

## Bolivia

### Joint Appraisal 2014

#### 1. Brief Description of Process

The Appraisal was prepared in stages:

- Analysis of the data available in the GAVI — HSS Project:
- Annual Progress Reports of FYs 2010, 2011, 2012 and 2013, care of the technical and administrative staff of the Project.
- Meeting with the Chief of Staff of the Minister of Health to coordinate matters relating to the Appraisal Mission agenda and the participation of the Minister of Health, Dr. Juan Carlos Calvinmontes Camargo, and the Vice-Minister of Health, Dr. Ariane Campero Nava.
- Coordination meetings with the EPI Manager and technical staff to deal with issues related to the arrival of the Appraisal Mission and the preparation of the report on results for said mission.
- Meetings of GAVI-HSS Coordinator, Ms María Cristina Delgadillo, with the Resident Representative of PAHO/WHO in Bolivia, Dr. Giovanni Escalante, to coordinate aspects regarding the Appraisal Mission agenda.
- Meeting with the Director General of Health Services to acquaint him with the arrival of the PAHO/WHO — GAVI Alliance Mission in Bolivia to evaluate the Project and request his participation in meetings with the Appraisal Mission.
- Meetings with the Interim Coordinator and technical staff of the National Health Information and Epidemiological Surveillance System (SNIS-VE) to inform them of the arrival of the PAHO/WHO — GAVI Alliance Mission in Bolivia to evaluate the Project and request the information required by GAVI for its report to the Appraisal Mission.
- The requirements and results obtained with GAVI support in the 37 priority municipalities covered by the Project in the departments of La Paz, Oruro, Potosí, Chuquisaca and Cochabamba were analysed with the SNIS Coordinator and the technical staff.
- Meeting with the Interim Coordinator and technical staff of the Health Services and Quality Network Unit (Health Network component — Quality Component) to inform them of the arrival of the PAHO/WHO — GAVI Alliance Mission in Bolivia to evaluate the Project and request the information required by GAVI for its report to the Appraisal Mission.
- Meeting with the Head of the Ministry of Health Planning Unit to inform him of the arrival of the PAHO/WHO — GAVI Alliance Mission in Bolivia to evaluate the Project and request the information required by GAVI for its report to the Appraisal Mission.
- Meetings with professionals who had been part of GAVI - HSS staff, former coordinators and technical personnel to learn about their experiences and the tasks they conducted from the project platform when they formed part of it.
- The process of preparing the appraisal was complex, since it consisted of gathering information from every unit depending on the Ministry of Health and related to GAVI — HSS intervention areas since the start of the project up to August 2014.
- Professionals from GAVI-HSS team, the EPI, the Health Services and Quality Network Unit, the Directorate General of Planning, the Directorate General of Health Services, the Directorate of Health Promotion and the Vice Minister of Health, SNIS-VE, UNICEF Bolivia, PAHO/WHO Bolivia, PAHO/WHO Washington and GAVI participated in preparing the Appraisal because of the importance of the GAVI Project to the country, contributing with the information necessary based on prior coordination of the activities undertaken in the 37 priority municipalities of the departments of La Paz, Oruro, Potosí, Cochabamba and Chuquisaca, in keeping with the lines of intervention set forth in the Agreement signed between the Ministry of Health and PAHO - the GAVI Alliance.
- The joint mission lasted 4 days, starting on 8 September and ending with the signing of minutes on 11 September 2014.

- The Appraisal process was aligned to in-country processes. For reasons beyond our control, it was not possible to meet with the Health Councils of the National Congress or with the Minister of Health, or hold interviews with the Health Councils of the National Congress or the meeting with ICC (COCOTEC) members.

## 2. Achievements and Constraints

- **You are confident that the country is meeting its vaccination coverage, drop-out and vaccine wastage targets this year and in overall trend? If not, why not?**
  - Administrative coverage levels show a great divergence in immunisation coverage rates for 2013, with a significant proportion of municipalities below 95% (78.6% for Penta3 and 71.6% for MMR); the 37 municipalities included in the HSS Project present low coverage rates and even show downward trends over the last few years. On another hand, the National Immunisation Coverage Survey (ENCOVA 2013), representative for the urban and rural areas on the level of the nine Departments as well as the city of El Alto, indicates that coverage on the national level is between 10 and 15% higher for the different vaccines (90.4% for Penta3 confirmed by written records, and 94.6% if verbal information from mothers is included); the percentage of complete basic schedules is 90.7% (94.0% in rural areas and 87.1% in urban areas).
  - Yes in terms of the components mentioned. Projected coverage levels for December 2014 are satisfactory, oscillating around 95%. It is vital to underscore that the population targeted for the present year consists of 208,000 infants under 1 year of age.
- **Equity issues are being actively assessed and then addressed, including geographic, wealth and gender coverage discrepancies and gender-based barriers to immunisation.**
  - GAVI – HSS has been faced with the following difficulties which might be understood as obstacles to the implementation of its activities:
    - Significant delay in administrative processes on all levels, hampering the implementation of plans. The same applies to the annual monitoring and evaluation processes for the GAVI Alliance APR.
    - The high rotation of human resources in the health system does not allow for supervision and monitoring of training processes and processes to strengthen resolution capacity at the national level. The system, and GAVI-HSS itself, require work stability for proper continuity.
    - Changes in the technical and administrative coordination of GAVI-HSS have hampered the implementation of activities and the continuity of decisions made previously, as has restarting the coordination process with the different subordinate levels and significant players in executing GAVI-HSS.
    - Changes in the different levels and subordinate levels of authority were an obstacle in the coordination processes, for which reason it was necessary to start again in line with the strategy previously described.
    - On another hand, as to the implementation of Municipal Health Councils, municipalities were found in which these were not organised and the population likewise had no organised social structure. Hence, starting this process entails the agreement of indigenous countryside authorities to carry out this process. This has led to exerting twice the effort to train and give form to the social structure.

