Application for:

GAVI ALLIANCE HEALTH SYSTEMS STRENGTHENING SUPPORT FOR MATERNAL AND CHILD HEALTH SERVICES IN BOLIVIA

(RESUBMISSION)

March, 2008.

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Abbreviations and Acronyms

- **AECI:** Spanish International Cooperation Agency
- **AIEPI:** Integral Management for Childhood Illnesses.
- **APL:** Adaptable Loans for Programmes
- **ASIS:** Integral Health Situational Analysis
- **BPRS:** Bolivian Poverty Reduction Strategy
- **CAI:** Information Analysis Committee
- **CAN:** Canadian dollars
- **CCI:** Inter-institutional Coordination Committee (EPI)
- **CEP:** Proposal formulation committee
- **CIDA:** Canadian International Development Agency
- **CIDOB:** Confederation of first and Indigenous Populations from the Bolivian East
- **CIMDM:** Inter-institutional Committee for the Millennium Development Goals
- **CNI** National Inter-Agency Immunization Committee
- **CNIDAI** National Committee for education-assistance integration.
- **COB:** Bolivian Central Union.
- **COCOTEC:** Technical Coordination Committee, Ministry of Health and Sports
- **CONASA:** National Health Council
- **CONAMAQ:** National Board of Markas and Ayllus of the Qullasuyu
- **CONE** Essential Obstetric and Neonatal Care
- **COEm** Emergency Obstetric Care
- **CSUTCB:** Bolivian Unified Confederation of Rural Workers Unions
- **DILOS:** Local Health Directorate
- **DS** Supreme Decree
- **ECLAC :** Economic Commission for Latin America and the Caribbean
- **EBRP** Bolivian Poverty Reduction Strategy (PRSP)
- **ENDSA:** National Demographic and Health Survey
- **ERBOL:** Bolivian Radio-phonic Schools
- **EU:** European Union
- **FIMs:** Municipal Institutional Pharmacies
- **FODA:** Strengths, Weaknesses, Opportunities and Threats (SWOT Analysis)
- **GAVI:** Global Alliance for Vaccines and Immunization
- **GDP:** Gross Domestic Product
- **HSS:** Health Systems Strengthening
- **HSCC:** Health Sector Coordinating Committee
- **IDB:** Inter-American Development Bank

- **IDH:** Human Development Index
- **IDH:** Direct Hydrocarbon Tax
- **IEC:** Information, Education and Communication
- **INE:** National Statistics Institute
- **JICA:** Japan International Cooperation Agency
- **LOPE:** Law for the Organization of Executive Branch
- **MDGs** Millennium Development Goals
- **M&E:** Monitoring and Evaluation
- **MSD:** Ministry of Health and Sports
- **NB – SABS:** Basic Standards, Goods and Services Administration System.
- **PAHO:** Pan-American Health Organization
- **PAI:** Expanded Program on Immunization (EPI)
- **PDS:** Sector Development Plan
- **PHC** Primary Health Care
- **POA:** Annual Operative Plan
- **PDM:** Municipal Development Plan
- **RCMs** Responsible officer for minor contracting.
- **RPS:** Popular health promoters
- **SAFCI:** "Family, Community and Intercultural" healthcare model
- **SAFCO:** Government Financial Administration and Control System
- **SD:** Supreme Decree
- **SEDES:** Departmental Health Services
- **SGP** Project Management System
- **SISER** Results Follow-up System
- **SNIS:** National Health Information System
- **SO:** Strategic Objective
- **S.R.:** Supreme Resolution
- **SUMI:** Maternal and Child Universal Insurance.
- **SUS:** Unified Health System
- **SU SALUD:** Universal Health Insurance
- **TGN:** National General treasure
- **UDAPE:** Analysis and Social and Economic Policies Unit
- **UNDP:** United Nations Development Programme
- **WHO:** World Health Organization
- **WFP:** World Food Programme

Executive Summary

Bolivia is a democratic Republic, located in the central part of South America 17 00 S, 65 00 W. The country is politically divided into 9 departments, 112 provinces and 327 Municipalities.

In its territory of 1,098,581 square kilometres, three predominant ecological areas are distinguished: the *Altiplano*, to the west of the country, occupies 28% of the territory; the *Valley*, in the central region, occupies 13% and the northern and eastern region, the *Llanos* constitutes the most extensive region of the country and encompasses 59% of the Bolivian territory. Because of the immensity of the territory, the population of the rural area lives scattered hindering their access to the basic services.

The country is both ethnically and culturally diverse. A significant proportion of the population conserves its native tongue and to a great extent, its cultural heritage. Spanish is the predominant language according to ENDSA 2003, four of every five women in her childbearing years speak this language, but there is a sizable number of people that speak Quechua (30.7%) and Aymara

The National Development Plan - PND (2006-2010) establishes a new social policy with a trans-sectoral character, that are oriented to guarantee the provision of basic services such as education, health, housing, communication, as well as to improve accessibility through the construction of roads, for the 164 municipalities considered most vulnerable.

The Ministry of Health and Sports, in the context of the PND has developed the Sectoral Development Plan (2006–2010) in which it establishes five health policies: 1) The Unified, Intercultural and Community Based Health System; a new model of health care; 2) Stewardship of the Health Sector trough a stronger Ministry of Health; 3) Social Mobilization for fostering community participation; 4) To address the Social Determinants of Health trough promotion and 5)To improve the solidarity of the system (eliminating undernourishment, violence and child abuse. The goals of these policies are to increase healthy life years, eliminate social exclusion in health, recover health sector sovereignty and eradicate infant undernourishment. The plan aims to strengthen service networks with a family, community and intercultural health focus (SAFCI), improving the functionality and management of services.

The Ministry of Health and Sports, with the technical assistance of the Pan American Health Organization (PAHO)/World Health Organization, has developed a broad participatory process for the design of the "GAVI Alliance Health Systems Strengthening Support for maternal and child health services" proposal to the GAVI ALLIANCE. Interventions considered for the GAVI HSS support are aligned with national policies, strategies and the 2006-2010 PDS programmes. The proposal development process was led by the Director of Planning and the Unit of Health Services and Quality of the MSD, in coordination with the Technical Health Coordination Committee (COCOTEC) and the support of a technical commission for the elaboration of the Proposal (CEP).

To proposal is based on existing health sector analysis and evaluations, and was built trough a participatory process consultation with national authorities, technicians and leaders of organizations at the national, departmental, municipal and community levels, including service providers and leaders of grassroots organizations, such as women's and rural workers' organizations, nurse's and physicians associations, neighbourhood boards at urban areas, among others. [9] Consultations and experience-sharing with other countries of the region (Honduras and Nicaragua) also occurred during two regional meetings in 2007.

A problem tree was elaborated, identifying the effects and the immediate, underlying and structural causes of the main barriers to achieve or sustain high immunization and other health services coverage's rates for mother and child populations. The main obstacles found in the participatory process are: **1. Insufficient access, poor quality of comprehensive maternal and child health care, and weak capacity of management, in the Health Services. 2. People, families and communities have unsuitable practices and/or lack of knowledge for the identification of their health needs.**

To address these obstacles, two strategic objectives and their respective lines of action have been established. Special emphasis will be placed on the health of children under 2 and health care for pregnant and women in their pre and postnatal period.

35 of the 167 municipalities prioritized at the national level by the National and Sectoral Development Plan –for their higher poverty index- have been selected for the support with GAVI HSS funds (please refer to list in Annex # 20). This effort will be complementary to the APL World Bank Project that will focus on other 82 municipalities.

The pursed goal is: ***To extend the coverage and improve the quality of maternal and child***

[9] In Bolivia, there are more than 1000 grassroots' organizations at the national, departmental and municipal level, representing rural workers, indigenous people, "colonizadores"(settlers), manufacturers, miners, women organizations, human rights advocacy groups, offices of people's advocates, municipal authorities' federations, "los sin tierra" (people without land), just to mention a few. Nevertheless, none of them are considered representative of a majority.

comprehensive care in health services, at 35 prioritized municipalities of the country by 2010.

