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EVALUATION REPORT:  
FAMILY PLANNING MANAGEMENT DEVELOPMENT  
BOLIVIA PROGRAM

JULY 1995

Peggy Levitt

**FAMILY PLANNING MANAGEMENT DEVELOPMENT**

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## ACRONYMS

AD	Associated Doctors Program
BOD	Board of Directors
CA	Cooperating Agency
CBD	Community-Based Distribution
CEMOPLAF	Centro Médico de Orientación Familiar
CIES	El Centro de Investigación, Educación y Servicios (The Center for Research, Education and Services)
CNS	Caja Nacional de Salud
CYP	Couple-Years of Protection
DHS	Demographic and Health Survey
FPIA	Family Planning International Assistance
FPMD	Family Planning Management Development
IEC	Information, Education and Communication
IPPF	International Planned Parenthood Federation
IUD	Intra-uterine Device
MIS	Management Information Systems
MOH	Ministry of Health
NGO	Non-governmental Organization
NRHP	National Reproductive Health Program
RA	Resident Advisor
RH	Reproductive Health
RHP	Reproductive Health Program
USAID	United States Agency for International Development

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## I. EXECUTIVE SUMMARY

FPMD's work in Bolivia focused primarily on two agencies: The Centro de Investigacion, Education, y Servicios (CIES) and the Caja Nacional de Salud (CNS). When FPMD began working with CIES, the organization was floundering. Its future leadership and direction was unclear, productivity had decreased, and donor confidence was declining. Likewise, the new Reproductive Health Program (RHP) at the CNS faced serious barriers to service delivery including the program's political vulnerability, the bureaucratic context in which services were delivered, and persistent physician opposition to family planning service delivery.

In response to these concerns, FPMD devised and implemented multiple interventions with each agency. Work with CIES focused on improving productivity and quality of care, strategic and operational planning, rationalizing and decentralizing financial and administrative management, revising and strengthening central office organization, improving management information systems, and bolstering financial management and self-sufficiency. With the CNS, activities centered on creating a RHP administrative and management structure, strengthening service delivery with a particular focus on quality of care, creating planning capacity, and instituting management information systems.

Section II of this report details the results of this evaluation of FPMD's work with the two organizations. The section is divided into subsections for each organization. Within those subsections, areas are looked at in terms of the state of affairs before FPMD interventions, what the interventions were, and the status of the activity area as of December 1994.

Both CIES and CNS have taken significant steps toward improving their management systems, due in large part to FPMD's assistance. Overall indicators of quality of care and productivity at CIES have improved. A survey of CIES clients revealed a generally high level of satisfaction with the agency's services, CIES staff acquired the capacity to produce and effectively use strategic and operational planning, staffing patterns and the service delivery mix are organized in a more rational, cost-effective way, and financial and administrative management has been decentralized. Though important gains have also been made with respect to financial management and self-sufficiency, this is still an area where CIES needs further assistance.

Work with the CNS has also resulted in significant gains. Despite serious political and organizational barriers, the RHP now has a management structure, staff capacity to produce strategic and operational plans, and heightened productivity. FPMD is currently working closely with 2 clinics to develop a replicable model for improving quality of care.

FPMD's work in Bolivia also resulted in important lessons learned, detailed in Section IV. Particularly salient is the need to think more about who the recipients of technical assistance should be. Capacity building needs to be shared among central office staff as well as be diffused more effectively to the clinic level. There is also a need to fine-tune the type of assistance that is provided and to build staff capacity to be effective recipients of that assistance.

## II. RESULTS

### *The Centro de Investigacion, Educacion, y Servicios (CIES)*

The Centro de Investigacion, Educacion y Servicios (CIES), founded in 1987, is one of the principal family planning providers in Bolivia. CIES' three areas of activity include service delivery; Information, Education, and Communications (IEC); and research. Before FPMD began working with CIES in 1991, the institution ran 6 clinics staffed by 52 employees and supported by a budget of \$293,803. Its clinics, Community-Based Distribution (CBD) program and Associated Doctors (AD) program distributed a total of 12,417 Couple-Years of Protection (CYPs). CIES was facing a serious leadership crisis. Its founder and Executive Director had taken an extended leave, the future leadership of the organization was in question, and productivity had decreased. Confidence in the organization had declined because donors perceived the organization was floundering.

FPMD worked with CIES in the areas of service delivery, planning, administration, finance, and management information systems. The following sections outline the state of affairs at CIES before FPMD began working with the organization, FPMD's activities in each of these areas, and CIES' status in December 1994.<sup>1</sup>

#### A. Service Delivery

##### 1. Quality of Care

*Before  
FPMD*

Prior to FPMD's work with CIES, quality of care varied widely among the agency's clinics because there were no established standards for care or systematized medical protocols. Since CIES had no data on client satisfaction, the agency was hardpressed to identify its strengths and weaknesses and to fine-tune services accordingly. CIES' method mix was skewed toward a single method; the agency offered a more restrictive range of methods and array of services. The agency's CBD and AD programs were also poorly administered.

*FPMD  
Activities*

FPMD worked with CIES to standardize medical and administrative procedures and to develop training and supervisory protocols that would ensure their implementation. FPMD helped CIES restructure and systematize the organization of service delivery, including the CBD and AD programs. FPMD also funded a client satisfaction survey.

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<sup>1</sup> This evaluation was completed in December 1994, six months before the end of FPMD's project. However, most project activities in Bolivia had been completed by this time. In cases where further work was anticipated, this is noted.

*Current Status*

All clinic directors have been trained and retrained in contraceptive technology, counseling, and clinic norms and procedures. Medical protocol manuals were developed and said to be distributed to all Clinic Directors. Site visits conducted for this evaluation, however, revealed that manual use was not consistent across clinics. Some clinic directors reported that although they had participated in developing clinic norms, they had not received the finished manuals. They used their own personal standards of care to guide their medical practice.

The distribution of CIES' method mix remains fairly constant. Whereas in 1991, 55% of new users accepted condoms and 27% used IUD's, now 30% and 52% use IUDs, and condoms respectively (See Table 1). Results from the client satisfaction study revealed that most CIES clients look favorably upon the agency's services. The study also suggested that CIES should think more about the particular population groups it serves, focus more on promotion among prospective client groups, and devote resources to improving counseling services (See Appendix 1 for a more in-depth account of study results). The agency has already taken steps to better its counseling program. A single, better-trained staff person has been made responsible for counseling in each clinic; information will be provided in a more private setting.

2. Productivity <sup>2</sup>

*Before FPMD*

Organizational productivity declined between 1991-1992 due to CIES' management crisis. Total family planning users across program components decreased from 33,781 to 27,429 (19 percent). (See Table 2/ Graph 1). In addition, clinic-based services including total attentions and total family planning attentions also declined. CIES donors were understandably concerned.

*FPMD Activities*

FPMD advisors worked closely with CIES managers to completely restructure the agency and to rationalize resource and staff expenditures. Technical assistance also focused on the number and locations of CIES clinics, staffing patterns, and the service delivery mix.

*Current Status*

CIES currently operates nine clinics (See Graph 2). Service utilization data are offered in Tables 1 - 8. Salient points are highlighted here.

Though CIES has yet to regain its 1991 service delivery levels (33,781 total family planning users), volume is steadily increasing. The total number of family planning users, across program components, increased from 32,014 in 1993 to 32,582 in 1994 (See Table 2/ Graph 1). CIES must put more effort into recruiting new family planning users which declined from 14,629 in 1993 to 13,423 in 1994 (8%).

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<sup>2</sup> Data from the last quarter of 1994 (September - December) are projected.

CIES did make progress toward improving clinic performance. Total visits (including all services) increased from 32,187 in 1993 to 32,725 in 1994. Though total family planning visits decreased from 9,812 in 1993 to 9,604 in 1994, the Couple Years of Protection (CYPs) distributed in clinic settings rose from 6,202 to 6,641 in that same time period (See Table 3/Graph 3).

The proportion of family planning services provided compared to other services remained fairly constant (30% of total attentions in 1993 compared to 27% of total attentions in 1994). Other services to women increased from 40% to 46% in the same period (See Table 4/Graph 4).

Though the number of CYPs distributed in clinics increased, overall CYPs across program components declined from 22,519 to 17,555. This is primarily due to a reorganization of the AD program (CYPs declined from 14,001 to 8,769) and changes in data collection procedures. There was also a slight decline, from 2,316 to 2,145, in the numbers of CYPs distributed by the Community-Based Distribution (CBD) program in the 1993-1994 period (See Table 5/Graph 5).

In-clinic productivity increased. Whereas in 1993, it took an average of 1.6 contacts to distribute one CYP, it took 1.4 in 1994 (See Table 6). Productivity declined slightly in the other program components (.5 to .6 for the AD program and 6.1 to 8.2 in the CBD program) but again, this may be due to program reorganization. The rate of patients seen per hour varied significantly by clinic with the older, more established clinics working at almost capacity (between 3.2 - 3.4 patients per hour) and the newer clinics ranging from 0.2 to 1.1 patients per hour (See Table 7).

CIES' performance with respect to yearly service delivery goals was mixed. By mid-year, the agency achieved 41% of its goal for clinic visits and only 32% of its goal for new family planning users (See Table 8/Graph 6).

Some reasons suggested by staff members for declines in service utilization include: (1) more competition from other providers, including those who provide lower cost or free services, (2) management improvements in the AD and CBD programs resulting in fewer users who were better served, (See Section C below), (3) better reporting procedures correcting for previously inflated totals, (4) clinic relocations or start-ups, (5) an emphasis on self-sufficiency at the expense of service delivery, (6) personnel changes, and (7) promotional campaigns by other agencies that were not offset by comparable publicity from CIES. CIES staff also raised the need to balance growth with service delivery consolidation, citing International Planned Parenthood Federation's (IPPF) support (the agency's current principal donor) for their decision to strengthen existing services rather than pursue further expansion.