- Significant administrative delay that hampered the procurement of resources on time for the various processes.
  - Geographical, language and literacy barriers posed a problem.
  - Problems are assessed within the Project on both administrative and technical levels, and each one is tackled with the area managers of the Ministry of Health in order to find solutions to make the fulfilment of GAVI – HSS targets feasible.
- As to the EPI, immunisation is guaranteed for the entire population without discrimination in Act 3300 of 2005. As to geographic obstacles, these are reduced by the presence of MI SALUD doctors, 5000 of which have spread throughout the national territory. Likewise, the support of medical specialists can be relied on in municipal capitals, along with special rapid action brigades (BEAR) in a reduced number for immunisation.
  - As regards barriers of gender in immunisation, we can affirm these do not exist, and that in the last 8 years of government, strong impose has been given to the equitable participation of both the male and female population in all spheres. In the National Immunisation Coverage Survey (ENCOVA) report, the heading Equity in Immunisation textually sets forth that "no significant differences in coverage by gender and other variables are observed".
  - Said report, moreover, adds that "no statistically significant differences in coverage are observed due to identification with indigenous nations or peoples at the national level o within the departments".
- **Marginalised or hard-to-reach populations are being targeted and reached.**
  - The national EPI is oriented towards covering 100% of the infant population of the country. In general, the rural areas of the 9 departments have higher coverage levels with respect to all vaccines, which may be indicative of Programme penetration.
  - According to the health system information analysis committees (IACs), targets are prioritised and defined to reach these populations of difficult access, above all with regard to geographic barriers. It is likewise important to underscore, as per the last Immunisation Coverage Survey (ENCOVA - 2013), that the EPI is the most equitable programme with the greatest scope throughout the country, and where it best shows its results is in the country's rural area.
  - Nevertheless, ENCOVA 2013 shows that there are great difficulties in the urban area due to the greater population burden, informal trade, and health establishments with restricted healthcare timetables for immunisation, and that the existence of private establishments for immunisation gives rise to incomplete records on the data of immunised children.
- **The country has appropriate plans to address the challenges identified? Does GAVI HSS contribute to the achievements/overcoming of challenges?**
  - The country has established the following as principles: the right to health, sector interaction, cross-culturality, social participation and mobilisation, decentralisation and the development of autonomy. Based on the Political Constitution of the State (2009) and the Bolivian commitments to UNASUR, health is established as a fundamental human and social right and a public asset, and the State is responsible for ensuring the health of all Bolivians.

- The current Health Sector Plan for Development 2010-2020, "Towards Universal Health", is the national planning instrument of the sector, orienting the activity of the entire health sector. In line with the new paradigms of the new Plurinational State set forth in the Political Constitution of the State (PCS) are the National Development Plan (NDP), the Government Plan 2010-2015 "Evo Bolivia Avanza" and the Intercultural Family and Community Health (SAFCI) Policy.
- The Sector Plan for Development 2010-2020 establishes:
  - The construction of the **single health system**, which spells out universal access to the Single Intercultural Community Health System by:
    - A. Guaranteeing the cost-free care provided for in the Constitution, eliminating any payment or private practice in the public and social security health establishments
    - B. Guaranteeing quality universal healthcare under terms of equity in all the public and social security services
  - The guaranteed delivery of essential and generic drugs, along with consultation and control over their trading.
  - The guaranteed direct financing of the state (the Treasury, prefectures and municipalities) and indirect financing in the case of social security.
  - Traditional medicine is included in this single health system and entails the acknowledgement of the customs and forms of health constructs pertaining to original indigenous nations in the countryside through the structuring of policies and mechanisms of healthcare and management.
  - Social Participation, Mobilisation and Control, which means establishing mechanisms of social participation and control (social movements and civil society) over the intercultural community SHS at all management levels of healthcare.
  - Participation is taken into account in public management decision-making in health through mechanisms of social control with decentralised, independent and autonomous decision-making powers, legally constituted within a humanised and integrated regulatory framework.
  - Governance and Sovereignty in health, which means: recovering and guaranteeing sovereignty and governance of the health system in formulating health policy and controlling and monitoring its fulfilment.
  - Definition of national, departmental, municipal and indigenous competencies at the different levels of healthcare and healthcare management.
  - The concerted alignment of departmental and municipal management and decentralised institutions with national health policies and priorities.
  - Autonomous character as well as the competencies to be defined for each level of management shall be governed by specific law, with progressive implementation.
  - Alignment of international cooperation with national priorities and policies
- Despite the fact that health centres have faced a growing demand, many have not attained the minimum conditions for offering adequate healthcare due to the lack of equipment and personnel. Likewise, the government has implemented payment of the "Juana Azurduy" Voucher created by supreme decree 0066 – 2009, which facilitates the timely recruitment of pregnant women. The Voucher also aims to contribute to decreasing maternal and infant mortality and chronic malnutrition in children under two years throughout the country.
- To combat social exclusion in health and render the national policy of Intercultural Family and Community Health operative, a national priority project mobilising human resources on a mass scale called Mi Salud was created. Mi Salud includes the mobilisation of health brigades focusing on integrated and intercultural medical care and activities of health

promotion and disease prevention, either in clinics or directly at home. In its community work, the Mi Salud programme also seeks to strengthen social participation and control in health and promote the complementary role of traditional medicine. During its first year of existence, the Mi Salud programme was implemented in 26 municipalities of 6 departments in the country, but its expansion to 110 municipalities is expected before the year ends. In its first year, 626,816 instances were attended to, majority of them (56%) home visits, assisting 346 births, saving 792 lives, and keeping maternal and infant mortality down to 0 in the population cared for by Mi Salud teams.

