five years were spent designing the project, neither CIDA nor the MSD could anticipate the collapse of the 2005 socio-economic model, or the implementation challenges experienced by the CAP in the face of deep structural changes occurring in the Bolivian State, hence in the country's health sector. Fortunately, CIDA's flexibility, its understanding of a complex situation and its recognition of the need to adapt all helped overcome shortcomings in the design of the project.
- Due to the nature and approach underlying Canadian technical assistance supplied by CIDA (i.e. RBM training, performance measurement, RBM monitoring and reviews, gender analysis, ongoing results analysis of the various components), the operational content could be adjusted on an ongoing basis, and outcomes and indicators could be reformulated. This promoted a joint participatory effort to re-

examine central aspects of the PASS with a critical eye, which ultimately facilitated the establishment of local capacity at the central and departmental level, with respect to results-based monitoring and ongoing evaluation.

- Efforts to ensure that short-, medium- and long-term expected results are clearly identified, formulated, disseminated and understood by all actors involved are conducive to project appropriation on the part of partners who rally to support a common cause.
- The PASS project developed different levels of managerial spaces through the Management and the Operational Committees. Although roles and responsibilities could be clearer and improvement in quality of strategic decision would be advisable, this organisational structure contributed to enhance participation and develop skills among the MSD authorities to assume better leadership and coordination.

Developmental Lessons

- A design that is innovative, integrated and comprehensive allows project stakeholders to act on all aspects of the health care system.
- The FLASS component turned out to be instrumental in achieving results associated with improved access to health services, and in securing community participation in decision making based on local health-related needs and requests.
- There are multiple advantages to involving municipal authorities in the design, programming, counterpart funds, and monitoring of health activities. Such implication encourages responsibility, accountability and appropriation. More importantly, it plays a critical role in future project sustainability.
- The ability of a project to work with all orders of health actors—from central bodies to departments, local institutions/facilities, networks, and communities and direct beneficiaries—is a major asset.
- The ability to put strong emphasis on continuous training, awareness building and information-education of the population in general—and vulnerable groups in particular—is a key success factor for achieving results and sustainability.
- Gender and intercultural approaches imply a long learning process, since it has to do not only with knowledge of concepts but with social and cultural paradigms shifts. These approaches should be thought as technical skills to be developed and followed up among health personnel in order to improve the quality of the services.

7.2 Recommendations

CIDA and MSD

Extension of the PASS Model

- This evaluation recommends that the MSD and the international cooperation community extend the PASS model (with the integrated components) to other SEDES in Bolivia, with an approach towards regional adaptation. The concept of gradual, systematic implementation based on a joint, rigorous diagnosis is unmistakably relevant, provided that a realistic assessment of human, material and financial resources is made to ensure sustainable results.

- It is important that the DGP transfers competences and skills to SEDES that allow for a harmonious strengthening between the national and regional levels. The aim is to create a spilling effect that would transfer the acquired capacities to the local levels.
- In order to sustain the progresses made by the PASS, the MSD must reconsider the need to create stable items for the Planning Units (Unidades de Planificación). The “consultants” are a short term strengthening strategy, and over the long term it leads to the loss of a human and financial resource for the MSD, as the staff eventually leaves the program.
- The diverse nature of situations and settings (from a social, political, cultural and economic perspective) witnessed in the participating departments call for specific interventions. This aspect should be closely examined and taken into account, in view of future interventions of this nature in other geographic areas.
- The complementarities of the PASS components were affected by the fact they had different timelines and the learning process and dissemination of best practices was not optimally established. It is recommended that these components should be integrated and coordinated.

Sustainability Plan

- Sustainability strategies must be identified that can maintain the coverage and strategies implemented by a project such as the PASS. For this, project proponents and partners need to collaborate at the very initial stage in designing a sustainability plan and in evaluating the initial risks analysis and subsequent mitigation strategies.
- Any withdrawal of the project must be based on an exit plan. For this, the progress attained in each targeted department must be assessed in order to establish a clear diagnosis. This will allow minimising trauma and optimising the preservation of results achieved and assets created.
- The processes for sharing experiences and methodologies must be reinforced to enhance mutual learning. This could become one of the strengths of the PASS model, if it is implemented in other regions and contexts.

Complementary Small-Scale Projects (FLASS)

- This component was raised as an adjunct to interventions in order to build bridges and strengthen the social structures of the SAFCI headquarters. The proposals involve the implementation of methodologies that ensure the participation of the authorities of the community, women and indigenous peoples. All project closure reports contained information on the key elements, which will hopefully contribute to sustainability. However, not all projects explicitly mentioned the challenges or recommendations that would ensure maintenance of the results achieved. This information should be produced at the small-scale project level and then be consolidated, systematised and disseminated by the MSD among key actors of the health system.
- The difficulty for the SAFCI social organizations in obtaining complementary projects directly could be corrected if, in the next opportunity, the NGOs submitting proposals integrate implementing partners of the SAFCI more directly, for methodological and technical transfers which would improve access and delivery of healthcare services and succeed at generating effective participation.

CIDA

Results-Based Management, Monitoring and Reporting

- A multi-component project of the magnitude of the PASS requires a comprehensive monitoring and follow-up system with a reporting scheme that encompasses all elements, consolidates results of all elements, and aggregates results of the high-level outcome analysis. This means that, from the beginning of the Program, it is important to develop a Results Framework with clearly defined and mutually agreed on indicators. The CIDA's Results Measurement Matrix, which identifies the indicators, the baseline, objectives, sources and measurement period, should be used. This allows identifying the likelihood of obtaining the information as well as its effectiveness for obtaining a better evaluation in the course of the evolution of the project, which would provide useful information for the management of the project. A guide issued by the Evaluation Directorate at CIDA for establishing such a system suggests a results-based report format.
- As mentioned in the previous paragraph, the size and the relevance of the Program deserves the appointment of a CIDA resource who could provide for a better monitoring and accompanying process to the MSD in order to develop greater management capacities.
- In the context of current, and future budget cuts within CIDA, whereby funds covering evaluation and monitoring activities within projects are expected to be reduced, the Agency as well as other donors, will need to identify creative ways to provide the necessary assistance in this regard, in particular in monitoring of projects of such an amplitude and importance. As it will become an increasing challenge to retain the services of Canadian monitors, CIDA should consider the possibility of providing intense short term technical assistance and training at the initial stage of future projects in order to provide local monitors with the adequate capacity to ensure effective and efficient monitoring of projects. Quality control of reports produced by local monitors could be done remotely, as well as distance coaching.
- The penetration of RBM principles and practices within MSD-DGP, SEDES and municipalities deserves to be pursued as it promises to improve overall management, enhance the effectiveness and efficiency of health project implementation strategies, and encourage authorities to more adequately allocate budgets to health-related results.
- It would be advisable to strengthen the participation mechanisms for social organizations - especially for women's organizations - at the planning and programming stages and to allow for a more appropriated exercise of social control and monitoring of the Programme implementation, either through the CAIs or other contribution mechanisms. This way, the inputs of the Programme to the SAFCI policy would be solidified and would drive the strengthening of the social networks in order to exert an efficient supervision of expected results and propose recommendations for the Programme.

Funds Earmarked for Gender Equity Activities

- Gender equity is an important crosscutting issue, especially in the context of such an initiative in the health sector. To generate concrete results in this area, it is essential to allocate specific budgets to programs that specifically target gender mainstreaming, otherwise chances are slim that words will translate into actions.