Expected results are:
1. Increase the coverage of pentavalent vaccine from 83% to 92% in 2010.
2. Increase the number of municipalities with coverage of pentavalent vaccine ≥80% from 195 to 220 municipalities in 2010.
3. Reduce infant mortality from 54 per 1,000 live births to 40 in 2010.
4. Reduce maternal mortality from 229 to 170 in 2010.

The proposed **objectives and lines of intervention** are the following:
Strategic objective 1: Reorganize health care networks and improve the quality of care, as well as the capacity for management in health at 35 prioritized municipalities, by 2010.
Lines of intervention:
1.1 Development and implementation of standards, methodologies, and tools for the strengthening of the managerial capacity of health teams, such as: planning and programming based on population data and health services coverage; needs assessments (human resources, teams' training, equipment, supplies, infrastructure and others); supervision, monitoring, and evaluation (M&E) of norms compliance; referral and counter-referral systems; information system and reporting (Monitoring, evaluation and reporting)
1.2 Training of personnel on current norms and regulations for adequate care of mother and child populations and actualization on management of health services.
1.3 Consensus-building and coordination between different levels of management and the international cooperation to generate synergies in the strengthening of healthcare networks.

Strategic objective 2: Strengthen promotion and prevention interventions in maternal and child health, with a community and intercultural approach; empowering communities in their responsibility for health care at 35 prioritized municipalities by 2010.
Lines of intervention:
2.1 Qualitative research on communities' knowledge, attitudes and practices in the prioritized municipalities, regarding children under five years of age and pregnant women/mother's care, as well as design and implement activities aimed to behavioural change.
2.2 Identification of needs and ways to address problems related to maternal, neonatal and child health; at the participatory planning and diagnostic processes held at the community level, and the existing entities of social control (Surveillance Committees and DILOS).
2.3 Health workers' induction on the intercultural approach and compassionate care for communities.

The required GAVI HSS support for the strengthening of Health Services Networks, accounts for **US$ 2.093.231.** Execution will be performed at a rate of approximately 700,000 dollars/year, in three years (2008–2010). Sustainability of the interventions and results will be ensured by:
- Health financing, at the departmental and municipal level through compliance with the

Section 1: Application Development Process

1.1: The HSCC (or country equivalent)

Name of HSCC (or equivalent):

Technical Coordination Committee, Ministry of Health and Sports (COCOTEC).

The MSD has the following intra-sector mechanisms of political and technical coordination which are related to the formulation and implementation of the proposal:

- The **Interagency Committee**. It is the sector's inter-institutional coordinating committee. It is chaired by the Minister of Health and Sports, with a Secretariat in charge of PAHO/WHO. Other members of the committee are: representatives of JICA, CIDA, European Union, USAID, Italian International Cooperation, UNICEF, UNFPA, UNDP, Spanish International Cooperation Agency, Belgian and French Cooperation, The World Bank, The Inter-American Development Bank, WFP and others. **The proposal was presented and discussed at a meeting of this committee, in order to coordinate future actions related to the proposal.**
- The EPI Interagency Coordinating Committee (**ICC**) or Immunization National Committee (CNI). **Members of the ICC/CNI were part of the Proposal Formulation Committee.**
- The **Ad hoc Committee for Sector Development**, a special Committee of the National Health Committee (CONASA). Participants include representatives from main grassroots organizations of the civil society. This Committee is conformed by the CONAMAQ (Indigenous and Ayllus Organization of the Qllasuyu), CSUTCB (National Organization of Rural Workers), Confederation of Settlers, "Bartolina Sisa" Women's Organization, Bolivian Central Union, Confederation of Indigenous Population of the Bolivian East (CIDOB), several professional associations within the health sector and one representative from the Social Security Boards–Health Funds. The Ad hoc Committee was democratically elected during the Second Expanded National Health Forum, held at Cochabamba on September 2007. **The Ad hoc Committee validated the proposal and will be the main coordination mechanism with civil society for the implementation of the proposal.**
- The Technical Coordination Committee of the MSD (COCOTEC), it is a national intrasectoral entity that establishes the mechanisms of technical coordination between programs and/or projects that are implemented in the health sector. It coordinates the operation of the technical units of the Ministry of Health and Sports. The COCOTEC **was in charge of the oversight and coordination for the formulation of the proposal.**

HSCC operational since:

The **COCO5 T 2**

The Board of the Committee is conformed by:

- Chairperson: Senior Programs and Project Advisor and General Coordinator of Sectoral Planning (Head of the MSD Planning Unit)
- Secretary General: Director General of Health Services, MSD.
- Two Vocals: The Director or National Authority of two technical units designated for the position by the committee itself.

Frequency of meetings:[10]

The COCOTEC meets regularly once a month (last Monday of every month) and extraordinarily whenever required.

Overall role and function:

Rules of Procedure for the Technical Coordination Committee, Ministry of Health and Sports, adopted under Ministerial Resolution No. 657 and dated 24 August 2007, establishes as general functions of the committee, the following:

- Coordinate technical actions for the formulation, execution, and evaluation of programs and projects in strict compliance with the health policy, within the National policies framework emanated from the National Government.
- Coordinate technical and operational actions with international cooperation agencies in order to harmonize health management, in the context of national policies and priorities from the National Government.
- Coordinate active participation of the population in national entities aimed to develop social control's mechanisms, transparency, and to improve effectiveness and responsiveness of public health management.

1.2: Overview of application development process

Who coordinated and provided oversight to the application development process?

The Director of Planning of the MSD and the Director of Health Services and Quality[11], in coordination with the COCOTEC.

Who led the drafting of the application and was any technical assistance provided?

The drafting of the proposal was conducted by the Proposal formulation committee (CEP) with the technical support of a national consultant, and the technical assistance of an international expert, as well technical advice provided by the Extended Program of Immunizations and Health Systems Advisors of PAHO/WHO Bolivia and the regional focal point for GAVI-HSS.

[10] Minutes from HSCC meetings related to HSS are attached in Annex 17 duly signed by the Chairman of the Board, as well as Ministerial Resolution for the creation of the COCOTEC and its Rules of Procedure; together with the minutes of the COCOTEC (HSCC) meeting when the application was endorsed (Annex 23).

[11] In correspondence with their attributions, established by the Law for the Organization of the Executive Branch of Government (LOPE, February, 2006).

Give a brief time line of activities, meetings and reviews that led to the proposal submission.