- As per 2011 data, 47% of the Bolivian population avails of formal health service coverage; 53% has no kind of coverage and more than half the population uses traditional medicine (PAHO, 2011). It is estimated that 82.7% of the health services are provided by the Ministry of Health, 5.6% by the various short-term insurance plans of Social Security and 11.7% by private service providers. By definition, the entire population under 5 years of age and over 60 should be covered, whereas women of child-bearing age and pregnant women are also covered by the Single System, albeit not completely, leaving men of different working age groups as the principal parties excluded. Nonetheless, geographic, economic and cultural barriers account for populations that, even while falling within priority age groups, do not enjoy medical coverage. The population excluded in health is primarily composed of the original indigenous countryside population in the Bolivian valleys, plateaux and plains, living marginally and exploited by the capitalist system still dominant in Bolivian society. Social exclusion in health is even more accentuated in the case of indigenous monolingual populations that only speak their language of origin. Currently also excluded from the exercise of their right to health are intercultural communities (ex-colonists) and the marginal urban population, largely employed in the informal sector and principally composed of a significant population of tradesmen, stratified into different social classes in accordance with their income.
- In this context, the access to health is still limited, although the challenge of the country is to consolidate a Single Health System that can guarantee Universal Access. This limited access expresses itself in high rates of disease, infant mortality, maternal mortality, chronic malnutrition and the prevalence of diseases that have not undergone great changes over the last few years.
- In conclusion, the country has annual national and departmental plans that are obtained from national evaluations, and after identifying weaknesses, action plans are prepared to resolve them.
- The HSS Project does not directly support the resolution of the challenges identified at the national level, but it acts at the level of the areas where it intervenes (prioritised municipalities).
- Moreover, the survey on Causes for Non-Immunisation (CNIs) and Lost Immunisation Opportunities (LIOs) conducted in the urban area of La Paz and El Alto this year reveals that 41.1% of the causes for non-immunisation may be attributed to the health services/staff. Within this category, the survey allows for sub-categories of causes relating to healthcare quality (51.4%), the application of standards and procedures (15.9%), the organisation of the services (201.3% and the operation of the immunisation service (12.45). LIOs are estimated at 26.5% in the study. These data will make it possible to define specific strategies for intervention and to monitor their results. Health Service Strengthening in support of the EPI includes the conduct of similar studies in other selected areas,

particularly rural zones and places served by mobile immunisation brigades, since the CNIs and LIOs could be substantially different.

- **Does the GAVI Business Plan fund equity, coverage or data quality improvement planning, or a country tailored approach? If yes, please comment on progress and results.**
  - Yes, the GAVI – HSS Business Plan will fund equity, coverage and data quality improvement planning or a country-tailored approach.
  - Following are the progress made and the results achieved:
    - Development and organisation of the Service Network focusing on Emergency Obstetric and Neonatal Care in priority municipalities from the management, administrative and clinical perspective, responding to the 3 healthcare levels, strengthening referral and counter-referral along with resolution and response capacity to these emergencies, under the premise of preventing the three delays causing maternal, neonatal, perinatal and infant mortality.
    - Human resource training and competences in obstetric and neonatal emergencies in line with level and complexity of healthcare based on standards in force, strengthening health management capacity and the organisation of the population as well as its co-responsible participation.
    - Training in Quality Management to the human resources of reference hospitals in the Service Networks of priority municipalities with the agreement of the organs of management and control, strengthening the application of the different quality instruments included in the Ministry of Health's National Project for Quality in Health.
    - Strengthening coordination in all GAVI-HSS levels and implementing units, enabling management (planning, development, monitoring and evaluation) of the various interventions and activities and responding to the objectives and indicators projected. This was achieved by holding six-monthly and yearly meetings with the different levels (Ministry of Health and its various Directorates and Units, the SEDES of 5 departments for the 37 priority municipalities, autonomous municipal governments, organised civil society and NGOs aligned with GAVI-HSS interventions).
  - All of this was achieved based on:
    - Management decision-making that enabled proper planning and implementation of GAVI-HSS activities, attained by developing the baseline along the variables identified in this process. This must be done cutting across sectors from an intercultural point of view, which was the main weakness since no variables were previously identified to enable decision-making for the implementation of the SAFCI Policy.
    - Strengthening the 37 priority municipalities with basic medical equipment. The participation of organised civil society exercising social control is important as the promoter of this entire process, participating in the delivery, control and proper use of this equipment.
    - It is important to include training in competencies as one of the activities of secondary and tertiary level healthcare hospitals as an ongoing and permanent process that enables human resources upgrading and the strengthening of their resolution capacity. It is thus vital to initiate internship processes in these health