## B. Strategic and Operational Planning

FPMD provided a wide range of supports in the areas of strategic and operational planning. The project facilitated three organizational and strategic planning workshops and sponsored a fourth round of long-range planning, which coincided with this evaluation. FPMD also supported the design and installation of a Management Information System to generate data needed for the planning process. Technical advisors worked with CIES to overhaul its mission statement, statutes, and the Board of Director's role.

### 1. Mission

*Before FPMD* Prior to FPMD's intervention, CIES' statutes consisted of 10 articles with goals and objectives that ranged from increasing national capacity to administer development projects to improving the psycho-social well-being of the Bolivian people. Family planning was not explicitly mentioned nor was a strategy for achieving the stated objectives outlined.

*Current Status* CIES has rewritten its mission statement twice in the course of the project, each time moving closer to a clear, more focused articulation of the agency's goals. The current version includes a sharp statement of the agency's priorities and values, stipulates a future orientation, and strongly commits CIES to working with adolescents.

Clinic Directors felt that the agency's sharper focus helped them direct its service delivery efforts. The Potosi clinic, for example, delivered a high volume of "other services" that did not include family planning. The Director used the new mission statement to call the staff's attention to the need to focus on family planning. Clinic Directors generally felt that their staff were cognizant of and supportive of CIES' goals.

### 2. Statutes

*Before FPMD* The division of labor between the Executive Director and the Membership Assembly (a large body with ultimate authority over CIES policy) was unclear. There was often confusion about the overlapping roles of staff who also served on the Assembly.

*Current Status* The agency's statutes have been revised. Such issues as the way in which CIES would dispose of its inventory if it were to close, the distinction between staff and assembly members' roles, and rules for serving on the Board of Directors have been clarified.

### 3. Strategic and Operational Planning

*Before FPMD* Though CIES had produced department-level plans, the agency had never devised an institution-wide plan to include both short-range and long-term goals and objectives.

*Current  
Status*

With FPMD's assistance, the agency produced its first operational plan in 1993. To look at the institutional mission, whether the organization was structured effectively, and what CIES' planning needs were, FPMD supported four strategic and operational planning exercises. Staff learned basic planning techniques, defined a shared vision for the agency, participated in team building activities, carried out environmental forecasting and market analysis exercises, and set programmatic goals and objectives.

CIES' most recent plan, completed with minimal FPMD input, includes goals and indicators to measure achievements during the next three years. Each programmatic area is writing its own operational plan. Particularly impressive is that staff are using the skills they learned from FPMD and at training courses offered by other organizations to custom-tailor a planning process best suited to their needs.

The process by which clinic-level staff participate in the planning process, however, needs improvement. While some staff said they actively participated in the goal setting, others complained that they did not have input nor had they seen the completed plans.

#### 4. Board Development

*Before  
FPMD*

Due to CIES' former family-style management, the Board of Directors (BOD) often assumed too much of a direct role in CIES' daily activities. Board Members needed training in what an appropriate role for BOD members would actually be.

*Current  
Status*

Despite initial plans to do so, FPMD has never done formal board training, though some informal direction has been offered during meetings with technical advisors. Though some clarification of roles has been achieved, there is still room for improvement in this area. It seems, however, that the next Board election will ameliorate naturally some of these issues. CIES is seeking to recruit more professional members whose specific areas of expertise would benefit the agency (politicians, technicians, feminists, journalists, administrators, etc.). These individuals will be less likely to intervene in the day-to-day operations of the agency and instead build useful external relations.

Current Board members expressed three persistent concerns. First, while they acknowledge that professionalizing CIES has accrued major benefits to the agency, they are concerned that all new employees share the same vision and commitment to the agency that staff members did when it was smaller and more family-style. They want to define an institutional policy with respect to abortion and sterilization, for example, and ensure that all new employees can support it even if they do not personally agree. Second, they fear that CIES has swung too far towards a medical service delivery model and would like the agency to achieve a better balance between clinic and

community-based services. Third, they believe CIES must establish a clear market niche for itself as the "provider-of-choice" for family planning services in Bolivia.

## C. Administration

### 1. Financial and Administrative Rationalization and Decentralization

*Before  
FPMD*

Prior to FPMD's work with CIES, financial and operational management were centralized at the Central Office level. The agency had no clear staffing pattern or standardized service delivery mix. Some services and staff were in great demand, whereas others were extremely underutilized.

*FPMD  
Activities*

Teresa de Vargas, of CEMOPLAF in Ecuador, was chosen to guide CIES through a reorganization of its service delivery system because of the similarities between the two institutions. Earlier in its history, CEMOPLAF resembled CIES with respect to size, structure and the population it served. Ms. de Vargas is also well-versed in the specific technical areas that CIES needed assistance in. She worked closely with CIES to its restructure service delivery model and to rationalize staff and resource utilization.

*Current  
Status*

During the first stages of Ms. de Vargas' work with CIES, the agency adopted a standardized service delivery model across all clinics. Each clinic was staffed by the same four providers (a physician who also functioned as the clinic director, a nurse, secretary/cashier, promotor/educator, and in some cases a lab technician) and offered the same basic mix of services (although some clinics added additional services such as laboratory or sonograms to the package). During a second stage of development, and in light of its self-sufficiency and service delivery expansion goals, CIES developed three types of service delivery models that will be implemented over the next three years. At Type A clinics, CIES will attend births and perform contraceptive surgery. At Type B clinics, CIES will provide its current service delivery package as well as dental, dermatological, and cardiological services based on a cost-sharing arrangement between CIES and providers. At Type C clinics, the current service delivery package will be provided (See Table 9). Such an approach is particularly important because it represents new sources of income for CIES that could potentially improve the agency's self-sufficiency. Staff patterns will vary by type of clinic.

Ms. de Vargas also worked with CIES to clearly define staff roles. Responsibility for day-to-day operational and financial management was delegated to clinic directors. Clinics were also charged with attaining financial self-sufficiency with an eye to eventually absorbing some of the central office's operating costs. The actual success of decentralized management varied by clinic according to each individual clinic director's aggressiveness and their level of comfort with this new role (i.e. those who had been with CIES longer tended to be more independent). Most directors hire and fire their own personnel and sanction staff for poor performance. While some clinic directors

still seemed very dependent on the central office for approval over financial decisions, others readily accepted the autonomy they were offered and, in some cases, exceeded it. Because they now enjoy more responsibility and autonomy, most directors seemed to feel a stronger sense of affiliation toward CIES. Whereas previously they were employees who complied with a schedule, many now viewed themselves as representatives who should improve and promote the agency's public image.

Each month, clinic directors send service statistics and budgetary information to CIES' central office where it is reviewed by appropriate staff. Though most clinics seem able to keep accurate service statistics, their financial reporting needs improvement.

Ms. de Vargas helped CIES develop a supervisory guide, based on FPMD's *Family Planning Manager*. The Medical Director and the Director of Information try to make systematic supervisory visits but these have been sporadic at best because they lack the staff and time to conduct them on a routine basis. The lack of continuity and support that clinic staff expressed as a result should be ameliorated somewhat when a Regional Coordinator, who will act as a liaison between central office and the clinics, is appointed. In the meantime, clinics receive a status report on their achievements with respect to goals for the first six months of 1994 and they receive written follow-up reports following each supervisory visit.

Ms. De Vargas worked with CIES to improve its two non-clinic-based service delivery models:

- *Associated Doctors Program (AD)*: Prior to FPMD, CIES distributed contraceptives to the physicians enrolled in the program without monitoring their quantity or destination. Despite the high numbers of CYPs distributed, staff were uncomfortable with this free-wielding management approach. Now CIES exercises much tighter controls over the AD program. The program was revamped, resulting in more rational service delivery and a significant decline in CYP volume. Fewer ADs distribute contraceptives in well-defined work zones selected so that they do not compete with CIES clinics or reach a population capable of paying other providers. The 72 physicians currently enrolled in the program (down from 92) must attend an extensive training program, funded by Development Associates. Whereas participating physician drop-out rates previously exceeded 50%, they are now below 30 percent. The number of IUDs received by ADs at any given time is limited to between 5-10. All physicians must report on their activities. If they do not do so in consecutive months, they are asked to leave the program.
- *Community-Based Distribution (CBD)*: Before Ms. de Vargas arrived, CIES' CBD program was also extremely weak. Few of the alleged promoters were actually working. A disjuncture between the IEC and CBD programs in CIES'

previous organizational model made it unclear which area was ultimately responsible for the program. The agency accepted any volunteers without thinking about which kinds of promoters were most likely to remain in the program or were best equipped to reach the target population.

CIES now has 1-2 paid promoters working at each clinic supervising 10-15 volunteer promoters who keep a percentage of their contraceptive sales. In November 1994, there were 78 promoters working throughout Bolivia. Each works from a fixed location, with a sign and credential from CIES, so it is easier for paid promoters to supervise and supply them and for users to find them. They receive four levels of training from CIES. Since the reorganization, promoter dropout rates declined precipitously from previous levels of over 50%.

In Oruro, for example, the educator is working with 22 promoters she recruited through radio announcements. They distribute vaginal tablets and condoms. She accompanies new promoters when they are first making home visits in search of new clients and when they are learning to complete reporting forms. CIES is also trying to use adolescent, male, and university student promoters as part of its new focus on adolescents.

## 2. Reorganization of the Central Office Management

*Before FPMD* Before FPMD, the roles and responsibilities of central office staff were often confused. Decisions were made using a family-style consensus model, not in a rational, organized fashion. Reporting lines were unclear and functions were often duplicated.

*FPMD Activities* FPMD supported a reorganization of the central office management system. It provided overall management support to the Executive Director by funding an internal management consultant and through often daily technical assistance from the FPMD Resident Advisor.

*Current Status* CIES has experimented with various organizational charts in the course of its work with FPMD. The latest represents an attempt by the Board and Executive Director to create a structure that maximizes delegation of responsibility, clearly delineates lines of communication, responds to CIES's three year plan, and reflects the agency's three major activity areas. It creates four new mid-level management positions (Directors of Services; Education and Training; Research and Projects; and Finance). The positions of Personnel Manager, Evaluation Director, Systems Manager, and Director of Quality Control were also created to provide adequate support in these areas. Finally, a Regional Coordinator, already referred to, will serve as a liaison between the central office and clinics to improve supervision and contact.