MSD

Disbursement of Funds

- The disbursement mechanism that prevailed throughout the course of the PASS was affected by numerous bottlenecks, which had consequences on the implementation of the activities. For this reason, government authorities should examine the relevance and feasibility of ways to ensure more

efficient and timely disbursements, especially in the case where the majority of activities are carried out in departments.

- The disbursement mechanisms should be reviewed seriously to make them more efficient, in particular with regard to ensuring funds to initiate activities at the beginning of the year. At the first meeting of the Management Committee in October 2007, bottlenecks were identified and some solutions proposed, although they were not followed up in the subsequent management committees. SEDES representatives suggested alternative ways of decentralising expenditures to allow for greater efficiency and timely disbursements. MSD is invited to examine these alternatives as potential solutions to these bottlenecks.
- CIDA and MSD are strongly encouraged to examine jointly how these bottleneck and significant delays in disbursements – which have no doubt affected PASS activities – can be addressed and corrected. In future initiatives in the health sector, CIDA (jointly with other donors) may want to consider specific technical assistance to accompany the MSD in its reflection on these key efficiency issues and assist in identifying pragmatic solutions.

Sustainability Plan

- The participation of the community is an essential element for improving the coverage and quality of the institutions, and thus for contributing to sustainability. The evaluation recommends strengthening the SAFCI strategies of reinforcing the social structure and interventions, taking into account experiences developed by the MSD and FLASS programs.

Infrastructure and “Interculturalidad”

- In light of the difficulties encountered in the construction of infrastructures and provision of equipment, any future programming in this area should include funding for the recruitment of a “health care-specialised” architect with experience in the construction/renovation of health facilities. In addition, communication between involved parties must remain fluid at all times in order to ensure the review of levels and technical specifications as well as the participation of the staff of the institution in the remodelling or building of infrastructure.
- Future interventions in infrastructure should plan for the participation of the staff of the health care facility as well as the community—in particular of the women—when performing renovations that involve the cultural adaptation of environments. Coordination with the community guidelines on *interculturalidad* is essential.
- Agreements with the municipalities should clearly establish the competencies and the specific responsibilities of all parties involved for the maintenance of infrastructure and equipment.
- Separating the operating room in SAFCI health centres from the regular patient rooms would facilitate the cultural appropriateness of the services to include elements that allow women to be more comfortable. The MSD should count on a specialised unit for the design and incorporation of technology, the prime responsibility of which would be to approve all construction and purchase of equipment, and have access to monitoring teams at the departmental level.

Capacity Development – Training, Technical Assistance and Institution Strengthening

- The criteria for selecting personnel to be trained must be clearly defined from the outset, and must include important elements such as relevance and significance of the training curriculum for trainees and their home institution.

- A database of trained personnel (by subject, department, category, etc.) should be established, primarily with a view to avoiding duplication of participants.
- With respect to administrative issues, technical assistance is required to ensure the implementation of transparent administrative systems and processes, and the efficient use of financial resources in support of the implementation of activities and the achievement of results.
- Tighter communication and coordination with the education sector is recommended, in particular in situations where the promotion and dissemination of healthy practices are embedded in the design of interventions.
- In order to prevent the absenteeism of staff, and added costs, on-site training should be promoted as much as possible.
- Given the significant problems and needs associated with human resources management, any future intervention within the health system and with the MSD should include a component that examines this issue and addresses associated risks and mitigation strategies.
- Training is a costly and significant line of activity in projects of this nature, and it is important to follow up on the acquired skills and competencies. A specific plan in this regard should be devised, and this plan should consider the training's nature, objectives, methodologies, indicators, follow-up mechanisms and funding.

APPENDIX 1 – Recommendations from the Mid-term Evaluation

- The MSD must exercise its leadership in the entire program, not only in the budget component.
- The UP must improve coordination with the SEDES.
- The financial controls should be done after the audits.
- The UP should consolidate results according to results.
- An advisory committee should be created to exchange experiences among PASS partners.
- National committees should address strategic issues (e.g. gender, intercultural, innovative practices to scale up).
- A departmental operational committee should be created.
- The FPS should be guided in construction standards.
- A consensus should be reached between the MSD, UNICEF and the FPS with respect to infrastructure.
- Infrastructure and equipment should be prioritised according to baseline.
- The PRICCAS should prepare a sustainability plan to transfer interventions to the SEDES, municipalities and other local institutions.
- The PRICCAS should prepare a gender action plan during the last two years of the program.
- The PRICCAS should disseminate best practices within the MSD and the development community at large.
- The FLASS should implement at least one project in Pando.
- The Emergency Obstetric Care Strategy should be strengthened.
- The financial systems of the SEDES and municipalities should be strengthened.
- Coordination should be established with the PAHO to disseminate and scale up interventions.
- Men should be included in the development of “men-friendly reproductive and sexual services.”
- Proactivity must be seen in gender and intercultural practices involving SAFCI.
- Technical assistance must identify financial and administrative bottlenecks in the SEDES.

APPENDIX 2 – Evaluation Matrix

Criteria	Questions	Indicators	Data sources	Data collection methods
1. Development-level results				
1.1 Effectiveness	What progress has been made with respect to real results—outputs, effects—and the performance framework of the program?	<ul style="list-style-type: none"> Nature and extent of results achieved with respect to fair, effective access for populations to integrated health services that are culturally adequate, taking gender equity into account Nature and extent of results achieved with respect to improved quality of comprehensive health services, in terms of resolution capacity, quality, intercultural appropriateness, and effectiveness in controlling illness Nature and extent of results achieved with respect to the capacity of the MSD, the SEDES, networks and health care institutions to exercise health authority within operational plans and programs Variations between planned and achieved results Level of satisfaction with results of Bolivian authorities 	<ul style="list-style-type: none"> Design and planning documents Annual and semi-annual reports Mid-term evaluation MSD National government authorities Municipal government authorities CIDA project team Operational committee Management committee SEDES and REDES FLASS representatives FPS representatives Beneficiaries 	<ul style="list-style-type: none"> Document review Interviews Focus groups Workshops Expert panel group
	Do these results facilitate the achievement of CIDA priorities, particularly under the theme of children and youth?	<ul style="list-style-type: none"> Degree of compatibility of CIDA's investment choices with MDG planned achievements Type of adjustments brought to Canadian programming based on Bolivia's degree of achievement of the MDGs 		
	What are the unexpected results—positive and/or negative—generated by the project?	<ul style="list-style-type: none"> Nature of unexpected (positive or negative) results Actual or potential effects on project operations and on the design and planning of the next phase 		
	What were the main success factors or limiting factors that affected results achievement?	<ul style="list-style-type: none"> Nature of success factors that affected results achievement Nature of limiting factors that affected results achievement 		
1.2 Cost-effectiveness	Is the ratio between costs and results reasonable?	<ul style="list-style-type: none"> Correlation between costs and results Correlation between financial resources disbursed and the achievement of results Nature and quality of the management of resources (funds, expertise, time, etc.) Adequacy of management expenses versus operational expenses 	<ul style="list-style-type: none"> MSD National government authorities Municipal government authorities CIDA project team Operational committee Management committee SEDES and REDES FLASS representatives FPS representatives 	<ul style="list-style-type: none"> Document review Interviews Focus groups Workshops Expert panel group
	Do real expenditures correspond to the expected expenditures, or is a detailed explanation of discrepancies required?	<ul style="list-style-type: none"> Actual versus planned expenditures Justification of discrepancies Quality and timeliness of partner financial information Relevance and timeliness of partner financial allocation 		
1.3 Relevance	Are the local partners' initiatives relevant with respect to the situation, the needs or the problems?	<ul style="list-style-type: none"> Match between needs and the nature of initiatives Perception of beneficiaries Level of satisfaction of local stakeholders regarding the adequacy of results with local political and economic contexts Existence, type and range of preliminary research on national needs and demands from beneficiaries Type and range of beneficiary needs and demands Level of participation of local stakeholders in the identification of needs and demands Existence and quality of documentation that justifies interventions Level of satisfaction of beneficiary country officials with the program design 	<ul style="list-style-type: none"> Design and planning documents Annual and semi-annual reports Mid-term evaluation Systematisation document MSD National government authorities Municipal government authorities CIDA project team Operational committee Management committee SEDES and REDES FLASS and FPS representatives Beneficiaries 	<ul style="list-style-type: none"> Document review Interviews Focus groups Workshops Expert panel group