- establishments so as to optimise resources.
  - Including representative civil society in coordination, strategic planning and management processes, as well as at the different subordinate levels, account taken of its needs and priorities in each case, has made it possible to obtain the best consensus on GAVI-HSS interventions.
  - The result and impact indicators initially formulated are projected on the national scale, not necessarily for GAVI-HSS interventions. These indicators will be modified, account taken of the fact that Bolivia has 339 municipalities and GAVI-HSS only has scope of action for 37. Hence, the indicators must be formulated in accordance with the service networks, the municipal level or depending on the scope of action defined in upcoming projects.
- On another hand, following improvements were also achieved:
  - Strengthening health promotion and disease prevention in maternal and child care with an intercultural community focus, empowering the community in its responsibility for healthcare in the 37 priority municipalities.
  - Strengthening of SAFCI policy implementation with the implementation of Municipal Health Councils.
  - Development of training processes in social health structures in line with the SAFCI policy.
- These advances were achieved through:
  - Organisation of the social health structure as per the SAFCI policy, which allowed for the development of venues of deliberation between the social and state structures, represented by the Public Health System and its different levels. This made decision-making at the municipal level possible for the preparation of the Municipal Development Plan (MDP) in Health as a five-year plan, giving priority to the population demand in health, education and social determinants, an instrument that facilitates annual planning and its monitoring through social control exercised by the population. This venue has strengthened participative social management in health. This has also allowed all the municipalities to initiate the process of preparing the Organic Municipal Charter in accordance with the promulgated Law on Autonomy.
  - The organisation of Local Health Authorities and the formation of Local Health Committees (COLOSAs) have been achieved through the process of training the population in participative social management in health, which empowered it in decision-making as to health, education and the allocation of priority in requiring/demanding attention to needs in terms of social determinants. The population has thus been organised.
- It was found that:
  - Different social organisations formed in Bolivia exist, representing the different nations of original indigenous peoples of the countryside and the population in general. Hence, in the process of organising the Municipal Health Councils, it is vital to include all the organised groups as well as those not organised that may be represented in this process. In this way, consideration is taken of the entire population demand and not only that of some influential groups.
  - The Municipal Councils require intervention on all levels and sub-levels in terms of technical and logistics support. Nonetheless, the total demand of the population must

be respected and its demands included in the identified axes of the Municipal Development Plan.

- To include the municipal authorities, ensuring their presence and active participation in the entire process of constituting the Municipal Councils and approving the Municipal Development Plan.
- What is important is to develop training strategies specifically for the population, with methods that enable and ensure an appropriate learning process. This way, the sustainability and operation of the organised social structure will develop without problems.

### 3. Coordination and Governance

- **Do the ICC and HSCC feel they are meeting their TOR? Do they circulate their minutes in a timely fashion with appropriate follow-up?**
  - The Health Sector Coordinating Committee meets when called by the EPI and HSS, during which the follow-up pertinent to GAVI support is conducted.
  - The technical advisory committee of the EPI and the Immunisation Advisory Committee (CAI/CNI), which participates actively in priority processes such as new vaccine introduction, the documentation of measles and rubella eradication and the validation of EPI standards and procedures meet monthly and, where necessary, hold extraordinary meetings. There are good, high-level technical relations between them and Government. The resolutions and conclusions of every meeting are signed on official record.
- **ICC, HSCC participation is at the level prescribed in their TOR? There is shared membership between ICC and HSCC? Civil Society Organisations actively participate?**
  - Yes, COCOTEC participation adjusts to the level prescribed in their TOR. However, civil society does not participate. The participation of these social organisations takes place systematically at the local level in events relating to data analysis and in acts of accountability for transparency.
  - The Immunisation Advisory Committee is a professionally acknowledged high-level body that meets the guidelines established for its composition. It would be timely to ratify and update its terms of reference so as to meet new challenges, such as the introduction of the HPV vaccine.
- **Are minutes released promptly, with clear conclusions and measures adopted? Are they followed up?**
  - Minutes are released in due time and follow-up is conducted, but it is necessary to strengthen levels of coordination.

### 4. Programme Management

- **There is an M&E framework for both HSS and NVS, with common targets and indicators based on the Health Sector Strategic Plan and Comprehensive Multi-Year Plan? The framework is actively followed, activities are resourced and used for decision-making.**
  - HSS follow-up and evaluation are conducted based on the Agreement signed between the Government of Bolivia and the GAVI Alliance, which establishes the common targets and



indicators set forth in the Health Sector Strategic Plan and the Integrated Multi-year Plan in what regards health system strengthening.

- On another hand, through its health sector plan for 2010-2020, "Towards Universal Health", the Plurinational State of Bolivia establishes a monitoring, follow-up and evaluation system for which the Directorate General of Planning of the Ministry of Health and the SEDES will be responsible. Likewise, this evaluation system would relate to the National Health Information system (SNIS). This process analyses processes, their impact and their interrelations towards improved reorientation in the design and implementation of health sector interventions. Likewise, through the health information analysis committees, the networks, the departmental health services and the Ministry conduct an integrated appraisal of all the indicators relating to immunisation coverage.
- In turn, the Plurinational State of Bolivia institutionalises a law of "Zero Corruption Tolerance" through the Policy of Transparency and the Fight against Corruption, which was prepared with the participation of the social sectors and which governs all government policies. In this framework, the Minister of Health and the technical directors of the SEDES draw up yearly reports on management and accountability and submit an annual management report that accounts for the activities undertaken, the fulfilment of objectives, achievements, and future challenges, all in all serving as a mechanism of accountability and transparency.
- Transparency is an authentic and responsible dialogue between government and society that takes place in an ethical environment of trust to establish commitments oriented towards the achievement of the common welfare, which, as a process, requires political, social and institutional changes.
- The components for promoting transparency in public management are: access to information, social control, ethics and public accountability.
- The sector plan defines each of the terms in the following way:
- **Monitoring:** This is the routine and continuous process of observation and data gathering regarding the different sector interventions and projects.
- **Follow-up:** This is the process of tracking the implementation of initiatives (projects, programmes and strategic axes) that makes it possible to check whether plans, programmes and projects are being implemented as projected.
- **Evaluation:** This is the process by which the fulfilment levels of formulated strategic objectives, immediate objectives of projects, intermediate objectives of programmes, final objectives of plans and impact on the Bolivian population are determined.
- The scheme observed is as follows:
- Resources-> Activities->Results->Objectives->Impact
- The evaluation criteria are: effectiveness, efficiency, impact and feasibility. Indicators have the following criteria: pertinence, reliability, simplicity, practicability, unequivocal character and coherence.
- On its side, the EPI meets twice a year for evaluation, during which barriers are identified and action plans approved.
- The EPI indicators are tracking indicators for the Health Sector Plan and follow-up is done in the information analysis committees at the municipal, departmental and national levels. In addition, these are fed into the high-level management reports.