Though each new organizational chart represented an important step toward better management, so much change in such a short time period is not without its costs. Such high levels of uncertainty have dampened staff morale, particularly because those who currently hold management positions will not necessarily remain in them later on.

### 3. Standardization of Personnel Management

*Before  
FPMD*

Before FPMD, there was no established human resource management system.

*FPMD  
Activities*

FPMD worked with CIES to develop personnel management protocols. These included such things as job descriptions and staff benefits.

*Current  
Status*

CIES produced a personnel manual but it is not universally accepted or used among staff. CIES still does not have a salary policy or written criteria for performance review. Some staff had serious questions about the utility of such a document.

## D. Management Information Systems

### 1. Service Statistics

*Before  
FPMD*

CIES used a Management Information System (MIS) designed for an operations research project. It was cumbersome and routinely collected more information than CIES needed. There appeared to be some confusion about how to accurately record certain kinds of services; significant reporting deficiencies and irregularities were probably common. The agency's financial and inventory control systems were all manual.

*FPMD  
Activities/  
Current  
Status*

FPMD funded an assessment of service statistic data quality which revealed many discrepancies between different components of the recording system. When FPMD advisors observed the actual data collection process at various clinic sites, they realized that too many parties were involved in data management and that staff were confused about how to correctly complete the forms they used.

In response to these problems, as well as to feedback from clinic staff, FPMD's technical advisors worked with CIES to streamline and clarify their data collection system, including the revision of all data collection instruments and procedures. The new instruments were specifically designed to collect information on the achievement indicators CIES stipulated in its three-year operational plan. At the time of this evaluation, the new forms were being pretested and revised. Once completed, instruction manuals were to be designed and on-site staff training would be organized. The data are processed using the Quipus system, used by all reproductive health providers in Bolivia.

## 2. Financial Management

### *Before FPMD*

Before FPMD began working with CIES, all of its financial management systems were manual. Because CIES used a single-entry (or budget-based) rather than a double-entry bookkeeping system, the agency could not track income and expenditures at the same time. It also used a cash rather than accrual accounting system and was therefore unable to take costs adequately into account as a result. The agency could not generate the data it needed to be able to calculate depreciation or overhead costs. Therefore there was no institution-wide budget or agencywide financial statements.

### *FPMD Activities*

FPMD's interventions in the financial management area focused on three goals: facilitating improvements in CIES' financial self-sufficiency through the development of income generation strategies, sharper market analyses and location studies, and incorporating financial data into operational planning (the subject of a separate section); strengthening and decentralizing the agency's financial management system, and designing and implementing a computerized financial management system. A series of FPMD-hired advisors, a senior accountant, and various consultants from CEMOPLAF, Tec-Apro, Stern and Associates, and other cooperating agencies assisted the agency toward this end. FPMD also supported CIES' first complete internal financial audit.

### *Current Status*

FPMD assistance yielded the least returns in this area. Though CIES has made significant gains, there are still major improvements to be made. An assessment of CIES' current financial health and reporting capabilities, and the reasons for its somewhat disappointing progress are as follows:

- a. The agency is currently funded by IPPF, FPIA, Development Associates, EEC/Ireland, Care, Path, and Pathfinder. CARE and the EEC are non-traditional funders of reproductive health services—a positive step toward financial viability. However, since each agency normally funds a specific project or clinic, CIES continues to face frequent cash flow problems because it lacks sufficient general funds to cover overall operating costs.
- b. CIES' budget has grown. Between 1991-1994, it increased from \$293,803 to approximately \$674,404.<sup>3</sup> CIES also manages more projects. In 1991, the agency had 8 projects; in 1994 it had 12. Though the amount of funds CIES commands has increased, the agency's capacity to manage these funds, though improved, has not kept pace with this growth. CIES' financial system is not sophisticated or developed enough to track the increasing amount and complexity of funds being channeled through the agency.

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<sup>3</sup> 2,960,632 in Bolivianos using an exchange rate of 4.39, or an increase of 56%

- c. CIES is still not in a position to meaningfully assess the level of self-sufficiency it has achieved. Because CIES could not calculate overhead and depreciation at the time of this evaluation, it is impossible to evaluate the level of self-sufficiency it has achieved.
- d. CIES' accounting system has improved, but further adjustments are needed. A significant impediment to progress in this area was that CIES lacked a counterpart who could receive and implement the technical assistance being provided. When FPMD tried to rectify this, by funding a senior financial consultant based at the agency, the auditing agency also assisting CIES was resentful, interpreting the consultant's presence as a watchdog function. The auditors were reluctant to channel information through their intended counterpart. Problems with communication and a constructive flow of information persisted.

The accounting system has improved, however, since the FPMD Technical Review in November 1993. A draft of the internal audit was submitted in December 1994. Overhead rates were scheduled to be finalized by early 1995. The final version of the financial statement audit had been submitted and approved along with the final letter of internal controls (CIES needs this so it can qualify to receive funds directly from AID rather than through an intermediary agency). The auditing consultant produced manuals on accounting procedures, for managing each type of account, for personal functions in the financial management area, and for purchases and acquisitions. He conducted a financial audit of 5 clinics. He also made suggestions about how to modify systems, produce financial statements, and restructure the finance unit. CIES now has an updated inventory, including actualized values for all its fixed assets and a depreciation table. Prior to this, the agency had an inventory but it did not include up-to-date values.

CIES now uses a double entry accounting system. However, as of December 1994, budgeting was still project-based. The agency's capacity to generate an institution-wide budget in 1995 appears likely but was still unproven. Staff claimed they could produce financial statements for each project. However, when they attempted to generate the trial balances necessary to do so, they could not. CIES is therefore still unable to produce accurate reports at the necessary level of detail. Reporting on projects is still donor-driven. Although CIES appears able to meet their donor-imposed deadlines, it does not automatically generate this information on its own, meaning the agency is not using financial data to manage or plan for its future.

CIES is still unable to calculate its cost-per-service. The current cost system is being conceptualized so as to generate cost by organizational unit. Eventually,

the agency will need to calculate a cost by product or service so it can determine if it is using its resources wisely.

- e. With respect to computerization of CIES' financial management system, the FPMD-funded management consultant visited ProSalud (a maternal and child health care NGO in Bolivia) to examine their financial management system and service delivery organization. After reviewing these and a number of other systems, including SBT, Dac-easy, and Tec-Apro, he chose Tec-Apro as best suited to CIES' needs.

A team from Tec-Apro conducted a needs assessment of CIES' financial management system which was supposed to have included an analysis of their manual accounting system. The management consultant and CIES' Executive Director selected the Tec-Apro modules that CIES would buy. The status of these modules in December 1994 was as follows:

- *Accounting:* As of December 1994, CIES' accounting system was still not computerized. A thorough overhaul of CIES' manual accounting system had recently been completed. Because this had not been done before, three previous attempts at developing appropriate accounting codes had failed. Some data organized according to project area had been incorrectly inputted into the computer.
- *Budger:* The appropriate module is installed and working correctly. Information on three funders from January - October was correctly inputted into the computer. To complete 1994, staff needed to input information about nine additional funders.
- *Fixed Assets:* This module was also working but since the codes that had been inputted differed from the accounting codes, it could not as yet generate useful reports.
- *Payroll:* Not working.
- *Inventory/Stock:* This module is not working. Contraceptive supplies to the clinics are generally adequate because quantities are automatically sent out on a regular basis. However, stocking of office supplies is inconsistent, with shortages of some materials and overstocks of others. There have also been overstocks of certain kinds of drugs. Some clinics have begun to make purchases from local distributors.

Initially, CIES contemplated using Tec-Apro to manage its service statistics as well. However, USAID decided that all Reproductive Health agencies in Bolivia would use the Quipus system. The fact that Quipus and Tec-Apro have never been linked, and it is unclear whether this is technically possible, means that CIES staff continue to transfer information manually from Quipus into Tec-Apro and that the agency cannot readily calculate cost-per-service.

In sum, though important steps have been taken computerizing financial management, further improvements remain. There are several explanations for this somewhat lackluster performance: (1) a thorough assessment and overhaul of the manual system was not carried out before computerization was attempted; (2) accounting codes were generated before the system was brought up to a basic level of quality, thus creating a typical scenario of "garbage in, garbage out;" (3) Technical assistance providers focused too much on one or two staff members and did not think enough about disseminating technical skills throughout the agency; when one critical individual unexpectedly resigned from the agency, the skills he acquired left with him; and (4) Staff in the financial unit were not adequately prepared to effectively absorb and accurately utilize the training they received.

- f. *Self-Sufficiency*: CIES is on much firmer financial ground than it was prior to the FPMD project. The agency faced the prospect of widespread withdrawal because of its leadership crisis. Now, donor confidence has been restored and, in fact, IPPF has made a major, long-term commitment to support CIES, though there are no plans for CIES to become an IPPF affiliate in the near future.

FPMD's work with CIES on financial self-sufficiency focused on two areas: income generating strategies and the development of a clinic for middle-class women. With respect to the first, technical advisors evaluated CIES' current income generating strategies and made concrete suggestions about changes in lab staffing, promotion, and cost schedules. They also assessed the feasibility of other types of activities. Several suggestions were made including: (1) CIES should capitalize on its internal markets. For example, physicians working with CIES should be encouraged to systematically refer their clients for lab work at CIES, (2) the agency should reduce lab staff so that costs are more in-line with demand, (3) CIES should use cost studies to plan future income generating endeavors, and (4) the agency should relocate its main lab from El Alto to the La Paz clinic.

CIES also contemplated scaling back its training activities as a cost saving measure. Ms. de Vargas, however, recognizing the agency's strengths in this area, suggested it externally market its training programs instead. In 1993, CIES conducted various training seminars for medical personnel and promoters from CARE, Foster Parents Plan, a Dutch government-funded NGO, and the Ministry of Health (MOH), some of which are new to reproductive health care. Cost savings and income generated as a result of these recommendations are assumed but have not been quantified.

