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FINAL REPORT

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**SOCIO-CULTURAL ANALYSIS OF THE SELF-FINANCING PRIMARY
HEALTH CARE PROJECT IN SANTA CRUZ**

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Self-Financing Primary Health Care Project

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INTRODUCTION

This report is made up of two sections. Part I is an analysis of the interview with the participant personnel of the cooperatives, the health professionals and the potential beneficiaries. In Part II, the main characteristics of each cooperative as they relate to the project and the results of the survey with potential beneficiary are presented.

The research was carried out with the collaboration of Licenciado Jaime Bravo and Peter Taylor. Jaime Bravo conducted part of the field-work in the Mineros area and the city of Santa Cruz. He also participated in the interviews of the health professionals. Peter Taylor conducted all the field work in the San Julian area. Their help in carrying out the field work and their knowledge of the areas contributed greatly to this work. The report was typed by Martha Ugarte. To all of them, my warmest thanks.

All interpretations and analyses are my own, and I am responsible for the overall accuracy of this report.

SUMMARY AND RECOMMENDATIONS

I. Personnel of the Cooperatives

. Thus far, the involvement of the personnel of the San Julian and Mineros Coops has been to reach a decision to participate in the project.

. La Merced had just named members of its staff to the newly created health committee and they were beginning to familiarize themselves with the project.

. In the case of the two rural coops, active participation may be difficult to achieve unless their roles and the resources they require to effectively carry out their role are clarified.

. The actual process of decision making and administrative capacity of the cooperatives are potential sources of constraints to the implementation of the project. A cooperative body with a clearly defined role and with resources to participate in the health project constitutes a strategy that may help deal with the constraints.

II. Health Professionals

. Several factors make probable the participation of health professionals in the projects: (a) a lack of incentives to work in Ministry of Health facilities; (b) competition in the field of private

health care; and (c) the saturation of health personnel in the urban area.

- . To ensure their participation, health professionals should receive an adequate package of incentives which could include competitive salaries, opportunity for professional advancement, and solutions to family concerns such as the education of their children or the lack of work for the spouse.

- . The problem of the physician in the rural area is one of maintaining his professional status vis-a-vis his urban counterpart. Adequate working conditions along with the economic and professional incentives could change the stereotyped image of the rural health professional.

III. Potential Beneficiaries

- . Pragmatism is the main characteristic of the behavior related to health/illness among the inhabitants of the three areas.

- . Health care is sought where services are perceived as effective and reliable.

- . Health practitioners consulted range from curanderos to medical specialists using a criteria of competence and pragmatism.

- . Health seeking behavior is a fairly predictable process that starts with self-treatment and progresses along the different levels of health care, only when the previous step has failed to produce a cure.

- . Along with a progression by levels in seeking health, there is a similar progression in related expenses with a clear tendency to defer

the most expensive services (the physician and hospital) until all other levels have failed to produce a cure.

- Health related expenses, therefore, are considerable and so frequent that the tendency is only to consider as health expenses those associated with the higher level services.

- Preference for health services among the potential beneficiaries is clearly the service that offers everything in one place. The availability of pharmaceuticals is considered essential to any health service.

- Place of residence as well as long established patterns of seeking health may affect the use of the different levels of services in the project. In the urban area and the rural community with access to stable roads, the promotor may be considered an "inferior good" in economic terms. In the urban area, level II may be considered in a similar way. Their role and functions may need to be different depending on where they are located.

IV. The Cooperatives, the "Communities", and the Health Project

- The appropriateness of Project's reliance on the "community" as the primary unit for the delivery of services and for support of the project needs to be questioned.

- The Cooperatives are made up of individuals or families who have a service relationship between them and the cooperative. There often is no formal relationship between the coops and the "community" or the neighborhood, in urban centers.

- Place of residence insofar as the cooperative is concerned is irrelevant. To the member, place of residence is important only in that it facilitates his using the services of the Coop.

- There is also the question as to whether any of the localities where the coops have members are communities. The evidence suggest that they at best are communities in-formation with a highly unstable population. The use of community to describe these localities implies social, economic, and cultural ties that are simply not present.

- It is more productive to conceptualize the coops members as making up limited social and economic networks of individuals residing over a wide area. In the case of La Merced even this concept is not appropriate since most members do not know each other, and the only point of contact is through the coops.

- Since the coops do not have any direct relationship with the "communities", an attempt to work with a community's non existing organizations may prove beyond their resources, capacity and present orientation.

- An alternative approach is to work with limited emphasis on community participation and support and rely on the sale of services at least initially and until the project has established a reputation and has attracted sufficient users.

- Sale of services is the preferred method of payment for the health system by almost everyone concerned.

- Regular fees for membership in the health services should only be considered if nominal and to insure sufficient subscribers to cover basic costs.

PART I

**THE PERSONNEL OF THE COOPERATIVES, THE HEALTH PROFESSIONALS,
THE BENEFICIARIES AND THE PROJECT**

Participating Cooperative Personnel and the Health Project

Research among the personnel of the participation cooperatives resulted in a set of findings that are different than the ones expected from the outline of topics in the scope of work. However, the findings not only may explain why there was a difference, but more importantly point out to a source of potential constraints for the implementation of the project.

The actual decision making process and the administrative capacity of the cooperatives involved are two areas that need to be examined in detail. The statements that follow are directed primarily to the San Julian and Mineros coops. La Merced is a different kind of institution, mostly because it has found a solution to the problems to be discussed below.

The basic conflict for the personnel of the cooperatives is one of "service" to the coop and rewards or lack of them for services rendered. In principle all positions of leadership in the coop are an obligatory service. While this notion of "service" is widely accepted, it turns into a problem when "service" becomes a burden as increasing amounts of time and effort are demanded of the persons in these positions. The problem is compounded because of the lack of distinction between roles of leadership and management or administration.

Often the president of the administrative council, whose role is one of leadership and decision making, is delegated all administrative and managerial responsibilities turning his job into a full-time one. A few

other officers of the coop, such as the president of the oversight council, may also find themselves in similar predicaments.

These offices which in practice do not have clearly defined roles, responsibilities, and resources are key offices in the running of the coops. However, as the tasks of these offices demand increasing amounts of time and effort to the detriment of the persons occupying them, they are eventually avoided or accepted reluctantly.

As it has already been mentioned, La Merced is one coop where the above is not a problem. It has a body charged with making decisions which is separate from its administrative and managerial plant. The people who run the coop are all salaried employees. The Mineros coop has partially solved the conflict by paying salaries to some of its officers, who also are involved in administration. In the San Julian coop, no officers receive a salary and it illustrates clearly the problem since the president of the administrative council practically runs the coop by himself.

Any new undertaking by the coops requires that a decision be made, that someone be given the task to carry out the decision, and that sufficient resources be allocated to facilitate the implementation of the decision. It is a lack of this type of a process that hinders the work of coops. Decisions are reached through a slow process where the officers of the coop delegate decision making to the assembly of representatives, who in turn delegates it to a general assembly. The general assembly in turn delegates it back to the officers claiming lack of sufficient information. The officers who may already be overburdened

with tasks are reluctant to accept new responsibilities especially if their tenure in the office is on a service basis. There is little if any discussion of needed resources or their source, and service to the coop is implied as a justification to ask someone to take the responsibility. Eventually someone may reluctantly accept the responsibility which will be vaguely defined. Showing any kind of initiative in this situation may result in being given the task. Since the task may be burdensome and there are no economic rewards for time and effort involved, it is likely to be avoided.

At the time this research was conducted, the main problem was the lack of a cooperative body clearly responsible for the study of the health project, formulation of strategies, and final decisions or recommendations. Present officers of the two rural coops seemed reluctant to accept the responsibilities of becoming fully involved in the health project. The tendency to defer all questions to a general assembly of members was a clear indication of the above set of problems. There is a real risk of long delays as the assembly and the officers try to get each other to take decisions. It should be said that the problem is one that affects all activities of the coop and is not restricted to the present project.

Since the health project will demand increasing effort and commitment of resources on the part of the coops, the problem is likely to repeat itself at every step. For example, recruitment of members of the health services in each locality will demand promotion of the project in each of the localities. The coop will have to create new

administrative positions to handle the implementation of the project. All of these will require the coops to allocate resources and personnel. Prior to that, the coop should nominate a body which will study and answer questions such as the types of services they would prefer from the provider organization, the methods proposed by the coops for integrating health services to their current programs, methods for promoting enrollment of members, etc.

The creation of Health Committees during the course of the research is an step in solving the problems discussed above. To make it a more effective body, their role as well as the costs involved should be clearly presented. Responses by the Coops to such proposals would probably constitute a good indicator of their commitment to the health project.

Finally, the two rural coops expressed feelings of anxiety that La Merced with its size, urban orientation and administrative capacity would overwhelm them. These views were expressed in the meeting between USAID and the three coops on March 24, and it was clear that they were partly due to a misunderstanding of the Provider Organization and the role of La Merced. The Provider Organization had been interpreted as part of La Merced. Although the misunderstanding was clarified, the fear of La Merced's role remains a factor that will influence future relationships between the three cooperatives.

Health Service Personnel

Physicians

One of the seven physicians interviewed classified the members of his profession into three types:

Commercial

Dogmatic

Responsible

He stated that the majority of the physicians had a commercial orientation. The primary motivation of physician with a commercial orientation is money. The dogmatic physician's primary motivation is to practice scientific medicine with little regard for the patient. The responsible physician is dedicated to the patients well-being.

All of the incentives, according to this physician, were for the members of his profession to become commercial. The dogmatic types were to be found in the University hospitals where they kept the gates closed to the rest by monopolizing all positions.

The responsible ones were few and usually held in low regard by their colleagues. The commercial ones were involved in various entrepreneurial activities for profit.

