



**BOLIVIA**

**GLOBAL HEALTH INITIATIVE STRATEGY**

**March 2012**



## MAP OF BOLIVIA



### Departments within the country of Bolivia:

1. La Paz
2. Santa Cruz
3. Chuquisaca
4. Tarija
5. Potosí
6. Oruro
7. Cochabamba
8. Pando
9. Beni

Source of map: [www.boliviabella.com](http://www.boliviabella.com)

## **ACRONYMS**

AECID	Agencia Española de Cooperación Interacional para el Desarrollo
AIDS	Acquired Immune Deficiency Syndrome
CDC	Centers for Disease Control and Prevention
CDCS	Country Development Cooperation Strategy
CSMS	Consejo Social Municipal de Salud (Municipal Health Committee)
DHS	Demographic Health Survey
DILOS	Directorio local de Salud (Local Health Directorate)
DPDM	Division of Parasitic Diseases and Malaria (CDC)
DPT3	Diphtheria, Pertussis, Tetanus vaccine (3 <sup>rd</sup> dose)
EcoPol	Economic Political Section (US Embassy)
EmONC	Emergency Obstetrics and Neonatal Care
FIM	Farmacia Intercultural Municipal (Intercultural Municipal Pharmacy)
FSNs	Foreign Service Nationals
GHI	Global Health Initiative
GOB	Government of Bolivia
HIV	Human Immunodeficiency Virus
HSS	Health Systems Strengthening
IMCI	Integrated Management of Childhood Illness
IMCI-Nut	Integrated Management of Childhood Illness-Nutrition
IMR	Infant Mortality Rate
JICA	Japan International Cooperation Agency
LAC	Latin America and the Caribbean
MDGs	Millennium Development Goals
MDR	Multi Drug Resistant
MILGRP	U.S. Military Group (Department of Defense)
MNH	Maternal Neonatal Health
MMR	Maternal Mortality Ratio
MOH	Ministry of Health
NMR	Neonatal Mortality Rate
NSHP	National Sectoral Health Plan (see PSD-S)
NTDs	Neglected Tropical Diseases
NIH	National Institutes of Health
PAC	Post Abortion Care
PAS	Political Affairs Section (US Embassy)
PAHO	Pan American Health Organization
PDC	Programa de Desnutrición Cero (Zero Malnutrition Program)
PMP	Performance Monitoring Plan
PND	Plan Nacional de Desarrollo (National Development Plan)
PSD-S	Plan Sectorial de Desarrollo-Hacia la Salud Universal (National Health Plan)
POAs	Plan Operativo Anual (Annual Work Plans)
Proyecto ISA	Proyecto Integrado de Seguridad Alimentaria (Integrated Food Security Project)
REDES	Red de salud (Health Network)
SAFCI	Salud Familiar, Comunitario e Intercultural
SDE	Sustainable Development and Environment (USAID)
SDP	Sectoral Development Plan (Plan Sectorial de Desarrollo)
SEDES	Servicio Departamental de Salud (Departmental Health Services)
SNIS	Sistema Nacional de Información de Salud (Health Information System)
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infections
TB	Tuberculosis
TFR	Total Fertility Rate
UNICEF	United Nation's Children Fund
USAID	United States Agency for International Development
USDA	United States Department of Agriculture
USG	United States Government

U5MR

Under 5 Mortality Rate

## 1. GHI Vision

The Global Health Initiative (GHI) Strategy in Bolivia (2011-2017) will cover an exciting, yet challenging time in Bolivian history. In the last few years, there have been significant changes in Bolivian health policy to address socio-economic inequalities contributing to poor health outcomes for much of the Bolivian population, especially among indigenous groups and particularly those living in rural, food-insecure areas of the country. The GHI Strategy for Bolivia builds upon past USG activities which have worked closely with the Ministry of Health (MOH), departmental and municipal governments, health authorities and communities, and the private sector, all of which are both participants and stakeholders in the delivery of health services to the Bolivian population. Consequently, the GHI Strategy will strengthen existing platforms to promote wider and more equitable participation of citizens in health policy and management decisions in their communities and municipalities, with the goal of improving technical performance in health facilities and health outcomes for the general population.

Working under the direction of the MOH's "National Sectoral Health Plan, 2010-2015" (NSHP), GHI will support the MOH's new emphasis on validating and incorporating intercultural solutions to the biomedical model of health, which is the basis of the SAFCI (Salud Familiar, Comunidad e Intercultural: Family, Intercultural and Community Health) model of healthcare attention. The NSHP espouses three Pillars: Universal Access to the Single Health System; Sovereignty and Stewardship of the Health Sector; and Health Promotion and Social Mobilization. These pillars are in clear alignment with GHI principles as well as the Paris Declaration principles and highlight the desire of the Government of Bolivia (GOB) to assume a stronger role in country ownership of the health care system, which will be a focus of future USG health investments in Bolivia under GHI. Moreover, under Pillar 1, the GOB lists improvements in human resource management and improvements in quality of care (components of health systems strengthening) as indispensable to achieve improvements in health for underserved communities. As such, the GHI strategy in Bolivia will include health systems strengthening as one of its core focus areas.

The GOB is committed to reducing gender disparities which is specifically listed under Pillar 2 of the NSHP (Health Promotion and Social Mobilization). USG investments in Bolivia will be directed at increasing women's empowerment and reducing gender based violence. USAID/Bolivia has recently completed a gender assessment and the forthcoming results of the study will inform implementation of GHI in Bolivia. Recent research conducted by MACRO International<sup>1</sup> indicates that Bolivia ranked #3 (out of 23 countries) on sources of empowerment and setting for empowerment indicators, which means that overall, the majority of women in Bolivia are empowered to make decisions for themselves, including decisions regarding their own health care. Secondly, the same report indicates that 52.8% of women in Bolivia make decisions regarding their health care alone, without the input of their husbands (another variable indicating women's empowerment), compared to Burkina Faso (ranked last at #23) where 75% of husbands alone (without input from their wives) decide if their spouse can obtain health care.

In order to better support the objectives of the GOB, the Bolivia mission will focus on the following GHI principles: Women, Girls and Gender Equality (with a focus on reducing Gender Based Violence); Country Ownership; and Health Systems Strengthening. In addition, as USG financial inputs in Bolivia are quite

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<sup>1</sup> Kishor, Sunita, and Lekha Subaiya. 2008. *Understanding Women's Empowerment: A Comparative Analysis of Demographic and Health Surveys (DHS) Data*. DHS Comparative Reports No. 20. Calverton, Maryland, USA: Macro International Inc.

modest, the GHI strategy will be implemented in two departments (as opposed to nationally): La Paz and Chuquisaca. Health indicators presented further in the document will substantiate this decision.

The Results Framework provides a useful tool in conceptualizing the intended impact of GHI in the country. The hypothesis of the Country Team is that by strengthening the Bolivian health system (logistics, human resources, and health information systems, for example) with an inclusion of intercultural approaches to health and by empowering rural populations to understand their rights and demand quality health care, an increase in access to quality intercultural health care will occur. The MOH plans to strengthen the health system by incorporating the SAFCI model which represents a paradigm shift in health care delivery in Bolivia. SAFCI is a family focused approach to health care, based on home visits by local health care providers, which allows them to understand the social determinants of health care of the target population. More importantly, given the ethnic diversity of Bolivia, the SAFCI model recognizes, accepts and validates the knowledge, wisdom and practices of Bolivia's indigenous, original and Afro-Bolivian populations as relates to health care. By implementing SAFCI and its community based decision making model for health care issues, the MOH is confident that previously underserved populations will appropriate the health care system as their own and, in the process, become empowered to participate in decision making regarding health at the local, district and municipal levels.

Key components to empower local populations include community engagement (a component of SAFCI) as part of health systems strengthening as well as the implementation of social and behavior change strategies, which are included in the GHI approaches for Bolivia. Increased demand and use of health services from an empowered population occurs in part when the population is aware of their rights to quality health care and possess the skills to demand it from the local and central governments. In addition, an empowered population is one that participates in citizen's municipal health committees (known as municipal health committees, another component of SAFCI) which will inform MOH and municipal health decisions. In addition, the municipal health committees serve as "social auditors" on the implementation of MOH Annual Work Plans.

Social and behavior change strategies will encourage populations to seek care promptly. Improvements in prompt care seeking behavior will lead to improved overall health of the target populations and USG health programs in Bolivia focus primarily on health improvements of women, girls and children under 5 years of age. On the supply side, strengthening the capacity of the logistics system will result in fewer stock outs of essential medicines and vaccines. It is further hypothesized that the increased availability of vaccines and medicines will lead to higher rates of childhood vaccination and reduced rates of childhood morbidity, which will reduce under-five mortality from immuno-preventable diseases. Improving the quality of the health information system will result in both better decision making and enhanced provision of timely health services.