In recent months, FPMD supported various cost-studies of laboratories, radiography, and other medical services that might prove profitable, including obstetrical, dental, surgical, and pediatric services. As mentioned previously, different kinds of cost-sharing arrangements between CIES and providers are being explored.

Clinic performance with respect to self-sufficiency varies within and between clinics. For example, the Oruro clinic was able to meet its costs until it was recently relocated causing utilization to decline. Other clinics could not cover the majority of their operating costs. Some clinic directors felt that they had not been adequately briefed about the self-sufficiency strategies they were supposed to implement.

Finally, CIES conducted an operations research project with the Population Council which tests the viability of a middle class clinic as an income generating strategy. The clinic opened in November 1993. It appears, however, that the preliminary market study done in preparation for this project was poorly conducted. The operating and infrastructural costs that CIES had to assume once the Population Council project ends were underestimated; they constitute an insuperable burden to the agency.

To date, the middle-class clinic has performed poorly because many of these women seek care from private providers. In the five months between August and November 1994, not one client had requested family planning services. However, the introduction of other services such as dermatology, endocrinology, weight control, physical therapy, and counseling had increased overall service delivery volume.

The relationship between CIES and the middle class clinic is somewhat strained. Whereas clinic staff look to CIES for financial support and assistance in promotion, CIES views the clinic as somewhat outside its traditional purview and as an income generating strategy. There is tension between medical and financial goals. Though CIES cannot afford to sustain the clinic indefinitely if it does not begin to generate profits, a financial reversal is unlikely if CIES does not dedicate the time and resources this would require. FPMD funded a revised market study, including a financial plan to achieve self-sufficiency by 1997 toward this end.

CIES also plans to begin purchasing its own infrastructure. Currently, the agency owns one clinic in El Alto. By the end of 1998, the agency hopes to own 5 out of its 12 facilities.

## ***Caja Nacional de Salud***

The Caja Nacional de Salud (CNS) delivers medical care to insured workers in Bolivia. The CNS began delivering reproductive health services in 1991, although some facilities initiated their services as late as 1993. The CNS' reproductive health program has five major components: (1) detection and management of reproductive risk, (2) family planning, (3) promotion of breast-feeding and birth spacing, (4) detection of cervical and breast cancer, and (5) detection of sexually-transmitted diseases. The family planning program at each polyclinic is staffed by a doctor, nurse, and social worker in the morning and afternoon clinic sessions.

Though the CNS is committed in principle to providing family planning services, actual service delivery varies widely across clinics. Significant barriers to improving service delivery include the program's political vulnerability, the unwieldy bureaucracy of the CNS, and persistent opposition among CNS physicians to family planning service delivery. Though improving, according to the DHS, the volume of services delivered by the public sector is low. In the first semester of 1993, however, the CNS provided an estimated 9% of all CYPs, representing a 36% increase over the second semester of 1992. Because of these dramatic increases and the organization's extensive system of providers, including 15 hospitals and 29 polyclinics, FPMD felt that its support of the CNS was warranted.

The CNS currently offers services in 9 hospitals, 18 polyclinics, and 2 rural centers (See Table 10). In 1995, it hopes to expand the RH program to rural areas including 6 sites in Santa Cruz, 4 in Potosi, 2 in the province of La Paz, and 2 in Trinidad.

FPMD's work with the CNS focused on program design, operational and strategic planning, management information system implementation, and team building. These activities are described in detail below.

### **A. Management Structure and Administration**

*Before  
FPMD*

The Management Needs Assessment conducted by FPMD in 1991 revealed that although there was support for reproductive health care provision within the CNS, the program lacked a clear organizational structure and adequate staff and resource support.

*FPMD  
Activities*

FPMD sponsored three planning workshops, which focused on program design, operational and strategic planning, defining management and administrative protocols, and team building. An organizational design for the program was selected. The FPMD Resident Advisor (RA) and consultant from the Development Group International (DGI - through August 1993 when he relocated to Miami) served as regular on-going advisors to the RH program. FPMD's current activities focus on improving quality of care and strengthening CNS management at the regional level. Technical assistance centers on two clinics.

## 1. Program Organization

One of the FPMD-sponsored workshops focused on program design. At FPMD's suggestion, a matrix model of program management was adopted, thereby allowing the Reproductive Health Program (RHP) maximum autonomy within the CNS structure. Workshop participants produced an organizational chart and a manual detailing personnel functions, supervisory systems, and lines of authority and supervision. For the first time, staff roles and responsibilities were clearly spelled out. Interviews revealed, however, that use of the personnel manual was inconsistent at best. Performance is evaluated but not based on job descriptions; salary increases are not linked to performance either.

FPMD tried to create conditions more conducive to effective program functioning such as relocating all staff to the same office so that better communication and coordination were possible and getting more, full-time staff assigned to the program. For example, central office staff now include the Director of the RHP, the head of IEC and her assistant, a program administrator, a secretary, a data processor, and a driver. They all work in the same office and are assigned full-time to the RHP. According to the program director, they each know what their roles and responsibilities are.

Though there is also a clear organizational chart and assignment of responsibilities in the regional program offices, including a Regional Medical Director, a Center Director, a Regional Program Coordinator, and a staff person responsible for the program during each shift, the RHP Director reports that these management structures work better in some clinics than in others. Because these are voluntary positions (i.e. staff receive no extra compensation for their management roles), RHP personnel are often not terribly motivated to be aggressive managers. Shift supervisors lack the authority to impose their will. Regional program staff interviewed for this evaluation claimed that the organizational chart was often a poor representation of the actual chain of command, the Regional Program and Medical Directors frequently being at odds with one another.

Though RH is now much more widely accepted among CNS staff, there is still more work to be done if the program is to become an integral part of the mission and activities of the institution. Many providers, as well as potential beneficiaries of the program, are still unaware that the CNS provides reproductive health care. Interviews with regional directors and staff members revealed a range of familiarity the RHP's mission; staff often failed to recognize RH as an integral part of the agency's preventive health mission. Problems with infrastructure and equipment shortages do little to alleviate the morale problem.

Some regional directors recognize that this must change. "Since staff earn their money from the CNS, they must be loyal to it," said one Clinic Director, "but until there is a national campaign to change the image of the agency, things will not improve."

## 2. Staff commitment

One particularly critical barrier to care has been the refusal by some providers to work in RH. Until November 1993, participation in the program was voluntary. Many physicians opposed family planning service provision for personal reasons or because they were being asked to provide an additional service without receiving additional pay. Providers who did not want to offer RH care to the patients assigned to them were supposed to refer them to other providers, creating a series of logistical difficulties and time constraints for clients that heightened barrier to care.

Staff participation has vastly improved. In the three clinics visited during this evaluation, almost all staff were working in the program.

## 3. Management Committees

During one of the FPMD sponsored workshops, program managers identified various administrative and interpersonal communications issues in need of resolution. In response, the CNS created two committees to facilitate better coordination, both attended regularly by the FPMD RA.

The Executive Committee, which met monthly, was intended to bring together regional program staff to share information on successful activities, barriers to care, and problems. Though staff found these meetings useful forums to air their grievances, they were not as effective as they could have been because the Program Coordinators who attended did not have the authority to ameliorate the problems that were presented. Regional medical directors, who do have such clout, have been invited to more recent meetings.

The Technical Committee, consisting of central office staff, serves as a weekly forum for planning and activities coordination.

Particularly at the beginning of the project, the FPMD RA actively participated in the day-to-day management of the RHP, either through her participation in these committees or her frequent visits to the RHP office. Though her assistance was critically important, there is some evidence that she may have become over-involved with the program, intervening in areas that were beyond her domain.

#### 4. Decentralization

When the RH program was created, the Program Manager had little authority to make decisions on her own. With help from the FPMD RA, she was able to secure permission to sign checks, plan supervisory trips, and allocate training resources without supervisory approval. Because of recent political events, the Medical Director of the CNS has decided to re-assume control over most of these tasks. As of January 1995, he will again be responsible for check signing, hiring, and training decisions. Although the Technical Committee will still make unofficial management decisions, members will have to secure the Medical Director's approval before they can implement their decisions. Thus, administrative management has taken a step backward, toward centralization.

Some decentralization of planning has occurred, however. Last year, during an FPMD seminar, RHP staff and program coordinators worked together to determine program goals. This year, regional program coordinators were asked to work with clinic staff to set their own goals based on previous levels of productivity. Central office staff provided forms and instructions to each physician who was to devise his or her own performance targets which regional program coordinators would then synthesize. Three clinics were able to complete this exercise on their own, 15% of the clinics have done no planning, and the rest of the clinics needed help from central office staff. The level of commitment and motivation of each program coordinator determined this range of outcomes.

Evaluation interviews revealed that not all clinics used their plans. Performance with respect to goal achievement varied widely, depending on provider effort and client acceptance of RHP services. Since, as one provider stated, "Not much happens if goals are not met," program coordinators have little recourse with which to sanction unproductive providers.

Budgeting decisions remain almost totally centralized. In fact, most regional program coordinators did not have up-to-date budgets with which to track expenditures or remaining funds. They manage petty cash but have little say about other purchases. This hinders the cash flow. According to one program coordinator, it took 45 days to purchase a pocket calculator.

#### **B. Service Delivery**

Prior to FPMD's work with the CNS, service delivery volume was extremely low due to the organizational and political issues described above. The CNS lacked concrete data on the quality of services being offered. It is widely believed that the public in general views all of the services offered by the CNS with some trepidation.

Though FPMD's technical assistance only peripherally touched on actual service delivery, such as assisting in the development of a medical protocols manual, the impact of its technical assistance is evident at the service delivery level. The project's current efforts focus on improving quality of care.

## 1. Quality of Care

FPMD sponsored six focus groups with CNS clients to determine perceptions of the RHP. These findings are summarized in detail in Annex 2. Of greatest salience here is the poor opinion most CNS users hold of the overall services and their lack of familiarity with, or understanding of, RH that constitute significant barriers to care. Many women did not know that the CNS offered RH care. Women were confused about what RH actually means. Even those women who had received program services did not always realize it because the program suffers from such a poorly defined identity. In addition, fears and misinformation about family planning as well as poorly trained staff ill-equipped to adequately respond to these issues also hinder program effectiveness.

