FAMILY PLANNING MANAGEMENT TRAINING

MANAGEMENT DEVELOPMENT PLAN FOR BOLIVIAN INSTITUTIONS WORKING IN FAMILY PLANNING

Performed by

Management Sciences for Health

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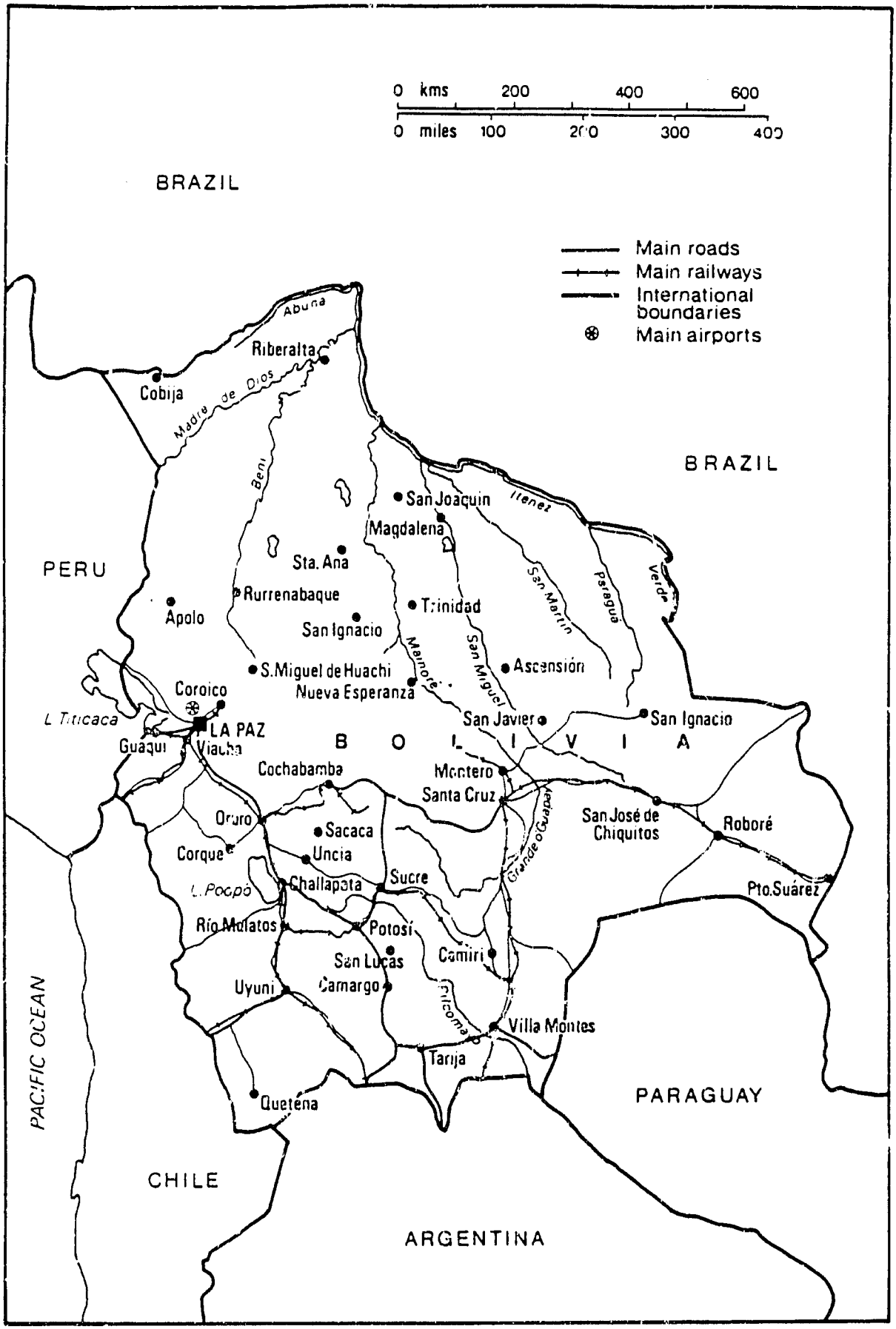
Bolivia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I. EXECUTIVE SUMMARY

At the request of USAID/LaPaz, members of a two person team worked for ten days in Bolivia to assess the management training needs of the private and public sector institutions which either provide or intend to provide family planning services in Bolivia. Interviews were conducted with the MOH, Unidad Sanitaria, the Hospital Obrero (IBSS), nine national non-profit and for-profit institutions and four international private voluntary organizations (PVOs). For the first time in ten years there is among them both a willingness to discuss the need for family planning services and an intent to move forward in the development of a family planning system.

The assessment came at a critical point of relative openness to family planning: there is attention and concern for the high abortion rate and for the high maternal perinatal mortality rate. The result is a recent USAID/MOH initiative, "La Lucha Contra El Aborto," of family planning services to high risk women in public hospitals in an attempt to combat the illegal abortions and high maternal mortality.

The Mission and team developed a strategy which includes:

1) continued work with the MOH to facilitate acceptance of family planning activities;

2) promotion of contact and exchange between the public and private sector institutions;

3) strengthening of public institutions which have begun to provide family planning services;

4) working closely with several key private organizations that provide services, are willing to take a stand, and can act as models;

5) the development of limited scope agreements with the public sectors, Unidad Sanitaria/La Paz and IBSS, which have indicated a desire to start programs immediately.

II. BACKGROUND

A. COUNTRY PROFILE

Bolivia is a country of 1,098,581 Kms situated in the center of South America. It is bordered on the north and east by Brazil, on the south by Paraguay and Argentina and on the west by Chile and Peru. A nation of vast arable land, mineral and forest resources, potential energy sources, towering ice-capped mountains, extended semi-arid wastes and tropical rain forests, it has been considered the second poorest nation in the Western Hemisphere. There are three distinct ecological zones. The Altiplano, situated between 3,600 and 4000 meters above sea level, comprises 17 per cent of Bolivia's territory. The valleys are located between 1800 and 2500 metres above sea level and comprise 15 per cent of the territory. The jungle and lowlands, at 100 to 800 meters above sea level, comprise 68 per cent of the territory.

1. POLITICAL

Bolivia is a constitutional republic, with executive power vested in a president and his appointed cabinet. Legislative power is vested in a bi-congress, comprised of a chamber of deputies with 130 members and a senate with 27 members. Bolivia is divided into nine departments, each of which elects three senators. The prefect of each department is appointed by the president.

The country has an unforunate historical record, both in terms of political instability and wars lost. Since independence from Spain in 1825, it has averaged one president a year, suffered numerous coups and frequent military intervention in the government. It has lost considerable territory to all its neighbors and has less territory now than at independence.

The Revolution of 1952 and the revolutionary government which followed, led by Victor Paz Estenssoro, brought fundamental social reform including nationalization of the larger mines, land reform and universal sufferage. Estensorro led Bolivia until 1956 and from 1960-1964 when, following widespread strikes and civic disorder, he was deposed by the armed forces. The following fifteen years were years of military stability; yet, after 1978 there were periods of political uncertainty.

In 1980, General Garcia Meza seized power and for two and a half years Bolivia was ruled by the military. Two years later the association between the government and the growing cocaine trade, violation of human rights in Bolivia and the withholding of overseas assistance to the military government left the Meza goverment discredited and without substantial support. The generals stepped down and Dr. Siles Suazo, a leader with Estensorro of the 1952 revolution and deemed to have been the winner of the 1980 election before Meza seized control, was invited to assume the presidency. He did so and democracy has prevailed since, despite a devastating economic crisis. However,

> pressure from within Congress, where he had no majority, and popular discontent fueled by an increasingly dire economic situation forced President Siles Suazo to cut short his presidential term by a year. A general election held on July 14, 1985, produced no outright winner and so Congress was again required to choose between the main contenders. This time Victor Paz Estensorro was elected, even though his MNR party had won only 26 per cent of the general election vote compared with 29 per cent won by the right wing Accion Democratica Nacional (ADN) whose leader is General Hugo Banzer Suarez. It was the vote of the smaller left wing parties that turned the tables in Congress...