1. PAHO/WHO Regional Workshop, carried out in Honduras for the presentation of the GAVI HSS initiative and preparation of the work plan for the development of a proposal from Bolivia (March 2007).
2. Contracting of the national consultant and first visit of an international expert, for sharing of other countries' experiences and support for the preparation work. (July 02-06).
3. Workshops at the national, departmental and municipal levels with the participation of grassroots organizations, for the identification of system's bottlenecks, definition of Objectives and strategic lines for the GAVI–HSS Proposal (August 8-18, 2007).
4. English Translation of proposal background documents (from August 15th to September 15th, 2007).
5. Formulation of first draft of the proposal and first review with the CEP with the participation of an international expert (second visit) (fourth week of August, 2007).
6. Meeting with the COCOTEC to validate the proposal, inclusion of observations and presentation to the Minister of Health (fourth week of August).
7. Regional Peer Review Workshop organized by PAHO/WHO in Managua, Nicaragua. Review of HSS proposals and experience sharing with Honduras and Nicaragua (third week of September, 2007).
8. Introduction of the observations arising from the Managua Workshop into the draft proposal, approval and signature of the proposal from the corresponding authorities of the Ministry of Finance and Ministry of Health and Sports (fourth week of September).
9. Submission of the proposals to GAVI HSS IRC (first week of October, 2007).
10. Reception and review of GAVI HSS IRC report by the MSD, Bolivia (17 December 2007).
11. Review of the IRC Report and coordination meeting between the MSD and PAHO/WHO. Preparation of a work plan for the reformulation of the proposal (January 15-18, 2008).
12. Working sessions for proposal reformulation between officers from the Planning and Health Services and Quality Units of the MSD, the national consultant and PAHO/WHO Bolivia HSS Advisor (January 21-23, 2008).
13. Formulation of a new proposal draft by the CEP (February 1st, 2008).
14. Working sessions between officers from the Planning and Health Services and Quality Units of the MSD officers, the national consultant and several PAHO/WHO Bolivia Advisors (6-8 February).
15. Revision of the second proposal with Dr. Mario Cruz-Penate, PAHO/WHO Regional Advisor on Health Systems Strengthening, GAVI-HSS Regional Focal Point, PAHO/WHO Washington, D.C. (La Paz, Bolivia, February 11-15, 2008).
16. CEP working meeting. Dialogue and validation of recommendations from PAHO/WHO Regional Advisor and agreement on new proposal.
17. Actualization of the proposal form, agreed upon modifications in the various work sessions (14-15/02-2008).
18. Validation with civil society organizations, Workshop with the Ad hoc Committee for Sector Development, a special Committee of the National Health Council (CONASA) (February 29th, 2008)
19. English translation of the proposal form and organization of background documents (18/02–05/03-2008).
20. Submission of a new GAVI HSS proposal from Bolivia (March 5th, 2008)

Who was involved in reviewing the application, and what was the process that was adopted?

The Technical Committee for the formulation of the proposal (CEP), the COCOTEC, the Planning Unit and the Health Services of Quality Unit of the Ministry of Health and Sports.

The formulation of the proposal benefitted from the technical advice of PAHO/WHO EPI, and Health Systems advisors. Representatives from the World Bank's Health Systems Reform Project, UNICEF, CIDA and PROCOSI (an NGO network) also participated. The first proposal was submitted to the Interagency Coordinating Committee–EPI (ICC).

The reformulation of the proposal, based on the recommendations of the GAVI Independent

Review Committee was coordinated by the national authorities and technical officers of the Planning and Health Services and Quality Units, of the Ministry of Health and Sports. Under the general leadership of the Senior Advisor, Sector Planning, Programs and Projects, MSD Bolivia. It also benefitted from the technical advice of PAHO/WHO consultants in Bolivia, in the areas of HSS, EPI and maternal and child health, and the support of the PAHO/WHO GAVI- HSS regional focal point. The new proposal was validated by the Ad hoc Committee for Sector Development of the National Health Council.

Who approved and endorsed the application before submission to the GAVI Secretariat?
It was approved by the Technical Coordination Committee, Ministry of Health and Sports, signed by the Minister of Health and Sports and the Minister of Finance, endorsed by the Interagency Committee and of the Ad hoc Committee for Sector Development of the National Health Council.

1.3: Roles and responsibilities of key partners (HSCC members and others)

Title / Post	Organisation	HSCC member yes/no	Roles and responsibilities of this partner in the GAVI HSS application development
Dr. Walter Selum Rivera, Minister of Health and Sports.	Ministry of Health and Sports.	Yes	The highest authority of the Ministry of Health and Sports, oversights all Directorates and National Units of this Ministry. He approves the final proposal for submission.
Dr. Juan Alberto Nogales, Viceminister of Health.	Ministry of Health and Sports.	Yes	Coordinates in the absence of the Minister of Health. He is responsible for the follow up and supervision of COCOTEC activities.
Dr. German Crespo. Senior Advisor, Sector Planning, Programs and Projects	Ministry of Health and Sports.	Yes	General advisor for the formulation programs and projects, coordination with international cooperation agencies and coordinator of the general MSD planning. He led Technical Committee for the formulation of the proposal and he is the delegated Chairman of the COCOTEC.
Dr. Roberto Tardío. Health Director	Ministry of Health and Sports.	Yes	Member of the COCOTEC. Reviewed and provided observations to the proposal.
Dr. Ruth Calderon. Health Services and Quality Unit Chief (Networks).	Ministry of Health and Sports.	Yes	Member of the COCOTEC and of the Technical Committee for the formulation of the proposal.
Dr. Magali Fuentes, EPI manager.	Ministry of Health and Sports.	Yes	Member of the COCOTEC and of the Technical Committee for the formulation of the proposal.
Dr. Carlos Ayala, Advisor on Health Systems and Services.	PAHO/WHO Bolivia	No	Member of the Technical Committee for the formulation of the proposal.
Dr. Olivier Ronveaux, EPI Advisor.	PAHO/WHO Bolivia	No	Member of the Technical Committee for the formulation of the proposal and member of the CCI.
Lic. Virginia Noriega, Nurses' Association President.	Nurses' Association of Bolivia	No	Validation of the proposal.
Dr. Jaime Torrez, Public Health Physicians' Society Representative	Public Health Physicians' Society of Bolivia	No	Member of the Ad hoc Committee for Sector Development of the National Health Council. Validation of the proposal.
Alipio Cuila Barrenoso, Health Secretary	CONAMAQ	No	Member of the Ad hoc Committee for Sector Development of the National Health Council. Validation of the proposal.
Cruz Rodas Condori, Health Secretary	CSUTCB	No	Member of the Ad hoc Committee for Sector Development of the National Health Council. Validation of the proposal.
Silverio Paucara, Secretary of Organization	COB	No	Member of the Ad hoc Committee for Sector Development of the National Health Council. Validation of the proposal.
Patricia Choque, Health Secretary	"Bartolina Sisa" National Women's Organization	No	Member of the Ad hoc Committee for Sector Development of the National Health Council. Validation of the proposal.
Ana Mamani Riveros, Representative	Human Rights Permanent Assembly	No	Member of the Ad hoc Committee for Sector Development of the National Health Council. Validation of the proposal.

1.4: Additional comments on the GAVI HSS application development process

Administration of Resources

Consonant with the Supreme Decree No. 27328, the MSD requests that the financial administration of all projects funded by external resources must be in charge of the National Directorate of Administration, under the regulations of the Basic Standards of the Goods and Services Administration System (SB-SABS) and the Internal Control Regulations of the MSD. The technical monitoring will be carried out by the Planning Unit, without the creation of a Project Implementation Unit.

The GAVI HSS proposal is related to the priorities of the Immunizations´ 5-Year Plan, 2007-2011

The EPI 5-year plan describes several weaknesses that need to be addressed (Pages 17-19 Spanish Version), select priorities and defines strategies to deal with them (Pages 20-26). It is important to point out that the Strategic Objectives and the interventions of the BOLIVIA GAVI HSS proposal are oriented toward some of those EPI Plan priorities, in such a way that, support for Health Systems interventions will correspond directly to the reinforcement of the vaccination coverage.

Civil Society participation

For the preparation of the proposal, participatory workshops were held at Municipal, Departmental, and National levels. At the municipal and departmental levels, local authorities and community grassroots organization leaders, represented in the Local Health Directorates (DILOS): neighborhood councils, organization of women, rural workers´ federation, among others, attended the workshops. (See attendance lists and proceedings of workshops in Annex 24).In addition, for the validation of the proposal for resubmission, a workshop was held with the Ad hoc Committee for Sector Development of the National Health Council.

