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ASSESSMENT OF THE BOLIVIA REPRODUCTIVE HEALTH SERVICES PROJECT No. 511-0568

by

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Glossary

ASBOLCOF	Bolivian Association for Help to Community and Family
A.I.D.	United States Agency for International Development
AIDS	acquired immune deficiency syndrome
Bs.	Bolivanos (unit of currency)
CCH	Community and Child Health (project)
CEP	Center for Population Studies, San Simon University
CIES	Center for Studies in Research, Education and Services
CNS	National Social Security Institute
COF	Center for Family Education
COMBASE	Bolivian Commission for Evangelical Social Action
CONAPO	National Population Council
CORDECRUZ	Development Corporation of Santa Cruz
CPCCM	Center for Prevention of Cancer in Women
CSM	contraceptive social marketing
DA	Development Associates
DHS	Demographic and Health Survey
DINAP	National Department for Attention to Low Income Population
FAMES	Foundation for Medical-Social Assistance
FPLM	Family Planning Logistics Management (project)
FPMD	Family Planning Management Development (project)
FSG	Fundacion San Gabriel
HIV	human immunodeficiency virus
IDB	Inter-American Development Bank
IEC	information, education, and communication
INE	National Statistics Institute
INOPAL	Operations Research in Family Planning and Maternal Child Health for Latin America and the Caribbean (project)
IPPF	International Planned Parenthood Federation
IUD	intrauterine device
JHPIEGO	Johns Hopkins Program for International Education in Reproductive Health (project)
JSI	John Snow, Inc.
M.Care	Mothercare (project)
ME.DI.CO	Medicine Directed toward the Community
MOH	Ministry of Health
MOP	Ministry of Planning
MSH	Management Sciences for Health
NGO	non-governmental organization
OPTIONS	Options for Population Policy (project)
ORS	oral rehydration salts
PAC IIb	Family Planning Training for Paramedical, Auxiliary, and Community Personnel (project)
PAHO	Pan-American Health Organization
PCS	Population Communication Services (project)
PROMEFA	Pro Family Medicine
PROSALUD	For Health
QUIPUS	computer program for logistics data and service statistics

RAPID	Resources for the Awareness of Population Impact on Development (project)
SIAP	Population Research and Action Service
SOMARC	Social Marketing for Change (project)
STD	sexually transmitted disease
TOT	training of trainers
UNFPA	United Nations Population Fund
UPP	Population Policies Unit

Project Identification Data

1.	Country	Bolivia
2.	Project Title	Reproductive Health Services Project
3.	Project Number	511-0568
4.	Critical Project Dates	
	Project Authorization	July 6, 1990
	Project Completion	September 30, 1995
5.	Project Funding	
	USAID/Bilateral	$9,300,000
	Host Country	$1,348,000

6. Mode of Implementation:
USAID bilateral grant agreement and direct procurement
USAID/Bolivia buy-ins to A.I.D./Washington centrally funded projects

7. Grantees: Ministry of Health, National Social Security Institute, Population Policies Unit

8. Cooperating Agencies:
Development Associates (PAC IIb); The Futures Group (SOMARC, OPTIONS, and RAPID); Johns Hopkins Program for International Education in Reproductive Health (JHPIEGO); Johns Hopkins University (PCS); John Snow, Inc. (Mothercare, FPLM); Management Sciences for Health (FPMD); Pathfinder International; The Population Council (INOPAL).

9. Major Activities:
Support to the Ministry of Health, National Social Security Institute, Population Policies Unit
Technical and financial assistance to NGOs through Cooperating Agencies
Social marketing program
Technical Assistance in IEC, training, research, policy, and service delivery
Project management and coordination

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The team would like to thank the many Bolivians who gave generously of their time, their suggestions, and recommendations. Thanks are due also to staff of USAID/Bolivia, especially those in the Health and Human Resources office, for their assistance, cooperation, and hospitality.

Executive Summary

Introduction

The five-year Reproductive Health Services Project was originally funded in 1990 for $9.3 million with the goal of improving maternal and child health in Bolivia. The project strategy has three elements: 1) support for the government of Bolivia's reproductive health program through assistance to the Ministry of Health, the National Social Security Institute, and the Population Policies Unit in the Ministry of Planning; 2) non-governmental organization activities; and 3) social marketing of contraceptives. Technical and some financial assistance is provided through buy-ins to 11 A.I.D. centrally funded projects implemented by eight Cooperating Agencies.

The project strategy and design were developed in the course of 1989 as a result of a USAID-funded Ministry of Health-Catholic Church sponsored workshop entitled "Fight against Abortion"; a USAID-supported workshop on reproductive health planning; and a government of Bolivia National Plan for Child Survival and Maternal Health which contained an important chapter on reproductive health.

The political climate for a greater effort in reproductive health has become increasingly favorable over the past several years and the project has achieved notable successes. The National Social Security Institute has begun a major effort to include reproductive health services throughout its network of hospitals and clinics; training centers have been established to train staff of various institutions in reproductive health care; the Population Policies Unit has produced an impressive series of population and reproductive health related studies which have contributed to the more favorable climate for reproductive health; several non-governmental organizations have made important progress in strengthening their reproductive health services programs; and the social marketing program is exceeding its goals in terms of contraceptive sales.

Public Sector Activities

Ministry of Health (MOH)

The MOH provides health care to an estimated 34 percent of the population in both urban and rural areas. Until 1989, the ministry did not offer reproductive health care. Reproductive Health Services Project support for the MOH has been limited to assistance for developing norms for reproductive health services in Bolivia, training, some equipment, and help in improving service statistics to better measure achievements in the reproductive health area. USAID's support has been limited because UNFPA/PAHO was to be the principal source of assistance to the MOH for development of its maternal and child health services. The MOH has recently changed its position and has requested USAID support to develop reproductive health services in selected districts where other donors (e.g., World Bank and the Inter-American Development Bank) are giving broader support to strengthen primary health and maternal and child health services. Such support to districts would be in accord with a recent MOH policy decision to decentralize its management structure.

National Social Security Institute (CNS)

The CNS provides integrated health services to insured affiliated employees, representing approximately 15-20 percent of the population, primarily in urban areas. With Reproductive Health Services Project support, including direct financial aid and technical assistance for management development, training, commodities and equipment (much from Cooperating Agencies), the CNS has begun to develop reproductive health services in a number of its facilities. Based on its initial success, and the increasing demand on CNS services in part because of the difficult economic conditions facing the country, CNS is planning to expand reproductive health services to a national scale.

Population Policy Unit (UPP)

The UPP undertakes population-related studies, does secondary analyses of Demographic and Health Surveys, sponsors workshops on population issues, and has an impressive publications program. UPP has developed a reputation for carrying out studies of high quality and for influencing favorably the climate for work in reproductive health.

Non-Governmental Sector Activities

Bolivia has many non-governmental organizations (NGO) active in reproductive health, some of which are large and relatively financially self-sufficient. NGOs add strength to the reproductive health field by broadening political support, testing innovations, and providing competition for the public and other sectors. To date, the Reproductive Health Services Project has provided substantial technical and financial support to PROSALUD, a major provider of primary health care; the Fundacion San Gabriel, which provides health care to a district of La Paz under a contract with the MOH; and CIES, an innovative and influential provider of reproductive health services. Other NGOs have received indirect support (technical assistance, training, and commodities), largely through Cooperating Agencies.

Contraceptive Social Marketing (CSM) Program

The CSM program was begun in 1988 with assistance from the SOMARC project. Local implementation of the CSM program was assigned to PROSALUD in January 1990. First-year sales of a USAID-donated contraceptive pill exceeded the program's target by 100 percent. The Reproductive Health Services Project has supported the CSM program through the buy-in to the SOMARC project, enabling the program to market additional products — a low dose pill and condom — and expand to a greater number of urban and peri-urban pharmacies across the country. The CSM program has already surpassed October 1993 sales targets for two of its products. From January through June 1992, the CSM program sold four times as many pills as were distributed by six USAID-assisted NGOs, the CNS, and the MOH combined. During that same period the CSM program also produced and aired a groundbreaking television campaign on reproductive health and contraceptive methods. The CSM program is now poised to roll-out to the rural areas and begin pilot condom sales through the informal or parallel sector (e.g., itinerant merchants and street vendors).

Cross-Cutting Issues

A number of issues were identified in the course of the evaluation which have relevance to more than one project component. The principal cross-cutting issues are the relative priority of urban versus rural target populations; the appropriate balance of project support for the public sector and for NGOs; measures to improve logistics and service statistics; needed modifications in IEC strategies; opportunities for linking the Reproductive Health Services Project with activities in health and in AIDS/STD; measures to reduce the medical barriers to contraception; and research and training needs in the Reproductive Health Services Project.

Project Management and Coordination

National Coordinating Committee for Reproductive Health

As a result of a USAID initiative, a National Coordinating Committee for Reproductive Health was established for the project. The committee includes representatives of the MOH, CNS, UPP, and an NGO on a rotating basis. There are also four technical subcommittees. This structure has been an effective mechanism for coordinating planning and implementation of project activities.

Implementing Entity for Reproductive Health Work in Health Districts

If USAID decides to help strengthen reproductive health services in selected health districts, it will be necessary to identify or create an implementing entity which can provide support to districts and help coordinate inputs, including those from Cooperating Agencies.

Project Management Unit

A project management unit in the Health and Human Resources Office at USAID is responsible for planning, monitoring, and evaluating project-supported activities. The unit has played an active role in encouraging the development and implementation of reproductive health activities, while being sensitive to political and religious factors.

Major Recommendations

General

1. Given the success of the project after two years and the increasingly favorable government attitude, the project should be extended by two years and funding should be expanded to a total of $16.5 million to accelerate the development of reproductive health services in the CNS and the MOH; to intensify work in training, operations research, and IEC to serve both the public and NGO sectors and to expand into additional urban areas; and to continue the expansion of the CSM program.

Public Sector

2. The project should be amended to provide support to strengthen reproductive health services in selected districts that are receiving support from other donors. Priority should be on urban and

peri-urban areas, but a few rural districts should be included. The project could support several districts initially with expansion to additional districts as experience warrants.

3. The project should continue support for CNS activities as currently designed with increased attention to training, management, IEC, and quality of care. Support should be provided for planning for expansion of reproductive health services to a national scale with technical assistance from the Family Planning Management Development project.

4. The project should continue to support the UPP.

Non-Governmental Sector

5. Major assistance to NGOs should be confined to those NGOs that can have a substantial impact on reproductive health. In this context, support should continue to be provided to PROSALUD, Fundacion San Gabriel, and CIES.

6. Other NGOs that are active in reproductive health, committed to achieving self-sustainability, and willing to provide services should continue to receive limited indirect assistance such as training and access to commodities for sale.

7. A study should be undertaken to determine the current volume and pricing of reproductive health services by private physicians with a view to determining the feasibility of using this group to reach under-served groups.

CSM Program

8. Support to the CSM program should be increased. Direct financial assistance to PROSALUD would permit the CSM program to a) pick up the pace of expansion; b) launch important mass media campaigns, such as the recent one, on a more regular basis; and c) expand its product mix, thus giving low-income Bolivians greater contraceptive choice and increasing the program's potential for cost recovery and eventual self-sustainability. Continued commodity support by USAID is strongly encouraged.

Cross-Cutting Issues

9. The project should retain its focus on urban and peri-urban areas with only selected efforts to reach rural groups. Several second rank cities should be reached through existing project mechanisms (NGOs, CNS, etc.). Together with current project-supported efforts in La Paz, Santa Cruz, and Cochabamba, the Reproductive Health Services Project would be operational in most of Bolivia's urban and peri-urban centers, representing 89 percent of Bolivia's urban population.

10. Given the potential health impact of a strengthened public sector, the balance of project support should be tilted more toward that sector, without neglecting NGOs.

11. The project should support the hiring of a full-time person to provide technical and other assistance to improve logistics and service statistics.

12. IEC activities should be modified to include greater professional input into the process and to accelerate development of messages for key audiences, such as peri-urban and rural women and men.

13. The project should develop linkages with AIDS/STD activities and with such health projects as the Community and Child Health project.

14. The project should support training, IEC and policy work designed to reduce such medical barriers as a limited range of contraceptives, inadequate curriculum in medical and nursing schools, and restrictions on who can provide various contraceptive methods.

15. Support to the INOPAL project should be increased to enable it to provide more technical and other assistance for practical operations research designed to improve reproductive health services.

16. Regarding training, JHPIEGO should continue to assist the reproductive health national training centers to ensure that they are fully functioning as part of a project-wide training plan. Development Associates should be given additional funds to enable it to help develop and implement a project-wide training program.

Project Management and Coordination

17. The project should continue to support the coordinating committee mechanism through financial and technical support from the Cooperating Agencies.

18. The project management unit at USAID should identify or establish an implementing entity which can provide assistance to health districts.

19. The project management unit should ensure that the MOH and the CNS have the necessary technical assistance to undertake a detailed diagnosis and planning effort for development and expansion of reproductive health services.

20. The project management unit should revise the plan for monitoring and evaluating the reproductive health project to take account of inadequacies in the current service statistics systems.

21. The project management unit should ensure that participating Bolivian institutions understand A.I.D. norms and regulations and should give the institutions increased responsibility for decision making regarding implementation of project-supported activities.

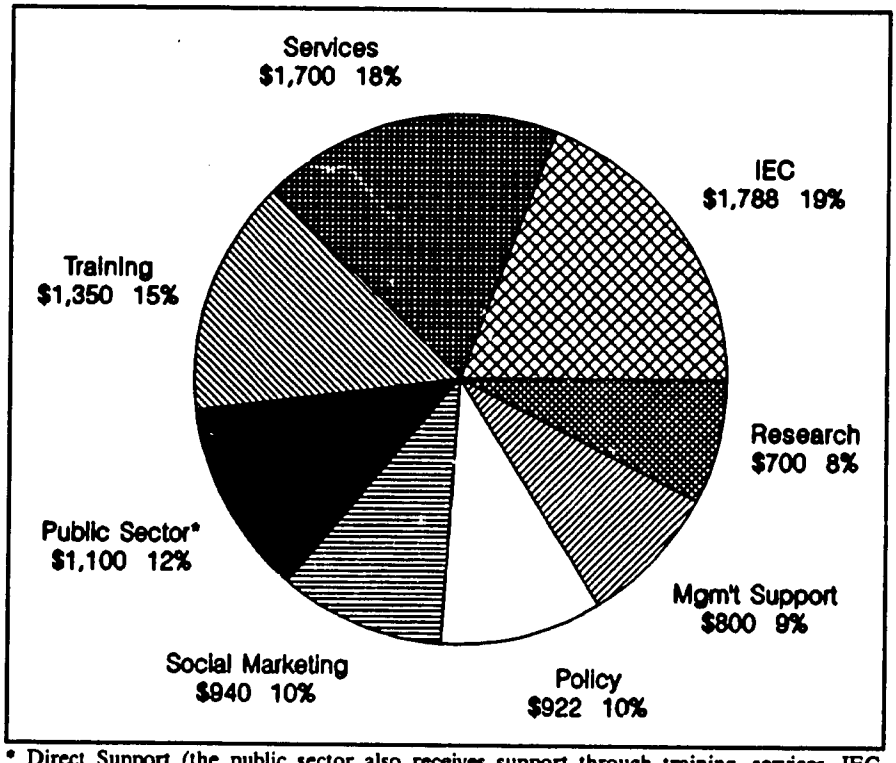
1. Introduction

1.1 Project Description

The Reproductive Health Services Project is a five-year project initially funded in 1990 for $9.3 million with the broad goal to improve maternal and child health in Bolivia. The project purpose is to increase access to and improve the quality of reproductive health services. The project strategy supports three elements 1) the government of Bolivia's reproductive health program; 2) NGO activities; and 3) social marketing of contraceptives. Crossing this sectoral framework, the project supports five technical activities: service provision, IEC, training, research and evaluation, and policy development. Under the bilateral project, USAID provides funds to three public entities: the Ministry of Health, the National Social Security Institute, and Population Policies Unit in the Ministry of Planning. Technical assistance is provided via a series of buy-ins to 11 centrally funded A.I.D. project implemented by eight Cooperating Agencies. Figure 1 highlights the amount of funding originally planned in the Project Paper.

Figure 1

Planned Project Funding
$9.3 Million



* Direct Support (the public sector also receives support through training, services, IEC, research, and management support.)
Note: Total of components does not equal 100 percent due to rounding.

1.2 Assessment Purpose and Objectives

The purpose of the present assessment is 1) to evaluate the strengths and weaknesses of the strategy of the project which consists of three elements: support for the government of Bolivia's reproductive health program; support for non-governmental organizations (NGO); and social marketing of contraceptives, and 2) to determine whether the priorities and strategy continue to be appropriate in the current Bolivian context.

The assessment objectives are to 1) examine the accomplishments to date of the three project components; 2) assess the issues and challenges of each component; 3) respond to a number of cross-cutting themes; and 4) provide recommendations regarding current and future project strategies. The team was also asked to examine the management structure for implementing the recommended strategy. See Appendix A for the complete assessment scope of work.

1.3 Team Composition and Assessment Methodology

The team consisted of Robert Wickham, management consultant and team leader; Brandel France de Bravo, consultant in social marketing; Earle Lawrence, A.I.D./Washington Office of Population staff member and communication specialist; and Jennifer Macias, International Population Fellow.

The assessment was carried out September 8-25, 1992. Team members reviewed documents; were briefed by USAID/Bolivia staff; and met with representatives of Bolivian governmental and non-governmental organizations, USAID staff, donor agency representatives, and staff of Cooperating Agencies (see Appendix B for the list of persons interviewed). The team divided into three groups for field trips with USAID/Bolivia staff to Santa Cruz, Cochabamba, and Oruro.

1.4 Country Background

Bolivia is a landlocked country of 6.3 million people within an area of 1,098,581 square kilometers. A nation of vast arable land, mineral and forest resources, potential energy sources, towering ice-capped mountains, extended semi-arid wastes and tropical rain forests, it remains the second poorest nation in the Western Hemisphere. There are three distinct ecological zones: the Altiplano (high plain), comprising 21 percent of Bolivia's territory and 46 percent of the population; the valleys, comprising 15 percent of the territory and 27 percent of the population; and the jungle and lowlands, comprising 64 percent of the territory and 27 percent of the population.

Bolivia's population is ethnically mixed — Mestizo (mixed Indian and Spanish), Quechua Indian, Aymara Indian, and those of European origin. The official language is Spanish; however, in the rural areas and in the city *barrios* (marginal or low income areas of the cities), the majority of people speak Quechua or Aymara.