.....In August 1985 the president unveiled his new economic policy.....The policy prescribed austerity and structural changes which explicitly rejected many of the values of the Revolution which President Paz Estensorro had led in 1952. The policy exposed the economy to international and local market forces and prompted widespread industrial unrest. But the government has stood firm, leaving the trade unions a much weakened political force. In October 1985 the MNR moved further to the right and forged an alliance with the ADN which assured President Paz of General Banzer's support and of a majority in congress. The alliance has survived - although it will not become a permanent feature of Bolivian politics - and the government has not been deflected from its orthodox aims during its first two years in office in spite of considerable hardship at home and the collapse of the market for its traditional export, tin, abroad. (1.)

(1.) Economic Intelligence Unit 1987-1988, Country Profile: Bolivia, page. 4.

2. ECONOMIC

The Bolivian economy has suffered a severe contraction in the last decade. After recording an average annual growth rate of 4.5 per cent in the period 1965 to 1980, GNP contracted in each of the following years. Between 1980 and 1985 the growth rate became an annual shrinkage rate of 4.5 per cent. Drought in the highlands and flooding in the lowlands contributed to this economic collapse in 1982 and 1983. Crop yields were only 40 to 60 percent of normal. Damages were recognized at $400 million. During this time inflation mounted and threatened to reach an annualized rate of 24,000 per cent in mid 1985 before it was finally brought under control. Officially, inflation reached 8,000 per cent by the end of 1985.

External factors also contributed to the economic crisis. Lower export prices, particularly for tin, a withholding of overseas credits and investments, and higher interests rates on mounting debts were just a few of the problems Paz Estensorro had to face when he became president in 1985. His new economic policy:

> removed many of the restrictions on exports and imports, lifted most price controls, ended subsidies, instituted a freeze (with controlled thaws) on public sector wages, and subjected the nationalised institutions to rigorous analysis and cost cutting. By mid 1986 inflation was under control and the international lending agencies had recognised that a serious attempt was being made, at considerable cost to the populace, to turn round the economy and possibly create the conditions for sustained growth.....The IMF assumed stand-by assistance in July 1986 and this was a signal for creditor nations to begin renegotiating debts and providing fresh assistance to Bolivia. (2.)

> As the formal economy has shrunk so the importance of the informal economy has grown: it is now the larger of the two, employing perhaps 62 per cent of the working population, generating up to twice as much foreign exchange as the formal sector, and providing three out of four of the dollars deposited with the Central Bank. It is nourished on the receipts from the production of coca paste and unrefined cocaine. (3.)

(2.) Economist Intelligence Unit 1987-1988, Country Profile: Bolivia, 1987, page 6.

(3.) Op.cit.

Agriculture contributes approximately 22 per cent to the GNP and employs approximately one half of the work force. Agriculture remains labor intensive and approximately 62 per cent of the agricultural labor force is engaged in subsistence farming, mainly in the Altiplano.

Production of food crops (rice, maize, potatoes and wheat) and of meats has not kept up with the increase in population. Food imports, particularly from the United States and Argentina, have risen. Following the weather disaster of 1982-1983, American food aid increased, and in 1984 totaled US $2,801,000 of which wheat was the largest commodity. (4.)

Sugar cane, cotton and rice are the main legal exports. The most lucrative agricultural product is, however, coca paste and unrefined cocaine, grown from the legal coca plant. Bolivia produces 40 to 50 per cent of the world's coca, principally in the Chapare. Periodic attempts by the Bolivian authorities to curtail the coca paste and cocaine production have met with no success until recently. In mid 1987 a new campaign, of compensation for farmers who take their land out of coca production and put their land into a rural development program for the area, appears to be making progress at least in the short term.

Natural resources in Bolivia include tin (mainly low grade ore) antimony, tungsten, gold, silver, zinc, lead, copper, and limestone. Bolivia used to be the world's largest tin producer, but output has steadily declined as a result of falling world prices and high extraction costs. In 1987 the government closed many state owned mines and laid off some 10,000 miners. Many of those miners have moved with their families to La Paz where they regularly protest the government's austere measures.

(4.) John Thomas, Food for Work: An Analysis of Current Experience and Recommendations for Future Performance. Harvard Institute of International Development, Cambridge, Ma. 1985.

3. CULTURAL

Bolivia's population is ethnically mixed. About 30 percent of the population is Mestizo (mixed Indian and Spanish), 25 per cent is Quechua Indian, 17 per cent is Aymara Indian and 12 per cent is of European origin.

The official language is Spanish; however, in the rural areas and in the city barrios, the majority of the people speak Quechua or Aymara.

4. POPULATION AND HEALTH

In the last census in 1976, population totaled 4.6 million inhabitants. The projected population for 1990 is 7.3 million. The population is concentrated in the urban areas of the Altiplano and in the valleys. Eighty per cent of the population is concentrated on 36 per cent of the territory. The population density has been estimated at 14.0 inhabitants per Km2 on the Altiplano, 9 inhabitants per km2 in the valleys and 1.5 inhabitants per km2 in the lowlands. (5.)

The Bolivian population is young. Forty-three per cent of the people is under 14, seventeen per cent is under 5 years. Thirty-eight per cent of the population is between 15 and 39 years old. 1983 data indicates that 23.4 per cent of women are in their fertile years. The Annual Growth Rate was estimated at 2.6 per cent in 1980. At that time the Global Fertility Rate was estimated at 6.3 children per woman (6.5 in the 1976 census). There are real regional differences here, as well as urban/rural differences. Figure (1) presents key fertility variables.

(5.) Background data on population and maternal and child health has been taken from the COF document cited above and from Encuesta de Prevalencia de Medicamentos, by Ruben Belmonte Coloma and Bertha P. de Ormachea, COBREH with Westinghouse Health Systems. The study was undertaken in 1983; the report itself is not dated. This data is judged to be the most valid and reliable data available.

Figure 1

Variables Affecting Fertility

1976 Census Data

Variable	Fertility Rate
Global Fertility Rate	6.5
1. Area of residence	
Urban	5.18
Rural	7.55
2. Level of Education	
None	6.60
1-3 years	6.45
4-6 years	5.65
7-12 years	3.96
13 years or more	3.12
3. Language	
Only Spanish	6.02
Only Indigenous	6.40
Spanish-Indigenous	5.99
4. Employment	
Active	5.22
Nonactive	6.08

Source: Bolivia Aspectos Demograficos, Centro de Orientacion Familiar. La Paz. Bolivia 1987. Page 75.

The high fertility rate is accompanied by an infant mortality rate among the highest in the Western Hemisphere. Life expectancy is an average 49.7 years (47.3 for men and 52.0 for women). Infant and child mortality (under two years) is reportedly 213/1000. Maternal perinatal mortality in 1983 was 48/~~1000~~ 10,000 with 27 per cent of those deaths due to complications from illegal abortions.

Figure (2) presents key population facts:

Figure 2

Population Data

Estimated population of 1987	6.8 million
Current rate of population growth	2.6%
Projected population for 1990	7.3 million
Urban population (1985)	47.7%
Women of reproductive age (15-44) (1983)	1.3 million
Total fertility rate	6.2%
Contraceptive prevalence rate	modern- 13% trad. - 11% total - 24%
Estimated national rate of abortion	20% of all pregnancies
Maternal perinatal mortality	48/1000
Rate of abortion complications	rate unknown; however, 60-80% of all gyn hospital beds are taken up with abortion complications
Life expectancy	females - 52 males - 47
Infant mortality Child Mortality	124/1000 213/1000
Mean age of population	18 years
Dependency ratio	820/1000

B. HISTORY OF FAMILY PLANNING

Institutionally, family planning in Bolivia began in 1973 with the creation of a branch of IPPF called the Asociacion Boliviana de Proteccion de la Familia (PROFAM). At that time other Latin American associations were at least seven years old. PROFAM was closed prematurely in 1977 when the government, responding to the demands of the Church, suddenly canceled the legal status of the association and ordered its termination.

Until then, in the years from 1973 to 1977, the government had offered a few tentative family planning services alongside PROFAM. But in 1978, when volunteers and Directors of PROFAM founded a new association by the name of Centro de Orientacion Familiar (COF), there were no other family planning services in existence in Bolivia other than those offered in private clinics to the middle and upper classes.

The early years of family planning, particularly those activities supported by the United States government, are clothed in tales of coersion and enforced campesino sterilization. Educated people throughout Bolivia believed that the Peace Corps engaged in forced sterilization of Altiplano women and that American food aid deliberately was infected with sterilizing ingredients. The story concluded that the Peace Corps was evicted from Bolivia for engaging in such activities. Despite the ludicrousnes of these beliefs, they serve as one basis for the fear and reluctance of international institutions to become involved in family planning activities, even on the level of IEC.