The GHI Vision for Bolivia includes ensuring that capacity building provided to the Ministry in the area of health systems strengthening will support the MOH to better manage human resources, logistics systems, health information systems, and other components of the WHO Building Block model for health systems, with the end result of strengthened leadership and stewardship of the public sector health program by the MOH. Moreover, the GHI vision includes increased coordination and cooperation with existing donors (and the limited number of USG agencies working in health) with the goal of supporting the achievement of the Millennium Development Goals (MDGs); increased country ownership of health activities by the MOH, as espoused in the Paris Declaration; and an increase in reaching underserved populations, including

indigenous women and girls, which are also target populations for the Bolivian government. Bolivia's Millennium Development Goals are as follows:

**Table 1: Bolivia Millennium Development Goals**

Millennium Development Goals (Health)	Actual (DHS, 2008)	MOH Bolivia Targets
<b>1. Eradicate extreme poverty and hunger</b>	27% chronic (height for age) malnutrition in children under 2 years of age	19.8%
<b>4. Reduce infant mortality</b>	50 deaths per 1000 live births	30 per 1000 live births
<b>5. Improve maternal health</b>	310 deaths per 100,000 live births <sup>2</sup>  66% institutionalized births	104/100,000 live births  70% institutionalized births
<b>6. Combat HIV/AIDS, Malaria, Chagas, and Tuberculosis</b>	HIV 0.2% prevalence  TB 85 % cure rate	HIV 0.2% maintained  TB 95 % cure rate

The GHI Strategy supports the NSHP by strengthening the health system and by providing a focus on select technical areas such as Maternal, Child Health, Family Planning and Reproductive Health, and Nutrition at the national, departmental, regional and community levels. In coordination with the MOH, the Bolivia mission has identified, **“Improve the Health of Bolivians by Reducing Social Exclusion from Health Services in Targeted Geographic Areas”** as the goal of the GHI strategy. This goal is also shared by the MOH.

The issue of assisting the MOH to attain sustainability is paramount for GHI. Specifically, the GHI health program will provide health systems strengthening support to the MOH in the logistics, human resources, administration and finance, health information systems and in strategic planning. USG support is being used to assist one local Bolivia NGO in achieving full sustainability in its ability to procure and distribute family planning commodities.

**Table 2: GHI Indicators for Bolivia**

Maternal Mortality Ratio (MMR) in target areas (disaggregated by rural/urban residence)
Under five mortality rate (U5MR) in target areas (disaggregated by rural/urban residence)
Infant mortality rate (IMR) in target areas (disaggregated by rural/urban residence)
Neonatal Mortality Rate (NMR) in target areas (disaggregated by rural/urban residence)

<sup>2</sup> DHS 2008 estimate: GOB estimate pending.

% of children under 12 months vaccinated with DPT3(disaggregated by rural/urban residence)
% of children under 24 months with chronic malnutrition (disaggregated by rural/urban residence)
% of women who deliver with skilled birth attendant
% of women using modern contraceptive method (disaggregated by age, rural/urban residence)

Sex-disaggregated data on the above indicators that are not sex-specific are available in DHS and provide a clearer picture of gender inequalities in Bolivia as relates to treatment and medical attention. The trend is one of general improvement, often with girls faring better than boys. Unfortunately, the national health information system in Bolivia (SNIS) does not disaggregate indicators by sex, only by rural or urban residence and incorporation of sex disaggregated data would entail revising the entire health information system. Future support to the MOH on improving the health information system will advocate for the importance of disaggregating these indicators by sex.

## 2. GHI Partner County Priorities and Context

The Bolivian Government’s National Development Plan (NDP) includes a section on health which has served as the template from which the MOH’s NSHP (2010-2015) was developed. The NDP reports that 57% of the population is excluded from access to health services, primarily in the rural areas of the altiplano and the valleys. Exclusion barriers are economic, geographic, cultural and social. The NSHP goal is for Bolivians “To Live Well” but as illustrated by Table 3 below, there remains much work to be done in Bolivia in the areas of maternal health, child nutrition and family planning. For example, nationwide, the U5MR is 63 per 1,000 live births but La Paz has an U5MR of 70 per 1,000 live births. Modern contraceptive prevalence is low in Bolivia overall, at 24% and the total fertility rate (TFR) ranges from a national average of 3.5 per woman to a high of 4 per woman in Chuquisaca. Adolescent pregnancy has increased to 18% nationwide, according to the 2008 DHS, with Chuquisaca registering an adolescent pregnancy rate of 17%. Rates of under-five malnutrition are higher than the national average of 24% in both La Paz (29.8%) and Chuquisaca (35.8%).

**Table 3: Health Indicators for Bolivia, including Departments of La Paz and Chuquisaca**

Indicator	Rate, Bolivia Overall	La Paz (Dept)	Chuquisaca (Dept)
Maternal Mortality	310 per 100,000 live births*	Not available	Not available
TFR	3.5	3.2	4
Modern Contraceptive Prevalence	24%	23.2%	38.1%
U5MR	63 per 1,000 live births	70 per 1,000 live births	31 per 1,000 live births
IMR	50 per 1,000 live births	59 per 1,000 live births	22 per 1,000 live births
Neonatal Mortality	27 per 1,000 live births	35 per 1,000 live births	19 per 1,000 live births
Child Malnutrition	27% chronically malnourished	29.8% chronically malnourished	35.8% chronically malnourished
Adolescent Pregnancy**	18%	12%	17%

DHS, 2008 and MOH statistics

\* Estimated

\*\*The age of adolescence in Bolivia is 15-19 years old

Other relevant health information includes the following:

- Bolivia also has one of the highest rates of sexually transmitted infections (STIs) (exclusive of HIV) in the LAC region, according to the Population Reference Bureau Data Sheet for 2011. The incidence of HIV increased steadily from 1984 to 2008, with the number of detected infections increasing at a rate of about 30% per year. Although nationwide prevalence of less than 1% is very low compared to other countries in the region, a recent study (SEMVBO- Study of Masculine Sexuality and HIV/AIDS in Bolivia, 2009), jointly funded by USAID and other donors, shows that among men who have sex with men, prevalence has risen to 15% in some cities.
- Tuberculosis (TB): Bolivia has the third largest number of TB cases in the Latin American region. The major challenges to improving service delivery are related to the need to train health workers in the new national norms for TB treatment, especially in rural areas, including treatment for the growing number of multi drug resistant (MDR) TB cases. (Evaluation of the TB National Program, 2010).
- Leishmaniasis: Bolivia has one of the highest incidences of leishmaniasis in South America. Previous USG and other donor-funded projects have worked in the Yungas and Chapare areas where leishmaniasis is prevalent and where poor economic conditions and weak institutional capacity impede patients from having access to adequate treatment.
- Malaria, Dengue and Chagas: In 2008, according to the National Health Information System (SNIS), malaria cases fell to a low of 9,748 -- a decline of 34% from the 14,610 cases detected in 2007. The number of cases of dengue fever increased tenfold in 2009, with major outbreaks in the Departments of Santa Cruz, Cochabamba, Beni, and Pando. The Pan American Health Organization estimates that as much as 22% of the Bolivian population is infected with Chagas, which is especially prevalent in the valleys of the Departments of Cochabamba, Potosi, and Chuquisaca. Recent reports from partners (PROCOSI, Quarterly Reports, 2010) indicate that Chagas cases are increasing in areas previously unaffected by the disease. Global climate change has increased the range of the vector and thus it is now affecting populations living at higher elevations.
- Water, Sanitation and Hygiene: According to the 2001 Census, only 27% of Bolivians have access to potable water, about 45% have sewerage services, and less than 10% of wastewater is treated.

To respond to these and other health sector challenges, the GOB has defined a new set of priorities that seeks to improve the efficiency, accessibility, and quality of health services. Several of the GOB's guiding principles are complementary to the GHI Strategy. These GOB guiding principles include:

- Social participation in decision-making as part of co-management of health facilities by rural and urban communities, municipal governments, health care providers and administrators.
- "Interculturality", which seeks to incorporate indigenous healing beliefs and practices into biomedical practice.
- Integrated health care that provides the user with a continuum of care from promotion, prevention, rehabilitation and recuperation.
- Cross-sectoral interventions to address socio-economic determinants of health through strategic alliances among different sectors.

Implementation of these policies and plans involves a shift in the allocation of limited Bolivian resources from a curative care model in third level hospitals (61 public sector tertiary and 215 secondary level hospitals) to a focus on primary and preventative care model in communities and households (including 1,354 health centers and 1552 health posts) within 107 health networks (or *Redes*), which cover one or more municipalities.