The lack of resources, means, and incentives in Public Health and in Public Hospitals was cited as one more reason to move into "commercial" medicine. Work in the rural areas was included as an example of the type of work a physician should avoid if it meant work in a Ministry of Health facility.

Physician's view work in a rural area, a public hospital, the Caja or Seguro Social, and other similar institutions as a last resort for a professional. These jobs are only taken if there are no other alternatives or in some cases as a convenient place to "capture" patients for private practice.

This stereotyped view of the physician is widely shared and although in general it seems to be correct, the situation has been changing and is more complex. Lucrative private urban practice is highly competitive and the field is saturated. There seems to be, however, agreement to maintain rates. At the same time the number of physicians in the urban areas is rapidly growing.

Physicians seem to be more willing to work where an opportunity exists not only in the peripheral urban areas, but also in rural areas. The development of shared income between physicians and Postas Sanitarias in Santa Cruz seems to have satisfied two needs: the physician's desire to make more than the salary paid in these facilities, and the Posta Sanitaria lack of resources to attract and keep good physicians. Cases were cited of physicians who had been working for 11 years in Postas that have this type of arrangement. The split is usually 70 percent of the fee for the physician and 30 percent for the Posta. The work is always part-time.

There is also a proliferation of physician's cooperatives, clinics, private postas, etc. The failure of the Public Health system seems to be generating a search for alternatives not only among physicians, but also the users of these services. Although no statistics exist, the majority

of the patients seen by private practitioners belong to the Caja or some other public institution, but prefer to pay for services despite the fact that they contribute to the cajas.

The Physician and the Rural Area

A physician working in a rural area faces a tremendous amount of pressure to stay there as short a time as possible. The association of the "Año de Provincia" with rural service gives the rural physician low status in the view of his colleagues, his patients, and almost everyone else. At least those physicians in their "Año de Provincia" are there for a legitimate reason: their obligatory service.

The situation becomes critical, however, if the physician stays longer than the minimum time expected or he goes to work in a rural area after having worked through his "Año de Provincia".

The physician often claims the drawback of practicing in the rural area is a lack of adequate resources, facilities and equipment. Though this is a legitimate concern, the main problem lies in his self-perception as having failed to live up to his and others' expectations.

The saturation of physicians in the urban areas combined with the fact that medical school graduates come from all socio-economic backgrounds is highly favorable to a change in the stereotype of the rural physician. Working conditions, economic and professional incentives that allow a physician to maintain his status vis-a-vis his urban counterpart may be all that is required to change the reluctance of physicians to work in the rural areas.

Favorable working conditions include a clearly defined role and adequate working tools, i.e. equipment and pharmaceutical supplies. Professional incentives include courses, seminars, etc., that allow the physician to improve and update his knowledge and skills. Economic incentives include not only a competitive salary, but access to cooperative benefits such as loans to build a house, buy a vehicle, and funding for the education of his children.

Nurses and para-professionals

The main characteristic of the auxiliary nurses is that of a link between the physician the low income or rural inhabitant. The time spent in direct contact with patients is considerably longer than that of the physicians. The amount of training and social background of the auxiliary nurses makes their social and cultural distance from patients less pronounced than the physician's from the patient. Because nurses are required to spend eight hours a day in their jobs they are continually exposed to patients whereas the physician's time with patients tends to be less and is more tightly scheduled. This factors contribute to make these type of professionals very often more sought after than the physicians in the rural areas.

The key characteristic of auxiliary nurses, however, is their ability to provide services judged competent and effective. One of the auxiliary nurses interviewed was preferred by a large number of patients to the physicians in a nearby Posta. He had been in the area for 10 years and had established a firm reputation as an effective health worker

and as someone who could be trusted and understood when communicating medical advice or instruction. Furthermore, this nurse did offer a one step service, since he maintained a small supply of medications.

For the nurses and para-professionals, the initial incentive is a job itself. In the rural areas, becoming a nurse is one of the few alternatives to becoming a rural teacher. The job as nurse or para-professional is also a means to higher status and a vehicle of social mobility which would eventually take him/her to the city and a hospital or a clinic. Nurses (Auxiliary II) who have spent five to ten years in rural hospitals and postas and who have often done the work of the absent physicians can easily move to a job in the city. Their skills and experience are sought after.

The school for auxiliary nurses in Montero attracts a high number of city born students who know that eventually they will be able to work in the city. These type of health professionals remain in the rural areas for long periods of time and eventually move to the city because of economic and family reasons. After years of experience, they know that they can obtain salaries in the city. At a certain point in the domestic cycle, their children are beyond the educational levels available in the rural area and providing for their continued education becomes a reason for moving to the city.

Incentives which offer competitive salaries and other economic benefits the cooperatives may provide along with help to solve the problem of the education of the children may constitute an attractive package for experienced nurses and para-professionals.

Beneficiaries and the Health Project

Pragmatic is the best way to describe the behavior of the potential beneficiaries of the Project in matters related to health and illness. Although some differences exist between the behavior of the urban and rural dweller, both act in pragmatic ways when seeking health.

The process of seeking health is fairly predictable among the inhabitants of the zone. When an individual first becomes ill, he/she will try self-treatment. Self-treatment usually includes herbs, teas, and pharmaceuticals. If self-treatment does not produce a cure, the next step is a visit to the pharmacy for diagnosis and prescription of a "stronger" or different drug.

Up to this point the urban and rural dweller act in the same manner. However, if there is still no cure or improvement, those in the rural area will begin to consult with different health curers. The type of health curers consulted is influenced by their:

- availability,
- appropriateness to "cure" the illness,
- accessibility,
- fees.

There is also a pattern to selecting a health curer. The first person consulted is a "neighbor" known for "understanding" problems of health/illness. This is especially the case in localities that are isolated. Next, it will be a "sanitario", if one is available and if he/she is recognized as being able to provide effective cures. Only if all the previous steps have not produced results, a physician will be

consulted. When the process gets to this point, which physician is consulted will depend on the reputation of the physician with little regard for distance or cost.

Appropriate Health Provider

Certain diseases are associated with certain kinds of health providers. For example, diseases that fall under the category of emotional or nervous disorders are usually thought to be within the area of expertise of a curandero (traditional health curer). It will be this health provider who is consulted rather than a physician. Distance to the curandero and cost are not important if the illness of the person is judged serious enough, and if the previous health seeking steps have not produced results.

Cost and Distance

The case histories of serious illness episodes suggest that rural families are not influenced by cost and distance if the illness is serious. Examples of considerable expenses were cited by a number of the respondents. Expenses included trips to Santa Cruz to consult with medical specialists and trips to Sucre for the same purpose.

Though from the evidence available it is difficult to state with certainty, age and sex of the ill family member seem to be factors in the decision to seek health care which is as expensive as in the examples cited above. The evidence suggests that the decision seek expensive care is more frequently made if the ill person is an adult member of the

household or a male child. Another factor which seems to influence this type of decision is the time of the year when it occurs and the prospect of loss of valuable time by the ill person. For example, if the member of the family is needed to perform an agricultural task such as harvest, he/she is more likely to receive health services without regard to cost.

The urban dweller unlike his rural counterpart, goes directly from self-treatment to the physician if his/her self-treatment did not produce a cure. Nurses and para-professional personnel are not consulted as in the rural area. It is likely that availability of the physician in the urban setting is the main factor influencing the decision to seek his/her aid.

Trust in the Health Provider

A series of questions were included in the interviews which were designed to determine what influences trust in a particular health provider. The answers given were always in terms of a particular person. The main criteria was the personal experience with a particular health provider who had produced a cure or had a reputation as an effective health worker. Whether the health provider was male or female or whether he/she was a physician a sanitario or a curandero were not considered important. Ability to cure was judged as critical.

Other than ability of the health provider, the following factors contributed to trust in particular health workers:

One stop service where the ill person can be diagnosed, provided with the treatment and/or medicines he/she needs,

Perception of sincere communication i.e. that the patient felt he/she was listened to and more importantly that the provider clearly explained his/hers illness and the treatment prescribed.

This last factor relates to social distance between the patient and the health worker. In the rural area, a sanitario or a nurse was often judged better than a physician simple because they were perceived as good listeners and communicators. The physician, it was often said, talks "too high" and did not listen to the patients complaints. Physicians dismissed a patient's description of his symptoms as superstitions and relied only on the physical examination for diagnosis; a behavior which is judged not only as intimidating, but seen as lack of interest. Such behavior also produced doubts as to the validity of the prescription and treatment.

The processes described above are for illness episodes which may start as non-serious and which gradually progress to serious cases. When an illness is considered serious is deducted from the health seeking behavior; that is from the point in the process when the ill persons begins to seek outside help. Physicians claim that patients, in the rural area come to them only when the illness has become a serious problem. The same is true of hospitals. The process is obviously a very expensive one, since the ill person has already incurred considerable expenses before he gets to the higher levels of health aid. Moreover, the expenses incurred in visiting a doctor and/or hospital are the highest and are thus likely to be remembered. Often these memories act

as deterrents and influence future health seeking behavior. High-cost treatment is to be avoided and only incurred into as a last resort.

Delivery of Services by the Project

Not all levels of service would be acceptable or supported by the different populations in the three projects.

Level I, the Promotor, will be welcome in those localities that are isolated and have no easy access to higher level services. The dispensing of medication by the promotor and his ability to deliver effective primary services will be judged crucial. The most acceptable solution to support of the services at this level will be the sale of services as remuneration for the promotor.

Payment of services already available in all three areas are in cash. Everyone interviewed said that they always paid for services in cash. What was seen as desirable was a flexible payment system where in each case, the users could decide with the promotor if species were acceptable payment.