The other basis for reluctance is a 1982 Ministeral resolution which forbade PVOs from working in family planning. Additionally, some, but not all, of the international PVOs have language written into their government agreements which forbid family planning activities.

In the years following the government's cancellation of PROFAM, termination of its own fledgling programs, expulsion of the Peace Corps, and enactment of the ministerial resolution, a number of national organizations quietly continued to provide minimal service to a small number of women by distinguishing these services as something else.

The secretive mentality largely continues. None of the organizations offering services in Bolivia, even those exclusively devoted to family planning, directly identify themselves as family planning agencies, nor include family planning in their name; and none have signs on the outside of their offices which indicate they offer family planning services.

III. CURRENT SITUATION

A. GOVERNMENT POLICY

The government of Bolivia does not have a formal declared policy on population, although it has, in fact, maintained a pro-natalist stance, citing the low population/land area ratio. The perception has been that Bolivia is a large country, rich in natural resources and that it needs more people to exploit these resources and improve its standard of living. Bolivia's population of 6.8 million occupies more than one million square kilometers. Eighty percent of the population lives on 35 per cent of the land.

In 1984 the National Population Council (CONAPO) was formed. To date, no formal population policy has been formulated. However, in recent months the government of Bolivia has been increasingly sensitive to the health implications of high and unwanted fertilit. Their attention has been drawn to studies on the incidence of abortion which indicate that perhaps 20 per cent of all pregnancies are terminated prior to term. Sixty per cent of all hospital beds in maternity units are devoted to complications from illegal abortions. The figure reportedly runs as high as 80 per cent in Trinidad. Nationally, maternal perinatal mortality is reported as 48/1000.

10,000

On the other hand, the Social Security Law of 1987, effective November 1987, is explicitly pro-natalist. It stipulates that employers in firms with over 15 employees must pay a maternity bonus of 18 "salarios minimos" for each pregnancy of an employee or that employee's wife. The bonus is paid monthly from the fourth month of pregnancy onward. These benefits are on top of the previous benefits of a three month maternity leave and a shorter working day for the woman that following year. It appears, however, that in reality, employers cannot and are not paying these maternity bonuses.

B. MINISTRY OF HEALTH

The Ministry of Health has recently begun a family planning program for the first time since the closure of activities in the 1970s. The objective is to provide information and services to high risk in-patient women in public hospitals. The approach is in terms of high risk interventions in favor of maternal and child health and against abortion. The program is called, appropriately enough, "Lucha Contra el Aborto". Family planning, or child spacing, is a health and quality of life issue rather than a demographic one.

This program is part of a one year old agreement signed with USAID/Bolivia and calls for enlisting 4 Minsitry of Health hospitals per year, with the target of twelve hospitals participating in three years. Since university hospitals have presented some resistance, the next hospitals to be chosen will be ones not associated with universities and geographically spread throughout the country.

The program opened in January 1988 at the (IBSS) Hospital Obrero in La Paz. The next hospitals for this year will be in Oruro and Potosi. Additionally, Unidad Sanitaria, Departmento La Paz, would like to implement services within its area of coverage (the city of La Paz and the Department of La Paz with a total population of 2.3 million people) and is receiving advice and support from IBSS to do so.

In general, the IBSS and Unidad Sanitaria are more confident than the Ministry of Health to move forward in the delivery of IEC and services, even in the name of "the fight against abortion." The MOH-Division Materno Infantil feels doubtful of the possibility of further widening the program. Although IEC materials have already been prepared at the Maternal-Child Health Division of the MOH, the division will leave to the area doctor at each location the decision, if and how to distribute those materials. The division has not included any norms of service in "La Lucha Contra el Aborto," which thereby allows each doctor to decide on service standards.

The overall apppproach to the program is a very cautious one. It emphasizes the rights of women, integral health programming, improvment of the abortion situation, rather than direct family planning, and use of the services of those doctors who choose to participate. The plan is to start carefully, build gradual acceptance by the medical staff, and provide significant education to the staff and the population.

C. CONSTRAINTS TO FAMILY PLANNING

Numerous factors have worked together over the years to impede the development of a family planning service delivery system in Bolivia. These factors have left Bolivia years behind neighboring Latin countries. The most commonly cited factor is the Catholic Church which has always been outspoken in its opposition to any but "natural" family planning methods. Such an explanation is insufficient, however, because neighboring countries are equally Catholic. Certainly an equally important factor was the abrupt closure of services ten years ago for political purposes. The closure of services has left a fearful mentality, even, so to speak, a ten-year hangover. Many people and institutions are unable to wake up to the new day.

Leftist and nationalist ideology continues to identify family planning with Indian genocide and with the delay of the beginning of development. Family planning is confused with population control. It is believed that population control would retard the population growth believed necessary to populate the underpopulated eastern and southern lowlands.

The lack of reliable statistics on population and health issues makes challenging this ideology more difficult. The last census was in 1976. There are no very reliable statistics on regional, urban, rural, or urban-rural population distribution; nor is the data on maternal and child health believed to be reliable. All abortions are performed illegally, most far from the urban confines where most data collection to date has taken place. (Bolivia continues to be over 50 per cent rural.) Most women continue to have children without pre-natal or post-natal care and to deliver in their own homes with a relative or neighbor attending the birth. Registration of deaths of children under one year old is not routine in the barrios and rural areas. The data on maternal and child mortality which would support a brief for the difference between the conception of a child and the healthy maternal rearing of that child is lacking.

The lack of reliable data means it is difficult to establish the services gap between services wanted and services provided, and it does not allow the decision makers to progress beyond the discussion of data towards a more objectively established policy.

A number of other situations has contributed to this failure to arrive at an objectively established policy. There has been no professional institutional support from the Society of Obstetricians and Gynecologists, little or no lobbying on the part of those institutions who would like to practice family planning, nor collaboration, mutual support or much communication between them. Within the MOH there is a constant rotation of staff at the senior levels. Staff who might be committed to family planning do not spend enough time in their positions to build the power base to change policy.

All is not negative, however. At this point the prospects for development of a family planning service delivery system are more promising than they have been in ten years. A number of important institutions in the public and private sectors are confident of their ability to move ahead and are resolutely moving ahead. Indeed a number of institutions in La Paz, Cochabamba and Santa Cruz have been quietly but surely providing services for several years.

One strength has been the rising power of the women's movement with its concern for womens' health and women's rights. It is not surprising that the group of people in the forefront of direct service delivery, first under the name of COBREH and now CIES, is a group of young women concerned about feminist issues. In each of the three cities the FPMT team visited, men and women linked together family planning and women's rights. All of these people had either studied, visited, or gone to conferences outside Bolivia.

Another strength lies in union acceptance of family planning. CIES and CIS have agreements with the COB, the National Workers Congress, and family planning services are offered in clinics in union halls in La Paz. Support for these services has come from such diverse unions as the transportation drivers and the teachers unions. The strength of the COB, although diminished from a few years ago, is still very sizable; it can command a large part of the urban formal sector. As individual union member demand for family planning services increases, it will become increasing hard to ignore.

Opportunities for family planning come out of these strengths and lay in the fact that the farther one goes from the center of La Paz, the more possible it is to provide services. It is easier in the barrios of La Paz, than in the center of the city, in Cochabamba than in the barrios of La Paz. In January 1988 would-be service providers in Santa Cruz scoffed at the highland mentality of La Paz and insisted that in the Oriente and Frontier a different mentality pervailed. Indeed, away from La Paz there has been a quiet provision of services to a limited number of women.

Within the country there is commitment and experience upon which to build. CIES, CIS, IBSS, Cruz del Sur, FEPADE have been providing services. FEPADE has begun a rural CBD program, APROMYN is about to begin one. The MOH, FEPADE, and CIS have produced IEC materials. They are determined people and institutions, in the private and public sectors, who are doing good work, want to expand, and do even better.

The opportunity to provide quality services has been enhanced with the "Lucha Contra El Aborto" and the appointment of family planning supporters to key positions in Unidad Sanitaria and the IBSS Hospital Obrero where they have worked to gain institutional support for family services as an institutional response to "La Lucha Contra El Aborto." The Mission is aware that this is a critical period of relative openness and is committed to supporting Bolivian initiatives.