Criteria	Questions	Indicators	Data sources	Data collection methods
	Are these initiatives consistent with the needs and priorities of the beneficiaries, the country or the region?	<ul style="list-style-type: none"> • Consistency between initiatives and the needs of beneficiaries • Consistency between initiatives and the priorities of Bolivia • Consistency between initiatives and the priorities of regions • Consistency between initiatives and the priorities of the health sector strategy 	<ul style="list-style-type: none"> • Design and planning documents • Annual and semi-annual reports • Mid-term evaluation • Systematisation document • National government authorities • Municipal government authorities • CIDA project team • Operational committee • Management committee • SEDES and REDES 	<ul style="list-style-type: none"> • Document review • Interviews • Focus groups • Workshops • Expert panel group
	To what extent did CIDA develop a gender equity strategy and effectively promote gender equity results through its investments?	<ul style="list-style-type: none"> • Level of implementation of gender equity strategies • Type and number of adjustments brought to gender equity indicators (social, political and economic participation) • Quality of gender equity strategies and results • Level of access by the project beneficiaries to benefits and resources associated with development initiatives • Perceived changes in the lives of women 	<ul style="list-style-type: none"> • Design and planning documents • Annual and semi-annual reports • Mid-term evaluation • Systematisation document • Gender equity strategy and M&E system • MSD • National government authorities • Municipal government authorities • CIDA project team • Operational committee • Management committee • SEDES and REDES 	<ul style="list-style-type: none"> • Document review • Interviews • Focus groups • Workshops • Expert panel group
1.4 Sustainability	What are the chances that the spin-offs/results will be sustainable, once the initiative has ended?	<ul style="list-style-type: none"> • Nature of long-term benefits achieved or potentially achieved following termination of the PASS activities • Nature and extent of potential risks to sustainability 	<ul style="list-style-type: none"> • Design and planning documents • Annual and semi-annual reports • Mid-term evaluation • Systematisation document • MSD • National government authorities • Municipal government authorities • CIDA project team • Operational committee • Management committee • SEDES and REDES • FLASS representatives • FPS representatives • Beneficiaries 	<ul style="list-style-type: none"> • Document review • Interviews • Focus groups • Workshops • Expert panel group
	To what extent is there local ownership on the part of local actors (i.e. the MSD, the SEDES) with respect to the approach and strategies used to achieve expected results and maintain the acquired practices?	<ul style="list-style-type: none"> • Degree of appropriation and ownership on the part of local actors • Nature of practices that have percolated within different levels • Nature and extent of potential institutional obstacles and/or limitations regarding ownership and appropriation 		
	To what extent does the MSD have the capacity to reproduce, replicate or adapt the intervention methodology in other Bolivian departments?	<ul style="list-style-type: none"> • Nature of institutional strengths and limitations with a view to replicating or adapting the project methodology in other departments • Examples of actual or potential initiatives towards replication and/or adaptation of the model in other departments 		
	Is the time allocated to project delivery and the achievement of results adequate and sufficient to ensure the sustainability of results?	<ul style="list-style-type: none"> • Capacity of executing agencies to deliver outputs and achieve results on time • Level of adjustment to the political and economic context of the country and/or region 		
	To what extent have risks associated with sustainability of results been adequately identified, analysed and managed?	<ul style="list-style-type: none"> • Quality of sustainability strategies • Nature of sustainability risks identified in the project design • Nature of sustainability risk reduction strategies identified and deployed during project implementation 		

Criteria	Questions	Indicators	Data sources	Data collection methods
2. Quality of the partnership				
2.1 Local ownership	Do the participants have a clear and comprehensive definition and acceptance of their roles and responsibilities with respect to the program?	<ul style="list-style-type: none"> • Level of understanding and acknowledgment on the part of various key actors in the program • Discrepancies seen in the understanding of roles and responsibilities and in justifications 	<ul style="list-style-type: none"> • Design and planning documents • Annual and semi-annual reports • Mid-term evaluation • Systematisation document • MSD • National government authorities • Municipal government authorities • CIDA project team • Operational committee • Management committee • SEDES and REDES • FLASS representatives • FPS representatives • Beneficiaries 	<ul style="list-style-type: none"> • Document review • Interviews • Focus groups • Workshops • Expert panel group
	To what degree has the MSD taken ownership of the program?	<ul style="list-style-type: none"> • Nature of concrete measures taken by the MSD to fully exercise its key role as leader and regulator • Nature of concrete measures taken by the authorities at the departmental level (i.e. SEDES and REDES) to take ownership of the program • Nature of concrete measures taken by the target communities to take ownership of results of the program • Level of involvement of key actors in the implementation of program activities • Perceived changes in local ownership (examples) 		
2.2 Joint responsibility for results	Is the responsibility for achieving results shared jointly?	<ul style="list-style-type: none"> • Examples of commitment by the partners (i.e. the MSD, the SEDES and local communities) in achieving the results and maintaining vested interests • Level of understanding of the importance of joint responsibility in view of achieving sustainable results 	<ul style="list-style-type: none"> • Annual and semi-annual reports • Mid-term evaluation • Systematisation document • Operational committee • Management committee • SEDES 	<ul style="list-style-type: none"> • Document review • Interviews • Focus groups • Workshops • Expert panel group
3. Success factors				
3.1 Sound concept, relevant model	Have the goals, objectives, expected results and performance indicators met CIDA's requirements concerning RBM, as defined within the framework of a participative approach, and based on a clear understanding of the local context?	<ul style="list-style-type: none"> • Existence of a management strategy to assess the performance of development interventions against stated results (outputs, outcomes, impacts) • Evidence of a RBM strategy, a monitoring/evaluation function and a risk management function • Nature and degree of participation of various key actors in the project • Degree of integration of past lessons learned in the design and implementation of the country program • Evidence that past evaluations have been used at the design and implementation phases of CIDA's country program 	<ul style="list-style-type: none"> • Design and planning documents • Annual and semi-annual reports • Mid-term evaluation • Systematisation document • MSD • National government authorities • Municipal government authorities • CIDA project team • Operational committee • Management committee • SEDES and REDES • FLASS representatives • FPS representatives • Beneficiaries 	<ul style="list-style-type: none"> • Document review • Interviews • Focus groups • Workshops • Expert panel group
	Are the strategies well adapted to the situation, the needs or the problems?	<ul style="list-style-type: none"> • Nature, extent and quality of strategies • Level of adaptation to various dimensions of the project (needs, institutional environment, etc.) 		
	Were risks well defined at the time of project design and planning?	<ul style="list-style-type: none"> • Evidence of a risk management strategy with clear and pragmatic mitigation measures 		
	What are the strengths and/or weaknesses of the multi-component model that has been implemented?	<ul style="list-style-type: none"> • Nature of strengths and weaknesses of the model • Extent to which the weaknesses were addressed over the course of the project • Extent to which the design and model were modified over the course of the project 		