The Global Health Initiative represents a unique opportunity to optimize USG resources in Bolivia. For example, there are several USG agencies supporting health activities in Bolivia, including USAID, United States Department of Agriculture (USDA), the MilGroup, and intermittent visits by CDC to support epidemiological studies with the MOH, local universities and Bolivian NGOs. Unfortunately, after decades of support to Bolivia, the Peace Corps officially closed operations in Bolivia on October 14, 2011.

USAID has worked in Bolivia for over 46 years and currently manages a substantial health portfolio. USAID is the primary USG agency implementing health activities in the country and is the designated “country convening lead agency” by State for developing the GHI Strategy. However, the context for USG programming in Bolivia is transforming; funding levels are adjusting and there are fewer agencies on the ground due to changing programs. Although USAID is still a significant part of the USG portfolio, there is also a downward trend in health funding. It should be noted that USAID/Bolivia no longer receives HIV funding, and TB funding will not be available after this year. Moreover, the Integrated Alternative Development (IAD) program, which provided some limited financial support to the health office, particularly for leishmaniasis and TB work in the Yungas, has had a significant funding cut and has closed. The overall health budget in USAID has been generally consistent during the last 7 years but yearly budget allocations will decrease starting next year.

Although Bolivia is not a “Feed the Future” (FtF) priority country for the USG, USAID’s Office of Sustainable Development and Environment (SDE) is currently implementing a multi-year Integrated Food Security (Project ISA) program through Abt Associates (Abt). This project represents an innovative approach to programming to reduce chronic malnutrition by working between technical offices and offers valuable lessons learned which may benefit other countries implementing Feed the Future programs. By working synergistically, USAID/Bolivia seeks to maximize limited USG funding in nutrition to reduce chronic malnutrition in women and children under 5 years of age. Moreover, the nutrition components of the project support GOB MOH policies, specifically, the Zero Malnutrition (Programa Desnutricion Cero-PDC) program, which seeks to eradicate chronic malnutrition in Bolivia. Project ISA receives maternal child health funding from the health office for the nutrition component of the project. In the first year the nutrition element was created, a portion of USAID/Bolivia funding was provided to the SDE office for the nutrition component of the ISA project. Due to recent funding modifications, nutrition and MCH activities in both the health and SDE offices now receive resources from the same stream of funds.

Continuing on the theme of Food Security, it should be noted that Bolivia has had Title II programs since 1995, but the program was closed in 2009. The United States Department of Agriculture (USDA) has also had a long history of supporting Bolivia with donated food commodities. In 2001, for example, USDA, through the Global Food for Education Initiative (GFFEI), provided funding to a US based PVO, Project Concern International (PCI), to provide school breakfast for students, providing training and to implement seed pilot projects. From 2002-2008, USDA provided support through its Food for Progress program and in 2003, USDA began supporting Bolivia through the Food for Education/McGovern-Dole program, which is slated to end in FY 2012. The Food for Education program seeks to increase attendance at school of all children, but primarily of girls, by providing them school breakfast and other meals. The PCI project is

currently being implemented in La Paz, Oruro, Potosi and Cochabamba. GHI provides a select opportunity for USAID and USDA, through Abt and PCI respectively, to coordinate on nutrition activities, as both organizations work in nutrition in similar geographic areas but serve different age groups. The USDA program is managed from the Lima, Peru USAID regional office and through contacts in the Embassy.

Currently, the Political Affairs Section (PAS), EcoPol and the office of Environment, Science and Technology, and Health in the US Embassy have no funding for health activities in Bolivia. CDC does not have an office in Bolivia but is supporting studies on the rotavirus vaccine and Congenital Chagas (NIH funded) with local institutions. GHI presents an opportunity for increased synergies between CDC and USAID since both organizations support the Ministry of Health and PAHO with capacity building activities.

The Milgroup (MILGRP) support is limited in Bolivia, and the office has reduced its personnel to one or two people. The MILGRP has had no health funding for Bolivia for the last three years and has continued construction on a burn clinic in Alto Irapavi, La Paz with money from previous budgets. In the past, the MILGRP has been able to provide minor sports equipment to the Sports section of the MOH.

**Table 4: USG Agencies working on Health in Bolivia**

Agency	Activities	% of total USG budget
USAID	Health Office: bilateral programs with PIOs, local NGOs in area of MCH, FP/RH, Health system strengthening, TB (FY 12 only)	73% of total USAID budget
USAID	Sustainable Environment Office: Integrated Food Security Project (Nutrition)	4 years funding
CDC	Congenital Chagas study; Rotovirus vaccine study	NIH funded; other funded
MILGRP	Construction of burn clinic	FY 2008 funds
USDA	School feeding program through US based PVO	FY10-12 funding

### 3. Other Donors working in Health

The USG is an active member of various donor coordination committees with other bilateral and multilateral agencies working in Bolivia. USAID, as the lead USG Agency for health activities in Bolivia, collaborates with other donors through a health sector donor group called the "Mesa Tecnica de Cooperantes" (MTC), which meets monthly. In addition, the MTC has formed two technical working groups that are not yet fully operational - one on human resource issues, led by Italy and another working group on support for health networks, led by Japan International Cooperative Agency (JICA). Moreover, since the Minister of Health, Dr. Nila Haredia, assumed her post, the MOH has led numerous donor meetings with the objective of facilitating and fostering greater coordination and collaboration among donors and with the MOH. The following is a general summary of the programmatic areas in which the major health sector donors are working, highlighting areas of common interest and potential collaboration:

- **UNFPA:** UNFPA's work in Bolivia is focused on three programmatic areas: Population and Development, Sexual and Reproductive Health, and Rights and Gender Equality. UNFPA does the following: supports adolescent sexual and reproductive health activities, with a focus on reducing teen pregnancies; supports activities that make SRH services more accessible; and works to prevent and respond to gender-based violence. These activities will support USAID's work in Family Planning, Reproductive health and Post Abortion Care (PAC).
- **World Bank:** The World Bank's Health Reform Program in Bolivia has two primary goals: 1) to increase coverage and quality of health services and related programs that would improve the health of the population and to empower communities to improve their health status; and 2) to strengthen national, regional and local capacities to respond to health needs. At the national level, World Bank assistance is being utilized to strengthen the health information system. The World Bank project specifically targets 41 health networks, plus peri-urban areas in El Alto, La Paz and Santa Cruz. Activities under this component focus on strengthening the referral networks that exist within the target areas of the project. Activities will focus on developing human resource capability and improving the physical infrastructure in the network institutions, including upgrading or purchasing equipment. The program also supports development of a health insurance system. The World Bank also has provided a concessional credit (2008-2013) to support the Bono Juana Azurduy (Conditional Cash Transfer) program which provides a financial incentive to mothers who complete a series of maternal child health, prenatal and postnatal care services.
- **Canada:** CIDA provides assistance for UNICEF's activities and provides the following support: budget support to the MOH in three SEDES (Pando, Beni, and Oruro); support for health infrastructure and equipment; grants to NGOs for complementary activities at the local level; and a micronutrient initiative in 60 municipalities to reduce nutritional deficiencies in iron, zinc and Vitamin A in children under five. Canada also contributes to a basket fund for nutrition (with Belgium and France), managed by the MOH.
- **Belgium:** The Belgian Technical Cooperation's (BTC) health program currently supports two projects and works through a model of "co-management" with MOH entities, which means that the public sector jointly manages the funds. The first project is the Integrated Health System for Chayanta Province in Potosi, a five year (2005-2011), project intended to strengthen the health network in the areas of primary care, integration of family/community medicine, health education, and nutrition. Other priority departments in addition to Potosi include Cochabamba and Chuquisaca. The second project is to extend coverage and improve the quality of medical attention in El Alto. The Belgians also contribute to the basket fund for nutrition with Canada and France. Total support to the health sector is for over six years. A new strategy between Belgium and the GOB is in the process of development.
- **France:** France's current health sector support has a number of components for the period 2009-2011. The first is support for SAFCI by strengthening thirteen health networks in Chuquisaca, Pando, Oruro and Potosi, with a focus on nutrition. France also contributes to the basket fund for nutrition and provides direct technical assistance to the MOH's planning unit. In addition, France is supporting the strengthening of the key laboratories, the health management information system, and selected hospitals around the country.