Bolivia has a history of political and economic instability. Democracy has prevailed since 1983 despite a devastating economic crisis throughout the 1980s. The economy suffered a severe contraction due to internal factors such as drought in the highlands, flooding in the lowlands, and tremendous inflation. External factors such as lower export prices, particularly for tin, a withholding of overseas credits and investments, and higher interest rates contributed to the crisis. By the late 1980s, structural adjustment policies were in place. A serious attempt was made, at considerable cost to the

people, to turn the economy around and create the conditions for sustained growth. The country has maintained its stabilization regime and for the first time in more than a decade, economic growth is being achieved as indicated in 1991 with a 4.2 percent gross domestic product growth rate.

Bolivian democracy, for all its institutional weakness and fragility, has continued to hold fast. Nevertheless, the years of economic stabilization without growth and inadequate care for the country's people have resulted in an emerging populist political tide which could have counterproductive consequences for economic stability and growth, democratic processes and stability, and such transnational issues as narcotics and the environment. Next year, 1993, promises to be a watershed for political activity; elections will be held in May with the new government in place in August.

1.5 Demographic and Health Data

Table 1

Bolivia Demographic and Health Data

Population Size[1]	6.4 million
urban	58%
rural	42%
under 15/over 65	43%/3%
growth rate	2.03%
Population Doubling Time	34 years
Birth Rate[2]	36/1,000 population
Death Rate	10/1,000 population
Life Expectancy at Birth	58 male/64 female
Infant Mortality[3]	91/1000 live births
urban	75/1000 live births
rural	114/1000 live births
Child Mortality[4]	157/1000 (under 5 years)
Maternal Mortality	48/10,000 births
Total Fertility Rate[3]	4.8
urban	3.2
rural	6.2
Contraceptive Prevalence Rate[5]	30% total/12% modern
Abortion Rate	23/1000 women of reproductive age (est.)
Family Planning Sources[5]	
Private doctors	54%
Ministry of Health	29%
Pharmacies	9%
National Social Security Institute	4%
Others	3%
Family Planning Clinics	1%

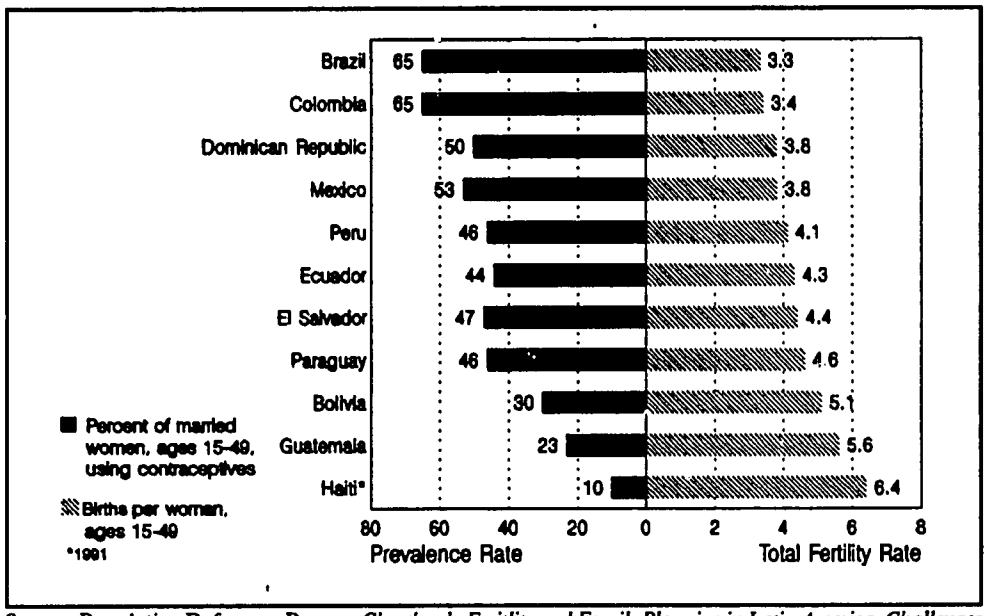
1. Preliminary Census (June 1992) Results.
2. World Population Data Sheet, 1992. Population Reference Bureau.
3. Situacion de la Planificacion Familiar en Bolivia. Unidad de Política de Población. La Paz: 1992.
4. Child Survival, 1985-1990: A Sixth Report to Congress on the USAID Program, Washington, D.C., May 1991.
5. INE-DHS. Encuesta Nacional de Demografía y Salud. 1989

1.6 Reproductive Health Background

Reproductive health is a sensitive policy issue in Bolivia. However, the low contraceptive prevalence rate, the large unmet need for family planning services, and the importance of reproductive health for improving maternal and child health (MCH) have made it necessary for USAID to try to find a way to work with Bolivia's traditional official opposition to family planning. See Figures 2-4.

Figure 2

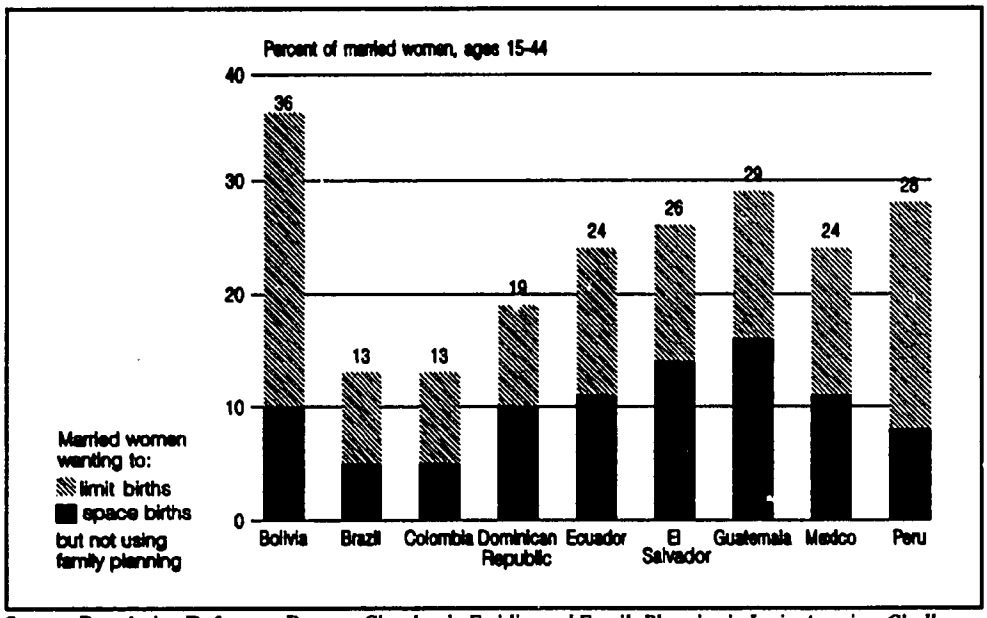
Contraceptive Prevalence and Total Fertility Rates, 1990



Source: Population Reference Bureau. *Chartbook: Feritlity and Family Planning in Latin America: Challenges of the 1990s* (undated).

Figure 3

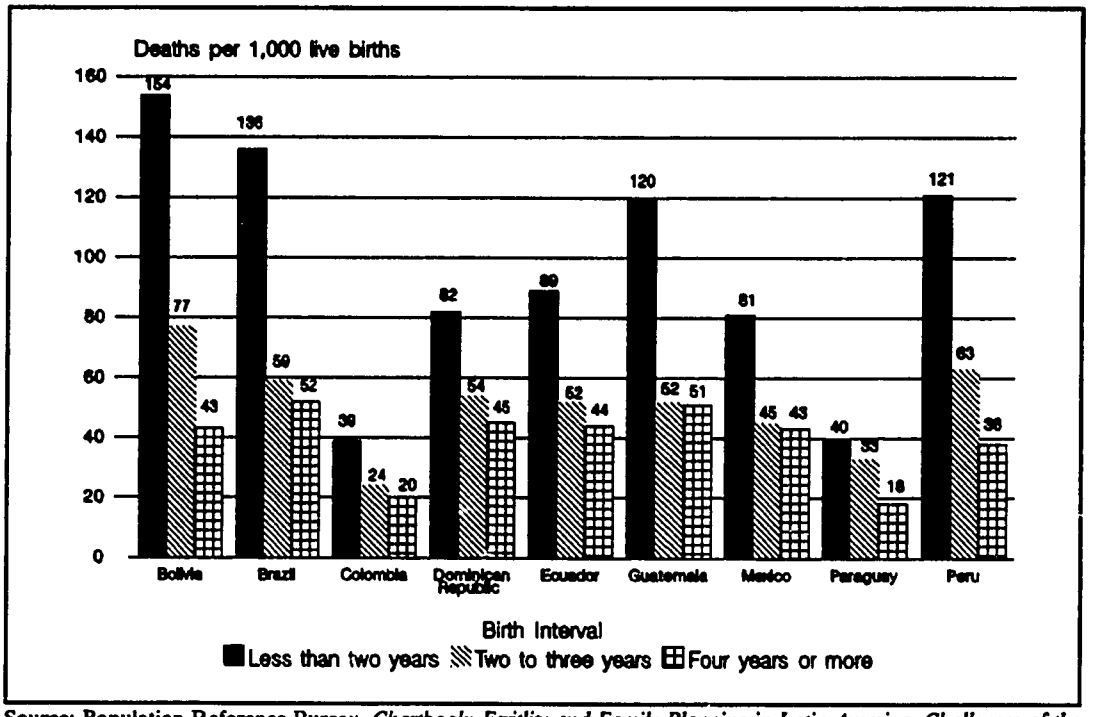
Unmet Need for Family Planning



Source: Population Reference Bureau. *Chartbook: Feritlity and Family Planning in Latin America: Challenges of the 1990s* (undated).

Figure 4

Infant Mortality Rates by Interval Between Births



Source: Population Reference Bureau. *Chartbook: Feritlity and Family Planning in Latin America: Challenges of the 1990s* (undated).

Work in family planning in Bolivia has faced significant obstacles during the last 20 years. Though from opposing camps, the two main social sectors opposing the expansion of family planning have been the Catholic Church and grass-root and leftist political organizations.

In 1968, a movie called *The Blood of the Condor* alleged that United States Peace Corps volunteers were sterilizing native women. As a consequence of the protests aroused by the film, the Peace Corps was expelled from the country in 1971 and did not return until 1990 to work in non-health development activities. Criticism of family planning activities made large segments of the population sensitive to the issues of population reduction and foreign intervention.

For many years, the government of Bolivia had a pro-natalist orientation. The argument was that Bolivia had a low population density, with vast sparsely populated areas, and that there was a need to increase the population size in order to populate all areas of the country.

During the 1970s, UNFPA began a maternal/child health care project which planned, among other things, to provide family planning services at Ministry of Health (MOH) facilities. When project commodities first arrived in 1975, however, Catholic church officials denounced the project as "massive birth control" and the government of Bolivia had to cancel the family planning component of the project. Due to this negative reception, the growth of services was insignificant and modern contraceptive prevalence remained unchanged for 15 years.

Concern about the need for family planning services started growing again in the late 1980s. In 1983, Westinghouse Health Systems with a local NGO conducted the first contraceptive prevalence survey

in Bolivia. The survey showed that only 10 percent of the women of reproductive age were using modern contraceptive methods.

By 1985, several small A.I.D. centrally funded population activities were under way, supporting local NGOs doing demographic research; information, education, and communication (IEC); and service delivery. CONAPO, the National Population Council within the Ministry of Planning, was founded with USAID support. With technical assistance from the Integrated Population and Development Planning (INPLAN) and Resources for the Awareness of Population Impact on Development (RAPID) projects, CONAPO developed a two-pronged strategy to present the population issue. First, regional demographic analyses were conducted to show that, although the national population density was low, certain regions of the country suffered from serious population pressure on the ecology and local economy. The second line of action was to educate policy makers on the relationship between fertility and infant and maternal health and mortality.

In 1986, USAID approached the MOH about initiating a contraceptive social marketing program with the A.I.D. Social Marketing for Change (SOMARC) project. The MOH did not agree to support this activity, so in 1988 USAID sought the help of the Bolivian Society of Gynecology and Obstetrics. The society agreed to support the program as long as there was no mention of any specific family planning method or publicity for the SOMARC products. The SOMARC program started distribution of family planning methods in 1989 through a commercial importer. The program was subsequently transferred to PROSALUD (For Health), an NGO in Santa Cruz, currently the official SOMARC local representative.

In 1987, USAID entered into a $35,000 Limited Scope Grant Agreement with the MCH Division of the MOH to provide limited family planning services to patients with abortion complications. The original name of this program, "Selective Family Planning," was later changed to "Lucha Contra el Aborto (Fight against Abortion)." Even this cautious approach was not supported by MOH officials, however, and almost no services were provided.

In 1989, USAID sponsored a national Demographic and Health Survey (DHS). The findings were critical in reinforcing the message of the linkage between reproductive health and child survival. (See Section 1.6).

In March 1989, USAID provided the total funding for a joint MOH-Catholic Church workshop also entitled "Fight against Abortion." The workshop was attended by over 100 representatives of public sector, private sector, union, church, and women's groups. The workshop recommendations stated that women have the human right to information and access to family planning methods. The workshop further recommended that the government of Bolivia should support this right to access, that family planning should be incorporated into government health programs, and that couples should be permitted to decide voluntarily on the size and spacing of their children. This breakthrough was tempered by a proviso saying that measures should be taken to stop "foreign intervention" in population policy decisions and activities in the country. These recommendations clearly influenced some of the political parties during the subsequent elections of May 1989. The new government that took office in August of that year quickly reversed the traditional government of Bolivia stance against family planning.

In October 1989, USAID conducted a workshop on reproductive health planning which resulted in the design of the first major bilateral USAID population project in Bolivia, the current Reproductive Health Services Project. This was the first time that the MOH and private family planning

institutions met to discuss plans in the reproductive health area. A.I.D.'s centrally funded population Cooperating Agencies were also invited to participate and describe their activities and resources.

In November 1989, the government of Bolivia launched the National Plan for Child Survival and Maternal Health, which contained an important chapter on reproductive health. This marked the initiation of reproductive health services within the Bolivian MOH and a legalization of the activities of all NGOs working in the field. USAID provided technical assistance in the development of the plan, and an executive presentation of the plan was made to the president of Bolivia, to his cabinet, and to national and regional public and private institutions. The USAID Reproductive Health Services Project agreement with the government of Bolivia was signed in July 1990.

The political environment in recent months has become less favorable toward reproductive health activities due to two factors. First, preliminary census results, published in July 1992, indicate a smaller total population than projected, yet tremendous urban growth. The Catholic Church has seized on these results to reinforce its opposition to family planning services. Second, because elections are planned for May 1993, the government remains unwilling to take a public stance in favor of reproductive health services. Nevertheless, given that the Reproductive Health Services Project is founded on a health rationale, the long-term prospects for its continued success remain positive, particularly given increased demand and developing service capability.

2. Overview of Project Implementation

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2. Overview of Project Implementation

In the two years of project operation, the project has achieved significant success. Although it is too early in project implementation to measure statistical output, progress can be seen in all project components. Some highlights include the following:

- A National Coordinating Committee for the government's Reproductive Health Program and for the Reproductive Health Services Project (which to a considerable extent are the same) has been established by the MOH, the Population Policies Unit (UPP), the National Social Security Institute (CNS), the Bolivian Society of Gynecology and Obstetrics, the Pan American Health Organization (PAHO), and USAID. Under the committee, technical subcommittees for services, IEC, training, research and evaluation, and policy were formed. All these committees function with the technical and financial support of the pertinent CAs. Many NGOs send representatives to subcommittee meetings.

- The CNS has launched a major effort to include reproductive health services throughout its national system of hospitals and clinics. The program is developing in Santa Cruz and Cochabamba and is expanding in La Paz and El Alto.

- The MOH has established systems for aggregating service statistics and facilitating contraceptive services delivery. An OPTIONS subproject has provided technical assistance in the QUIPUS system, a computer program for tracking and managing contraceptive logistics.

- The IEC subcommittee, with technical assistance from the Population Communication Services (PCS) project, has produced a national logo and print materials that are being used by the MOH and NGOs around the country. The Mothercare project in Cochabamba has launched a mass media project that will cover all aspects of maternal/child health.

- Two training centers for clinical methods have been established by the Johns Hopkins Program for International Education in Reproductive Health (JHPIEGO) and training programs have begun. Development Associates, through the PAC IIb project, has begun a training of trainers (TOT) program and has begun work on incorporating reproductive health into the curriculum of auxiliary nursing schools. Training has focused on both private and public sectors.

- In support of the research and policy component, the UPP has produced a large array of detailed and comprehensive studies. The Population Council's Operations Research in Family Planning and Maternal Child Health for Latin America and the Caribbean (INOPAL) project has set up a country office and embarked on a number of studies.

- Close to a dozen NGOs have received direct or indirect (commodities or training) assistance under the project.

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- PROSALUD, an NGO which manages a network of non-profit, primary health care clinics and which has the potential for having a national impact, is already making progress in meeting the reproductive health needs of a significant number of women in Santa Cruz, has launched a program in El Alto, and will soon open clinics in La Paz.

- The Fundacion San Gabriel, an NGO, is offering health services in La Paz's District 3 under a contractual arrangement with the MOH, and is one of the national training centers.

- The Center for Studies in Research, Education, and Services (CIES), an NGO with clinics in La Paz, El Alto, Oruro, and Potosi, is undergoing major reorganization with the assistance of the Family Planning Management Development (FPMD) project.

- The social marketing program, now managed by PROSALUD, has already surpassed sales targets laid out in the Project Paper. The program also launched a television campaign with technical assistance from SOMARC.

Recommendation

1. Given the initial success of the Reproductive Health Services Project, expansion of activities, particularly in the public sector, is warranted. The project should be extended for at least two years. The overall funding should be increased by $7.2 million for a total of $16.5 million. Figure 5 shows how increases would be allocated. Although a pipeline analysis of expenditures indicates ample margins currently, additional funds need to be allocated for the following reasons:

a. The start-up phase of the project has ended and many of the activities (e.g., the CNS, IEC, training, and social marketing activities) will be accelerating their expenditure rates in the second half of the project.