IV. THE PUBLIC SECTOR

A. UNIDAD SANITARIA

The Unidad Sanitaria de La Paz is the Ministry of Health's regional organization in charge of administering and providing services for the Departamento de La Paz, which includes the city of La Paz. The Departamento's population is estimated at 2,080,000 habitants, equivalent to about 30 per cent of the country's population. The people who use the services are predominately poor, rural or of rural background, unable to afford the services of a private doctor and not entitled to the services of IBSS (social security).
The El Alto area of the city of La Paz is the major focus of the Department's service delivery. El Alto has an estimated population of 400,000 to 500,000 low income people (including the recent miners' immigration due to the closure of COMIBOL mines). In a 1983 study, close to 90 per cent of sampled adults were rural migrants; roughly 90 per cent of the women had less than five years of schooling; 72 per cent of the mothers had never received pre-natal or post-natal care.(6.)

This area is attended to by the Unidad Sanitaria with one 20 bed hospital, the 20th de octubre, with a total professional staff of 12, including shifts, and a core medical staff of:

1 doctor, a gynecologist who sleeps there.
1 pediatrician, who works only in the morning.
1 general doctor, who works only in the morning.
1 anethesiologist, who comes only on call, during day hours.

According to the director of Maternal Child Service of the Unidad Sanitaria, the 20th de Octubre provided about 1200 deliveries in 1987 and is estimated to double that number in 1988, due to the influence of the food-for-children programs, which are expanding and which require mothers to deliver institutionally. In El Alto, the Unidad Sanitaria has also 80 "puestos", or health posts, with a staff of about 120 doctors and nurses. These puestos are only for outpatient services and have a cot for emerdencies.

(6.) Situation Assessment and Goal Establishment, Johnson, Cobb, and Baker, Foster Parents Plan International, La Paz, Bolivia, 1984.

The Director estimates that about 20 per cent of the population in El Alto is attended to by the IBSS and 8% by private small clinics, which leaves about 72 per cent to be attended by Unidad Sanitaria. If, of this percentage, 22 per cent are women of fertile age and half of them would be interested in family planning services, the potential El Alto family planning market population of Unidad Sanitaria would be 39,600 women.*

Additionally, services are provided in rural areas through a network of about 500 health delivery posts ("puestos"), staffed with doctors and/or nurses and some hospitals.

The Unidad Sanitaria Maternal Health Service is interested in participating in the MOH's new program "La Lucha Contra El Aborto" in providing family planning services, and is working closely with the IBSS. There will be a significant emphasis placed on education and information for the medical staff (doctors and nurses) of the clinic at El Alto and the "puestos". Later, this process is to be expanded to include the other urban and rural clinics and "puestos". In the next weeks, the staff of El Alto will receive information on family planning services from personnel at the Hospital Obrero of the IBSS.

Clearly, given the scarcity of funds available to the Unidad Sanitaria of La Paz, sourcing of supplies and basic equipment is critical.

The director of Maternal Health Service expressed the following needs:

1) Education and training for the staff of doctors and nurses on the maternal health benefits of Family Planning, in contrast to birth control, and in FP techniques and methods;
2) Total provision of clinical supplies and equipment and materials for IEC and service delivery.
3) Training and technical assistance in the design of a system for coverage of the La Paz population;
4) Supervisory systems for the new service to bring about sufficient coverage of the La Paz Departamental population.

*(500,000*22/100*72/100*50/100)

B. INSTITUTO BOLIVIANO SEGURO SOCIAL

The Instituto Boliviano Seguro Social (IBSS), formerly called the Caja, provides health coverage for those salaried employees affliliated with it. Health services are supported by joint employee/employer contributions. By law the employee must contribute 3.5 per cent of his salary and the employer must contribute a sum equal to 8 per cent of that salary to the IBSS. Salaried employees are almost totally urban workers and are estimated to comprise, with their dependents, 25 per cent of all Bolivians. Health services are provided through the IBSS hospital in each of Bolivia's sizable cities. There is no fee for services.

The FPMT team interviewed the director of Ob-Gyn services at the Hospital Obrero in La Paz. The Hospital Obrero is the biggest of the IBSS hospitals and is always filled to overflowing in all wards and outpatient clinics. One thousand women were hospitalized last year in the ob-gyn unit, 48 per cent of them because of abortion complications. In the Tarija hospital, that figure is reportedly 80 to 90 per cent. The director noted that one third of all maternal deaths are due to abortion complications.

The director of Ob-Gyn services in La Paz has a staff of 27 including five part-time doctors, ten full time residents and twelve nurses. This group services the ob-gyn inpatient needs and staffs an outpatient clinic, with an average of 70 women weekly. Currently the clinic is open three afternoons a week and they are hoping to add one more afternoon.

On January 4, 1988, the Hospital Obrero was the first institution to begin "La Lucha Contra El Aborto" and the first major institution to offer such services in ten years. The hospital is offering both contraceptive services (the pill, IUD and barrier methods) and IEC. Contraceptives and supplies come from the MOH which receives them from AID. IEC materials are those developed by the MOH. The director reported that support for the program goes all the way to the top of the IBSS, including both medical and non-medical personnel. Support is based on concern for maternal health, a belief in the right of a couple to decide when and how many children they want, and a desire to cut the financial costs which caring for the complications of illegal and unsanitary abortions performed outside the hospital impose upon the hospital.

Now, in the early days of the program, services are offered in the following order of priority: post-abortion-complication inpatient women, other high risk women, and birthspacing for women in general (affiliated with the IBSS). IEC on sex and family planning is offered one afternoon a week to those women who are inpatients for post-abortion complications. So far the response has been excellent. Hospital staff are asking for the same services for themselves.

This year the IBSS will open one more program in Oruro. IBSS hopes to arrive at all 12 hospitals within two years. The director of Ob-gyn in La Paz feels the time has come for such services, and IBSS is willing to be in the forefront.

V. THE PRIVATE SECTOR

A. NATIONAL PRIVATE NON-PROFIT ORGANIZATIONS

1. CENTRO DE ORIENTACION FAMILIAR (COF)

COF, the local IPPF affiliate headquartered in La Paz, was founded in 1978 by the directors and volunteers of PROFAM, the first family planning organization in Bolivia. After only four years of operation, PROFAM was shut down by order of the government in 1977. Until then, the government had offered a few tentative family planning services along side PROFAM. But in 1978, when the ex-PROFAM directors and volunteers founded the new association, to be named Centro de Orientacion Familiar, there were no other family planning services in Bolivia other than those offered quietly in doctors' private offices. In the years since then, COF has lived and operated in fear that it could once again be shut down by government decree.

The mission of COF is threefold:

1. to promote family planning and responsible parenthood as a human right and a guarrantee toward maternal health;

2. to motivate the institutions with decision making power and the population in general about the importance of demografic factors in family wellbeing;

3. to coordinate with other institutions which seek rapid socio-economic change so as to achieve human rights and social justice.

An executive director reports to the board of directors, elected from a very large volunteer general assembly, composed of people from all parts of Bolivia and from all walks of life.

A staff of 60 people operate from 14 clinics in the eight major cities of Bolivia: La Paz (four clinics), Cochabamba, Oruro, Potosi, Santa Cruz, Sucre, Tarija, and Trinidad. The majority of these "clinics" comprise hours of medical consultation, which include family planning services, offered within the health clinics of working class and trade union organizations. COF has agreements to provide family planning services in the health clinics of as diverse groups as the Drivers Trade Unions in Oruro and Cochabamba, the Mothers' and Teachers' Cooperative in Tarija and the Trade Union Associates in La Paz. COF meets the costs of medical and auxillary personnel. A small fee is charged for each visit (price varies from clinic to clinic, usually 0-5 Bolivianos or up to $2.50) and for the contraceptives themselves.

General medical consultation is offered with considerable emphasis on gynecology and pediatrics. Prescriptions, supplies and follow-up of contraceptive methods are offered. The pill and IUD are most common. In the interview with the FPMT team, the executive director estimated COF's coverage was 10,000 active users. In contrast, IPPF audit and evaluation data of March 1987 indicate a far less sucessful coverage.

In 1988 COF revenues totaled roughly $145,000 of which 80 to 90 per cent (depending on various accounts) came from IPPF. The remainder is from fees, mainly in La Paz.

Last year COF underwent an "Overall Progam Evaluation and Management Audit" by IPPF London. A series of important recommendations follwed, including management training.

