Equitable access to quality health for the most vulnerable: vision or reality?

An ex-post impact study of the country programme in Bolivia

Swiss Red Cross

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Content

1. Background

The general purpose of the access review study is to provide an insight in each project through the individual country reviews and ex-post reviews around the following aspect: how effective the project has been in achieving sustainable access for the population to health care, both in terms of access criteria from the demand side as well as the provider side. The findings will feed into lessons learnt and recommendations for other on-going or future projects in the respective countries under review.

In the case of Bolivia: From 2002-2012 the Swiss Red Cross (SRC) has supported a farmers organization in the Subcentralia Campesina Tomina, in the Chuquisaca Region of Bolivia with the aim to: a) improve their access to health services b) empower the peasant organization c) improve education and d) income-generation. A capitalization about the history of the organization, the perceived changes which occurred during this decade in the community and the value of working together has been undertaken**.** However, the aspect of access to health services and better health has not been explicitly quantified and reviewed. This review looked specifically at the aspect of access to health in the Tomina municipality.

2. Setting the Context

Bolivia has a population of 10.5 million inhabitants. In the year 2010, about 66% of total population were living in cities and 34% in rural areas[1]. Politically and administratively, Bolivia is organized into nine departments and 327 municipalities. According to the 2001 census, about 60 per cent of the population self-identified as indigenous belonging to any of the 37 recognized ethnic groups. The Aymaras and Quechuas make up the majority of the Bolivian indigenous population[2].

Bolivia is a country immersed in a process of political, social, and economic change that began in 2006 with the election of Evo Morales, the first indigenous president.[3] The levels of poverty started to drop in the 2007 and it was further reduced by more than 10 percentage points by the 2009 from 37.7% to 26.1%. With respect to extreme poverty, by the year 2012, the country was only two points short of meeting the Millennium Development Goal (MDG) target of cutting its 1990 level in half. This progress can be attributed in part to monetary transfers policies through several public benefit programs.[4]

According to the Gini coefficient scale (which goes from 0 to 1), inequality in Bolivia declined from 0.59 in 2006 to 0.51 in 2009. However, high levels of inequality persist in rural areas, where the indigenous population is predominant and remains the most vulnerable group[5].

[1] Estimaciones de población año 2010. Instituto Nacional de Estadística.

[2] Erika Silva & Ricardo Batista (2010) Bolivia maternal and child health policies: successes and failures. Focal Project, Ottawa, Canada.

[3] Health in the Americas. Country Chapter:Bolivia. Panamerican Health Organization http://www.paho.org/saludenlasamericas/index.php?option=com_content&view=article&id=24&Itemid=25&lang=pt

[4] Unidad de Análisis de Políticas Sociales y Económicas. Database [Internet]. As reported in: Health in the Americas. Country Chapter:Bolivia. Panamerican Health Organization

[5] Unidad de Análisis de Políticas Sociales y Económicas, Comité Interinstitucional Metas de Desarrollo del Milenio. Sexto informe de progreso de los Objetivos de Desarrollo del Milenio en Bolivia

In terms of health, during the period 1994-2008, child mortality decreased more than 50%- from 132 to 63 per 1,000 live births. However, when compared by place of residence, families in rural areas account for a larger proportion of child mortality.[6]

Maternal mortality in Bolivia has historically been, after Haití, the largest within the Latin American region. During the period 1989-2000, there was a significant decrease from 416 to 235 deaths per 1000 live births. This decrease was however stagnated during the period 200-2003 and the most recent DHS survey from 2008 reported an increase in maternal mortality rate to 310 per 1000 live births. Several authors argue that this increase responds to access barriers that still exist in rural areas of Bolivia[7].

The municipality of Tomina is in the second municipal section of Tomina province, within the department of Chuquisaca. Tomina municipality is made up of three districts: Tomina, Arquillos y Rodeo.

In terms of community organization, there are 26 peasant communities and 6 neighborhood associations. As per the 2012 census, there is a total of 8,435 inhabitants. This represent a decrease in population size since the 2001 census accounted for 9,060 inhabitants.[8]

3. Describing the Swiss Red Cross (SRC) project in Tomina

The project in Tomina had a pre-intervention phase (1998-1999) and the full intervention during the period 2002-2010. The principal beneficiary was the Subcentralía de Tomina, a rural peasant union. The important characteristic of the intervention was the fact that the Subcentralía designed and implemented the project themselves, receiving the financial support and technical assistance from SRC, but the decision-making rested within the Subcentralía.

During the entire period, the project was implemented around 4 pillars: a) health b) education c) productivity and d) social organization. In each of these pillars, there were activities that included training of different community groups (women, mothers, local leaders) and community providers of services (community health workers, traditional medicine), rights literacy to strengthen the community demand for health care and education services and the development of small economic activities.
In terms of strengthening the social organization, the project included specific activities aimed to the empowerment of local leadership (through knowledge and skills around legal framework, solidarity etc.,) and strengthening the management capacities of the Subcentralia. Through the Project, the board members of the Subcentralia met monthly to monitor the implementation of activities and plan for the next cycle. This space was very important to deliver training, discuss about goals and strategies and building a common identity. This same space was also replicated in the communities whenever the leaders of the micro-regions would visit the different communities[9].

[6] Erika Silva & Ricardo Batista (2010) Bolivia maternal and child health policies: successes and failures. Focal Project, Ottawa, Canada.
[7] Ibid.
[8] Bolivia: Población por provincias y municipios, Censos 2001 y 2012, tasas de crecimiento intercensal. Instituto Nacional de Estadística.
[9] Source: Programa Bolivia. *Informe Anual 2010*.

In the year 2006, the Subcentralía won the municipal government election and it have been in power since then, being re-elected already once. This event was a major boost and challenge for the organization. For the first time they would be able to have direct influence in the planning and allocation of public resources. They would also have decision-making in terms of priorities for public investment.

