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EXPANDING FAMILY PLANNING OPTIONS

Research on the Introduction and Transfer of Technologies for Fertility Regulation

QUALITATIVE ASSESSMENT OF REPRODUCTIVE HEALTH CARE IN BOLIVIA

WORLD HEALTH ORGANIZATION
GENEVA

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QUALITATIVE ASSESSMENT OF REPRODUCTIVE HEALTH CARE IN BOLIVIA

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Table of Contents

Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ASONGS	Association of Non-governmental Organizations
CEASS	Central de Abastecimiento de Suministros (Central Supply Warehouse)
CNS	Caja Nacional de Salud (Social Security)
DHS	Demographic and Health Survey
DIDES	Direcciones Departamentales de Salud (Departmental Health Directorates)
DILOS	Direcciones Locales de Salud (Local Health Directorates)
ELISA	Enzyme Linked Immunosorbent Assay
HRP	Special Programme for Research, Development and Research Training in Human Reproduction
IUD	Intrauterine device
NGO	Non-Governmental Organization
OTB	Organización Territorial de Base (Community-Based Organization)
PAO	Plan Anual Operativo (Annual Operating Plan)
PROISS	A World Bank Project
RPS	Responsable Popular de Salud (Community Health Worker)
SNIS	Sistema Nacional de Información de la Salud (National Health Information System)
SNS	Secretaría Nacional de Salud (National Secretarit of Health)
STD	Sexually Transmitted Disease
UBAGES	Unidades Básicas de Gestión (Basic Administrative Units)
URES	Unidad Regional de Equipamentos y Suministros (Regional Unit for Equipment and Supplies)
VDRL	Veneral Disease Research Laboratory
WHO	World Health Organization

Foreword

The Secretariat of health, concerned with the persistence of negative information about national health conditions, inconsistencies in data related to the efforts undertaken in recent years - but very expressive and demonstrative data on which areas and regions have the greatest difficulties - decided to place some of its priority interventions in the area of women's health under greater scrutiny and to clarify the role of these interventions in the context of recent health policies.

The objective of this assessment was not to disclose new issues in the development of health services or in the characteristics of the users of these services. From a macro-social perspective, the influence of institutional reforms will undoubtedly allow for the development of a more humane and just society. However, what we were most interested in was understanding what statistics cannot convey: the motives, motivations and behaviors of all the major actors involved in health care for women. We were interested in what lies between the institutional efforts and the attitudes of the population in relation to women's health.

During this exercise, the fundamental themes of family planning and obstetrical care were highlighted. Qualitative and participatory research methodologies were used which facilitated the process of arriving at valuable and significant conclusions and recommendations, necessary for the future development of activities in the area of women's health.

It is important to point out that the Law of Popular Participation and administrative decentralization will create opportunities for generating solutions to the problems of credibility and quality found within health services, including in the undervalued and poorly understood area of women's health. We are in the process of developing and adjusting a new public health system - decentralized and participatory - along with a number of other sectoral initiatives. We hope these reforms will give us the privilege of being accepted by the community as their most effective public servants, committed to their personal well-being.

We are also interested in assuring that the conclusions of this assessment are recognized by donor institutions and other agencies which work collaboratively with the Secretariat of Health. This will optimize the use of available resources and the development of sustainable, truly local health systems, dedicated to providing integrated health care for women and children in all the regions in need in the country.

We would like to give our sincerest thanks to the assessment team, guided by Ruth Simmons, for having allowed us to participate in a reflection which will assist us in perfecting our professional service and responsibility to the community. We congratulate the Departmental Health Directorates of La Paz, Cochabamba and Santa Cruz, who together with District Directorates, health personnel, municipal leaders, leaders of neighborhood organizations, agricultural organizations, and women's groups carried out the important tasks of conveying their experiences, observations, and worries which make up the majority of the contents of this document.