- On a monthly basis, with SNIS data, the directorate of epidemiology follows up immunisation coverage.
- **There is an annual immunisation action plan; with cost and funding identified and endorsed by the ICC? Does it take into account past performance and emerging trends?**
  - There is an annual action plan with costs. The annual plan with costs and the financing determined is reflected in the Annual Operational Plan (AOP). The AOP and GAVI-HSS budget is approved every financial year by the Ministry of Health based on the Financial Law. Hence, it is an integrated part of the Ministry of Health budget and AOP..
  - GAVI-HSS funds are deposited into Official Government Account No 3987069001, Single Treasury Account (CUT), as per officially-signed agreement. Subsequently, these funds are authorised over Bankbook No 00465508004, for which the Project Management Unit (UGESPRO) dependent on the Directorate General of Administrative Affairs of the Ministry of Health is responsible.
  - The GAVI-HSS implementing unit prepares the programme based on the AOP and the budget, and requests disbursement from the Directorate General of Administrative Affairs (DGAA) of the Ministry of Health. This body authorises UGESPRO to make the disbursement with respect to the entity that will implement the activities (GAVI-HSS). AOPs are prepared in the light of the previous year's performance and new tendencies.
  - During this process, the Directorate General of Administrative Affairs, the Budget Unit, the Directorate General of Services, the Directorate General of Health Promotion and the Directorate General of Planning are in permanent coordination as regards the technical and administrative aspects relating to GAVI-HSS.
  - GAVI-HSS sends quarterly reports on physical and financial implementation to the Directorate General of Planning of the Ministry of Health as well as monthly Project Management Forms to the Budget Unit of the Directorate General of Administrative Affairs. GAVI-HSS sends periodic reports to the Transparency Unit of the Ministry of Health or to other units as part of the Accountability process.
  - Likewise, with respect to the EPI, the Annual Operational Plan (AOP) is prepared each year. Moreover, there is the Five-Year Action Plan 2011-2015, prepared as part of the international EPI evaluation. These include historical implementation reflecting progressive increase in areas that are complementary to vaccine procurement.
- **There are current or anticipated budget shortfalls? If yes, in what areas (e.g. GAVI co-financing, purchase of traditional vaccines, operational costs).**
  - No budget shortfalls are expected in GAVI-HSS. No budget shortfalls are likewise expected in the EPI, which is even considering introducing the HPV vaccine. The entire national immunisation schedule is guaranteed by the Bolivian state. With respect to co-financing, there is no default risk. Nonetheless, additional reinforcement is considered necessary for communication, information and research.
- **Committed funds arrive in a timely fashion? If not, what are the major barriers?**
  - The funds earmarked for the GAVI-HSS programme are received punctually.

- In the case of the funds earmarked for the pneumococcal vaccine introduction into the country, the funds arrived late. Due to bureaucratic procedure within PAHO/WHO, in the end they could not be transferred. Nonetheless, the funds earmarked for the EPI were received on time.
- **Sub-national micro-plans are systematically developed and guide implementation?**
  - No sub-national micro-plans are systematically created in the GAVI-HSS team because work is done in accordance with valid requirements and premises based on historical data.
  - This is done in the EPI in general immunisation planning at the municipal level. Micro-planning is specifically applied in intensive immunisation activities, national campaigns and new vaccine introduction.
- **An adequate training and supportive supervision system exists for the health workforce? If not, what steps are being taken using GAVI or other funds and are they sufficient?**
  - GAVI – HSS has no training and supportive supervision for the health workforce of prioritised municipalities.
  - For the EPI, cascade training is applied at the different healthcare levels. Currently, work supported by UNICEF and PAHO is being done on preparing an interactive computer program for management training and the training of different programme components that can be imparted over CDs in all the health establishments throughout the country.
  - Rapid analysis prior to this evaluation made it possible to identify coordination weaknesses between HSS and the EPI in the implementation of these activities. For this reason, the decision was made to closely coordinate the implementation of follow-up, monitoring and evaluation activities in the priority municipalities.

## 5. Programme Delivery

- **Immunisation improvement activities are being implemented to schedule and budget? If not, what the implications for future introductions are? Whether GAVI HSS contributes?**
  - Yes, activities to improve effective vaccine management are implemented in keeping with the established plan, totally funded by the National General Treasury (TGN). As regards GAVI – HSS, it contributes to supporting effective vaccine management by furnishing refrigerators to priority municipalities.
- **There is regular over or under-stocking? Indicate the trend of these over time. Has it been possible to determine the major factors? Are these being addressed?**
  - As regards vaccine management in general, there is sufficient stock for their administration to all departments. Nonetheless, with regard to pneumococcal introduction, this was insufficient at the national level, since immunisation for all children under one year of age was projected at the time of introduction.
  - Vaccine availability is guaranteed by the PAHO Rotating Fund for vaccines. Special situations have given rise to circumstances of crisis or under-stocking, such as the scarcity of yellow fever vaccine (due to deficiencies in global production) and the potential under-stocking of pneumococcal vaccine due to problems in the initial plans.