The executive director identified the need and desire for such training during the FPMT visit. He is concerned with training in strategic planning and self-financing, mid-level management training for the clinic directors, and MIS assistance with service statistics

COF's plans for the future, if IPPF funding is secured, include:

1. the opening of one model family planning clinic in La Paz, which will offer full IEC and services, to serve as a model for the entire country for proper FP services;

2. expansion of coverage into the smaller cities/towns, then into the rural areas;

3. a study of the socio-cultural factors related to acceptance of family planning in the Altiplano.

2. CENTRO DE INVESTIGACIONES SOCIALES (CIS)

CIS is an independent, private, non-profit organization with legal approval of Bolivian laws, with no political commitments and without any kind of descrimination." Founded in 1972 under the auspicies of the National Academy of Science, CIS's mission is the analysis and study of the factors and conditions which influence the lifestyles and social problems of the country. As a matter of strategic planning, its activities and programs are diversified across the breadth of the social sciences; thus, its activities do not highlight any one area as a target for political or religious retaliation.

As a social research center headquartered in La Paz, it works in the elaboration of guidelines, analysis, technical assistance, follow-up and basic or applied social research in various disciplines within the social sciences. Activities lie in five areas: urban studies, family studies, population and development studies, human resources, and women's studies. Family planning is one of its many activities, which fits into one of the study programs above as appropriate.

Structurally, CIS is led by an appointed, unpaid executive director who works with 36 unpaid, professional associates, mainly University faculty, who work part-time on CIS projects to the extent they are written into and funded on such grants. Over the years CIS has had a variety of grants beginning with a Population council grant in 1973. Project funds have been for pure and applied research, service delivery, training,and technical assistance.

For example, from 1983 to 1987 they trained 200 M.D.s on a Pathfinder project, and from 1974 to 1984 they trained pharmacists in family planning for both the Population Council and Pathfinder. Currently CIS is working on two projects, both from Enterprise. The second project, for $25,000 is for family planning service delivery from railroad cars moving across the Altiplano.

CIS projects income as follows for the following year:

self-generated, mainly sale of publications	$ 500
First Enterprise project	60,000
Second Enterprise project	25,000

Management problems lie in many areas. Primary among the problems is strategic planning and long term financial planning. They are absolutely dependent on contracts and appear to stretch the institution very broadly, both to give the appearance of being a nonpartisan social science institution and to generate income. CIS exists by paying no salaries, working out of a family-donated office with family donated equipment. They have few fixed assets and few fixed costs.

3. CENTRO DE INVESTIGACIONES, EDUCACION Y SERVICIOS (CIES)

In name, CIES is a new institution; in fact, it comprises all of the staff, except the executive director, and all of the project funds of a previous organization named COEREH from which the staff under the leadership of the assistant director broke off and took the centrally funded AID contracts with them. The major difference between the two institutions, according to the director of CIES, is that COEREH was a profit making institution and CIES is non-profit. The central office in in La Paz.

CIES has service delivery projects, as did COEREH, in La Paz, El Alto and Oruro, funded by Pathfinder, Population Council and FPIA. In La Paz they have five clinics including four clinics which are part-time and staffed by a team of two health workers who move from site to site offering services for four hours a week to factory workers, a teachers union, and a camposinos union. Additionally CIES has a clinic in El Alto, and a clinic in Oruro opened very recently.

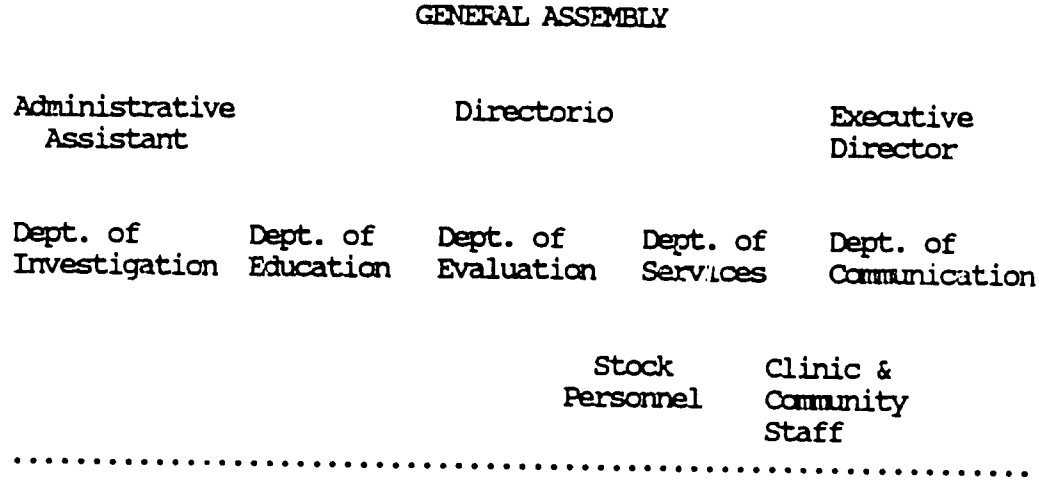
CIES is the most forthright private sector agency in La Paz. Family planning is the focus of its work and everyone acknowledges this. It maintains excellent lines of communication within the government and places of power and is the institution which plans most strategically. Last year their goal was to increase coverage by 900 new users. They only reached 600 but have nevertheless increased their 1988 goal to 1,200. Women come to their clinics for maternal and child health; 40 per cent also receive family planning services.

CIES has begun the first urban CBD system in Bolivia under the $98,000 Pathfinder project. The project includes installation of three new clinics and training of 300 promoters who will work on a 50 per cent commission from the sale of contraceptive supplies (including pills after an initial clinic visit) and a 50 per cent commission for referral of women for IUDs.

Promoters and supervisors are chosen from among union membership ranks and promote family planning services within the ranks. In the Pathfinder project there is one supervisor per five promoters, while in the Population Council project it is one per twenty promoters.

CIES is severely strained by the fact it is brand new, yet has the major program and financial responsibilities of an established organization. It is running a $98,000 Pathfinder project, a $12,000 Development Associates project, a $50,000 Population Council project and a $45,000 FPIA project. Figure 3 presents the newly developed organizational chart of CIES.

Figure 3
Organization Chart
CIES



CIES has a total of 25 personnel on the payroll, all of them supported by AID projects. The board of directors (general assembly) is composed of nine persons including seven "socios activos" (staff) and two invited members who do not work on the payroll. Power is then passed to a group of four staff persons, which includes the executive director, who compose the "Directorio" which attempts to work on a concensus basis. As the director commented, members of the Directorio are friends who have worked together for years.

The administrative assistant is part-time and does all the accounting and financial management.

CIES NEEDS

A. Technical assistance in strategic planning and organizational development, including assistance in development of professional structures and systems.
Specifically:

1. development of financial management and control systems.

2. development of human resource management systems including task assignment, supervision and evaluation.

B. Training in program planning, management and evaluation.

4. FEPADE

The Fundacion Ecumenica Para el Desarrollo (FEPADE) is a secular non-profit entity established under the auspices of European religious organizations and staffed by lay members of these organizations. The mission and activities of FEPADE include:

1. Development of small-scale agriculture and industry
2. Health training and promotion
3. Education and social promotion (to support the above two activities)
4. Family planning, principally education and supply

FEPADE has a central office in Cochabamba and 13 rural locations ("postas") distributed among three active project areas and one project area in formation. The central office and "postas" provide services to 55 communities with an estimated population served of 20,000 persons. The four activities listed previously are executed throughout these projects. A "posta" is, in essence, a multi-functional building which includes:

1. a small medical post with a doctor's office,
2. a classroom,
3. and dormitory space for the medical staff, when it is not from the community.

The philosophy of FEPADE is to promote the self-reliance of a community, through establishment of a "posta" and the training of community members to assume the staff roles. All the "postas have trained the midwives in the community in hygiene. Low-cost operations are thus established for small communities of 40-50 persons. At the current time, eight of the 13 "postas" are run by members of the respective communities. Each "posta" has a health promoter and an agricultural promoter, and five are staffed by FEPADE personnel, currently totalling 26.

FEPADE has established the first rural CBD system in Bolivia. The basis of the system is the referral by a health promoter of a prospective contraceptive user to a doctor for the first visit and a prescription. Thereafter, the client receives supplies from the health promoter who delivers to their home.