Localities with easy access to higher level services and the urban neighborhoods will most likely see the promotor as a very limited service and opt for level II services. As in the case of the promotor availability of drugs will determine use of these services, as well as the attractiveness of a one stop service post.

Level III services in the rural area are likely to be treated as they are now, that is only sought in cases judged as serious or emergencies. In the rural area, the respondents' preference for this

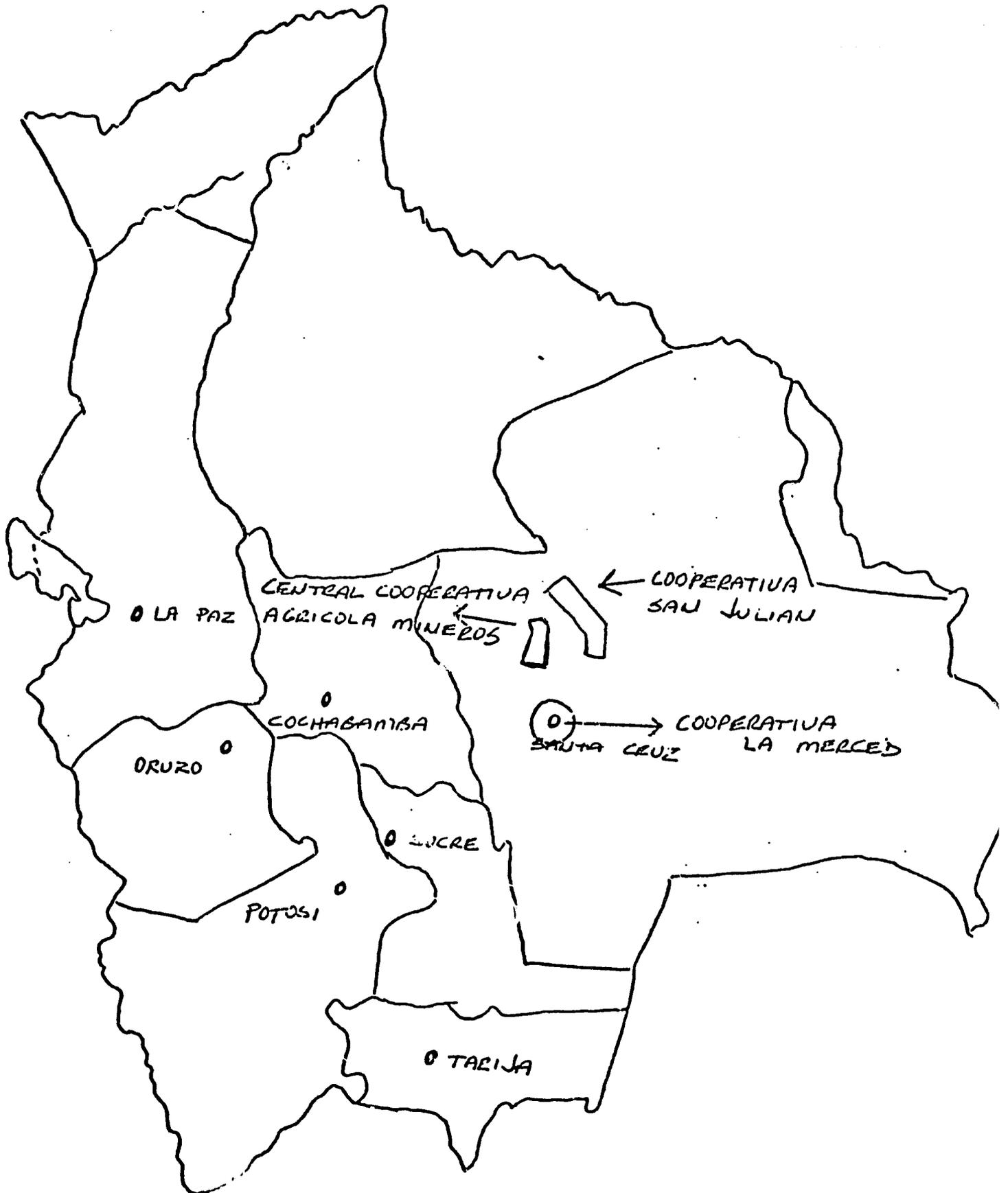
type of service was a loan fund that will allow them to borrow money for expenses at this level. In the urban area, the respondents' preference was almost exclusively for these level services along with a pharmacy.

In all three areas, the key element at any level of the delivery system is the availability of drugs.

PART II

CHARACTERISTICS OF THE THREE COOPERATIVES THAT RELATE TO THE
HEALTH PROJECT, AND RESULTS OF THE SURVEY

MAP N° 1 - LOCATION OF THE THREE COOPERATIVES



Characteristics of the Mineros Cooperatives that Relate
to the Health Project

There are three characteristics of the composition of the Central de Cooperativas Agrícolas de Mineros (CCAM) that are relevant to the health model proposed for this project. They are: geographical dispersion, number of members in each locality, and the question of whether these localities can and should be considered communities.

Geographical Dispersion

The 14 Cooperatives that make up CCAM are located in 15 localities over a wide geographical area. Map number 2 illustrates their location in relation to the town in Mineros. Approximate distance in kilometers and traveling time in the dry and wet seasons between each locale and Mineros are given in Table 1. During the dry season, all localities can be reached by motor vehicle; however, during the wet season (November-April) seven of the localities are difficult to reach and for the most part walking is the only means of transportation.

The need in these isolated localities for basic health services is something everyone agrees on, and the residents are enthusiastic supporters of having a health provider reside among them, especially during the wet season.

Geographic isolation in these localities results in a highly unstable population. Few of the original settlers remain in any of these localities. They are made up of a small core of permanent residents and a large number of temporary residents. The permanent ones are those who

MAP N° 2 - LOCATION OF THE COOPERATIVES THAT MAKE UP
THE CENTRAL OF COOPERATIVAS AGRICOLAS DE MINEROS

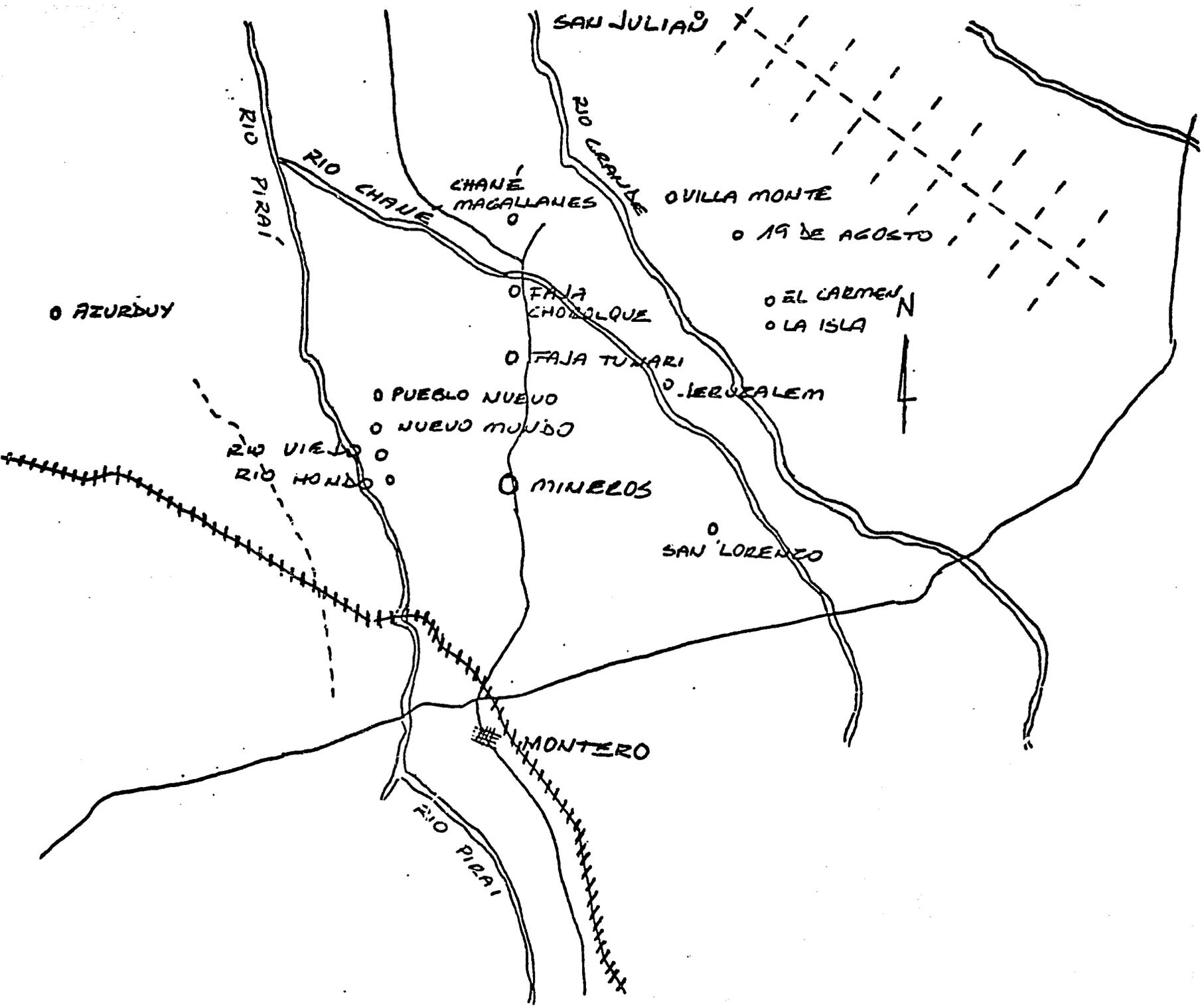


TABLE 1

Approximate Distance and Traveling Time in the Dry and Wet
Seasons Between Mineros and the Member Cooperatives

Community	Approximate Distance from Mineros km	Traveling time	
		Dry Season Hours	Wet Season Hours
1. Río Hondo	8	5	-
2. Río Viejo	22	1	4
3. Pueblo Minero	10	5	5
4. Nuevo Mundo	18	7	5
5. Jerusalem	30	1	1
6. Faja Tunari	17	1	1
7. Faja Chorolque	25	1	1
8. Chané Magallanes	23	1	1
9. San Lorenzo	38	1	8
10. 19 de Agosto	65	8	15-20
11. El Carmen	65	4-5	15-20
12. La Isla	75	5	20-24
13. Villa Monte	85	8	20-24
14. San Julián	150	7-9	30-36
15. Azurduy	185	3-4	3-4

have not been successful enough to move to a town or locality with access to permanent roads and of those original settlers who did not abandoned their lots due to total failure.

