

IPPF Independent Progress Review 2012
DRAFT Report – CIES Bolivia

International Planned Parenthood Federation

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Acronyms

CIES	Centro de Investigación, Educación y Servicios
CORE	Cost revenue analysis tool
CAC	Comprehensive abortion care
DALY	Disability adjusted life year
EC	European Commission
HPV	Human papilloma virus (causes cervical cancer)
IPPF	International Planned Parenthood Federation
LGBT	Lesbian, Gay, Bisexual and transsexual
M&E	Monitoring and Evaluation
MA	Member Association (of IPPF)
MMR	Maternal mortality rate
MSH	Management Sciences for Health
MSI	Marie Stopes International
PAC	Post abortion care
PPA	Programme partnership Arrangement
SRHR	Sexual and reproductive health and rights
UE	Uterine evacuation
UMOSAS	Mobile health units (Spanish acronym)



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Executive Summary

This document provides the findings from a country based study of the Bolivian International Planned Parenthood Federation (IPPF) MA – CIES - as a contribution to the DFID Programme Partnership Arrangement (PPA) independent mid-term review. IPPF receives on average £8.6 m per year between 2011 and 2014. Whilst IPPF is a global organisation working in more than 173 countries, this PPA gives particular priority to **45 focus** countries, as well as directing funding to the Regional and Central Offices.

The purpose of this review is to measure the achievements, challenges, outcomes and impacts resulting from the DFID PPA. Because the PPA is unrestricted (or core) funding we have taken the approach of looking at the overall performance of the organisation, rather than focusing on the impact of just the DFID funds

Though classified as a middle income country Bolivia continues to experience high levels of poverty with 50.6% of the population living in poverty and 26.1% of the population classified as extremely poor. Bolivia's health indicators are worse than most other Latin American countries. In 2008 the maternal mortality rate (MMR) was 310 per 100,000 live births – but estimates of rural MMR could be as high as 600 in some communities. The Bolivian government is committed to addressing the longstanding inequality in the country with a rights based approach to health.

CIES offers services in 15 static centres (five hospitals, five clinics, five health centres) and three mobile health units located in the capitals and surroundings of Beni, Cochabamba, La Paz, Oruro, Potosi, Santa Cruz, Chuquisaca, Pando and Tarija provinces. Most of the services are located in urban or peri-urban areas, with the exception of the mobile health units (UMOSAS) that are targeted at hard to reach rural communities. In total, services reach 36 municipalities, where over 500,000 people are served.

Conclusions

CIES provides excellent services in urban areas through an extensive network of clinics and in the Chaco de Chuquisaca rural areas through donor funded mobile clinics. The services are affordable and accessible to a range of poor and vulnerable groups – with services and delivery designed in an appropriate way that is based on a good understanding of the needs of clients and potential clients and the social and cultural barriers to service access; a focus on young people; technical excellence, good practice and evidence of what works; and efficient referral to other appropriate services.

CIES success is due to external support from USAID and IPPF, effective CSO coordination and an improving enabling environment for human rights and SRHR. Internally the leadership and management skills have contributed to the good results, as has the service quality, efficient systems, relationship with government and the clear strategy and mission – especially for reaching vulnerable groups.

In 2011 CIES has provided 328,449 SRHR services, of which 98,642 were provided to young people. 72% of all clients were poor, socially excluded or underserved. Family planning services provided 30,708 CYPs and prevented 3,044 DALYs.

CIES family planning services provide very good value for money. The average cost per DALY saved is £76 compared to GDP per capita in Bolivia of US\$1,731 (£1,103). The overall cost per CYP of £4.90 compared to £9.20 (\$14.46) in the Latin America region¹.

¹ Adding it up. Costs and Benefits of Contraceptive Services. Estimates for 2012. Susheela Singh and Jacqueline E. Darroch. Guttmacher Institute and UNFPA. June 2012



Lessons Learnt

- The CORE programme for producing and analysing unit costs is good enough for CIES and could be used in other MAs. This can only be done if there are defined service time norms and the management capacity is good enough to monitor them.
- The South-South learning programme that is funded and managed by the Western Hemisphere regional office has been successful in driving new initiatives in CIES and for them to promote learning from their own organization This is a lesson for other regions to be more systematic in their approach to South-South learning.
- The importance of the clinic “educator” or counsellor is crucial as they as a gatekeeper and facilitator for the most difficult situations and services. It increases access for young people and for poor people and it also provides essential information about and access to FP, harm reduction service, free services, HIV and STI prevention and detection etc. it is something that marks CIES out from other providers.
- Youth and women’s empowerment programmes are evolving into empowerment and accountability initiatives.

Recommendations

1. Better coordinate with other non-state health service delivery organisations, especially international NGOs.
2. Improve internal communications and lesson learning opportunities for non-management staff.
3. Improve the website making sure there is a better understanding of the different audiences that might use the website and how they can access information
4. Increase the already successful efforts to provide comprehensive abortion care in all facilities and mobile units
5. Analyse the reasons for shortfall in HIV services against targets and for the low level of service utilisation by young men and adolescent boys
6. Consider providing more women friendly birth services
7. Increase efforts to support government to build capacity – particularly in the areas of HMIS and financial management
8. Ensure that the CIES advocacy team has enough people to deliver the ambitious advocacy plans; and develop a more logical presentation of advocacy objectives and activities.
9. Develop a better understanding of market segments and develop strategies for reaching different markets with specialised services and differentiated pricing.
10. Develop a more transparent differentiated payment structure
11. Improve impact assessment
12. Introduce the main functions of the CORE software into the routine of the SAP system.
13. Ensure clinic managers keep the CORE figures up to date and that they can use unit cost and market information for fine tuning differentiated pricing and for improving clinic efficiency.
14. Introduce a more methodical approach to price differentiation and subsidies, including some rules of thumb regarding what price should be set for the services,
15. Explore a more economical arrangement with SAP – a global contract in partnership with other Latin American NGOs or an alternative arrangement with a SAP like software firms.
16. Explore mixed institutional arrangements, where a for-profit- unit directly subsidises CIES activities, like the mobile units, whilst ensuring that the social objectives of the organisation are not compromised.



1. Introduction

1.1 Purpose of evaluation

DFID has a Programme Partnership Arrangement (PPA) for £25.8m of flexible strategic funding to the International Planned Parenthood Federation (IPPF) between 2011 and 2014. This is equivalent to £8.6m per year, the same amount that IPPF has already been receiving annually from DFID since 2008. Whilst IPPF is a global organisation working in more than 173 countries, this PPA gives particular priority to **45 focus** countries, as well as directing funding to the Regional and Central Offices. The PPA desired outcome is: to improve the health status of poor and young people, in particular women and girls. There are three target outputs:

1. Increase in access to and use of a package of essential services centred around family planning
2. Engage and influence policy mechanisms for SRH and choice at global, regional and national levels
3. Strengthen the economy, efficiency and effectiveness of IPPF's network

This report presents the findings of one of three country studies for the IPPF PPA independent mid-term review. This country study covers the Bolivian MA, CIES (Centro de Investigación, Educación y Servicios). The document will explain the methodology for the review and then will provide findings for each of the review criteria: Relevance, Efficiency, Effectiveness, Results and Impact, Value for Money, Sustainability and Lesson Learning and Innovation. The report will conclude with conclusions and recommendations.

1.2 Methodology

The overall purpose of the review is to measure the achievements, challenges, outcomes and impacts resulting from the DFID PPA. Because the PPA is unrestricted (or core) funding we have taken the approach of looking at the overall performance of the organisation, rather than focusing on the impact of just the DFID funds. In accordance with the Terms of Reference (ToRs), the review investigated:

- Relevance of CIES services;
- Organisational efficiency and value for money within operations;
- CIES effectiveness;
- Results and impact resulting from CIES interventions;
- Sustainability of CIES services and other interventions;
- Innovation, lesson learning and sharing within CIES and with external partners and the wider IPPF network;
- CIES organisational culture and the extent to which it supports the above.

The independent review in Bolivia was carried out by two consultants: Georgia Taylor, a health and gender consultant and Veronica Vargas, a Chile based economist. It involved:

- Desk review of key documents (see Annex 1);
- Adaptation of interview and FGD tools²;
- Interviews with staff and volunteers of CIES, with officials from the government Ministries of Health and Education and with a selection of civil society partners;
- Clinic visits in La Paz, El Alto and Cochabamba;
- Focus groups with young people, street children, women and LGBT groups, most of whom were clients of CIES and some who were not clients;
- Discussion and analysis by the consultants of the main findings from the interviews and FGDs;

² The originals had been developed for the independent review in Pakistan.



- Debrief with CIES headquarters staff in La Paz;
- Report writing.

CIES led arrangements for the site visits, all interviews and focus group discussions, with plenty of consultation with the consultants. The site visits focused on urban-based services (El Alto, La Paz and Cochabamba). Rural areas served by mobile services could not be included as they were too remote for the timescale of the review. Youth services and the street children programme were the main focus of the focus group discussions, though the women's empowerment project was also included.

Because the team did not include a local consultant it relied on CIES to organize the non-service user interviews, which they did with partners for the street children programme and through contacts with the LGBT community. However there were very few non-service user street children and they were very difficult to communicate with.

The economic analysis focused on collecting and testing data that was being collected by the SAP (integrated project and financial management software) and the CORE (Cost Revenue Analysis tool) systems in order to make an assessment of value for money. Because CIES is already collecting data on unit costs (through CORE) the review team focused on an analysis of this data and comment on the usefulness of the processes. The team has found that there is an error in the MSI (Marie Stopes International) Impact2 estimator CYP calculations, so these have been checked with the USAID conversion factors.

2. Background for Bolivia SRHR situation and CIES

1.1 SRHR in Bolivia

Though classified as a middle income country Bolivia continues to experience high levels of poverty with 50.6% of the population living in poverty and 26.1% of the population classified as extremely poor. There is a high level of inequality (see map in figure 1) between ethnic groups and rural/urban areas. Sixty one percent of the 10.4 million Bolivians self classify as indigenous and there is a disproportionate level of poverty among these groups. Almost eighty percent of indigenous people living in rural areas are poor, with 68.2% extremely poor³. This situation reflects years of discrimination, abuse and neglect of indigenous populations. Since 2006, when the current administration was first elected, there has been an effort to redefine relations between state and civil society. The government is promoting a development model that aims to include indigenous peoples. This is described in the new State Political Constitution and the National Development Plan. The political changes have at times lead to mistrust of externally funded NGOs and particularly of family planning programmes targeted at indigenous populations.

Bolivia's health indicators are worse than most other Latin American countries. In 2008 the maternal mortality rate (MMR) was 310 per 100,000 live births – but estimates of rural MMR could be as high as 600 in some communities. The government's Intercultural Community-based Family Health Policy was established in 2008 and takes a health promotion and prevention approach that also incorporates the cultural differences and social participation of the population. However there remain significant gaps in service provision in rural and remote areas, particularly in the high mountainous areas. Most hospitals with perinatal care units are located in cities and far from the reach of rural women.