Oscar Sandoval Morón
National Secretariat of Health

Introduction

In the last several years, the Secretariat of Health (SNS) of Bolivia has made important strides in broadening and improving integrated health services for women. Not withstanding the achievements in increased coverage and quality, a number of qualitative and quantitative deficiencies remain. Maternal mortality, unplanned pregnancy and induced abortions are just some of the public health problems that persist despite the efforts of the SNS. Consequently, the Secretariat feels compelled to undertake a continuous review of the situation of women's health in order to evaluate progress and identify new strategies for accelerating the process of improving health care.

It was within this context that the SNS considered with great interest the new strategy for the introduction of contraceptive methods developed by the World Health Organization (WHO). The strategy is consistent with the position of the Bolivian Government in the belief that family planning should not be an isolated issue but rather a component of the broader area of reproductive health which includes obstetrical care among others. The strategy involves an assessment of technology and service delivery capacity while also taking into account socio-cultural conditions, user and gender perspectives, and reproductive rights. Within this conceptual framework, the contraceptive introduction strategy proposes to answer three central questions: 1) Is there a need to improve the provision of contraceptive methods currently available? 2) Are there methods available in the country which should be removed because there are newer, safer formulations or because the methods have not proven safe? and 3) Is there a need to introduce new contraceptive methods into the public sector?

The WHO strategy (Spicehandler and Simmons, 1994) has already been implemented in several developing countries in Latin America, Africa, and Asia. In Latin America, the process is well underway in Brazil. A number of different individuals and organizations who are active in both providing and utilizing women's health services have participated in the process and have contributed valuable input towards making positive changes in the service delivery system.

The WHO strategy has three phases:

a) Assessment of the situation in regards to contraceptive method mix

b) Research derived from the findings of the initial assessment

c) Proposals for interventions based on the first two stages

The WHO strategy evolved from a set of experiences with contraceptive introduction efforts in several countries where comprehensive assessments of users' needs and the capacity of the service delivery system to absorb new methods were not undertaken. One example involves the introduction of Norplant® contraceptive implants in several countries. These introduction

efforts demonstrated that in some cases, even when introductory research was successful, the incorporation of the method into the service delivery system was difficult or impossible due to the inability to manage the method with a high degree of quality. In other cases, the introductory process moved forward and a number of serious problems emerged, for example, when the need arose to provide implant removal and the service system was not prepared to meet the high demand for removal requests. Under the new strategy it is essential that the introduction of methods respond to the country or region's true needs, and equally important, that the service delivery system be adequately prepared to add the new technology.

The first stage in the strategy is different from other evaluations in a number of ways. First, it is a qualitative assessment based on and including quantitative information; a background document is developed first and serves as a basis for current knowledge. Next, the assessment combines data found during the literature review with information collected during fieldwork. Finally, the analysis for and writing of the final report is undertaken by the same team who carried out the fieldwork.

Having learned about the strategy, the Secretariat of Health of Bolivia contacted the WHO to discuss possible collaboration. From the beginning, the SNS established that if Bolivia were to adopt the strategy, it would have to do it using a broad concept of women's health, focusing primarily, on obstetrical care and family planning. For its part, WHO was interested in participating in a process which could serve to demonstrate that the introduction of contraceptive methods could be implemented within a broader framework of reproductive health and integrated women's health care.

The Secretariat discussed with WHO the need to do an assessment using the strategic methodology but which included the following series of questions to complement the existing ones pertaining to family planning: 1) At what scientific, technical, organizational, and operational level are obstetrical services functioning in the country? and 2) What components of obstetrical care should be improved to guarantee greater coverage for emergencies and their resolution?

After a visit from WHO representatives in November of 1994, it was decided that the assessment would be conducted in three regions of the country: La Paz (Altiplano), Cochabamba (Valles) and Santa Cruz (Llanos). WHO agreed to include obstetrical care as an essential component of the assessment and research recommendations.

The first activity undertaken was the development of a background document, a comprehensive review of publications about reproductive health in the country, in both the medical and social sciences. This document served two purposes: 1) To identify the areas in which most institutions and authors working in reproductive health have concentrated their work and 2) To identify the areas in which enough information has already been collected and further research is unnecessary. This activity was fundamental for guiding the fieldwork and writing the Stage I assessment report. The National Secretariat of Health will publish the document which will serve as a detailed referral source for publications in reproductive health.