These findings were reviewed with Medical Directors at the FPMD-sponsored Quality of Care seminar. Though not all physicians agreed with the findings, according to one physician, "they made us pay attention, they opened our eyes." However, some program coordinators interviewed for this study were unaware of the findings. Some had mistakenly interpreted the results as reflecting particularly badly on nurses, though the RH Program Director thinks they are an indictment of all program staff.

FPMD's technical advisor conducted three workshops for regional managers in quality of care which focused on such topics as service delivery with a client-oriented focus, team management, and continuous quality improvements. Focus group findings were also used as a pedagogical tool with which to redirect behavior. She is currently working in-depth with two clinics to develop demonstration models for quality of care management that, once polished, could be replicated throughout the CNS system.

## 2. Productivity

CNS clinics' exhibit a wide range of productivity levels. In Oruro, the clinic works well because the on-site director is dynamic, has successfully built a cooperative team, and functions as both Program Coordinator and Director of Outpatient Services, thereby enjoying sufficient authority to make management decisions stick. Other clinics exhibiting lower productivity levels are characterized by little team work, poor coordination, and low staff morale. Other problems include: (1) new doctors are hired under non-renewable contracts, meaning that clients must deal with constantly changing providers and administrators must constantly train a new cadre of staff, (2) some women prefer to see female providers and there are not enough women doctors to meet

the demand, and (3) the CNS is plagued by constant strikes. Productivity also varies between morning and afternoon shifts.

RHP productivity has improved considerably since the program began. Visits by new family planning clients increased 37% between 1993 (4,661) to 1994 (7,413). Return family planning visits also increased by 57% in the same time period (from 2,500 to 5,854). Total RHP visits increased by 46% with particularly impressive gains in Sucre (83%), Oruro (87%) and Potosi (76%). The total number of CYP distributed increased by 46% from 9,247 to 17,036. However, an overwhelming number of CNS RHP clients use the IUD, which account for 95% of the CYPs achieved. Three-quarters of the way through the year, the program had only achieved 38% of its goals for contraceptive distribution across methods. Other program components were not far behind ranging from STD's (51% goal achievement), obstetrical risk (38%), reproductive risk (37%) and pap smears (22%). These low productivity levels are attributable to unrealistic goal setting as well as the program's lackluster performance. However, whatever gains the CNS program is able to achieve must be evaluated against a backdrop of the organizational and political difficulties involved in providing such a politically sensitive service in a bureaucracy of this kind.

### 3. Supervision

An FPMD consultant worked with RH program staff to devise supervisory guidelines to be used during twice yearly visits to each clinic. Lack of time and resources have meant that central office staff have been unable to keep up with such a rigorous supervisory schedule. The Program and IEC directors have made some visits, however, during which they interviewed clients, met with staff, went over previous service statistics, reviewed reporting procedures, etc. After such visits they make written recommendations which are also forwarded to the Medical Director. Each clinic also receives a three month progress report which compares service delivery goals to performance. Though supervision and central - regional office contact is much improved since before FPMD; the fact that the Program Director enjoys limited autonomy curtails her ability to perform as an effective supervisor. When she is accompanied on her visits by senior-level staff, she feels that her impact increases.

One change currently under consideration that may ameliorate this would be to contract three supervisors/trainers who would each assume responsibility for various regions. This would also prevent the momentum and motivation generated during supervisory visits from quickly dissipating because the intervals between contacts are too great.

### C. Management Information Systems

Prior to FPMD there was a very weak data collection system.

*Before  
FPMD*

*FPMD  
Activities*

FPMD and Pathfinder conducted an overhaul of the CNS data collection system. The two agencies redesigned data collection instruments and instruction manuals and trained staff in their use.

*Current  
Status*

Though data collection and accuracy have greatly improved, the Program Director feels that under-reporting is still a problem because physicians are negligent about filling out forms. There are also major discrepancies between the numbers of contraceptives distributed according to clinic registries and the sums generated by the system of inventory control.

### ***Additional Project Activities and Benefits***

FPMD also supported a range of additional activities that are briefly summarized below.

#### **A. Activity Facilitation and Coordination**

USAID asked FPMD to facilitate and coordinate the activities of other Cooperating Agencies (CA) non-resident in Bolivia. The RA worked with the following agencies:

##### **1. Population Communication Service (PCS)**

FPMD supported PCS in their efforts to develop a 5-year national RH communications campaign. It helped develop a national logo, print materials, media campaigns, in-clinic videos, and promotional cassettes for buses. Though these materials were primarily targeted at urban audiences, PCS is now refocusing its energies to reach rural audiences. The FPMD RA also helped facilitate PCS' training seminars in RH counseling and marketing.

##### **2. Development Associates (DA)**

DA sponsors training of trainers courses for nurses and health promoters. The FPMD RA managed the training course preparations and implementation process.

##### **3. JHPIEGO**

The FPMD RA helped JHPIEGO set up its operations in La Paz, where it supported RH training centers developed by the Pan American Health Organization (PAHO). The RA's efforts focused on coordinating the development of a RH reference manual for physicians.

## **B. Other Activities**

FPMD was instrumental in forming training, management, service-delivery, and IEC sub-committees composed of all the RH providers in Bolivia. The RA facilitated and coordinated the work of each of these groups. Members of the services committee took the initiative to form their own sub-committee aimed to standardize service statistics terms among all RH care providers. Often referred to by USAID as the Bolivia Model, this approach was considered so successful that its replication was planned for several other Latin American contexts.

CIES staff attended three continuous quality of care workshops with FPMD support.

## **III. SIGNIFICANCE OF FPMD INTERVENTIONS TO THE NATIONAL PROGRAM**

The Catholic church, grass-roots organizations, and leftist political groups successfully impeded reproductive health care delivery in Bolivia until the early 1980's. The Bolivian government traditionally adopted a pro-natalist stance, claiming the country had vast, sparsely-populated areas that needed to be settled. As a result, low contraceptive prevalence and persistent high fertility, as well as mortality declines, have contributed to high 2.03% annual growth rates. (*Assessment*, 1994) According to the 1994 Demographic and Health Survey, the total Global Fertility Rate was 4.8, which represents a steady decline from 6.2 in the period between 1979-1984, 5.7 between 1984-1989, and 5.0 in 1989-1994. (Instituto Nacional de Estadística et. al., 1994) The average number of live births was 2.7. There are dramatic differences between urban (3.8) and rural (6.3) fertility levels and fertility by maternal education: no education - 6.5, primary - 6.0, intermediate - 4.9, and high school or more - 2.7. In contrast, only small regional differences in fertility were found: high plains (4.7), valley (4.6), and flatlands (5.0).

With respect to contraceptive knowledge and use, 82% of all women were familiar with some contraceptive method. Seventy-six percent were aware of modern methods and 72% knew of traditional methods. However, only 47% of all women and 66% of women in union had actually used a method, with only 30% of all women and 45% of married women actually using a method at the time of the survey. These low levels exist despite the fact that 67.6% of the women in union surveyed did not want more children. However, these numbers do represent a significant increase over 1989, when method knowledge and actual modern method and traditional method use among women in union were 30, 12, and 18 percent, respectively.

Eleven percent of all the women surveyed (and 18% of women in union) used modern methods, while 18% of all women (and 28% of women in union) relied on traditional methods of contraception. Most women in union using modern methods used the pill (3%) or the IUD (8%). The majority of those using traditional methods used the rhythm method (22%).

Government policies are now more supportive of population-related activities due to a growing recognition that these are a necessary component of any successful national development plan. Officials have tried to devise an approach balancing the need for socioeconomic growth with the relative youth of Bolivia's population, its low density, and its skewed regional concentration. (Unidad de Políticas de Población; Ministerio de Planeamiento y Coordinación 1992) The government established the National Reproductive Health Program (NRHP) in July 1990. The program's goal was to upgrade the public sector's Maternal and Child (MCH) program and to incorporate family planning as an integral part of reproductive health services. The NRHP has five basic components: (1) service expansion and improvement; (2) information, education, and communication; (3) training; (4) research/evaluation; and (5) population policy development. Services were to be provided by the MOH, the CNS, NGOs and segments of the commercial sector.

FPMD's program contributes to the first four of these five program components. The project also provides support to public and private sector service providers. Because of the scope of FPMD's activities, both with respect to substance and range of beneficiaries, the project does make a significant contribution to the Bolivian national program.

#### **IV. DISCUSSION**

Both CIES and the CNS have taken significant steps toward improving their management systems which are, in large measure, due to FPMD's technical support. Clearly, some interventions have been more effective than others, and FPMD has learned important lessons about strengthening management capacity along the way. Some of these are outlined below:

- FPMD's efforts have focused too much on improving central office functioning and not enough on the process of diffusing these innovations to the clinic level. While "putting the central office house in order" was a necessary precursor for improvements at the clinic level to take hold, evaluation interviews revealed that many of the procedures and protocols in place at the center had not been disseminated to the periphery. In fact, the disjuncture between central and field office perceptions was often striking. Future efforts need to focus more on replicating change at all levels of the agency structure.
- Similarly, even within the central office, technical assistance must be thoughtfully targeted and strategically spread through the agency. Rather than focusing training on one or two staff members, FPMD should have trained a variety of CIES employees, thereby ensuring an institutional bank and memory for technical expertise that better safeguards against staff turnover.
- More attention must be paid to the actual process of technical assistance provision. Some of the training manuals, as well as the content of the actual training sessions, were overly technical for the level of expertise staff needed to master. During its last

training visit, Tec-Apro sent two individuals who use its system as part of their jobs in other RH agencies. Their day-to-day familiarity with the system, as well as their ability to communicate this in an easy-to-understand fashion, seemed to fit better with CIES users' needs. Teresa de Vargas' effectiveness also lends credence to this argument.