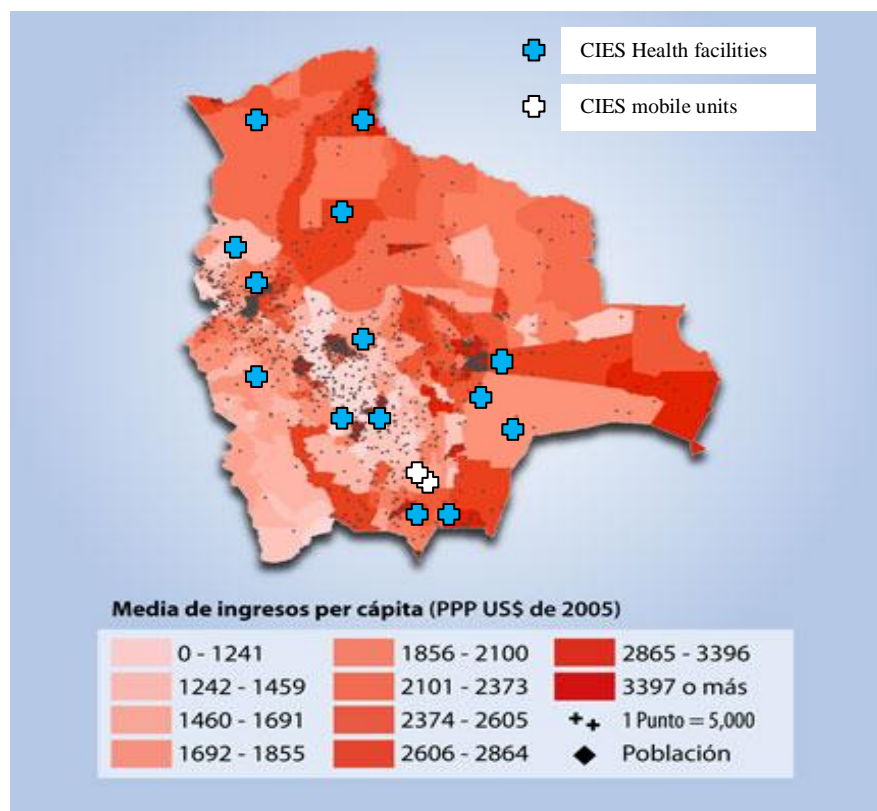
Family planning is scarce in public health facilities and poverty, gender inequality and stigma inhibit access to sexual and reproductive health (SRH) services. Young people have trouble

³ Data from the Inter-American Development Bank Bolivia Country Strategy 2011 - 2015



accessing SRH services and tend to be treated badly by health providers⁴. Consequently there are high levels of adolescent pregnancy. 17% of adolescents who leave school do so because of pregnancy and half of young women aged between 15 and 19 years have had a pregnancy. Three out of every five pregnancies among young people are not wanted⁵. Abortion is legally limited to cases of rape, incest or when the woman's health or life is endangered. However safe abortion is not often an option for women without resources as the doctor must receive a judicial authorisation to legally perform an abortion. Consequently unsafe abortion figures are high and account for a third of maternal deaths.

Figure 1: Income per capita in Bolivia and CIES locations



1.2 CIES background and overall budget context

CIES has been working on SRHR in Bolivia for 25 years. In 2005 CIES experienced serious management problems which resulted in one of their donors (the Global Fund) suspending funding. IPPF's Western Hemisphere Regional office investigated the situation and worked with the governing board to prompt and support changes at the senior management level. This provoked a process of re-engineering, supported by USAID, IPPF and with the services of Management Sciences for Health (MSH - a US based health organisation). For CIES, the last five to six years have resulted in a massive improvement in efficiency and effectiveness and this can be directly related to the strong leadership in the organisation.

CIES offers services in 15 static centres (five hospitals, five clinics, five health centres) and three mobile health units located in the capitals and surroundings of Beni, Cochabamba, La

⁴ Diagnostico de posibilidades, retos y limitaciones para la implementación del modelo de servicios de salud sexual integral diferenciados para adolescentes – CIES research 2010. This was backed up by the reviews FGD feedback from young people.

⁵ Diagnostico de posibilidades, retos y limitaciones para la implementación del modelo de servicios de salud sexual integral diferenciados para adolescentes.



Paz, Oruro, Potosi, Santa Cruz, Chuquisaca, Pando and Tarija provinces. Most of the services are located in urban or peri-urban areas, with the exception of the mobile health units (UMOSAS) that are targeted at hard to reach rural communities. In total, services reach 36 municipalities, where over 500,000 people are served.

The main areas of work are organised as follows:

- Educational – in the clinics, as part of the youth services and in the communities
- Health services – SRH prevention, detection and treatment services for men, women and adolescents; other general health services and surgery
- Advocacy and accountability – at national, provincial and local levels
- Research – situational analysis and M&E

CIES has special programmes in the following areas:

- Street children and adolescents – access to health services and preventative support. This project is funded by DANIDA, Irish Aid and the European Commission (EC)
- Women’s empowerment – building women’s leadership capacity, self esteem and knowledge of SRHR. This project is funded by USAID
- Youth programme – training and supporting youth leaders and providing specialist services to young people. These services are integrated into the clinic services
- Gender based violence – prevention, detection and treatment approaches that are integrated into clinic services.
- Support to strengthened services to reduce harm from unsafe abortion including post abortion care and harm reduction with misoprostol. This was funded through the IPPF WHR office.
- HPV vaccine programme supported by the Innovation Fund (core funded).

Table 1: Donor funding⁶

	2010		2011	
	£millions	%	£millions	%
Internally generated funds	1.69	38	2.27	43
USAID	1.51	34	1.42	27
IPPF core and Innovation Fund	0.40	9	0.49	9
Plan International / EC	0	0	0.32	6
Irish AID	0	0	0.14	3
Bergstrom	0.09	2	0.11	2
Other ⁷	0.72	16	0.48	9
Total	4.41	100	5.23	100

CIES’s internally generated funds have increased during the last three years from 34% of total funds to 43%. However, the organisation is still highly dependent on international donors especially USAID. IPPF unrestricted plus Innovation Fund funding accounts for only 9% of overall funding and DFID funding represents only around 2%. However, this is highly valuable for CIES because of its flexibility and its targeted use for innovation, reaching the most vulnerable and addressing difficult issues. There is also evidence that the money coming from IPPF (as part of the PPA) particularly has had a wider impact on the health system and government services (see section 3.2) and has increased the overall organisational effectiveness of CIES (see section 3.4).

⁶ Source: Resumes de Fuentes Financiamiento 2009 – 2011, CIES

⁷ Other includes: UMS Implantes, HIV, Gardasil, FFC, Danida, WB, USAID VAT Tax, Care VBG, Pathfinder, IBIS Hivos, EAPC Canada, MSH, RSFU/Suecia, Advocacy Jovenes FUSA, UNFPA, CM Tarvita, Solidaridad Internacional, ICCO



3. Evaluation Results

3.1 Relevance

This review has found that CIES core activities and related programmes are highly relevant to the local context, the policy environment, to the needs of the people they serve and to donor priorities. This is due to the local ownership of the organisation and the analytical and strategic approach to programme development and targeting. The vision and leadership of the Executive Director have also been key. The services are also relevant to poor and vulnerable people, but to a lesser extent than the overall population and young people.

Policy environment and links with the public sector

There are two key health policies that guide the health sector in Bolivia:

- Plan de Desarrollo Sectorial (Health sector development Plan)
- Salud Familiar Comunitaria Intercultural (Intercultural community and family health policy)

These plans place a great emphasis on all people's right to health and the aim to eradicate inequalities in the health sector. They propose that it is the state's responsibility to provide a functioning and equitable health sector. The sector focuses on strengthening of the public health system and provides a negative evaluation of the previous "neo-liberal" privatization of the sector. This strategy worked against CIES at first as there was a negative attitude towards externally-funded, private sector health providers. There was also nervousness around family planning programmes that were funded from outside of Bolivia, as they were seen to be about population control of indigenous peoples. This is ironic in many ways as the IPPF and CIES mission is all about a human rights approach to SRH. Over the last two years CIES has managed to establish an important place within the Bolivian health sector through the technical expertise, innovation and willingness to support the Ministry of health with its goals⁸. CIES has also gained in status with the Bolivian government by demonstrating that it can effectively reach its target groups: adolescents, women, indigenous populations and LGBT.

CIES has managed this by having a close relationship with the Ministry of Health and by ensuring they have a very good analysis of the gaps in the health system and how the CIES services can strengthen public services to address the gaps. For example, CIES has been successful in strengthening HPV vaccination services (also in partnership with the Ministry of Education) and services to prevent, detect and address gender-based violence. Both of these initiatives have been funded through IPPF/PPA funds (either the Innovation Fund or from the WHR office). CIES has also managed to be relevant to public policy by being responsive to government requests and requirements. For example, during the doctors' strike in 2011, CIES was able to provide the health sector with emergency cover through their own personnel.

Relevant to the context

CIES has a good understanding of the economic and social profile of the different areas of Bolivia, and they have a presence in all nine departments. Most of the static clinics and health facilities are in urban areas, but these tend to be based in locations where there are more likely to be a high proportion of poor and vulnerable people. However, they own most of their facilities, so are not likely to move location if the profile changes. When new facilities are investigated there is a market research study undertaken, which looks at the profile of potential service users and public and private services available. For example, CIES in Cochabamba is currently investigating the possibility of opening up an outlet in a slum area in the outskirts of the city – to better serve some of the most vulnerable people who they

⁸ Ministry of Health verified that they had a very high opinion of CIES expertise and support.



know need better access to services. This study is currently under development and CIES is assessing if it should include a full social analysis and the specific barriers to access in that population.

Box 1: Assessment of vulnerable communities.

There has been a recent (2011) baseline survey of several of the communities where CIES is implementing the USAID funded women’s empowerment project and the mobile clinics. Results for a rural municipality, Tarvita in Chuquisaca, show a very low level of awareness of contraception, and high levels of violence and gender inequality. More than 50% of those interviewed had recently suffered from intimate partner violence. The area is one of the poorest in the country with 97.9% of the population classified as poor; 85.7% of the population are ethnic Quechuas, nearly 50% are illiterate and they mostly live in very basic conditions, with only 9.9% coverage of electricity and 13.9% of drinking water. Fertility is 7.9 and supposedly 90% of births take place in a facility – though the baseline survey revealed that under 50% of births were taking place in the facility.

Though CIES does target low income groups, the service charges are not necessarily accessible for the poorest and most vulnerable people or for the rural areas. There is specific restricted donor funding for reaching these groups – where the services are entirely subsidised – e.g. the mobile clinics and the street children programme. However, each of the CIES staff members interviewed in health facilities stated that they would not turn away a client because of lack of funds. They aim to provide services to all who want them. However there is no transparent or systematic way of assessing income levels of clients or who should be provided with free services beyond the special targeted programmes to young people and street children. Every candidate for free or lower prices will be seen by a specialist member of staff who assesses the situation. The health counsellor and educator in the clinic, who is also a social expert, tends to be the filter for such requests. Health fees are transparent and are clearly posted at the entrance of the health facility along with the list of doctors and health personnel who are on duty that day.

The issue about promotion of free services and transparency of eligibility for free services is a tricky one to resolve. If the clinic were to promote free services they may be inundated with demand. However it may well be advisable to at least do some market research on the issue of free service demand from the very poorest, and to assess whether transparency around eligibility may increase access to the poorest.

Differentiated pricing and prices for special services (such as post abortion care) are not transparently displayed. For example, young people who are participants in the “Tu Decides” youth leadership training receive health services including family planning for just one boliviano (about 10p). The participants of the focus groups were pleased with this differentiated pricing and stated that it made the services very accessible for them. Street children who are in the DANIDA or Plan programme are able to access the health services in the clinics for free. Post abortion care costs 50 bolivianos (approximately £5), but this was not displayed outside the clinic.