For the SRC, this project aimed to improve health, education and the income of Tomina families, through the strengthening and empowerment of a community-based social organization (Subcentralia). The SRC Programme Bolivia refers to this project as supportive of citizens´ rights and the assertion of rural indigenous families[10].

4. Methodology

The methodology for the study was prepared by the lead consultant (Kate Molesworth) then discussed and agreed among Kate Molesworth, Walter Flores and the officer responsible at SRC (Monika Christofori).

The methodology follows the access framework by Lavesque et al [11] to assess the aspects related to access to health care services and selected OECD/DAC evaluation criteria to assess project quality.[12]

The specific techniques applied during the review were the following:

Document review: included project documentation, reports on Bolivia health system, national statistics and others.

Key informant interviews: these were interviews to SRC staff in Bolivia who had direct involvement with the project and past national level authorities.

Individual interviews: key authorities such as Tomina Mayor, the municipal health director, health providers at facilities in Fuerte Rua and Rode El Progreso and the provincial health authority were all individually interviewed.
Group interviews: these were carried-out with a) Sub-Centralia board b) community members in Fuerte Rua and Rodeo el Progreso.
Review of M&E data: This was data specific to Chuquisaca region and Tomina municipality in specific.

[10] Ibid

[11] Levesque et al. Patient-centred access to health care: conceptualising access at the interface of health systems and populations. *International Journal for Equity in Health* 2013 12:18 doi:10.1186/1475-9276-12-18

[12] *Country Project Review Framework and Methodology.* Review and ex-post learning of Swiss Red Cross health projects 2014. Kate Molesworth. July 7 2014.

5. Findings

Findings will be presented following the different aspects of Lavesque´s et al framework and selected OECD/DAC evaluation criteria.

5.1 Provider related access:

5.1.1. Approachability

The level of engagement, sharing of information and outreach among the Subcentralia, the municipal director of health care services and municipal government authorities, were evident during the different interviews and site visit to the communities. A board member of the Subcentralia stated: "*now that we have control of the municipal government, we have channels of communication with all public officials, this level of communication and engagement did not exist before*". The municipal director of services also stated that prior to the year 2006, there was not much coordination between the medical directorate and the municipal government. The director feels that since the Sub-Centralia came into government, the coordination has been crucial to advance actions related to improving the services for the communities. During the interviews to health providers in the health centers of Fuerte Rua and Rodeo, the medical doctors and nurses commented that outreach activities were planned in advance together with municipal authorities and community organizations. The opinions gathered during the field visits to health post and communities did show a strong approachability wiht positive impact on health facilities, health care providers and users of services.

5.1.2. Acceptability

One key area that both Subcentralia and municipal health authorities reported as a priority, is the work to reduce the level of abuse and discrimination from health care providers to patients. The municipal director of health expressed:
"*there use to be a lot of abuse and discrimination towards patients because they could not understand each other. Now that we have expanded the number of health workers who speak the local language, this has made so much difference and patients do not report abuse anymore. And because patients are not afraid anymore of being the target of abuse, the number of users at hospitals, health centers and health posts have steadily increase in the past years*".

5.1.3. Availability and accommodation

Since the Subcentralia came into government, they have prioritized the expansion of health care facilities. They reported that there are 10 health post that have been re-equipped and 3 new ones are being built. Working hours of health facilities have been expanded together with an increase of personnel. In the year 2002, there were a total of 20 health care workers. In the year 2014, there were 60 health care workers.

In Rodeo El Porvenir, one of the two communities visited, there is a brand new health center. This facility already includes an option for pregnant mothers to deliver using the traditional methods, a room for the family member accompanying the mother during delivery and hospital stay, and a specific room for the traditional healer to prepare infusions and other treatments in case the delivering women request it. This new type of health facility is part of the national government polices for intercultural health.

In the community of Fuerte Rua, the health post had new equipment, a solar panel to maintain the cold chain and internet access to improve communication with referral centers.

5.1.4. Affordability

Probably the most significant change in the past few years is the increment in the allocation that decentralized municipalities receive from the central government. In the case of Tomina, in the last eight years, the municipal yearly budget increased from 47 thousand BOB to 15 million BOB- from this amount 2 million (about USD 290.000) are specifically allocated to health.

The above amount has been important to increase the share of public funding and to reduce the amount of co-payment that users must pay at health care facilities. In the year 2006, the co-payment for an emergency consultation was 600 BOB and nowadays is 270 BOB (USD 39) and a regular consultation is only 3 BOB (USD 0.43). The municipal director of health stated that *"previously when the budget was extremely low, if patients did not pay the stated co-payment, they would not receive the services they needed. Now is different, the co-payment is very low and there are no patients returning home without the treatment they need*".

5.1.5. Appropriateness

Despite all the achievements, the municipal authorities are aware about the need to expand their understanding of new health care programs and services designed at central level of the ministry of health and that must be implemented through municipal governments. For instance, a council of the municipal government stated: "*We still need technical training because there are new health programs that we are expected to implement and that we do not yet understand how they work*".

5.1.6 Discussion on supply side access

In general, respondents from the municipal government, health authorities and health care providers have positive opinions about improvements in access within Tomina. The consultant attempted to corroborate whether these positive opinions are also reflected on coverage of basic health care services statistics. The official statistics from the National Institute of Statistics does not provide disaggregated information for municipalites, only by province. Looking at the data of Chuquisaca province (in which Tomina belongs to), it is clear to observe an increase in coverage as shown by the tables below:

Table 1. Out-patient consultations in children under 5 years. Chuquisaca department. Period 2003-2012

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
New consultations	334285	337505	347072	366783	388102	379144	359404	359722	391239	412173
Follow-up consultations	32131	30953	31674	34024	34627	29210	27819	58322	71530	76830
Percentage of follow-up consultation	9,61	9,17	9,13	9,28	8,97	7,70	7,74	16,21	18,28	18,64

Source: Anuario Estadístico 2012. Instituto Nacional de Estadística

Table 1 shows that during the period 2003-2012, the new consultation of children under 5 years old increased about 23% (from 334,285 to 412,173) whereas the total number of follow-up consultations more than doubled (from 32,131 to 76,830).