- Service delivery agencies may need help to be able to effectively use consultants. There is a tendency for staff to see the technical assistance provider as the undisputed expert, rather than as a resource which can be challenged and shaped to meet agency needs. There were clear problems with the technical assistance CIES received in its financial area but in-house staff did not have the capability nor the confidence to challenge the steady stream of consultants who passed through. Though FPMD's attempts to ameliorate this, by funding an agency-based consultant, were not as successful as intended, some actions which help agencies be more effective receptors of technical assistance or be more effective counterparts are certainly called for. These might also include supporting a professional recruitment process so that appropriate staff with the necessary skills are hired by the agency.
- CIES also needed more on-going, intensive support in its finance area. More frequent, consistent contacts would have helped to identify and mollify problems sooner. The agency began to act as if technical assistance would be forthcoming indefinitely, rather than as if it were part of a finite process with a definite end.
- Technical assistance needs to be modulated. The level of contact needed at the start of a project is much more intense than that needed as a project winds down. Both CIES and CNS staff expressed a range of opinions about this. While some felt that the RA's day-to-day involvement in their affairs was appropriate and useful, others felt that she overstepped her bounds in a way that created dependency and was therefore counterproductive. Such comments suggest that a staged approach may be called for, where TA is more intense at the outset but is purposefully decreased at appropriate intervals.
- That being said, in highly politicized, volatile policy environments like Bolivia's, agencies may need a "padrino" to protect them from the political winds. The close relationship between FPMD's RA and CIES meant that she became an effective advocate for the agency. The price for such support may be limits on autonomy beyond what is developmentally called for.
- More attention must be paid to the institutional and political context within which technical assistance is provided. We too often forget that the same package of interventions is not appropriate across the board. The fact that CNS Medical Directors know that "nothing much happens when goals are not met," means that planning and motivational strategies must be adjusted accordingly. Furthermore, goals with respect

to working with the CNS must take the intrinsic political and bureaucratic difficulties of working with such an agency squarely into account. Just as efforts to summarily export American-style democracy have often failed, so efforts to export management techniques must also be tailored to fit better with the cultural, institutional, and political context in which they are being introduced.

- The issue of incentives deserves further thought. CNS employees in particular have become accustomed to being rewarded with training courses or new equipment in exchange for performing their normal duties. Such efforts may have been necessary at first, when so few providers were willing to offer RH services. However, such actions set a dangerous precedent. Evaluation interviews revealed a striking sense of entitlement on the part of providers that they should receive something extra simply for doing their jobs.
- By fostering decentralization and clinic autonomy, CIES must also take care that its clinics still maintain a strong sense of affiliation with the agency. The balance between self-rule and institutional loyalty may perhaps be more complicated than previously anticipated. This is especially critical as CIES looks to its clinics to assume more and more of the central office operating costs.

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ANNEX 1  
CLIENT SATISFACTION STUDY RESULTS

Results from the client satisfaction survey conducted at five CIES clinics during a two week period are summarized below:

1. CIES needs to examine closely the profile of the women they are serving. Are these the women the agency wants to reach? Most women were educated (77% had some education), native-Spanish speakers (86.7%), and commerce or private sector workers (41.4%). Thirty-two percent classified themselves as middle class and 83.2% said they lived in homes with running water. The majority were between 21-30 years of age (50.6%); three-quarters had lived in La Paz for more than 10 years.
2. CIES' principal competitors are the Ministry of Health and private practitioners.
3. CIES boasts a respectable return visit rate. Sixty-seven percent of those interviewed were revisits. Of those, 52.5% had been to CIES 2-3 times.
4. CIES may need to put more resources into publicity. Among first visits, 78.8% said they had not come before because they did not know about the agency. Only 12.3% learned about CIES from one of its health promoters. CIES is well thought of, however, by those who know the institution. Fifty-two percent came to CIES because it was recommended by a family member or friend. Ninety-one percent said they would recommend CIES to others.
5. Few women come to CIES for family planning. Sixty-three percent are not using a family planning method. Rather, more women come to the agency for gynecological services (50.5% of the revisits were for gynecological care).
6. There appears to be some problem with follow-up among family planning users. Of those women who are family planning users, 62% use IUD's. Though most reported no problems with their method, of the 30% who did, 43% felt that CIES did not help them resolve it.
7. Clients were generally satisfied with the services they received. Almost 90% felt CIES clinics were easy to get to. Sixty-seven percent liked the clinic environment. There were few complaints about the cost. Though 55% waited between 15 - 60 minutes, 48% did not consider this to be out-of-the-ordinary.
8. Counseling appears to be a weak component of CIES' services. Counselors work with new and "needy" clients. They give talks and show videos to clients in the waiting room. Some are beginning to visit rural areas. Forty-six percent of the women, however, said they had not been shown how to use their methods. Fifty-one percent said that side effects had not been explained; 56% reported that their problems with their methods had not been resolved. Several counselors complained about the shortage of adequate publicity and educational materials.

ANNEX 2  
SUMMARY OF CNS FOCUS GROUP RESULTS

Six focus groups were conducted among CNS female clients between the ages of 15-49 between August 3-12, 1994 by a firm contracted by FPMD, Encuestas Y Estudios. The purpose of this exercise was to collect data on client familiarity with the RHP, the perceptions of the program among actual users, and barriers to care among eligible users who do not use the service. Users and non-users of the RHP were included. Focus Group results are summarized below:

1. All of the participants are quite familiar with the CNS. It is part of their everyday lives. However, most clients have an extremely negative impression of the CNS. They believe the quality of care is very poor and that it takes a tremendous amount of time to receive services. If they had the economic resources they would go elsewhere.
2. Most women who receive care from the RHP do so for pre-natal or post-natal care. Very few clients go for family planning services.
3. Most women attributed the poor quality of care to the medical providers. Providers "don't respect their clients, don't consider how the client feels, and are very uncommitted to their work." Communication between clients and providers is impersonal. Even seen from an administrative point of view, patients are "record cards", if seen from the point of view of the nurses, they are a "burden." In general, the CNS is characterized by a medical and administrative system that is complex, unfluid, messy, bureaucratic, and discriminatory.
4. Though participants did not have much good to say about any of the providers, they criticized the physicians the least. Still, they felt that they were unprofessionally treated because the doctors wanted to be through with them as soon as possible, often acting as if they were doing the patient a favor. They "give calmantes instead of real medicine, aren't informed about improvements in medical practice, don't cure their patients, and tend to put the patient last. They do not explain things well to patients and they do not care if the patient understands. There is always a long wait for a short visit. Most participants would opt to go to private providers if they could. In fact, they think the CNS doctors would be different if they were working in a private office.
5. Nurses are particularly poorly viewed. They are the "darkest aspect of the medical personnel at the CNS because they are hard, distant, indolent, lazy, disrespectful, and rigid."
6. Clients also complained about the administrative hoops one must jump through to get care at the CNS. There are too many papers and lines. The designated personnel are often absent. They do not know the meaning of the word "urgent." Cumbersome, administrative requirements are clearly a barrier to care.

7. Many complaints were raised about the facilities. They are uncomfortable, unclean, and there are insufficient personnel to staff and maintain them properly. CNS pharmacies are particularly poor. The hours during which the CNS offers services are not compatible with most workers' schedules. Hours are frequently curtailed at the whim of the providers.
8. The RHP has major problems with respect to a program identity. Even those users who had received services from the program, did not identify it as a separate entity. The staff assigned to the program were also confused about the program identity. Clients do not understand clearly what reproductive health means. It is something they have heard about on T.V. but they do not know that they can obtain RH services at the CNS. There are no social workers or health promoters working to educate the public. Some participants had picked up videos or educational materials that were around but this was accidental and isolated. Most people found out about RH from other sources and then get additional information from the CNS. Those who do recognize the term, tend to associate it at least indirectly with family planning methods or maternal and child health.

Those who have sought out these services before, found it was difficult to get accurate information or to find staff who would help them with RH. Some people associated RH with family planning.

9. Those clients who know something about family planning are only partially informed. They recognize names of methods but they do not know how to use them or about the advantages or disadvantages that each method entails. Most found out about family planning from friends, neighbors, or classmates. Educational activities at the CNS are considered inaccessible. The efforts are uncoordinated and the personnel is not well trained.
10. Patients are also afraid to ask physicians about family planning. Though there appears to be good communication among couples, there is poor communication between clients and CNS providers.
11. Those focus group participants who had not been seen by the RHP that program were confused about whether they had ever received services from the program in the past. Because the program does not have a clear identity and because they are confused about what the program is, even those who gave birth at the CNS or have received gynecological services there do not realize that this is part of the RHP. For those who know they have gone, they have received educational materials but not been helped to select the method that fits best with their needs or lifestyles.

Those women who have not attended do so because they lack information and they are fearful of the program and family planning methods themselves. This

misinformation, coupled with CNS' bad reputation as a whole, constitute significant barriers to care.

12. Finally, clients expressed the realization that Bolivia is undergoing a period of rapid health policy changes. They hear talk about delegating responsibility for health service provision to local municipalities. Such discussions have many women fearful that they will lose the only medical care that they have.

ANNEX 3  
METHODOLOGY

The data for this evaluation come from a variety of sources. First, all reports generated during the lifetime of the project were reviewed. These included the Technical Review, an in-depth, mid-term report prepared in November 1993, consultant reports, quarterly reports prepared by the Resident Advisor, and trip reports turned in by FPMD staff.

Second, service statistics, financial records, files and internal management documents were reviewed for each institution. For example, the evaluation of data collection and management organization were evaluated by comparing service statistics forms and organizational charts in place prior to and after the project. These versions of CIES' statutes were reviewed to assess changes in the organization's mission and focus. Pertinent documents were also reviewed to construct a demographic profile of Bolivia.

Third, interviews with board members and central office and regional staff at CIES and the CNS were conducted. These included in-depth questions about procedures before and after the project as well as staff awareness of and perceptions about the effectiveness of FPMD. One particular area of interest was the diffusion of training and innovation from the central office to each organization's clinic sites. Supplementary interviews with relevant Bolivian government officials, NGO staff, and AID employees were also conducted.