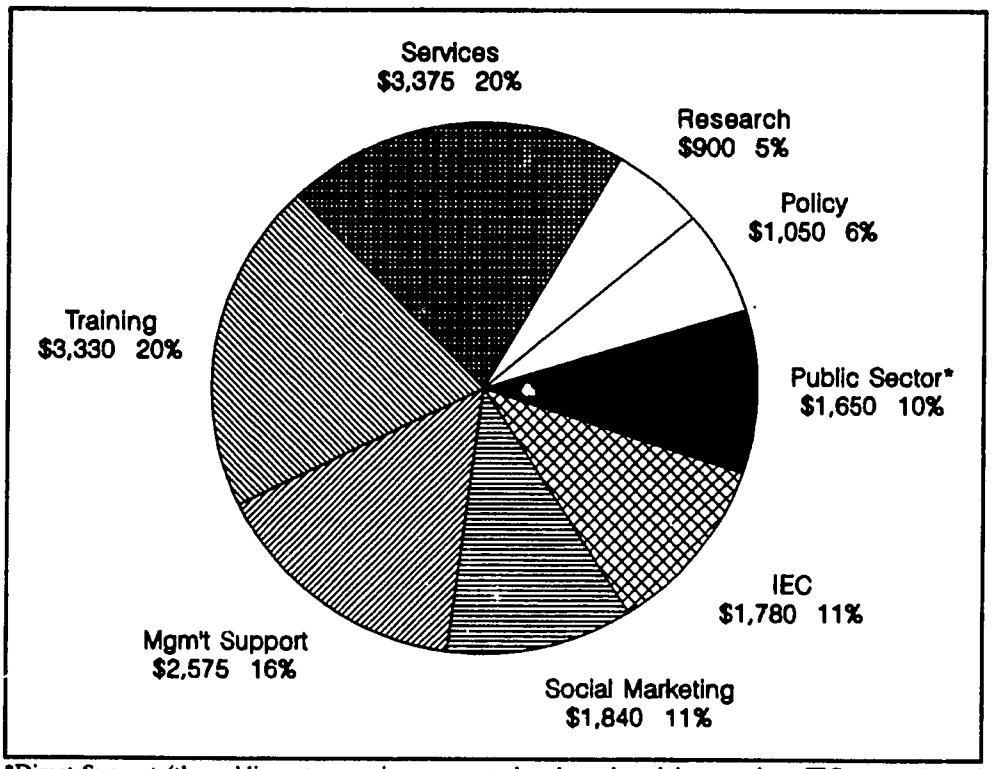
b. By appropriately seizing targets of opportunity, the project managers have invested beyond the planned amounts in priority activities such as services, training, management, and project coordination carried out by Pathfinder International, Mothercare, and FPMD.

c. New opportunities are opening up, particularly in public sector health services, which warrant greater investment. An implementation unit and an increased level of buy-ins to centrally funded projects will need to be funded immediately to take advantage of these opportunities.

In addition to new initiatives with the MOH, the recommended expansion of project activities calls for greater depth and breadth of existing activities. For example, the research portfolio of INOPAL would expand to accommodate urgent needs of service providers. Existing IEC and training activities and indirect NGO support would be expanded to include the areas of Tarija, Oruro, and Sucre. Together with current efforts in La Paz, Cochabamba, and Santa Cruz, the Reproductive Health Services Project would be operational in most of Bolivia's urban and peri-urban centers, representing 89 percent of Bolivia's urban population.

Figure 5

Recommended Project Funding
$16.5 Million



*Direct Support (the public sector receives support also through training, services, IEC, research, and management support.)
Note: Total of components does not equal 100 percent due to rounding.

3. Public Sector

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3. Public Sector

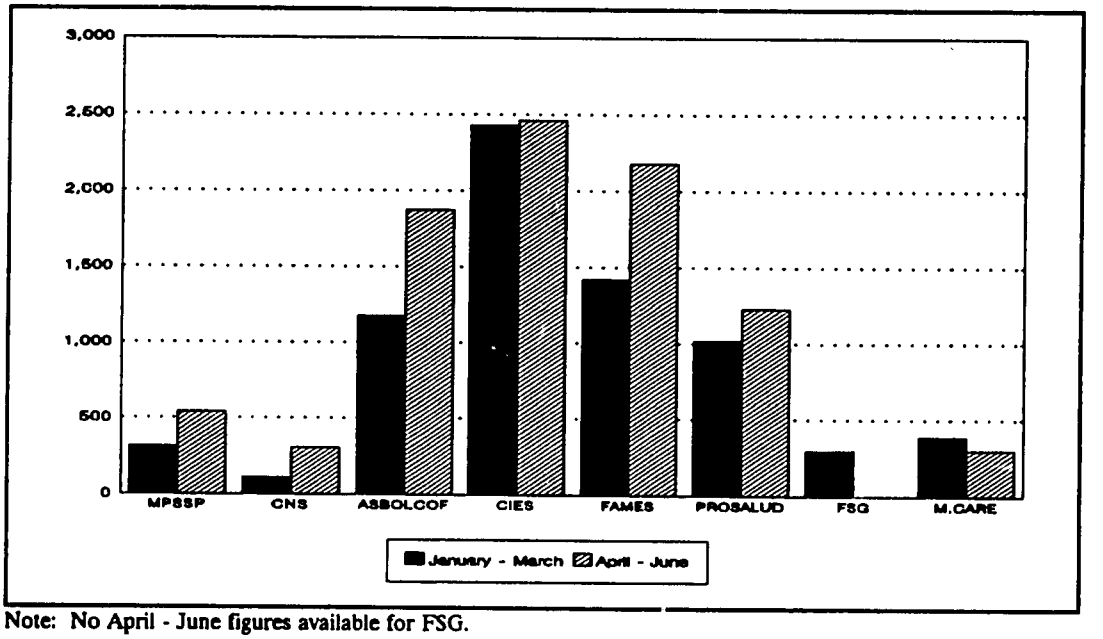
3.1 Ministry of Health

The MOH provides health care to an estimated 34 percent of the population. With a substantial health services infrastructure (hospitals in most of Bolivia's 88 districts and 448 area health centers), the MOH has considerable potential to be a major provider of reproductive health services. As discussed in Section 1.6, with the gradual change towards a more favorable attitude toward reproductive health and family planning, the MOH launched a National Plan for Child Survival and Maternal Health in November 1989. On the basis of this plan, the MOH, with support from PAHO/UNFPA, began the process of developing MCH services, including family planning. The PAHO/UNFPA support was designed to help establish reproductive health services in up to 30 of Bolivia's 88 districts by 1995. The MOH also accepted support from USAID's Reproductive Health Services Project for training and curriculum development in reproductive health, equipment, production of IEC materials, and technical assistance in logistics and development of service delivery norms.

Progress in developing MCH and reproductive health services in MOH facilities through PAHO/UNFPA support has been relatively slow (see Figure 6 and Table 2). After two years, the program is operating in a limited number of districts, quality of care is at a rudimentary stage, and desertion of trained staff in some districts has been substantial. A.I.D. assistance through JHPIEGO has contributed to the establishment of an MOH reproductive health training center at the Garita de Lima health facility in La Paz and at an MOH maternity hospital in Cochabamba. JHPIEGO has also helped the MOH to develop reproductive health service norms which are being distributed throughout the ministry. Curricula in reproductive health have been developed with the assistance of Development Associates for auxiliary nursing schools. With technical assistance from the PCS project, the MOH has prepared and distributed some IEC materials. Less progress has been made in improving logistics.

Figure 6

New Family Planning Users by Institution and Trimester for 1992



Note: No April - June figures available for FSG.

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Table 2

Service Statistics, 1992

	Jan.-Mar.	Apr.-July
MOH		
new visits	314	541
revisits	360	916
CNS		
new visits	107	307
revisits	229	328
PROSALUD		
new visits	1,021	1,230
revisits	3,549	3,114
CIES		
new visits	2,432	2,463
revisits	4,841	4,011
FAMES		
new visits	1,425	2,181
revisits	252	1,445
Fundacion San Gabriel		
new visits	295	not available
revisits	669	not available
Mothercare		
new visits	389	302
revisits	224	226
ASBOLCOF		
new visits	1,178	1,876
revisits	130	189
TOTAL		
new visits	7,161	8,900
revisits	10,254	10,229

The MOH unit responsible for reproductive health has recently asked USAID for additional assistance for reproduction of IEC materials, for additional training centers, for JHPIEGO help with medical and nursing school curriculum reform, and possibly technical assistance from INOPAL for operations research.

The director general of the MOH has requested USAID support to develop reproductive health services in health districts which are receiving support from such donor agencies as the World Bank and the Inter-American Development Bank (IDB). USAID assistance to districts, rather than through MOH headquarters, would be in accordance with MOH policy to decentralize responsibility for provision of health care. The World Bank project is to function in 17 urban districts located in

four *unidades* (units). World Bank support will include strengthening service delivery; in-service training; and institutional development at the MOH's central level. The World Bank is encouraging the ministry to enter into agreements with NGOs whereby the latter will operate health services in some geographic areas. The World Bank project also includes a structured effort to develop links with communities in order to identify priority health problems. The IDB project will operate in six rural and six urban districts of six *unidades*. Project activities include strengthening health services through infrastructure improvement and equipment; institutional strengthening, including decentralization; and strengthening primary health care, with emphasis on MCH. Representatives of both the World Bank and IDB indicated that support from USAID in reproductive health in selected districts could result in improved quality of reproductive health care.

Recommendations

2. The Reproductive Health Services Project should be amended to provide support to strengthen reproductive health services in selected districts which are receiving support for improved service delivery from the World Bank, IDB, the Community and Child Health (CCH) project,[1] and other donors. Priority should be on urban and peri-urban areas, but a few rural districts should be included. Required support should be determined on the basis of detailed diagnosis and planning carried out collaboratively with district and *unidad* authorities and the relevant donor agency. The project could support several districts initially with expansion to additional districts as experience warrants. Criteria should be developed for selection of districts to participate in the project. Criteria could include committed leadership in reproductive health at the district level; commitment to maintain key staff in place for at least two years; support from the *unidad* level; selection of two districts from a given *unidad* to facilitate exchange of experience between districts and to make training and other interventions more cost effective. In order to implement this recommendation, it would be necessary for the USAID Health and Human Resources Office to identify or create an implementing entity. This is discussed further in Section 7.2.

3. Project management should explore with the MOH unit responsible for reproductive health what additional support is needed (e.g., IEC, training centers, etc.) to strengthen the ministry's reproductive health work and how the CAs that participate in the project could best assist. Support to the MOH should be designed so as to reinforce the development of reproductive health service capability in the selected districts.

3.2 National Social Security Institute

The CNS provides integrated health services to insured affiliated employees, who constitute approximately 20-25 percent of the population primarily in the urban areas of Bolivia. Although at the forefront of advocating family planning services in the late 1980s, the CNS did not expand services beyond one hospital in La Paz until early 1992. The CNS plans to implement the

[1]This is a USAID-funded effort to strengthen, among other things, primary health care and water supplies in six rural health districts.

reproductive health program in a network of 15 hospitals and selected urban polyclinics. The CNS receives direct funding from the Reproductive Health Services Project, management support from Management Sciences for Health, and technical assistance, commodities, and equipment from Pathfinder. The director of the reproductive health services program sits on the National Coordinating Committee, and CNS personnel participate on the IEC, services, and training subcommittees. The CNS is using the IEC materials produced by the subcommittee.

The CNS has begun to expand services after two years of considerable management and technical inputs. The CNS now offers services in two hospitals and four polyclinics in the La Paz/El Alto urban area. In July 1992, it initiated services in Cochabamba and Santa Cruz. In Santa Cruz, four gynecologists and three family doctors have been trained to insert IUDs. In Cochabamba, five family doctors and several clinical gynecologists provide reproductive health services. Trained nurses and social workers are integrated within the system. There are plans to replicate training internally for all technical levels.

Demand for CNS services is increasing with the deteriorating economic situation in Bolivia. Service statistics in La Paz highlight significant growth in new family planning clients. Although it is too early to judge progress in the regions, site visits confirmed overflowing clinics and personnel enthusiastic about providing reproductive health services, but the quality of the care provided is at a low level. Regional directors are also supportive, although gynecologists continue to resist providing family planning with the CNS primarily for personal economic reasons. Gynecologists passively resist providing family planning within CNS by referring women to their private practices. Also, gynecologists oppose family planning training of CNS "family doctors," stating that this service should be provided by specialists, thus limiting the number of providers.

The CNS is an important component in the overall effort to improve reproductive health services. The potential for service expansion and outreach to women in the fertile age range is tremendous. An opportunity exists to develop and maintain a reputation for quality care. To assure a good quality program, management support, technical training and communication activities must be enhanced. Strategic thinking and planning must be reinforced to expand the program nationally.

Recommendations

4. Support for this activity as currently designed should be continued with increased attention to training, management (including clinic management), IEC, and quality of care. Pathfinder is in a particularly strong position to provide continued technical assistance for improved clinic management.

5. Support should be provided for detailed diagnosis and planning for expansion of the reproductive health program to a national scale by 1993. FPMD is the appropriate CA to provide this assistance.

3.3 Population Policies Unit

The UPP (formerly CONAPO) is located in the Ministry of Planning. The UPP undertakes studies of population issues (e.g., the status of family planning in Bolivia), does secondary analyses (e.g., of the 1989 DHS), publishes information bulletins, and sponsors workshops on population-related topics. Studies resulting from analyses of the 1989 DHS include the status of family planning in urban areas

of Bolivia; family planning among migrant and native women; case studies on reproductive behavior, contraception among adolescents, and sterilization in the female population. UPP also contracts with Bolivian research entities for special studies. UPP's principal focus currently is on reproductive health; consequently, it works closely with the MOH and participates in the National Coordinating Committee for the Reproductive Health Program (see Section 7.1). UPP has also established a national data bank on population and development and has contributed a draft chapter on population policies for a national social development strategy which the government of Bolivia is currently in the process of formulating. UPP has reached agreement with the National Statistics Institute to do the secondary analysis of the 1992 census.

Support from the Reproductive Health Services Project includes direct financial assistance for staff salaries and for studies and operating costs as well as technical assistance from Research Triangle Institute.

UPP has developed a reputation for carrying out high-quality population-related studies and for influencing favorably the climate for work in reproductive health. At the same time, the Ministry of Planning's current focus on economic more than social development means that UPP's role is probably less influential than it has been in the past.

<u>Recommendation</u>

6. The Reproductive Health Services Project should maintain a flexible position with respect to support in the area of policy. If the political/governmental climate is favorable, support to UPP should be continued at current levels for additional studies and analyses. If the climate is less favorable, the project should support UPP at a reduced level and should seek ways of funding studies at such Bolivian research institutions as the Development Corporation of Santa Cruz (CORDECRUZ), the Center for Population Studies, San Simon University (CEP), and Population Research and Action Service (SIAP).

4. Non-Governmental Sector

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4. Non-Governmental Sector

4.1 Non-Governmental Organizations

NGOs add strength and vitality to national reproductive health programs by broadening political support, reaching special target groups, testing innovations, creating competition with other sectors, and sometimes offering a superior standard for quality of care and a model of excellence. Bolivia has many non-governmental organizations active in reproductive health, some of which are largely self-sustaining or nearly self-sustaining institutions. Bolivia does not, however, have an International Planned Parenthood Federation (IPPF) affiliate at this time.

To date, the Reproductive Health Services Project has provided different levels of indirect support to two categories of NGOs: 1) those which because of size, good management, relative financial self-sufficiency, reputation, impact on reproductive health or a combination of these are thought to warrant substantial continuing financial and technical assistance; and 2) those which have less chance of having an impact on reproductive health because of limited coverage, unlikelihood of achieving substantial financial self-sufficiency, lack of strong management, etc., and thus do not warrant substantial assistance. Some of the NGOs that have received major institutional or project support include PROSALUD, the Fundacion San Gabriel, and CIES. Another group of NGOs has received a modest level of support through Mothercare or other groups. These include ASBOLCOF, FAMES (for contraceptive logistics and distribution), ME.DI.CO., COMBASE, PROMEFA, and CPCCM, the Center for Prevention of Cancer in Women. A third group of small NGOs, including SIAP, COF, and others, has received training, commodities, and other in-kind assistance from various CAs. See Appendix D for a brief description of the major NGOs involved in reproductive health.

The dilemma faced by donors worldwide in attempting to support not-for-profit private sector institutions is that despite the vigor and importance of these groups, a cost-benefit analysis of their activities is problematic. Typically, such efforts are costly and global experience has shown limited results. In the case of health NGOs, the limited number of women who receive reproductive health services makes the costs per beneficiary too high and prohibits programs from demonstrating a national impact. Economic self-sustainability is an important goal for NGO programs. The USAID/Bolivia position to date has been to give the most support to those NGOs with the greatest coverage. The following recommendations reinforce the existing policy and should assist in subsequent impact evaluations of this component.

Recommendations

7. Major assistance under the Reproductive Health Services Project should be confined to those NGOs that can have a substantial impact on reproductive health.

8. Direct support should be provided to PROSALUD to facilitate the rate of clinic expansion in El Alto and La Paz and to test a health clinic franchising concept. Indirect support of PROSALUD should be continued and expanded appropriate to the institution's absorptive capacity. (See Section 5 on the contraceptive marketing program for suggested assistance to the PROSALUD social marketing effort).

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9. Support for Fundacion San Gabriel should be increased to extend reproductive health services to its outreach clinics and networks.

10. Management support for CIES, through FPMD, should continue contingent upon a strong commitment on the part of CIES and rapid progress toward self-sufficiency.

11. Other NGOs active in reproductive health that are committed to self-sustainability and willing to provide service statistics should continue to receive limited indirect assistance such as training and access to commodities (which must be sold rather than given away).

12. Criteria for limited grants to selected NGOs should be established. They should include service to special target groups of interest to USAID and collaboration in operations research activities.

4.2 Private Physicians

The Reproductive Health Services Project does not have direct activities with private physicians. However, the project design, through activities with both the commercial and private not-for-profit groups, recognizes the importance of this sector. In many mature programs, the commercial sector and private physicians supply up to 70 percent or more of reproductive health services. According to the 1989 DHS, 54 percent of reproductive health services in Bolivia was provided by private physicians. Indirect support is given to the private physicians who are trained under the project by virtue of their holding appointments in the public sector in addition to their private practices.

Not enough is known about the nature of reproductive health services supplied by private physicians or the potential of this group to serve an expanded clientele through minor incentives.

Recommendation

13. A study should be undertaken to determine the current volume and pricing structure of reproductive health services supplied by private physicians, the extent of underemployment in this group, and the feasibility of utilizing this resource to reach under-served groups.

5. The Contraceptive Social Marketing Program

5. The Contraceptive Social Marketing Program

5.1 Program Overview

The goal of the contraceptive social marketing (CSM) program is to increase family planning knowledge and use of modern contraceptive methods in Bolivia. Program objectives include 1) making affordable, high-quality contraceptives available to middle- and low-income Bolivians through the commercial infrastructure; 2) conducting appropriate market research and collecting impact data; and 3) producing educational, motivational, and promotional materials and media. The program was targeted to reach urban populations first and then to roll-out to the rural areas in the later phases.