Criteria	Questions	Indicators	Data sources	Data collection methods
3.2 Community involvement (FLASS projects)	To what extent are the projects implemented by NGOs in the three departments relevant?	<ul style="list-style-type: none"> Consistency of project design with the PASS approach and principles 	<ul style="list-style-type: none"> Design and planning documents Annual and semi-annual reports Mid-term evaluation Systematisation document MSD National government authorities Municipal government authorities CIDA project team Operational committee Management committee SEDES and REDES FLASS representatives FPS representatives Representatives of the <i>Fondo Local de Salud</i> (Local Health Fund) Beneficiaries 	<ul style="list-style-type: none"> Document review Interviews Focus groups Workshops Expert panel group
	What is the degree of complementarity with efforts made by major partners of the PASS?	<ul style="list-style-type: none"> Extent to which partners communicate, exchange and stimulate cross-fertilisation Evidence (or lack thereof) of overlap or duplication of efforts Evidence of cross-fertilisation experiences between NGOs and the MSD and between the MSD and the FPS 		
	To what extent have the departmental partners (i.e. the SEDES, the REDES and communities) taken ownership of know-how implemented by the NGOs?	<ul style="list-style-type: none"> Evidence of appropriation of NGO know-how and results of NGO initiatives Degree of involvement of local stakeholders in the design, management and monitoring of the sample of projects during the program Results achieved in terms of capacity building and overall improvements and performance within beneficiary institutions 		
3.3 Timely interventions (risk management)	To what extent are the networks effective and do the methods enable the identification and evaluation of mainstream trends and key changes that are likely to affect the program?	<ul style="list-style-type: none"> Efficient management mechanisms and coordination between the major partners of the PASS (i.e. the MSD, the PRICCAS-UNICEF, the FPS and the FLASS) 	<ul style="list-style-type: none"> Design and planning documents Annual and semi-annual reports Mid-term evaluation Risk management framework MSD National government authorities Municipal government authorities CIDA project team Operational committee Management committee 	<ul style="list-style-type: none"> Document review Interviews Focus groups
	To what extent are the strategies and practices adapted to the nature and level of inherent and external risks that could affect program funding and assets?	<ul style="list-style-type: none"> Existence of a risk management framework Number and quality of risk reduction initiatives that were designed and used during the country program funding period Type of risks identified and matching mitigation strategies adopted to reduce potential risks during implementation of the country program Quality of decisions taken during implementation of the country program, in light of the ongoing analysis and management of risks 		
		<ul style="list-style-type: none"> Existence and quality of the performance measurement framework Level of compatibility of the performance measurement framework (and indicators) with the Bolivian implementation context and with CIDA's capabilities in the field Regularity of reporting Relevance, timeliness and quality of reporting 		

Criteria	Questions	Indicators	Data sources	Data collection methods
3.4 Gender equity	To what extent has the country program strategically and operationally integrated crosscutting themes?	<ul style="list-style-type: none"> • Existence of a policy framework for gender equity issues • Incorporation of relevant analyses of gender issues into the planning and implementation process • Existence of crosscutting strategies within monitoring processes 	<ul style="list-style-type: none"> • Design and planning documents • Annual and semi-annual reports • Mid-term evaluation • Systematisation document • MSD • National government authorities • Municipal government authorities • CIDA project team • Operational committee • Management committee • SEDES and REDES • FLASS representatives • Beneficiaries 	<ul style="list-style-type: none"> • Document review • Interviews • Focus groups • Workshops • Expert panel group
	What is the degree of ownership of gender equity by partners in the field (i.e. the SEDES and the REDES)?	<ul style="list-style-type: none"> • Level of awareness of crosscutting issues among representatives from the Government of Bolivia and civil society • Level of application of gender equity principles and practices 		

APPENDIX 3 – List of Documents Examined

Acta de Resoluciones y Recomendaciones de la Primera Sesión del Comité de Gestión. [n.p.] October 2007.

Annual matrices of indicators of progress accomplished.

Care Internacional Bolivia. *Solicitud de No de Objeción – Proyecto Hass para Flass Pando.* [n.p.] November 2010.

CIDA. *Acuerdo de Contribución PASS.* [n.p.] March 2007.

CIDA. *Acuerdo de Financiación entre la ONG Samaritan's Purse, Cooperación Francesa y la Agencia Canadiense para el Desarrollo Internacional, para el Proyecto “Agua Segura para las Poblaciones en el Departamento de Pando.”* [n.p.] April 2012.

CIDA. *Anexo A1: Fondo Local de Apoyo a la Salud del Departamento de Pando.* [n.p.] [n.d.].

CIDA. *Descripción del Proyecto, Agua Segura para Poblaciones Vulnerables en el Departamento de Pando.* [n.p.] [n.d.].

CIDA. *Descripción del Proyecto, Construyendo Redes Sociales en Torno a la Salud de Nuestros Pueblos.* [n.p.] [n.d.].

CIDA. *Descripción del Proyecto, Desarrollo Infantil Integral Comunitario: “Desde mis raíces.”* [n.p.] [n.d.].

CIDA. *Descripción del Proyecto, Fortaleciendo el Bienestar Familiar y Comunitario a través de Redes Locales de Salud.* [n.p.] [n.d.].

CIDA. *Descripción del Proyecto, Movilizando la Comunidad para Construir Puentes entre las Mujeres y los Servicios de Salud en Municipios Indígena.* [n.p.] [n.d.].

CIDA. *Descripción del Proyecto. Mujeres de Áreas Rurales del Beni Promueven sus Derechos Mediante Estrategias de Participación Comunitaria.* [n.p.] [n.d.].

CIDA. *Descripción del proyecto, Un Aguayo para un Parto sin Riesgos en los Municipios de la Mancomunidad Aymaras sin Fronteras del Departamento de Oruro.* [n.p.] [n.d.].

CIDA. *Enmienda Acuerdo de contribución.* [n.p.] May 2010.

CIDA. *Health Situation in the Country.* [n.p.] [n.d.].

CIDA. *Informe 4, Fortaleciendo el Bienestar Familiar y Comunitario a través de las Redes Locales de Salud.* [n.p.] July 2011.

CIDA. *Informe Evaluación Final Salud ACDI/BENI.* [n.p.] May 2011.

CIDA. *Informe Final Salvando Vidas de Madres y Niños en el Municipio de San Pedro de Totora.* [n.p.] December 2010.

CIDA. *Informe final, Un Aguayo para un Parto sin Riesgos en los Municipios de la Mancomunidad Aymaras sin Fronteras del Departamento de Oruro.* [n.p.] October 2010.

CIDA. *Planilla de Asistencia, Reunión de Socialización del Proyecto, Tendiendo Puentes entre las Comunidades y los Servicios de Salud para la Humanización y Adaptación Cultural del Parto.* [n.p.] March 2011.