Table 2. Out-patient consultations in people 5 years of age and above. Chuquisaca department. Period 2003-2012										
	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
New consultations	599801	612094	651527	767033	814056	820376	889962	884654	946850	940173
Follow-up consultations	168164	185522	183275	196411	209082	213334	226702	231692	257516	245201
Percentage of follow-up consultation	28,04	30,31	28,13	25,61	25,68	26,00	25,47	26,19	27,20	26,08

Source: Anuario Estadístico 2012. Instituto Nacional de Estadística

Table 2 shows that the increase in coverage was also very relevant for all population above 5 years of age. The new consultations increased about 56% (from 599,801 to 940,173). The percentage of follow-up consultation remained more or less the same during the period.

Table 3. Growth monitoring consultations. Chuquisaca department. Period 2008-2012						
	Under 1 year old		1 year old		2 to 4 years old	
YEARS	New consultation	follow-up consultation	New consultation	follow-up consultation	New consultation	follow-up consultation
2008	25373	65980	14351	70175	30622	146234
2009	22663	75174	13115	69622	30223	145296
2010	25206	97844	15555	84738	26119	152376
2011	22181	113687	15490	99884	25681	149244
2012	19290	111221	15879	104769	18190	149668

Source: Anuario Estadístico 2012. Instituto Nacional de Estadística

Table 3 shows that in relation to growth monitoring, there is an increase in coverage related to follow-up consultations in the group under 1 year old and 1 year old. It is important to note that new consultations decreased under 1 years old and remained stagnated in the 1 year old population. In terms of the group 2 to 4 year old, there is a major decrease in new consultation and stagnation in follow-up consultation. This could be partially explained by the fact of new policies in the country (as well as other countries in the region) that are giving priority to monitor nutritional status and health of children under two years old.

Table 4. Antenatal consultations. Chuquisaca department. Period 2003-2012										
	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
New antenatal consultations	3270	3279	1671	0617	8896	9359	0036	8705	8026	5866
Antenatal consultation starting before 5th month	3301	4320	3474	3478	2577	3683	5087	4569	4635	3240
Antenatal consultation starting after 5th month	969	959	197	139	319	676	949	136	391	626
Pregnancies with 4 antenatal consultations	2128	3529	3819	2149	2231	3388	5192	5498	5817	4014

Source: Anuario Estadístico 2012. Instituto Nacional de Estadística

Table 4 shows an increase in coverage of antenatal consultations, both as new consultations and also the number of pregnancies that had 4 antenatal consultations.

Table 5. Deliveries and postnatal consultations. Chuquisaca department. Period 2003-2012										
	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Total of deliveries*	3181	2388	2820	2614	2205	3709	1838	3017	2481	2264
Total institutionalized deliveries** (as % of total deliveries)	2055 (64%)	1441 (60%)	1981 (70%)	1803 (68%)	1588 (72%)	1654 (44%)	1813 (98%)	2743 (90%)	2293 (92%)	2111 (93%)
Total home deliveries***	172	868	988	840	608	057	719	105	953	847

Total cesarean sections	777	750	901	939	400	185	477	773	808	950
First postnatal consultation	688	320	1079	1037	917	337	673	395	464	210

Notes:
* Deliveries attended at health facilities, at home attended by health personnel or trained birth attendant.
** Deliveries attended at health facilities, or home by health personnel
***Deliveries attended at home by health personnel or trained birth attendant.
Source: Anuario Estadístico 2012. Instituto Nacional de Estadística

Table 5 show a mixed coverage situation of deliveries and postnatal consultations. Although there is an important increased in institutionalized deliveries reaching above 90% for the 2009-2012 period, the coverage for first postnatal consultation are very low in those years. It would be assumed that being institutionalized deliveries, the first postnatal consultations would be easier, however the coverage remains very low.

In general, the tables above show an important increase in coverage for the Chuquisaca province. Although the consultant searched for disaggregated data of coverage for Tomina to compare whether the municipality reflects also the general increase in coverage of the Province, the available data was very limited. The few statistics found are presented in the table below:

Table 6. Pregnancies, institutionalized deliveries and antenatal care coverage in Tomina municipality. period 2002-2009

Total of pregnancies	320	317	316	314	311	309	307	305
Percentage of institutionalized deliveries	58,6%	N/A	N/A	65,8%	N/A	61,3%	57,9%	53,3%
Percentage of antenatal care with 4 visits	N/A	N/A	N/A	N/A	N/A	51,1%	59,3%	51,2%

Source: Conexión Fondo de Emancipación. http://www.conexion.org.bo/uploads/Chuq_Tomina.pdf

Table 6 shows that the number of pregnancies have remained steady during the period, however, the number of institutionalized deliveries have not improved-apart for small increases in the year 2005 and 2007, the coverage for institutionalized deliveries was lover in the years 2008 and 2009 than the coverage reached in year 2002. Coverage of antenatal care also appears stagnated.

Although there is not enough disaggregated statistics for Tomina to do a complete comparison with coverage levels in the Chuquisaca region, it is possible to say that in relation to maternal health, the performance of Tomina has not been at the level of the Chuquisaca region-at least up to the year 2009. During the field visits, the consultant verified the level of investment that the municipal government is doing in new health centers and expanding the equipment and refurbishing the ones already in function. It is probably that statistics for the year 2014 and 2015 may show improvements. However, such statistics were not available during the time of the consultancy.

5.2. Demand-side access elements

5.2.1. Ability to perceive

During the group interviews in the two communities, participants expressed satisfaction with the improvements to local health care facilities, increased number of health personnel and expansion of working hours. Several of them made emphasis on how their level of trust have increased now that they have health care providers that speak Quechua language.