The CSM program was begun in 1988 by SOMARC. Under the Reproductive Health Services Project, SOMARC channels funds and provides technical assistance to the program. Since January 1990, PROSALUD has been the local entity responsible for program implementation (previously it was sponsored by the Society of Gynecology and Obstetrics). PROSALUD's largely self-financing clinics began offering family planning as part of their reproductive health package in 1990-91. The CSM program manager works out of PROSALUD headquarters in Santa Cruz but is paid by SOMARC.

In 1989, the CSM program launched its first product — a contraceptive pill donated by USAID and marketed under the brand name of Noriday. The first year sales target of 20,000 cycles was easily met and surpassed.

In July of 1990, the CSM program began sales of Sultan condoms on behalf of the MOH which found that it had a surplus of the USAID-donated commodity (the MOH had earmarked the condoms for STD/AIDS prevention activities, but had received more than it could use in these efforts). The CSM program packaged, promoted, and distributed the condoms, giving the larger share of sales revenues to the MOH. The CSM program has already sold all the Sultan condoms given it by the MOH and is now receiving Sultan condoms directly from USAID/Bolivia under the mission's AIDS/STD Prevention and Control Project.

In December of 1991, the CSM program added to its product mix a low dose, slightly higher-priced pill (Minigynon) made available to the program by Schering. This new pill comes already packaged and currently sells for 3 Bolivianos (Bs.) as compared with Noriday which sells for 2.5 Bs. Schering gives the CSM program a share of Minigynon sales revenues in exchange for the program's promotional support of the product.

Since moving from the Society of Gynecology and Obstetrics, the CSM program has dismissed or replaced many of its subcontractors, including the distributor, Abendroth. The program recently re-registered its products under PROSALUD, and in early 1992 contracted a new distributor. The new distributor, ACENTRAL, which is headquartered in Cochabamba, has no exclusive rights and has an extensive national distribution network. In addition to the CSM program, it expects to work with other, departmental distributors with rural coverage. In 1993, the CSM program plans to hire additional staff (2-3 persons) to help develop non-traditional points of sale in the informal or parallel sector (itinerant merchants and street vendors).

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The market research firm responsible for twice yearly pharmacy audits has performed only one, and it fell short of the assigned scope of work.

Recent work with the production company Atelier resulted in the groundbreaking reproductive health campaign that aired on Bolivian television from the end of April 1992 through June 1992. The eight spots that constituted the campaign were the first to openly discuss and depict reproductive organs, contraceptive methods, sexually transmitted diseases including HIV/AIDS, etc.

Cost recovery efforts, which are not a specific program objective but are expected to be built into the program over time, have taken a backseat to more important issues such as creating an appropriate social climate for improving reproductive health and expanding the program's coverage. The launch of Protektor condoms (SOMARC's regional brand), slated for early 1993, will provide for increased cost recovery. Protektor's price is expected to be two and half times that of Sultan (2.5 Bs. versus 1 B. for a three-pack).

5.2 Sales Figures

By October 1993 the CSM program was to have sold 186,000 cycles of Noriday and 738,000 condoms. To date, the program has sold over 270,000 cycles of Noriday and 829,407 condoms, putting it a full year ahead of schedule.

5.3 Product Positioning

According to the CSM program's draft marketing plan for 1992-94, the program is planning to promote the higher-priced Minigynon and Protektor at the expense of the lower-priced Noriday and Sultan. Plans to phase out Sultan have to do with A.I.D.'s decision to discontinue the brand. Sultan's demise aside, CSM program plans reflect longstanding SOMARC policy, which has been 1) to wean social marketing programs from donated commodities by transferring the responsibility for social marketing to private contraceptive manufacturers such as Schering, and 2) to increase cost recovery, thus Protektor's relatively high price.

Evidence indicates that Noriday and Sultan are popular, well-established brands. A quick phase-out of these brands may not be advisable, particularly as the program plans to expand to rural areas where the higher price of Minigynon and Protektor could be a barrier to use.

5.4 CSM Program Sales Compared with Other Provider Service Statistics

In 1991 the CSM program sold 88,934 cycles of Noriday, nearly two and a half times the amount distributed or sold by five USAID-assisted NGOs (37,900). The CNS (National Social Security Institute) distributed 200 cycles. The CSM program sold 376,743 Sultan condoms in 1991. The NGOs sold or distributed 680,000 condoms.

In the first six months of 1992, the CSM program sold 64,761 cycles of pills (Noriday and Minigynon combined), or four times as many cycles as were sold or distributed by six USAID-assisted NGOs, the CNS, and the MOH combined (see Table 3). In those same six months, the CSM program managed to sell 165,168 Sultans in spite of stock-outs and a change of distributor, as compared with 169,245

condoms sold or distributed by six USAID-assisted NGOs. The CNS and MOH together distributed and sold nearly 3,000 condoms.

Table 3

CSM Program Sales Compared with Other Providers

1991		
	PILLS (cycles)	CONDOMS (pieces)
PUBLIC		
1. CNS	200	11,300
NGOs		
1. CIES	1,900	348,000
2. FAMES	10,100	243,900
3. PROSALUD	13,600	6,900
4. ASBOLCOF	8,900	61,400
5. Mothercare	3,400	19,800
TOTAL	37,900	680,000
CSM	88,934	376,743
1992 (Jan.-June)		
	PILLS (cycles)	CONDOMS (pieces)
PUBLIC		
1. CNS	252	806
2. MOH	197*	2,144*
NGOs		
1. CIES	689	101,585
2. FAMES	4,267	37,471
3. PROSALUD	8,953	2,961
4. ASBOLCOF	1,059	24,477
5. Mothercare	501	2,409
6. F. San Gabriel	66*	342*
TOTAL	15,535	169,245
CSM	64,761	165,168

* = First quarter only

5.5 SOMARC's Management of Buy-In Funds

SOMARC pays 100 percent of the CSM program manager's salary. The program manager devotes approximately 65 percent of his time to the CSM program and 35 percent to helping PROSALUD market its clinical services. The program manager can afford to divide his time in this manner because often he is unable to proceed with social marketing activities while waiting for approvals or

a disbursal of funds from SOMARC. SOMARC's management structure appears unduly complicated: the chief technical advisor to the program is in Colombia; the regional office is located in Mexico; and the central office which controls all financial decisions is in Washington, D.C.

Movement or disbursement of funds is one problem; under-budgeting could prove to be another. The Reproductive Health Services Project's yearly buy-in to SOMARC has ranged from $150,000 to $250,000. If mass media campaigns such as the most recent one are to be carried out on a yearly basis, however, these amounts are insufficient. The eight-spot campaign, totaling 23 minutes, cost less than $15,000 to produce but over $100,000 to air.

The CSM program manager appears able and ready to handle greater technical and financial responsibility.

5.6 The CSM Program and PROSALUD

The CSM program manager is clearly involved in PROSALUD activities, but the degree to which PROSALUD is involved in the CSM program, or to which the two entities interact, is somewhat unclear. PROSALUD rents office space to the CSM program, handles its accounts, etc. The only CSM product that PROSALUD sells at present is Minigynon. PROSALUD's institutional marketing capacity consists of one person — the CSM program manager. Additional staff are scheduled to come on board in 1993.

5.7 Coordination between the CSM Program and Other Components of the Reproductive Health Services Project

The CSM program has little or no interaction with the other components of USAID's Reproductive Health Services Project. The NGOs do not seem to be referring their continuing pill and condom users to the CSM products available in pharmacies. The CSM program manager attends IEC subcommittee meetings from time to time. He did not mention ever having attended services subcommittee meetings.

Recommendations

14. SOMARC should use the remaining planned buy-in funds over the proposed extended life of project (until September 1997) for technical assistance. An additional $900,000 should be provided directly through the appropriate funding mechanism to PROSALUD for management and implementation of the CSM program, including salaries.

15. Social marketing, in general, and the CSM program, in particular, should be firmly institutionalized within PROSALUD. The current program manager and the additional staff scheduled to come on board in 1993 should all become full-fledged PROSALUD employees.

16. The CSM program should expand its product mix. Funds to PROSALUD for CSM should be front-loaded so that the program can make a serious push towards acquiring

new contraceptive and other products essential to increasing its potential for cost-recovery and eventual self-sustainability.

17. USAID should continue to provide pills and condoms for the CSM program. As mentioned above, the CSM program should maintain a low-priced pill and condom in its product mix.

18. An effort should be made toward greater coordination between the CSM program and NGOs. A CSM program staff member should try to attend IEC subcommittee meetings once quarterly. The CSM program manager should market the CSM program — the social marketing approach as well as the program's products — to the NGOs and other providers of reproductive health services.

19. The role of the CSM program should be expanded to include supplying the NGOs with commodities. By 1995/96, the CSM program should be carrying the same mix of products currently offered by NGOs in their clinics and through community-based distribution, i.e., IUDs, pills, condoms, and spermicides. By that time, all USAID-assisted NGOs should be charging clients for family planning commodities.

6. Cross-Cutting Issues

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6. Cross-Cutting Issues

6.1 Priority Target Groups

The project has focused on the urban and peri-urban populations around La Paz, Santa Cruz, and Cochabamba. It has included some rural areas where special targets of opportunity have been available, such as the Mothercare work in Inquisivi and operations research and training activities in rural areas in the department of Cochabamba. The urban and peri-urban emphasis, with a few highly focused rural activities, has given the project guidance for inputs and is likely to achieve a solid impact.

To date, over half of Reproductive Health Services Project resources has been directed to the non-governmental sector. An additional 10 percent has gone to CSM activities.

Recommendations

20. The project should retain its focus on urban and peri-urban populations with selected rural activities that provide knowledge and experience for reaching this group.

21. Through existing mechanisms (NGOs, the CNS, etc.) and expanded MOH activities, Tarija, Oruro, and Sucre should be added to La Paz, Santa Cruz, and Cochabamba as target areas for the project. With the addition of these secondary cities, the project will be operational in most of Bolivia's major urban and peri-urban centers, representing 89 percent of Bolivia's urban population.

22. Men should be included as a special target group, given their importance in reproductive health decision making. Also, young adults should be a special target group because of their predominance in the population.

23. Given the potential health impact of a strengthened public sector and the growth potential of the commercial sector (CSM), the balance of project support should be tilted more toward those sectors, without neglecting NGOs.

6.2 IEC Activities

A large part of the IEC activities are being orchestrated through the IEC subcommittee, implemented by individual agencies, and supported through a buy-in to the PCS project. In addition, the Mothercare project has embarked on a mass media campaign in Cochabamba and PROSALUD/SOMARC conducted a mass media campaign in support of the social marketing effort.

Under the auspices of the IEC subcommittee, one of the most active subcommittees, a national logo was developed and is being used throughout the country by both private and public sector institutions. Workshops and training have been given and a set of materials describing contraceptive methods has been developed and distributed throughout the country. All groups in the country have tremendous pride and a sense of ownership of the materials, and it appears the institutionalization goals of the IEC strategy are well under way.

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The materials have been criticized for being too medical in content and lacking originality in presentation. With greater input by communication specialists, such as an advertising agency, it is anticipated that the materials will be improved next round. By design, the materials were aimed at an urban audience. This leaves a gap, even in the peri-urban areas and communities, such as El Alto, which are largely immigrant populations from rural areas.

The IEC strategy calls for a phased approach so that a demand is not created for services that do not exist and people are not directed to clinics that could be easily overwhelmed. Although this is a logical approach, communities need to be monitored carefully for improved service capabilities. El Alto, for example, currently has under-utilized services at the CNS and has rapidly expanding services in the NGO sector and even in the public sector under a World Bank project being supported in that district by the Dutch government.

Some elements of the IEC strategy are independent of clinic services. Mothercare in Cochabamba is proceeding with a television campaign initially aimed at policy makers, physicians, and community leaders to set the stage for more specific messages to follow. A great deal of IEC work needs to be done with males; some of that work could begin now.

Recommendations

24. Future IEC products should include greater professional communication input into the process.

25. The current strategy should be modified to accelerate development of messages for key audiences, such as peri-urban and rural women and men from all segments of Bolivian society.

26. The PCS project should coordinate closely with Mothercare and PROSALUD/SOMARC, which have moved into television and radio, and should collaborate with UPP to support policy initiatives.

27. The PCS project should expand the breadth of its current activities to include Tarija, Oruro, and Sucre as services become available.

6.3 Training

The major training effort under the Reproductive Health Services Project has been carried out through buy-ins to JHPIEGO and Development Associates. JHPIEGO has helped the MOH develop family planning services guideline. and has established two national reproductive health training centers at Hospital San Gabriel in La Paz and Hospital Materno-Infantil German Urquidi in Cochabamba. Personnel have been trained to open future centers at Garita de Lima, Hospital Maternidad Percy Boland in Santa Cruz, Hospital Gineco-Obstetrico "Dr. Jaime Sanchez" in Sucre, and the CNS Hospital Maternidad "18 de Mayo" in La Paz. JHPIEGO is also working on introducing reproductive health into the curriculum of the three medical schools and the national nursing colleges.

Development Associates has conducted clinical training in Ecuador for physicians from seven Bolivian NGOs, sponsored additional training in Guatemala for participants from two MOH centers and three

NGOs, and trained community-based distribution workers with CIES in La Paz, Oruro, and Potosi. This has been both TOT and training of service providers. Development Associates also has been working with auxiliary nursing schools to change curricula and to train faculty to implement the changes.

A good start has been made in developing a TOT infrastructure. A more comprehensive approach is needed, however, in order to 1) make sure the six clinical centers have all the requisite inputs, and 2) ensure that training does not occur in isolation but accompanies other essential inputs such as supervision, provision of contraceptive and other necessary supplies, information systems, and provision of technical norms. To this end, a project-wide training plan needs to be developed.

Recommendations

28. JHPIEGO should assess the needs of the identified six training centers and work with each of them until they are fully functional and operating.

29. The project should arrange a major buy-in to the PAC IIb project (Development Associates) to help develop and implement a project-wide training strategy for both pre- and in-service training.

6.4 Research

The INOPAL project has a resident advisor in place who has set up an office, conducted several workshops, and launched several studies including the following: a clinical pre-introduction study of the sub-dermal contraceptive implant (Norplant); a comparative study of three strategies to improve the financial sustainability of a Bolivian family planning provider; a comparative analysis of three strategies to improve the availability and acceptability of family planning in rural indigenous communities; and a study of ways to dispel fears and rumors about modern contraceptive methods.

Considerable interest exists among reproductive health organizations for short, practical studies that can help them solve management and program problems. INOPAL is receptive to working on these problems.

The INOPAL project is off to a good start in making operations research a key part of program development, implementation, and evaluation. A testimonial to the early success of the project is that demands for technical assistance and studies exceed resources. Testing of community-based distribution approaches, optimal pricing for services, client follow-up schemes, and countering rumors and fears are examples of problems that service delivery groups need operation research assistance to solve. Additional INOPAL personnel are required for this activity to fully meet the needs of the Reproductive Health Services Project.

Recommendation

30. The buy-in to The Population Council should be increased to add an additional research/project management professional plus support staff to the INOPAL project to enable it to provide more technical assistance, carry out more studies, and provide managers with timely information to improve operations.

6.5 Logistics

The project management unit at USAID (see Section 7.3) is responsible for tracking and ordering commodities. Last year, the mission contracted FAMES to clear USAID-donated commodities through customs and distribute them to other NGOs. USAID has not wanted to be directly involved in this activity because it is time consuming and politically sensitive. It is not certain that FAMES will renew its contract, however.

The mission has provided organizations receiving USAID-donated commodities with the QUIPUS system, a computer program for tracking and managing contraceptive logistics, as well as technical assistance from the Family Planning Logistics Management (FPLM) project. A consultant from the FPLM project has made several visits to Bolivia to assist with consumption data collection and inventory control, to estimate future commodity requirements, and to conduct a logistics workshop for those organizations receiving A.I.D. commodities. One of the consultant's recommendations was that contraceptives be sold rather than distributed free of charge in order better to determine the actual quantities consumed. The CNS is prohibited from charging for commodities, drugs, etc. Most of the NGOs have a sales policy that requires that contraceptives be sold.

Although logistics management has improved, problems persist due to the number and range of organizations, each with its own logistics system.

Recommendations

31. The Reproductive Health Services project should hire a full-time person, located within the proposed implementing entity (see Section 7.2), to focus on logistics issues. This person would be responsible for making commodity projections, ordering commodities, and clearing and distributing commodities to the appropriate service providers until the contraceptive social marketing program takes over these responsibilities. He/she would provide continuous, hands-on assistance to NGOs and the CNS in the use of the QUIPUS system. Furthermore, this person would coordinate a to-be-established logistics subcommittee attached to the services subcommittee. The logistics specialist could also help the MOH in terms of monitoring the availability of commodities at the district level. The logistics specialist should maintain linkage with the FPLM project or could perhaps be contracted through a buy-in to that project.

32. All NGOs should, for purposes of improved logistics management and cost recovery, sell USAID-donated commodities rather than distribute them free of charge. When clients pay for contraceptives, they are far more likely to use them.

6.6 Data Collection and Evaluation

6.6.1 Service Statistics

All reproductive health service providers receiving commodity support from USAID or the CAs are required to submit service statistics. To facilitate the prompt delivery of uniform statistics, USAID invested in the computer software program called QUIPUS which supports service statistics as well as logistics. An OPTIONS subproject provides periodic technical assistance related to QUIPUS and

its use. The MOH (even though it currently does not receive commodity support from USAID for family planning), the CNS, ASBOLCOF, CIES, FAMES, Fundacion San Gabriel, Mothercare, and PROSALUD are all using the QUIPUS system. To date, the mission has received two quarterly reports from these providers. The service statistics consist of a) new and continued users broken out by method; and b) commodities distributed, including calculations for couple years of protection.

Service providers are still struggling with QUIPUS. Reactions to the software are mixed. Some institutions have adopted it wholeheartedly, finding it useful, while others use it only to satisfy USAID and cross-check their own, more comprehensive and/or easier to use software programs for tracking services.

A number of service providers are having difficulties with discrepancies between commodities distributed and the number of new users and revisits.

The consensus is that institutions need more time working with QUIPUS and continuous, hands-on assistance before the system can be properly evaluated.

Recommendations

33. The full-time logistics specialist mentioned in Section 6.5 and attached to the implementing entity, should be responsible for a) assisting health providers with QUIPUS; b) recommending to USAID the duration and timing of technical assistance visits from OPTIONS; c) collecting and refining service statistics; and d) helping service providers use this data to improve commodity management and service delivery.