The temporary residents are made up of those original settlers who have moved elsewhere, but maintain their lots, or by residents of other localities who have obtained a second or third lot of land in the locality. Temporary residents are also considerable number of peones, who work on the lands of the absentee land-owners and work during the harvest time.

Although the isolated localities have the greatest need for health services, its unstable population base is a constraint to the organization of the residents to achieve the objectives of the project. Health committees may be difficult to maintain and consistent support for the health promotor difficult to achieve.

In the isolated localities, probably out of the need, there is nearly always a neighbor who is known for his/her abilities to provide some health, usually curative, services. That person was picked as the best candidate for promotor. Sale of services can be a solution to the unstable population base, through a flexible payment system that includes cash and species.

Accessible localities

Accessible localities also have the problem of an unstable population base, since many of their residents travel elsewhere to work their lands. However, the main obstacle to project success in these

localities is the accessibility of health services in nearby towns and cities. Long established patterns of obtaining health services among residents of this localities can become the main constraint to the permanent organization of the residents for health objectives and for support of the health personnel.

Health services that are competitive or better than those already existing seems to be what the residents of these localities will prefer. The health Promotor in these localities will be considered an "inferior good", to use an economic term. His role will be different than in the isolated localities.

Population in the Localities and Number of Members of the Cooperatives

Approximate number of families in each locality and the number of members of the cooperatives in each locality is presented in the table below. (Table 2).

Both sets of figures are only estimates. The number of families in each locality is difficult to obtain. The Instituto Nacional de Estadística (INE) estimated the population on the basis of the 1976 census. The figures given by informants in the area are noted in Table 3. One problem in calculations is the limits used by each source when referring to a given locality. A second difficulty is the aforementioned unstable population base.

The number of members per coop is also different depending on whether the census figures kept in the central or the figures given by members of each coop are taken as the correct source.

TABLE 2

Number of Families and Number of Cooperative Members
in each Community

Cooperative	Community	Estimated ¹ Number of Families	Number ^{2 3} of Socios
El Triunfo	Río Hondo	117	21
6 de Agosto	Río Viejo	70	24
24 de Enero	Pueblo Nuevo	133	27
Agrícola Minero	Nuevo Mundo	72	31 (17)
24 de Mayo	Jerusalem	80	25 (15)
Unión Faja Tunari	Faja Tunari/Chorolque		16
Ag. Chané Magallanes	Chané Magallanes	120	25
San Lorenzo	San Lorenzo	75	23 (18)
19 de Agosto	19 de Agosto	80	39 (18)
El Carmen	El Carmen	30-45	45
La Isla	La Isla	56	42
1° de Enero	Villa Monte	45	26
San Julián	San Julián	132	33
4 de Marzo	Azurduy	100-150	17
	Total		394

- Sources:
1. INE Santa Cruz and estimates by members of the communities. Total population divided by 6.6 to obtain approximate number of families.
 2. List of members - Central Office - Mineros
1 member= 1 family
 3. Responses by members of the Cooperatives. Indicate number of active members, while list includes everyone registered.

TABLE 3

Population Estimates by the Instituto Nacional de Estadísticas
and by Members of the Localities

<u>Community</u>	<u>Number of Families¹</u> <u>INE Estimate</u>	<u>Number of Families²</u> <u>Community Estimate</u>
Río Hondo	117	80
Río Viejo	70	70
Pueblo Nuevo	135	600
Nuevo Mundo	72	300
Jerusalem	80	120
Faja Tunari/Chorolque		
Chané Magallanes	130	160
San Lorenzo	75	500
19 de Agosto	80	40-80
El Carmen	45	300
La Isla	56	150
Villa Monte	4	200
San Julián	132	132
Azurduy	100	500

- Source:
1. INE projections to 1983 based on 1976 census figures.
 2. Informants estimates.

The difference refers to the distinction between registered members and active members; that is those who participate in coop affairs. The significance of these figures for the project is that in each case an effort will have to be made to recruit new members to obtain a minimum population size to support the health services to be offered by the project.

Localities and Communities?

The Central de Cooperativas Agrícolas de Mineros is best described as a network of campesino settlers that reside in a number of localities, throughout the area. The ties that make up the network are primarily economic ones. That the network is also a social and political force in the area is derived from its economic strength.

The relationship is between members and the services offered by the Central. The services are provided to the members and their place of residence or their place of work is only a factor insofar as easy access allows the member greater participation in the coop affairs and greater use of the services.

There is really no relationship between the coop and the "community" except to the point that members residing in a "community" may get together to exert influence on the Central offices to obtain benefits for themselves.

It may be a mistake for the project to equate a coop in a locality with the "community". They are not the same and in fact, there is little relationship. Furthermore, the question arises as to whether these

localities can be considered communities. The ties that make up a community are not there yet. The localities are made up of a number of families who share only their experience as settlers in the area. The interests of these families extend beyond the limits of the locality to other areas in the colonization zone, to their places of origin, and to towns and cities where they may have relatives or socio-economic relationships with residents of these places.

Their experience as settlers has usually included common actions for specific goals, such as the building of a school, a road, a Posta Sanitaria, etc. These common efforts may have generated ties among the settlers which facilitate further common action. However, these efforts have almost always generated disagreement, conflict and fragmentation.

At best, these localities can be considered communities-in-formation. The instability of the settlement is, in a way, a search for new and more stable solutions out of which communities can finally emerge.

In this context the active members of the Mineros cooperative probably represent not only the more stable segment of the population (despite the fact that many of them may have dual residences), but also have more at stake in the zone as evidenced by their economic and organizational success.

The health project may need to review the model proposed for the Mineros area to incorporate the dynamic social and economic processes taking place among the population of this zone. A model based on the concept of community as a clearly defined geographical, social, economic,

and cultural entity will generate constraints to its implementation that may overwhelm the cooperatives.

The Survey

In the following sections, the results of interviews with 15 family members of the coop are presented.

Difficulties of access to communities greatly reduced the population from which the sample could be selected. Seven of the 15 interviews were conducted in the Central office of the coop in Mineros. These interviews were with members from the isolated communities who had come to the Central or personal or coop affairs. The next eight interviews were conducted in localities that could be reached by vehicle. The following is a breakdown of interviews by localities:

<u>Locality</u>	<u>Number of Interviews</u>
Faja Tunari/Chorolque	5
Chané Magallanes	4
Jerusalem	1
19 de Agosto	3
Pueblo Nuevo	<u>2</u>
TOTAL	15

Socio-Economic Characteristics of the Sample in the Mineros Cooperatives

Demographics

The total population included in the 15 interviews was 102 persons, 63 or 67.7 percent of the total were male and 39 or 38.2 percent were female. The breakdown by age groups is as follows:

AGE	0-1	1-4	5-14	15-24	25-34	35-44	45 +
SEX	M F	M F	M F	M F	M F	M F	M F
NUMBER	2 2	4 5	25 15	14 4	8 7	3 4	7 2

The average number of persons for family was 6.6.

Occupations

The main occupation of the heads of the family was farmer. In five of the 15 cases, a second occupation was given. These second occupations included three drivers, one heavy machinery operator, and one comerciante (retail business outlet).

It should be noted, however, that holding more than one occupation seems to be a common characteristic of the farmer in the Mineros region. Years of school censuses and numerous interviews for different studies have conditioned the population to the point that automatic responses to questions on occupation are agricultor for the male and "labores de casa" for the female. It is only through further questioning that the varied and multiple nature of the occupations of a settler's family begins to

emerge. Occupations of household heads, however, seem to be mostly related to agricultural work.

Land Tenure

In 14 of the 15 cases, answers were obtained about land ownership and land actually under cultivation.

The size of the property varied from a low of 10 hectares to a high of 150 hectares. Three families own more than 100 hectares, seven families own properties of 40-50 hectares and four own properties of 10-39 hectares. Land under cultivation was more uniformly distributed, its size varying from a low of three hectares to a high of 20 hectares. The average was 9.9 hectares.

The larger plots of land under cultivation were planted with sugar cane. However all 14 cases cultivated rice and corn as well as sugar cane.

Another important characteristic of land ownership was the fact that eight of the 14 families had land in two or more localities. Those eight families had their main residences along or very close to the main road of Mineros - Chané Independencia. Their second plots of land were located at distances of 30-60 Km., mostly on the North East band of the Río Grande.

Owning more than one plot of land seems to be a common pattern of the settlers in older colonization areas such as the area around Mineros. In some cases, the settlers had their original parcela in the area around Mineros and have acquired a second one in a spontaneous

colonization area to increase their production or to take advantage of richer land after having exhausted the fertility of the first plot. In some cases, settlers in the spontaneous colonization areas, which are far away and are difficult to reach, have moved to an area closer to or on the main road while maintaining their first plot of land.