Section 2: Country Background Information

2.1: Current socio-demographic and economic country information[12]

Information	Value	Information	Value
Population (2006 estimation)[13]	9,627,269	GNI per capita[14]	$US 895
Annual Birth Cohort[15]	274,272	Under five mortality rate	75 / 1000
Surviving Infants*	261,588	Infant mortality rate[16]	54 / 1000
Percentage of GNI allocated to Health[17]	6.6%	Percentage of Government expenditure on Health [18]	1.94%

* Surviving infants = Infants surviving the first 12 months of life

[12] Since the application identifies activities that are to be undertaken at a sub-national level, sub-national data is provided in Annex XX.
[13] INE, 2006.
[14] INE, estimated data (p) 2003.
[15] INE-MSD, 2003.
[16] ENDSA data 2003.
[17] Ministry of Finance, National Accounts Studies (p) 2005
[18] INE-UDAPE. National Accounts Studies (p) 2005. (Total expenditure was 7%, includes public expenditure: 1.94%, social security expenditure 2.17% and private expenditure: 2.45%)

2.2: Overview of the National Health Sector Strategic Plan

Sector Development Plan

The Ministry of Health and Sport, under the direction of the Ministry of Planning and Development elaborated a Sector Development Plan. The Plan was validated trough participatory assemblies with representatives of civil society, foreign aid agencies and professional associations within the Sector. This Plan is to be implemented during the presidential term 2006-2010. It proposes as a national objective: the elimination of social exclusion, to be attained through the implementation of a community based Unified Health System with an intercultural approach.

It defines as a strategic goal that 100% of the Bolivian population (under 21 years of age) will have access to the Unified Community and Intercultural Health System, by 2010. It also aims to eliminate under-nutrition in children under the age of five and to allow Bolivians to achieve the longest healthy life possible, with a reduction in the incidence of disease. These changes will allow for the achievement of the health related Millennium Development Goals by 2015.

Main Policies:
1. The Unified, Family, Community and Intercultural Health System. The strategy of this policy is universal access to an integrated health system.
2. Health Stewardship. To recuperate sovereignty and leadership of the system: leading trans-sector action for health, strengthening management capacities, Universal Assurance, management of technology and research.
3. Social mobilization. Promotes active, participative and co-responsible citizenship in health, as well as self-care of individuals at the community level (getting them involved in management, mobilization and social control); by empowering and mobilizing health councils at the national, departmental and municipal levels.
4. Focus on Health Determinants. A mayor responsibility from the State is required to develop a comprehensive health culture; in order to achieve a greater quality of life for individuals and families.
5. Solidarity. This policy develops a national alliance between all social and sector stakeholders for the eradication of under-nutrition and violence to children, women and the elders, by eliminating the exclusion suffered by the vulnerable underprivileged groups which live in extreme poverty.[19]

Medium Term MSD Plan (2006-2010)

The Ministry of Health and Sports Medium Term Plan 2006-2010 defines the programs to be implemented and interventions projected in the context on the Sector Development Plan. There are three main programs:
1. Expansion of health coverage, from fixed units and mobile health units, services will reach the most scattered and unprotected populations of the entire country.
2. Strengthening of Healthcare Networks: Infrastructure, equipment, inputs, drugs, and country-wide managerial training.
3. Quality management, intercultural and community approach for health care, taking into account gender and generational issues, in order to generate a better response from the System to the community. Respect for indigenous population rights, promoting the recovery of traditional practices and knowledge of the native people.

[19] National Health Sector Development Plan 2006-2010.

Section 3: Situation Analysis / Needs Assessment

3.1: Recent health system assessments[20]

Title of the assessment	Participating agencies	Areas / themes covered	Dates
ENDSA	INE	National epidemiological trends and health status of the population.	2003.
Bolivia Health Situation Analysis, 2004.	MSD SNIS Ministry of National Planning and Development	Demographic characteristics of the Country, health risks´ assessment, morbidity and mortality data.	2004
Health Sector Development Plan	MSD Ministry of National Planning and Devolopment	Health Sector Analysis (introductory part) and sector development policies.	2006
Medium Term Plan	MSD	Programs and projects to be implemented between 2006 and 2010 based on the politic direction of the Sector Development Plan	2007
Assessment of the availability, access and use of obstetric emergency care services in Bolivia.	MSD UNFPA PAHO/WHO	Evaluation of prenatal care, delivery care and postnatal care services. Analysis of maternal mortality causes, sexual and reproductive health and capacity of public health services to provide obstetric emergency care.	2006
EPI multiyear Plan (5 years)	EPI, MSD PAHO/WHO UNICEF	Evaluation of the EPI, immunization coverage rates, SWOT analysis of the Immunization Program. Definition of goals, strategies, activities and budget for 2007-2011.	2006

3.2: Major barriers to improving immunisation coverage identified in recent assessments

In addition to the information from health national evaluations such as the Sector Development Plan, Medium Term Plan, ENDSA and Health Situation Analysis, results have been included from evaluations carried out in participatory workshops organized for the definition of objectives at the national, departmental (Potosi and Chuquisaca) and municipal levels, as well as those resulting from the EPI evaluation.

The principal obstacles were synthesized in two main problems; that impede an improvement in the quality of maternal and child care services and to sustain or increment vaccination coverage, these problems are:

1. Insufficient access, poor quality of comprehensive maternal and child health care, and weak capacity of management, in the Health Services.

2. People, families and communities have unsuitable practices and/or lack of knowledge for the identification of their health needs.

These problems are described in detail ahead.

[20] Within the last 3 years.

1. Insufficient access, poor quality of comprehensive maternal and child health care, and weak capacity of management, in the Health Services.

Issues related to the supply and management of health services.

a. Scattered population, communities without access to services, networks/establishments, and/or absence of services.
b. Poor technical quality of services, due to partially implemented standards of care by: lack of training and competencies for clinical care, consonant with the standards; lack of supervision, and M&E of the implementation of the standards.
c. Health workers with limited competencies for actions related to health promotion and prevention. Limited managerial abilities to administer comprehensive maternal and child care services, with an intercultural and gender sensitive approach.
d. Insufficient support services, equipment, diagnostic tools and treatment supplies: i.e. blood banks and laboratories.
e. Deficient logistics: inadequate supply and distribution of drugs and other inputs.
f. Lack of means of transportation for attention at remote communities, and patient referral in emergency situations from the first level of care to other levels of superior complexity.
g. Inadequate management of the information system, supervision, monitoring and evaluation.

2. People, families and communities have unsuitable practices and/or lack of knowledge for the identification of their health needs.

Issues related to the demand of health services.

a. Insufficient and/or inadequate access to health information, in order to modify traditional and unsuitable practices of care for children and pregnant women.
b. Absence of mechanisms for dissemination of information and communication to raise people's awareness of the existence of certain State guarantees provided trough the Maternal and Child Universal Insurance (SUMI), and the availability of health services.
c. Unsatisfactory characterization of health needs in the municipal diagnoses; and limited assessment of the health situation of mothers and children under 5 during the community participatory planning process.

3.3: Barriers that are being adequately addressed with existing resources

Some of the obstacles are being addressed with national or departmental activities that are carried out in accordance with the Sector Development Plan of the MSD, which integrates international cooperation projects and articulate actions with other sectors, as well as the decentralized entities. However, in many cases current efforts are still partial and incomplete. In this context the support from GAVI–HSS will be additional and complementary to other efforts the country is undertaking in association with international health cooperation.