- CIDA. *Programme d'appui au secteur santé en Bolivie, Cadre de référence*. [n.p.] [n.d.].
- CIDA. *Reporte de Cierre de Proyecto*. [n.p.] January 2011.
- CIDA. *Reporte de Cierre de Proyecto*. [n.p.] July 2011.
- CIDA. *Reporte de Cierre de Proyecto*. [n.p.] October 2010.
- CIDA, and MSD. *Plan de Implementación del Programa de Apoyo al Sector Salud – Versión preliminar*. [n.p.] Mayo 2007.
- CIDA, and Samaritan's Purse. *Informe de Cierre, Proyecto "Fortaleciendo el Bienestar Familiar y Comunitaria a través de las Redes Locales de Salud" Flass Canadá 2009-2011*. [n.p.] August 2011.
- CIDA, and UNICEF. *Increasing Coverage and Quality of Health Care in Beni, Pando and Oruro, Bolivia*, [n.p.] March 2009.
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- CIES. *Informe Final, Mujeres de Áreas Rurales del Beni Promueven sus Derechos Mediante Estrategias de Participación Comunitaria*. [n.p.] September 2010.
- CIPOAP. *Mapa: Ubicación Geográfica Comunidades Indígenas de Pando*. [n.p.] [n.d.].
- CIPOAP. *Tabla: Detalles Comunidades Pando*. [n.p.] [n.d.].
- Coupal, Françoise, Lynn Johnson, and Waldo Gutierrez. *Mid-Term Evaluation of the Bolivian Health Support Programme*. [n.p.] November 2009.
- Encuesta Nacional de Demografía y Salud. *Tasa de Mortalidad Neonatal e Infantil Bolivia 2003-2008*. [n.p.] [n.d.].
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APPENDIX 4 – List of Evaluation Informants

Participants in Semi-Structured Interviews, Focus Groups, Roundtables or Workshops

Name	Title/functions	Level	Coordinates	Comments
Management committee of the PASS (including current and former CIDA representatives)				
Juan Carlos Calvimonte	Minister of Health and Sports	National		Interview (newly appointed)
Harley Rodriguez	Vice-Minister of Public Investment and External Finance	National	harley.rodriguez@vipfe.gob.bo (2) 231 74 24; Directo 211 32 99 Celular 70595000 / 72007544	In-depth interview. La persona del VIPFE que lleva Canadá es Estephani Bellot, Telf. (2) 2317424 int. 1132 Mail estephani.bellot@vipfe.gob.bo, (aunque a los Comités de Gestión han venido también otras personas).
Roxana Encinas	Jefe de Gestión de Convenios FPS	National	roxencinas@fps.gob.bo (2) 241 24 74	In-depth interview
Andrew Scyner	Chief of the Canadian Government Cooperation	National	Andrew.Scyner@international.gc.ca (2) 241 51 41	In-depth interview
Luc St-Laurent	Primer Secretario Cooperación ACDI (Programa Salud)	National	Luc.St-Laurent@international.gc.ca (2) 241 51 41	In-depth interview
Anne-Marie Hodgson	Former Primer Secretario Cooperación ACDI (Programa Salud)	National	annemarie_hodgson@acdi-cida.gc.ca 819-997-4749	In-depth interview
Michel Thieren	PAHO representative in Bolivia	National	mthieren@bol.ops-oms.org (2) 241 24 65	In-depth interview
Operational committee of the PASS				
Germán Crespo	Former Director, MSD-UP	National	crespo_german@yahoo.com (2) 244 35 21	Group discussion/UP
Leslie La Torre	PASS Funding Consultant, MSD	National	leslielatorre@hotmail.com (2) 244 35 21	Group discussion/UP
Johnny Sánchez	Former Director, MSD-UP	National	j_saurio@hotmail.com (2) 244 35 21	Focus group Ha intervenido en el PASS desde el inicio
Rafael Cortés	Especialista infraestructuras de Salud FPS	National	rcortez@fps.gob.bo (2) 241 24 74	Focus group
Pilar López	Health Consultant UASCC	National	plopez@uascc.bo (2) 241 15 11	In-depth interview
Erica Silva	Former Health Consultant UASCC	National	esilvavega@hotmail.com	In-depth interview
Eliana Gallardo	Responsible for Gender UASCC	National	egallardo@uascc.bo	Expert panel
Ivana Calle	Gender Responsible UNICEF	National	icalle@unicef.org	Expert panel
Ivette Sandino	Health & Program Manager UNICEF	National	isandino@unicef.org (2) 277 02 22 / 71527921	In-depth interview
Rosario Quiroga	Health Specialist/UNICEF	National	rquiroga@unicef.org (2) 277 02 22 / 71559716	Focus group/interview
Roberto Amusquivar	SEDES Director Oruro	Departmental	010 (2) 5257708	Focus group/interview

Name	Title/functions	Level	Coordinates	Comments
César Lijerón Suarez	SEDES Director Beni	Departmental	010 34621199 / 22818	Focus group/interview Nuevo en el cargo
Alicio Guzmán	SEDES Director Pando	Departmental	010 3842 / 3474 / 3473	Focus group/interview Nuevo en el cargo
USAID				
Marina Cardenas		National		In-depth interview
MSD				
Rene Lenis	Chief of the Epidemiology Unit	National		In-depth interview
Nila Heredia	Ex-Minister of Health and Sports	National		In-depth interview
PRICCAS operational committee				
Leda Asad	Community Health Officer	National		Group interview/UNICEF
Ivana Calle	Gender Officer	National		Group interview/UNICEF
National Social and Productive Investment Fund (FPS)				
	Infrastructure Manager			
Rosendo Copa	Gerente FPS Oruro	Departmental	5255770 / 5279980	In-depth interview
Carlos Gómez	Gerente FPS Beni	Departmental	70265012 / 70265013	In-depth interview
Sergio Condori	Gerente FPS Pando	Departmental	8423344	In-depth interview
FLASS				
FLASS Oruro				
Wendy Mc Farren y Fernando Arduz Loayza	Directora y Gerente Adm. CFB		farduz@bolivia.childfund.org (2) 2791408 / (2) 2799619	Focus group/FLASS
	CARE			
Luis Ramirez	Director Save the Children		bolivia@savechildren.org.bo (2) 248 16 06	
	Samaritan's Purse			
Eduardo Alfaro	CECI		(2) 212 57 02	Focus group/FLASS
	Support National Health Dialogue			
Eddy Vásquez Calderón	Alcaldía Municipal San Pedro Totora		vasquez_calderon@hotmail.com 2-5278608, Celular: 71215481	Focus group/FLASS
FLASS Beni				
Anastasio Choque	Responsable legal APROSAR		contacto@aprosarbolivia.org.bo 2-52-63622	Focus group/FLASS
Jhonny López	Director CIES		jlopez@cies.org.bo (2) 248 51 11	Focus group/FLASS
Enrique Carrasco	Director Nacional Programas Samaritan's Purse		ECarrasco@samaritan.org (2) 279 23 87 / 277 53 68	Focus group/FLASS