Transfer of land among settlers is very common, and there is a pattern of land acquisition among the most prosperous settlers. Investing money in land was mentioned as the best strategy against inflation and loss of purchasing power of money.

The implication of the pattern of land ownership in different places is that while a family may reside for most part of the year in one locality, at least the head of family spends a considerable amount of time on his different plots of land during the agricultural cycle.

It is also common for families with more than one plot of land to employ peones at least on a temporary basis.

Health Related Issues: Illness in the previous two weeks

The rest of the questions in the interview were related to health. One set of questions was designed to determine illness episodes during the two previous weeks and expenditures associated with health care.

Of the 15 families that were interviewed, 11 had had one or more illness episodes in the previous two weeks. The 11 families had had a total of 24 persons who had been ill. The 24 ill persons constituted 23.5 percent of the total population in the sample. The distribution by sex and age of the ill persons is as follows:

AGE	0 - 4		5 - 9		10 - 14		14 - 40		41 and more	
SEX	M	F	M	F	M	F	M	F	M	F
NUMBER	2	2	3	4	2	2	2	4	2	1

Expenses

Of the 24 ill persons in the previous two weeks, 17 (or 70.8 percent) had incurred health related expenses. Although an attempt was made to breakdown expenses into categories, most people could not remember the details -- only the entire amount spent.

Expenses ranged from a low of 50 pesos to a high of 15,000 pesos. The average expenditure was \$b3,258 per person and \$b3,692 per family. The expenditures included only cash payments.

Days of work lost to illness, among the adult population ranged from one to 20 days. There were five cases where the adults had lost work days.

Sources of Health Care

The sources of health care varied greatly among the 11 families and the 24 ill persons.

The most common answer to "Where did you go to obtain health care?" was "self-treatment".

In 12 of the 24 cases, the persons had treated themselves. These included the use of home remedies as well as the use of purchased medications.

In five cases a nurse (Auxiliar I II) had been consulted in a nearby Posta Sanitaria or a private practitioner nurse. In four cases a doctor had been consulted. In two of the four cases the doctor was a private practitioner. In one case a private clinic in Santa Cruz had been the source of health care. In two cases a neighbor had been consulted.

In general, all illness episodes were first treated at home. If no improvement was obtained, a neighbor was then consulted and if available nearby an auxiliary nurse. Only in cases judged to be serious or after all three previous steps had been taken, a doctor, a clinic or a hospital were considered.

The Pharmacy

In 17 of the cases where expenditures were incurred, the biggest expense was drugs, as indicated before. (The breakdown of expenses was not obtained for all cases.) However, in only five of the 17 cases, there fees were involved. The other 12 cases reporting expenses were all for drugs.

Access to a pharmacy was cited as an important factor in attempting self-treatment. The most common answer was that a visit to a health professional would result in a prescription and that, consequently, it was cheaper to go directly to the pharmacy and either buy a drug that was already known from a previous illness episode or ask the pharmacist for advice. The most common drugs used were for gastrointestinal disease and penicillin for almost anything else.

Health Problems and Expenses During the Last Year

A series of questions were also included about illness in the family during the past year (other than the two previous weeks). The purpose of these questions was to obtain indicators of the types of health practitioners consulted by a family and some sort of an indication of expenses throughout the year.

It is well known that most people would have difficulty in remembering all illness episodes and health related expenses in a family during a given year. However, it was hypothesized that all of them would remember serious illness episodes that involved a substantial expenditure. It was for these two reasons that the questions were included.

Illness During the Past Year

As expected, most of the answers to a question of illness during the past year were for serious cases such as post-partum complication or members of the family with chronic health problems.

The most common health workers consulted for these health problems were the physician and Auxiliary Nurses. It is difficult to breakdown the answer into separate categories of health workers consulted, as in almost all cases a series of providers were consulted. The sequence in general is auxiliary nurse, pharmacy, medical doctor, and hospital or clinic.

Expenses

Of the 15 families interviewed 12 had had one or more persons ill during the past year. There were actually 20 illness episodes reported. The expenses varied from a low of 100 pesos to a high of over 21,500 pesos. The average expense per family was 8,800 pesos and per ill person 5,300 pesos.

As was indicated before, the findings should not be interpreted to represent all or even most of the expenditures for health for a family during the year. As the finding on expenditures for the past two weeks suggests, the expenses related to health care for a family during a year are much higher than the above figures indicate.

What is clear from the answer to this set of questions is the prevalence of illness considered serious enough to move people to seek medical treatment at the higher level of the health service system, and to spend considerable sums of money in seeking health care.

The Coop and Health Services

A series of questions as to whether the coop should and could offer health services were included.

Of the 15 families interviewed 13 responded in the affirmative to the question of whether their Cooperative could offer health services. One said "no" and one was undecided.

To the question "Should the cooperative offer health service?" 11 responded yes and four had no opinion.

Answers to the types of health services the cooperative should offer were varied. The breakdown of the answer is as follows: (In some cases more than one answer was obtained.)

<u>Type of Health Service</u>	<u>Number of Answers</u>
Promotor	1
Enfermera/o	1
Posta Sanitaria	3
Médico	6
Drugs/Pharmacy	6
Hospital	4
Insurance Fund	<u>1</u>
Total	22

"Who and how should their services be paid for?" was a question that elicited the greatest variety of answers. In general respondents were very cautious since it seemed they interpreted the question as a request to commit themselves to a form or forms of payment.

Payment by the members through a variety of forms was the most common answer (7 out of 14). Acceptable forms of payment might include: monthly contributions as part of their agricultural loans; a combination of the two above, etc.

The remaining answers are too different to categorize them. They range from "paid by somebody - an institution - outside the community", to "the cooperative from its profits". Most, however, were undecided or did not want to commit themselves. Most respondents, even those who

expressed a preference for a form of payment, qualified their answer by saying that it should be decided in a cooperative meeting.

It is interesting to note that only one respondent said it should be paid through the sale of services, especially drugs. This response is interesting because it does reflect what almost everyone interviewed said outside of the survey during the discussions and open ended questions.

Ideal versus real behaviour

The questionnaire, as was explained before was a combination of open-ended questions and questions that required a short answer or the selection of one answer out of several alternatives. The questions of "who should pay for the health services?" and "how should the payments be made?" elicited two types of answers. The first was actually reluctance to give an answer as they did not want to commit themselves to any one answer. The second type of answer implied ideal behavior: cooperative members should pay for services received from their cooperative.

When asked for details about how the members would pay for the services, the answer was not as clear. Members paying for services meant paying only for services when received. The notion of regular payments was only acceptable if by services it was meant complete medical services, and especially payments for hospitalization and major expenses. In short regular payments would be acceptable to some of the members only if it meant comprehensive coverage. The cases where this answer was obtained were in families where a member or members have had recurring health problems and considerable expenses.

For example, in one case the respondents estimated they had spent over 180,000 pesos seeking treatment for their six-year-old son during the past 3 years. Health curers consulted included everyone from a curandero to specialists in Santa Cruz. A second example is the wife of a respondent who estimated that every year, they spend approximately \$20,000 pesos in her treatment.

In any event, payment for services was meant as a nominal fee. A fee that would give access to all the services with no further payments.

Real behavior

All the evidence from the interviews, discussion and case histories indicates that the preferred method of payment by all members is the one single payment that includes all costs.

Furthermore, it is also clear that if members know they can get in one place all the required services, that is consultation, prescription, drugs and treatment, they prefer this service to one where they must make more than one stop to get health care.

In that respect, the Sanitario (Auxiliary Nurse II) in Chané Independencia was often cited as being the best source of health care in the area, the most trustworthy and the most efficient. "You get all you need in one visit" was the answer as to why they preferred his services to the hospital or a medical doctor.

Another example of the preference for one stop service is the reasons given for self-treatment with drugs as the visit of the pharmacy for diagnosis and drug buying.

Respondents claimed that by going directly to the pharmacy, they could save the fees of the doctor, who in any case was going to send them to pharmacy to buy the drugs. Respondents claimed that they often reused an older prescription several times to get the drug that had helped cure them.

Finally the use of drugs such as penicillin, cloranfenicol and a few other for almost any illness has effectively turned these drugs into over-the-counter drugs that are self-prescribed by most adults.

Characteristics of the San Julian Cooperative
that Relate to the Health Project.

The three levels of services proposed in the health project fit the physical lay out of the colonization area of San Julian. The nucleos and the NADEPAS correspond to the levels I and II services and organization in the proposed project.

Thus geographical dispersion is not a disadvantage given the fact that the nucleos are symetrically distributed. The obstacles are lack of stable roads and access to the main roads and the NADEPAS. (See map 3 and diagrams of the Nucleo NADEPAS.

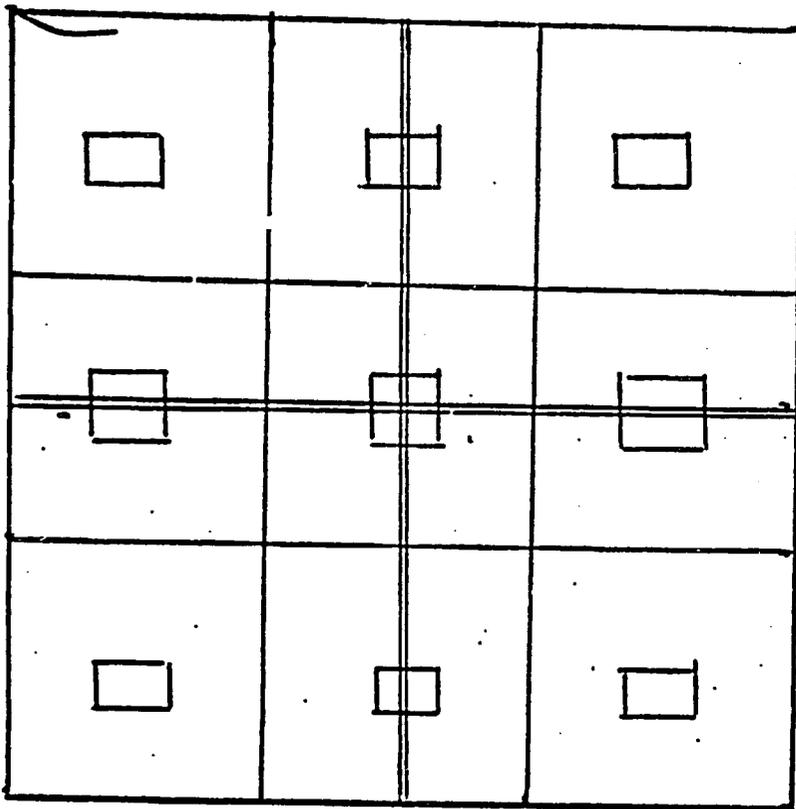
Although geographical dispersion is not a problem in the San Julian area, two other factors, namely the proportion of members in each nucleo, and the question of whether the nucleos are communities, are relevant to the health Project.