The most important themes related to obstetrical care and family planning elaborated in the background document were:

- Needs, perspectives and strategies of women and the community in relation to health
- Implementation process of the Integrated Women's Health Care Programme
- Level of utilization, access and quality of women's health care services
- Main technical strengths and weaknesses of services
- Implications of new laws on the implementation of the Integrated Women's Health Care Programme
- Principal strengths and weaknesses at the administrative level which affect programme implementation

Fieldwork was carried out in urban and rural areas of the departments of Santa Cruz, Cochabamba, and La Paz by a multi-disciplinary team (physicians, sociologists, psychologists, anthropologists and other social scientists), representing the National Secretariat of Health and WHO. Other national and international advisors serving on the team had experience working with women's groups, with gender perspectives, and in public health.

The fieldwork, including the finalizing of instruments, was undertaken in the period of four weeks. Included among the places visited were service delivery sites of the SNS, the Caja Nacional de Salud (Social Security - a national health insurer and provider), NGOs, members of the Church and Church-run service sites, and the private sector. We observed the functioning of services and interviewed providers (physicians, dentists, nurses, nurse auxiliaries and others). Health authorities at a number of levels were interviewed as were mayors and town councils of municipal governments, and representatives of neighborhood organizations, unions, civic groups, and churches. We spoke to women who sought health care services, men and women in the community, traditional healers (with and without formal training) and students.

This report includes a review of the background on the history and current state of policies in women's health care, the establishment and development of the Integrated Women's Health Care Programme, the principal findings of our investigation, and finally conclusions and recommendations for interventions, as well as for research that could generate a better understanding of and improvements in the health of Bolivian women.

This project was possible due to the unselfish collaboration of many people in the health sector and in communities, to whom we give our sincerest thanks.

The Concept of Women's Health

During the last decade, health programmes in Bolivia directed at women have been modified to include new foci and broader interpretations of the social and economic importance of quality women's health care. These transformations resulted from a series of factors, the most important of which was a desire of the SNS to reflect changes occurring at the international level in national level policies and processes. In recent years, the international community has played a decisive and historic role in bringing the situation and condition of women to the forefront.

Between the years 1978 and 1988, numerous national initiatives were proposed in the area of maternal health in Bolivia. Family planning programs, including post-abortion contraception, cervical/uterine cancer care, and sex education were all introduced, but their duration was limited because of a variety of circumstances.

The Integrated Women's Health Care Programme incorporates maternal health with a number of other activities often carried out in isolation from one another, for example family planning and PAP tests, and incorporates concerns for quality of care and for a greater understanding of sociocultural influences, including gender relations, as they affect women's health.

Regarding the issue of women's health, which has not necessarily been well understood by all the involved actors and institutions including the State, the following objectives have been outlined as a response to societal demands:

- Reevaluate the social and cultural value placed on women's health in Bolivian society.
- Reintroduce the concept of the right to health and promote the exercise of this right.
- Develop and disseminate the concept of integrated care among the internal bodies of the SNS and other related institutions.
- Establish services that provide care for women at all stages of life, including such elements as promotion, prevention, and recovery.
- Improve and broaden programmatic efforts directed towards women.

These five points serve as foundations of the Reproductive Health Strategy which forms a part of the Integrated Women's Health Care Programme. They also serve as important objectives in their own right. The overarching goal is for a woman to be treated as a whole from the time she is born until the time she dies. A woman's different life experiences, often erroneously seen as separate events from the perspective of programmes and health services, are for women, all part of one process.

The government has taken a clear position in recognizing reproductive health as a basic component for overall health as well as legitimating family planning as a human right. This

conceptualization is part of the population and sustainable development perspective which includes a focus on economic growth, social equity, the rational use of natural resources, and political stability. "From this integrated vision of development, the issue of population transcends the demographic perspective and becomes the main focus for sustainable development" (Ministry of Human Development 1995).