Table: 2 Price of services displayed at the entrance of El Alto clinic

Type of service	Bolivianos	UK £
General health consultation	25	2
Gynecological consultation	35	3
Pediatric consultation	35	3
Adolescent health 10 – 19 yrs	10	1
Ultra sound	80 - 90	7 - 8
Birth pack from first ANC visit for normal birth	1300	116
Birth pack from first ANC visit with caesarean section	3800	339



Addressing gaps in health service coverage

While CIES does a good task of identifying poor, vulnerable and under-served groups, they can by no means reach all of these groups in Bolivia and their services to the very poorest are limited by lack of funds. The strategy for addressing this is to:

- **Respond to sexual and reproductive health needs of the population that have not been addressed adequately.** CIES has done this by identifying, along with other partners, that there is a crisis of cervical cancer in Bolivia⁹. They have addressed this by expanding access to the HPV vaccine and to detection and treatment services. CIES partnered with the Ministry of Health to implement school-based free vaccination against HPV and aims to bring the vaccine to some of the most vulnerable populations in Bolivia where cervical cancer mortality remains among the highest in the world. The services were promoted through an innovative public campaign through TV, radio and press. The Ministry of Health has recently released a new National Cervical Cancer Plan 2010 – 2015 based on the CIES prompted methodology.
- **Build capacity within the public health system.** This is done through technical capacity exchange and capacity building within the health sector. It has involved the development of protocols or standards and guidelines, as in the work they have done with government on gender based violence¹⁰. It can also involve combined advocacy and service delivery in order to scale up services within the public sector and establish policies and practice. This was undertaken for the HPV vaccine and CIES is continuing to support the government¹¹ to roll out the vaccine in public schools in urban and in hard to reach rural areas. There is a great opportunity for CIES to capitalise on its current good relationship with government and its standing as a technical expert in SRHR. More work can be developed to further strengthen the public health system and service delivery.
- **Work with partners to reach additional underserved populations and avoid overlap.** CIES is expanding its work through strategic partnerships with pharmacists, laboratories and private providers. It will be important to monitor this work and to find a way of assessing what kind of reach and impact it has. CIES works well with most other CSO health service providers, but there is more that can be done with organisations such as MSI and ProMujer. There is some overlap of services and locations with MSI and this is of particular concern since MSI also receives PPA funding from DFID. Dialogue is needed to ensure good use of funds to cover as many underserved people as possible. ProMujer reaches the very poorest women and provides microfinance and health services. Partnership and closer work with them and other similar NGOs would increase potential for coverage of hard to reach populations.
- **Cross subsidising services and facilities** so that low costs can be charged to those that would not otherwise access services – particularly young people. Interestingly the IPR has found this to be successful within a sustainable clinic (La Paz and Cochabamba youth services not including the street children project) as well as in a clinic that is located in a lower income area and is nearing sustainability (El Alto youth services).

⁹ 5 women die every day from cervical cancer in Bolivia

¹⁰ Protocolo: Detección, atención y referencia a personas en situaciones de violencia basado en genero. Gobierno Autónomo del Departamento de la Paz. Servicio Departamental de Salud La Paz.

¹¹ Prevenir el cáncer de cuello uterino y evitar la muerte de mas mujeres bolivianos. Guía de capacitación para facilitadores.



Enabling environment

CIES is focusing its advocacy and communications for improving the enabling environment for SRHR by targeting laws and policies at national and local levels:

- To improve overall sexual and reproductive rights.
- To review legal restrictions on safe abortion in order to enable better access to safe abortion services. Unsafe abortion accounts for more than 30% of maternal deaths and disproportionately affects poor and vulnerable women, particularly young women.
- To improve the legal and policy framework ensuring that young people have access to services and sexual and reproductive rights.

CIES works with partners in PROCOSI¹² and through various coordination mechanisms (such as the Mesa Nacional de Derechos Reproductivos y Derechos Sexuales – the National coordination “table” for SRHR.)

Ensuring quality of care for young people

CIES has undertaken surveys to understand the needs that young people have with respect to SRHR services and the gaps in the public health sector. These surveys ensure a continual improvement in the services and spaces provided by CIES for young people. Above all young people want to be treated with respect and without stigma when they go for sexual and reproductive health services. The focus groups and interviews confirmed that CIES is successful in this respect. Differentiated services are available and are integrated into the main clinics. For example, the youth programme has evolved over the years due to client feedback, from a purely SRHR and behaviour change programme to one that builds the overall self esteem, skills and capacity of young people to become leaders and responsible citizens. There has also been an evolution of the youth spaces that are attached to all of the CIES clinics. (see Box 2 below). A theory of change for the youth work has been developed as part of the IPR and a diagram with assumptions can be seen in Annex 3. This tries to capture the short term, medium term and long term changes that are resulting from this programme and the assumptions that being made about how the changes take place. It may be useful for CIES to develop this further and to use for evaluating the programme at some stage.

¹² El Programa de Coordinación en Salud Integral (PROCOSI) is the largest health NGO network in Bolivia and consists of 32 organisations that together virtually cover the whole country. The network consists of the following organizations: ADRA Bolivia, APSAR, APROSAR, Ayuda en Acción (Action Aid), Care, CecaseM, CEMSE, CIEP, CIES, CEPAC, Combbase, Consejo de Salud Rural Andino, Catholic Relief Services, Child Fund, Crecer, Cruz Roja, Esperanza Bolivia, Fundación Contra el Hambre, Fundación Cuerpo Cristo, Fundación Cultural Quipus, IPTK, Louvain Développement, CEPAS Caritas, Plan International, PROAGRO, Concern International, ProMujer, ProSalud, Save the Children, Universidad Nur, World Vision.



Box 2: Tu Decides (You Decide) Youth Programme

The youth programme has four objectives:

- Improve young people's access to integrated health services – through CIES clinics and public policies.
- Promote SRHR training and awareness-raising processes for adolescents and youth – through schools programmes and out of school activities in urban and rural areas.
- Support young people with advocacy objectives – through local and national legal reform and policy processes.
- Encourage young people to participate in public decision-making processes, particularly to build social accountability mechanisms – by opening spaces for dialogue between young people and public health service providers and government.

Each CIES clinic has a youth services space where young people can meet, have training and workshops and access services. CIES provides leadership training to young people and those young people become peer educators. The training not only provides them with the tools to share information about sexual and reproductive health and rights, but also builds self esteem, political skills and overall life planning skills. Young leaders who are part of the “Tu Decides” programme are able to access health services in the CIES clinics for 1 Boliviano per consultation. They also benefit by attending national meetings, networking with other peer educators throughout Bolivia and participating in the CIES governance structure. The youth services under this programme are completely integrated into the CIES clinic, so are included in calculations for financial sustainability.

Since 2007, 2,594 young people have been trained as leaders and 465 public officials and politicians have been sensitised to the needs of young people. Young people receiving training through this programme demonstrate a 40% increase in their knowledge of SRHR. In addition, 1,673 teachers and over 72,000 parents have been trained as part of this programme (CIES data from presentation).

“People used to think that adolescents and young people were no good and could not be trusted. They had a bad image. But now we are finding that adults are more willing to have a dialogue with us”. (Focus group participant, La Paz)

“Tu Decides was a life saver for me. There are so many needs that you have and here they have a space where you can talk about everything. There are also meetings for parents here. Everything I learned here I taught my mum. They give you condoms. I took some home and my mum said she wished she had had some as she had not finish school due to pregnancy.” (Focus group participant, El Alto)

3.2 Efficiency

Organisational efficiency

The review team was pleased with the level of organisational efficiency that was observed during visits and interviews. **Leadership and management** appears to be particularly strong, both at central and clinic level. Leaders and managers have a good knowledge of all programme activities and service use levels. This is partly because of the excellent information and financial management system, which allows clinic level information to be available in real time at the head office. But it also demonstrates good communication between managers and staff.



The CIES vision and strategy is clearly articulated and is well focused on the current priorities of the organisation. The strategic objectives come from an analysis of what is needed in the context and is not designed to fit in with the 5 A's (IPPFs strategic objectives – abortion, aids, adolescents, advocacy and access). However it does fit nicely with the change goals and with the IPPF/WHR strategic plan for 2010-2015. All MAs in the WHR region received input into strategic plans in order to make sure that the priorities established for the region were incorporated into the MAs' strategic plans, taking into account local needs and priorities.

CIES Strategic Objectives

IPPF Change Goals

- 1. Access to sexual and reproductive health
- 2. Research and information for sexual and reproductive rights

Deliver

- 3. Communications
- 4. Advocacy and influence

Unite

- 5. Institutional strengthening
- 6. Financial sustainability

Perform

There is a very good level of awareness of the CIES mission and strategic objectives throughout the organisation. Similar language is used by staff and youth/peer educators around rights and choice in sexual and reproductive health¹³. Some terminology about service delivery came up again and again, for example: “servicios con confianza, confidencialidad y privacidad” (trust, confidentiality and privacy) and “con calidad y calidez” (with quality and warmth/care). This demonstrates an effective coherence within the organisation and effective communications of the CIES strategy and theory around SRHR.

Governance structures appear to be working effectively and are following the IPPF guidance on gender equality and youth participation. The National Assembly consists of 15 women and 9 men – including 4 young people. The Board of Directors consists of 5 women and 1 man. In total, CIES employs 297 people, of which 60% are women. Young people who participate in the assembly are satisfied with the processes for electing members and the functioning of the board¹⁴.

As mentioned before the **management information and financial management** systems are very good. For accounting, routine reports and financial analysis CIES uses the international SAP information system. SAP is arranged into distinct modules, covering most management functions on site: financial and bookkeeping, human resources, and planning. Each module handles specific business tasks on its own, but is linked to the others where applicable. For instance, an invoice from the clinical services billing would pass through accounting, where it will appear in accounts receivable and cost of services sold. This system is used well to monitor and make real-time decisions about programme management.

CIES also use the CORE system for calculating unit costs in the clinics and mobile units. However this system is not well used. The review team found that this information was not up-to-date and the data was not being used to make management decisions at clinic level.

¹³ Interviews and focus groups

¹⁴ Meeting with three youth representatives on the CIES Assembly.



Clinic managers did not have a good understanding of the use of unit cost data. (An analysis of the CORE system and the data is available in section 3.6). CIES is investigating how to integrate the CORE system into the SAP for more effective use, but this alone will not address the issue of management using the information, which may take longer to implement.

CIES has good **management and quality assurance systems**. The Director meets with clinic staff on a monthly basis and they discuss results. Because of the SAP, the Director and the Technical Director can address issues as they see them arising in the data. There is a weekly assessment of clinic data. Quality assurance visits appear to be regular and effective – and there was a good attitude in the clinics to this system. Client satisfaction is measured through regular exit interviews and surveys. However, there appears to be little or no on-going monitoring of the accessibility of the clinics for those who are not using the clinic services. Community-based surveys or peer monitoring of access would be advisable. There is no direct promotion of free services for those who cannot pay. In addition, there is little impact assessment. Results of programmes are articulated in terms of numbers of people served and not in terms of the impact on the community. Better methodology for measuring the social impact over time needs to be developed. The baseline assessment that has been described in Box 1 would be a good place to start with an impact assessment in two or three years, to see what the social impact has been. There should also be some qualitative data collection systems developed.

External visibility and marketing is very strong. CIES runs communications campaigns for certain issues. Recently they circulated leaflets, put up posters and had radio spots for a campaign called “Mamita te quiero sana” (mummy I want you to be healthy). CIES has been successful in developing a close relationship with three TV stations. In exchange for SRHR services to their employees one of the TV stations provides 5 – 7 spots SRHR promotional shorts. There is also a chat show on SRHR once a week. CIES benefits from having hired a professional media and communications expert to take forward this work. It would be useful for him to work closely with the Advocacy lead also to exchange ideas and methodology.