- **Japan:** JICA has several health initiatives including: a program to strengthen integrated health in Santa Cruz; a rural maternal-child health project in La Paz; and a health network improvement project in Cochabamba with an emphasis on rights, interculturality, and gender. JICA is also supporting an urban water and sanitation project in Cochabamba. JICA has committed funding for the years 2010-2013.
- **Spain:** The Spanish Cooperation (AECID) has just completed a 2 year program (2007-2009) to strengthen MOH stewardship of the sector, consolidate the SAFCI model, strengthen the health management information system, and help integrate traditional medicine and practices into the primary health care. Spain also established a technical assistance fund for the MOH to use for developing policies, conducting research, and strategic planning. AECID is currently implementing a project for the years 2008-2010 related to strengthening SEDES and municipalities by supporting mobile health units to improve the health system's capacity to respond to emergencies in urban areas and increase access to services in rural areas.
- **Italy:** Italy contributes to promotion of technologically and culturally appropriate approaches in the building or refurbishing of health infrastructures and in the procurement of biomedical technologies, together with the development of maintenance systems in the health sector, with a well-established and dynamic cooperation program in Bolivia's poorest department of Potosi. At this level, coordination among local and international actors, as well as their integrated planning and action is promoted. Special attention is devoted to the integration between indigenous-traditional and conventional western approach to health. For the Italian Cooperation, health education is a fundamental component.

As part of GHI, the USG will strengthen coordination with all donors working in health to ensure country coverage. For example, the USG is coordinating with Canada which is also implementing a health project with UNICEF, but in Oruro, Beni and Pando, geographic areas not covered by USG investments. The donor organizations of Belgium, Italy and Japan are implementing health projects in Potosi, an area not covered by the GHI strategy in Bolivia. Coordination among USG agencies in Bolivia during GHI will be limited, as USDA support to Bolivia will end in FY 12 and CDC support to Bolivia is limited to Congenital Chagas and Rotavirus vaccines studies.

While the USG is pleased to provide continued support to the health sector in Bolivia, several barriers to achieving GHI goals must be acknowledged. First, current and proposed future changes in availability of USG funding in Bolivia have altered the scope of the health program from a national program to a program that now includes 2 departments. This limitation will reduce the ability of the USG to meaningfully assist Bolivia in achieving the MDGs in health and gender issues on a nationwide scale. In November 2011, a new U.S.-Bolivia framework agreement was signed, paving the way for an improved bilateral relationship between the USG and GOB. In addition, the health office is working closely with the MOH on a final revision of the Assistance Objective Agreement document (AOAg) which has recently been submitted to the MOH for approval. Insufficient regulations for NGOs, both local and international, have presented implementation challenges to USAID/Bolivia and consequently, during FY 2012 and at the suggestion of the MOH, USAID/Bolivia will be working with Public International Organizations (PIOs) (UNICEF and

PAHO) for the first time, which may delay program implementation while both UN organizations become thoroughly familiar with the regulations and *modus operandi* of USAID. Additionally, there are some challenges, in-country to fully embrace family planning as an effective means to reduce maternal mortality. USAID will continue to look for creative ways to increase demand for family planning and reproductive health at the local level. Lastly, while GHI health projects in Bolivia seek to strengthen health systems and capacity of the MOH to fully embrace its role as steward, excessive turnover of GOB health staff and resource shortages are longstanding challenges that may negatively impact GHI implementation in Bolivia.

#### 4. GHI Objectives, Program Structure and Implementation

Achievement of the NSHP's goal will be measured by declines in maternal and infant mortality; lower rates of childhood malnutrition; decreased transmission rates of key endemic diseases (Chagas, Tuberculosis, VIH/SIDA); and increased access to safe water and sanitation. These goals will dictate several of the GHI indicators the Bolivia mission will support which are dependent on funding for key elements.

The premise upon which the GHI Strategy in Bolivia (2011-2015) is based is that of the Bolivian MOH: **"The health of the Bolivian population will improve when social exclusion to healthcare is reduced through improvements in living conditions and increased utilization of health services."** The population will increase its use of services when services are culturally acceptable, accessible and there is an enabling environment for changes in knowledge, attitudes and practices. Services will be accessible when economic, social, and cultural access barriers are eliminated. Health services will be acceptable when they are based on an intercultural model that includes appropriate biomedical and local cultural practices negotiated through a partnership between empowered communities, representative leaders, and healthcare providers. The health care system will be sustainable and accountable as long as there is active participation in monitoring outcomes, and political and financial support.

**The overall GHI goal in Bolivia is to "Reduce social exclusion to health services in targeted geographic areas."** Reduced social exclusion is defined in the NSHP as "a total or partial lack of access to health services due to barriers that may be systemic, economic, geographic, cultural or ethnic in nature." The Bolivian NDP reports that 57% of the population is excluded from access to health services, primarily in the rural areas of the altiplano and the valleys. Exclusion barriers are economic, geographic, cultural and social. The goal was developed by examining data on inequities in health outcomes in Bolivia based on ethnicity, sex, residence, education, and wealth. Therefore, to achieve the goal, the GHI will focus first and foremost on systemic barriers, but it will also work to identify and mitigate economic, socio-cultural, and political barriers that inhibit access to and delivery of high-quality maternal, child and reproductive health, nutrition, family planning, TB and HIV services. GHI will strive to provide technical assistance to the GOB and civil society organizations to develop viable strategies to eliminate the barriers that make the current health system inequitable.

Although there are indications in the recent 2008 DHS that the gaps between urban and rural health indicators are narrowing for some outcomes, rural poor indigenous populations are still most likely to suffer death and disability from largely preventable causes or poor living conditions. Also, the DHS indicates that a majority of the population relies on the public sector system for numerous key services related to delivery, family planning, childhood illness, and respiratory infections, given the lack of private health service providers outside of urban and peri-urban areas. In order to meet the needs of both rural and urban populations, the GHI Strategy will focus primarily on the public sector in order to reduce rural/urban disparities, but will also conduct some limited work with the private sector (i.e. strengthening

social marketing of contraceptives) to address specific gaps and with selected NGOs with proven community health expertise in rural areas.

The GHI Strategy is designed to support implementation of the MOH's SAFCI model health service delivery and co-management models, as well as other GOB policies such as the National Plans for Sexual and Reproductive Health, the Reduction of Maternal and Neonatal Mortality, and Integrated Health for Adolescents and Youth, via a health systems strengthening approach. Despite the GOB's efforts to create a more inclusive government, the legacy of Bolivia's history of discrimination based on ethnicity and socioeconomic class leaves many citizens with limited or no access to social services, such as health and education. The indigenous populations are the principal groups suffering the consequences of social exclusion. SAFCI aims to push healthcare services out from the facilities into the communities they serve. To ensure that healthcare responds to the needs and preferences of the local population and is sensitive to their cultural beliefs and practices, as part of SAFCI, each community elects a Local Health Authority to serve on the Local Health Committee which oversees the management and performance of the nearest health post or center. SAFCI also stipulates that local indigenous healers are part of the healthcare system and that traditional medicine is an integral part of community health. It is incumbent on the biomedical healthcare system to enter into constructive and respectful dialogue with local residents on how to maximize both models of healing to improve the health and Well Being (Vivir Bien) of target populations.

The GHI Strategy does not propose significantly different activities than those currently being implemented under current USG programs, but re-packages and re-focuses them to more explicitly support the MOH's policies and priorities, focusing and concentrating in key departments in select areas of HSS. The GHI is intended to build on the strengths of the current program and platforms, eliminate weaknesses, and take into account lessons learned in Bolivia. GHI reflects a comprehensive view of USG collaboration with other donors to support and improve the functioning of the health system in Bolivia. Both the USG and bilaterals, including Canada and Belgium, as well as the multilateral PAHO and UNICEF, are using similar service delivery platforms to support the MOH SAFCI model. All agencies provide direct assistance on common objectives listed in the SDPH document to strengthen the MOH.

One of the goals of GHI is to strengthen the health system. Using a health systems strengthening approach, Bolivia's GHI Strategy will concentrate efforts in two Departments (La Paz and Chuquisaca) and will prioritize three focus areas, which have been discussed and accepted by the MOH after approximately two years of negotiations with USAID/Bolivia. The GHI will support the Bolivian health system to upgrade the management and provision of government health services at all levels of the health system by focusing on the following results:

1. Strengthened operations systems and participatory management at all levels of the health system (Participatory Management and Leadership).
2. Increased access to and improved quality of intercultural health care (Access and Quality).
3. Underserved rural populations (particularly women and girls) empowered to seek/obtain culturally appropriate health care (Equity and Rights).