Current health policies are not oriented towards achieving merely quantitative objectives for family planning acceptance but rather towards improving education, and the quality of and access to services. The objective is to ensure that unsatisfied demand for family planning is met and that people can exercise their right to health.

In the area of maternal health, besides reinforcing the traditional components of MCH, beginning in 1994, greater emphasis was placed on emergency obstetrical services. This initiative is linked with the concept of social responsibility for obstetrical care, and the organization of local solidarity funds, community networks, and services to address the problem of maternal mortality.

Gender perspectives, the opinion of users, accessibility of services, improvements in technical care and appreciation of cultural variety are all considered important conditions for guaranteeing high quality services. A tripartite commission made up of the Subsecretariat for Gender, the National Directorate for the Health and Nutrition of Women and Children, and PAHO/WHO have made several advances in the area of gender perspectives at the intra- and inter-sectorial levels.

Today, reproductive health is considered a component of integral health (biological, mental, and social); the right of people to enjoy completely all of their biological, emotional and spiritual potential is also recognized. Family planning is considered a fundamental human right of all couples and individuals.

Likewise, reproductive health services, which require the offering of broad, objective, complete and truthful information for affording people the widest variety of options, are considered essential. Population policies should be decided within the broadest framework of autonomy and sovereignty of the nation.

Current Situation in Women's Health

Despite evidence of real progress in the last several years in both the coverage and quality of care for women's health, there remain a series of qualitative and quantitative problems in service delivery. These deficits ultimately translate into poor health indicators. For example, maternal mortality in Bolivia is very high as is the rate of abortion, while the prevalence of contraceptive use and the percentage of women delivering their babies in health institutions are both low. Maternal mortality for the period 1989 to 1994 was estimated to be 390 per 100,000 live births (ENDSA, 1994).

There is a fairly large variation in maternal mortality rates between regions and areas of the country. In urban areas, the maternal mortality rate is approximately 262 per 100,000 live births compared to 563/100,000 in rural areas. In the Llanos area, maternal mortality is around 166/100,000

while it reaches a high of 591 in the Altiplano region. The rate is the highest in rural areas of the Altiplano: approximately 929/100,000 live births.[2]

The majority of maternal deaths occur in the home. Within SNS facilities, 81 maternal death were reported to the national health information system (SNIS) in 1994. This translates into a hospital maternal mortality rate of 129 per 100,000 live births (SNIS 1994). In the social security health system and the private sector, the rate is lower.

According to the 1994 Demographic and Health Survey (ENDSA), three quarters of maternal deaths in Bolivia occur during pregnancy or at the time of delivery. The principal causes of death are hemorrhaging, induced abortion, and hypertension among others. Data published by other sources than the SNS estimate that abortion is responsible for 27 to 35% of maternal mortality.

In the area of prenatal and delivery care, the 1994 DHS indicates that 53% of pregnant women receive prenatal care and 47.2% deliver their babies under medical supervision. The difference between rural and urban women is significant; in urban areas, two-thirds of pregnant women obtain prenatal care while in rural areas of the Altiplano, for example, coverage for prenatal care only reaches 20%.

Approximately 10% of all births in the country occur among adolescent women according to the 1976 and 1992 censuses. The 1994 DHS shows that 18% of women ages 15-19 are mothers. Forty percent of 19 year olds are mothers or are pregnant, and 9% of the women in this age group have at least two children. Most girls grow up with very little or no sexual education. It is estimated that 69% of abortions occur among women 14 to 19 years of age (SBGO, 1991).

The percentage of women using any type of contraceptive method increased between 1983 and 1994 from 23.6% to 45.3%. The proportion of women using a natural method doubled in the last decade. Periodic abstinence or rhythm is the most widely used natural method. The use of modern methods has increased by 80% during the last decade but continues to be relatively low; among modern methods, the IUD is the most popular followed by female surgical sterilization and the pill.