5.2.2.Ability to seek

Participants in the group interview at the community level also confirmed the statement of the medical doctor referring to a greater demand for services. They stated that in the past few years, the improvement to local health care services and more personnel have motivated them to seek for services when needed.

5.2.3.Ability to reach

In the group interview with community families, they identify as an achievement the improvements in the access road to the local health center and health post. They also perceive as an achievement the continuation of the traditional medicine program. More importantly, during the interview, communities perceived that health and education are equally important and identified as achievements the fact that through their demands, they have been able to expand the local public school which now is also offering secondary level education in Fuerte Rua and the expansion of a boarding school in El Rodeo Porvenir community. Although these expansion in schooling are not directly related to healthcare services, they are important examples of community agency and the effective collaboration between municipal authorities and community based organization that are bringing such demands to the attention of authorities.

5.2.4.Ability to pay

In Bolivia, users must pay to access public services. This has been a constant barrier, which has been tackled in the past 10 years through different schemes of public insurance targeted to specific population groups, for instance the insurance for mothers and children. The most recent addition is the insurance for students, which cover children up to 18 years of age. These different insurances have improved the ability to pay of patients and have steadily increased the demand for services. Tomina is still preparing to implement two new additional insurances: one for elderly population and another for population with disabilities. The medical director anticipates that the implementation of this new insurance schemes will require additional health personnel. It is important to note that these different insurance schemes are government policies, so improvements in the ability to pay are the direct result of government policies. The SRC project in Tomina provided training and capacity building to the leaders that are now functioning as elected municipal authorities. Hence, it can be said that the SRC project contributed to the management capacity of the authorities that are now in government.

5.2.5.Ability to engage

Both the municipal authorities and the medical director agreed that the participation of communities have been crucial in the expansion of services at community level. The medical doctors stated that throughout Tomina, "*communities organize themselves and support weighing of children, delivering food supplementation and completing the family records*". An important component

5.2.6 Discussion on demand side access

An important component of the SRC project in Tomina was the training and capacity building of different community groups, including women, health promoters and traditional medicine. The documentation of the project reviewed by the consultant, included detailed reports on the planning of activities and use of resources by the Subcentralía and basic monitoring such as reporting on completion of planned activities. All of these reports relate to accountability in the use of resources but do not provide information on how "demand-side" aspects of the different community groups changed during the course of the project. As an external evaluator, I would have expected to see documentation on aspect such as a) how the level and quality of agency of the different community groups benefited by the project, changed during the course of the project; b) the changes in the understanding by community members, of the problems and its causes that they are addressing c) changes in the tactics and strategies that community organizations implement to solve problems. This type of documentation is obtained either through survey of beneficiaries or through ethnographic and qualitative methods. During my review of project documentation, I did not identify such documentation.

Based on my many years of experience I can sense that the SRC project was important and relevant for the benefited communities. However, without the documentation explained above, it is difficult to identify where and how the SRC project influenced demand side access.

5.3. Project Quality

5.3.1 External and internal coherence

The project clearly present both external and internal coherence. As stated in the context setting, rural indigenous families are among the most vulnerable populations in Bolivia. In addition, supporting a community-based social organization was a crucial intervention to promote social empowerment surely contributed to the efforts of the Subcentralia to present itself to elections, controlling government and performing to the level that have been reported in the previous sections.

5.3.2 Appropriateness:

In general, the activities implemented by the project were appropriate and the benefits generated have been of use to all the different actors involved.

The Municipal Mayor, who was a beneficiary of the SRC support while at the Subcentralia, states that "*through the support of the project, we learned how to manage funds in a transparent and responsible manner, this have been very useful to us now that we are in charge of the municipal government*".

One gap that was identified during the review was the monitoring and evaluation of the capacity building of the both the individual members of the Subcentralia and the Subcentralia as an organization. During the interviews, it was evident that there are many more achievement in relation to capacity building and social empowerment that are not documented. The reasons is that the formats that were used in the project documentation are appropriate for the accountability of funds but not to document other capacity building processes such as the application of skills and knowledge and overall empowerment. See the sections of general comments and recommendations below for further explanation.

5.3.3 Efficiency:

In the evaluation framework developed by the principal consultant (Dr. Kate Molesworth) efficiency is understood as an assessment of the sustainability and continuation of M&E system as it relates to access[13].
Based on the above, sustainability of the activities related to capacity-building implemented by the Subcentralía with their affiliated communities, this has been very limited. In the group interview at Fuerte Rua, communities stated that during the time of the red cross project, leaders from the Subcentralía would pay frequent visits and provide training and other capacity building to the local families. However, since the SRC support finished, there is no training in the community. I asked about this situation to the representatives of the Subcentralía and they confirmed the information that the Subcentralía does not currently have funding to continue with the training of local leaders in their affiliated communities. One board member stated: "*Continuing with the training of local leaders is very important and we wish we could have the SRC support again".*

5.3.4 Effectiveness

There is evidence that activities aimed to improve access have continued after the end of the SRC project with the support of the municipal government. This seems to be possible due to a) the management capacity developed by the Subcentralia and exercised through the municipal government and b) the increased allocation of financial resources from the National Government to the Municipal Governments.

5.3.5 Connectedness

In general, local authorities in many countries do not value the need of long term planning but rather short term interventions. The evaluator was positively surprised to see the importance that both the municipal authority and the representatives of the Subcentralia give to long term planning. During the interviews, they would frequently make reference to the previous strategic planning developed during the life of the SRC project and did comment that they are now in need of producing a follow-up long term strategic planning. The local Mayor insisted in several occasions that he saw as crucial the chance to implement a process to develop a 10 year strategic plan between the local government and the Subcentralía and to identify joint goals and the roles of each sector to achieve those goals.