- **Recent vaccine introductions and campaigns went according to plan and schedule? If not, what lessons should be learnt? Is subsequent coverage on track?**
  - Yes, pneumococcal vaccine introduction (PCV-13) was projected as a programme for FY 2013. Nevertheless, it was postponed due to the difficulties encountered. These included difficulties with the allocation and disbursement of funds to the departments to support pneumococcal launching, the execution of programmed activities and the inclusion of part of a cohort of unprogrammed births. All these funds will be planned and managed appropriately in the future.
- **There is coordination and linkages between GAVI NVS and HSS support, particularly the use of vaccine introduction grants and HSS.**
  - Yes, these exist, but coordination is in the process of resuming, as it was neglected during previous financial years.
- **Reaching Every Child/ District activities are being implemented and scaled up?**
  - Yes, in effect, activities to reach every child are being implemented and expanded based on the capacities of health staff from the priority municipalities, the expansion of health networks, the delivery of equipment to the municipalities, and the preparation of municipal plans in the sense that each municipality identifies its set of problems, obtains a diagnosis of the situation and formulates the solution to these, and integrated action is jointly taken by the community, the health staff and social and local authorities.
- **Vaccination training and supervision activities are being implemented according to needs?**
  - Yes, in accordance with demands. In general, there is an adequate level of participation in these activities. The national level is conducting specific activities to improve training, supervision and evaluation.
- **Health centres have funding to conduct outreach vaccination in hard-to-reach areas?**
  - They do not have these funds. Everything for the implementation of this activity is financed by the central level, in some cases with support from the municipalities.
- **Social mobilization activities are increasing community demand for vaccination?**
  - Yes, through the presentation of the vaccines among the population demanding them.

## 6. Monitoring and Evaluation, Surveillance and Data Quality

- **What is the country doing to assess and improve the quality of data produced by its routine administrative system, and strengthening actions needed. For example: Has the country institutionalized a routine mechanism for tracking data quality over time? Does the country have an improvement plan based on assessment findings and other evidence? What is the status of implementation of the improvement plans?**

- Difficulties in the data-gathering process are encountered in local medical centres, a problem that impacts the consolidation of partial as well as final data at the departmental and national levels.
  - The data sent from the local centres to the departmental and national information systems are incomplete.
  - To assess data quality, the EPI has institutionalised the "Basic Template" where data quality revision is conducted during supervision done throughout the national health system.
  - As regards data quality strengthening, the EPI has planned to implement the nominal system to improve the data on the number of male and female children immunised and the doses administered, starting with field tests in selected departments.
  - In addition, two immunisation data quality evaluations have been conducted (PAHO and GAVI), the results of which oriented the application of specific interventions to correct deviations. The supervision guides for the national and department levels contain techniques for evaluating data quality.
- **The country's schedule for conducting household surveys to produce independent measures of coverage and equity, and strengthening actions needed. For example: Does the country have a survey with a full birth history at least every five years? Does the country have an interim coverage survey in the middle of the five year period? Does the country have a plan for comparing immunisation coverage data with country administrative data to understand potential data quality issues?**
- The country conducted an immunisation coverage survey in FY 2013 (ENCOVA), which shows favourable results with the administration of the 3rd dose of pentavalent to children under one year of age at 81.4% and MMR at 83%. During the EPI evaluation meeting, the results were presented to the EPI managers and teams of the SEDES. In addition, there are plans to conduct the ENDSA during the first half of 2015.
  - The 2012 population census poses serious problems to the EPI, since it underestimates the infant population by around 15%. There are no other mechanisms or validated information sources for estimating the population.
- **The status of the country's disease and vaccine safety surveillance systems and impact monitoring, and strengthening actions needed including data collection, analysis, interpretation and communication of these data to key stakeholders. Eg., does the country have a mechanism for regularly comparing immunization coverage, disease surveillance and vaccine safety data? Are these data regularly communicated to key stakeholders including health care workers, programme managers and decision-makers such as the NITAG?**
- As regards vaccine-preventable disease surveillance, the national EPI has a surveillance system on the three healthcare levels which includes recording and immediate notification to the pertinent levels, who conduct the research and follow up the reported cases. There is also a surveillance system for Adverse Effects following Immunisation (AEFIs).
  - There is an information system integrated into the SNIS on the doses administered at each health unit in the country with which to calculate coverage rates at the different levels.
- **The performance framework for the country's HSS support, and strengthening actions needed. Eg., is the performance framework current and fit-for-purpose? Is**

**the country completing the measurement activities described in the framework in a timely manner and is it reporting consistently against it?**