Some aspects of external communications need to be addressed. At times, the organisation is so visible¹⁵ that it overwhelms smaller partners that don't have the same level of resources. They need to take care to support the strengthening of smaller more diverse partners rather than flooding the market with their material and publicity. The message is as important as the institutional image. There is also an issue with the website, which is difficult to navigate. There is a need to target sections to particular audiences – e.g. service users, youth, donors, press, others. In particular the service users need more information and direction. The website does not appear to be for them.

Financial efficiency

The IPR financial management assessment tool was used to assess this aspect of CIES's management practice and medium to high VfM was found for all criteria (see Table 3). Areas for improvement include asset management, payroll and audit functions. Human resource management is very thorough and covers the range of issue that should be expected in an organisation of that size. There is low turnover of staff of about 6%, which may be partly due to the fairly substantial salary increases that the staff have received over the last 5 years. However salaries are in line with the public sector, so the turnover level is a good indication that employees are happy with conditions overall.

¹⁵ Only one interviewee mentioned this, and it was about a couple of events only.



Table 3: CIES Financial Management Assessment

SCORING GRID					
Blocks	Low VfM	Medium VfM			High VfM
	less than 50%	between 51% - 60%	between 61% - 70%	between 71% - 80%	more than 80%
1: Organisation structure and human resource					X
2: Accounting and reporting					X
3: Budgeting and planning systems					X
4: Purchasing and payables					X
5: Invoicing and receivables					X
6: Treasury functions (cash and bank)				X	
7: Payroll			X		
8: Asset management system		X			
9: Audit			X		
Total	-	1	2	1	5

3.4 Effectiveness

CIES has been effective in delivering services to a wide range of people of middle to lower income groups and has also reached some very vulnerable people through special programmes. It is because of the CIES core services and standing capacity and high level of financial sustainability, that they are able to mobilize and provide high quality services to different populations. They also have been effective in influencing and building capacity within the public sector.

There are a few areas where CIES could improve – for example the comprehensive abortion care and the coverage of HIV services. HIV testing services have underperformed against targets in nearly every clinic.

Box 3: Comprehensive Abortion Care

CIES provides post abortion care in all of its clinics and applies a Harm and Risk Reduction Strategy in about 5 clinics (CIES presentation on abortion). Ipas originally trained CIES in use of MVA and they supply the MVA kits. Since then CIES has made a lot of progress in the provision of services and advice – treatment of post abortion complications has increased every year, reaching 55,322 UE services in 2011. However further work is needed to expand the Harm and Risk Reduction work to all of the clinics and services and to prepare for a potential change in the abortion law.

Clinics are of high quality and some have very up to date equipment. The La Paz clinic has been kitted out to be a model clinic and could be used for training in a number of technical areas. At El Alto clinic they deliver between 25 and 30 babies per month. Births only take place on a bed and they do not offer a choice of birth position, which is a bit contrary to overall human rights-based approach.

CIES complements their own health services with pharmacy and lab services sub-contracted through joint ventures with private companies. There are plans to expand these partnerships in the near future. CIES also plans to start a supplies distribution company in order to ensure costs are lowered further and to increase supplies security. Though this is not agreed yet at board level. CIES needs to ensure that their core business and social objectives do not get compromised.



CIES has been effective in developing services that are of interest to central and local government. Local municipalities provide a small proportion of funding for the mobile clinics. CIES intends to increase this proportion every year until the local authorities can take over the entire cost at some point, though this may not be in the near future as funds are scarce. Other forms of funding such as public private partnerships and further cross subsidies may be explored. Public health centres have started using the violence against women methodology (Vivir Sin Violencia) and the protocol introduced by CIES. There is now a national HPV vaccination plan that is owned by the government and was supported by CIES. The ministries of health and education are enabling roll out of the HPV vaccine in schools, though they are in negotiation with GAVI to obtain free vaccines and this may not be possible.

CIES youth leaders have been successful in supporting policy development and legal changes at municipal level (“Cartas Organicas”) and at national level through the Committee Impulsa Juvenile (Youth Action Group). For example, in Tarjia a new Youth Law to prevent sexual violence against children was agreed due to participation of young people in the decision-making processes.

CIES produces a survey every year to assess the vulnerability of people accessing their services (see Box 3). This shows good monitoring of access, but it does not include surveys of those who are not able to access services, but who would want to. CIES could potentially develop a methodology for monitoring non-users with public sector providers, who would be particularly interested in the underserved.

Box 4: Vulnerability assessment survey

CIES has been using the IPPF vulnerability assessment methodology for the last two years and is now helping the WHR office to roll out the tool to the rest of the region. The tool has been adapted to the local context by using local poverty classifications. The National Health Survey (ENSA) questions have been used for the questionnaire. It has also been developed into a computerised system that randomly selects service users for a vulnerability interview over the whole year. Each clinic (or site) interviews up to 100 people every year. The data is collected by the health educator/counsellor and is directly input into the computer programme. This means that the head office can extract real time data at any point in the year. However, the full sample is only available at the end of the year. Verification of data is done when CIES undertakes routine QA visits.

The following classifications are used:

- Poor - People living on less than US\$2 a day.
- Marginalised and socially excluded – People who do not have Access to health, education or employment opportunities for reasons of poverty, physical distance, language, religion, education, employment, migration, or other disadvantage.
- Underserved – People who are not normally served by SRHR services or programmes

In 2010, 56% of CIES’s clients were categorised by this survey as poor, excluded or underserved. The 2011 data showed that this had risen to 72% due to measures taken by the clinics and organisation to better target vulnerable groups.

Advocacy

The advocacy work is extensive and is managed through a range of different interest groups and with members of PROCOSI. This is effective as there are a range of groups giving broadly the same messages. The interest groups are trained and empowered to represent



their communities. The work has also evolved into an empowerment and accountability approach, whereby women and young people have begun to demand better health services from the government. In some instances women are complaining about aspects of certain health centres and so are beginning to provide a kind of social watch. It would be advisable to better evaluate and document this part of the work as there is little international evidence available.

Overall the advocacy work appears a little unfocussed and is a lot for one person to be managing. CIES may want to think about increasing the number of professional staff working on advocacy or sharing staff with other NGOs in PROCOSI. It is really important for CIES to articulate the understanding of its advocacy work in a more logical format so that donors and others can better understand the objectives and methodology. Advocacy projects are particularly difficult to evaluate and it is really important to clearly explain the processes and identify process indicators for success. The following structure may be useful:

- Primary and secondary objectives
- Partners – e.g. PROCOSI
- Networks
- Interest groups – e.g. young people and women
- Communications methods – e.g. direct dialogue, media
- Processes – policy processes or dialogue with authorities
- Influence – e.g. making themselves useful and known, informal communications through contacts with government
- Results – e.g. HPV, Youth Law

Feedback from special target groups

Focus groups revealed a high degree of satisfaction with the CIES health and other services. The young people were particularly pleased with the Tu Decides programme and several of them said that they were interested in becoming politicians, particularly the girls. It was clear that their capacity to lead, their dialogue skills and their knowledge of SRHR was extremely high. It was clear that the new participants were shy and found it difficult to express themselves in contrast to those young people who had been in the programme a number of years – demonstrating the impact that the programme has had on their capabilities.

The street youth were also pleased to be given services and to be treated better than in the public health system. However one or two still had perceptions of being low priority for the clinic. Street children who were not services users had virtually no knowledge of SRHR and did not want to talk.

The women in the empowerment programme had received training from several organisations, but said that the CIES training was the most useful as it meant they could campaign for better health services and control their fertility. They were active in their communities organising women's groups to inform other women of SRHR. However, many of the women were living too far from the CIES clinics to use the services. They were quite keen on a market gardening initiative that another organisation had started with them and would have liked further support for their vegetable gardens. The women were keen to include more men in SRHR training as they were mostly ignorant and negative about family planning. *"I have been using an IUD for 15 years without my husband knowing".*

The LGBT group were non-service users overall as they tended to use other health organisations. However, they were positive about the treatment that they had received from CIES in the past. The perception was that LGBT communities were not a priority for CIES.



Monitoring and evaluation

Monitoring and quality assurance is excellent. There are systems and processes with on-going managerial support and commitment. CIES reporting against indicators to the IPPF Secretariat is not always accurate and there are some discrepancies that have been picked up by the review team. In Table 4 below it shows the differences. The figures in the review results column have either been calculated with data directly from the CIES information system or they have been taken directly from the reporting excel files or from presentations given to the review team. The IPPF column comes directly from the IPPF logframe multi country results spreadsheet. This may just be a question of input errors into the eIMS or communications with London. However the figures need to be checked.

Evaluation and impact assessment is weaker. There was no rigorous evidence of impact provided to the review team beyond service figures and anecdotal evidence. Advocacy impact examples were provided, but these are hard to attribute to just CIES initiatives as there are so many other actors involved. It would be useful if organisations working on advocacy were more transparent about the particular role they played and the role of others when they report on advocacy work.

3.5 Results and Impact

CIES impact goes well beyond the figures that are measurable because of their interaction with the public sector and the youth leadership and education programmes. Their theory of change hinges upon the consecutive implementation of service delivery and enabling environment interventions and interacting with a range of vulnerable groups. There are certain assumptions that could be tested further – but there is already anecdotal evidence that CIES work is impacting the functioning of the health system, the overall cultural and social enabling environment and the attitudes and behaviour of young people.

Table 4: Logframe results from CIES 2011

Selected Indicators	2011 IPPF	IPR calculations (CIES Data) ¹⁶
Unintended pregnancy averted	13,767	7,325
DALYs averted	1,864	3,044
Unsafe abortions averted	5,538	1,878
Successful policy initiatives	8	- ¹⁷
SRH services provided	1,214,059	1,214,059 ¹⁸
SRH services to young people	509,576	508,998
% clients who are vulnerable	57.5%	72%
CYP	47,803	47,691 ¹⁹
HIV/RTI services provided	284,396	284,396 ²⁰
Comprehensive abortion services	6,263	5,990 ²¹
Long term reversible methods	28,018	25,400 ²² (items) 28,018 ²³ (services)
Cost per CYP	£24.80	£4.90

¹⁶ Impact data is calculated using Impact2 Estimator (MSI). CYPs calculated with USAID conversion factors using data from CIES clinics

¹⁷ It was not possible to verify the advocacy results reported to IPPF during the IPR visit.