Twenty-five promoters, 18 of whom are still active, were trained in 1987 for CBD distribution. In 1987 there were a total of 494 referrals to two doctors located in Cochabamba. Patients from these projects travel up to 80 kilometers for the family planning referral. During this FPMT visit, the question arose and will be pursued whether a mobile Cruz del Sur team (doctor and nurse) might visit and provide the initial physician services to these communities.

FEPADE has agreements with FPIA and USAID for supplies sourcing; however, these supplies have not been regular. FEPADE has had to refer to other PVOs when supplies have depleted.

FEPADE has produced excellent IEC materials. The materials are culturally appropriate and suited to the rural setting and population in the area. They deal with family planning and other health services and care. Health promotion and health education is provided by promoters and builds on "Clubs de Madres," Mothers Clubs. These meetings provide an organizational framework out of which FEPADE provides health education including education on family planning.

The Central Office has a staff of nine, as follows:

1 Executive Director
1 Accountant
1 Assistant Accountant
1 Secretary
1 Messenger
1 Driver
1 Coordinator/Planner/MIS staffer
1 Medical Services and Training Specialist (a doctor)
1 Education staffer (for materials and courses)

The last three spend about 70 per cent of their time in field operations.

FEPADE has an anti-birth control clause in its agreement with the MOH; however, FEPADE has not been restricted by this clause. The MOH does not supervise nor try to enforce the clause, perhaps due to FEPADE'S location. FEPADE is in Cochabamba which is more progressive than La Paz and in the rural areas where inspection is more difficult. FEPADE's experience indicates that it is possible to provide family planning services without government retaliation. The belief is that the government only gets bothered or annoyed when there are massive campaigns for family planning. Moreover, FEPADE's family planning services are part of an integrated maternal and child health program.

There have been no real problems with the Church; however, the possibility of USAID food aid to FEPADE being cut off by CARITAS has been raised. In Potosi there were reported threats to withhold food from a similar organization which provides family planning services.

The following are the management training needs identified by FEPADE, which is particularly interested in an emphasis on their applicability to the rural nature of FEPADE's operations:

1. Strategic Planning:
   a. for the self-sufficiency of FEPADE
   b. to increase coverage
2. Improved research systems to establish data for planning
3. Organizational planning to reduce improvisation
4. Self-financing schemes for the "postas" and their FP services, so that in time the communities will be able to maintain these posts. Plans should be specific for rural and sub-urban "postas"
5. "Postas" administration

Additionally, their needs include: regular supplies, funding to pay for imports and much better information for marketing and planning.

FEPADE's 1988 budget consists of roughly U$ 300,000 from the international agencies and approximately U$ 100,000 in-kind community contributions for construction of "postas" and so forth. There have been occasional difficulties with a lack of funds to pay for customs expenses for imports and for the purchase of supplies.

5. CENTRO MEDICO CRUZ DEL SUR

Centro Medico Cruz del Sur is a private non-profit organization, directed by a Euuropean trained psychiatrist who is also the president of the board and a board of directors composed largely of European consular officials. The board meets once a month following the monthly meeting of the consular body of Cochabamba, although only a minimum of three meetings per year are required according to the Internal Regulations ("Reglamento Interno") of Cruz del Sur.

Centro Medico Cruz del Sur operates three maternal and child health clinics which include family planning among their services. The first, opened in 1983 and self-financed, is in the barrio Huayrakasa; the second, opened in October 1987 with Pathfinder funding, is outside Cochabamba at the approach to the Chapare; and the third, Tiquipoya, also opened with Pathfinder funding in October 1987, is in a rural unserved area about a half hour from the city.

The Huayrakasa clinic receives referrals from the Unidad Sanitaria of the MOH and provides all FP methods except sterilization. It offers contraceptive methods and weekly talks on sex and family planning as a component of maternal health. Staffed by a part-time obstetrician, a part-time pediatrician and a full time nurse, it potentially serves an area of approximately 62,000 people. Additionally, it runs a kindergarten that follows the Ministry of Education's program and whose certificates are accepted at primary schools.

The two rural clinics are staffed in a similar manner and include a promoter for community outreach. The clinic at the approach to the Chapare, center of coca production in Bolivia, is situated in a community with several other clinics which offer FP services to a population of about 14,000 people. Fees for services at Cruz del Sur are lower than at the others and Cruz del Sur serves a poorer population. The third clinic is situated in a rural village of about 3,000 people with no other medical facility. Potential clinic population would include other nearby villages. As in the other clinics, minimal fees are charged for services.

The director of Cruz del Sur expressed the following management training and technical assistance needs:

1. Strategic planning for self-sufficiency and sustainability. The concern is for sustainability when Pathfinder supports ends. Maintenance of quality service and volume as well as the an increase and diversification of revenue are of particular concern. Cruz del Sur would like technical assistance in the development of a strategic plan for generating referrals from other organizations for family planning services.

2. Marketing for the particular environment. Cruz del Sur needs to develop effective marketing plans. All clinics are underutilized and functioning much below capacity.

3. Organizational development. The president/executive director has recognized the need to formalise the institutional characteristics of Centro Medico Cruz del Sur, particularly if the organization is to expand operations. This includes hiring an administrator to run day-to-day operations, formalize statutes of incorporation, establish levels of authorization for expenditures and other usual matters. It appears that this change will be very gradual over the next years.

6. CLINICA SAN PABLO

Clinia San Pablo, opened last year, is a private, for-profit clinic situated in a pleasant residential section of Cochabamba. It is significant in an analysis of family planning service delivery in Bolivia in that it was opened and is operated with the support of AVSC for the delivery of a minilap program. It appears to be the only clinic openly providing minilaps although it is possible urban private physicans are providing such services quietly to selected patients.

The clinica San Pablo is a 20 bed mini-hospital complete with fully equiped rooms for surgery and for deliveries. It is staffed by 2 physicians, one medical resident, five nurses, one receptionist, a promoter and several support persons. Only two of the beds were occupied, and neither the surgery or the delivery room was in use when the FPMT team visited. The director of the Clinica would like to rent the use of the surgery, but so far demand for the use of the facility has been low.

Most patients come to the clinic for family planning services from the public hospital where the director of the Clinica works part-time and from where he makes referrals to the Clinica. In addition to the mini-lap program (currently 20-25 mini-laps a month), the Clinica also offers IUDs and the pill. The director indicated there is a good deal of competition for patients in Cochabamba.

AVSC pays for 60 per cent of the operating monthly budget, in addition to having provided all of the capital budget for the new facility. In return the Clinica provides minilaps on a sliding scale of free to a maximum cost of about US $20.

The management training needs identified by Clinica San Pablo were administration, financial management and marketing.

7. PROSALUD

PROSALUD is a self-financing primary health care project, incorporated in 1985, with the financial support of USAID and the technical assistance of Management Sciences for Health, Boston. PROSALUD works in the semi-urban areas of Santa Cruz and in the rural areas due east of the city. The population of the city proper is approximately 600,000 and 1,200,000 when the semi-urban areas are included. By June 1987 PROSALUD's modular MHO type system for delivering primary health services had reached 16,000 clients through 10 clinics.

PROSALUD operates from a network of semi-urban and rural clinics offering a package of ambulatory medical consultation, by physicians and nurses; basic lab tests; provision of medicines; preventative child health services including immunization, growth monitoring, IEC, hygiene and oral rehydration, early treatment of respiratory infections; and beginning in 1988 with FPIA and DA assistance, family planning.

PROSALUD is a regional model of self-financing primary health which has been remarkably successful in generating income and controling costs, despite the national economic problems. Management Sciences for Health is collaborating with PROSALUD to support its marketing, pricing, MIS and financial management capabilities. PROSALUD stood out among all the institutions which the team visited as being particularly well planned, directed and managed.

PROSALUD is just initiating family planning services, however, and the staff did identify management training needs in connection with the new services. They are:

1. mid-level managerial training in the administration of family planning services for the directors of the clinics;

2. assistance in developing a marketing plan for such services;

3. additionally, PROSALUD identified the need for IEC materials. They, like the other institutions FPMT visited, were unaware of who had produced what materials for IEC in Bolivia.

8. APROMYN

The Associacion Pro Madre y Nino (APROMYN) is a new organization recently registered as private non-profit entity in Santa Cruz. It is led by three people who previously were affiliated with COF through which they were involved in the training of promoters with funds from FPIA and DA. Each of the three is affliated, either professionally or personally, with a private clinic in Santa Cruz which provides family planning services. The three clinics are in different parts of the city.