34. The QUIPUS system should be evaluated one year from the appointment of the resident logistics/service statistics specialist. An outside group with no stake in QUIPUS, such as PRISMA[2] or a similar organization, should be contracted for the evaluation. If QUIPUS proves too difficult to incorporate, or inappropriate to the needs of the various service providers, an alternate system will have to be found or developed.

6.6.2 Management Information System

It is critical that NGOs have the capability to determine the costs of their services and products so that over time they can work towards increased financial self-sufficiency. PROSALUD and the Fundacion San Gabriel reportedly have this capability and CIES, with support from one of the Reproductive Health Services Project CAs (FPMD) is in the process of developing it.

Recommendation

35. Assistance should continue to be provided to collaborating NGOs to develop cost accounting capabilities and to encourage them to set targets for increased financial

[2]A Peruvian NGO contracted to manage the public sector logistics system, particularly the distribution of commodities for the Peruvian MOH.

self-sufficiency. Pathfinder and other CAs should also give attention to these requirements.

6.6.3 Surveys

Limited statistical information existed prior to the USAID-supported national DHS in 1989. The DHS has been instrumental in reinforcing the health rationale for family planning activities. For example, among its most striking findings was the relationship between chid spacing and infant mortality: 154 infants per 1,000 live births died when births were less than two years apart. This high infant morality rate fell to 77 per 1,000 when births were two to three years apart. Information gleaned from the DHS has highlighted the unmet need for family planning services; knowledge, attitudes and practices regarding modern family planning methods; and variations in fertility and contraceptive levels by place of residence and education. These elements are critical in planning and guiding program direction and activities.

DHS results from 1989 continue to provide the basis for demographic and health data in most national documents. The DHS has been the source of several secondary analyses used to promote the need for family planning services in Bolivia.

Recommendation

36. A second DHS in Bolivia, scheduled for 1993, should continue to be supported as planned.

6.7 Medical Barriers

With modern method contraceptive prevalence of just 12 percent and the well-documented desire of Bolivian women to limit their fertility (see Figure 3), unmet need in this country is exceedingly high. Constraints exist which affect the development of programs, however. Key among these are widespread misinformation regarding modern methods, limited access via private physicians and pharmacies, the cultural and linguistic isolation of Bolivia's large indigenous population, and continued opposition from some political and medical leaders.

Bolivia presents a classic case of medical barriers. Family planning provision is limited to doctors or, in some cases, specialists. A conservative medical hierarchy maintains control of medical and nursing school curricula. Providers frequently reinforce inaccurate information and myths. A strong economic self-interest of public sector doctors exists to funnel potential clients to their private practices. A limited choice of contraceptives is offered by the public sector and NGO clinics. The method mix includes condoms, orals, IUDs, and spermicides. The recently developed MOH norms do not mention injectables or implants, and sterilizations are permitted only under stringent conditions. Providers tend to favor particular methods rather than offer as wide a range of choices as possible. Family planning is defined within a limited concept of "reproductive risk." Elite providers discriminate in their treatment of indigenous women. These are just a few examples. Although the MCH service delivery norms recently published by the MOH, represent a tremendous advance in service delivery policies, they reinforce several of the above-mentioned barriers.

Medical barriers are difficult to disentangle from the political, cultural, religious, and economic influences against the provision of family planning services in Bolivia. The demand for family

planning is growing, however. The reproductive health program has begun to disseminate the message to policy makers, the medical establishment, and potential users. It appears that the program has reached a point where it would be difficult to dismantle. The challenge will be to develop and maintain a program that provides high-quality services, not only to guard the health of contraceptive users but to ensure a positive reputation for family planning. It is critical to defuse rumors and misinformation that will harm the reproductive health services program.

Recommendations

37. Training should continue to be provided to ensure the technical competence and counseling skills of providers.

38. Training should continue to be provided to a wide variety of providers: doctors, nurses, auxiliary nurses, social workers, community-based distributors, health promoters, traditional birth attendants, pharmacists, etc.

39. Training should continue to be provided in a broad context — e.g., management skills, medical skills, interpersonal skills, logistics, quality care, and motivational seminars.

40. Clinic personnel should be trained in teams to ensure that the same information is transmitted to the client, to facilitate patient flow, and to gain the confidence of potential clients.

41. Efforts to expand method mix through IEC, policy, and commercial activities should be promoted.

42. Support should be provided to the public sector on future editions of the MOH's MCH norms to ensure that they include approval of more methods, support the authorization of more service providers, and broaden the criteria for women who are eligible for the use of different methods.

6.8 Reproductive Health and AIDS/STD Linkages

USAID initiated AIDS prevention activities in Bolivia in 1988 with a $500,000 grant to support MOH prevention and education activities. In 1991, this project was amended to provide an additional $3.5 million and to include STDs in the scope of work. The new phase of the project, called the AIDS/STDs Prevention and Control Project, is being implemented through a participating agency service agreement with the Centers for Disease Control in Atlanta. The new phase focuses on population groups with behavior that puts them at high risk for STDs and HIV infection: commercial sex workers, police recruits, street children, itinerant merchants, truckers, miners, and others.

A few NGOs, like CIES and FAMES, are starting to get involved in AIDS/STD prevention and control. Activities include the production of print material, outreach education to sex workers and other high risk behavior populations, and behavioral research, and in the case of the CSM program, the promotion and sale of Sultan condoms in a three-pack carrying the phrase "Stop AIDS." Moreover, the CSM program's recent television campaign featured a spot devoted to STDs and AIDS.

Involvement to date among reproductive health providers has consisted primarily of discrete, often donor-driven activities. Service providers have yet to focus on STD/AIDS screening and counseling as an important part of the reproductive health care package. Presumably a significant number of married women of reproductive age are at high risk for STDs and HIV due to the extramarital practices of their husbands. As many of these women do not know or do not want to know about their husbands' activities, and because STDs in women are often asymptomatic, service providers are not inclined to steer women towards condoms and away from more effective methods of family planning. Hence, the health of these women must also be addressed through interventions targeted at men. AIDS/STD education provides an opportunity to increase male involvement in reproductive health. A workplace education and counseling program on AID/STDs/ reproductive health could eventually pave the way for condom sales in factories, mines, etc.

Recommendations

43. USAID should identify an appropriate organization to conduct a study to measure the incidence of STDs among women seeking reproductive health care. This information would be useful in planning the integration of AIDS/STD prevention and control activities and reproductive health services. If the incidence of STDs proves to be high, service providers may want to consider reducing the IUD's share in the method mix.

44. A workplace-based education program on AIDS/STD/ reproductive health should be developed. An appropriate NGO or institutional consortium should target predominantly male factories, mines, labor organizations, etc., with a primary objective of delivering AIDS/STD education, and a secondary objective of providing other reproductive health information, including family planning.

45. USAID should identify an appropriate organization to conduct a study to determine how and where men self-treat for STDs (pharmacies, injectionists, traditional practitioners, etc.). By ascertaining where men go to seek help when they have STDs, USAID can plan to use that network for the dissemination of AIDS/STD and other reproductive health information. Once again, condom sales could follow.

6.9 Reproductive Health and Health Projects Linkages

The Community and Child Health Project (CCH) represents an effort to improve MOH services nationwide in four areas: diarrheal disease and cholera control; immunizations; Chagas disease; and water and sanitation. In addition, the project is working to improve priority health services in six rural districts of three *unidades*. There would seem to be opportunities to strengthen the reproductive health component of the health services in the six districts through staff training, IEC materials, supplies, etc., which should contribute to a reduction in maternal and infant mortality.

The CSM project component of the Reproductive Health Services Project is distributing contraceptives through pharmacies and plans to begin distribution through the informal sector. The CSM effort could achieve increased financial self-sufficiency with an expanded array of products, including some in the health area (e.g., oral rehydration salts [ORS]).

Recommendations

46. A diagnosis should be made of reproductive health services needs in selected districts of the CCH project, and the Reproductive Health Services Project should be amended to provide the required inputs.

47. The possibility of incorporating health products such as ORS in the CSM scheme should be explored.

6.10 Role of CAs

USAID/Bolivia is generally pleased with the role of the CAs, and it appears that this group of specialized organizations has contributed significantly to the progress of the Reproductive Health Services Project. Collaboration has been unusually good to date due, in part, to the close involvement of the mission and a unique coordinating mechanism, namely the FPMD-funded country representative who has coordinated the activities of JHPIEGO, Development Associates, and PCS. (See Table 4 on the next page for planned funding levels and total obligations to date.)

The issue of collaboration will be even more important as the project expands existing activities and embarks on new activities, particularly with the public sector. The implementation unit for the public sector is an additional group that will need to be kept in the communications loop. Although no new mechanisms for coordination appear advisable, all participants will need to make sure their inputs are timed in harmony with general program development to ensure effectiveness of efforts.

Table 4

Reproductive Health Services Project
Project Financial Status ($ 000)

Element	Description	Total LOP Planned PACD 9/95	Total Oblig. to Date FY 92	Revised Funding PACD 9/97	Additional Funding Needed
I.	Support for Government of Bolivia Activities				
	1. CONAPO	400	400	400	0
	2. CNS	450	450	600	150
	3. MOH/MCH	250	250	250	0
	4. Management Support @				
	a. USAID	312	487	600	113
	b. Audit & Evaluation	208	103	150	47
	c. Commodities	155	275	700	425
	d. Logistic Support	125	120	125	5
	e. Implementation Unit			1,000	1,000
	1. MOH/Districts			400	400
	Subtotal	1,900	2,085	4,225	2,140
II.	Support for NGO Activities				
	1. PCS #	1,788	954	1,780	826
	2. Pathfinder	1,000	1,066	2,000	934
	3. MotherCare	700	900	900	0
	4. Population Council #	700	350	900	550
	5. DA	350	350	1,300	950
	6. JHPIEGO	500	250	530	280
	7. FPMD #	500	600	1,500	900
	8. RAPID IV	450	450	450	0
	9. OPTIONS	172	150	150	0
	10. DHS	300	450	450	0
	11. PROSALUD			400	400
	12. SAN GABRIEL			75	75
	Subtotal	6,460	5,520	10,435	4,915
III.	Contraceptive Social Marketing				
	1. SOMARC #	940	550	940	390
	2. PROSALUD			900	900
	Subtotal	940	550	1,840	1,290
	TOTAL	9,300	8,155	16,500	8,345

@ Includes $120,000 operating year budget transfer for commodities, 5/91
# Fiscal year 1989/90 transfers to
PCS ($235,000)
Population Council ($200,000)
FPMD ($250,000)
SOMARC ($209,000)

Recommendation

48. The following summarizes recommendations for each Cooperating Agency/project:

- Development Associates — Increase funding level by $950,000 for expanded scope of work (see Section 6.3).
- FPMD — Increase funding level by $800,000 for added management technical assistance, particularly to the public sector.
- Pathfinder — Increase funding level by $934,000 for technical assistance in service provision to public and private sectors.
- Population Council — Increase funding level by $550,000 for increased operations research and additional in-country personnel.
- JHPIEGO — Maintain planned funding level for clinical training in accord with revised implementation plan.
- PCS — Maintain planned funding level for IEC in accord with revised implementation plan (see Section 6.2).
- RAPID — Maintain policy activities with current obligated funding.
- OPTIONS — Maintain policy activities with current obligated funding.
- SOMARC — Maintain planned funding level for technical assistance to CSM program.
- Institute for Resource Development — Maintain planned funding for 1993 DHS Survey.
- Mothercare — Maintain planned funding for project completion.

7. Project Management and Coordination

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7. Project Management and Coordination

7.1 National Coordinating Committee for Reproductive Health

As discussed in Section 2.2, as a result of an initiative by USAID, a National Coordinating Committee for Reproductive Health was established for the Reproductive Health Services Project in January 1990. This committee includes representatives of the MOH, the CNS, UPP, an NGO on a rotating basis, and USAID. The PAHO representative in Bolivia participates as a permanent observer. The principal purpose of the committee is to coordinate implementation of reproductive health activities carried out by agencies participating in the project in accordance with the norms and regulations of the government of Bolivia and USAID. There are also four technical subcommittees: services; training; research, evaluation and policy development; and IEC. Membership on subcommittees is composed of technical representatives of the participating organizations and representatives of CAs and contractors.

The coordinating committee mechanism, together with its subcommittees, has clearly been an effective means for both planning activities which involve several organizations and keeping all participating institutions informed. This mechanism has also helped to ensure consistent and compatible work in such areas as IEC.

Recommendation

49. The project should continue to support the coordinating committee mechanism and the technical subcommittees through financial and technical assistance from the CAs.

7.2 Implementing Entity for Reproductive Health Work in Health Districts

If USAID/Bolivia decides to propose amendments to the Reproductive Health Services Project in order to help strengthen reproductive health services in health districts (as recommended in Section 3.1), it will be necessary to identify or create an implementing entity which can provide support to districts and help coordinate the various inputs, including those from CAs. These inputs could include technical assistance and financial support for training, equipment, IEC materials, management development (including strengthened supervision systems), operations research to improve quality of services, etc. It is estimated that the entity would require a staff of two or three professionals, including the specialist in logistics and service statistics recommended in Section 6.5.

Recommendation

50. An implementing entity should be identified or established which can provide technical and financial assistance to health districts, coordinate and collaborate with other donor agencies working in the districts, and help coordinate CA assistance in this area.

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7.3 Project Management Unit

The Reproductive Health Services Project has a project management unit in the Health and Human Resources Office, USAID/Bolivia which is responsible for planning, managing, coordinating, monitoring, and evaluating reproductive health activities funded under the project as well as centrally funded activities in Bolivia.

The project management unit has played an active role in encouraging the development and implementation of reproductive health activities, while being sensitive to the fact that reproductive health and family planning continue to be issues which are sometimes controversial in political and religious contexts. The unit has been particularly effective in being able to work with a relatively large number of diverse institutions — both providers and recipients of technical and financial assistance.

Although the unit has provided effective management of the project, there are several areas in which planning, monitoring, and evaluation could be strengthened. In the area of planning, for example, the project management unit could ensure that one or more appropriate CAs (e.g., MSH [FPMD] and Pathfinder) are available to assist the CNS to carry out a systematic, detailed diagnosis and planning effort with respect to expansion of reproductive health services to additional CNS facilities in 1993. With regard to monitoring and evaluation, the Project Paper calls for data collection and analysis which goes beyond that which is currently being obtained. Given the existing inadequate service statistics systems in Bolivia particularly, although not exclusively, in the public sector, it may make sense to scale down the current, rather ambitious monitoring plan outlined in the Project Paper. Finally, with respect to ongoing coordination of project activities, it would be desirable to place increased emphasis on ensuring that participating institutions understand the norms and regulations which govern their project activities with a view to letting them assume increasing responsibility for decision making regarding implementation of project-supported activities.

Recommendations

51. The project management unit at USAID should ensure that the MOH and the CNS have the necessary technical assistance to undertake a detailed diagnosis and planning effort for development and expansion of reproductive health services.

52. The project management unit should revise the plan for monitoring reproductive health activities to take account of inadequacies in the existing service statistics systems.

53. The project management unit should ensure that participating Bolivian institutions understand A.I.D. norms and regulations and should give the institutions increased responsibility for decision making regarding implementation of project-supported activities.

Appendices

Appendix A

Scope of Work

Appendix A

Scope of Work

DELIVERY ORDER

STATEMENT OF WORK

BACKGROUND

In response to an improved public climate for family planning in 1989, USAID developed a new bilateral project which supports the government of Bolivia and many small NGOs that provide information and services regarding reproductive health services. Funded in 1990 for five years, the goal of the Reproductive Health Services (RHS) Project is to improve maternal and child health in Bolivia. The purpose of the project is to increase access to and the quality of reproductive health services in Bolivia. The project strategy has three elements: support for the 1) GOB reproductive health program 2) NGO activities and 3) social marketing of contraceptives. Within this framework the project emphasizes five activities: services; information, education and communication; training; research and evaluation; and policy.

Please refer to Attachment C, entitled Background, which highlights the reasons for a reproductive health services project in Bolivia and describes the Bolivian family planning situation leading up to the current bilateral project. Additionally, the background document discusses each project element; the purpose of working with each element, issues and challenges and project response.

Article I - PROJECT DATA

Project Title:	Reproductive Health Services Project
Project Number:	511-0568
Date of Obligation:	07/31/90
PACD:	09/30/95
Implementing Agencies:	M.P.S.S.P. (Ministry of Health), Caja Nacional de Salud (Social Security), Unidad de Politica Social y de Poblacion
Major Contractors:	Pathfinder International, MotherCare/ JSI, JHU/PCS, JHPIEGO, DAI, MSH/FPMD, Population Council, The Futures Group (SOMARC, RAPID IV, OPTIONS II)
Authorized Funds:	$9,300,000

Article II - ASSESSMENT OBJECTIVE

The purpose of this assessment is to evaluate the strengths and weaknesses of the Reproductive Health Services Project strategy and determine whether the priorities and strategy of the RHS project continue to be appropriate in the current Bolivian context.

The objectives are: 1) to examine the accomplishments to date of the three elements within the RHS project; 2) to assess the issues and challenges of each component; 3) to respond to the cross-cutting themes presented; and 4) to provide recommendations regarding the continued and future strategy of the RHS project. In addition, the team will examine an appropriate supporting management structure to implement the recommended strategy.

This assessment is not an evaluation of individual CA activities supported by the RHS project; the assessment is to take a holistic approach regarding project priorities and strategy and identify the most appropriate TA needed to meet the project goal and objectives.

Article III. - ASSESSMENT STRATEGY

A team planning meeting will be held at the start of the in-country assessment activities to review the SOW, define reporting timelines, identify team member responsibilities, and review scheduled meetings and interviews. In addition to USAID/B representatives, three U.S. resident representatives working in Bolivia under the auspices of the RHS project may participate in this meeting.

The basic background document for review is the RHS Project Paper (July 1990) and attached background paper. Several additional documents will be prepared by the HHR Office in anticipation of this assessment, for example: Highlights of a Rapid Opinion Survey of the RHS Project; Responses from US-supported CAs involved in the RHS project, background assessments of each project element. Data may be culled from the DHS (1989), DHS secondary analyses, CONAPO publications, QUIPUS reports, MotherCare quantitative and qualitative studies, KAP surveys, and CA trip reports.

The team will conduct interviews in the public sector with the Ministries of Health and Planning and the National Social Security Institute and visit several public sector facilities offering RHS. In the private sector, the team will conduct interviews of all the NGOs receiving USAID/B assistance under the RHS project and visit their clinics offering RHS. Additionally, the team will meet with other Donor agencies in Bolivia, such as PAHO, UNFPA and the World Bank in order to coordinate activities

in the sector. The team may meet with NGOs and US organizations working in Bolivia yet not directly involved in the USAID funded RHS project if it is determined that these agencies may contribute to the RHS project strategy.