¹⁸ CIES spreadsheet plus FP data from WHR plus referral data

¹⁹ CYPs calculated with USAID conversion factors using data from CIES clinics

²⁰ CIES reconciled data on number of services provided

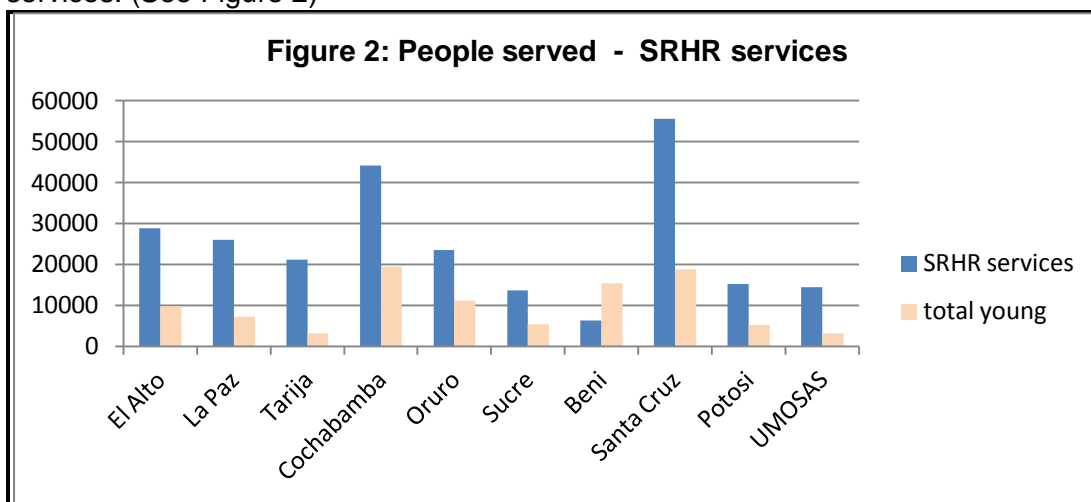
²¹ This figure does not include referrals. With referrals the figure is 6,263

²² CIES clinic data

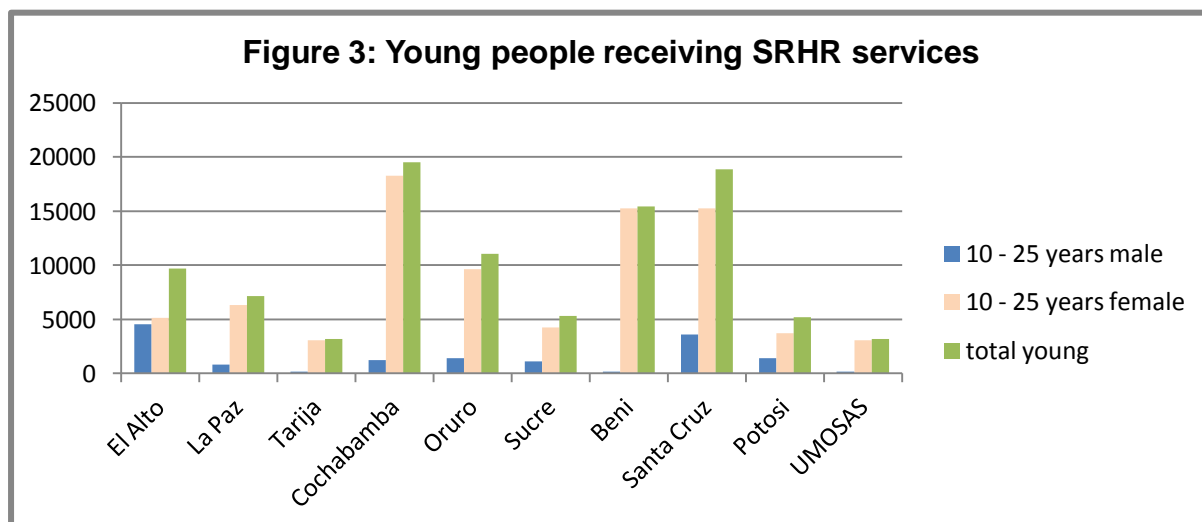
²³ WHR spreadsheet



Overall CIES has exceeded its own targets in most respects. Comprehensive abortion care (CAC) and youth services have performed particularly well. However abortion services remain a small percentage of overall SRH services (less than 0.3% in La Paz and El Alto and about 0.1% in Tarija) and some areas provide no CAC services at all (UMOSAS and Potosi)²⁴. Young people have been accessing between 30 and 50 % of overall SRHR services. (See Figure 2)



However as can be seen from the chart below, the bulk of the youth services are for young women, which may mean that young men either don't need the services or don't perceive that the CIES centres are for them services. Most of the men were receiving services under the "Men's SRH consultation", which does not specify the type of services. Men were not disproportionately represented in any other service type.



Enabling environment

CIES has supported local and national processes and has had results in the following areas:

- Santa Cruz – law ratifying the Latin American Convention on the rights of young people
- Tarija – Law to establish policy to prevent sexual violence against children and adolescents.

²⁴ Data from CIES clinic service data spreadsheets



- La Paz – Violence against women Protocol
- Tarija – Municipal level policy for establishing an HIV prevention committee
- Potosi – Policy to establish a violence prevention day
- La Paz- El Alto Policy for week of youth well being
- Chuquisaca – municipal policy to establish a day against gender based violence
- Chuquisaca – Yamparaez municipal policy for month of November to take action to end violence against women, and funding for activities.

These achievements were listed in CIES's GI report and several of the interviews confirmed the level of municipal and departmental activity that was taking place, especially through the youth organisations. This list indicates a sort of scattergun approach with a number of issues being part of advocacy objectives. In interviews the team had the impression that advocacy objectives were being defined by the interest groups themselves, which is fine, but does mean that a comprehensive and targeted approach might not be possible. The IPR team were not able to visit each of these local governments to verify. Only national government was interviewed.

Finance and attribution

About 2% of CIES's financing can be said to come from DFID PPA, so it is a bit meaningless to attribute specific results directly to the PPA, but the PPA is responsible for overall performance and institutional strengthening, without which CIES would not have been able to achieve what it has.

CIES has been part of an IPPF initiated performance based finance (PBF) pilot (a log frame indicator), which also included the MAs in Barbados, Ghana, Albania, India, Uganda and Cambodia. The pilot relied on MAs to have good quality information systems with reliable data in order to be able to measure and assess performance. Both the Central Office and regional office were involved in the PBF pilot. It involved the production of a baseline and then a calculation of the incentive finance due for different levels of performance. The pilot was completed in 2011. Using the feedback gained from the MAs involved in the pilot study IPPF has further developed the PBF methodology and this has been rolled out across the Federation in 2012 further strengthening the link between funding and performance

Additionality

The funding from IPPF is highly valuable for CIES because of its flexibility and its targeted use for innovation, reaching the most vulnerable and addressing difficult issues. There is also evidence that the money coming from IPPF (as part of the PPA) particularly has had a wider impact on the health system and government services (see section 3.2) and has increased the overall organisational effectiveness of CIES (see section 3.4).

The IPR has also found that CIES is providing important services that would otherwise not be available to street youth, women in rural areas and young people. They are also providing family planning services that are said to be scarce, according to interviewees of the review. USAID reports that 28% of family planning methods in Bolivia in 2011 are coming from CIES and there is still unmet need. Interviewees testified that government clinics were overcrowded, offered poor quality and hardly ever had a choice of FP methods. CIES tends to complement the public sector services and referral exists between them. The only area that might threaten additionality is overlap with other International NGOs who receive DFID PPAs. MSI appears to have a policy of opening up service delivery where there is already an established demand. This means that there may be overlap between CIES and MSI. This needs to be addressed at central office level.



Wider changes in civil society and accountability

CIES' work on women's empowerment and with young people has had a wider impact on citizen-state engagement. Several interviews during the review revealed actions that young people and women are taking to hold the government to account, particularly in the area of SRH services. CIES has also supported LGBT efforts to establish rights.

3.6 Value for Money

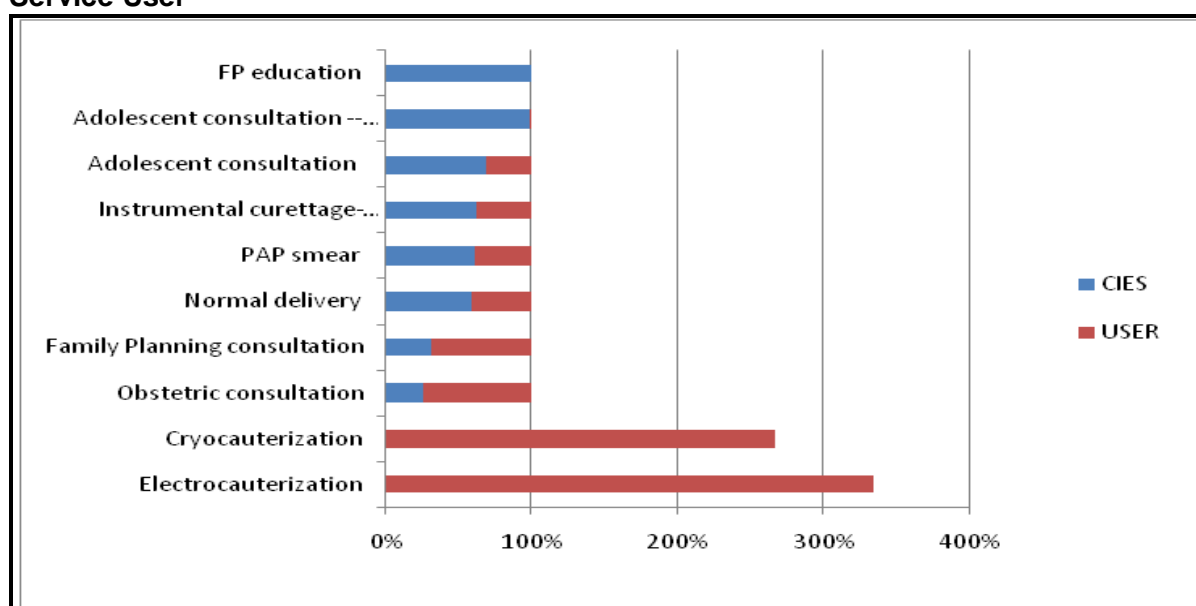
Analysing costs

USAID/MSH has supported CIES in the introduction of several tools to strengthen the organisation and improve its financial sustainability, including the Cost Revenue Analysis program (CORE). CORE was adapted for NGOs in the Latin America region to help clinic networks improve market analysis capacity, and diversification of clinic services.

CORE is a spreadsheet-based analysis tool for determining clinic costs and revenues. The costs of services are estimated from the bottom up, based on normative staffing, or the amount of time staff members spend delivering services; amount of time staff members spend on administrative tasks; and estimation of use of resources. CIES is only able to use this tool as they have established norms for service times that are monitored by clinic managers. Health professionals are obliged to stick within the service norms to maximize clinic efficiency. The tool can be used to do a cost and revenue analysis, comparing the current situation to future scenarios. Revenue analysis includes fees, donations, and grants received from clients, and external sources.

Analysing revenues from users is used to estimate the relationship between the fee charged and the cost of providing a service. For some services, the facility may receive more revenue per service than the amount spent providing it. Producing a surplus on a service or providing the service for a loss is a strategic decision. One such strategy, had been to increase the fee for high tech services - for which there is demand and not much offer in Bolivia for example cryocauterization²⁵'s fees are about 2.5 times higher than actual cost, and counselling poor adolescents on family planning services are free of charge, in an attempt to increase the demand for these services (Figure 4).