1. Insufficient access, poor quality of comprehensive maternal and child health care, and weak capacity of management, in the Health Services.

a. **Scattered population, communities without access to services, networks/establishments, and/or absence of services.** The 5-year health Plans at the municipal level include the construction and/or equipment of local health facilities, different sources and budget lines have been established for funding these plans (APL3–World Bank, JICA, French Cooperation, among others). In addition, with the support from the Cuban Cooperation, 20 second level hospitals at rural areas have been reconditioned and equipped to attend population. These efforts are still insufficient in order to reach all the farthest and most dispersed municipalities in the country. However the support of GAVI-HSS will not intervene in the construction of infrastructure, due to the small amount of resources.

b. **Poor technical quality of services, due to partially implemented standards of care by: lack of training and competencies for clinical care, consonant with the standards; lack of supervision, and M&E of the implementation of the standards.** With a World Bank loan through the APL 3 Project, the implementation of the new model of Community, Family and Intercultural Health Care (SAFCI) will be supported in 82 identified municipalities, out of the 167 prioritized municipalities due to extreme poverty.
c. **Health workers with limited competencies for actions related to health promotion and prevention. Limited managerial abilities to administer comprehensive maternal and child care services, with an intercultural and gender sensitive approach.** JICA, UNFPA, UNICEF, PAHO and the Italian Cooperation support actions on this matter.
d. **Insufficient support services, equipment, diagnostic tools and treatment supplies: i.e. blood banks and laboratories.** With funds from the French Cooperation, 8 blood banks were constructed at departmental level, and support was given for the strengthening of blood transfusion services at selected second level hospitals.
e. **Deficient logistics: inadequate supply and distribution of drugs and other inputs.** The Maternal and Child Universal Insurance (SUMI) provides drugs for 600 stipulated benefits through the FIMs, nevertheless this contribution is still insufficient in order to meet all the needs of the health services.
f. **Lack of means of transportation for attention at remote communities, and patient referral in emergency situations from the first level of care to other levels of superior complexity.** Starting on the present administration, the MSD in association with the Spanish cooperation is making efforts to provide with two units of transportation to each municipality, in order to serve the demand (in a one year period).
g. **Inadequate management of the information system, supervision, monitoring and evaluation.** Funding from the French and Spanish Cooperation support actions to improve the quality of information on the National Health Information System (SNIS) at the national level. However it is required the support to strengthen the information system at the municipal level.

3.4: Barriers not being adequately addressed that require additional support from GAVI HSS

Some of the issues related to the supply and management of health services are not being adequately addressed and will require the additional support from GAVI HSS, these are the following:

- **Poor technical quality of services, due to partially implemented standards of care by: lack of training and competencies for clinical care, consonant with the standards; lack of supervision, and M&E of the implementation of the standards.**
- **Health workers with limited competencies for actions related to health promotion and prevention. Limited managerial abilities to administer comprehensive maternal and child care services, with an intercultural and gender sensitive approach.**
- **Insufficient support services, equipment, diagnostic tools and treatment supplies: i.e. blood banks and laboratories.**
- **Deficient logistics: inadequate supply and distribution of drugs and other inputs.**
- **Inadequate management of the information system, supervision, monitoring and evaluation.** Complementing the efforts of the APL3, a project that will design and set up an adequate system of monitoring and evaluation. The GAVI HSS support will help implement the same system in 35 selected municipalities.

All the identified issues related to the demand of health services will require support from GAVI HSS:

- **Insufficient and/or inadequate access to health information, in order to modify traditional and unsuitable practices of care for children and pregnant women.** Nongovernmental organizations are carrying out isolated actions for population behavioural change in some municipalities of high vulnerability.

- **Absence of mechanisms for dissemination of information and communication to raise people's awareness of the existence of certain State guarantees provided trough the Maternal and Child Universal Insurance (SUMI), and the availability of health services.** The Ministry of Health and Sports has developed information campaigns on the Maternal and Child Universal Insurance, but targeting only department's and municipalities' capital cities. Disperse population at communities or rural areas located far from main cities do not have access to that information.
- **Unsatisfactory characterization of health needs in the municipal diagnoses; and limited assessment of the health situation of mothers and children under 5 during the community participatory planning process.** Despite the existence of mechanisms for participatory planning, the population does not prioritize and assesses problems related to their health.

Section 4: Goals and Objectives of GAVI HSS Support

4.1: Goals of GAVI HSS support

The strategic goal of GAVI HSS support is:
To extend the coverage and improve the quality of maternal and child comprehensive care in health services, at 35 prioritized municipalities of the country by 2010[21].

4.2: Objectives of GAVI HSS Support

Strategic objective 1: Reorganize health care networks and improve the quality of care, as well as the capacity for management in health at 35 prioritized municipalities, by 2010.
Lines of intervention:
1.1 Development and implementation of standards, methodologies, and tools for the strengthening of the managerial capacity of health teams, such as: planning and programming based on population data and health services coverage; needs assessments (human resources, teams' training, equipment, supplies, infrastructure and others); supervision, monitoring, and evaluation (M&E) of norms compliance; referral and counter-referral systems; information system and reporting (Monitoring, evaluation and reporting)
1.2 Training of personnel on current norms and regulations for adequate care of mother and child populations and actualization on management of health services.
1.3 Consensus-building and coordination between different levels of management and the international cooperation to generate synergies in the strengthening of healthcare networks.

Strategic objective 2: Strengthen promotion and prevention interventions in maternal and child health, with a community and intercultural approach; empowering communities in their responsibility for health care at 35 prioritized municipalities by 2010.
Lines of intervention:
2.1 Qualitative research on communities' knowledge, attitudes and practices in the prioritized municipalities, regarding children under five years of age and pregnant women/mother's care, as well as design and implement activities aimed to behavioural change.
2.2 Identification of needs and ways to address problems related to maternal, neonatal and child health; at the participatory planning and diagnostic processes held at the community level, and the existing entities of social control (Surveillance Committees and DILOS).
2.3 Health workers' induction on the intercultural approach and compassionate care for communities.

[21] Municipalities were selected using priority criteria that included: poverty index, infant mortality rate, food insecurity, and fertility rate.

Section 5: GAVI HSS Activities and Implementation Schedule

5.1: Sustainability of GAVI HSS support

1) This proposal is aligned with the Sector Development Plan and the Medium Term Plan of the Ministry of Health and Sports. Both of them to be implemented during the period of the current presidential mandate (2006–2010), with financing coming from the National General Treasure (TGN) and the support of the international cooperation.
2) There is a financial commitment from the Ministry of Finance to assign 10% of the total costs of the proposal as national counterpart for the operation of activities. (see Annex 19)
3) In the draft for a new Constitution, consensus has been reached to praise health as a fundamental human right. In consequence the responsibility for the State to guarantee investments for health is been acknowledged.
4) The expanded SUMI guaranties funds for maternal and child healthcare (children under 5), as well as for women of childbearing age, providing free services that are financed by the sharing of revenues coming form hydrocarbon taxation.
5) The period for the implementation of the proposal (2008-2010) coincides with the period of Government (2006-2010).
6) The Medium-term Plan of the MSD establishes the compulsory nature of assignments to be covered by the Sector General Budget, for activities of the different centralized and decentralized units within the health sector.
7) The Administrative Decentralization Law establishes the obligation for the municipalities to designate funds from their budgets to cover health units' expenditures in their territory. In addition, Prefectures at the departmental level have also the obligation to allocate resources for the good operation of the Departmental Health Services, aligning their expenditures with the national sector policies. For the fulfilment of these obligations, the National Government, through a National Law, has established specific budget allocations for health, both for the Prefectures and for the municipalities. Resources come from the direct tax to hydrocarbons revenues. [22]
8) Some activities of the GAVI HSS support will be guided to better defined health needs, disseminate findings and to promote investments in health at the departmental and municipal level.