There will be three field visits by various team members: Cochabamba, Santa Cruz and Oruro. In Cochabamba the team members will meet with the several NGOs supported by the project (including FEPADE working in the rural areas) and the Maternidad. In Santa Cruz, the team members will meet with PROSALUD and the Ministry of Health. The purpose of a field visit to Oruro is to explore conditions for providing RHS outside major urban areas.

Article IV - STATEMENT OF WORK

The team will conduct an assessment of the Reproductive Health Services Project to meet the objectives defined above. Specifically the assessment team will respond to the following questions according to project component: 1) support for the GOB reproductive health program 2) NGO activities and 3) social marketing of contraceptives. A fourth segment focuses on cross-cutting themes.

1) Support to the GOB Reproductive Health Program

To date, the basic approach of the RHS project with the public sector has been to provide direct financial resources and technical assistance to the MOH and CNS to significantly expand their provision of services and to the MOP to develop population policy activities. Please refer to Attachment C for an expanded discussion of the public sector.

a) What is the most appropriate way to support public sector reproductive health service activities? What should be the focus for USAID support: urban vs. rural activities, geographic region, specific TA, underserved populations? Is there an expanded role for direct USAID project support to the Ministry of Health?

2) Support to Private-NGO Activities

The RHS project has supported Bolivian NGOs via existing AID/W CAs; these agencies provide direct support for technical assistance and service provision. Ten Bolivian NGOs that provide family planning services receive direct assistance from 13 U.S.-based CAs. Please refer to Attachment C for an expanded discussion of private sector activities.

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a) Does work with the private sector complement, replace, provide alternative, and/or compete with activities of the GOB? What implications do the findings have for the direction of activities and allocation of bilateral funds?

b) Should a set of criteria be established for choosing family planning NGOs, or do the basic assumptions mentioned in the background document still hold?

c) In terms of private sector strategy, should the project focus on larger NGOs e.g. San Gabriel, PROSALUD which, via agreements with the MOH, are serving populations that would otherwise go to public sector services? What is the niche for smaller NGOs? Should the PVO network be extended? If yes, to what type of organizations? Should the project support NGOs not currently offering FP services?

d) In the last two years of the project has the status of reproductive health advanced beyond the point when the program can be selective in choosing which FP PVOs are appropriate to work with? What are the implications regarding balance of emphasis between public and private sectors?

e) What is the nature of support that USAID should provide the private sector? What are USAID/B's strengths in terms of support? Should USAID provide support directly to registered NGOs rather than use the intervening CA mechanism? Should the project support activities such as operating expenses, salaries, and direct training costs or continue providing support in terms of technical assistance?

f) What is the population the NGOs are reaching? If GOB RHS were strengthened, what populations should NGOs reach with bilateral funds? e.g urban/rural, adolescents, men?

g) Given the focus on RH as opposed to strictly FP, is it not incumbent on the project to work in rural areas where high fertility and maternal mortality rates manifest themselves so strongly? What is the most cost-effective way to deliver services in rural areas in Bolivia?

3) Social Marketing of Contraceptives

SOMARC's strategy has been to increase awareness of family planning and correct use of modern contraceptive methods through general media campaigns, target group interventions with pharmacies and distributors, and sustained availability of low cost contraceptives. Please refer to Attachment C for an expanded discussion of commercial sector activities.

a) What is the contribution of SOMARC to the goals of the RHS project? Is there a role for expanded SOMARC activities? In what areas? Should SOMARC be the only CSM conduit?

b) Is SOMARC's market strategy appropriate to the Bolivian context? Is product pricing appropriate? Marketing mix? What are the possibilities for cost recovery for SOMARC activities? What are the implications for further bilateral funding and project support?

c) Is there a linkage between SOMARC distribution activities and the private NGO network? What are the implications for strengthening a national logistics system?

c) Should the project differentiate between CSM and CBD activities regarding target populations? What are the implications for future bilateral funding?

4) Cross-Cutting Themes

a) Assess the status of family planning in Bolivia. Has it changed in the last two years? In what direction? What are indications of this change? (i.e. did Government Ministers or personnel discuss openly their involvement with FP to non-medical, non- technical audiences?) Who or what provided the catalyst for the so-called opening of discussion of family planning? (e.g. PROSALUD TV spots, CONAPO policy presentations, SOMARC activities with pharmacies?) What role did the project play in any change? What are the implications for the RHS project?

b) Assess the National Reproductive Health Coordinating Committee (NCC) and four subcommittees. What were the original objectives? Are the objectives being met? What role do the subcommittees serve currently? What role do the subcommittees have in the future? What are the linkages with the GOB, CAs and USAID and what recommendations would strengthen these linkages?

c) What is the interaction between private sector organizations and GOB? How do the activities inter-relate? How do the MOH and NGOs communicate and coordinate activities?

d) Assess the logistics component of providing RHS. Where are the gaps? Should the private and public sectors be assessed separately? What is the role for CEASS (MOH) as a national distributor of RH commodities? What are the linkages between the private and public sectors? Under the RHS project, What is the best way for USAID to contribute to strengthening a national logistics system? Do we need other logistic support networks?

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e) Are the indicators as identified in the project paper appropriate? Accurate? Quantifiable? Are systems in place to collect reproductive health information? Is the information collected appropriate to the indicators and objectives of the RHS project? What changes are needed to strengthen current MIS activities in the private and public sectors?

f) FP/STD Relationship. What are the linkages between FP and STDs in Bolivia? What are the implications of linking the two subjects? What is the appropriate relationship between AIDS/STD activities within NGOs offering RHS, in terms of information, services, commodities, referrals and resources allocated?

g) Are the structure and functions of the HHR Management Unit appropriate for such a complex project? Is the Project Management Unit giving adequate attention to the following technical areas:
- collection program information, analysis of data;
- contraceptive supply system;
- appropriateness of TA;
- direct support to MOH;
- method mix, including natural FP, breastfeeding?

h) What is the role and participation of additional U.S. cooperating agencies? For example, what is the niche for the ten PROCOSI NGOs not currently involved in the RHS project? What are the funding and management implications of expanding the number of implementing organizations?

Article V - REPORTS

The team will prepare a written report containing the following:

a) Table of Contents

b) Executive Summary

c) Body of the report which should follow the format of the detailed Scope of Work:

Support to GOB Reproductive Health Program
- Overall Profile
- Issues/Challenges
- Project Response
- Recommendations

Support to Private NGO Activities
- Overall Profile
- Issues/Challenges
- Project Response
- Recommendations

Social Marketing of Contraceptives
Overall Profile
Issues/Challenges
Project Response
Recommendations
Cross-cutting Themes
Theme Discussion
Issues/Challenges
Project Response
Recommendations

d) Lessons Learned, Recommendations, Conclusions

The report should not exceed 50 pages plus appendices. It should include a full statement of findings, conclusions and recommendations, and should specify what entity should pursue the recommended action.

e) Appendices are to include, at a minimum, the following:
- Description of assessment methodology;
- List of documents reviewed;
- List of institutions and persons consulted;
- Summary of recommendations; and
- Completed USAID Project Evaluation Summary Form 1330-5 (see attached).

The draft report, will be presented to USAID/Bolivia before the team leaves Bolivia. Feedback from the Mission will be given at the time of oral presentation and, as necessary, forwarded to the contractor during the following week. The contractor will include any feedback and/or revisions and submit the final report to USAID/Bolivia within three weeks after leaving country.

Five copies of the draft report shall be submitted to USAID/Bolivia. Ten copies of the final evaluation report shall be submitted, in both English and Spanish, to the Director, Health and Human Resources Office, USAID/Bolivia.

Article VI - PERSONNEL QUALIFICATIONS

The team will be composed of four members. It is recommended that the assessment team consist of (1) Family Planning/Population Specialist with experience in management and public sector activities; (2) Economist/Financial specialist with social marketing experience. The team leader could be either of these technical specialties. It is anticipated that a staff member of the Office of Population, AID/W will participate. The fourth team member will be the International Population Fellow based in the HHR Office in La Paz.

This team will be responsible for reviewing documents, conducting interviews, preparing and presenting the assessment report.

Input and assistance will be provided by the USAID Project Officer, USAID Project Coordinator and, USAID Evaluation Specialist.

Team Leader: Will have responsibility for the general direction of the assessment and the writing and presentation of the final report. S/he will have extensive A.I.D. project evaluation experience, be fluent in Spanish and have a thorough knowledge of national family planning programs. It is required that the team leader have previous team leader experience. Familiarity with public sector health programs, management programs and/or institutional development activities in Bolivia will be particularly useful. S/he must be able to communicate effectively with the implementing agencies. An advanced degree in public health, public policy and/or public administration is highly desirable. Ten years of experience in family planning evaluation and/or organizational development activities is desirable.

Team Consultant: will assist the team leader in analyzing the RHS project and make recommendations regarding future direction. S/he she will have an economics or finance background with experience in the private commercial sector, cost-recovery strategies, and social marketing programs. An advanced degree in economics, business administration or health administration or equivalent experience is desirable. Spanish fluency is required.

The contractor will submit names of the recommended candidates for the above two positions for consideration and approval of USAID/Bolivia.

R&D/POP Team Member: will assist the team leader in analyzing the RHS project and make recommendations regarding future direction. S/he will have a communications background with experience in IE&C activities in national family planning programs. Knowledge of AID policies, processes and regulations is desirable. An advanced degree in communication, public health, health education or equivalent experience is desirable. Spanish fluency is required.

International Population Fellow: will assist the team leader in analyzing the RHS project and make recommendations regarding future direction. Her emphasis may be on management information systems, project logistics and the linkages between training activities and service delivery. An advanced degree in public health or health education or equivalent experience is desirable. Spanish fluency is required.

All team members will collaborate on the cross-cutting themes presented in the detailed scope of work.

Article VII - WORK SCHEDULE

The contractor will commence evaluation activities in Bolivia on/or about September 10th, 1992. This PIO/T authorizes the team leader and consultant 18 days in the field, based on a six-day work week. In addition, time is allocated for final report preparation. The estimated period of performance including submission of the final report is approximately 6 weeks.

This contract will require 46 work days of effort, based on a six-day work week as follows:

Team Leader: 18 days in-country, 7 days final report preparation in country of origin.

Team Consultant: 18 days in-country, 3 days final report preparation in country of origin.

It is anticipated that the R&D/POP team member will be supported by R&D/POP OE funds. And the International Population Fellow will be funded by the International Population Fellows Program.

Article VIII - ILLUSTRATIVE BUDGET (See Attachment B)

Article IX - SPECIAL PROVISIONS

(1) Duty Post

La Paz, Bolivia

(2) Language Requirements and other Required Qualifications

Spanish language ability at the FSI 3/3 level is required for all team members.

(3) Access to Classified Information

Contractor shall not have access to any Government classified material.

(4) Logistic Support

The contractor will provide office space, as needed, for the team. The contractor will need to provide computers for the team leader and consultant. R&D/POP will provide a computer for the R&D/POP staff member.

(5) Work Week

A six day work week is authorized for all consultants.

(6) Health

For short-term technical assistance, the following applies: The altitude of La Paz (12,000 feet above sea level) can have a deleterious effect on the health of persons with pre-existing medical problems and; or respiratory infections. Individuals with hypertension, diabetes, angina pectoris, coronary heart disease, asthma, emphysema, chronic bronchitis, or any history of heart attack, heart disease, or lung disease, should have a thorough evaluation by their physician prior to traveling to La Paz. Persons with any respiratory infection, such as colds, bronchitis, or pneumonia should delay travel to La Paz until they have fully recovered. Persons with sickle cell trait or disease should not come to high altitude at any time. Individuals who are significantly overweight do not do well at high altitude and should not come to La Paz unless specifically cleared by a physician to do so.

USAID/Bolivia requires a doctor's statement declaring that incoming short-term personnel are not afflicted by any of the above pre-existing medical problems. If such problems exist, a full physical exam is required prior to departure for Bolivia.

Adjustment to the altitude usually requires only a few days. Personnel should, if at all possible, limit their physical activity for the first 36-48 hours after arrival in La Paz. Try to rest, eat light meals, avoid alcoholic beverages, smoking and gas-producing food, and increase intake of fluids. Limit carbonated drinks or allow them to go flat before drinking them.

The Health Unit in the American Embassy La Paz strongly recommends that all adults coming to La Paz take the drug diamox (Acetazolamide) contraindicated with sulfa allergy, 250 milligrams by mouth twice a day for three days prior to arrival. This drug must be obtained by prescription from a physician. Diamox significantly reduces and in most cases prevents the symptoms of high altitude sickness.

Infectious hepatitis, amoebic dysentery, bacillary dysentery, giardiasis, cholera, rabies, and typhoid are endemic in Bolivia. Yellow fever and malaria are present in tropical areas of Bolivia.. The usual sanitary precautions concerning food and water should be observed and all immunizations should be up to date prior to arrival in country. Gamma globulin and typhoid vaccine are recommended for all adults. Yellow fever vaccine is mandatory for all personnel travelling to tropical areas. Rabies pre-exposure prophylaxis (not the low-dose intradermal injections) is recommended for all personnel who plan to spend considerable

time outdoors on foot. The Embassy Health Unit can advise personnel travelling to tropical areas concerning malaria prophylaxis on a case by case basis (the precautions and need for medications are determined by the duration of travel, the extent of exposure, and drug allergy history.)

(7) Security

The Regional Security Office advises the following: La Paz and the cities of Santa Cruz and Cochabamba are all rated medium terrorist threat areas by the Department of State. Trinidad and Chimore are rated high terrorist threat areas. USG employees are urged to exercise caution while travelling and working Bolivia. Increased security measures such as varying times and routes and avoiding predictable patterns should be implemented. Personnel going to the Chapare area should check with the RSO before departure.

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Appendix B

List of Persons Interviewed

Appendix B

Lists of Persons Interviewed

Ministry of Health (MOH)
Dr. Jack Antelo
Dr. Roberto Borht
Dra. Virginia Camacho

MOH/National Department for Attention to Low Income Population (DINAP)
Dr. Roberto Borht
Dra. Virginia Camacho

MOH/Garita de Lima Hospital, District I
Dr. Carlos Barbosa
Dr. Luis Duenas
Dr. Miguel Angel Ugalde

MOH/Unidad Sanitaria, Oruro
Dr. Gustavo A. Vega Davila
Lic. Miriam Leyton
Lic. Elizabeth Vallejes
Dr. Tito Villarroec
Dra. Dora Villegas

MOH/District Hospital, Oruro
Dr. Gonzalo Nigoevic Heredia

National Social Security Institute (CNS)
Dra. Betty Eyzaguirre
Dra. Ana Maria Paredes
Dra. Cristina Renteria

CNS/Cochabamba
Dr. Henry Solis Fuentes

Population Policy Unit
Lic. Hugo Torres
Lic. Franklin Garcia

CCH
Dr. Alvaro Munoz

ASBOLCOF
Dr. Eduardo del Castillo

CIES
Ramiro Caballero
Dr. Marcelo Farfan
Lic. Carlos Salazar

FAMES
Dra. Mariela Loayza
Lic. Rolando Mariaca
Dr. Luis Rodriguez
Lic. Luis Taja
Dr. Winston Uzin
Eunice Zambrana

Fundacion San Gabriel
Dra. Lieselotte Bauer de Barragan
Lic. Jose Barragan
Lic. Ramiro Claure
Lic. Eddy Jimenez
Dra. Gladys Pozo de Veizaga
Dr. Oscar Viscarra

PROSALUD
Dr. Carlos Cuellar
Dr. Antonio Arrazola
Dr. Federico Gomez Sanchez
Lic. Sonia Moscosco
Pamela Putney
Dr. Luis Santa Cruz

Society of Obstetrics and Gynecology
Dr. Gustavo Mendoza

Other
Lic.Rene Pereira

FPMD
Sandy Wilcox
Manuel Olave

PCS
Dr. Luis Ramiro Beltran

Mothercare
Lisa Howard-Grabman
Bill Bower
Bob Grabman
Ariel Perez

Population Council
John Skibiak

Integrated Program for Basic Health Services (MOH/IDB)
Dr. Daniel Guzman Gonzalez

PAHO
Dr. Daniel Gutierrez

Project for Strengthening Primary Care, District III, El Alto
Dr. Peter Gondrie

UNFPA
Rainer Rosenbaum
Waldo San Martin

UNFPA Evaluation Team
Luise Lehmann
Steven Mendelsohn

World Bank, Human Resources Division, Latin America and the Caribbean
Miriam Schneidman

Centers for Disease Control/AIDS
Bill Boyd
Joel Kuritsky

USAID/Bolivia, Health and Human Resources Office
Paul Hartenberger
Sigrid Anderson
Rafael Indaburu
Charles Llewellyn
Elba Mercado
Isabel Stout

USAID/Bolivia
Carl Leonard
Steve Allen
Sonia Aranibar
Lon Barash
Rene Uriona

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Appendix C

Bibliography

Appendix C

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Cooperating Agency comments (solicited):

-Association for Voluntary Surgival Contraception
-Development Associates
-John Snow, Inc. (FPLM)
-Johns Hopkins University (JHPIEGO)
-Johns Hopkins University (PCS)
-John Snow, Inc. (Mothercare)
-Management Sciences for Health
-The Population Council
-The Futures Group (RAPID)
-The Futures Group (SOMARC)

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FPMD, Managerial Technical Assistance to CIES. May 25-31, 1992.

FPMD, Preliminary Report on CIES. August 17, 1992.

FPMD, Technical Assistance and Second Organizational Workshop with the Caja Nacional de Salud. April 7-26, 1992.

FPMD, Technical Assistance in Strategic Planning for CIES and Cochabamba's Overall Management Development Strategy in Family Planning. March 9-20, 1992.

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FPMT, Report on Center for Research, Education and Studies (CIES), Strategic Plan. 1990.

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Appendix D

Organizations

Appendix D

Organizations

Organization: **PROSALUD**

Director: Dr. Carlos Cuellar

Address: Av. Isabel la Catolica
P.O. Box # 1231
Santa Cruz, Bolivia

c. Jorge Saenz 1382, Miraflores
P.O. Box # M-10112
La Paz, Bolivia

Telephone: (591-3) 529477/525031
Fax: 526823

(591-2) 392663/4
392477

Founded: 1985

Est. Cap. Worth:

Est. Op. Bud: /yr.

No. of Employees:

% AID Fin.