Name	Title/functions	Level	Coordinates	Comments
FLASS Pando				
Chris Sykes	Director CARE		Chris.Sykes@bo.care.org	Focus group/FLASS
Alexia Escobar	Coordinadora FCI		aescobar@fcimail.org	Focus group/FLASS
Enrique Carrasco	Director Nacional Programas Samaritan's Purse		Ecarrasco@samaritan.org	Focus group/FLASS
SEDES				
SEDES Oruro				
	Operational Coordination Committee			
Dr. David Choque	Chief of the UP	Departmental		Focus group/SEDES
Dr. Rodolfo Martinez	UP Counterpart for PRICCAS	Departmental		Focus group/SEDES
	Chief of Reproductive Health Department	Departmental		Focus group/SEDES
	Chief of Child Health Department	Departmental		Focus group/SEDES
	Gender Responsible	Departmental		Expert evaluation model/SEDES
	Chief of Epidemiology Department	Departmental		Focus group/SEDES
	Promotion Unit Responsible	Departmental		Focus group/SEDES
	Red Asanaque: Dr. Abundio Taquimallcu	Local		Focus group/REDES
	Red Cuenca Poopó: Dr. Ladislao Iñiguez	Local		Focus group/REDES
	Red Occidente. Dr. Reino Alvarez	Local		Focus group/REDES
	Red Minera: Dr. Jorge Viracochea	Local		Focus group/REDES
	Red Urbana: Dr. Mario Coro Alvarez	Local		Focus group/REDES
	Coordinador Departamental de FPS	Departmental		In-depth interview
	San Juan de Dios Hospital Director	Local		Focus group/hospital
	Walter Khon Hospital Director	Local		Focus group/hospital
	Huanuni Hospital Director	Local		Focus group/hospital
	AMUPEI	Departmental		Expert evaluation model/SEDES
	Eucaliptus Mayor	Local		In-depth interview
	Trainees Group			Focus groups
	Community Leaders	Local		Focus groups
Ruth Bolaños	SECI Manager of Un Aguayo para un parto de calidad	Local		In-depth interview

Name	Title/functions	Level	Coordinates	Comments
SEDES Beni				
	Operational coordination committee			
Dr. Justiniano	Ex-SEDES Director	Departmental		In-depth interview
	Chief of the UP			Focus group/SEDES
	Chief of Child and Maternal Department	Departmental		Focus group/SEDES
	Nutrition Responsible	Departmental		Focus group/SEDES
	Red 1 Trinidad: Dr. Luís Suárez Pova	Local		Focus group/REDES
	Red 2 Moxos: Dr. Miguel Ángel Melgar	Local		Focus group/REDES
	Red 3 Iténez. Dr. Julio Cesar Franco	Local		Focus group/REDES
	Red 6 Ballivian: Dr. Pedro Chávez Sorioco	Local		Focus group/REDES
	Red 7 Riberalta: Dr. Edgar Suárez Gonzales	Local		Focus group/REDES
	Mayor of Riberalta	Local		In-depth interview
	Maternal and Child Hospital Director			In-depth interview
	Mobile Health Brigade personnel			Focus group/brigades
	Multiprogramatic Campaign Responsible			In-depth interview
	Community Leaders Group			Focus group
	Mayor of San Ignacio de Moxos	Local		In-depth interview
	Departmental FPS Manager			
SEDES Pando				
	Operational coordination committee			
	Chief of the UP	Departmental		Focus group/SEDES
	Chief of Epidemiology Unit	Departmental		Focus group/SEDES
	Chief of Child and Maternal Department	Departmental		Focus group/SEDES
	Nutrition Responsible	Departmental		Focus group/SEDES

Participants in Interviews, Focus Groups and Field Visits

Name	Organisation	Title/duties
Operation committee – La Paz		
Rosario Quiroga	UNICEF	
Ana Amador	Samaritan's Purse	
Roxana Rios	CIES	
Marcos Paz	FCI	
Pilar Lopez	UASCC	
Luis Ramirez	Save the Children	
Johnny Sanchez	DGP/MSD	
Leslie La Torre	DGP/MSD	
Yolanda Gutierrez	FPS/Salud	
Rafael Cortez	FPS-Central	
Oruro – FLASS and Samaritan's Purse		
Angelina Gongora		Promotora de Salud
Carla Salvatierra		Madre Pesadora
Yaqueline Espindola		Madre nutricionista
Beatriz Quispe		Capacitadora en salud y nutrición
Francy Galvez		Capacitadora en salud
Elianay Loras	Samaritan's Purse	Coordinadora proyectos salud
Gaston Duran	Samaritan's Purse	Sup. De filtros
Adaliz Cuellar	SEDES – Beni	Apoyo programa nutrición
Manuel		
Adolfo Reyna	SP Beni	Gerente
Oruro – SEDES		
Dora Gómez	AMUPEI	Consejo consultivo
Pierina Fortun	AMUPEI	Asesora social
Maya Zuazo	SEDES – Programa Género	Programa genero y no violencia
Katiuska Gómez	SEDES – Oruro	PASS Canadá
Carmen Miranda	AMUPEI	Jurídica
Cintha Velasco	SEDES	Planificación
Oruro – Centro de Salud Totorá		
Sabino Soto	CSH Totorá	Auxiliar en enfermería
Dra Kalunia Gómez	SEDES Oruro	Responsable PASS Canada
Int Claudia Rojas	CSH Totorá	Int Licenciatura
Avigail Rodriguez	CSH Totorá	Int Licenciatura en enfermería
Bania Silvestre	CSH Totorá	Int Medicina
Patricio Sojoma	CS Totorá	Aux enfermería
Raul Bustillos	PS Huacanapi	Presidente de médicos tradicionales
Daria Choque	PS Huacanapi	Medicina tradicional
Porfirio Ríos	PS Calazaya	Medico cirujano
Wilma Duran	PS Centro Warawara	Medicina tradicional
Basilía Marnani	CS Totorá	Lic. en enfermería
Vladimir Velásquez	CS Totorá	Medico de planta
Mauricio Lara	PS Sora Sora	Aux enfermería

Name	Organisation	Title/duties
Felix Ramirez	PS Crucero	Aux enfermería
Alicia Mamani	PS Calazaya	Aux enfermería
Leonardo Copaja	GAM	Administración
Castro Pomachurani	GAM Titora	Técnico Agropecuario
Perciliano Villazon	PS Alto Yanque	Lic en enfermería
Elizabeth Mamani	GAM Titora	D.N.A
Zejeja Marca	GAM Titora	Limpieza
Dr. David Ross	CSH Titora	Medico de Bono JAP
Dra. Lutgarda Ticona	CSH Titora	Medico de municipio
Dr. Nazario Anconi	CSH Titora	Conductor de ambulancia
Dr. Walter Choque	CSH Titora	Odontólogo de planta
Oruro – SEDES		
Dr. Alfredo Rawalo	Centro de salud Viato	Medico
Dr. Groul Busanto	HGSJ	Responsable SICAP
Dra. Mirna Toro	HGSJDD	Residente pediatra
Dra Elsa Cala	HG Challapata	Pediatra
Lic. Virginia Herbas	Hospital general Oruro	Neonatología
Dr. Katushia Gómez	SEDES Oruro	PASS Canada
Dr. Ladislao Iñiguez	SEDES Oruro	Coordinador red cuencas
Dra. Mirtha Carrero	HGSJDD Oruro	Pediatra
Dra. Alison Cheque	Hospital SMP	Pediatra
Dra. Paola Navarro	Hospital San Andrés	Medico
Dr. Hermes Achacollo	Red Norte	Coordinador
Lic. Cynthia Gorená	SEDES Oruro	Técnico en Planificación
Dr. Pomerano Juniez	Hospital general	
Dr. David Choque	SEDES Oruro	Unidad de planificación
Dr. Ernesto Vasquez	SEDES Oruro	Zoomosis Ai epidemial
Dr. Luis Gutierrez	SEDES Oruro	Unidad de servicios
Lic. Maya Zuazo	SEDES Oruro	Programa genero y no violencia
Dra. Carolina Veliz	SEDES Oruro	Programa ALEPI NUT
Lic. Roberto Medina	SEDES Oruro	Unidad administrativa y financiera
Rosendo Copa	FPS Oruro	Gerencia Oruro
Edson Copa	FPS Oruro	Técnico operativo
Dr. Rodolfo Martinez	SEDES Oruro	Proyectos
Israel Ramirez	Occidente	Coordinador
Mario Coro	Red Doly	Coordinador
Ladislao Iñiguez	Red cuenca	Ex coordinador
Gerardo Choquecallo	Red minera	Coordinador
Marcela Flores	Red C	Coordinador
Pando – SEDES		
Monica Vargas	HRGT	Jefe de servicios de maternidad
Lidia Vianaya	Hospital RST	Ginecología
Nancy Janco	HRGT	Lic. enfermería
Alfredo Ossio	SEDES Pando	Medico, coordinador red 01 Cobija
Jhonny Cueto	SEDES Pando	Medico, coordinador red 02