All three Focus Areas are closely inter-linked, inter-dependent and demonstrate "smart integration" with a focus on health system strengthening. In developing the GHI Strategy, lessons learned from prior program implementation were taken into account. For example, under the previous USAID health strategy, several programs worked with select municipalities, rather than REDES. In addition, programs were implemented over a very large and dispersed area, with a focus on five departments in the "Eastern" part of the country,

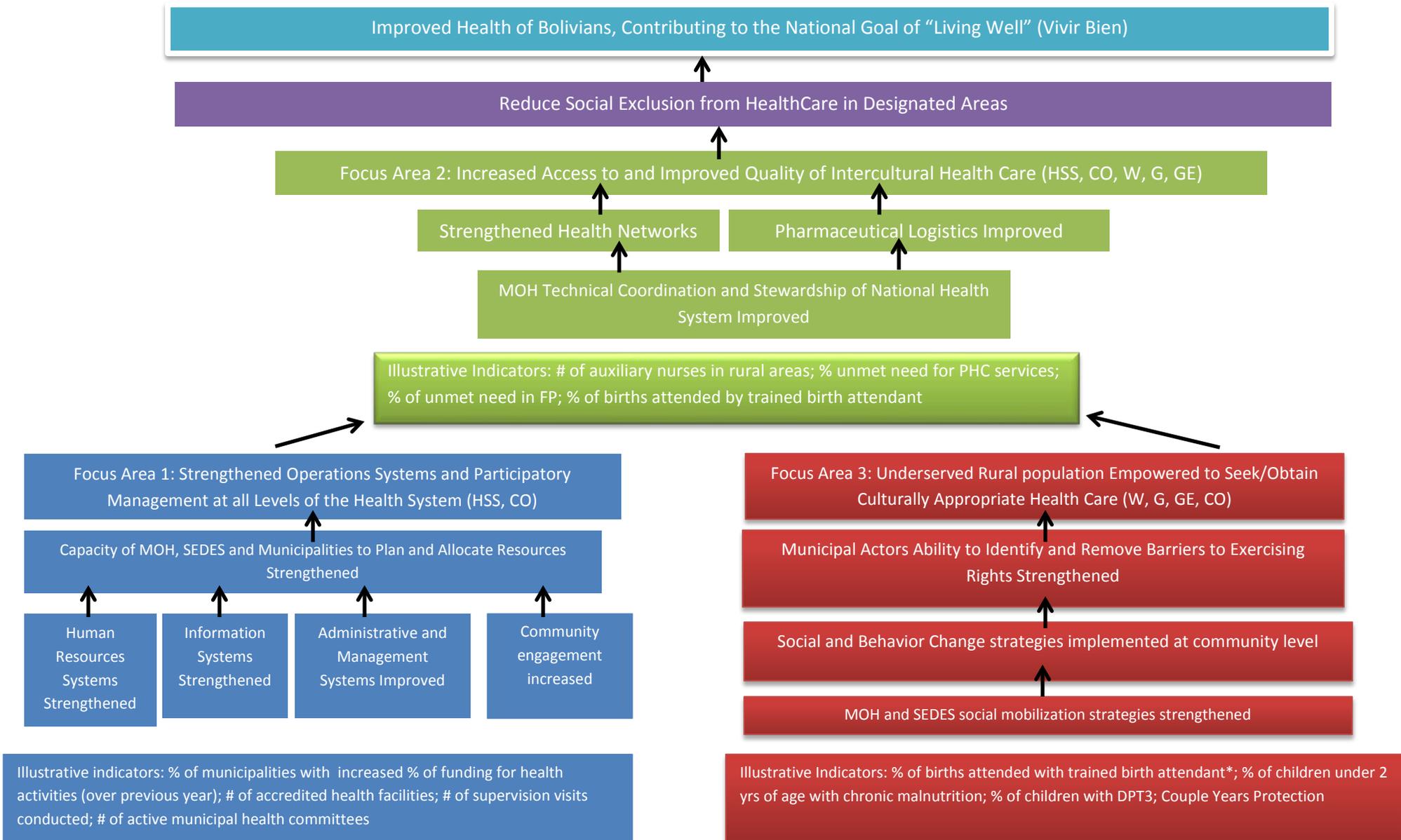
which made it more difficult to coordinate actions among the USG, other donors and implementing organizations or to integrate actions across different levels of the health system. However, the work implemented during the previous strategy has produced excellent outcomes and two of those departments, Tarija and Santa Cruz, now have some of the best health indicators in the country. A third department, Beni, is making substantial progress on improving their health outcomes as well. Consequently, these three departments will not be prioritized under GHI, but the lessons learned from these successes will be applied to the GHI.

Bolivia's GHI strategy also takes into consideration where other donors are operating in order to complement their efforts without duplicating them. The geographic target areas proposed for the GHI includes the departments of Chuquisaca and part of the altiplano and valleys of the department of La Paz. Exact municipalities and REDES have yet to be determined but are under discussion with other donors and the MOH. These departments are areas where the majority of the population is poor, underserved by health services, socially excluded, and food insecure. Per the 2001 National Census, the indigenous populations in Chuquisaca and La Paz are approximately 64% (majority Quechua) and 78% (majority Aymara) respectively. In addition, the MOH's Health Sector Plan states that Chuquisaca is one of the departments with highest risk of exclusion from health services at 76%.

In addition, these target areas also offer compelling reasons (high levels of poverty; high maternal and infant mortality; high rates of chronic malnutrition among children) which will increase the likelihood that investments in communities, municipalities and health networks will lead to changes in health outcomes. The main focus of the GHI will be the rural areas of these departments since health indicators for child nutrition, contraceptive prevalence, neonatal mortality, maternal mortality, and the incidence of diarrheal and acute respiratory infections are consistently worse in these areas. By working in the prioritized departments, GHI has an opportunity to ensure that lessons learned and best practices are applied homogeneously to all target geographic areas. As the prioritized departments are geographically contiguous and culturally similar, exchanges between the SEDES and among municipalities will be relevant and more likely to occur. After this year, funding for tuberculosis in Bolivia will no longer be available. TB efforts will be focused in the urban and peri-urban areas of Santa Cruz, Cochabamba and El Alto where the incidence of these infectious diseases is higher and increasing. These same urban and peri-urban areas will be targeted for adolescent reproductive health activities, given the rural to urban migration of many families.

The GHI Results Framework, which appears below, illustrates how the GHI Strategy will work on systems strengthening at various levels to accomplish the three focus areas.

**Graph 1: GHI Results Framework- Bolivia**



## **Focus Area 1: Participatory Management and Leadership: Strengthened Operations Systems and Participatory Management at all levels of the Health System**

Priorities for Focus Area 1 of the Bolivia GHI Strategy include improving the systems, procedures and processes needed to develop and maintain a functioning health system. These processes and procedures are critical to remove operational barriers that make it difficult to increase access to quality health care (Focus Area 2) and on increasing participation in key processes that will help to create a more equitable health system that respects citizens' rights (Focus Area 3). The framework above supports the MOH's SAFCI co-management model, which establishes participatory mechanisms for planning and oversight of health activities and use of health sector resources at all levels of the system.

GHI will work to produce the following **Outputs**:

1.1 The Capacity of the MOH to plan and allocate resources strengthened. This will be accomplished by implementing activities which will strengthen key management systems at the central Ministry of Health level to both facilitate implementation of SAFCI and help build the MOH's capacity to eventually receive USAID funding directly. Activities under focus area 1.1 will include: evaluating systems; developing and implementing action plans for systems improvements; and evaluating the impact of systemic changes on the MOH's capacity to implement SAFCI. Ministry systems and functions that will benefit from targeted, prioritized improvements include: the health information system; human resources management; administration; financial management; strategic planning and coordination; logistics; procurement; and communication.

1.2. At the regional level, Capacity of SEDES (Departmental Health Services: Servicio Departamental de Salud) to allocate program resources will be improved. This includes strengthening health management and support at the departmental level, which is the responsibility of SEDES. GHI will work intensively in three SEDES to improve their management systems. However, materials and methodologies developed will be disseminated to all the other 6 SEDES. Systems and functions that will be improved at the SEDES level will include: personnel management; planning; communication of MSD policies to lower levels; data management

1.3. At the local health network level, REDES (Red de Salud: Health Network) ability to support municipalities to plan, budget, and co-manage services improved. Activities supporting 1.3 will strengthen health networks in order to effectively support municipal health planning; help relevant municipal actors in health establish and implement SAFCI co-management mechanisms; and establish or improve communication links to SEDES so that the experiences of REDES may be used to inform regional health initiatives.

1.4. At the municipal level, GHI will strengthen the capacity of municipal actors to ensure that management of health services is equitable, effective and efficiency is improved. Under output 1.4, the GHI Strategy will support the creation and/or strengthening of a newly established participatory management mechanism, called the Municipal Health Committee or, CSMS (Municipal Health Committee: Consejo Social Municipal de Salud), which is intended to ensure that the health needs and preferences of communities, families, and local health facilities are transmitted up the health system chain. This information will then be used for decision-making, planning, and the allocation of resources, which will be supported and evaluated. To accomplish this, activities will not only target health sector actors, but also

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## **Innovative CHW Retention Strategy- Santa Cruz, Bolivia**

The quandary of how to retain and incentivize CHWs has plagued community health projects for decades. In San Ignacio de Velasco, in the department of Santa Cruz, Bolivia, the municipality has devised an innovative solution to the problem which also strengthens the health system.