Political Context

Since April 1994, national health policy has made explicit the priority to be given to women's health (Plan Vida 1994), and is based on a conceptual framework that the Government has adopted as part of a new development strategy.

The development model which prevailed from the time just after the Second World War was one that did not benefit the majority of the population. This model crumbled and left the country in a profound crisis, not only failing to eliminate underdevelopment but creating greater inequality, damaging the environment and increasing to unprecedented levels the external debt of the region[3].

This difficult experience led the government to formulate a concept of development which harmonizes economic needs with human needs, with the objective of assuring equitable

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[3] Message by President Gonzalo Sánchez de Lozada, National Population Day, 1 July 1995.

growth and an improved quality of life for all Bolivians.

The governing policy is directed at a search for equity and social justice as indispensable requirements for assuring sustained and sustainable development, and incorporating members of the civil society in the process of decision-making and improving the efficacy of the State. The new Strategy for Sustainable Development attempts to blend, in a balanced manner, social equity, economic growth and political stability with the rational use of natural resources.

In order to apply this new perspective for national development, legislation has been passed to make feasible a series of profound normative and structural changes. These are considered essential to carrying out this revolutionary process of transformation within the democratic system.

One of the most relevant changes put in place has been the Law of Popular Participation which is designed to redistribute political and economic power, and thus narrow the enormous gap which separates the rich from the poor, the country-side from the city, and women from men. This law turns representative democracy into broader participatory democracy.

Another important transformation has taken place in the educational sector intended to improve quality and the rate of school drop-out. The structure of the State has also been reformed through the creation of the Ministries of Economic Development, Human Development, and Sustainable Development. The concept of human development provides a framework for guiding governmental actions.

Of the aforementioned reforms, what is summarized below are the changes in the health sector intended to help the citizens of Bolivia exercise their right to good health as well as the commitment of the State in guaranteeing that that right is exercised. The health sector is forging ahead with the development of a more just and united social structure, one that recognizes the equal role of women as participants in and products of the development process, and which supports women's on-going search for social justice, participatory democracy, and equal rights.

From the perspective of the health sector, attention is focused on the development, formulation, and implementation of health policies for women and children. A key assumption of this policy effort is that reductions in infant and maternal morbidity and mortality will not be produced through isolated efforts. The need to see women's health issues through many lenses and to consider women as key actors in development are essential.

These shifts in viewpoint are not only the result of decisions made by the government but are also responses to more broad social changes. On the one hand, women's organizations have had a critical role in generating a process of internal discussion, and are responsible for introducing the on-going debate over the needs and perspectives of women. On the other hand, due to the legal recognition on the part of the State of ethnic groups and the growing demand of these groups for their historic rights and respect of their culture, the formation of health policy has paid particular attention to ethno-cultural diversity and to indigenous women.

Institutional Framework

The Integrated Women's Health Care Programme: The current Integrated Women's Health Care Programme includes the following elements: prenatal, delivery and postpartum care; family planning; and the prevention and control of cervical/uterine cancer and sexually transmitted diseases.

The inclusion of each one of these components is a product of continual changes in the perception of women's health, changes which evolved from national debates over key problem areas and which require institutional changes within the very governmental organizations enacting reforms.

The reproductive health strategy (one element in the process of reaching the objectives of integrated women's health care) consists of matching interventions to the needs of women and the diverse reality of the population on a permanent basis. The implementation of the strategy has included a concentrated effort at extending and improving the quality of services by upgrading equipment and providing medical supplies, medications, and contraceptive methods. In addition, intense and systematic support has been given to the development of human resources at the administrative, operative, and technical levels.

In the sections to follow, we will attempt to answer the following questions:

- What is the institutional framework within which integrated women's health services are developed, especially in regards to obstetrical care and family planning? What objectives guide the actions taken?

- How is the current framework functioning and what are some of the perspectives on the future role of the institutional framework? What are some of its strengths and weaknesses?

- What mechanisms could be implemented to overcome the current weaknesses or to achieve the objectives of the framework?