The short-term objective of APROMYN is the establishment of a self-financing CBD system built upon community outreach from these three clinics. Twenty promoters, trained previously with COF, refer women to one of the three clinics for an intial visit. Promoters will be paid for that referral and will sell follow-up contraceptive supplies through a CBD network.

APROMYN is currently staffed solely by the three unpaid persons mentioned above. However they have developed and presented to AVSC a proposal for a "Micro Clinica de Maternidad" which would provide complete family planning services that include minilaps and IEC. The proposal also includes staff funding for the three.

The management training needs which APROMYN identified are strategic planning, financial planning and program design.

B. INTERNATIONAL PRIVATE VOLUNTARY ORGANIZATIONS

1. ROLE OF INTERNATIONAL PVOS

Because international private voluntary organizations play an extremely important role in the delivery of primary health education and services in Bolivia, the Mission asked the FPMT team to include, in the needs assessment, several PVOs which had expressed interest in child spacing for maternal health. International PVOs are believed to provide most of the health promotion and care which is offered in rural areas. In the Altiplano, numerous PVOs offer primary health care programs, particularly maternal and child health, in a variety of development projects which cover most of the area. PVO coverage is less comprehensive in the Yungas or valleys; however, PVOs are still believed to be the primary providers. In the lowlands coverage is spotty due to the low population density of the area and the need for PVOs, as well as other institutions, to be cost effective. In all areas, however, the coverage of the PVOs exceeds that of the MOH. PVOs have the financial resources which the MOH lacks, particularly since the recent economic crisis.

It has been the role of the MOH to provide norms and standards for service delivery for health care in general and specific guidelines for those PVOs with whom it has agreements. Some, but not all PVOs, have agreements with the MOH. Since 1982, those that do have such agreements have had a clause in their agreements which specifically prohibits family planning activities. This clause has prohibited PVOs with MOH convenios from engaging in health education, promotion or referral on family planning. Additionally, it has made all PVOs, even those without such a clause, reluctant to become involved in such activities.

The international PVOs with whom the team talked recognized the importance of child spacing to maternal and child health. When the MOH permits them to do so, they will include, in their health programs, education and promotion on child spacing and referral for services to the national PVOs which, to date except for FEPADE, are mainly in urban areas.

2. CARE

CARE International began working with needy people in Europe after the second world war; thirty years later it began a program of rural development in Bolivia. CARE's mission is to promote rural development through the transfer of material resources and through the teaching of skills through which communities can, through their own initiative, better the quality of community life.

CARE has regional offices in La Paz, Sucre, Tarija and Oruro. From these offices programs of rural development totaling US $2 million are implemented. Potable water, agriculture and primary health, including child survival, are focal.

CARE's staff in Bolivia is composed of expatriates and Bolivian nationals. Programs are implemented with counterparts in Bolivian institutions; for example, water projects are implemented through agreements with seven institutions.

CARE/Bolivia considers child survival and health education activities important components of its work in rural development. The director of the health project indicated a desire and willingness to include education and promotion on "child spacing" and to participate in training activities to this end.

3. FOOD FOR THE HUNGRY

Food For The Hungry, whose international headquarters is in Geneva, has been working for eight years in Bolivia, most actively in the last four years. Its mission is health, nutrition and agriculture. Currently, it is structured with an adminisrative headquarters in La Paz and zonal offices in El Alto, Potosi and Oruro, from which offices promoters go out to 200 rural communities with over 4000 families.

Food for The Hungry does not itself maintain health clinics. Rather, paid promoters, who each work with 7 to 10 communities in health education and promotion, refer families to the Unidad Sanitaria and MOH for services. Agency staff, with whom the team spoke, expressed the intention to be in compliance with MOH policy and the recognition of the importance of birth spacing to maternal and child health. They would be interested in and supportive of collaboration in a system of health education, promotion and referral for birth spacing, provided such collaboration was approved by the MOH.

4. PROJECT CONCERN INTERNATIONAL

Project Concern International has been working in integrated primary health care, nutrition and agriculture in Bolivia for seven years. It works with approximately 15,000 rural families outside of its centers in Potasi, Oruro, Las Yungas and Cochabamba. Health promotion activities are carried out by voluntary promoters who report to Unidad Sanitaria supervisors. Referral for any type of health services is made theoretically to MOH or Unidad faciliities; however, such secondary support is, in fact, unavailable in most rural areas.

Project Concern stated they would be interested in becoming involved in a system of promotion, education and referral for family planning services if the MOH supports such activities.

5. MEALS FOR MILLIONS/FREEDOM FROM HUNGER

Meals for Millions/Freedom from Hunger has been working in nutrition and agriculture for two years in rural communities around Lake Titicaca. They are presently working in 35 communities with 32 paid staff and approximately 2500 families. Although they recognize the importance of family planning and birth spacing to maternal and child health, they state the institution cannot become involved in family planning activities, even referral, until the government and culture openly delares support for such activites.

VI. BOLIVIAN FAMILY PLANNING SYSTEM NEEDS

The focus of the FPMT team's work was an assessment of the management training needs within those many private and public sector institutions which either are or would like to provide family planning services to women to promote maternal and child health. While the team was conducting the assessment, it noted four interrelated systemic needs which we would like to highlight here. They are:

1. Country level research on family planning demand to provide a basis for policy formation.

2. Management training and technical assistance with the major public and private institutions, both urban and rural, which can be models for family planning service delivery.

3. Development of technical norms for service delivery.

4. Statement of acceptance of family planning services by the MOH.

Country level research on demand is needed to provide a basis for objective policy formation. The demand for family planning appears obvious in the abortion statistics which reflect only the women who die or are hospitalized from abortion complications. Yet, to date no good document has been produced which presents research on maternal and child health and family planning demand. It is needed. Rough estimates indicate that the current gap in services is about 500,000 women. (7).

Management training and technical assistance is needed and should be provided to those institutions, both in the private and public sector, who are willing to move ahead in the direct delivery of needed services. A strategy and a workplan for such training and technical assistance follow in the next section.

(7.) Estimated population in 1982 is 6.5 million of whom women ages 15 to 45 constitute 22 per cent or 1.3 million. Assuming on the basis of previous work and current abortion statistics that half these women would like family planning services, the total target market is estimated, roughly, as 650,000 women. Currently total services are to perhaps up to 150,000 women yearly, leaving a gap in services of 500,000 women.

Thirdly, technical norms for family planning service delivery need to be developed and publicized among providers. Because of the secrecy which surrounds the delivery of family planning services, no entity, not even the Society of Obstetricians and Gynocologists has developed such norms. Such norms are critical to quality care and to efficient provision of quality service. Currently some PVOs require women to return monthly, indefinitely, after IUD insertion and monthly for six months after prescription of the Pill.

Fourthly, although a family planning system can be developed in the absence of official acceptance from the MOH, acceptance by the MOH is to be sought because it would facilitate a rapid expansion and coverage of family planning services which would assist the maternal and child health status in Bolivia.

VII. STRATEGY DESIGN

In light of the four following factors:

a) the MOH's reluctance to openly promote family planning in Bolivia;
b) the enthusiasm at the Instituto Boliviano Seguro Social (IBSS) and at Unidad Sanitaria (US);
c) the requirement set by the international PVOs to receive governmental assurances in order to provide any family planning activities (even major IEC) and;
d) the enthusiasm of the national private non-profits,

the team recommends the following strategy:

1). Continue to work with the governmental agencies and other public entities (IBSS and US) to further promote the tacit, as well as explicit, acceptance of family plannning activities, initially oriented to achieve MOH issue of "permissions to provide FP services" to the international PVOs.

2). Promote the further contact and exchange between the public and private sector institutions and designed to allow both to arrive at mutually agreed "modus operandi." This should result in a referral system between the public and private organizations for family planning service delivery in a mutually complementary way, on a regional basis and built on the particular strengths of each sector.

3). Significantly strengthen the public institutions which have just begun to provide family planning services as part of a total health service and which are interested in widening their reach while reducing their costs. These institutions are the Bolivian Social Security Institute which recently initiated the first pro-active public provision of family planning services and Unidad Sanitaria La Paz, which wishes to do the same.