Figure 4. Clinic La Paz Selected Services: % of service unit cost funded by CIES and Service User



²⁵ Freezing of abnormal cells on the cervix

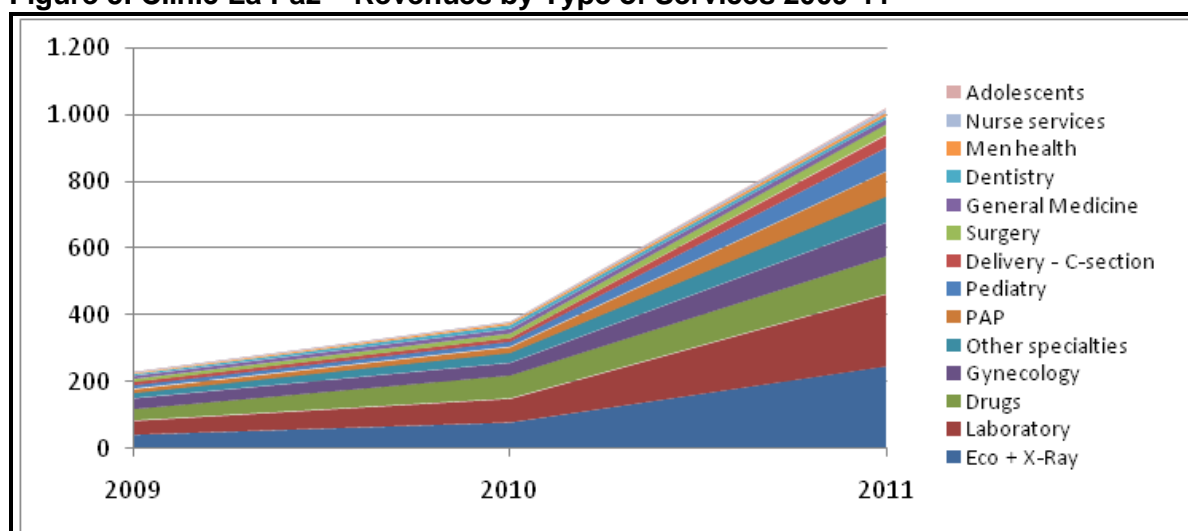


Cross subsidies

One goal in conducting a cost and revenue analysis is to determine how much revenue the clinic could make (while keeping services affordable) and to explore ways in which this revenue could support the cost of providing some other services at a lower cost for clients who are unable to pay. This approach to covering costs is called “cross-subsidisation.” Cross-subsidisation is an important way for an organisation to cover costs while at the same time offering a subsidy for services to the target population and meeting the organization’s goals. Cross-subsidisation can take many forms and CIES uses some of the following strategies:

- **Charging more than full cost for high-demand services to subsidise other services.** CIES subsidises the cost of selected services such as sexual education to adolescents with high-tech services for which a fee is charged that exceeds the cost of providing that service. Using these services to subsidise other services allows CIES to subsidise services for those that can only pay low prices.
- **Increasing the volume of high-revenue services to subsidize others.** Some high-revenue services such as laboratory services recover more revenue than they cost to provide. CIES uses these high-revenue services to subsidise entire categories of services, such as family planning, for which they cannot charge high enough fees to recover the full cost of providing the service (Figure 5).
- **Using some facilities to subsidize other facilities.** CIES has facilities in both middle-income and poorer neighbourhoods, i.e. La Paz and El Alto respectively. In this way, increasing revenues at facilities that serve middle-income groups is helping to subsidize facilities in poorer neighbourhoods. Popular and profitable services (such as x-ray and ultrasound services) in middle income neighbourhoods, like La Paz, could be promoted in order to increase income.

Figure 5. Clinic La Paz – Revenues by Type of Services 2009-11



Clinics Financial Sustainability

To evaluate the financial sustainability of the clinics a ratio of revenues (generated from fees) over expenditures have been calculated for each clinic during the period 2009-2011.

As shown in Table 5 the ratio of sustainability has increase from 60% in 2009 to 77% in 2011. However, there are only two clinics that are financially sustainable Cochabamba and



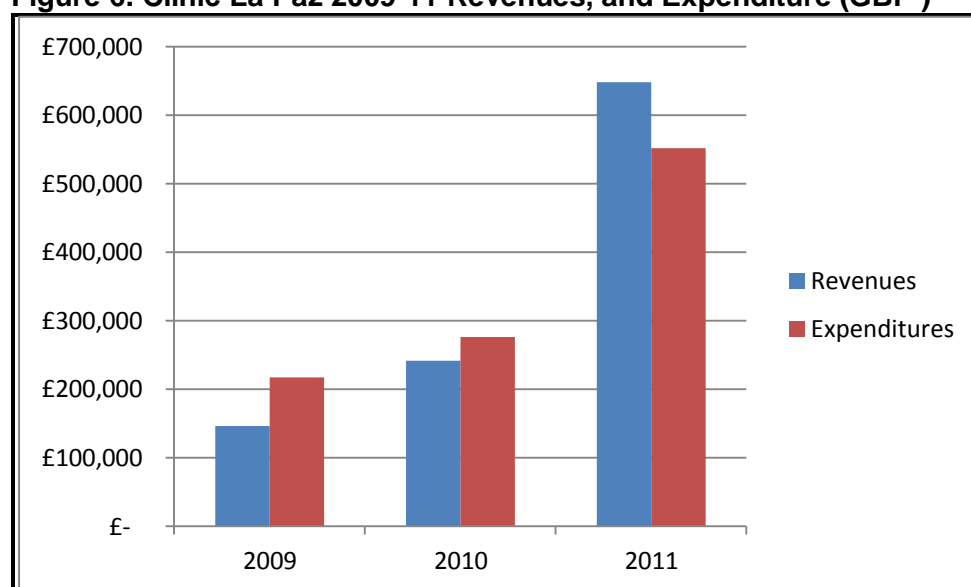
La Paz and that had occurred recently. This is not a problem for the organisation as there is sufficient donor funding to sustain the less profitable clinics and services. It is also important to note that services to some sectors of the population will always need to be subsidised, so sustainability of individual clinics will always vary. However it is also interesting to note that the sustainable clinics of La Paz and Cochabamba are sustaining vibrant youth centres and low cost youth SRH services as part of the clinic services. This shows that financial sustainability is not entirely incompatible with the provision of services to vulnerable groups.

Table 5: CIES Sustainability of 9 Clinics (Revenues as % of Expenditures)

Clinics	2009	2010	2011
Cochabamba	91%	103%	107%
El Alto	81%	87%	90%
La Paz	70%	88%	117%
Oruro	63%	67%	78%
Potosi	51%	54%	61%
Santa Cruz	98%	101%	98%
Sucre	63%	66%	74%
Tarija	66%	74%	90%
Trinidad	44%	45%	41%
TOTAL	60%	69%	77%

According to Figure 6, during the period 2009-2011, Clinic La Paz has doubled its revenue and has become financially sustainable. From covering about one third of its expenditures in 2009, it now has a revenue surplus and is able to subsidise other clinics. This is probably due to the high value services that are offered and the known quality of equipment, health providers and services in the La Paz clinic. In addition it was notable that the clinic director was particularly impressive as a leader and technical expert. Adding new services or new service delivery sites are opportunities for increasing revenue.

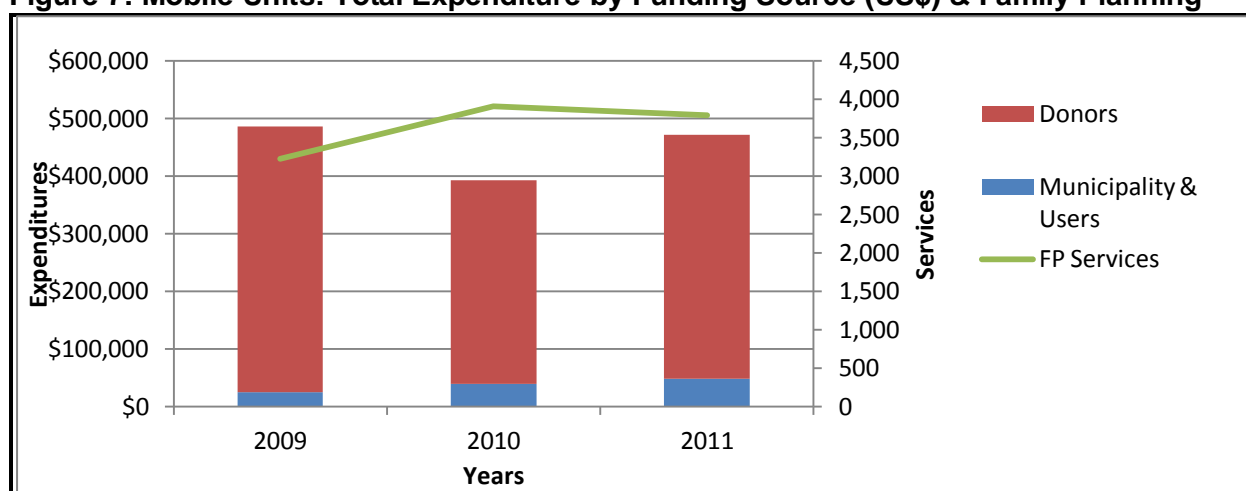
Figure 6. Clinic La Paz 2009-11 Revenues, and Expenditure (GBP)



Mobile Clinics Financial Sustainability

The units make monthly rounds to 11 municipalities, including more than 40 communities. Reaching these communities means driving across rocky and unpaved roads, mountainous cliffs, and flooded valleys for 36 weeks per year - carrying medical supplies and equipment, such as a stretcher, oxygen tank, intravenous kits, pocket-sized ultrasound machines, and medications. Many indigenous women face challenges in receiving proper medical care because of language barriers, and literacy. The mobile clinics' staff speaks Guarani —the most commonly spoken language in Bolivia's rural region. CIES educators also deliver talks promoting health behaviours among both indigenous women and men. These talks cover basic anatomical information, contraceptive methods, sexually transmitted diseases, including HIV/AIDS, women's rights, and prevention of violence against women. CIES works closely with the Ministry of Health to refer high-risk cases -- such as pregnancy related complications, to public medical health centres.

Figure 7: Mobile Units: Total Expenditure by Funding Source (US\$) & Family Planning



The total expenditure of the Rural Mobile Units has been around US\$ 0.42 million during the last year. As we can see in Figure 7, around 90% of total expenditures are donor dependent. However, over the last two years the municipality and users contribution has grown from 5% to 11% of total expenditures. In 2011 the family planning services accounted for just 11% of all mobile health services, which were dominated mostly by general health services and to a lesser extent general gynaecological services.

Unit Costs

The unit costs of services were taken from the CORE system that CIES already has functioning. The economist was able to extract unit costs for certain family planning services from this system for the Cochabamba clinic. However there were some issues with the system and its use. The CORE system in Cochabamba was not up to date and not all methods could be costed. Also it proved difficult to extract any method specific family planning data from La Paz CORE system. The diversification of services (up to 100 types of services) and the growth in the number of services provided by the CIES clinics is leaving the core services of FP underreported in the CORE spreadsheet module. In La Paz Clinic, services are grouped under a general Family planning label and the information is not broken down into different contraceptives, therefore there was no information available on unit cost for individual contraceptives methods. In contrast, Cochabamba with fewer services the unit costs for most important contraceptives services were available in the CORE spreadsheet.



For this reason there are unit costs from other local sources as an estimation in the table below. These were used to build the total expenditure on family planning services. To work out the total expenditure on family planning the total number of family planning services by method was used. This was then multiplied by the unit costs.

Table 6: Unit cost of FP services

Services	Unit Cost (GBP) – 2012	Source
Long-acting and permanent methods		
Female Sterilisation	26.4 ¹	La Prensa.com. Bolivia La Paz 2011
Male Sterilisation	55.6 ¹	La Prensa.com. Bolivia La Paz 2011
Implants- 5 year	34.6	CIES -- Cochabamba Clinic 2012
IUD- 10 year	2.5	CIES --Cochabamba Clinic 2012
Short-term methods		
Condoms	0.6	CIES -- Cochabamba Clinic 2012
Pills (cycles)	6.9	CIES -- Cochabamba Clinic 2012
1-month injectables	8.5	CIES – email communication 2012
3-month injectables	2.7	CIES – email communication 2012
Emergency contraception (pills)	6.1 ²	Newspaper La Razon Bolivia 2012
Total		

Notes ¹Adjusted by 1.25% to include delivery costs. http://www.laprensa.com.bo/diario/actualidad/la-paz/20111008/proponen-implantes-anticonceptivos_8609_14496.html Accessed July 26 2012 ²Adjusted by 10% to include delivery costs Press, http://www.la-razon.com/sociedad/ONG-fomenta-uso-pildora-despues_0_1534046649.html Accessed July 26 2012

Annual Utilization of FP services

The number of services delivered by the clinics and mobile units is based on data provided by CIES and total cost by type of method are derived from the unit cost figures from the previous table 6.