[22] IDH

5.2: Major Activities and Implementation Schedule

Major Activities	Year 1 (2008)				Year 2 (2009)				Year 3 (2010)			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Objective 1: Reorganize health care networks and improve the quality of care, as well as the capacity for management in health at 35 prioritized municipalities, by 2010.												
Activity 1.1: Hold a participatory workshop for implementation arrangements, including the preparation of Annual Operative Plans; and generate consensus-building and coordination opportunities in order to generate synergies between different levels of management and international cooperation agencies with the objective of strengthening service networks.												
Activity 1.2: Purchase and distribution of basic equipment for comprehensive care at first level healthcare facilities in prioritized municipalities.												
Activity 1.3: Support specific surveys to gather population data and maternal and child care services coverage rates.												
Activity 1.4: Assist in the preparation of needs assessments for the operation of the municipal networks of primary care (including, gaps in care coverage, infrastructure, logistics, transportation, communication and others).												
Activity 1.5: Training on the application of maternal and child comprehensive care standards for health workers at all health establishments located in areas of intervention.												
Activity 1.6: Arrange training workshops on health networks management tools, methodologies and standards instruments in order to improve management of health services.												
Activity 1.7: Strengthen the information, monitoring and evaluation system (M&E), supporting decisions affecting maternal and child healthcare services at health units and network administrations (SIP, SVEMMN and others) in the 35 prioritized municipalities.												

Major Activities	Year 1 (2008)				Year 2 (2009)				Year 3 (2010)			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Activity 1.8: Supervise, monitor, and evaluate the fulfilment of multi-programmatic activities related to maternal and child comprehensive health care in the areas of intervention.				■	■	■	■	■	■	■	■	■
Objective 2: Strengthen promotion and prevention interventions in maternal and child health, with a community and intercultural approach; empowering communities in their responsibility for health care at 35 prioritized municipalities by 2010.												
Activity 2.1: Create a census of community health volunteers (Popular Health Trustees, health promoters, community agents, midwives and others) in the 35 prioritized municipalities.			■									
Activity 2.2: Standardize the knowledge of all community health volunteers based on current standards of care and protocols for maternal and child health services.				■	■	■			■	■		
Activity 2.3: Assist the realization of KAP surveys (knowledge, attitudes, and practices) at sample communities of the 35 municipalities.			■				■				■	
Activity 2.4: Prepare and disseminate primers, guides, manuals, and other information, education and communication materials (IEC) regarding issues identified trough the analysis of surveys findings to promote changes in population's behaviour, attitudes, and practices to improve maternal and child care in the context of he SAFCI.				■	■	■	■	■	■	■	■	■
Activity 2.5: Assist the realization of workshops on participatory planning at municipal level for the identification of health needs and problems and to propose solutions to be incorporated in the municipal Plans of Action (POA).				■				■				■
Activity 2.6: Implement training programs for community agents, health advocates, surveillance committees for intercultural health of health facilities, for a more effective participation at the Local Health Directorates (DILOS), Municipal CAI in compliance with the Popular Participation Law (LPP).				■		■	■			■	■	

Section 6: Monitoring, Evaluation and Operational Research

6.1: Impact and Outcome Indicators

Indicator	Data Source	Baseline Value[23]	Source[24]	Date of Baseline	Target	Date for Target
1. National DTP3 coverage (%)	SNIS –EPI	83%	SNIS – EPI	2006	89%	2010
2. Number / % of districts achieving ≥80% DTP3 coverage	Municipalities SNIS-EPI	195	SNIS – EPI	2005	220	2010
3. Under five mortality rate (per 1000)	ENDSA - INE	54	ENDSA - INE	2003	40	2010
4. Infant Mortality rate	ENDSA - INE	75	ENDSA - INE	2003	57	2010
5. Maternal mortality rate (per 100,000 live births)	ENDSA - INE	229	ENDSA - INE	2003	170	2010
6. Institutional perinatal mortality rate (per 1,000 pregnancies of 7 or more months)	ENDSA - INE	31	ENDSA - INE	2003	25	2010

[23] ENDSA-INE surveys are planned for 2008 and 2012. For that reason final evaluation of some of these indicators in 2010 will be based on trends and estimations.
[24] Important for easy accessing and cross referencing

6.2: Output Indicators

Indicator	Numerator	Denominator	Data Source	Baseline Value[23]	Source	Date of Baseline	Target	Date for Target
1. Coverage of the fourth prenatal check-up	Number of pregnant women with four prenatal check-ups	Number of pregnant women	Municipal-Networks Reports ENDSA-INE	58%	Monitoring forms and Survey.	2003	70%	2010
2. Reduction of the incidence of early pregnancy (percentage of pregnancies in women from 15 to 19 years)	Number of pregnancies among women from 15 to 19 years.	Number of pregnancies in all age groups	ENDSA-INE	13%	ENDSA-INE	2003	10%	2010
3. Coverage of Institutional Delivery Care	Deliveries attended by skilled personnel at health facilities	Total of expected deliveries	ENDSA-INE	61%	ENDSA–INE	2003	70%	2010
4. Drop out rate of pentavalent vaccine.	Number of children who receive 3rd Dose of pentavalent vaccine	Number of children who received the first dose of pentavalent vaccine	SNIS-EPI	5%	SNIS-EPI	2006	1%	2010
5. Number of health workers trained, applying new standards of comprehensive care for maternal and child populations, including the intercultural approach for healthcare.	Number of staff trained applying the new standards	Total number of existing health workers at 35 selected municipalities	Health Facilities Registries and reports from the municipal level.	N/A	Health Facilities Registries and reports from the municipal level.	2008	85%	2010
6. Percentage of municipalities that carry out community CAI	Number of municipalities that carry out community CAI	Total number of selected municipalities	Health facilities Reports	N/A	Reports	2008	90%	2010

Indicator	Numerator	Denominator	Data Source	Baseline Value[23]	Source	Date of Baseline	Target	Date for Target
7. Number of health Volunteers trained in maternal and child comprehensive health care participating in health promotion and disease prevention with intercultural approach at the community level.	Number of Community Health Volunteers that were trained and are actively participating in maternal and child health promotion and disease	Total number of community health Volunteers trained in selected municipalities.	Municipal-Networks Reports	N/A	Monitoring forms	Semiannual	60%	2010
8. Number of Families that have assumed healthy maternal and child practices	Percentage of families that have assumed healthy practices	Total number of target families at selected municipalities	Operational Research Reports	N/A	KAP Surveys.	Semiannual	80%	2010

6.3: Data collection, analysis and use

Indicator	Data collection	Data analysis	Use of data
Impact and outcome			
1. National DTP3 coverage (%)	Health Networks - EPI ENDSA - Surveys conducted every four years (programmed for 2008 and 2012)	- Quarterly analysis of achievement of goals - Sectoral and intersectoral analysis at the COCOTEC - Trends analysis using charts (participatory surveillance tools mural)	- Monthly meetings with community and health personnel at the municipal CAI. - Monthly reports to local governments and civil society, through participatory meetings - EPI annual Report
2. Number / % of districts achieving ≥80% DTP3 coverage	Coverage report by health services at municipal level	- Consolidation of reports by Health Networks municipal administration. - Analysis of municipalities at risk at departmental level - EPI CCI sector Analysis	- Health Roundtables and monthly meetings with community and health networks personnel and municipal staff. - Quarterly reports to local governments and civil society through participatory meetings
3. Under five mortality rate (per 1000)	ENDSA – Survey conducted every four years	- Sector analysis by Directors and National Unit Chiefs at COCOTEC, - Social Ministerial Council and UDAPE	- Sectoral and intersectoral al analysis (UDAPE) - Inter-institutional Committee for the Millennium Development Goals
4. Infant Mortality rate	ENDSA – Survey conducted every four years.	- Sector analysis by Directors and National Unit Chiefs at COCOTEC, - Social Ministerial Council and UDAPE	- Sectoral and intersectoral al analysis (UDAPE) - Inter-institutional Committee for the Millennium Development Goals
5. Maternal mortality rate (per 100,000 live births)	Survey every four years.	- Sector analysis by Directors and National Unit Chiefs at COCOTEC, - Social Ministerial Council and UDAPE	- Sectoral and intersectoral al analysis (UDAPE) - Inter-institutional Committee for the Millennium Development Goals
6. Institutional perinatal mortality rate (per 1,000 pregnancies of 7 or more months)	Survey every four years.	- Sector analysis by Directors and National Unit Chiefs at COCOTEC, - Social Ministerial Council and UDAPE	- Sectoral and intersectoral al analysis (UDAPE) - Inter-institutional Committee for the Millennium Development Goals
Output			
1. Coverage of the fourth prenatal check-up	Records at Municipal Health Networks Quarterly monitoring reports ENDSA	- Analysis in the health roundtables at Municipal and Departmental level - Analysis with DILOS at the municipal CAI	- Health Roundtables and monthly meetings with community and health networks personnel and municipal staff. - Quarterly reports to