Institutional placement of the Programme within the National Secretariat of Health: The Integrated Women's Health Care Programme is carried out within the Division of Women's Health which is a sub-section of the Directorate of Health and Nutrition for Women and Children. This Directorate, together with other administrative/technical directorates, constitute the normative control level of the national health system which is headed by the Subsecretariat for Public Health, a division of the National Secretariat for Health (SNS).

The Secretariat and the Sub-secretariat have technical and normative authority over the 9 Departmental Health Directorates (DIDES) which are responsible for organizing and controlling local health service networks, including maternity centers and regional hospitals. The Departmental Directorates depend administratively on departmental governments but work closely with local sectoral administrative units. Local Health Directorates (DILOS) are comprised of representatives of municipal governments and oversight committees of Local Territorial Organizations (OTB). The Local Health Directorates are the administrative unit which shares responsibility with local community members for the building and maintenance of the health infrastructure as

well as the organization and control of health services.

The Integrated Women's Health Care Programme is the responsibility of each administrative and technical unit of the Secretariat of Health. That translates into the delivery of services to the population at regional and local levels. Interventions for improving women's health are therefore carried out as part of a package of basic health care, which also includes health care for infants and children and infectious disease control, among other areas.

Inter-institutional relationships between the Secretariat of Health, the Ministry for Human Development and other ministries: The National Secretariat of Health (SNS) is a branch of the Ministry for Human Development; at the same level as the SNS are the National Secretariat of Education; the National Secretariat for Ethnic, Gender, and Generational Affairs; and the National Secretariat for Popular Participation.

The Integrated Women's Health Care Programme maintains a functional relationship with the National Secretariat for Education based largely on the issue of revising formal educational materials in the areas of health and sex education. A tripartite commission has been formed between the Programme, the Subsecretariat for Gender, and PAHO/WHO in order to strengthen the political and social prioritization of women's health in the entire country through various activities including formal training, education, and information giving. Relationships have been established with the different Subsecretariats for Popular Participation to coordinate priorities of the different territories covered by the Programme with other activities that favor the development of municipalities. The goal is to try to incorporate the basic elements of policies favoring women's health into local decision-making processes for the allocation of funds and for other local efforts. In general, however, attempts at inter-institutional coordination between different parts of the Government lack the necessary continuity to assure that processes designed to strengthen activities for women's health are undertaken.

The National Social Security System (comprised of various *Cajas*) provides health services to women insured under their programme using the norms established by the National Secretariat of Health. Agreements designed to facilitate the sharing of services between the *Cajas* and the SNS are in place such that resources available to the *Cajas* can be utilized for increasing the coverage of priority programs. In exchange, however, the SNS must face a number of unnecessary and at times absurd restrictions in services which affect the most basic components of women's health care interventions. For example, the SNS and *Cajas* share facilities for carrying out prenatal care visits but each is currently incapable of offering normal childbirth services to women who are supposed to be covered by the other institution.

Besides the institutions located within the Ministry of Human Development, there are a number of public organizations that in one way or another play an important role in the implementation of the Programme. The Army has emergency health posts and health centers that offer services to military personnel and their families as well as to geographically dispersed populations with limited access to care.

The Army has incorporated the majority of the interventions for women's health defined by the SNS in its services, including obstetrical services and family planning. The National Police receives many women with obstetrical complications and is working to train its personnel for greater and more useful collaboration with the SNS. It is not uncommon for the SNS to confront a number of problems in implementing simple joint efforts with these institutions at the local level due to rigidity and inflexibility at the central, administrative levels of these institutions'.

Relationships with donor agencies: The Government of Bolivia receives credit and donations from a number of international agencies to develop health projects and services. Among those, a number collaborate with the SNS on women's health care programmes.

The two most important creditors for in the health area are the Interamerican Development Bank (IDB), which finances a project for the development of local health services and programs (PSF), and the World Bank, which also provides credit for the development of local health services (PROISS). These loans are restricted by certain laws and the activities for which the money is used are already established. Thus, while there is very little flexibility in how these funds can be utilized, the SNS has the ultimate responsibility for making decisions about their use. The country has proposed a new budget to the Interamerican Development Bank which would direct money not only towards investments in hospitals and service networks, but also towards the development of local processes intended to reduce maternal mortality in selected districts.