5.3.6 Impact

Malnutritions is a major problem in Tomina. The municipal director of health reported that prevalence of chronic malnutrition in children under 5 years of age was 20% in 2006. At the end of 2013 was 17% and the most recent assessment in June 2014 revealed an 11% rate. The medical authority believes that this reduction has been possible due to the inter-sectorial work and the expansion of supplementary feeding to all children under two year of age. The possibility of implementing effective inter-sectoral work has been led by the Municipal Government and the Subcentralía. However, this impact is mostly related to the higher level of public expenditure in the past 3 years, so it may not have been a direct contribution of the SRC project. Nonetheless, the municipal authorities report that while implement municipal policies and services, they are using the skills and knowledge that they acquired during the SRC project. Hence, one may say that there is an indirect contribution in there.

[13] Kate Molesworth. Country Project Review Framework and Methodology. PPT, 7 July 2014

6. Outstanding challenges:

Despite the achievements described above, municipal authorities and communities identify the following key challenges that still remain:
Weakening of women groups: Women that participated in group interviews in both communities (Fuerte Rua and Rodeo Porvenir) stated that their organization is now weak after the support of the red cross stopped. "*When the SRC was supporting us, we used to have monthly meetings, training workshops and other activities that made us strong and organized as women. Without support, we do not have opportunities to meet and continue our skill development*".

Access to water: During the visit to the two communities: Fuerte Rua and Rodeo el Porvenir, both community participants in group interviews and health personnel agreed that the greatest need at the moment is water. They stated that there is not enough water in the communities for food production. Water insufficiency also affects the possibility of improving health in the community. The Tomina Mayor arrived to the meeting a few minutes later and confirmed that access to water has already been identified as a priority for several communities within the municipality but distance and topography make it a high cost project, so it is yet to be implemented. In the community of Rodeo el Progreso, they also stated that the lack of water also affects the possibility of producing food locally, hence many people must migrate to other areas looking for seasonal work. One male participant expressed that: "*The high migration of people in our community is affecting the possibility of strengthening our organization, if we were able to resolve the water problem, we would increase local production and people would not have to migrate anymore*".

Continuing the capacity building: During the group interview with communities, it was stressed several times by them that through the support of the SRC, the Subcentralía was able to provide training to women, men and youth in different topics. This training has nonetheless stopped. One female from the community of Fuerte Rua was very eloquent: *"…yes, we now have control of the Municipal government, however I do believe that we still need to continue the training to the different groups in the communities, it is only through the training that all people get to know about their rights and make specific demands to our authorities*".

Strategic planning: During the interviews, Subcentralia and municipal authorities valued how the past strategic planning helped them to guide their goals and activities. They stated that since that plan concluded in 2012, there is a need to produce a new strategic planning cycle. The Municipal Major stated that:
"*It is important to have long term plans and clear goals. I want to request that SRC provide us assistance to develop a participatory strategic plan with the Subcentralía".*

Expanding the number of local leaders able to perform as public officials:
As stated earlier, Bolivia is going through a rapid social, political and economic change. This include changes to the existing legal framework that directly affects municipal governments and the general population that must learn about the new regulations to access public benefits and services and the new benefits they are entitled to. This challenge was clearly articulated by a community leader member of the Municipal government: "…*As Subcentralía, we are in our second term administering the local government. However, we need to train many more local leaders so they can alternate with existing elected officials and ensure that we will continue delivering for our communities".*
Information campaigns: In terms of informing the general population about the new entitlements, a community member from Fuerte Rua expressed: *"There is now a bonus (cash transfer) for the*

elderly population, however, very few of the old inhabitants are informed about it and some of them do not even have proof of identity, so they are still not benefiting from an exiting new law".

7. Conclusions

The salient feature of the SRC was the capacity building and empowerment of a community-based social organization. During the field interviews, one can gather that the capacity building and empowerment did occur in the organization. However, there is no adequate documentation about how this process took place, and what were the mechanisms that allowed it. As stated earlier, this type of documentation is absent because the project used traditional forms and tools that are appropriate for the accountability of funds but not to document other capacity building processes. This project lasted 10 years, hence it was a missed opportunity to understand and learn how social empowerment occurs, under what conditions and what are the triggering mechanisms. Since the SRC is currently implementing similar projects with other social organizations, it would be crucial to implement monitoring and evaluation strategies that are appropriate to document these types of processes.

In relation to supply side access, the statistics available for the period 2002-2009 for Tomina show that its performance in terms of coverage increase was not as good as the increase in Chuquisaca region. But it is important to note that available statistics only reach up to the year 2009. The information gathered by the consultant during the field visit showed that new health care facilities and refurbishment of existing ones have been occurring in the years 2013 and 2014, also a significant increment in funding for health care services-including increase in the health workforce. It is therefore likely that statistics for the years 2013 and 2014 may present a better situation than those in the years up to 2009.

An aim of this review was trying to identify the contributions of the SRC project to supply side access. For the past 8 years, there has been an increase in public resources in general to all municipalities in Bolivia, which has translated in higher allocation to public services, including health. This makes difficult to identify what has been the exact contribution of the project, however, the authorities that are spending a larger amount of resources and taking the decisions in Tomina were community leaders that benefited directly from the SRC project. Hence, it is reasonable to assume that the SRC project contributed to strengthen the knowledge and capacity of community leaders that are nowadays using such knowledge effectively while running the municipal government.

In relation to demand side access, as it was explained earlier, there is comprehensive documentation for the project in relation to how the Subcentralia planned and reported the use of the resources provided by the SRC project. However, systematic documentation (from beginning of the project to the end) on how the project influenced the capacity of agency of the different community groups and the tactics and strategies to address problems is absent. Although one can identify that aspect of empowerment and agency did occur, without such systematic documentation is not possible to infer how this process occurred, under what circumstances and the direct effect that resources provided by the project had on both the community groups and the Subcentralia as an organization.