NADEPA

Nucleos Agrícolas de Producción

Superficie total 18.000 has.

Capacidad de población 360 flias.

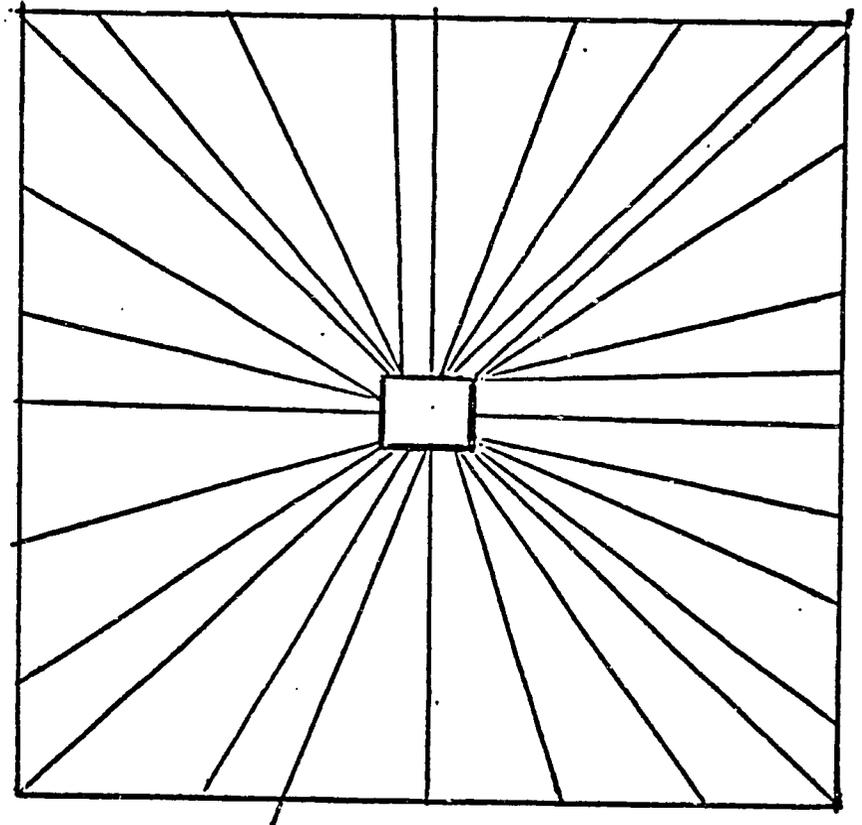


NUCLEO

Superficie 2.000 has.

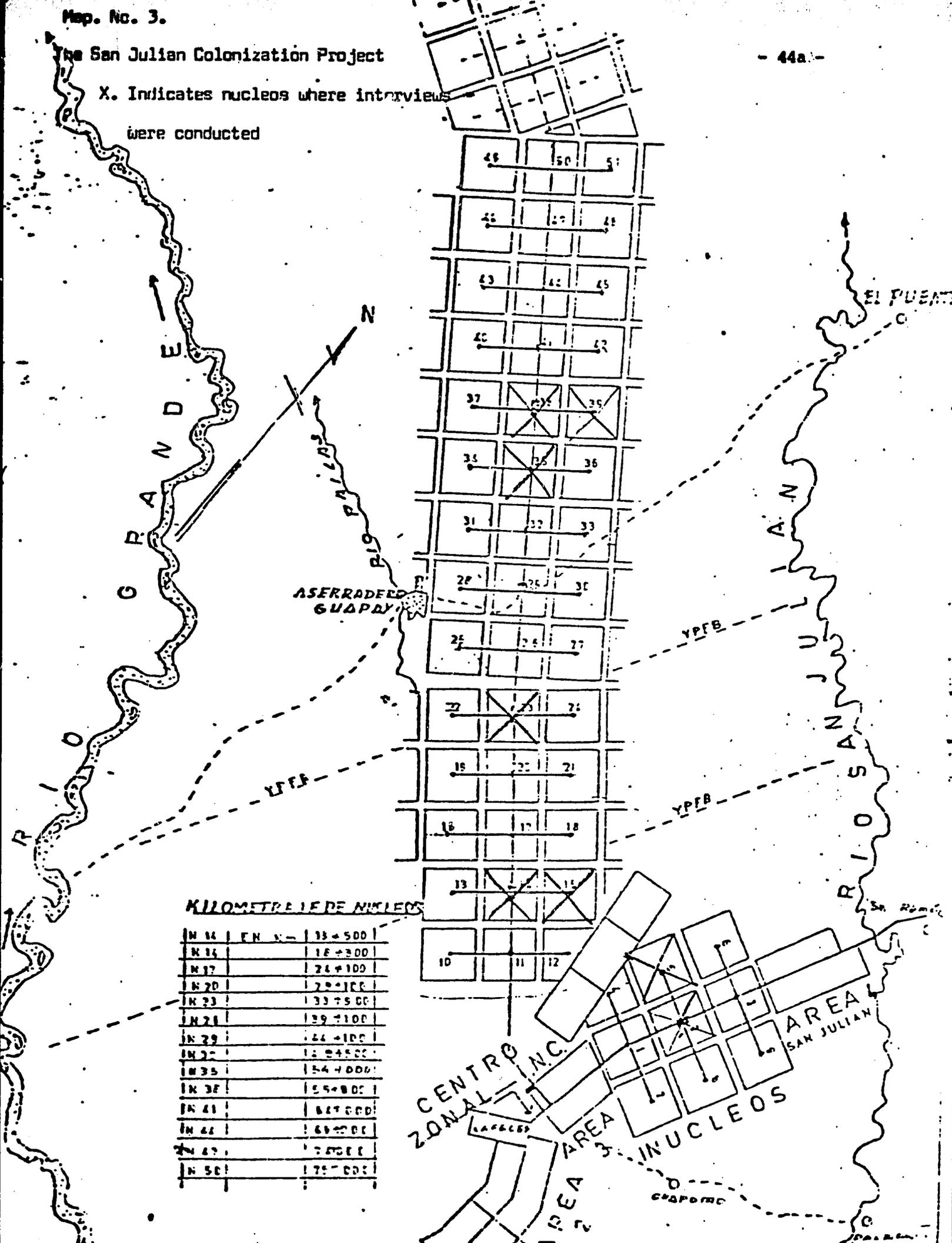
Superficie de rotación 50 has/F

Capacidad 40 familias



The San Julian Colonization Project

X. Indicates nuclei where interviews were conducted



KILOMETRE LE DE NUCLEOS

N 14	13 + 500
N 16	18 + 300
N 17	24 + 100
N 20	20 + 100
N 23	33 + 500
N 24	39 + 100
N 29	24 + 100
N 30	12 + 500
N 35	54 + 000
N 38	55 + 000
N 41	64 + 000
N 42	69 + 000
N 47	70 + 000
N 50	75 + 000

CENTRO ZONAL
 AREA 1
 AREA 2
 AREA 3
 AREA NUCLEOS
 SAN JULIAN

Population in the Nucleo and Number of Members in the Coop.

A 1980 estimate, provided by FIDES, fixed the total population in the San Julian Colonization at 5,440 persons and 1,861 families.

In 1982, the total number of members of the San Julian Coop., was 858. Most members are heads of household, though in a number of households more than one person is a member of the Coop. Assuming that all members represent families, only 46.1 percent of the total number of families in the San Julian Colonization area are member of the Coop.

A partial list of the nucleos where interviews were conducted illustrate the problem at the local level.

Place	Number of Families	Number of Members	%
Nucleo 2	60	10	16.6
14	65	30	46.
15	40	25	62.5
23	65	15	23.
35	40	25	62.5
38	60	23	38.3
39	35	19	54.2

Only one response was taken. However, it should be pointed out that in the nucleos where more interviews were conducted, the respondents

provided different figures for the number of members and for the total number of families.

The inexactness is again not so much one of inaccuracy on the part of the respondents, but of the fluid situation of the population and of the difference between registered and active members in the Coop.

Localities or Communities?

The San Julian Colonization experience represents an attempt, through the physical lay out and the rules of behavior among the settlers, to recreate communities. The process continues at the present and has better chances of achieving its goal than the spontaneous colonization efforts.

However, the nucleos are not yet communities. Settlers in San Julian area, in spite of all the rules, are likely to repeat the experience of the older colonization areas: dual residence, acquisition of more land, and diversification of economic activities are processes also taking place in San Julian.

Finally, the Coop of San Julian, like that of Mineros can not be equated with the community. The relationship is again between members and the services of the Coop.