Name	Organisation	Title/duties
Sergio Condori	FPS	Gerente departamental Pando
Marcos Daza	SEDES Pando	Planificador
Gaby Mamani	SEDES Pando	Laboratorio biología molecular
Roxana Lima	SEDES Pando	PAI
Sandra Shimokawa	SEDES Pando	Calidad
Rosmery Ledesma	SEDES Pando	Programa Nutrición
Waldredo Gutierrez		Programa ITS/VIH/SIDA
Cristina Alto	SEDES Pando	Programa SNIS/VE
Aleida Bautista	SEDES Pando	Programa NNA
Marilyn Ariza	UNICEF	Consultora-Coordinadora EQI
Denis Aranabia	UNICEF	Asistente de coordinación
Jakeline Suarez	SEDES Pando	Programa genero y violencia
Harmosell Fanola	SEDES Pando	Programa salud sexual y reproducción
Teddy Luna	SEDES Pando	Técnico planificación
Leticia Echeverria	SEDES Pando	Jefe administrativo y financiero
Beni – SEDES y Hospital		
Ma. Antonia Costales	Hospital	Pediatra
Cecilia Vásquez	HMI	Enfermera
Rasam Dana	HMI	Pediatra
Vivian Rodal	HMI	Lic. enfermería
Daniela Rioja	HMI	Lic. nutrición
Fabiola Yrigoyen	HMI	Pediatra
Amanda Moreno	HMI	Jefe departamento ginecología-obstetricia
Newton Andia	HMI	Ginecólogo-obstetra
Rocio Cardozo	SEDES Beni	SSC
Sebastian Ortiz	UNICEF	Coordiandor EQI
Eduardo Soloza	SEDES Beni	Planificador
Rocio Cardozo	SEDES Beni	SSC
Nacira Vargas	PAI Beni	ODS/OMS PAI Beni
Patricia Dávalos	SEDES Beni	PAI
Rosmery Baltazar	SEDES Beni	Nutrición
Aracy Pere	SEDES Beni	Genero – VIF
Oscar Avila	FPS	Profesional técnico
Rene Mercado	SEDES Beni	SSyR Beni
Pedro Chavez	Red 06 Ball	Coordinador de red
Ricardo Sosa	Red 05 Y	Administrador

APPENDIX 5 – Logic Model of the PASS

Note: The following is a loose translation of the original, Spanish version.

Narrative summary	Expected results	Indicators	Assumptions and risks									
<p>Goal</p> <p>Improve the health situation of the Bolivian population, especially in the departments of Beni, Pando and Oruro</p>	<p>Impact</p> <p>Increase the years of healthy life</p>	<ul style="list-style-type: none"> • Life expectancy at birth • Municipal health index or other synthetic index with maternal and infant mortality • Undernourishment rate for children under 5 years old 	<ul style="list-style-type: none"> • Social, political and economic stability • Effective commitment of the departmental and municipal governments • Compliance of counterparts at their respective levels 									
<p>Purpose</p> <p>Help improve the primary health care public services and reinforce public management capacities in this area, especially in the targeted departments</p>	<p>Outcomes</p> <ul style="list-style-type: none"> • Effective and equitable access of the population to comprehensive, culturally-appropriate and gender-equitable health care services • Improved quality of integrated health services with respect to resolution capacity, quality, intercultural appropriateness, gender equity, and effectiveness of the control of communicable diseases • Increased capacity within the MSD, the SEDES, the REDES and health institutions to exercise leadership in the health sector, following the operational plans and program frameworks 											
<p>Outcome 1. Effective and equitable access of the population to comprehensive, culturally-appropriate and gender-equitable health care services</p>												
<p>Activities</p>	<p>Outputs</p> <p>1.1 Integrated fixed or mobile health services that are regularly delivered to populations and families, with an emphasis on marginalised towns and communities</p>	<table border="1"> <tr> <td data-bbox="1035 857 1549 927">1. Number of families, communities and towns fully served through mobile services with the SAFIC model, at least four times a year</td> <td data-bbox="1554 857 1948 1312" rowspan="9"> <ul style="list-style-type: none"> • Effective commitment of the departmental and municipal governments • Compliance of counterparts at their respective levels • Complementary contributions from other financial sources • Sufficient human resources in terms of quantity and quality, and complementary logistic resources • Appropriate human resources management (rational distribution according to the profile level, stability, responsible labour union action, etc.) </td> </tr> <tr> <td data-bbox="1035 930 1549 984">2. Number of families served through home visits with the SAFIC model</td> </tr> <tr> <td data-bbox="1035 987 1549 1040">3. Number of families served within multiprogramming campaigns</td> </tr> <tr> <td data-bbox="1035 1044 1549 1097">4. Number of services to families, per year and per service (service usage index, service/person/year)</td> </tr> <tr> <td data-bbox="1035 1101 1549 1154">5. Percentage of decrease in the urban/rural coverage gap for the pentavalent vaccine</td> </tr> <tr> <td data-bbox="1035 1157 1549 1187">6. Micronutrient coverage for children under the age of 5</td> </tr> <tr> <td data-bbox="1035 1190 1549 1219">7. Coverage of the 4th prenatal care</td> </tr> <tr> <td data-bbox="1035 1222 1549 1276">8. Number of families at risk with community health workers and brigade home visits</td> </tr> <tr> <td data-bbox="1035 1279 1549 1308">9. Institutionally-covered child birth</td> </tr> </table>	1. Number of families, communities and towns fully served through mobile services with the SAFIC model, at least four times a year	<ul style="list-style-type: none"> • Effective commitment of the departmental and municipal governments • Compliance of counterparts at their respective levels • Complementary contributions from other financial sources • Sufficient human resources in terms of quantity and quality, and complementary logistic resources • Appropriate human resources management (rational distribution according to the profile level, stability, responsible labour union action, etc.) 	2. Number of families served through home visits with the SAFIC model	3. Number of families served within multiprogramming campaigns	4. Number of services to families, per year and per service (service usage index, service/person/year)	5. Percentage of decrease in the urban/rural coverage gap for the pentavalent vaccine	6. Micronutrient coverage for children under the age of 5	7. Coverage of the 4th prenatal care	8. Number of families at risk with community health workers and brigade home visits	9. Institutionally-covered child birth
1. Number of families, communities and towns fully served through mobile services with the SAFIC model, at least four times a year	<ul style="list-style-type: none"> • Effective commitment of the departmental and municipal governments • Compliance of counterparts at their respective levels • Complementary contributions from other financial sources • Sufficient human resources in terms of quantity and quality, and complementary logistic resources • Appropriate human resources management (rational distribution according to the profile level, stability, responsible labour union action, etc.) 											
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Narrative summary	Expected results	Indicators	Assumptions and risks
Reinforce community participation in health care	1.2 Organised communities that actively exercise their right to health care and that participate in social monitoring of health care delivery	1. Number of municipal health committees with regular meetings (with minutes) 2. Number of local health committees with regular meetings (with minutes) 3. Number of committee resolutions that are applied 4. Number of areas within the organisation that are incorporated into their institution's health committee 5. Percentage of women who participate in municipal health care committees 6. Percentage of municipalities that are accountable to the community 7. Number of conflicts about health care services that are resolved through community and municipal committees 8. Number of officials who take part in the promotion of health care services and programs	<ul style="list-style-type: none"> • Legal and institutional recognition of the operations of community organisations • Community's willingness and capacity to actively organise itself • Standards are relevant, approved, appropriately disseminated and stable • Health care personnel is willing and trained to share decision-making power with the community
Reinforce health care promotion services	1.3 Families, communities and populations that look over their own health and demand quality health services, taking into account cultural diversity and gender equity	1. Percentage of people (by cultural background) who obtain correct answers from the CAP (knowledge, attitudes and practices) about priority topics (mother-child, nutrition, diseases, etc.) 2. Number of families and communities that make an effective contribution to health care actions (promotional and preventive) 3. Number of information/education/communication messages transmitted that deal with intercultural and gender equity	<ul style="list-style-type: none"> • Sufficient knowledge from the population about the new service offer and about its rights • Appropriate incentives policy • Hierarchy of rural functions and values associated with social service
Outcome 2. Improved quality of integrated health services with respect to resolution capacity, quality, intercultural appropriateness, gender equity, and effectiveness of the control of communicable diseases			
Activities Train human resources about key topics related to comprehensive health care	Outputs 2.1 Human resources within the REDES who have improved skills (knowledge, practices and judgment) in maternal and child care, comprehensive care for nutritional childhood diseases, expanded immunisation programs, and communicable diseases	1. Percentage of institutions with trained human resources that apply existing technical standards—obstetric and neonatal care, nutrition and epidemiology, etc. 2. Percentage of human resources with positive supervision results 3. Percentage of institutional assisted child births that are performed according to intercultural health standards 4. Percentage of users who are satisfied with the quality of services	<ul style="list-style-type: none"> • Standards are approved and disseminated • Appropriate human resources management (rational distribution according to the profile level, stability, responsible labour union action, etc.) • Capacity and willingness of the personnel to change attitudes • Motivated personnel who identifies with the new management and care models (SAFCI) • Appropriation by human resources