Table 7: Delivery of FP services: Nine Clinics and three Mobile Units 2011

Type of Services	Number	Estimated Total Cost (GBP)
Long-acting and permanent methods		8,821
Female Sterilisation	348	9,187
Male Sterilisation	28	1,557
Implants- 5 year	799	27,645
IUD- 10 year	7,646	19,115
Short-term methods (# commodities)		114,839
Condoms	78,527	47,116
Pills (cycles)	8,686	59,933
1-month injectables	3,079	26,196
3-month injectables	13,876	37,548
Lactational Amenorrhoea Method (LAM)	3,000	
Emergency contraception (EC) (pills)	668	4,075
Country specific method 1	7,003	
Total	123,660	232,373

Short term methods account for the majority of the financial resources, around 73% -- especially pills, condoms and injectables followed by implants, a long term method. CIES have managed to get the cost of some commodities down by accessing supplies from different companies.



Cost effectiveness – whole programme DALYs

Table 8: Cost-effectiveness of the 9 urban clinics and three rural mobiles units 2011

Clinics	Unintended pregnancies averted	Abortions averted	Total DALYs saved	CYP	Total costs (2012 GBP)	Cost per CYP	Cost per DALY (2012 GBP)
Cochabamba	1.999	513	831	8.341	25,405	3.03	31
El Alto	599	154	249	4.883	20,663	4.24	83
La Paz	1.098	281	456	11.892	16,772	1.40	37
Tarija	397	102	165	4.220	14,306	3.40	87
Santa Cruz	401	103	167	2.818	11,135	4.00	67
Sucre	420	108	174	2.856	11,424	4.00	65
Oruro	417	107	173	2.570	10,178	4.00	59
Beni	126	32	52	1.279	9,178	7.20	176
Potosí	516	132	214	1.618	8,113	5.00	38
Subtotal or average	5.972	1.531	2.482	40.477	127,175	3.10	51
Mobile	1.354	347	563	7.214	105,198	14.60	187
Total or average	7.325	1.878	3.044	47.691	232,373	4.90	76

To estimate the Couple Years of Protection (CYP), the USAID CYP conversion factors have been used

The CYP and cost per DALY gained through FP services by clinics and mobile units is estimated by the program Impact2 (see annex 2). The software uses data on utilisation of services, unit costs from Table 6 and assumptions on maternal and child mortality embedded in the software.

The average cost per DALY saved is £76 including the mobile units, and £51 for just the clinics. The mobile units have the highest cost per DALY at £187, which is not surprising as the clinics have to travel large distances over difficult road conditions. The next highest cost per DALY is the clinic located in Beni at £176. These figures are based on the Cochabamba and the externally sourced unit costs, so cannot be considered to present an accurate picture of the differences in cost per DALY of the individual clinics beyond the number of services that they are providing. If CIES were to update the CORE system and to ensure all family planning methods are fully costed it would be fairly simple to undertake the calculations to establish more accurate cost per CYP and cost per DALY by clinic. The overall or average cost per CYP and cost per DALY can be considered to be fairly accurate.

According to WHO, an intervention with a cost-effectiveness ratio less than the national GDP per capita for each DALY gained should be considered highly cost-effective and 2 and 3 times the GDP per capita, as cost-effective. The GDP per capita in Bolivia is US\$1,731 (£1,103) suggesting that all FP services provided by all the clinics are highly cost-effective investments. The average cost per CYP of £4.90 compares very favourably to the cost per user per year of £9.20 (\$14.46) in the Latin America region from a recent Guttmacher/UNFPA report²⁶.

²⁶ Adding it up. Costs and Benefits of Contraceptive Services. Estimates for 2012. Susheela Singh and Jacqueline E. Darroch. Guttmacher Institute and UNFPA. June 2012



3.7 Sustainability

CIES has a strong management drive around sustainability in terms of financial, social and institutional sustainability. The organisation currently covers 43% of its budget from internally generated funds. As seen in the section above, several of the clinics are 100% financially sustainable. The clinics financial costs include the youth programme. It is highly likely that a good deal of the clinic and youth services would be maintained if donor funding were to be cut. However the work with vulnerable groups needs continued funding. Some of this is gradually being taken over by government, but very slowly (e.g. municipalities are funding the mobile units in rural areas and the street children programme in Cochabamba).

Overall the whole CIES programme, being locally owned and driven, shows a high level of institutional sustainability. The relationship and support of government means that many of the initiatives (such as the violence against women and HPV activities) will grow and scale up independently of CIES support. The work on the enabling environment also means that changes supported by CIES will be sustained over the medium to long term.

There have been increases in demand and knowledge of SRHR, that are likely to be sustained within the Bolivian culture once a tipping point has been reached. The key to this is the young people and CIES will need to reach even more young people in order to ensure this takes place.

3.8 Lesson Learning and Innovation

South-South exchange and learning – there is on average \$15,000 available per MA from IPPF's Western Hemisphere Region available for south-south learning visits, material and meetings. This funding is provided by the regional office in New York in response to requests from the MAs in the region. It is financed from IPPF core funds, so the PPA directly contributes. CIES has been both a receiver of learning and has undertaken capacity building in other countries. Notably CIES will be providing support to the Dominican Republic, Central America and Paraguay on the vulnerability assessment methodology. They will give training, demonstrate the tools and support the development of an action plan and budget that the MAs can then present to the regional office. CIES has received support from the Colombia MA on fertility treatment, from the Mexico MA on the Safe abortion harm and risk reduction approach (Nov 2011), from Argentina (FUSA) and Venezuela on providing services to adolescents and on gender based violence. There is a high level of awareness amongst staff of the South-South learning programme and the areas of support that have been received, which suggests good internal cascading of the knowledge.

CIES needs to improve the communication of their work more widely within the country. Specifically impact assessments, change stories and evaluations should be produced and be made widely available. The website only has documents dating back to the 1990s and there are no current evaluations available. There is also a chance for CIES to coordinate the service delivery work and share lessons with members of PROCOSI. Currently the organisation tends to focus on advocacy.

Training and capacity building is good and well thought of within the organisation. CIES clinic staff interviewed were happy with the level and quality of training that they were receiving. Senior and midlevel staff were all very knowledgeable about methodologies and organisational policy, which indicated a good level of internal feedback and lesson learning. Regular monthly meetings of clinic management are used for discussing lessons and monitoring progress. However there was a feeling that less senior staff were missing out on lesson learning and internal communications. There were a couple of interviewees who thought that internal communications and lesson learning could be improved.



Much of CIES's work to reach excluded groups or to provide new services is very innovative. There are few organisations in the country that use the same integrated approach to service delivery, advocacy and empowerment. They are also reaching out to other organisations to link with their services (e.g. micro health insurance). The culture in CIES encourages innovation as there is a high degree of decision making power resting in the clinic management and in the different technical areas. Nearly all senior interviewees referred to both standardised approaches and innovations they had introduced or were thinking of introducing. The government interviewees were particularly pleased with the CIES flexible approach that brought a high level of technical expertise to problem solving.

4. Conclusions and recommendations

4.1 Conclusions

Overall

CIES provides excellent services that are affordable and accessible to a range of poor and vulnerable groups – with services and delivery designed in an appropriate way that is based on:

- Good understanding of the needs of clients and potential clients and the social and cultural barriers to service access
- Technical excellence, good practice and evidence of what works
- Includes referral to other appropriate services

There is some coverage of the most marginal areas in the altiplano (high rural region) through mobile clinics, but this is limited and completely reliant on donor funding (USAID).

CIES success is due to external and internal factors as follows:

External

- Close management and support by USAID and MSH
- South-South cooperation and learning and close collaboration with IPPF
- Effective CSO coordination and cooperation
- Response from the population, especially young people
- Improving enabling environment for human rights and SRHR

Internal

- Excellent leadership and management skills throughout the organisation
- Clinical and quality excellence
- Efficient project management, information and financial systems and monitoring processes
- Being useful to and building relationship with government
- Clear strategy and mission – especially for reaching vulnerable groups

CIES family planning services provide very good value for money. The average cost per DALY saved is £76 including the mobile units, and £51 for just the clinics. The mobile units have the highest cost per DALY at £187. This compares favourably with the GDP per capita in Bolivia of US\$1,731 (£1,103) suggesting that all FP services provided by all the clinics are highly cost-effective investments. The overall cost per CYP of £4.90 compares very favourably to the cost per user per year of £9.20 (\$14.46) in the Latin America region from a recent Guttmacher/UNFPA report²⁷.

²⁷ Adding it up. Costs and Benefits of Contraceptive Services. Estimates for 2012. Susheela Singh and Jacqueline E. Darroch. Guttmacher Institute and UNFPA. June 2012



Risks

1. Relationship with government is good – but CIES need to be careful of losing their strategic focus on SRHR and becoming diluted with all sorts of politically driven initiatives.
2. There is a balance to be struck with the drive for financial sustainability and the social focus and mission to serve poor, vulnerable and underserved people. There is a risk that the organisation could veer towards a more mainstream private sector health provider. However up to now CIES has been managing this balance well and is able to increase access to services for vulnerable groups at the same time as increasing sustainability.

4.2 Lessons Learnt

1. USAID has played an important role in the re-engineering of CIES and the consequent good management practice. (However there are still challenges with the abortion work even though the Global Gag Rule no longer stands). Donors and IPPF can play a catalytic role when the board needs strengthening. Donors can and should provide important technical capacity and drive to support improvement initiatives. IPPF and DFID could aim to take a more active role supporting MA institutional improvements – particularly for better VfM and reaching the most marginalized.
2. Good management, governance and financial information systems are essential for efficient implementation. However the systems need to be accompanied by good leadership and management in order for them to work efficiently. Strong leadership is essential for a strong institution.
3. Financial sustainability can be improved at the same time as increasing access to vulnerable groups. CIES has shown that the percentage of poor and vulnerable users has gone up substantially at a time when clinics are becoming more sustainable. They have also shown how youth and violence against women programmes can be integrated into clinic financial envelope.
4. The CORE programme for producing and analysing unit costs is good enough for CIES and could be used in other MAs. However in order to be used well it requires a strict definition of norms and standards for service times. The calculations of the unit cost are based on these norms rather than clinic surveys of actual time spent on each service. This means that the unit cost is only accurate if there is a high level of discipline in sticking to the norms – a situation which would preclude MAs that do not have good enough clinic management or monitoring systems.
5. The South-South learning programme that is funded and managed by the Western Hemisphere regional office has been successful in driving new initiatives in CIES and for them to promote learning from their own organization (CIES will present the SAP at regional event just after the review visit). This is a lesson for other regions to be more systematic in their approach to South-South learning.
6. The importance of the clinic “educator” or counsellor is underplayed and does not get enough visibility. The educator acts as a gatekeeper and facilitator for the most difficult situations and services. It increases access for young people and for poor people and it also provides essential information about and access to FP, harm reduction service, free services, HIV and STI prevention and detection etc. it is something that marks CIES out from other providers.
7. There is quite advanced work on empowerment and accountability that is growing from the youth “Tu Decides” and women’s empowerment programmes. Better impact assessment and learning needs to come out of this.
8. Diversification of services can lead to a de-prioritisation of family planning, where different FP methods are not being adequately monitored.