Fourth, six focus groups were carried with CNS clients on August 3-12, 1994. One-half of the women were RHP users, while the other half were not. The goal of the groups was to assess client knowledge of and use of family planning and to evaluate satisfaction with the CNS' RHP. Some of the topics covered included knowledge and experiences with the CNS, quality of care, physician vs. nursing care, management issues, facilities, reproductive health services, and knowledge and use of family planning.

Finally, a client satisfaction study of CIES clients was also carried out. One thousand CIES clients between the ages of 15-19 in La Paz, Oruro, El Alto, Sucre and Tarija, were surveyed. Data collection took place between July 30-August 8, 1994. One out of every two CIES clients, visiting these clinics during that period were surveyed. The questionnaire collected data on the socioeconomic status of CIES clients, their use of CIES' facilities, quality of care, and family planning utilization. Interviewers were selected who had sociodemographic characteristics similar to the population being surveyed.

Both the client satisfaction survey and the focus groups were carried out by the Bolivian firm Encuestas y Estudios. After interviewing various research and consulting companies, this organization was chosen because of their data processing capabilities, prior experience, and ability to coordinate field work in various sites throughout the country.

ANNEX 4  
TABLES AND GRAPHS

Table 1  
 Changes in CIES Method Mix Among New Users  
 All Program Components  
 1991-1994

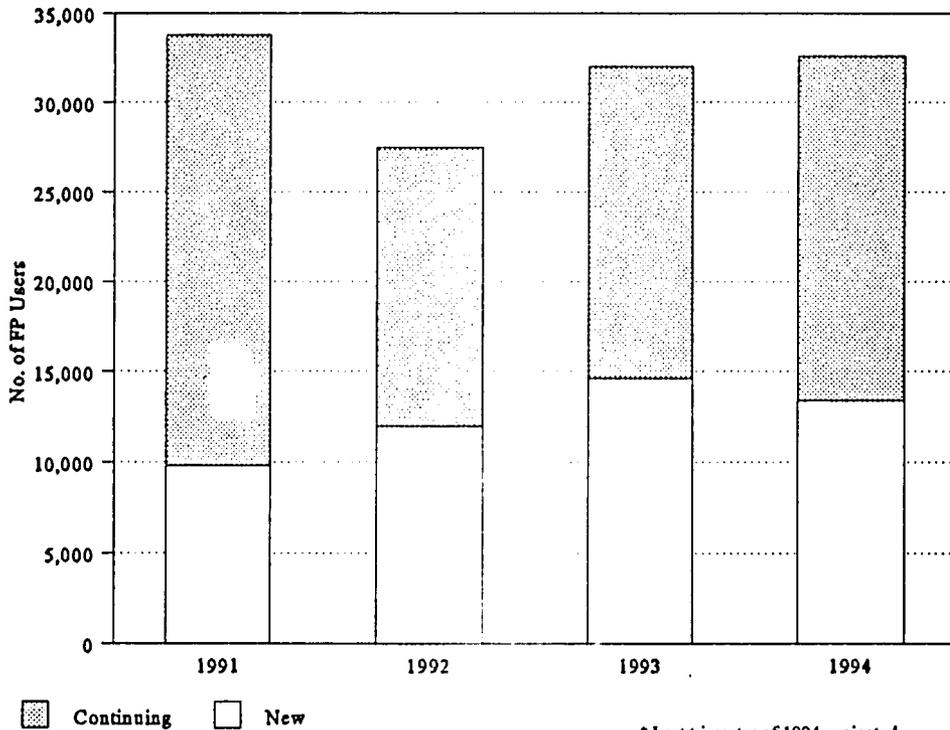
Method	1991		1992		1993		1994	
	N	%	N	%	N	%	N	%
IUD	2,674	27	4,032	34	5,459	37	3,984	30
Pill	449	5	710	6	1,208	8	1,190	9
Condom	5,436	55	5,949	50	6,269	43	7,039	52
Vaginal Tablets	720	7	802	7	1,042	7	1,096	8
Foam	437	5	256	2	476	3	0	0
Combination	124	1	144	1	133	1	57	.5
Natural			25	0	42	1	57	.5
<b>Total</b>	<b>9,840</b>	<b>100</b>	<b>11,918</b>	<b>100</b>	<b>14,629</b>	<b>100</b>	<b>13,423</b>	<b>100</b>

Table 2  
 CIES Performance in Family Planning for All Programs  
 (Clinic, CBD, AD)  
 1991-94

Family Planning Users	1991	1992	1993	1994*
New	9,840	11,918	14,629	13,423
Continuing	23,941	15,511	17,385	19,159
<b>Total</b>	<b>33,781</b>	<b>27,429</b>	<b>32,014</b>	<b>32,582</b>

\* Last trimester of 1994 projected.

Graph 1  
 CIES Performance in Family Planning for All Programs  
 (Clinic, CBD, AD)  
 1991-94\*



Graph 2  
CIES Facilities

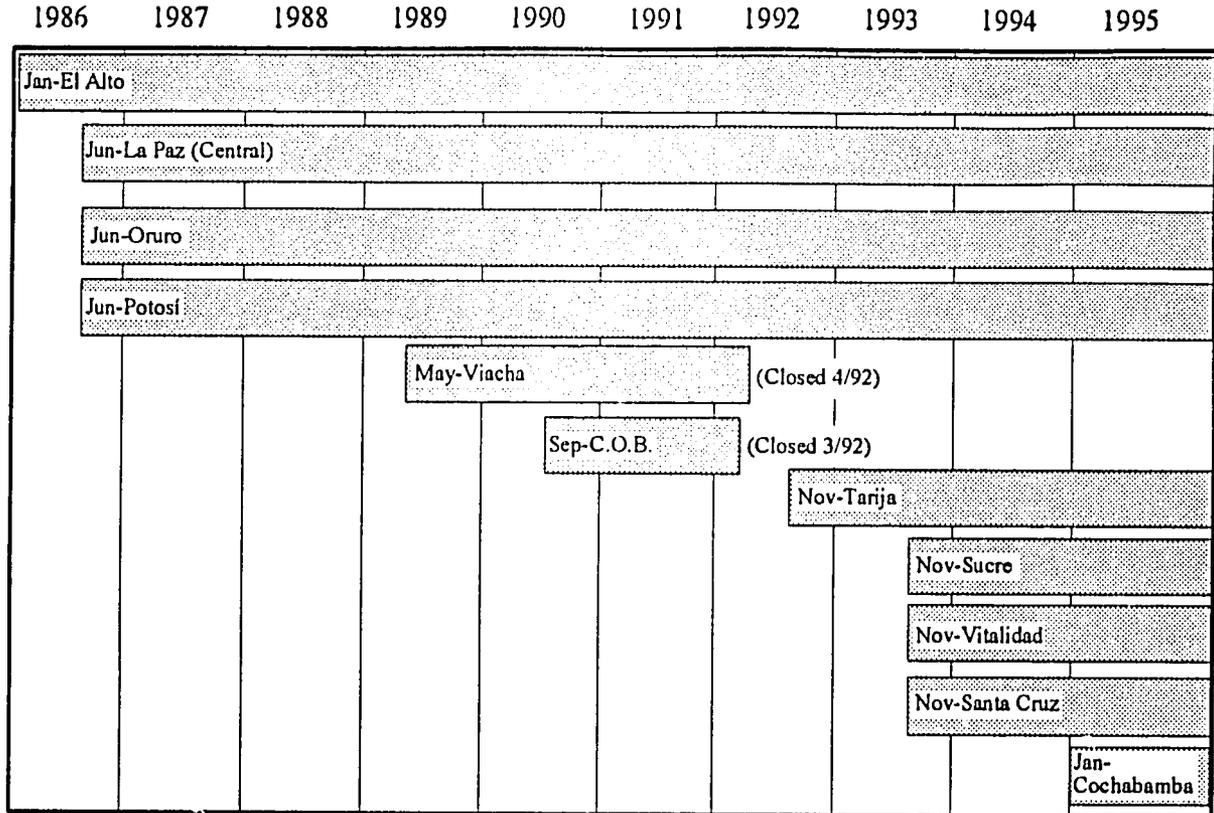


Table 3  
CIES Clinic Performance  
1991-94\*

	1991	1992	1993	1994*
Total Attentions	30,336	28,080	32,187	32,725
Total FP Attentions	7,671	8,225	9,812	9,604
CYPs	4,954	5,282	6,202	6,641

\* Last trimester of 1994 projected.

Graph 3  
CIES Clinic Performance  
1991-94\*

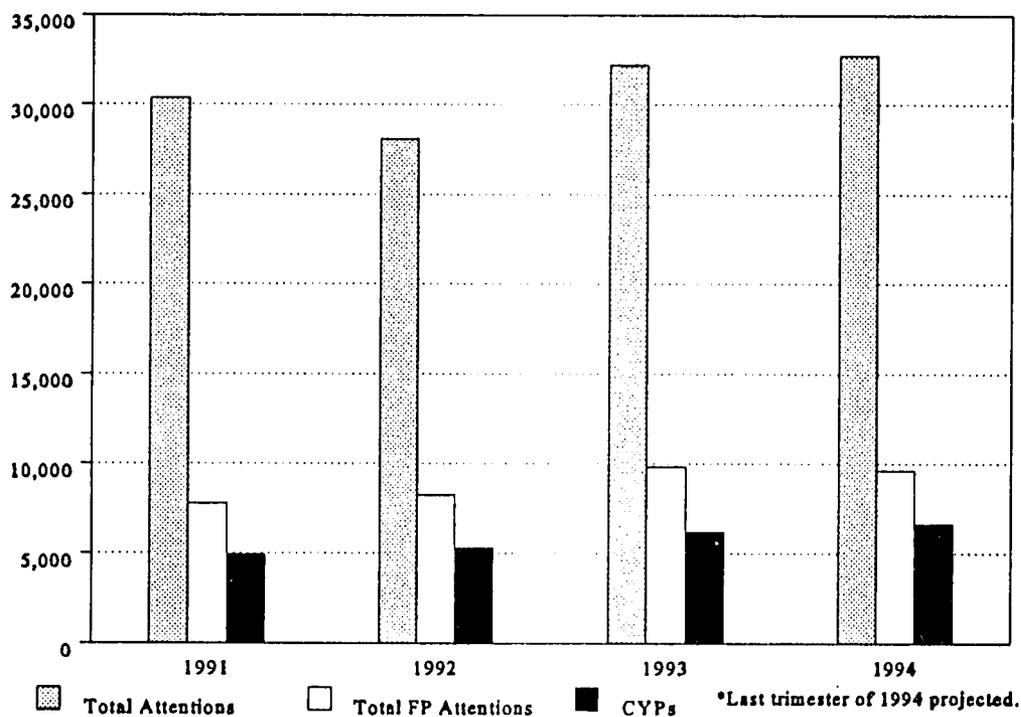


Table 4  
 CIES Family Planning Services as a  
 Proportion of Other Services  
 1991-94\*

	Family Planning		Women		Child		Other	
	N	%	N	%	N	%	N	%
1991	7,671	25	13,497	44	5,200	17	3,968	13
1992	8,225	29	12,250	44	4,042	14	3,563	13
1993	9,815	30	12,891	40	4,374	14	5,107	16
1994*	9,604	27	16,056	46	3,584	10	6,013	17

\* Last trimester of 1994 projected.