Active CHWs in the municipality are encouraged to undergo a 6 month to 1 year training program to become auxiliary nurses. As is the case in many parts of the world, auxiliary nurses form the majority of healthcare workers in health posts. Once they have completed the training, the CHWs are now auxiliary nurses and are placed on the MOH payroll, which addresses the issue of sustainability and country ownership. As CHWs are people from the community, they are located in a nearby health post. The strategy ensures cultural compatibility and confidence of the community with the health system.

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municipal governments to increase their awareness of their obligations to the health sector under SAFCI. As a result, municipal Annual Operating Plans (POAs) will increasingly include priority health activities and DILOS (Local Health Directorate: Directorio Local de Salud) and CSMS will be trained to follow up and ensure that POA activities are executed.

1.5. At the community level, this output works to ensure health providers and CLS equitable participation in planning, management and monitoring of health activities is increased. Output 1.5 is aimed at supporting mobilization of individuals, families and communities to actively participate in the co-management of local health services. Local representatives and committees will be identified and trained in analytical and advocacy skills to enable them to communicate their needs and preferences up through a chain of consultative mechanisms to administrative units that can respond to their needs. GHI activities will facilitate entry into the participatory decision making process for women's groups at the municipal and sub-municipal level.

### **Focus Area 2: Access and Quality: Increased Access to and Improved Quality of Intercultural Healthcare**

Focus Area 2 is related to the implementation of the public health service delivery model and aims to improve the clinical knowledge, cultural awareness, interpersonal communication skills and service delivery techniques of health care providers so that they prioritize interventions and practice medicine in a manner that is technically correct, responds to needs identified by the population (Focus Area 1) and is respectful of peoples' rights (Focus Area 3). Technical activities implemented under this Focus Area will support the establishment of integrated health networks that provide maternal and child health (MCH), emergency obstetric and neonatal care (EmONC), reproductive health (RH), family planning (FP), post-abortion care and TB services. Technical interventions will build upon USG's extensive experience and lessons learned in each of these technical areas.

#### **Outputs:**

2.1 MOH technical coordination and stewardship of national health system and technical programs improved. Activities supporting achievement of Focus Area 2.1 will largely concentrate on the development and dissemination of models, norms and standards for quality, integrated service delivery, with the ultimate goal of establishing a national standard for implementing health networks. In addition, support will be provided to establish and/or improve accreditation processes and pre-service curricula for health professionals, and for research into how to operationalize the intercultural aspects of SAFCI.

2.2 SEDES capacity to improve health providers' competence and health network operations improved. Activities will upgrade SEDES technical support

services by improving training materials and developing innovative training methodologies within a jointly developed training plan; supporting the development of an integrated, facilitative supervision system; building SEDES capacity to develop and implement an agenda for operations research to address key obstacles to effective service delivery; improve laboratory performance; develop and implement a system for improved referral/counter-referral; and develop and implement regional behavior change communication strategies.

2.3 Capacity of REDES to deliver, integrate, and supervise services improved. In support of output 2.3, REDES staff will benefit from training, technical assistance and tools that will enable them to provide high quality technical support to the health facilities that they supervise. This will include applying the improved supervision and on-the-job Health Program training techniques developed under 2.2, and implementing improved referral/counter-referral systems to strengthen linkages between the various facilities within the health network.

2.4 Health centers' capacity to apply norms and protocols and respond to local needs improved. Activities will primarily aim to ensure that health workers are trained in and use national norms for providing clinical services. To accomplish this, under a new approach in GHI, health staff will be taught to self-evaluate their application of the norms and standards in which they have been trained; identify any obstacles that are preventing them from meeting requirements; and develop plans to improve performance. Facilities will also receive technical assistance to help them analyze what steps need to be taken for them to be accredited (by the Accreditation Unit of the MOH) and to develop and implement corresponding action plans; develop and implement outreach programs to improve linkages of health centers with communities; and establish municipal pharmacies to ensure the availability of essential medicines, including contraceptives. Contraceptive social marketing activities will also help ensure the availability of contraceptive commodities. In addition, direct provision of services through mobile health brigades and HIV voluntary counseling and testing centers will be supported in selected areas.

2.5 Community level health providers' ability to provide culturally appropriate health care and communicate knowledge of healthier behaviors and practices increased. Activities under output 2.5 will enable community members to increase their knowledge about social and economic factors that affect health. Moreover, community members will learn preventive behaviors they and their families can adopt to become healthier. Through the newly awarded Healthy Community Project (HCP), which focuses on community level health interventions, the project will train and support community health workers (CHWs) who will model healthy behaviors to the overall community. CHWs will be responsible for several activities at the community level including: helping community members identify and eliminate barriers to their adoption of such healthy behaviors; educating family, friends and neighbors on key health issues affecting the community; facilitating analysis of how communities can address factors external to the health system (clean water, sanitation) that impact negatively on health; and supporting health promotion efforts of MOH health care workers. CHWs will receive non-monetary incentives including regular training and supervision visits from the MOH and project staff; materials such as identification cards, vests, backpacks and other supplies and building on USAID's CHW experience with PROCOSI (a Bolivian NGO), the project will identify proven retention strategies for CHWs. One major thrust of the HCP will be to ensure that the MOH includes CHWs as respected members of the health care team. The communities will receive technical assistance to help them define what "access" means to them as well as what characteristics "quality" services should possess. This information will be provided to their local health providers to

encourage them to adopt or adapt practices within health posts and centers that will increase use of services with a focus on access and quality.

### **Focus Area 3: Equity and Rights: Underserved Rural Population Empowered to Seek/Obtain Culturally Appropriate Health Care**

Focus Area 3 will contribute to creating an environment in which the population is aware of its right to health care and is prepared to demand better services. As a consequence, the population will: be mobilized to participate in planning health sector priorities; call for greater accountability within the health system (Focus Area 1); insist that service providers respect their cultural traditions; and demand that services are organized in a way that facilitates their access to them (Focus Area 2).

#### **Outputs:**

3.1 MOH social mobilization strategies strengthened. Output 3.1 aims to help the Ministry of Health disseminate information to the public on their rights related to health; develop and implement mechanisms for soliciting civil society input on national policy; and strengthen civil society's capacity to advocate for rights-based services, new laws and policies, and adequate enforcement of existing laws.

3.2 SEDES' ability to strengthen social mobilization strategies. Under 3.2, GHI activities will support the development of regional plans for disseminating national mobilization strategies; help establish or strengthen mechanisms that enable SEDES to integrate input from civil society into regional plans and to communicate such input to the MOH to influence national policy; and support regional fora to help civil society organizations build consensus for and develop advocacy plans.

3.3 Municipal actors' ability to identify and remove barriers to exercising rights strengthened. Activities supporting 3.3 will include raising municipal governments' awareness of citizen rights, and helping municipal governments understand their obligations to facilitate the exercise of those rights and identify and eliminate obstacles that are limiting citizens' ability to exercise their rights.

3.4 Capacity of all community members to identify, develop and negotiate solutions to health problems and obtain access to healthcare improved. Output 3.4 is intended to support activities that increase citizen awareness of their rights to healthcare and empower them to advocate for rights-based services. Under GHI, this will include support for development of local advocacy plans and small grants to selected communities for implementation of such plans, including plans related to issues such as reducing gender-based violence.

#### **5. Examples of Support for GHI Principles:**

The following are illustrative of how the Bolivia GHI strategy will incorporate select GHI principles:

- **Interculturality:** SAFCI is the MOH strategy to increase the intercultural focus in health care, which seeks to recognize and validate the cultural values in health held by the 36 ethnic groups in Bolivia. SAFCI seeks to help communities appropriate the health care system, making it their own with the inclusion of non-harmful cultural practices in medicine. To that end, SAFCI is also striving to train health care workers in indigenous languages (Quechua and Aymara, for example) to improve the quality of care provided and increasing understanding of the cosmovision of communities. While the MOH's definition of

interculturality is largely focused on blending traditional and biomedical approaches, the Program will mainly aim to promote culturally sensitive/appropriate co-management structures and service delivery. However, some research and pilot activities related to introducing traditional practices/medicines into health facilities will also be supported. The MOH is currently working on indicators to measure benchmarks for interculturality. Increasing culturally appropriate and accessible services is also a new factor to consider for sustainability and scale-up of proven interventions. This activity supports the GHI principle of country ownership.

- **Participatory Planning:** Activities will strengthen the capabilities of communities and municipalities in participatory planning, monitoring, research, and evaluation. These approaches will facilitate communication and cooperation among community authorities, healthcare providers, indigenous healers, women and men in communities to forge successful partnerships for the design co-management, and monitoring of local intercultural models of health prevention and treatment. This activity supports the GHI principle of country ownership.