4. Work closely with the several key private sector organizations which already provide services, organizations which are willing to take a stand and act as models. These organizations should be supported in:

a. the development of appropriate strategies for their political environment.

b. the establishment and considerable growth of their marketing capability, differentiated for the population in each region and for their rather distinct environmental conditions. This would include consideration of programs to increase coverage of target population and to determine clinic locations, increase capacity utilizations of clinics, management of CBD, pricing of products and services, IEC activities.

c. working towards their financial long term survival which includes pricing and costing of services and products, financial recording and reporting systems, internal controls, and configuration of clinic staffing for maximum productivity and quality service.

d. the installment of effective and efficient human resource systems.

e. the development of inter-action and support among private organizations and with international PVOs in order to expand coverage, improve the quality of service, amplify supplies and strengthen these institutions.

VIII. RECOMMENDED FPMT TRAINING ACTIVITIES FOR NEXT 12 MONTHS

1. Strategic planning for maternal health workshop:
   a five day workshop with senior staff of IBSS, US, and major national private non-profits.

2. Mid-level managerial training in management by objectives, program planning and budgeting:
   a. with the public sector: IBSS and US, a four day workshop.
   b. with the selected private sector organizations: CIES, PROSALUD, Centro Medico Cruz del Sur, FEPADE, COF, also a four day workshop.

3. Financial management and funding workshop:
   a four day workshop with senior staff from the previous private and public organizations.

4. Marketing and sales workshop:
   a four day workshop with senior staff and staff members as above.

5. Follow-up technical assistance with CIES:
   a. Strategic plan development and execution.
   b. Management information systems development
   c. Financial and cost accounting systems development

6. Follow-up technical assistance for marketing and sales programming and implementation:
   CIES - urban model:
      a. development of a marketing and sales plan with top management.
      b. follow-up technical assistance for a year.
   FEPADE - rural model:
      a. development of a marketing and sales plan with top management.
      limited follow-up technical assistance.

7. Short term training and study tours in US and Latin America, particularly focused on public sector.

8. Long term training in US for one person.

ANNEXES

A. LIST OF PERSONS CONTACTED

B. DOCUMENTS REVIEWED

C. POPULATION AND HEALTH DATA

LIST OF PERSONS CONTACTED

BOLIVIA (591) (La Paz 2)

1.) USAID
Avda. 16 de Julio, 1628
Edificio Bisa, 2do. piso
La Paz, Bolivia
Phone: 32-08-24
32-02-62
Mr. Michael Hacker, Director of the Health and Human Resource Division
Mr. Paul Hartenberger, Deputy Director of the Health and Human Resources Division, Population Officer
Ms. Elba Calero, Assistant Population Officer, Health and Human Resource Advisor

NATIONAL PRIVATE VOLUNTARY ORGANIZATIONS

2.) CENTRO DE ORIENTACION FAMILIAR (COF)
Administrative Center
Avda. Camacho 1423 - 3er. pisa
Casilla Expresa 7522
La Paz, Bolivia
Phone: 35-83-48, 32-06-37
Lic. Luis Llano, Executive Director

Community Clinic
Consultorio Leon de la Barre
La Paz, Bolivia
Dr. Carlos Salamanca

3.) Centro de Investigaciones, Education y Servicios (CIES)
Casilla 1453
La Paz, Bolivia
Phone: 37-34-16 (of Bertha Pooley)
Leda. Bertha Pooley, Executive Director
Celia Taborga, Chief of Research

4.) Centro de Investigaciones Sociales (CIS)
Casilla 6931 - Correo Central
La Paz, Bolivia
Oficina: Edificio Alborada Pisa 11 of. 1105
Loaiza Esq. Juan de la Riva
Phone: 35-29-31
Dr. Antonio Cisneros, Executive Director
Carmen Cisneros
Carlos Salazor, Psychologist
Maria Teresa de Cisneros, Psychologist

5.) Centro Medico Cruz del Sur
Oficina: Avenida Barrientos 2149 - Km.0
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FERTILITY DIFFERENCES
ACCORDING TO
1976 CENSUS DATA

FERTILITITY DIFFERENCE BY:	FERTILITY RATE
Total Country	6.50
1.) Area of Residence	
Urban	5.18
Rural	7.55
2.) Level of Education	
none	6.60
1-3 years	6.45
4-6 years	5.65
7-12 years	3.96
13 years and more	3.12
3.) Language	
Only Spanish	6.02
Only Indigenous Language	6.40
Spanish-Indigenous	5.99
4.) Conditions of Employment	
Active	5.22
Not Active	6.08

Source: Insituto Nacional de Estadistica; Centro Latinoamericano de Demografia, Bolivia: Estimaciones y Proyecciones de Población, Marzo 1985, Bolivia Aspectos Demograficos, Centro de Orientación Familiar, La Paz, Bolivia, 1987, p. 75.

BOLIVIA
INFANT MORTALITY RATES
1950-2000

PERIOD	RATE OF INFANT MORTALITY PER THOUSAND
1950-1955	175.70
1955-1960	169.68
1960-1965	163.61
1965-1970	157.49
1970-1975	151.32
1975-1980	138.24
1980-1985	124.43
1985-1990	109.87
1990-1995	93.39

Source: Instituto Nacional de Estadistica; Centro Latinoamericano de Demografia. Bolivia: Estimaciones y Proyecciones de Población. Marzo 1985, cited in Bolivia Aspectos Demograficos, Centro de Orientacion Familiar, 1987, p. 59.

BOLIVIA
LIFE EXPECTANCY
1950-2000

YEAR	BOTH SEXES	MEN	WOMEN
1950-1955	40.44	38.49	42.49
1955-1960	41.91	39.90	44.02
1960-1965	43.45	41.39	45.61
1965-1970	45.06	42.95	47.27
1970-1975	46.74	44.58	49.01
1975-1980	48.64	46.46	50.92
1980-1985	50.74	48.55	53.03
1985-1990	53.07	50.85	55.41
1990-1995	55.90	53.97	58.34
1995-2000	59.44	57.00	62.00

Source: Insituto Nacional de Estadística; Centro Latinamericano de Demografia, Bolivia: Estimaciones y Proyecciones de Población, Marzo, 1985, cited in Bolivia Aspectos Demograficos, Centro de Orientacion Familiar, 1987, p.55.

BOLIVIA
GLOBAL FERTILITY RATE
1950-2000

PERIOD	GLOBAL FERTILITY RATE	RATE OF GROWTH
1950-1955	6.75	3.29
1955-1960	6.69	3.26
1960-1965	6.63	3.23
1965-1970	6.56	3.20
1970-1975	6.50	3.17
1975-1980	6.39	3.12
1980-1985	6.25	3.05
1985-1990	6.06	2.95
1990-1995	5.81	2.83
1995-2000	5.50	2.68

Source: Insituto Nacional de Estadíistica; Centro Latinoamericano de Deomografia, Bolivia: Estimaciones y Proyecciones de Población, Marzo, 1985, cited in Bolivia Aspectos Demograficos, Centro de Orientacion Familiar, 1987, p.65.

PROJECTED BOLIVIAN POPULATION
BY AGE AND SEX

1990

AGE GROUP	POPULATION IN THOUSANDS			POPULATION IN PERCENTAGE		
	TOTAL	MEN	WOMEN	TOTAL	MEN	WOMEN
TOTAL	7.314	3.605	3.709	100.00	49.29	50.71
0-4	1.264	637	627	17.28	8.71	8.57
5-9	1.053	527	526	14.40	7.21	7.19
10-14	895	447	448	12.24	6.11	6.13
15-19	757	376	381	10.35	5.14	5.21
20-24	635	313	322	8.68	4.28	4.40
25-29	532	261	271	7.27	3.57	3.70
30-34	450	219	231	6.16	3.00	3.16
35-39	378	183	195	5.17	2.50	2.67
40-44	321	155	166	4.39	2.12	2.27
45-49	259	125	134	3.54	1.71	1.83
50-54	213	102	111	2.91	1.40	1.51
55-59	178	85	93	2.43	1.16	1.27
60-64	145	69	76	1.98	0.94	1.04
65-69	105	49	56	1.44	0.67	0.77
70-74	68	31	37	0.93	0.42	0.51
75-79	39	17	22	0.53	0.23	0.30
80	22	9	13	0.30	0.12	0.18

Source: INE-CELADE, Bolivia, Estimaciones y Proyeciones de Población. Fascículo F/BOL 1, Marzo 1985, Bolivia Aspectos Demograficos, Centro de Orientacion Familiar, La Paz, Bolivia, 1987, Quadro 4, page 21.