% Other Donors

% Self: 40

Operation Area: Santa Cruz, El Alto, (La Paz - 1993)

Est. Pop. Served: S.C. 700,000, E.A. 120,000

Clinics: S.C.: 15 plus hospital, E.A. 6 (20 - 93) (La Paz 4 - 93)

Outreach: S.C.: CBD Program

Service Statistics: 1991: 2,981 CYP

Special Projects:

Runs Bolivia's Social Marketing Project

Growth Plan:

Hopes to expand in other major cities and franchise clinics in smaller communities.

Comments:

Well managed organization with marketing/cost recovery orientation.

Emphasis on high quality services.

Organization: **Fundacion San Gabriel**

Director: Dra. Lieselotte de Barragan

Address:

Telephone:

Founded: 1969 Est. Cap. Worth:

Est. Op. Bud: /yr. No. of Employees: 276 (12% MOH)

% AID Fin. % Other Donors % Self

Est. Pop. Served: 125,000

Clinics: Major 112 bed Hospital, 9 health posts

Outreach:

Service Statistics: (1991/2)

Special Projects:

Foundation also works in education, training, community development.

Growth Plan: Serves only one district.

Comments:

The Foundation has been given complete responsibility for District 3 by the Ministry of Health, a promising model of public sector delegation.

The hospital appears clean and efficient. Reproductive health services have been integrated recently.

The hospital is one of six reproductive health training centers.

Organization: **Foundation for Medical-Social Assistance — FAMES**

Director: Dra. Ruth Maldonado

Address: Av. Mariscal Santa Cruz No 1364
Piso 17 B, Oficina 6 - La Paz

Telephone: 390762

Founded: 198? Est. Cap. Worth:

Est. Op. Bud: /yr. No. of Employees: 90

% AID Fin.	% Other Donors	% Self
	60	30
	Pathfinder; FPIA	

Operation Area:

Oruro, Tarija, Cochabamba, Santa Cruz, El Alto, La Paz

Est. Pop. Served:

Clinics: 20

Outreach: 70 private practice physicians, primarily gynecologists

Service Statistics: (1991/2)

1991= 18,983 CYP

Special Projects:

FAMES is distributor for USAID donated contraceptives.

Outreach is done through network of private physicians.

Growth Plan:

First need is self-sustainability

Comments:

Salaries of center level staff are paid by FPIA.

Heavy dependency on FPIA and Pathfinder.

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Organization: **Center for Research, Education and Service — CIES**

Director: Lic. Ivan Prudencio

Address:

Telephone:

Founded: Est. Cap. Worth:

Est. Op. Bud: /yr. No. of Employees:

% AID Fin. % Other Donors % Self

Operation Area: El Alto, La Paz, Oruro, Potosi

Est. Pop. Served:

Clinics: 4

Outreach: 6 CBD in El Alto; plus some promoters

Service Statistics: 1991: 11,713 CYP

Special Projects:

CIES used to supply services to COB - Central Obrera Boliviana in La Paz

CIES has been contracted by the Dutch/World Bank project in El Alto to provide reproductive health services training to the MOH.

Growth Plan:

Comments:

CIES has received extensive management assistance from FPMD and has embarked on an ambitious self-sustainability program.

Organization: **Private Community and Family Aid Society - ASBOLCOF**

Director: Dr. Eduardo del Castillo

Address: Edif. Santa Isabel
Av. Arce 2539, Bloque A, 1er Mezzanine, Oficina M106
La Paz

Telephone: 343669, 783038 Fax: 322195

Founded: 1991 Est. Cap. Worth:

Est. Op. Bud: /yr. No. of Employees:

% AID Fin. % Other Donors: 100 % Self
IPPF, Save the Children

Operation Area: La Paz, El Alto, Inquisivi, mobile train clinic

Est. Pop. Served: Train Clinic target of 5,800 users.

Clinics: 1 in Le Ceja in El Alto, 1 in La Paz, 1 Mobile Train Clin.

Outreach:

Service Statistics: (1991/2)

Special Projects:

Mobile Train Clinic

Growth Plan:

Mobile bus clinic - La Paz

Comments:

Dynamic Leadership

USAID candidate to become IPPF Affiliate

Organization: **Bolivian Commission for Evangelican Social Action - COMBASE**

Director: Dr. Jose Velasquez

Address:

Telephone:

Founded: 1964 Est. Cap. Worth:

Est. Op. Bud: /yr. No. of Employees:

% AID Fin. % Other Donors % Self: 100

Operation Area: Southeast Cochabamba

Est. Pop. Served:

Clinics: 17-Bed Hospital

Outreach:

Service Statistics: (1991/2)

Special Projects:

Growth Plan:

Comments:

Recently started providing reproductive health services with Mothercare assistance

Completely self-supporting, COMBASE assists in 80 deliveries per month. Minor assistance has provided potentially large payoff.

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Organization: **Center for Prevention of Cancer in Women - CPCCM**

Director: Dr. Oscar Nino de Guzman

Address:

Telephone:

Founded: Est. Cap. Worth:

Est. Op. Bud: /yr. No. of Employees: 8 p.t.

% AID Fin. % Other Donors % Self

Operation Area: Cochabamba

Est. Pop. Served:

Clinics: 1 plus mobile van clinic

Outreach: Promoter works with Mothers' clubs

Service Statistics: (1991/2)

Special Projects:

Offers reproductive health services in women's jail

Growth Plan:

Comments:

Organization: **Medicine Directed Toward the Community - ME.DI.CO.**

Director: Dr. Jorge Quiroga

Address:

Telephone:

Founded: 1991 Est. Cap. Worth:

Est. Op. Bud: /yr. No. of Employees: 20

% AID Fin. % Other Donors % Self

Operation Area: Peri-urban Cochabamba

Est. Pop. Served:

Clinics: 5 health outposts

Outreach: 15 promoters

Service Statistics: (1991/2)

Special Projects:

Growth Plan:

Comments:

Offers only condoms and orals.

Organization: **Center for Family Education - COF**

Director: Lic. Aleira Bolanos de Urgarte

Address: Centro Commercial "El Condor"
Av. Camacho 1425 - La Paz

Telephone: 358348

Founded: 1978 Est. Cap. Worth:

Est. Op. Bud: /yr. No. of Employees:

% AID Fin. % Other Donors % Self

Operation Area: La Paz, Oruro, Potosi

Est. Pop. Served:

Clinics: 5

Outreach:

Service Statistics: (1991/2)

Special Projects:

Growth Plan:

Comments:

Former IPPF Affiliate

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Appendix E

The Contraceptive Social Marketing Program

Appendix E

The Contraceptive Social Marketing Program

Project Background and Inputs

The goal of the social marketing program is to increase family planning knowledge and use of modern contraceptive methods in Bolivia. Program objectives include: 1) making affordable, high quality contraceptives available to middle and low-income Bolivians through the commercial infrastructure; 2) conducting appropriate market research and collecting impact data; and 3) producing educational, motivational and promotional materials and media. The program was targeted to reach urban populations first and then roll out to the rural areas in the later phases.

PROSALUD, a Bolivian NGO with headquarters in Santa Cruz, is the local entity responsible for implementing the contraceptive social marketing or CSM program. The CSM program was begun in 1988 by SOMARC (Social Marketing for Change), a Futures Group project funded by AID/Washington. Under USAID/Bolivia's Reproductive Health Services Project, SOMARC channels funds and provides technical assistance to the social marketing program.

The CSM program was designed to complement reproductive health services offered by the public sector and the private, not-for-profit sector, principally NGOs. The Ministry of Health and the National Social Security Institute (CNS) together are estimated to reach less than 60 percent of the Bolivian population. The NGOs serve approximately 1 percent.

In terms of providing family planning services and commodities, the commercial sector has historically been the main source. According to the 1989 Demographic and Health Survey, private doctors and clinics are the leading providers of modern family planning methods (54 percent). If clinical methods such as the IUD and sterilization are excluded, the importance of pharmacies as a source of modern methods of family planning soars. Some 35 percent of married women of reproductive age using contraceptives procure family planning commodities through pharmacies as against 42 percent through private health providers.

Given costly private doctor fees and the high price of commercial brand contraceptives available through pharmacies, modern family planning methods until recently were only accessible to upper-middle and upper-income Bolivians. By introducing affordable contraceptives into the commercial infrastructure, the CSM program has dramatically increased the availability and accessibility of modern family planning methods. In the past the distribution of high priced commercial brand contraceptives was limited to large urban areas where purchasing power was greatest. Hence, smaller cities, as well as peri-urban and rural areas were under-served or not served at all for family planning needs by the pharmacy network. CSM products are now making in-roads into those previously under-served areas. Moreover, competition from CSM products has resulted in pharmacists lowering the price of contraband contraceptives. In short, CSM is helping to close the gap that existed between the traditional, for-profit commercial sector on the one side, and the public and NGO sector on the other.

The full potential of the CSM program is far from being realized. A large proportion of the Bolivian population, due to geographical dispersion and limited government resources, does not have access to reproductive health services of any kind. Yet those same people engage in commercial transactions of one form or another every day. For many low-income people, purchasing contraceptives at a pharmacy or other commercial outlet is the most convenient or preferred method of procuring family planning commodities. For those people not yet served by the public or private health care system, CSM may be the only way of providing them with modern means of practicing birth spacing.

The CSM program has undergone major changes since its inception in 1988. At the outset SOMARC's principal collaborator was the Bolivian Society of Obstetrics and Gynecology. The Society was SOMARC's

local representative, in charge of overseeing the contraceptive social marketing program. ABENDROTH, a pharmaceutical importer, acted as distributor.

In 1989 the CSM program launched its first product — a contraceptive pill donated by USAID and marketed under the brand name of NORIDAY. The first year sales target of 20,000 cycles was easily met and surpassed. The Society was willing to support social marketing as long as there was no mention of specific methods or brand promotion. The Society of Obstetrics and Gynecology's major contributions to the CSM program consisted of endorsing a SOMARC funded reproductive health campaign in 1988-89, and giving a series of sexual education talks to students and mothers' clubs.

In January 1990, SOMARC moved the CSM program to PROSALUD. The program manager works out of PROSALUD headquarters in Santa Cruz but is paid by SOMARC. PROSALUD is a not-for-profit network of primary health care clinics. These clinics, which are largely self-financing, began offering family planning as part of their reproductive health care package in 1990-91.

In July of 1990 the CSM program began sales of SULTAN condoms on behalf of the Ministry of Health which found that it had a surplus of the USAID-donated commodity. The MOH had earmarked the SULTANS for STD/AIDS prevention activities. The CSM program packaged, promoted and distributed the condoms, giving the larger share of sales revenues to the MOH. The CSM program has already sold all the SULTAN condoms given it by the MOH and is now receiving SULTAN condoms directly from USAID/Bolivia under the Mission's AIDS/STD Prevention and Control Project.

In December of 1991 the CSM program added to its product mix a low dose, slightly higher-priced pill made available to the program by SCHERING. The new pill is MINIGYNON. It comes already packaged and currently sells for 3 Bolivianos as compared with NORIDAY which sells for 2.5 Bolivianos. SCHERING gives the CSM program a share of MINIGYNON sales revenues in exchange for promotional support.

In addition to changing its host institution, the CSM program has recently dismissed or replaced many of its sub-contractors. Many of the previous sub-contractors (the distributor, market research firm, advertising agency, etc.) did not measure up in terms of performance, professionalism, and willingness to cooperate and support program objectives.

ABENDROTH had negotiated a contract whereby it was the exclusive distributor for CSM products. This had numerous disadvantages, chief of which was that the program was locked into ABENDROTH's limited distribution network of pharmacies. ABENDROTH was unable or uninterested in expanding to rural areas. Additional problems included an unacceptably high level of sampling, and a less than satisfactory training program for pharmacy owners and employees. The CSM program ended its relationship with ABENDROTH, re-registered all CSM products under PROSALUD, and contracted a new distributor in early 1992. The new distributor, ACENTRAL, has no exclusive rights and has an extensive national distribution network. It is headquartered in Cochabamba. In addition the CSM program expects to work with other departmental distributors with rural coverage. In 1993 the CSM program plans to hire additional staff (2-3 persons) to help develop non-traditional points of sale.

The market research firm responsible for twice yearly pharmacy audits has performed only one and it fell short of the assigned scope of work. A new firm will likely be contracted. The CSM program has not had the benefit of audit data, and because it recently changed distributors, has yet to get a handle on the number of retail outlets through which its products are being sold. In terms of measuring program impact, the CSM program has had to rely mainly on monthly sales figures.

Recent work with the production company ATELIER resulted in the ground-breaking reproductive health campaign that aired on Bolivian television from the end of April 1992 through June 1992. The eight spots that comprised the campaign were the first to openly discuss and depict reproductive organs, contraceptive methods, sexually transmitted diseases, including HIV/AIDS, etc.

Cost recovery efforts, which are not a specific program objective but are expected to be built into the program over time, have taken a back seat to more important issues such as creating an appropriate social climate for improving reproductive health and expanding the program's coverage. The CSM program will need to increase the number of products and broaden the mix in order for it to achieve self-sustainability. The launch of PROTEKTOR condoms (SOMARC's regional brand), slated for early 1993, will provide for increased cost-recovery. PROTEKTOR's price is expected to be two and half times that of SULTAN (2.5 Bolivianos versus 1 Boliviano for a three-pack).

Findings and Conclusions

Sales Figures

By October 1993 the CSM program was to have sold 186,000 cycles of NORIDAY and 738,000 condoms. To date the CSM program has sold over 270,000 cycles of NORIDAY and 829,407 condoms, putting it a full year ahead of schedule. Sales projections for pills other than NORIDAY (low dose and triphasic) and IUDs are unlikely to be met. Protracted negotiations with SCHERING delayed the launch of MINIGYNON, cumulative sales of which total 28,020 (through August 1992). Adding a triphasic pill and Copper-T 380A IUDs will require further study and negotiations.

CSM sales figures have proved two things: 1) that the program has been a resounding success; and 2) that program management made a wise decision when it discontinued with ABENDROTH in favor of ACENTRAL. In spite of a two month stock out of NORIDAY (through no fault of the CSM program) sales through July 1992 exceeded sales for all of 1991. SULTAN sales, too, are showing a marked increase over the previous year.

Market Share and Product Positioning

It is not clear what the CSM program's share of the pill and condom market is. In a draft marketing plan for 1992-94 the CSM program determined the pill market in this way: the 1989 DHS pegged pill prevalence at 1.9 percent or 271,107 cycles but commercial distributors believe the pill market to be 20 percent greater, bringing the number of cycles up to 325,000. Add to this a 7 percent annual increase. Using this formula the CSM program's NORIDAY captured 22 percent of the pill market in 1991. However, in another, more recent document, SOMARC estimates NORIDAY's market share at 40 percent. There are three possible explanations for this discrepancy: 1) the CSM program/SOMARC is making very confident projections for 1992; 2) they revised their method for quantifying the total pill market; or 3) the overall pill market has shrunk.

Whatever the explanation, several impact evaluation issues remain. If the pill market is growing steadily at 7 percent per year but NORIDAY's share is increasing from 22 percent in 1991 to 40 percent in 1992, does that mean that many NORIDAY users are simply switching from more expensive commercial brands ? Who are NORIDAY and MINIGYNON consumers ? Are they, in fact, the targeted middle and low-income consumers? What percent are low-income ?

Social marketing programs with solid educational and promotional components often increase demand not only for their own brands but for all competing brands — be they distributed for free or sold — in that product line. Have the efforts of the CSM program in Bolivia resulted in this so-called "halo effect?"

The condom market was estimated to be 1,318,000 units in 1991. SULTAN captured 29 percent of this market.

According to the draft marketing plan for 1992-94 referred to above, the CSM program is planning to promote the higher priced MINIGYNON and PROTEKTOR at the expense of the lower priced NORIDAY and SULTAN. Plans to phase out SULTAN have to do with A.I.D.'s decision to discontinue the brand. SULTAN's demise aside, CSM program plans reflect longstanding SOMARC policy: 1) to wean social marketing programs from donated commodities by transferring the responsibility of social marketing to private contraceptive

manufacturers such as SCHERING; and 2) to increase cost recovery, thus PROTEKTOR's relatively high price.

Whatever their respective market shares, evidence indicates that NORIDAY and SULTAN are popular, well established brands. Perhaps the CSM program should not be so quick to phase them out, particularly as the program plans to expand to rural areas where the higher price of MINIGYNON and PROTEKTOR could be a barrier to use.

CSM Program Sales Compared with Other Provider Service Statistics

In 1991 the CSM program sold 88,934 cycles of NORIDAY, nearly two and a half times the amount distributed or sold by five USAID-assisted NGOs (37,900). The CNS distributed 200 cycles. The CSM program sold 376,743 SULTAN condoms in 1991. The NGOs sold or distributed 680,000 condoms. If the CSM program's estimate of the 1991 condom market is correct (1,318,000 pieces), that would mean the NGOs accounted for over 50 percent. Either the CSM program underestimated the market, or people have radically changed their contraceptive procurement practices since the 1989 DHS which found that 66 percent of Bolivian users get their condoms from pharmacies.

In the first six months of 1992, the CSM program sold 64,761 cycles of pills (NORIDAY and MINIGYNON combined), or four times as many cycles as were sold or distributed by six USAID-assisted NGOs, the CNS and the MOH combined.

In those same six months the CSM program managed to sell 165,168 SULTANs in spite of stock outs and a change of distributor, as compared with 169,245 condoms sold or distributed free of charge by six USAID-assisted NGOs. The CNS and MOH together distributed or sold nearly 3,000 condoms.

SOMARC's Management of Buy-In Funds

USAID has obligated, through September 1993, $550,000 out of the $940,00 budgeted for the CSM program. SOMARC pays 100 percent of the program manager's salary. The program manager devotes approximately 65 percent of his time to the CSM program and 35 percent to helping PROSALUD market its clinic services. The program manager can afford to divide his time in this manner because often he is unable to proceed with social marketing activities while waiting for approvals or a disbursal of funds from SOMARC. SOMARC's management structure appears unduly complicated: the chief technical advisor to the program is in Colombia; the regional office is located in Mexico; and the central office which controls all financial decisions is in Washington, D.C. Movement or disbursement of funds is one problem. Under-budgeting could prove to be another. The yearly buy-in to SOMARC has ranged from $150,000 to $250,000. However, if mass media campaigns such as the most recent one are to be carried out on a yearly basis, these amounts are insufficient. The eight spot campaign, totaling 23 minutes, cost less than $15,000 to produce but over $100,000 to air.

The CSM program manager appears able and ready to handle greater technical and financial responsibility.