The current Health Program which is being assisted by FIDES shows signs of lack of sustained community participation in the support of the health promotor. In the FIDES quarterly report of July-September of 1982, it is shown that none of the promotors was being remunerated by the community. Of the 12 promotors working 3 got some remuneration from the

sale of drugs, 3 from service fees, and 6 were listed as receiving no remuneration or as volunteers.

The Survey

In the following sections the results of the interviews with 16 households are presented. All interviews were conducted in the residences of the families.

Nucleos, where the interviews were conducted, were selected to represent length of residence. Road conditions did not permit the inclusion of the newest nucleos.

The following is a breakdown of the interviews conducted by nucleo:

Nucleo	2	4	interviews
14	1	"	
15	1	"	
23	3	"	
35	2	"	
38	4	"	
39	1	"	

(See map for location of nucleos)

Socio-Economic Characteristics of the Sample in the
San Julian Cooperative

Demographics

The total population included in the 16 interviews was 86 persons. 50 or 58.1 percent were male and 36 or 41.8 percent were female. The breakdown by age groups is as follows:

AGE	0-1	1-4	5-14	15-24	25-34	35-44	44 +
SEX	M F	M F	M F	M F	M F	M F	M F
NUMBER	3 5	3 4	18 7	13 9	2 3	6 3	5 5

The average number of persons per family was 5.4

Occupations

All of the heads of the family interviewed were farmers. Spouses of the heads of the family declared their occupations as household workers. San Julian is a fairly new colonization area and offers few work opportunities other than agricultural work. However, in the NADEPAS that is the centers of 8 nucleos, there is a proliferation of small retail shops that do provide the residents of the NADEPAS with sources of income other than agricultural work. However, the interviews were with families still residing in the nucleos and therefore with families that are engaged almost exclusively in farming.

Land Tenure

The size of the properties is evenly distributed in San Julian.

San Julian as a directed colonization project, and a relatively new one, does not yet seem to be undergoing changes in land tenure patterns similar to older colonization areas elsewhere in the area.

Of the 16 families interviewed 12 had properties of 41-50 hectares which is the size of property established by the colonization project. Four of the 16 had properties of 100-150 hectares. Three specified that they owned properties of 50 hectares, but also worked a second 50 hectares plot registered in the name of and in partnership of a son. One settler had 3 plots of 50 hectares each. Land actually under cultivation ranged from a low of 1/2 hectares to a high of 5 hectares. The average was 2.2 hectares per family.

Land of Residence in San Julian

Fifteen of the 16 families interviewed had been in San Julian between 3 and 5 years. One settler had been in San Julian 10 years.

Health Related Issues

Of the 16 families that were interviewed, 8 had had one or more illness episodes during the previous two weeks. The 8 families had had a total of 10 ill persons which amounted to 11.6 percent of the total

population in the sample. The distribution by age and sex of the 10 ill persons is as follows:

AGE	0-4	5-9	10-14	14-40	41 and more
SEX	M F	M F	M F	M F	M F
NUMBER	- 3	1 1	1 -	2 -	1 1

Expenses in the Previous two Weeks

Six of the 8 families with illness episodes during the previous two weeks had incurred in expenses. These ranged from a low of 200 pesos to a high of 5,500 pesos. The average expenditure was 1,400 pesos per person. Expenses included fees, drugs and others costs.

Sources of Health Care

Of the 8 families with illness episodes in the previous two weeks, 4 treated themselves, 2 went to the local health promotor and 2 went to a Medical Doctor -- one in San Ramón and the other to Montero.

Of the 4 who treated themselves, 2 used drugs and 2 used herbs and teas.

Although no breakdown of expenses for all cases was obtained, it was clear that drugs were the biggest expense category.

Health Problems and Expenses During the Last Year

Health problems during the last year, other than the two previous weeks, revealed a different situation for the settlers in San Julian. While illness episodes during the previous two weeks were relatively few

in number, illness episodes during the past year were experienced in all 16 families interviewed.

Of the 86 persons included in the sample 46 (or 53.4 percent) had been ill during the past year.

Expenses

Fourteen of the 16 families had incurred health related expenses during the past year. The expenses ranged from a low of 220 pesos to a high of 26,150 pesos. The average expense per family was 5,700 pesos.

These figures should be interpreted as representing the most dramatic cases during the year, and not the total health related expenses.

Sources of Health Care

As in the Mineros case, it is difficult to tabulate the types of health providers consulted during the illness episodes of the previous year. However, availability of certain type(s) of health worker seems to be a determining factor. Consequently, the majority of the persons who did seek health services consulted the promotor and the auxiliary nurses in the area. For the more "serious" cases, trips to the Hospitals in San Ramon and Montero were not uncommon.

Reliance on self treatment was also more pronounced than in Mineros. What is striking is that in all cases, drugs were stored in the house. The drugs kept in the house nearly always included penicillin and other antibiotics as well as drugs such as aspirin and vitamins.

Factors influencing the storage of drugs at home are the isolation of San Julian from services and the fact that the health projects

currently active in the area have made drugs available at lower costs than in pharmacies elsewhere.

The Coop. and Health Services

Answers to questions relating the cooperative and health services are conditioned by the respondents experiences with health services in the area.

To the question of whether the coop could offer health services, 13 responded with "yes", while 3 were undecided.

To the question of whether the coop should offer health services, 10 answered in the affirmative, 2 did not respond and 4 were undecided and thought the matter should be carefully analysed.

Types of services the cooperative should offer were clearly influenced by the respondents' experience to date with services in the area. Medications was the most common answer. In fact, 15 thought that sale of drugs should be one of the services offered by the cooperative. Education on the use of pharmaceuticals was also often mentioned as a desired service. The current FIDES health project which has made drugs available at reduced costs was clearly something that the respondents favored. Other services included health promoters, and Postas Sanitarias only three mentioned a Hospital and or medical doctor as a desirable service.

The question of who should pay for health services elicited a great variety of responses. The main characteristic of the responses was a lack of opinion. The most common (5) responses were the government should pay through items for personnel; some payment should be through contribution by the members; and through the sale of services and drugs.

The following question "How should the services be paid for?" elicited similar undecided responses. The most common (7) was that member should decide in a general assembly of the cooperative.

What this set of questions reveals is that there seems to be a reluctance on the part of the respondents to commit themselves to any one answer. There is some recognition that member should pay for services, but only a nominal fee. The expectation seems to be that the government should provide these services, or at least an outside institution. Their experience during the colonization process where the Instituto de Colonización has provided health services, the current FIDES health project, and the Catholic church services in the area are all factors which have influenced responses to these questions. The attitude is clearly one of "Why commit oneself to paying for services that are nearly free at the present?"

Characteristics of La Merced Cooperative that
Relate to the Health Project

There are a number of characteristics of the membership of La Merced coop that require a rethinking of the proposed delivery model of the health project. The primary characteristic refers to the nature of the membership in the coop.

The interviews with the members of the coop strongly suggest that the main motive for membership is simply to obtain a service. Anyone can be a member of the coop. Thus of the 42,000 members, only 28,000 are considered active according to an officer of the coop. In the 28,000 are included infants, students, heads of households, housewives, and others.

Membership is on an individual basis and very often more than one member of a family is a coop member. Of the 78 persons included in the sample, 47 members of the coop belonged to only 15 families. In the lists of the two neighborhoods provided by La Merced for selection of the sample, there were 70 persons with an occupation out of a total population of 163 persons. This means that 93 members of the coop were housewives, students and minors. It was difficult to determine how many families were represented in the two lists.

The individual memberships in the coop are significant to the project in that it means a smaller population base of potential users of the health services. Infants and students as well as other persons with no income are unlikely to become users of the health services unless the income-earning members of their families pay for these services.

The sample is not large enough not is it a sample that is representative of the membership as a whole. But it does suggest along with other evidence that a majority of the urban members of La Merced have access to health services. The Cajas are the main resource for health services. Private practitioners and private clinics as well as private medical services plans are widely used by members of La Merced.

The second major problem is that of the relationship between the member, the coop, and their neighborhoods. As in the rural coop, the relationship is one between the member and the coop services. The place of residence of the member is irrelevant to that relationship. There is no relationship among members of the coop which related to their

neighborhoods. In fact, members of La Merced can be next door neighbors and not know each other.

Furthermore, as the size of the lists of members in these two neighborhoods suggest, the members are a very small proportion of the total neighborhood population.

The membership in any given neighborhood is highly heterogeneous. There is little sense of a neighborhood other than the fact that they are referred to by names. Very few neighborhoods have any form of organization except for the Juntas Vecinales, and the sport associations. The neighborhoods are more planned neighborhoods than actual ones.

Finally, in almost every neighborhood there already exists a member of health services available to the residents. There are 22 Postas Sanitarias in the peripheral areas of the city, along with an undetermined number of private clinics, Doctor's offices, private nurses, etc.

Cooperative La Merced, Santa Cruz - The Survey

Members of La Merced live throughout the city of Santa Cruz. Since the project was only intended to serve the population in the peripheral neighborhoods of the city, two of these neighborhoods were selected using the criteria of an employee of La Merced who indicated they were neighborhoods that were representative of the peripheral areas where La Merced had members.

A computerized listing of the members in each neighborhood was obtained and members were selected for interviews. The selection was made with the criteria of including members of each of the occupations listed in the printout.

The first effort to contact selected members in one of the neighborhoods failed because the members had moved out of listed addresses or had not been active in the cooperative in the last year or two. A second attempt to visit persons listed in the second neighborhood produced only one interview of the 8 selected.

In view of the lack of results in the field visits, it was opted to interview members who visited the central offices. La Merced provided a space in the central offices and asked members who visited the offices if they were willing to be interviewed. Only members living in the peripheral areas were interviewed. Eleven interviews were obtained in the offices of La Merced and four in the neighborhoods. The interviews included members living in 10 different neighborhoods.