Indicator	Data collection	Data analysis	Use of data
			local governments and civil society through participatory information meetings
2. Reduction of the incidence of early pregnancy (percentage of pregnancies in women from 15 to 19 years)	Records at Municipal Health Networks Quarterly monitoring reports ENDSA	- Analysis in the health roundtables at Municipal and Departmental level - Analysis with DILOS at the municipal CAI	- Health Roundtables and monthly meetings with community and health networks personnel and municipal staff. - Quarterly reports to local governments and civil society through participatory information meetings
3. Coverage of Institutional Delivery Care	Records at Municipal Health Networks Quarterly monitoring reports ENDSA	- Analysis in the health roundtables at Municipal and Departmental level - Analysis with DILOS at the municipal CAI	- Health Roundtables and monthly meetings with community and health networks personnel and municipal staff. - Quarterly reports to local governments and civil society through participatory information meetings
4. Drop out rate of pentavalent vaccine.	Records at Municipal Health Networks Quarterly monitoring reports ENDSA	- Analysis in the health roundtables at Municipal and Departmental level - Analysis with DILOS at the municipal CAI	- Health Roundtables and monthly meetings with community and health networks personnel and municipal staff. - Quarterly reports to local governments and civil society through participatory information meetings
5. Number of health workers trained, applying new standards of comprehensive care for maternal and child populations, including the intercultural approach for healthcare.	Records at Municipal Health Networks Quarterly monitoring reports KAP Surveys	- Analysis in the health roundtables at Municipal and Departmental level - Analysis with DILOS at the municipal CAI	- Health Roundtables and monthly meetings with community and health networks personnel and municipal staff. - Quarterly reports to local governments and civil society through participatory information meetings
6. Percentage of municipalities that carry out community CAI	Records at Municipal Health Networks	- Analysis in the health roundtables at Municipal and Departmental level - Analysis with DILOS at the municipal CAI	- Health Roundtables and monthly meetings with community and health networks personnel and

Indicator	Data collection	Data analysis	Use of data
			municipal staff. - Quarterly reports to local governments and civil society through participatory information meetings

In each participating municipality, the results and progress of the proposal will be monitored and evaluated in a participative manner. The purpose of this strategy is to empower the local monitoring and the municipal capacity in decision-making, measuring at the municipal level maternal and child health indicators and the performance of local authorities in health.

6.5: Operational Research

In the context of GAVI HSS support, operational research is going to be carried out within three areas: 1. Municipal population census and coverage of services; 2. Mapping of health volunteers at community level and 3. KAP Surveys at the municipal level, conducted by the SNIS teams on behalf of the Planning Unit with support from Health Networks staff in 35 selected municipalities (sample communities).

Section 7: Implementation Arrangements

7.1: Management of GAVI HSS support

Management mechanism	Description
Name of lead individual / unit responsible for managing GAVI HSS implementation / M&E etc.	Implementation will be in charge of the Health Services and Quality Unit of the MSD. The SNIS team will be responsible for monitoring the Planning Unit will be accountable for general oversight and evaluation.
Role of HSCC (or equivalent) in implementation of GAVI HSS and M&E	COCOTEC will analyse progress, based on results from evaluations, auditing the achievement of goals and targets set for the GAVI HSS support.
Mechanism for coordinating GAVI HSS with other system activities and programs	The Planning Unit is responsible for coordinating all initiatives that receive external cooperation and in general, also conducts the formulation of strategic and operational plans within the MSD. In consequence, one of the main roles of the Planning Unit during implementation will be to safeguard the complementarities, synergy, and coordination of GAVI HSS supported actions with other activities and programs. In addition it will be in charge of reporting to the Interagency Coordinating Committee on the advances in the execution of the proposal.

7.2: Roles and responsibilities of key partners (HSCC members and others)

Title / Post	Organisation	HSCC member yes/no	Roles and responsibilities of this partner in the GAVI HSS implementation
Dr. Walter Selum Rivera. Minister of Health and Sports	MSD	Yes	Responsible for prioritizing and approving health sector's programs and projects at the national level and general political conduction of the Ministry of Health. He approved the GAVI HSS proposal.
Lic. Luis Alberto Arce Catacora. Minister of Finance.	Ministry of Finance	No	Responsible for the articulation of the Nation's General Budget. He assigned 10% of counterpart funding for proposal implementation.

Title / Post	Organisation	HSCC member yes/no	Roles and responsibilities of this partner in the GAVI HSS implementation
Vice minister of Public Investment and Planning for Development.	Ministry of Planning and Development	No	Responsible for incorporating GAVI HSS support in the portfolio of national programs and public investment projects.
Dr. Juan Alberto Nogales. Vice minister of Health.	MSD	Yes	Responsible for prioritizing and approving programs and projects in the absence of the Minister of health.
Dr. German Crespo. Senior Advisor, Sector Planning, Programs and Projects	MSD	Yes	Responsible for the monitoring of programs and projects in the Ministry of Health and Sports. For GAVI HSS support he will be in charge of the oversight of implementation, budget approval and in particular of the monitoring and evaluation.
Lic. Gaby Ayoroa, General Director-Administration	MSD	Yes	Responsible for accounting and financial monitoring of the portfolio of investments of the Ministry of Health and Sports. She will be accountable for the financial administration of GAVI-HSS funds, and responsible for supervising the budgetary execution of the project.
Dra. Ruth Calderon. Unit Chief, Health Services and Quality Unit	MSD	Yes	She directs the general operation of public health services at the national level. For GAVI HSS Support she will be directly in charge of implementation of activities trough several Health Services Networks.
Dr. Jorge Jemio, National General Director, Health Promotion Unit	MSD	Yes	Responsible for monitoring and supervising Health Promotion projects and interventions. The Health Services and Quality Unit will coordinate with this unit for activities related with participation and social organization at community level.
Dra. Magali Fuentes, EPI manager	MSD	Yes	She will provide technical support during implementation, monitoring and evaluation on matters related with immunization coverage.
Dr. Carlos Ayala, Health Systems and Services Advisor	PAHO/WHO	No	Technical and financial Assistance in the implementation of the project.

7.3: Financial management of GAVI HSS support

Mechanism / procedure	Description
Mechanism for channelling GAVI HSS funds into the country	Transfer of funds from the GAVI Fund to the National Central Bank of Bolivia into an account named Ministry of Health and Sports-GAVI HSS support. Funds will be then incorporated to the MSD budget and transferred in accordance with annual budget programming to an independent account at a commercial bank on the name of the MSD.

Mechanism for channelling GAVI HSS funds from central level to the periphery	In accordance with the Action Plan for proposal implementation, the central level of the MSD will carry out the necessary procurements annually, and will distribute to the municipal networks, all required materials. Cash transfers to the municipal levels might be also required for the execution of some activities.
Mechanism (and responsibility) for budget use and approval	The Annual Plan of Action and Budget will be agreed upon at the beginning of the implementation during a Launch Workshop.

a) Selection based on quality and cost;
b) Selection based on lower cost;
c) Selection based in fixed budget and;
d) Selection based on quality

7.5: Reporting arrangements

Quarterly reports will be requested from the operational units, in order to confirm the accomplishment of planned activities and to approve the following transfers according to the Action Plan. The Health Services and Quality Unit of MSD will prepare semi-annual reports to the Planning Unit, which will be presented to the COCOTEC. These reports will include only output indicators and progression in the achievement of goals for process (intermediate) indicators.