- **Gender:** Women's and men's equitable participation will be supported by both separate and joint approaches that seek to reduce the incidence of Gender Based Violence and that engage men in exploring how differential constructs of masculinity can support or undermine the health of both men and women, as well as explore their own sexual and reproductive health and reproductive rights, concerns and needs. The USG has almost 10 years working on women's empowerment in Bolivia, as a tool to reduce gender based violence. That experience will be expanded under GHI. The USAID/Bolivia Mission conducted a gender analysis in October 2011, as part of its new Country Development Cooperation Strategy (CDCS) for FY 2013-2017. Additionally, the Health team will ensure that the new Health Program's gender related activities are consistent with the Global Health Bureau's gender guidelines. Women's empowerment, male involvement in family planning, and a focus on providing sexual and reproductive health services to adolescents are some of the gender activities to be undertaken through GHI. The GHI will support activities that engage men and women in formative and operational research into intercultural service delivery approaches and local gender-related beliefs about gender-based violence and family planning (or other issues), and how they affect practices and the impact on the lives of women, men, and children. In addition, during GHI implementation, DHS data sets for Bolivia will be analyzed to determine mortality and morbidity trends among boys and girls in both rural and urban areas. This activity supports the GHI principle of women, girls and gender equality.

• **Sustainability:** The objective of the sustainability is to build a stronger health system and work systematically within the various levels of the health system to identify the obstacles to the provision of quality healthcare for marginalized populations. Through GHI, USG programs will collaborate with the public sector to improve policies, procedures and systems, with the goal of increasing access to care. Through the GHI strategy, USG programs will provide technical assistance to the MOH to strengthen logistics, administrative and financial systems (to name a few) with a goal of making those systems functional and sustainable in the near future. Moreover, the focus on empowering communities to take greater control over their own health and efforts to strengthen the advocacy and planning skills of community and municipal actors to improve funding for health activities and quality services are both key to ensuring continued political and financial support for the sector. This activity supports the GHI principle of health system strengthening.

## 6. **Implementation of the GHI:**

Program activities will be designed in a way that will allow them to be flexible, based on local needs. Therefore, while it is necessary to work at all levels of the health system to achieve the objective of Reducing Social Exclusion to Health Care in Targeted Areas, interventions may differ according to need.

Implementation of the GHI in Bolivia for health system strengthening will be accomplished by a new way of doing business, via formal partnerships with UNICEF and PAHO, established Public International Organizations (PIOs). In addition, our new way of doing business includes support that will facilitate USAID providing more direct support to the MOH. UNICEF will focus on strengthening the health system at the level of the SEDES, municipalities, health networks (REDES) and health facilities. PAHO will focus systems strengthening efforts at the national and departmental levels, complementing efforts to translate national policy to and implement systems within the health networks and health facilities. These efforts complement the MOH's implementation activities related to improving key technical programs at the national and regional levels. It is envisioned that under the GHI, the roles of UNICEF and PAHO would gradually diminish over time, as the MOH increases its capacity to manage USAID funds and activities, with the intention of moving towards direct MOH implementation of key parts of the GHI Strategy.

In the GHI, the MOH will be both a recipient of technical assistance

### What's New with GHI?

-USAID health program implementation through Public International Organizations (PIOs).

-Improved coordination with USG agencies in Bolivia working on health (USAID, USDA, CDC).

-Improved coordination between technical offices (health and sustainable development and environment) on nutrition activities.

-Specific focus on health systems strengthening to improve MOH's "readiness" to receive and manage USG and other donor funds.

-Strengthened strategic coordination with other bilateral donors to support Bolivia's achievement of the MDGs.

and an implementer of programs. Technical assistance and activities will be provided to the MOH to further its stewardship role in the health sector and to improve its financial and administrative systems, with the objective of enabling the MOH to directly receive USAID (and other donor) funds in the future. Technical support under the GHI will build on successful platforms and MOH priorities. An example of a successful platform is USG support to the GOB's "Zero Malnutrition Program" via an ongoing USG (USAID) funded food security program (Project ISA). This project includes a nutrition component linked to health, agriculture, environment, education, production and other relevant activities to address a variety of factors that affect malnutrition. In addition, USAID/Bolivia's Health program has worked with the MOH to develop the Integrated Management of Childhood Illness-Nutrition (IMCI-Nut) protocol, which is the MOH's strategy for community-level nutrition interventions. This best practice will inform the ISA program approach in child health and nutrition as well as nutrition activities in GHI to reduce chronic malnutrition, especially of children under 5 years of age.

GHI will prioritize the implementation of the MOH's SAFCI policy in communities, municipalities and REDES to increase community participation and advocacy efforts and to ensure that community needs are taken into account by higher levels of the health system, complementing the work being done by UNICEF and across the three GHI Focus Areas.

Illustrative examples of how support of the SAFCI model at the community level will be achieved include the following:

- improved communications materials, training and retention strategies for community health workers;
- training and support to local health authorities and community members in efforts to promote the adoption of health behaviors and prevention practices, as well as educate community members about their rights and empower them to act;
- assist communities in identifying risk factors for health and develop plans to address them;

GHI will utilize key local Bolivian NGO expertise for implementing GHI priorities in services, logistics and commodities:

PROSALUD, a Bolivian private non-profit NGO, is a health service provider throughout the entire country, with clinics largely in urban and peri-urban areas and mobile outreach clinics to more rural areas. PROSALUD is the only not-for-profit organization in Bolivia capable of guaranteeing the timely, reliable delivery of contraceptive commodities throughout the country. Therefore, PROSALUD, as an implementer of GHI activities will support the nation-wide social marketing of contraceptives in support of Bolivians' rights, per the new Constitution and MOH policy, to reproductive health. PROSALUD will use its own resources to purchase contraceptives, and USAID assistance will help ensure their nationwide distribution, but there will be a specific emphasis on availability in GHI's target geographic areas. USG support will also allow PROSALUD to market contraceptives to low income Bolivians who otherwise would not have access to these supplies. USG support, enhanced through select Global Health field support mechanisms, will include improving the MOH logistic system (forecasting of needs, ordering commodities, and the delivery system); updating health care providers on modern contraceptive methods; and ensuring compliance to USG family planning compliance laws. USG support will also include efficient provision of the contraceptive commodities that are a management responsibility of the municipal governments, especially to the municipal pharmacies (FIMs).

CIES is a Bolivian NGO which has become a national leader in providing high-quality, low-cost sexual and reproductive health and other services while recovering its costs by charging modest fees for its services. CIES currently operates 15 health centers in eight of Bolivia's nine departments, and three mobile units in rural Chuquisaca. Under a new program within GHI, USAID proposes a results-based focus with CIES to support a portion of its operational expenses to ensure that it can continue to deliver high quality services and advocate for reproductive rights as it moves towards financial sustainability. Until new activities related to integrating family planning and reproductive health services with maternal and child health services are up and running, CIES will also be the main source of family planning results for GHI, with expected support from the public sector in the future. Pending availability of funds in GHI, it is anticipated that CIES will also support the continuation of adolescent empowerment/education activities, reproductive health advocacy efforts and the provision of HIV voluntary counseling and testing (VCT) services and HIV outreach activities targeting most-at-risk populations.

## 7. Monitoring, Evaluation, and Learning

The Results Framework can be found on page 16. The Strategy Matrix is included as Annex I.

As the lead USG Agency working in Health under GHI, USAID's Health Office has developed a performance management plan (PMP) that includes impact and output indicators to measure progress towards achieving the GHI indicators. These indicators will have to be approved by the MOH as part of the process of validating the proposed GHI Health program. Of the 21 Performance Management Plan (PMP) indicators, three are also Operational Plan (OP) indicators and will be reported to USAID/W. Four additional OP indicators were not selected for performance management use, but will be collected and reported to USAID/W. At least six indicators - related to the number of accredited health facilities, client satisfaction, DPT3 coverage among infants, trained birth assistance, and unmet need for primary healthcare - are also named in the Ministry's Health Sector Development Plan for the period 2010-2015, "Towards Health for All." Baseline information for various indicators will be obtained through special surveys conducted specifically for the program. These survey data will be collected and reported at baseline, midterm, and the close of the program period. These surveys will include control municipalities that are similar to the areas in which USAID-financed activities will take place and will facilitate evaluation of program impact. For the other indicators, data will be collected and reported on an annual basis from implementing partners or other sources, including the National Health Information System. As the GHI program begins implementation in the coming months, the USG will work with the GOB, UN, and bilateral agencies to identify existing data systems that can provide indicators useful in monitoring and evaluating USG activities, or upon which the USG could help build additional indicators. USAID will also work with the implementing partners to develop a comprehensive monitoring and evaluation program. The box below lists several HSS indicators to be monitored as part of GHI.