Graph 4  
 CIES Family Planning Services as a  
 Proportion of Other Services  
 1991-94\*

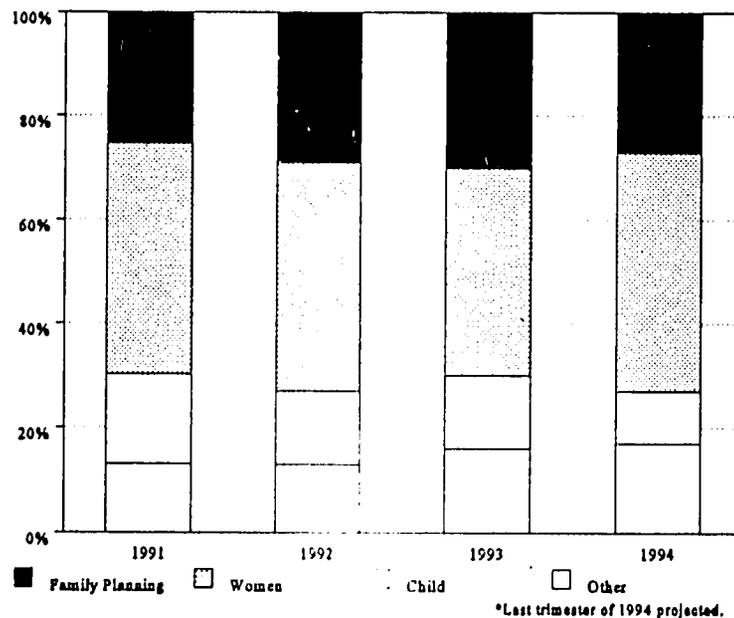


Table 5  
 CIES CYPs Distributed by Program Component  
 1991-94

	1991	1992	1993	1994
Clinic	4,954	5,282	6,202	6,641
Associated Doctors	4,670	8,924	14,001	8,769
CBD	2,793	1,556	2,316	2,145
<b>Total</b>	<b>12,417</b>	<b>15,762</b>	<b>22,519</b>	<b>17,555</b>

Graph 5  
 CIES CYPs Distributed by Program Component  
 1991-94

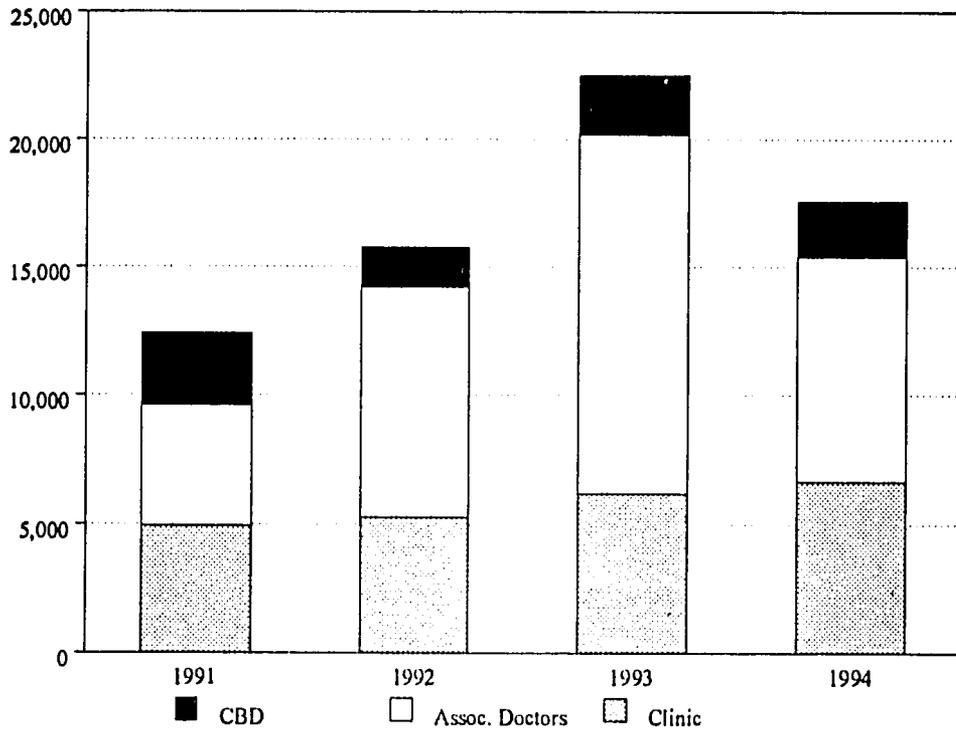


Table 6  
 CIES Average Number of Provider Contacts  
 to Provide One CYP  
 1991-94

	1991	1992	1993	1994
Clinics	1.5	1.5	1.6	1.4
Associated Doctors	.67	.64	.5	.6
CBD	8.2	8.6	6.1	8.2

Table 7  
 Productivity Per Hour  
 At CIES Clinics - 1993

Clinic	Patients/ Hour
La Paz	3.2
Vitalidad*	0.2
El Alto	3.4
Oruro	3.4
Potosi	3.4
Tarija	1.1
Sucre	0.8
Santa Cruz**	0.2

\* Only for Nov-Dec

\*\* Only for Dec

Table 8  
 Summary of CIES Performance Goals  
 First Semester 1994

	All Visits	Other Visits	FP Attentions	New FP Attentions	Continuing FP Attentions	% CY
Goal	36,800	24,940	39,150	16,980	22,060	25,470
Performance	15,041	11,409	13,721	5,508	8,213	8,430
<b>% Achieved</b>	<b>41%</b>	<b>46%</b>	<b>35%</b>	<b>32%</b>	<b>37%</b>	<b>33%</b>

Graph 6  
 Summary of CIES Performance Goals  
 First Semester 1994

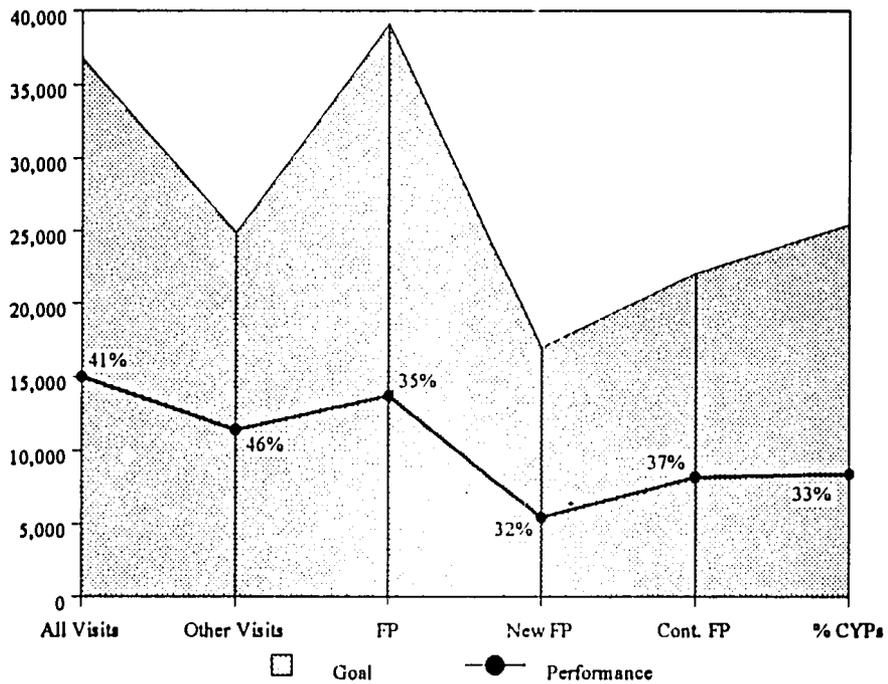


Table 9  
CIES Service Delivery Expansion Plan  
1994 to 1997

Centers	1994	1995	1996	1997
Center A	El Alto	El Alto La Paz*	El Alto La Paz	El Alto La Paz Santa Cruz Cochabamba
Center B	La Paz	Potosi Tarija Sucre Oruro Santa Cruz Cochabamba	Santa Cruz Cochabamba Potosi Tarija Sucre Oruro	Potosi Tarija Sucre Oruro Trinidad Ribalta
Center C	Potosi Tarija Sucre Oruro Santa Cruz Cochabamba*		Trinidad	Montero Quillacollo
<b>All Centers</b>	<b>7 Centers</b>	<b>8 Centers**</b>	<b>9 Centers</b>	<b>12 Centers</b>

\* Implemented and organized during the last trimester of the year for activities to begin the following year.

\*\* Does not include CIES' clinic for middle-class women, Vitalidad, which is a different service delivery model.

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Table 10  
 CNS Facilities Providing RHS by Region and Type

Medicos	Hospitales	Policonsultorios	Centros
La Paz	2	7	1
Cochabamba	1	3	
Santa Cruz	1	1	
Sucre	1	1	
Oruro	1	3	
Potosi	1	2	
Beni (rural)			1
Trinidad	1		
Tarija	1	1	