Socio-Economic Characteristics of the
Sample in La Merced Cooperative

Demographics

The 15 interviews included a total population of 78 persons. 53 persons or 67.9 percent were female and 25 or 32.1 percent were male.

The breakdown by age groups is as follows:

AGE	0-1	1-4	5-14	15-24	25-34	35-44	45 +
SEX	M F	M F	M F	M F	M F	M F	M F
NUMBER	- 1	4 3	4 14	4 13	5 5	3 5	5 12

The average number of persons per family was 5.2.

Occupations

Of the total sample, 28 persons had occupations, which means that more than one person per family was self-employed or worked for wages.

In order of frequency the occupations are the following: comerciante (retail business) 6, employer 5, teacher 4, domestic servant 4, mechanic 2, electrician 1, seamstress 1, shoemaker 1, taxi driver 1, and farmer 1. (Two who lived off income from investments.)

Family Income

The persons interviewed were asked to estimate their monthly family incomes. Fourteen responses were obtained, and the figures given range from a low of 6,000 pesos to a high of 64,000 pesos. Six members had incomes below 10,000 pesos a month, 6 had incomes between 13,000 and

44,000 pesos a month and 2 had incomes of 50,000 and 64,000 respectively. All estimates are of family incomes for a month.

Living conditions

A series of questions on living conditions were included in the interview in an effort to determine the relative well-being of the families included in the sample.

Of the 15 families 12 own the houses they lived in, 1 rented a house, 1 had a house in anticretico, and 1 had some other arrangement. The numbers of rooms other than a kitchen and bathroom ranged from 2 rooms to 7. Fifteen of the houses had water piped into the house. Only 6 of the houses were connected to the sewage system. The next 6 had only outhouses and 2 had no waste disposal at all. 13 of the houses had electricity. Only five houses had a telephone, and only one family had a vehicle, which was a taxi.

Although no statistics on these indicators exist for the peripheral areas of the city, it seems that the majority of the families in the sample were relatively well-off. It is also difficult to state what segment of the population of the city the sample was representative of. However, it is relatively safe to state that the sample is representative of the majority of the membership of La Merced.

As was stated before, the list of all members of La Merced in two neighborhoods was obtained. A comparison of the occupations listed in the printouts with the ones obtained through the interviews shows the same distribution of occupations. Trips through the peripheral

neighborhoods tend to confirm the heterogeneity of the same through the appearance of the houses and conversations with neighborhood residents. In almost every neighborhood, one can find professionals to unskilled workers.

Length of Residence in the House

The length of residence in the same house ranged from 1 1/2 years to 24 years. The average length of residence was 9 years. Eight of 15 families had resided in the same house 5 or less years.

Permanent Employment and Economic Well Being

Only 8 of the 15 respondents had permanent employment. 7 stated that their employment was temporary or done through contracts.

A question was included which asked the respondents to judge whether their economic situation during the past year had gotten better, worse or remained the same. Only 1 person stated that her situation had remained the same during the past year. Fourteen claimed it had gotten worse.

Residence Before Moving to the City of Santa Cruz

Ten of the families had moved to the city of Santa Cruz from elsewhere in the department or the country. Only five had lived all their lives in the city. Four had lived in three different places before moving to the city, 2 in two places and 4 in one place.

Reasons for moving to Santa Cruz were as follows:

Family	1
Studies	4
Economic	4
Health	1
Better Living Conditions	1

Some respondents gave more than one reason for moving to the city.

Of the 15 families, 7 had relatives in the same neighborhood.

Finally, only 3 families had agricultural properties in the places from which they had moved and still traveled to their properties to work or to administer them.

Health Related Issues

Questions about illness episodes in the previous two weeks and related expenses were also included in the city interviews. Eight of the 15 families had had illness episodes in the previous two weeks. A total of 13 persons had been ill which represented 16.6 percent of the total population in the sample.

Sources of health care were as follows:

(per family)

Self-treatment	2
Pharmacy	1
Doctor	3
Cooperative	1
Hospital	1

Expenses

Seven of the eight families had incurred expenses related to their illness episodes during the previous two weeks. The expenses ranged from a low of 1,310 pesos to a high of 3,340 pesos. The average was 2,110 pesos per family. The frequency of illness and the amount spent are considerably lower than in the rural areas of Mineros and San Julian.

The distribution of ill persons by age and sex is as follows:

AGE	1-4	5-9	10-14	15-30	40 and more
SEX	M F	M F	M F	M F	M F
NUMBER	1 -	1 1	1 1	- 1	- 7

Health Providers

A number of questions were designed to find out the types of health services used and the types of health workers consulted.

Only 2 persons stated that they consulted with other than health professionals. In both cases the person consulted was a curandero.

The health professional most often consulted was the doctor. Access to a doctor was obtained through a variety of means. The most common was consultation with a private practice physician, through one of the Cajas, or through the cooperative.

Finally a question was included to find out if any member of the families in the sample had ever been to a hospital or clinic. Four families responded that they had a member who had been admitted to Hospital and 6 had a member who been in a private clinic. In all cases, the reason for being in a Hospital or Clinic had been surgery or analysis which required staying overnight.

The Cooperative and Health Services

The interviews included a question on the kinds of health services available in the respondents, neighborhoods. Keeping in mind that a respondent may not be aware of all the services available in his/her neighborhood, the following were noted:

Post Sanitaria	9
Private Nurse	5
Pharmacy	4
Private Clinic	4
Physician	1
Naturista	1

The distance to any of these services was in no case more than 6 city blocks.

Health Institutions

Ten of the families interviewed did have access to one or more of the Cajas de Seguro or Caja of the institution for which they worked for health services. Five did not belong to any of these institutions.

Seven of the 10 that belong to a Caja were unhappy with the services they received. The reasons given were time lost, lack of drugs, and unsatisfactory attention.

All 15 families had access to the cooperative pharmacy and the physician referral system. However, only four respondents said they used either service.

Finally the members asked what health services they thought the cooperative should offer. Their answers were as follows: (more than one answer per respondent)

Permanent physician	5
Cheaper services	5
Pharmacy in the Neighborhood	4
Physician in the Central	
Office and in the Neighborhood	3
Laboratory	1
Nurse in the Neighborhood	1
Nursing Courses	1
Bigger Loans	1
Did not know	5

ANNEX 1: SCOPE OF WORK

SCOPE OF WORK

I. Research Objectives

The contractor will design and conduct field research which identifies the principle socio-cultural constraints to the implementation of a self-financed primary health care program. The study will be carried out principally through primary data collection supplemented by a review of appropriate secondary sources. The final product will be a written report that not only identifies the principle socio-cultural constraints to project implementation, but suggests strategies that can be incorporated into the project to deal with the constraints.

II. Research Foci

The study will have three foci: (1) personnel of the participating cooperatives; (2) beneficiaries; and (3) health service personnel.

A. Participating Cooperative Personnel

The Consultant will gather the following data on personnel (e.g. Boards of Directors) of each of the three participating cooperatives.

1. Perspective on the specific health services they would prefer from the provider organization;
2. Preferences as to the structural relationship between the cooperatives and the provider organizations.
3. Methods proposed by cooperatives for integrating health services into their current programs.

4. Methods for promoting enrollment of members into the health program, specifically, estimates of staff requirements to do so and how such staff will be compensated.
5. Package(s) of health services for coop membership preferred by provider organization and proposed methods of payment for services.

B. Beneficiaries

The research will include a sample of 15 potential beneficiary families from each of the 3 cooperatives (45 total) to determine the following:

1. The various types of health practitioners (e.g. traditional healers, para-professionals, professional modern personnel (doctors, nurses), consulted during illness.
2. Variances in behavior vis-a-vis the different types of healers.
3. Methods of payment (in-kind cash; immediate-deferred) used for each type of curer.
4. Are different types of curers used for different types of illnesses?
5. Concepts of what constitutes good health and what constitutes illness.
6. Importance of norms of modesty relative to seeking medical service (i.e. do women prefer to be examined by female

practicioners and men by male practitioners); is architectural design of health service centers (e.g. private examining rooms) an important factor in determining use of services?

7. Significance of social distance between patient and health service personnel in determining beneficiary participation - i.e. are poor farmers more comfortable dealing with lower middle class para-professionals than with upper-middle, upper class professional doctors?
8. Concepts of beneficiaries concerning clinics, health center, hospital and the like.

C. Health Service Personnel

The research will include a sample of 10 physicians, 10 nurses, and 10 para-professional nurse practitioners "type" modern health practitioners who could be involved in the program, to determine the following:

1. Perception of each type of practitioner concerning working with campesinos.
2. Perception of each type of practitioner relative to campesino concepts concerning cause of disease and curing.
3. Opinions of each type of practitioner concerning administrative structure for participation of professionals (i.e. doctors, nurses) in the project.

4. Preferences of various types of practitioners concerning work schedules, payment for services procedures and living arrangements (where applicable).
5. Elements of positive incentive packages (e.g. possibilities for publication, scholarships for further study) to induce various types of practitioners to participate in the program.

III. Methodology

The primary data will be gathered through a combination of quantitative and qualitative research tools. The research will design adequate interview schedules-questionnaires to solicit numerically verifiable information from the beneficiaries and "type" modern health practitioners who could participate in the program. These data will be complemented by information obtained through participant-observation and in-depth interviews with key-informants. Review of secondary sources will be conducted to round out the primary data that is collected.

IV. Reports

At the completion of the research, and prior to leaving Bolivia, the contractor will present a written draft report in English for USAID/B review. After USAID/B comments are made contractor will submit a final report with one copy each in both English and Spanish. Final report will be reproduced by Mission for distribution.

ANNEX 2: BIBLIOGRAPHY

BIBLIOGRAPHY

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