4.2 Recommendations

Relevance

1. Better coordinate with other non-state health service delivery organisations, especially international NGOs. Ensure there is a better emphasis on healthy competition rather than unhealthy competition. PROCOSI seems to coordinate mostly for the advocacy activities, but it could also be a body for coordinating service delivery and filling gaps – where also government could be invited in some circumstances.

Efficiency

2. Improve internal communications and lesson learning opportunities for non-management staff.

3. Improve the website. Make sure there is a better understanding of the different audiences that might use the website and how they can access information. It would be good to have different portals for different users: e.g. service users, young people, donors, government etc. There is also an opportunity to have a lot more information on the website that reflects CIES technical capacity. For example for service users there could be a Q&A section on SRHR issues, or sections on certain taboo topics. There also needs to be much better and slicker information for donors, with up to date research and other documents that have been produced by CIES. There should also be summaries of impact, results and VfM for donors. Overall the website needs to be much neater, easier to use and better targeted.

Effectiveness

4. Increase efforts to provide comprehensive abortion care in all facilities and mobile units. CIES has made good progress on providing post abortion care and with their risk and harm reduction programme to avert complications from unsafe abortion. However it would be better if women could access comprehensive abortion services in all CIES clinics. CIES needs to ensure the drive for legal change is sustained and that they work effectively with Ipas – who have extensive experience in these situations.

5. Analyse the reasons for shortfall in HIV services against targets and for the low level of service utilisation by young men and adolescent boys compared to that of young women and girls.

6. Consider providing more women friendly birth services in all clinics – allowing a choice of delivery positions and ensuring a birth plan is completed with the woman in ante-natal care services.

7. Increase efforts to support government to build capacity – particularly in the areas of Health Management Information Systems (HMIS) and financial management. There are also interesting social accountability initiatives that are quite new and that the government may be interested in – for monitoring improvements in the public health service. The work that CIES is doing with government should be shared with other MAs to support the IPPF strategy of impacting on health systems.

8. Ensure that the CIES advocacy team has enough people to deliver the ambitious advocacy plans; and develop a more logical presentation of advocacy objectives and activities. The advocacy activities are extensive and there is only one professional working on this area in the CIES office, though other senior staff are involved as necessar. He has to maintain relationships key government officials and coordinate all of the youth advocacy teams and other activities. CIES should explore sharing of advocacy staff with PROCOSI members or strengthen their own in house department. CIES also needs to have much clearer objectives and monitoring framework for the advocacy work.



9. Develop a better understanding of market segments and develop strategies for reaching different markets with specialised services and differentiated pricing. Ensure that marketing and communications are appropriate for reaching different target groups (this can include a range of media and different methodology at community and national level). More targeting of services to the LGBT community is advisable.

10. Develop a more transparent differentiated payment structure. Make sure that service users and potential users are aware of the conditions under which they can receive free services. This may have to be preceded with some good market research into the level of demand for free services in each of the clinic catchment areas and a risk assessment and mitigation plan for different demand scenarios.

Impact

11. Improve impact assessment. Plan to undertake community based surveys or peer monitoring of access on an on-going basis. One methodology might be to start a longitudinal study with young people in several different communities. Service users and non-service users could be included to see how people's lives are changing over time and what wider impact the programme is having. This would be especially interesting for the "Tu Decides" programme. Overall it would be important to measure impact of the CIES work on the cultural and social enabling environment, including attitudes to gender equality and rights. It would also be important to measure impact on the health system.

Value for money

12. Make the following improvements and incorporate into the routine data collection of the information system:

- **Introduce the main functions of the CORE software into the routine data collection of the SAP system.**
- Ensure clinic management staff keep the CORE figures up to date and that they can use unit cost and market information for fine tuning differentiated pricing and for improving clinic efficiency. Make sure all family planning methods can be costed in the CORE system in each clinic.
- Introduce a more methodical approach to price differentiation and subsidies, including some rules of thumb regarding what price should be set for the services?, what should be maximum and minimum level of cost recovery?, Should core services subsidize others?, where should the focus of marketing be? Which option will produce the greatest total increase in revenue relative to costs? (see recommendation number 9)

13. Explore a more economical arrangement with SAP – a global contract in partnership with other Latin American NGOs or an alternative arrangement with a SAP like software firms.

14. Explore mixed institutional arrangements, where CIES units or subsidiaries that are able to make a profit can directly subsidise activities that are not able to generate profit, such as the mobile units.

Recommendations from the focus groups: young people, women, street kids and LGBT groups:

- Some young people would like all of the services to be free. They think that CIES should set up some kind of social security that covers health services
- There is very little dissemination about what CIES is doing. Many other youth organizations in other sectors do not know about the work that CIES is doing.



- Allow two of the national youth representatives to attend the CIES assembly and board.
- CIES should do more work in schools and universities.
- Provide free maternal delivery services for street youth
- Treatment of street kids should be improved
- Provide services for anorectal disorders
- Provide more services and awareness raising for men – including training on SRHR issues and women's rights



Annex 1: Bibliography

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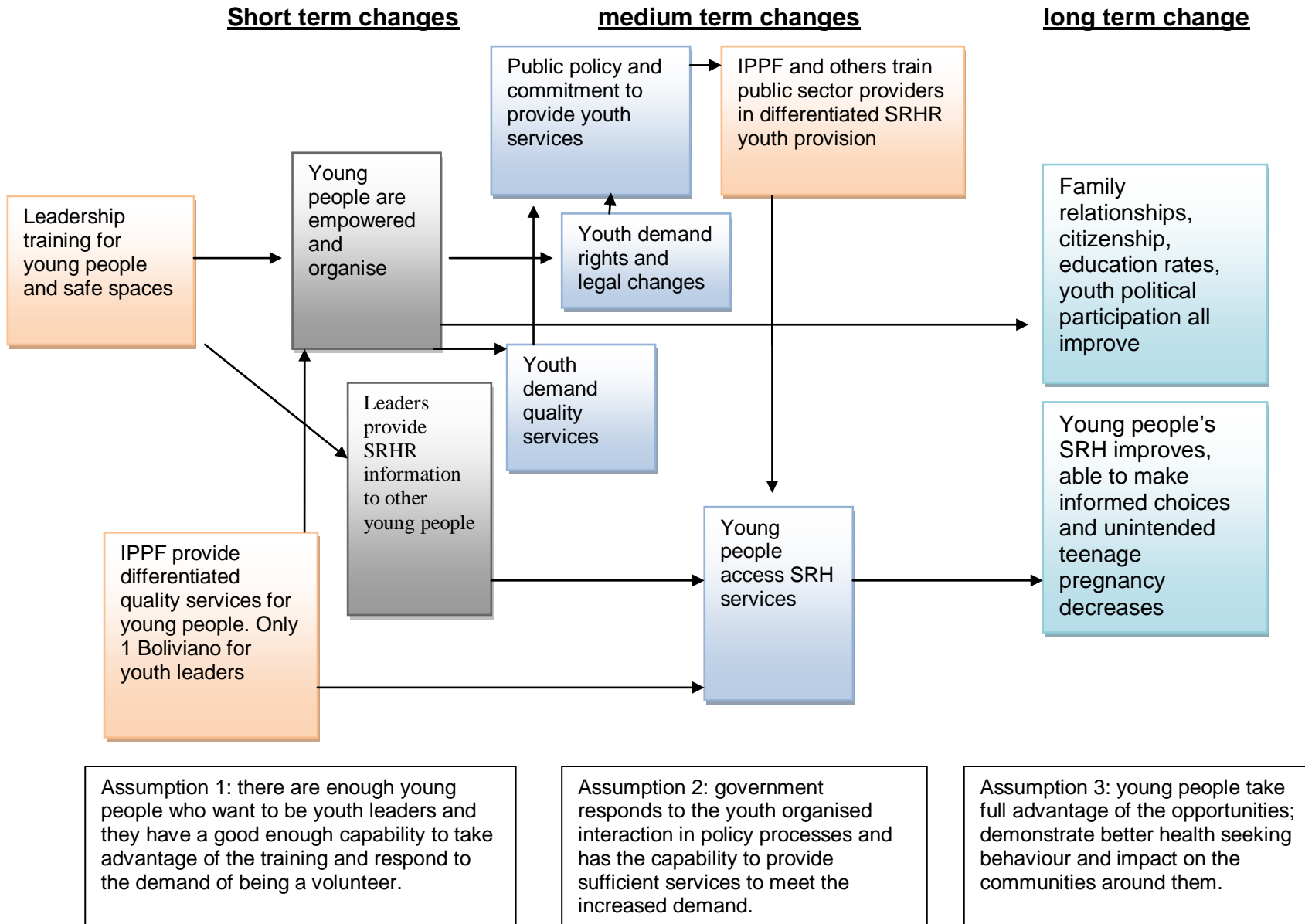


Annex 2: service figures – number of people served

	SRHR services	10 - 25 years male	10 - 25 years female	total young	counselling	VCT	STI	VCT&STI	CAC
El Alto	28773	4549	5166	9715	7594	795	3440	4235	155
La Paz	56798	832	6324	7156	6943	595	2318	2913	150
Tarija	21187	151	3058	3209	7209	785	3278	4063	65
Cochabamba	44122	1208	18281	19489	7107	665	985	1650	193
Oruro	23435	1421	9648	11069	10510	521	2198	2719	151
Sucre	13653	1092	4252	5344	7334	247	1882	2129	146
Beni	6202	184	15236	15420	5852	492	913	1405	125
Santa Cruz	55462	3614	15236	18850	11050	1307	6818	8125	218
Potosi	15166	1438	3743	5181	10285	687	1273	1960	0
UMOSAS	14370	151	3058	3209	6162	0	1509	1509	0
total	248,403	14,640	84,002	98,642	80,046	6,094	24,614	30,708	1203



Annex 3: Theory of Change picture for Youth work – Tu Decides



Annex 4: List of interviewees

CIES

Dr. Jhonny Lopez, Executive Director
Dr. Jose Luis Alfaro, Technical Director
Carlos Cespedes
Pahola Penaranda
Cristian Espindola
Carmina Rojas
Martin Gutierrez, Communications and
Marketing Manager
German Uzeda, Systems Manager

El Alto clinic

Dr Quispe
Carmen Mamani
Freddy Laura

La Paz clinic

C Cespedes

Cochabamba clinic

Fuantina Ugarte
Saul Mareno
Guido Cossio
Roxana Mostajo

PROCOSI

Sergio Aguirre, Programme Director
Cecilia Espinoza, Finance and
Administration Manager
Dr Ignacio Carreno

Ministry of Education

Pilar Chavez

Ministry of Health

Dr Jhonny Vedia

USAID

Dra. Rocio Lara Palma, Health
Programme Officer

Coordinadora de Jovenes

Ana Cecilia Seja, Youth CIES board
member

ADESPROC

Alberto Moscoso Flor, Executive Director

Ipas

Malena Morales, Programme Associate

ProMujer

Mauricio Claure, Commercial and
Marketing Manager
Mauricio Peredo, Planning and Project
Manager

Marie Stopes International, Bolivia

Ramiro Morales, Country Director

Focus Groups:

Young people (10), El Alto
Young people (15), La Paz
Women (7), El Alto
LGBT (3), El Alto
Street Children service users (7),
Cochabamba
Street Children non-service users (3),
Cochabamba
Youth Theatre group, La Paz