- At GAVI-HSS, evaluations are based on compliance with an Annual Operational Plan, which responds to the strategic objectives of the project.
- An evaluation of the activities conducted: courses, workshops, seminars on specific topics, in addition to medical equipment and cold chain strengthening, aimed at strengthening the health system and mother-child healthcare services.
- **The mid-term and end-of-grant evaluations of HSS or other support, and strengthening actions needed. Eg. is the performance framework current and fit-for-purpose? Is the country completing the measurement activities described in the framework in a timely manner and is it reporting consistently against it? Is the country responding to lessons learned to help strengthen future introductions?**
- The GAVI – HSS baseline evaluation was conducted in FY 2010. Service network evaluation was conducted in 2011. A multi-programme evaluation on the mother-child tandem was also carried out in Potosí Department in 2012.
- For this year, the conduct of an evaluation on the implementation of the Continuous Course of Life is projected at the Betanzos Municipal Hospital and, afterwards, similar tasks in all the municipalities prioritised by GAVI – HSS.
- The project is also analysing the conduct of a multi-programme evaluation in all the priority municipalities.
- The performance framework for the project is continuously being adjusted to fulfil its objectives.
- As regards the strengthening of future vaccine introductions, specific analyses and monitoring in the administration of PCV-13 have been conducted wherein a significant deficit was found in simultaneous administration with other vaccines (polio and penta), which may be possibly attributed to the non-acceptance of simultaneously injected doses. During the National Evaluation, this topic was emphasised and specific instructions were given to revert the situation, with the commitment to achieve a minimum immunisation coverage of 80% in the cohort of children born in 2014. This is a critical topic, given the potential introduction of the injectable polio vaccine.
- In addition, the national EPI has planned to conduct the evaluation of pneumococcal introduction for September of this year, with the participation of the 9 EPI – SEDES.

## **7. Global Polio Eradication Initiative, if relevant**

- **Polio Endgame timelines are on track, including IPV introduction before the end of 2015? DTP3/Penta3 coverage increases by 10% year-on-year in polio high-risk districts?**
- The eradication of polio has been maintained in the country and the guidelines for the contention of wild poliovirus in laboratories have been complied with. With regard to the fulfilment of timelines for polio eradication, the National EPI is in the phase of analysis for the introduction of the new IPV.

- As regards the increase of immunisation coverage rates for the 3rd dose of pentavalent in accordance with the population distribution of the INE, the municipalities considered at risk, now 65%, have fallen out of this selection since their population has decreased in comparison to the previous financial year, per data up to July 2014.
- **Polio, RI and other supplementary immunisation activities share a single annual work plan? Polio field-staff are trained on RI? Do their TOR describe 50% contribution to RI?**
  - Yes, the AOP. According to the analysis of polio immunisation in Bolivia, the health staff at all healthcare levels regularly immunise all children under 5, along with the other vaccines found on the immunisation schedule. The staff is considered trained. Nonetheless, it is needful to maintain permanent training due to staff rotation on all healthcare levels in health establishments.

## 8. Health System Strengthening

- **HSS (including CSO-implemented) activities are carried out to schedule and budget? Funds have been used for the purposes intended? Challenges to implementation are assessed and corrective actions carried out?**
  - The health system strengthening achieved through the delivery of medical equipment and cold chain improvement for GAVI – HSS priority municipalities is reflected in contributions towards achieving intermediate results.
  - It is underscored that the funds allocated have been used in compliance with the Project lines of intervention.
  - HSS activities, including those in which civil society intervenes, adjust to the calendar and budget allocated by the project to each. It must nonetheless be clarified that the civil society organisations, not forming part of the structure of the Ministry of Health, do not receive any budget allocation in cash from the Project.
- **Targets and intermediate results are being achieved? If relevant, what are lessons learned from GAVI's performance-based funding approach?**
  - Project implementation is conceived as a process and in this context, targets and intermediate results have been achieved in support of state policies aiming at health service strengthening at the national level, with project emphasis on mother-child healthcare and EPI support in the 37 priority municipalities.
  - The lesson learned is that citizen participation in the sphere of health is of vital importance, since the citizen becomes a key player in the change of conduct and in decision-making. Health is seen from an integrated perspective, not only as care providers, with the final objective being recruitment into cross-sectoral work in health, particularly in the sphere of disease prevention, central to the SAFCI policy implemented by the Bolivian State.
  - For the EPI, in general, coverage levels are maintained for all vaccines in all the departments. Analyses at the municipal level show highly variable coverage levels, most of them below 90% due to the problems in denominators previously mentioned. The rest of the EPI indicators have remained stable over the last few years.

- **The quality of the country's M&E of HSS is satisfactory? Programme and financial reporting is satisfactory?**
  - The quality of HSS monitoring and evaluation in the country is satisfactory, since as GAVI – HSS officials, we have seen that in the last five months the project has been rechaneled, applying the interventions to the strategic project objectives that are contemplated in the sector and national Development Plans.
  - The programme and financial reports are drawn up on a quarterly basis and sent to the Directorate General of Administrative Affairs of the Ministry of Health, which takes charge of evaluating the data provided.
- **Technical assistance for HSS is well planned and of sufficient quality.**
  - HSS technical assistance planning and quality are satisfactory, as an adequate level of coordination is maintained at the national, departmental and local levels.
- **Civil society organisations (CSOs) are involved in HSS implementation, following a transparent process for identifying and contracting them, prompt fund transfer to them, with sufficient quality of reporting, and lessons learnt from their engagement.**
  - Civil society organisations have participated in HSS implementation through the Municipal Health Councils, which have also worked on identifying health needs and in decision-making for health service strengthening, in addition to the change of conduct in the rural population.
- **Proposed future GAVI-funded HSS activities are in line with the IRC-approved work-plan and budget and with broader HSS and other donors' initiatives?**
  - The GAVI – HSS Project has no information on health service strengthening activities implemented by other donors. Nonetheless, it is in standing coordination with the "Proyecto Fortaleza".
  - HSS activities financed by GAVI for the future are in line with the approved work plan and budget.

## 9. Use of non-HSS Cash Grants from GAVI

- **Activities are being carried out to schedule and budget? Funds have been used for the purposes intended? Challenges to implementation are assessed and corrective actions carried out?**
  - Activities are implemented in accordance with a calendar and budget established in coordination with the pertinent offices. The funds are used to respond to the strategic objectives formulated in the project.
  - The challenges to implementation basically arise from the bureaucracy of administrative procedures. The implementation of a system for following up such processes as a counter-measure is an option.