Annually a Progress Report will be prepared to the GAVI Alliance, and submitted no later than May 15th of every year of implementation. Previously, the report prepared by the Planning Unit will be approved by the COCOTEC and presented to the Interagency Committee.

7.6: Technical assistance requirements

Activities requiring technical assistance	Anticipated duration	Anticipated timing (year, quarter)	Anticipated source (local, partner etc.)
1. National consultant for physical monitoring of activity implementation, technical support to operative units in charge of execution and preparation of reports.	3 years	2008-2010	Local
2. Financial administration and accounting.	3 years	2008-2010	Local
3. Design and implementation of healthcare and health services networks management standards.	3 years	Last quarter 2008.	Partner (PAHO/WHO and others)

Section 8: Costs and Funding for GAVI HSS

8.1: Cost of implementing GAVI HSS activities

Area for support	*Cost per year in US$*				
	Year of GAVI application	Year 1 of implementation	Year 2 of implementation	Year 3 of implementation	**TOTAL COSTS**
	2008	2008	2009	2010	
Activity costs					
Objective 1					
Activity 1.1		6.686	6.686	6.686	20.057
Activity 1.2		522.800	242.000	155.000	919.800
Activity 1.3		3.696		3.696	7.392
Activity 1.4		3.696			3.696
Activity 1.5		13.097	52.388	52.388	117.873
Activity 1.6		13.097	39.291	39.291	91.679
Activity 1.7		5.000	8.000	10.000	23.000
Activity 1.8		3.760	12.533	12.533	28.826
Subtotal		**571.831**	**360.895**	**279.596**	**1.212.322**
Objective 2					
Activity 2.1		2.053		2.053	4,107
Activity 2.2		9.155	36.620	36.620	82,395
Activity 2.3		4.479	8.958	8.958	22.395
Activity 2.4		77.653	232.959	310.612	621.224
Activity 2.5		11.473	11.473	11.473	34.418
Activity 2.6		3.646	14.584	14.584	32.814
Subtotal		**108.459**	**304.594**	**384.300**	**2.009.675**
Support costs					
Management costs[26]					
M&E support costs[27]		13,520	27,040	27,040	67,600
Technical support		3,403	5,394	7,159	15,956
TOTAL COSTS		**697.213**	**697.925**	**698.093**	**2.093.231**

[26] Costs provided by MSD.
[27] Accountant and consultant services for physical and financial monitoring of GAVI HSS support.

8.2: Calculation of GAVI HSS country allocation

GAVI HSS Allocation	Allocation per year (US$)				
	Year of GAVI application	Year 1 of implementation	Year 2 of implementation	Year 3 of implementation	TOTAL FUNDS
	2008	2008	2009	2010	
Birth cohort		278.885	279.170	279,237	
Allocation per newborn		$2.5	$2.5	$2.5	
Annual allocation		**697.213**	**697.925**	**698.093**	**2.093.231**

Source and date of GNI and birth cohort information:

GNI: INE, 2004.

Birth cohort: INE-MSD, 2004.

Total Other: Bilateral agreements documents by financial source.

8.3: Sources of all expected funding for health systems strengthening activities

Funding Sources	Allocation per year (US$)			
	Year 1 of implementation	Year 2 of implementation	Year 3 of implementation	TOTAL FUNDS
	2008	2009	2010	
GAVI	**697.213**	**697.925**	**698.093**	**2.093.231**
Government (10% counterpart funding for GAVI HSS support)	69.721	69.793	69.809	**209.323**
Donor 1. APL 3 WB (p)[28]	3.750.000	3.750.000	3.750.000	**11.250.000**
Donor 2. PASS[29] **CIDA/UNICEF**	340.000	340.000	340.000	**1.020.000**
Donor 3. CIDA/UNICEF Infrastructure[30]	900.000	900.000	900.000	**2.700.000**
Donor 4. France	462.875	462.875	462.875	**1.388.624**
TOTAL FUNDING	**6.219.809**	**6.220.593**	**6.220.777**	**18.661.179**

Source of information on funding sources:
GAVI: Estimates based on guidelines.
Government: Ministry of Finance
Donor 1, 2, 3 and 4: MSD, Planning Unit.

[28] Preliminary. Countrywide project implementation starts in 2008.
[29] The Health System Support Program has several components. One of these components is oriented to strengthen institutional management at the Planning Unit and departmental SEDEs of Oruro, Beni and Pando.
[30] Other PASS component consists in infrastructure development (reparations, remodeling and additions in first level health units at the departments of Oruro, Beni and Pando).

Section 9: Endorsement of the Application

9.1: Government endorsement (Please see the Spanish formatl including signatures)

The Government of ***Bolivia*** commits itself to providing immunisation and other child and maternal health services on a sustainable basis. Performance on strengthening health systems will be reviewed annually through a transparent monitoring system. The Government requests that the GAVI Alliance funding partners contribute financial assistance to support the strengthening of health systems as outlined in this application.

Ministry of Health:	***Ministry of Finance:***
Name: *Dr. Walter Selum Rivero*	Name: *Lic. Luis Alberto Arce Catacora*
Title / Post: *Minister of Health and Sports*	Title / Post: *Minister of Finance*
Signature:	Signature:
Date:	Date:

9.2: Endorsement by Health Sector Coordination Committee (HSCC) or country equivalent

Members of the COCOTEC (Health Sector Coordination Committee) endorsed this application at a meeting on *March 3, 2008*. A first application was endorsed on *September 27, 2008*. The signed minutes are attached as Annex 23.

Chair of HSCC (or equivalent):

Name: Dr. German Crespo	Post / Organisation: Senior Advisor, Sector Planning, Programs and Projects. Ministry of Health and Sports.
Signature:	Date:

9.3: Person to contact in case of enquiries:

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ANNEX 1 Documents Submitted in Support of the GAVI HSS Application

Document (with equivalent name used in-country)	Available (Yes/No)	Duration	Attachment Number
Background and support documents checklist	Yes		1
Banking form	Yes		2
National Health Sector Strategic Plan (Health Sector Development Plan and Medium Term Strategic Plan for the MSD)	Yes	5 years	3 and 4
cMYP (EPI Multiyear Plan)	Yes	5 years	4
Multiyear Plan EPI	Yes	5 years	5
EPI Evaluation 2006.	No		6
Documents on the strategy for the struggle against poverty	Yes		7
Impact assessment of the maternity and childhood insurance in Bolivia 1989-2003. UNICEF-UDAPE (section 3) – Spanish version available	No	15 years	8
Bolivia Country Profile. PAHO/WHO	Yes		9
Healthcare Model (SAFCI) preliminary	Yes		10
SUSALUD Universal Health Insurance documentation	Yes		11
Sections from the National Demographic and Health Survey (ENDSA)	Yes	4 years	12
Evaluation of the availability, access and use of obstetric emergency care services (COEm) - Spanish version available	No	4 years	13
Supreme Decree 28748 SUSALUD	Yes		14
Proceedings from the first national workshop for proposal preparation	Yes		15
Report and results of the National Objectives Workshop	Yes		16
Minutes from COCOTEC (HSCC), CCI and CEP signed.	Yes		17
Minutes from presentation to Ministers	Yes		18
Letter from the Minister of Finance	Yes		19
List of selected municipalities	Yes		20
CEP and CONASA minutes	Yes		21
Proceedings from the meeting with the Ad hoc Committee for Sectoral Development of the National Health Council (endorsement)	Yes		22
COCOTEC endorsement	Yes		23
Participation lists of several participatory workshops.	Yes		24
HSCC minutes, signed by Chair of HSCC and other relevant documentation from the proposal development process.	Yes		25