The CSM Program and PROSALUD

The CSM manager is clearly involved in PROSALUD (approximately 35 percent of his time) but the degree to which PROSALUD is involved in the CSM program or to which the two entities interact, is somewhat unclear. PROSALUD rents office space to the CSM program, handles its accounts, etc. The only CSM product that PROSALUD sells at present is MINIGYNON. PROSALUD's institutional marketing capacity consists of one person — the CSM program manager.

Coordination between the CSM Program and Other Components of the RHS Project

The CSM program has little or no interaction with the other components of USAID's Reproductive Health

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Services Project. The NGOs do not seem to be referring their continuing pill and condom users to the CSM products available in pharmacies. Clinics should consider developing referral policies concerning the re-supply of continuing pill and condom users. If a consulting fee is charged each time, the user is being unnecessarily burdened. If no consulting fee is charged, the clinic and its staff may be shouldering an unnecessary burden in terms of commodity management and logistics, as well as staff time.

The CSM program manager attends IEC subcommittee meetings from time to time. He did not mention ever having attended services subcommittee meetings. Presumably a PROSALUD staff member regularly attends these meetings. The CSM manager expressed a willingness to attend IEC subcommittee meetings more frequently and share with its members CSM educational and promotional materials provided he was not required to obtain their approval for distribution or broadcast.

Recommendations

1. Increase Funding to CSM through PROSALUD

SOMARC should use the remaining planned buy-in funds over the proposed extended life of project (9/97) for technical assistance. SOMARC should consider focusing on three areas: advertising; monitoring and impact evaluation research; and where necessary or beneficial, international negotiations to obtain new products for the CSM program. An additional $900,000 should be provided directly through the appropriate funding mechanism to PROSALUD for management and implementation of the CSM program, including salaries. A suggested annual apportionment is $250,000/$250,000/$200,000/$200,000. PROSALUD/CSM would be free to contract for additional technical assistance as needed.

PROSALUD is the only organization capable of implementing the CSM program given a) its involvement to date, including the appearance of PROSALUD doctors in the recent, pioneering TV campaign on reproductive health; b) its own marketing orientation; and c) its proven ability to manage USAID funds. Importers/distributors such as ABENDROTH have shown themselves, for the time being, to be incapable of properly serving the social objectives of the CSM program. Not even SCHERING is willing to make the educational/promotional investment necessary given Bolivia's relatively small contraceptive market, which is why they chose, rather, to collaborate with the CSM program. Moreover, given the Bolivian socio-cultural environment, the CSM program should continue to be based in, or affiliated with, a not-for-profit, clinical organization.

2. Greater Integration of CSM within PROSALUD

Social marketing, in general, and the CSM program in particular should be firmly institutionalized within PROSALUD. The current program manager and additional staff scheduled to come on board in 1993 would all become full-fledged PROSALUD employees.

3. CSM Should Expand its Product Mix

Funds to PROSALUD for CSM should be front-loaded so that the program can make a serious push towards acquiring new contraceptive and other products essential to increasing its potential for cost-recovery and eventual self-sustainability.

In terms of contraceptives, there is a need for longer-duration, and therefore relatively less expensive, products such as an IUD. Higher priced contraceptives can be used to generate income and cross-subsidize lower priced contraceptives. They should not, however, substitute for or be marketed in place of lower priced family planning products. In other words the CSM program should continue to sell a pill in the price range of NORIDAY (already high for rural areas) and a condom in the price range of SULTAN, if not the actual brands, NORIDAY and SULTAN .

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Cost recovery and sustainability would be better achieved, that is without compromising the program objective of serving low-income Bolivians, through the sale of curative, primary health care products such as ORS. PROSALUD/CSM should consult and possibly collaborate with the Child and Community Health Project (CCH) on product selection and education/promotion.

4. USAID Should Continue Commodity Support for the CSM Program

USAID should continue to provide pills and condoms. As mentioned above, the CSM program should maintain a low priced pill and condom in its product mix. Given that NORIDAY and SULTAN are well established brands, the program should consider a) continuing to market LO-FEMENAL as NORIDAY (if the program is unhappy with the dose or composition it can always substitute another USAID-donated pill, calling it "new and improved NORIDAY"); and
b) ordering and applying SULTAN stickers to the foil of A.I.D.'s NO LOGO/MADE IN USA condoms — over the manufacturing date which customers tend to confuse with expiry date.

5. Greater Coordination between the CSM Program and NGOs

A CSM Program staff member should try to attend IEC subcommittee meetings once quarterly. The CSM program manager should market the CSM program — the social marketing approach as well as the program's products — to the NGOs and other reproductive health services providers. He could do this making several presentations to the services subcommittee and attending their meetings at least twice annually. The CSM program stands to gain from greater collaboration and coordination in two ways: a) clinic referrals to pharmacies; and b) when and if the program offers IUDs or other methods labelled "clinical," it will be able to refer consumers for insertion and/or follow-up to a larger pool of clinicians in a greater number of geographical areas (PROSALUD has limited geographical coverage). The CSM program should consider incorporating the Reproductive Health logo in its packages.

6. Expand the Role of CSM to Include Supplying the NGOs with Commodities

By 1995/96 the CSM program should be carrying the same mix of products currently offered by NGOs in their clinics and through community based distribution: IUDs, pills, condoms, and spermicides. By that time all USAID-assisted NGOs should be charging clients for family planning commodities. The CSM program could sell the products at wholesale prices to the NGOs, who in turn could make a retailer margin on their sale to clients. CSM distribution to the NGOs would be beneficial to the CSM program, the NGOs, and USAID. The CSM program would benefit from an expanded, medically-supported distribution network; the NGOs would benefit because they would be able to offer their clients advertised, name brand products; USAID would benefit because the implementing entity — specifically the logistics/service statistics specialist — would be relieved of ordering, picking up and delivering commodities.

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Appendix F

Recommendations

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Recommendations

General

1. Given the initial success of the Reproductive Health Services Project, expansion of activities, particularly in the public sector, is warranted. The project should be extended by at least two years. The overall funding should be increased by $7.2 million for a total of $16.5 million. Although a pipeline analysis of expenditures indicates ample margins currently, additional funds need to be allocated for the following reasons:

   a. The start-up phase of the project has ended and many of the activities (e.g., the CNS, IEC, training, and social marketing activities) will be accelerating their expenditure rates in the second half of the project.

   b. By appropriately seizing targets of opportunity, the project managers have invested beyond the planned amounts in priority activities such as services, training, management, and project coordination carried out by Pathfinder International, Mothercare, and FPMD.

   c. New opportunities are opening up, particularly in public sector health services, which warrant greater investment. An implementation unit and an increased level of buy-ins to centrally funded projects will need to be funded immediately to take advantage of these opportunities.

Public Sector

Ministry of Health

2. The Reproductive Health Services Project should be amended to provide support to strengthen reproductive health services in selected districts which are receiving support for improved service delivery from the World Bank, IDB, the Community and Child Health (CCH) project,[1] and other donors. Priority should be on urban and peri-urban areas, but a few rural districts should be included. Required support should be determined on the basis of detailed diagnosis and planning carried out collaboratively with district and *unidad* authorities and the relevant donor agency. The project could support several districts initially with expansion to additional districts as experience warrants. Criteria should be developed for selection of districts to participate in the project. Criteria could include committed leadership in reproductive health at the district level; commitment to maintain key staff in place for at least two years; support from the *unidad* level; selection of two districts from a given *unidad* to facilitate exchange of experience between districts and to make training and other interventions more cost effective. In order to implement this recommendation, it would be necessary for the USAID Health and Human Resources Office to identify or create an implementing entity.

3. Project management should explore with the MOH unit responsible for reproductive health what additional support is needed (e.g., IEC, training centers, etc.) to strengthen the ministry's reproductive health work and how the CAs that participate in the project could best assist. Support to the MOH should be designed so as to reinforce the development of reproductive health service capability in the selected districts.

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[1]This is a USAID-funded effort to strengthen, among other things, primary health care and water supplies in six rural health districts.

National Social Security Institute

4. Support for this activity as currently designed should be continued with increased attention to training, management (including clinic management), IEC, and quality of care. Pathfinder is in a particularly strong position to provide continued technical assistance for improved clinic management.

5. Support should be provided for detailed diagnosis and planning for expansion of the reproductive health program to a national scale by 1993. FPMD is the appropriate CA to provide this assistance.

Population Policies Unit

6. The Reproductive Health Services Project should maintain a flexible position with respect to support in the area of policy. If the political/governmental climate is favorable, support to UPP should be continued at current levels for additional studies and analyses. If the climate is less favorable, the project should support UPP at a reduced level and should seek ways of funding studies at such Bolivian research institutions as the Development Corporation of Santa Cruz (CORDECRUZ), the Center for Population Studies, San Simon University (CEP), and Population Research and Action Service (SIAP).

Non-Governmental Sector

Non-Governmental Organizations

7. Major assistance under the Reproductive Health Services Project should be confined to those NGOs that can have a substantial impact on reproductive health.

8. Direct support should be provided to PROSALUD to facilitate the rate of clinic expansion in El Alto and La Paz and to test a health clinic franchising concept. Indirect support of PROSALUD should be continued and expanded appropriate to the institution's absorptive capacity.

9. Support for Fundacion San Gabriel should be increased to extend reproductive health services to its outreach clinics and networks.

10. Management support for CIES, through FPMD, should continue contingent upon a strong commitment on the part of CIES and rapid progress toward self-sufficiency.

11. Other NGOs active in reproductive health that are committed to self-sustainability and willing to provide service statistics should continue to receive limited indirect assistance such as training and access to commodities (which must be sold rather than given away).

12. Criteria for limited grants to selected NGOs should be established. They should include service to special target groups of interest to USAID and collaboration in operations research activities.

Private Physicians

13. A study should be undertaken to determine the current volume and pricing structure of reproductive health services supplied by private physicians, the extent of underemployment in this group, and the feasibility of utilizing this resource to reach under-served groups.

The Contraceptive Social Marketing Program

Coordination between the CSM Program and Other Components of the Reproductive Health Services Project

14. SOMARC should use the remaining planned buy-in funds over the proposed extended life of project (until September 1997) for technical assistance. An additional $900,000 should be provided directly through the appropriate funding mechanism to PROSALUD for management and implementation of the CSM program, including salaries.

15. Social marketing, in general, and the CSM program, in particular, should be firmly institutionalized within PROSALUD. The current program manager and the additional staff scheduled to come on board in 1993 should all become full-fledged PROSALUD employees.

16. The CSM program should expand its product mix. Funds to PROSALUD for CSM should be front-loaded so that the program can make a serious push towards acquiring new contraceptive and other products essential to increasing its potential for cost-recovery and eventual self-sustainability.

17. USAID should continue to provide pills and condoms for the CSM program. As mentioned above, the CSM program should maintain a low-priced pill and condom in its product mix.

18. An effort should be made toward greater coordination between the CSM program and NGOs. A CSM program staff member should try to attend IEC subcommittee meetings once quarterly. The CSM program manager should market the CSM program — the social marketing approach as well as the program's products — to the NGOs and other providers of reproductive health services.

19. The role of the CSM program should be expanded to include supplying the NGOs with commodities. By 1995/96, the CSM program should be carrying the same mix of products currently offered by NGOs in their clinics and through community-based distribution, i.e., IUDs, pills, condoms, and spermicides. By that time, all USAID-assisted NGOs should be charging clients for family planning commodities.

Cross-Cutting Issues

Priority Target Groups

20. The project should retain its focus on urban and peri-urban populations with selected rural activities that provide knowledge and experience for reaching this group.

21. Through existing mechanisms (NGOs, the CNS, etc.) and expanded MOH activities, Tarija, Oruro, and Sucre should be added to La Paz, Santa Cruz, and Cochabamba as target areas for the project. With the addition of these secondary cities, the project will be operational in most of Bolivia's major urban and peri-urban centers, representing 89 percent of Bolivia's urban population.

22. Men should be included as a special target group, given their importance in reproductive health decision making. Also, young adults should be a special target group because of their predominance in the population.

23. Given the potential health impact of a strengthened public sector and the growth potential of the commercial sector (CSM), the balance of project support should be tilted more toward those sectors, without neglecting NGOs.

IEC Activities

24. Future IEC products should include greater professional communication input into the process.

25. The current strategy should be modified to accelerate development of messages for key audiences, such as peri-urban and rural women and men from all segments of Bolivian society.

26. The PCS project should coordinate closely with Mothercare and PROSALUD/SOMARC, which have moved into television and radio, and should collaborate with UPP to support policy initiatives.

27. The PCS project should expand the breadth of its current activities to include Tarija, Oruro, and Sucre as services become available.

Training

28. JHPIEGO should assess the needs of the identified six training centers and work with each of them until they are fully functional and operating.

29. The project should arrange a major buy-in to the PAC IIb project (Development Associates) to help develop and implement a project-wide training strategy for both pre- and in-service training.

Research

30. The buy-in to The Population Council should be increased to add an additional research/project management professional plus support staff to the INOPAL project to enable it to provide more technical assistance, carry out more studies, and provide managers with timely information to improve operations.

Logistics

31. The Reproductive Health Services project should hire a full-time person, located within the proposed implementing entity, to focus on logistics issues. This person would be responsible for making commodity projections, ordering commodities, and clearing and distributing commodities to the appropriate service providers until the contraceptive social marketing program takes over these responsibilities. He/she would provide continuous, hands-on assistance to NGOs and the CNS in the use of the QUIPUS system. Furthermore, this person would coordinate a to-be-established logistics subcommittee attached to the services subcommittee. The logistics specialist could also help the MOH in terms of monitoring the availability of commodities at the district level. The logistics specialist should maintain linkage with the FPLM project or could perhaps be contracted through a buy-in to that project.

32. All NGOs should, for purposes of improved logistics management and cost recovery, sell USAID-donated commodities rather than distribute them free of charge. When clients pay for contraceptives, they are far more likely to use them.

Data Collection and Evaluation

Service Statistics

33. The full-time logistics specialist attached to the proposed implementing entity, should be responsible for a) assisting health providers with QUIPUS; b) recommending to USAID the duration and timing of technical assistance visits from OPTIONS; c) collecting and refining service statistics; and d) helping service providers use this data to improve commodity management and service delivery.

34. The QUIPUS system should be evaluated one year from the appointment of the resident logistics/service statistics specialist. An outside group with no stake in QUIPUS, such as PRISMA[2] or a similar organization, should be contracted for the evaluation. If QUIPUS proves too difficult to incorporate, or inappropriate to the needs of the various service providers, an alternate system will have to be found or developed.

Management Information System

35. Assistance should continue to be provided to collaborating NGOs to develop cost accounting capabilities and to encourage them to set targets for increased financial self-sufficiency. Pathfinder and other CAs should also give attention to these requirements.

Surveys

36. A second DHS in Bolivia, scheduled for 1993, should continue to be supported as planned.

Medical Barriers

37. Training should continue to be provided to ensure the technical competence and counseling skills of providers.

38. Training should continue to be provided to a wide variety of providers: doctors, nurses, auxiliary nurses, social workers, community-based distributors, health promoters, traditional birth attendants, pharmacists, etc.

39. Training should continue to be provided in a broad context — e.g., management skills, medical skills, interpersonal skills, logistics, quality care, and motivational seminars.

40. Clinic personnel should be trained in teams to ensure that the same information is transmitted to the client, to facilitate patient flow, and to gain the confidence of potential clients.

41. Efforts to expand method mix through IEC, policy, and commercial activities should be promoted.

42. Support should be provided to the public sector on future editions of the MOH's MCH norms to ensure that they include approval of more methods, support the authorization of more service providers, and broaden the criteria for women who are eligible for the use of different methods.

Reproductive Health and AIDS/STD Linkages

43. USAID should identify an appropriate organization to conduct a study to measure the incidence of STDs among women seeking reproductive health care. This information would be useful in planning the integration of AIDS/STD prevention and control activities and reproductive health services. If the incidence of STDs proves to be high, service providers may want to consider reducing the IUD's share in the method mix.

44. A workplace-based education program on AIDS/STD/reproductive health should be developed. An appropriate NGO or institutional consortium should target predominantly male factories, mines, labor

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[2]A Peruvian NGO contracted to manage the public sector logistics system, particularly the distribution of commodities for the Peruvian MOH.

organizations, etc., with a primary objective of delivering AIDS/STD education, and a secondary objective of providing other reproductive health information, including family planning.

45. USAID should identify an appropriate organization to conduct a study to determine how and where men self-treat for STDs (pharmacies, injectionists, traditional practitioners, etc.). By ascertaining where men go to seek help when they have STDs, USAID can plan to use that network for the dissemination of AIDS/STD and other reproductive health information. Once again, condom sales could follow.

Reproductive Health and Health Projects Linkages

46. A diagnosis should be made of reproductive health services needs in selected districts of the CCH project, and the Reproductive Health Services Project should be amended to provide the required inputs.

47. The possibility of incorporating health products such as ORS in the CSM scheme should be explored.

Role of Cooperating Agencies

48. The following summarizes recommendations for each Cooperating Agency/project:

- Development Associates — Increase funding level by $950,000 for expanded scope of work
- FPMD — Increase funding level by $800,000 for added management technical assistance, particularly to the public sector.
- Pathfinder — Increase funding level by $934,000 for technical assistance in service provision to public and private sectors.
- Population Council — Increase funding level by $550,000 for increased operations research and additional in-country personnel.
- JHPIEGO — Maintain planned funding level for clinical training in accord with revised implementation plan.
- PCS — Maintain planned funding level for IEC in accord with revised implementation plan
- RAPID — Maintain policy activities with current obligated funding.
- OPTIONS — Maintain policy activities with current obligated funding.
- SOMARC — Maintain planned funding level for technical assistance to CSM program.
- Institute for Resource Development — Maintain planned funding for 1993 DHS Survey.
- Mothercare — Maintain planned funding for project completion.

Project Management and Coordination

National Coordinating Committee for Reproductive Health

49. The project should continue to support the coordinating committee mechanism and the technical subcommittees through financial and technical assistance from the CAs.

Implementing Entity for Reproductive Health Work in Health Districts

50. An implementing entity should be identified or established which can provide technical and financial assistance to health districts, coordinate and collaborate with other donor agencies working in the districts, and help coordinate CA assistance in this area.

Project Management Unit

51. The project management unit at USAID should ensure that the MOH and the CNS have the necessary technical assistance to undertake a detailed diagnosis and planning effort for development and expansion of reproductive health services.

52. The project management unit should revise the plan for monitoring reproductive health activities to take account of inadequacies in the existing service statistics systems.

53. The project management unit should ensure that participating Bolivian institutions understand A.I.D. norms and regulations and should give the institutions increased responsibility for decision making regarding implementation of project-supported activities.