In relation to project quality, the review shows that the SRC project did well in almost all aspects. The aspect of "appropriateness" was assessed with gaps, particularly in relation to the systematic documentation of the capacity building and the strengthening of a social organization such as the Subcentralía.

8. Recommendations

Due to the philosophy of SRC projects in Bolivia that privilege strengthening of community-based social organizations and their empowerment, there is an urgent need to include appropriate monitoring and evaluation strategies for that purpose. There is a large diversity of approaches to carry-out this type of work that range from very academic[14] to highly participatory processes[15].

Support the process of developing a 10 year strategic planning between the Municipal Authorities and the Subcentralia. Once the plan is developed, it would be important to support the implementation of two or three activities that would have the potential of strengthening the aspects that were identified as weak or as challenging, such as the training of women to demand specific projects from the Municipal Government and information campaigns about the new benefits and entitlement for the population.

The fact that a community-based organization was popularly elected to administer a municipal government is highly uncommon in the development world. In most cases, local political elites have control over municipal governments and they are more responsive to the national political elite than their own population. Certainly there is a lot of learning that would be acquired from documenting the Subcentralia experience in administering the Municipal Government of Tomina, and this learning can benefit other social organization in Bolivia and in other countries of the region with similar contexts (i.e. Ecuador, Guatemala, Perú, Colombia, México). The specific recommendation is to carry-out a case study of this experience. This case study might also apply recent innovations in documenting social change that include prospective follow-up of the experience and the involvement of key actors as participant observers of the change process.

[14] See for example: Measuring Empowerment: Cross-Disciplinary Perspectives. Deepa Narayan. The World Bank.
[15] See for example the case studies, methods and tools available at COPASAH: www.copasah.net and http://betterevaluation.org/toolkits/equal_access_participatory_monitoring

Annex 1: Review TOR

Swiss Red Cross
International Cooperation

TERMS OF REFERENCE

Subject/purpose of mission: Evaluations and ex-post evaluations of selected Swiss Red Cross health projects

Country: Five countries (Laos, Cambodia, Ghana, Bolivia and Romania)

Program/Project name: ‚Grundlagen Gesundheit und DRR' im Rahmen von DEZA Programmbeitrag 2013-2016

Project code: 450036

Timeframe of mission/consultancy: 15 May 2014 to 28 February 2015

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1. BACKGROUND INFORMATION

The Department of International Cooperation (IC) of the Swiss Red Cross (SRC) is working in more than 30 low and middle income countries engaging in the two core business areas of disaster management and health (see Strategy 2020 of the IC). The work of the SRC takes place in the realm of humanitarian aid (emergency relief, early recovery and rehabilitation) as well as in long term development sector. In some countries, SRC has stayed engaged since more than 40 years.

In the health sector, the aim of the SRC has since long been to facilitate an increased access to health. The health policy 2012-2017 outlines "enabling access to equitable quality health services for vulnerable groups and communities" as one of the core objectives of the development cooperation.

In order to achieve this, the SRC works in the interface of the health system and the beneficiaries to bridge the gap between service providers an service recipients (see annex 1)

The SRC pursues, in accordance with its health policy, the following four priority approaches aimed at reinforcing linkages between the population and the health system:

- Consolidation of the health competences of local communities
- Strengthening of the health system
- Promotion of healthy living conditions
- Advocacy for health

Depending on the context, different methods for community empowerment, social accountability, quality control and sustainability enhancement are used. Individuals, community based organisations, volunteers and the health professionals play an important role in this process.

Through this working approach the SRC assumes to have an impact in improved access to health. Thus access to health is one of the key outcomes described in the SRC impact model (see annex 2). However, the expected impact of SRC programmes to improve access to health on the long run has never been systematically evaluated. No studies have been conducted looking back on the impact the projects have made that still remains after the phasing out of SRC programmes.
Within their ongoing dialogue on programme implementation the Swiss Agency for Development and Cooperation (SDC) and the Swiss Red Cross (SRC) have developed key issues for joint learning and reflection for the period of 2013-2016. Based on the need for an in-depth understanding of the interface between the population and the health system, the SRC wishes to look closely into the matter of improved access and wanting to know to what extent SRC programmes have contributed to better access to health and which approaches were the most successful**.**

2. PURPOSE OF MANDATE/ MISSION

The purpose of this mandate is to conduct evaluations and ex-post evaluations of four different SRC health programmes in four different countries in order to examine to what extent these programmes have contributed and facilitated access to health.

The choice of programmes has been based on the following criteria:

- Length and duration of the programme (minimum 5 years)
- Thematic input (have a choice of themes, e.g. health financing, quality improvement, community empowerment; etc.)
- Programmes that are still ongoing and programmes which have ended maximum 5 years ago.
- Programmes, where good secondary data are available

Thus the following countries are proposed to be included in the study:

1) **Laos**: The SRC has since 2002 supported the introduction and implementation of Health Equity Funds (HEFs) in six districts of provinces in Laos with the aim to improve access of the most vulnerable population to health services. A large database as well as annual analysis are available, based on which access to health services can be examined in a quantitative manner. This task requires a desk review only without travel to the country.
2) **Cambodia**: The SRC has supported the Health System Strengthening programme in 2004 of Cambodia in two districts (Ang Rokar and Kirivong) in order to provide

better access and improved quality in health service delivery. The SRC engagement terminated in mid 2011. An ex-post evaluation should show how and whether impact on better access to health for the population has sustainably been achieved beyond the phasing out of the project.