<b>Illustrative Health System Strengthening Indicators</b>
% of municipalities with established and active municipal health committees
% of municipalities with increased funding for health activities over previous year
# of community health action plans developed

In addition, measurement of many GHI indicators will be done via a DHS, which occurs every four years in Bolivia. Planning is underway with other donors and the MOH for this health survey, including departmental level data for secondary analysis on select indicators, which is scheduled to be conducted in 2012.

## **8. Communications and Management Plan**

Since USAID is the primary USG agency working on health sector development in Bolivia, internal communication and coordination procedures will be relatively straight forward. During the GHI strategy development process, communication has been initiated with USDA and CDC. Communication and reporting to Washington will follow GHI guidance and procedures. If other USG partners enter Bolivia to work in the future, a GHI structure will be established with the Chargé de Affaires, as coordinator.

GHI program management in Bolivia will be the responsibility of the USAID/Bolivia Health Office. USAID/Bolivia's Communication Office, located in the program office, will assist in the dissemination of success stories, case studies and other communication products related to GHI. Upcoming procurements will be managed by USAID using its established staff and procedures, but that information will also be shared with our colleagues at the Embassy and with MILGRP.

## **9. Linking high-level goals to programs**

At its highest level, the GHI program in Bolivia will help the Government of Bolivia meet its Millennium Development Goals in Health. All Bolivian governments since 1995 have committed to achieving Bolivia's MDG targets. The current government has reiterated its pledge to reduce maternal and child mortality, and to reduce the incidence of infectious diseases in the National Sectoral Plan for Health, as well as in recent updates to sub-sectoral plans for SRH and MNH, and the National Malnutrition Zero Program.

**Annex I: Bolivia GHI Strategy Results Matrix**  
**GHI Indicators**

	Baseline Information		Strategy		Key USG partners
Health Area	GOB National Plan & USG targets	Relevant key GOB priorities/initiatives	Key Priority Actions likely to have largest impact	Key GHI Principles	
<b>HIV/AIDS:</b> Prevent more than 12 million new infections, provision of care to more than 12 m people, and treatment for more than 4 million	<b>No USG funding for this element</b>  HIV cases (1984 - 2010): 1,481	VCT and PMCT are priorities for the MOH	The Global Fund Round 9 is funding actual activities to support purchasing of ARVs and will support IEC/BCC/stigma activities.	Not applicable  MOH has a national HIV/AIDS plan until 2015	
<b>Malaria:</b> Reduce the burden of malaria by 50% for 450 m people.	<b>No USG funding for this element</b>  In 2010, 11, 993 cases of malaria were detected in Bolivia		The Regional Malaria program, called the Amazon Malaria Initiative is managed from Peru and provides limited support; in Bolivia it is implemented through PAHO.	Not applicable	
<b>TB:</b> Save 1.3m lives by reducing TB prevalence by 50%. Treat 2.6m new TB cases and 57,200 MDR cases of TB	<b>USG funding only for FY 12</b>  8,000 cases of TB reported annually in Bolivia  Case detection rate 2009 85%  Cure Rate 2009 83%  <b>GHI Target:</b> 95% cure rate (MOH)		Lab strengthening, training of CHWs in sputum collection, testing HIV+ patients for TB  TB funding for FY 11 only  Global Fund activities are in place until 2012.  Bolivia will apply to the GF for Round 11	<b>Country ownership HSS</b> The National TB Control Program of Bolivia coordinates well with implementing USG partners that support TB (HCI/URC and JSI) activities.	UNICEF  Global Fund for TB, AIDs and Malaria  National TB Control Program (NTBCP)
<b>Maternal Health:</b> Save approximately 360,000 women's lives by reducing MMR by 30%	MMR= 310/100,000 l.b. MDG: Reduce MMR by ¾ by 2015  <b>GOB MOH Targets:</b> MMR=104/100,000	Maternal Neonatal Health Plan Technical Tables (Mesas Tecnicas)  Bono Juana Azurduy	Emergency Obstetric Care  Delivery with trained birth	<b>Country Ownership HSS</b> Reduction of Maternal mortality is a priority of the	UNICEF  PAHO  Healthy Community Project

across assisted countries	<p>I.b. (MOH, NHP)</p> <p>SBA=70% (MOH, NHP)</p> <p><b>GHI Target=</b> MMR=104/100,000 I.b.</p>	<p>(conditional cash transfer)</p> <p>SAFCI model</p>	<p>attendant</p> <p>Family Planning (both modern and natural methods)</p> <p>Child Spacing</p> <p>Inclusion of intercultural approaches to childbirth</p>	<p>GOB, which has developed the Bono Juana Azurduy to encourage women to obtain PNC and deliver in health facilities with trained provider.</p>	
<p><b>Child Health:</b> Save approximately 3 million children's lives, including 1.5 newborns, by reducing U5MR by 35% across assisted countries</p>	<p>Neonatal=27/1000 I.b. IMR=50/1,000 I.b. U5MR=63/1,000 I.b.</p> <p><b>GHI Targets: Reduce U5MR by 35% by 2015</b></p> <p><b>GHI NMR targets=</b> La Paz=22/1,000 I.b. Chuqui=12/1,000 I.b.</p> <p><b>GHI IMR targets=</b> La Paz=30/1,000 I.b. Chuqui= 14/1,000 I.b.</p> <p><b>GHI U5MR targets=</b> La Paz=41/1,000 I.b. Chuqui=20/1,000 I.b.</p>	<p>Maternal Neonatal Health Plan Technical Tables (Mesas Tecnicas)</p> <p>Bono Juana Azurduy (conditional cash transfer)</p> <p>SAFCI model</p> <p>IMCI-Nut</p> <p>Zero Malnutrition Program</p>	<p>IMCI-Nut (ORS, appropriate attention to ARIs, EBF, appropriate weaning)</p> <p>Cook stoves (reduce ARIs)</p> <p>Essential newborn care</p> <p>Vaccination campaigns</p>	<p><b>Country Ownership HSS W, G, GE</b> Reduction of under 5 mortality is a priority of the GOB, which has developed the SAFCI health care model.</p>	<p>UNICEF</p> <p>PAHO</p> <p>Healthy Community Project</p>
<p><b>Nutrition:</b> Reduce child under nutrition by 30% across assisted food insecure countries in conjunction with FtF</p>	<p>Baseline: Chronic malnutrition rate (nationally) =27.1%</p> <p><b>GOB MOH Target:</b> Reduce chronic malnutrition of children under 24 months to 19.8%</p> <p><b>GHI target= 19.8%</b> La Paz current rate: 29.8% Chuqui current rate: 35.8%</p>	<p>Program Zero Malnutrition</p> <p>IMCI-Nut (EBF, appropriate weaning)</p> <p>SAFCI</p>	<p>IMCI-Nut (EBF, appropriate weaning)</p> <p>School feeding programs (FY 12 only)</p>	<p><b>Country Ownership HSS W,G, GE</b> Nutrition is priority of MOH, which has developed the PDC to eradicate childhood malnutrition</p>	<p>UNICEF</p> <p>PAHO</p> <p>Healthy Community Project</p> <p>Integrated Food Security project (SDE)</p>
<p><b>FP/RH:</b> Prevent 54 m unintended pregnancies.</p>	<p>TFR=3.5</p> <p><b>MCPR= 24% (all women)</b></p>	<p>Seguro Universal Materno Infantil (SUMI)- Universal Mother Child Health Insurance which will</p>	<p>Support to logistics systems for FP commodities</p>	<p><b>Country Ownership HSS</b> The private sector</p>	<p>CIES</p> <p>PROSALUD</p>

<p>Reach a modern contraceptive prevalence rate of 35% across assisted countries, reflecting an average 2% point increase annually</p>	<p>MCPR=34.6%(women in union)</p> <p>MCPR=48.1% (sexually active women, not in union)</p> <p><b>GHI Target = MCPR=35% (The GOB has not set a goal for this indicator)</b></p>	<p>pay for contraceptives</p>	<p>Adolescent sexual and repro health programs in peri urban areas</p> <p>Women's empowerment activities</p> <p>Male involvement in Sexual Repro health programs</p>	<p>provides the bulk of contraceptives to the private and public sector.</p>	
<p><b>Neglected Tropical Diseases (NTDs):</b> Reduce prevalence of NTDs by 50% among 70% of the affected population.</p>	<p><b>No USG funding for this element</b></p>	<p>No USG funds to support Chagas elimination activities since 2009.</p> <p>USAID was able to improve more than 12,000 houses up until 2009. These improvements eliminated the primary location where the Chagas vectors (vinchucas) inhabit. In addition, USAID (through JSI) was able to supply 4000 Glucantime treatments to the MOH for distribution in the Yungas.</p>		<p>Not applicable</p> <p>MOH has a national Chagas program which is under the epidemiology unit.</p>	

Source: DHS, 2008 and MOH