## 10. Financial management

- **Financial reports and audit reports are provided to GAVI on time?**



- The last audit was conducted in FY 2012 and the conduct of an external audit for FY 2014.
- **Financial reports and audit reports are provided to the relevant in-country oversight committee and discussed at these meetings, as evidenced in meeting minutes?**
  - The financial and audit reports were submitted to the pertinent offices of the Ministry of Health for the application of corrective measures.
- **There are outstanding financial clarifications to be provided to GAVI?**
  - Progress Reports are made every year in which an evaluation is made of the progress of programme activities. This is sent to the GAVI ALLIANCE platform for subsequent analysis.
  - Nevertheless, the subject of co-payment for the pneumococcal and rotavirus vaccines needs clarification.
- **The flow of GAVI funds to regions/districts is effective?**
  - There is an AOP that plans the activities or operations to be implemented every year, which have a set budget with a ceiling for equitable distribution to priority municipalities.

## 11. NVS Targets

- The country has made the political decision to introduce the HPV vaccine for pre-adolescent girls nationwide. It avails of a cost-benefit analysis indicating that this vaccine is highly cost-effective in the various scenarios under study. The National Immunisation Committee (CNI) has favourably analysed the pertinence of its introduction due to the high incidence of cervical and uterine cancer in the country. Since the vaccine is not offered this year by the Rotating Fund, the feasibility of direct purchase is being studied. The support of the GAVI Alliance in this sense would be highly significant.
- As regards IPV, national authorities have given priority to the consolidation of the pneumococcal vaccine and it is still being analysed for possible introduction.
- Interpreting the administrative information is hard because of the problems caused by the estimate for denominators; the recommendation on the results of the 2012 Census is to analyse the tendency in doses administered, regardless of calculated coverage rates (all the vaccines are estimated to reach coverage rates of approximately 110%).

## 12. Immunisation Financing and Sustainability

- **More could be done to ensure financial and programmatic sustainability of the EPI Programme and GAVI HSS grant, especially in the context of any decentralised systems or upcoming graduation (if applicable)?**
  - Financial sustainability for the Expanded Programme on Immunisation is guaranteed by the Vaccine Law, No 3300; every year there is a progressive increase in the general Programme budget, absorbing the increase in the co-payment of new vaccines. In what

regards the subsidy for HSS, it is very important in order to strengthen the demand from the different municipalities with immunisation coverage risks.

- Since resources are managed at the central level, this does not currently require decentralised administrative handling.
- **There is a budgeted plan for recurrent maintenance and running of HSS-funded capital items? E.g., fuel, salaries.**
  - There is a programme for these in the annual budget.
- **The Government share of the immunisation budget is growing? Resources are transferred effectively from national to decentralised levels? The country fully finances its RI, including vaccines? The projected EPI budget for the coming years is covering all expected vaccine expenditure needs?**
  - The state avails of an adequate budget for the National EPI and transfers this effectively to all the departments. The country finances immunisation for all the vaccines except for pneumococcal and rotavirus, which are gradually being assumed by the state with GAVI support. For the next financial year, the EPI has calculated a budget sufficient to respond for the needs of the programme components (which will be approved in FY 2015).
- **Immunisation performance is likely to continue once graduated from GAVI support.**
  - Following a national evaluation conducted in September of FY 2014, the country intends to improve performance in what regards new vaccine introduction.

### 13. Technical assistance

- It is necessary to strengthen the information systems of the Ministry of Health at the local, departmental and national government levels. Nonetheless, this question must be answered by the EPI.
- The technical assistance provided by the PAHO is excellent. We adore our consultant. As part of the Maintenance and Health Service Strengthening Plans in support of the EPI, it is indispensable to recruit a technical professional and an administrative employee into the National Programme, so that activities can be implemented and monitored.

### 14. Recommendations for the Review Panel

Topic	Recommendation
New Vaccine Support (NVS)	Pending the decision on IPV introduction in 2015
	Support for HPV vaccine introduction

### 15. Programmatic Actions for Other Stakeholders

See annex

## ANNEX

Due to logistic circumstances, the Senior Country Manager was not able to participate in the Joint appraisal visit postponed from July to September 2014. The Joint appraisal was filled by PAHO regional and country focal points and government counterparts and sent without recommendations for actions to be taken by the country. The recommendations below are consolidated from Gavi Secretariat teams.

<b>Topic</b>	<b>Action Point</b>	<b>Timeline</b>
Coordination and Governance	Ensure the revitalization/strengthening of the ICC/HSCC as a priority as mentioned in the annual progress report.	Q1 2015
Programme management	Provide additional information on ways the ministry plans to address HR problems (turnover of GAVI-HSS coordinating team) as encountered difficulties with first HSS grant implementation.	Before possible approval of 2 <sup>nd</sup> HSS grant in Q1 2015
	According to the M&E framework, poor performance and not meeting certain targets have not been addressed in previous IRC reports (July 2012) – reasons and corrective actions should be provided.	Q4 2014
	Vaccine introduction grant (VIG) funds should be reported on and lessons learned should be recorded for future corrective action.	Q4 2014
Data Quality	Provide more information on plans to implement nominal registration and plans to address data quality	Q4 2014
Health System Strengthening	Ensure an evaluation of completed HSS grant is conducted to improve and use lessons learned for a possible future HSS grant (if approved).	Q4 2014-Q1 2015
Financial Sustainability	Provide more concrete information on financial sustainability plans and develop a graduation assessment plan of action	Q4 2014