3) **Bolivia**: From 2002-2012 the SRC has supported a farmers organization in the Sub Centralía Campesina Tomina, in the Chuquisaca Region of Bolivia with the aim to improve their access to health services, empower the peasant organization, improve education and income-generation. A capitalization about the history of the organization, the perceived changes which occurred during this decade in the community and the value of working together has been undertaken. However, the aspect of access to health services and better health has not been explicitly quantified.
4) **Ghana**: The SRC has supported the Ghana Red Cross Society and the Ministry of Health in providing eye care services since 1990, in the Brong Ahafo Region since 1996. After a 10 year engagement, the SRC phased out its work in the Brong Ahafo region and handed over the complete eye care management to the local ministry. While sustainability of services has been examined by an external consultant in 2010, the utilization and access after phasing out has never been examined and would provide valuable insight in the continuation of other SRC eye care programme in West Africa and Asia.

3. SPECIFIC TASKS

The consultant will be the team leader of this study. She will herself conduct country studies in three countries (Laos, Cambodia and Ghana) and coordinate the country study Bolivia, which is carried out by a consultant from Guatemala. The consultant from Guatemala will receive a separate ToR.

As the team leader, the consultant will do the following tasks:

1) Prepare a study methodology and specific Terms of Reference for each country study in collaboration with the Health Advisor of the SRC IC and the respective SRC programme coordinators and local SRC delegations
2) Share the study methodology with the consultant from Guatemala in order to streamline the approach.
3) Collect the country study from Bolivia from the consultant from Guatemala.
4) Prepare a consolidated report of all four SRC programmes impact on access to health; outlining successes and challenges
5) Make recommendations to the SRC in how access to health could be better enhanced and monitored in SRC programmes.
6) Assist the SRC IC in adjusting the SRC impact model depending on the findings of the study.

   As the consultant responsible for three individual country studies (Laos, Cambodia, Ghana):
7)
8) Conduct a literature review of the health situation of the different countries
9) Do a primary data review of these SRC programmes

10) Conduct a country visit of maximum 7 days per country in Cambodia; Laos and Ghana.
    - Assessing and describing the health status of the population in the intervention areas and the possible contribution from the SRC projects
    - assessing the utilization of the health services and the situation of the service providers and their ability to offer 'better' access due to SRC interventions using different research techniques
    - Assessing the beneficiaries perception of 'better' access to health and health services due to SRC interventions using different research techniques
    - Assessing stakeholder's perception (community, health providers, Government Ministry of Health public health offices) on whether and how SRC projects have influenced the shaping of health policies and health systems in terms of improved access.
11) Prepare individual country reports

4. ADDITIONAL TASKS

None

5. EXPECTED OUTPUTS

The expected outputs of the consultant are three-fold:

1) The consultant will produce individual documents for each country study based on the ToR. Each country study should not exceed more than 30 pages..
2) The consultant will produce one written documentation not longer than 50 pages which compiles the results and findings of all individual country study findings. The documentation also includes future recommendations as outlined in point 3.5 and 3.6.
3) Based on the study findings, the consultant will furthermore advise on the adjustment of the SRC impact model as outlined in 3.7.

6. METHODOLOGY and SCHEDULE

The methodology will include:

1) Primary and secondary literature review
2) Questionnaire surveys
3) Focus Groups discussions with local and regional health staff and beneficiaries (individuals, community groups, project team, other stakeholders)
4) Observation

The study will take place between April to December 2014 and may have the following schedule:

Time frame	Task	Days of work

15.-30. May 2014	Finalisation of ToR and study methodology	1
June, July 2014	Secondary data literature review	4
	Literature review and report writing country 1	7
August 2014	1 week study in country 1	7
	Report writing country 1	2
September 2014	1 week study in country 2	5
	Report writing country 2	2
October 2014	Study in country 3	7
	Report writing country 53	2
November 2014	Compilation all reports and draft submission	5
December 2014	Finalization	2
TOTAL		44days

7. ADMINISTRATIVE MATTERS

The consultant will keep in regular touch with the SRC IC Health Advisor throughout the whole study period. She will also communicate with the consultant in Guatemala. Key moments of communication are the development of the study methodology, the sharing of information and before and after the individual field studies.
During the country studies, the consultant will be supported by the SRC local delegations. The consultant will receive a travel allowance and per diem in the respective countries. In-country travel will be arranged by the local SRC programmes and country delegations. It is the duty of the SRC IC Health Adviser to communicate the purpose, methodology and requirements for this study to the relevant SRC programme coordinators, SRC delegations and partners.

The SRC code of conduct will be signed by the consultant and is an integral part of this mandate.

8. ACCOUNTABILITY AND COMMUNICATION NETWORK

SRC internal communication:
The consultant reports to the SRC IC Health Advisor in HQ Berne. The SRC IC Health Adviser is responsible to inform, involve and report to the respective programme Coordinators at SRC HQ and the local SRC country delegations. The SRC IC Health Advisor will ensure that the partners and partner national societies and stakeholders are informed and gave consent to the study and the process.

External communication:

Prior to undertaking the country studies, the SRC IC Health Advisor will ensure that the local delegations propose a list of stakeholders and actors that need to be interviewed or consulted during the field mission. Further individuals or actors that are identified during the process can be included.

9. RESPONSIBILITY AND COMPETENCE

In all your professional tasks you will comply with the security plans of the SRC in the respective countries.

All outputs resulting from this assignment are the intellectual property of the Swiss Red Cross. They should be considered confidential and are not be shared with individuals or organization except those mentioned in these Terms of References (ToRs) unless written consent has been obtained by the SRC.

Any specific needs or resources necessary for carrying out your assignment will need to be discussed with the SRC IC Health Advisors and SRC country representative well ahead of taking up your assignment.

These ToRs are an integral part of your contract.