Narrative summary	Expected results	Indicators	Assumptions and risks
Improve the infrastructure and provide equipment to selected institutions	2.2 Networks and priority health facilities with infrastructures and maternal and child care equipment that meet quality standards appropriate to their level	1. Number of health institutions with standard infrastructure and equipment	<ul style="list-style-type: none"> Standards are relevant, approved, appropriately disseminated and stable Compliance of counterparts at their respective levels
		2. Number of networks possessing equipment and infrastructures that are 100% standard	
		3. Percentage of medical equipment that is operational in the 3rd year	
		4. Percentage of certified and accredited institutions	
Reinforce the organisation and operation of selected service networks, with full application of the SAFCI model	2.3 Networks and health services that are set up to meet the SAFCI standard and address the needs of communities	1. Number of patients referred and counter-referred	<ul style="list-style-type: none"> Sufficient human resources in terms of quantity and quality, and complementary logistic resources Standards are relevant, approved, appropriately disseminated and stable
		2. Number of REDES that apply the SAFCI model	
Outcome 3. Increased capacity within the MSD, the SEDES, the REDES and health institutions to exercise leadership in the health sector, following the operational plans and program frameworks			
Activities Develop a specific national standard for health management, and apply this standard at every level within the selected departments	Outputs 3.1 Decentralised and participative management model standards, developed and implemented	1. Administrative organisation standards are developed	<ul style="list-style-type: none"> Continuity of management policy Continuity or deepening of a decentralisation model that promotes integration and national solidarity Legitimacy and recognition of the MSD's leadership at every level
		2. Specific planning, programming, investment and health control standards (MSD) are developed	
		3. Number of municipal networks and network managements that have implemented administrative organisation, planning, programming, investment and health control standards	
Reinforce the capacity of health authorities to regulate sectorial institutions, intersectorial actions and the civil society	3.2 Health interventions that are coordinated and jointly managed by health sector institutional and social stakeholders and by other socio-economic development partners involved in the targeted departments	1. Number of operational intersectorial municipal networks	<ul style="list-style-type: none"> Existence of systems at various management levels (national health information system, medication and inputs purchases, etc.) Continuity of the intersectorial policy
		2. Number of resolutions passed by nutritional care departmental committees and municipal health committees	
		3. Number of projects and intersectorial actions implemented in the municipalities	
		4. Number of resolutions passed by departmental and municipal health councils	
Reinforce the structures and processes used for planning, alignment, control and evaluation	3.3 SEDES and municipal plans and programs that align with the Health Sector Development Plan for 2010-2020 and that are duly evaluated	1. Number of aligned departmental and municipal health care plans	National Development Plan that is sufficiently continuous and stable
		2. Number of plans that align between sectors, NGOs and civil organisations	
		3. Number of management commitments made between municipalities, the SEDES and the MSD	

Narrative summary	Expected results	Indicators	Assumptions and risks
Reinforce financial capacity at every level	3.4 Increased health sector investments that are managed efficiently within the SEDES and the municipalities and that support a program approach to health care	1. Number of MSD programs and projects that have harmonised financial modalities and that are efficiently implemented 2. Number of municipal annual operational health care plans with increased local funding 3. Percentage of increase in departmental budgets that are allocated to health care in annual operational health care plans 4. Number of institutions in which annual operational health care plans are actually carried out beyond the 80% mark 5. Percentage of municipalities with annual operational health care plans in which funds are used beyond the 80% mark 6. Percentage of municipal annual operational health care plans with local contributions that exceed 70% (i.e. sustainability)	Economic and institutional stability of counterparts at their respective levels
Train human resources at all three levels in health care management	3.5 MSD, SEDES and DILOS officials who strengthen the management capacity within the health sector	1. Number of MSD and SEDES officials trained, with satisfactory follow-up and evaluation	Sufficient human resources in terms of quantity and quality, and complementary logistic resources
Carry out comprehensive management of the PASS	3.6 Effective and efficient management of all PASS components	1. Number of approved resolutions of the operational committee) 2. Number of resolutions adopted by the management committee that have been effectively enforced 3. Components of the PASS (PRICCAS, FPS, SEDES) that are supervised and technically supported at the implementation stage	Stability in decision-making bodies of the program partners