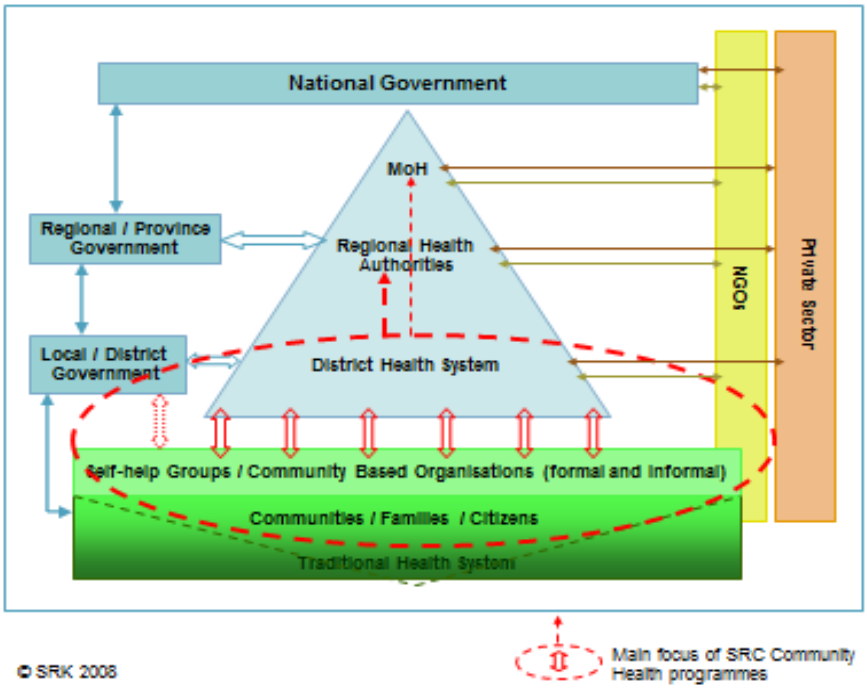
In all your professional tasks you will comply with the condition of employment for SRC delegates and the code of conduct as accepted by you with the signature of the contract.

These Terms of Reference are an integral part of your employment contract/mandate.

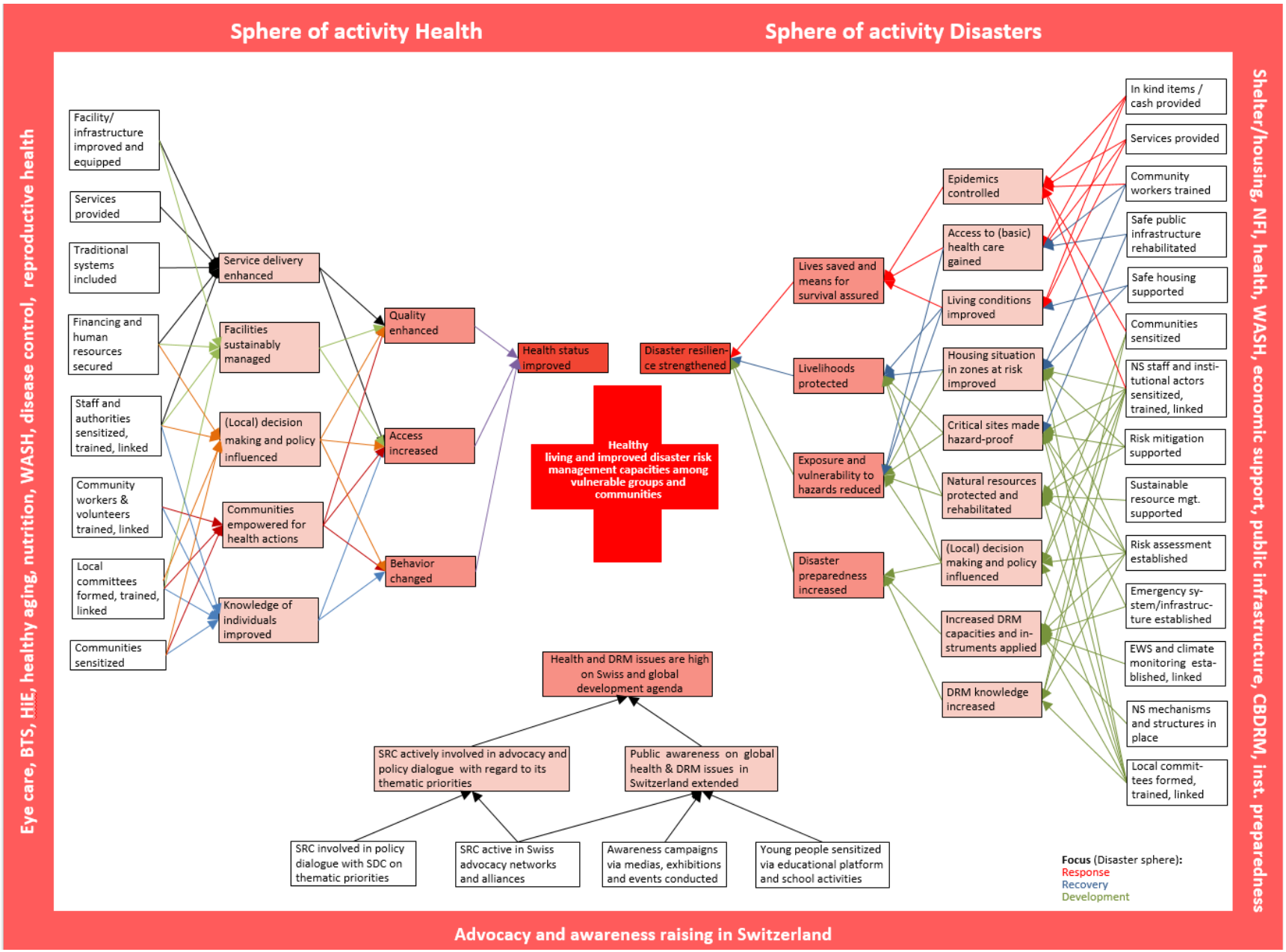
Berne,
Swiss Red Cross
International Cooperation

(no signature, as ToR are integral part of the employment contract)

Annex 2: SRC model on community based health systems



Annex 3: SRC Impact Model



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