The United Nations Population Fund (UNFPA) finances a reproductive health project administered by PAHO/WHO and implemented by the SNS. This project and its predecessors have facilitated the development of important aspects of the Integrated Women's Health Care Programme.

The United States Agency for International Development (USAID) also finances a reproductive health project managed by the SNS. One of the most important components of the programme is the development of local health service delivery systems via a project called Child and Community Health or CCH.

UNICEF provides funding for the on-going functioning of almost all health service facilities in certain regions characterized by high levels of poverty. Additionally, UNICEF collaborates in the financing of some institutional needs for the Integrated Women's Health Care Programme.

Other agencies provide support to women's health through agreements with the SNS. These include: GTZ (Germany), JICA (Japan) and ODA (UK).

Outside of donor agencies, several international organizations are working with the SNS on women's health programmes in research, service delivery, and technical assistance. These include the World Health Organization (WHO), the Pan American Health Organization (PAHO), the International Planned Parenthood Federation, and cooperating agencies of USAID.

Nongovernmental organizations: There are numerous nongovernmental organizations working in the area of health and specifically in the area of

reproductive health in Bolivia. Although it is not completely clear whether or not these organizations cover territory or populations that the public sector cannot, it is true that they have developed activities and offered health services for a significant number of low-income families. Some NGOs work in certain places within restricted timetables because of the irregularity of financial support. However, other NGOs have developed local health systems where they have been assigned by the government the function of directing the provision health care in a designated area.

Many NGOs do not have any relationship with the governmental health care system. There are several possible reasons for this, including the fact that NGOs consider themselves a part of an alternative system of health care, or simply because there is a lack of will or capacity on the part of public institutions to collaborate. This unfortunately creates a situation where service delivery sites are redundant or badly placed, physical and human resources are underutilized or inefficient, services are not prioritized to deal with the most pressing needs, and procedures and medical instruments who safety is not assured are used.

On January 15, 1990, the National Secretariat of Health, through the Directorate for the Health and Nutrition of Women and Children, international organizations, and nongovernmental organizations agreed to a memorandum of understanding which was designed to develop a National Strategy for Reproductive Health through an effective coordination of activities.

This first formal inter-institutional relationship with NGOs working in the reproductive health field was difficult to formulate due to: 1) the lack of a normative definition of the relationship between the State and NGOs; 2) mistrust on the part of NGOs that the government was interested in infringing on their organizational, policy-making and financial autonomy; 3) the large variety and dispersed nature of NGOs; and 4) weaknesses in effective coordination mechanisms.

It is important to point out that some NGOs have developed a series of strategic bilateral relationships with regional governmental bodies, and have thus carved out a legitimate presence in the communities where they work. They have an integrated focus on reproductive health which includes sexual and reproductive rights for all people, and they adhere to the Integrated Women's Health Care Programme as documented in the *Plan Vida*.

One event which deserves highlighting is the agreement signed in 1994 between the SNS and PROCOSI, one of the major, national umbrella groups for NGOs working in reproductive health. PROCOSI's organizations have incorporated the essential components of the Integrated Women's Health Care Programme and maintain a close relationship with the SNS. In particular, there is a collaborative effort for the development of activities with groups of women in the self-diagnosis of their situation and participatory planning of reproductive health activities using the WARMI methodology designed by Save the Children. The contribution of MotherCare in developing and normalizing women's health care services in SNS-designated priority areas also deserves special mention.

Relationship with the Church: The National Directorate for the Health and Nutrition of Women and Children signed an agreement with the Episcopal Conference of Bolivia in 1994 which commits each institution to a collaborative effort to reduce maternal mortality; avert induced abortions; promote breast-feeding; and promote family planning and the spacing of children with the guarantee that natural methods play an important role in this promotion. This agreement has opened the door for the implementation of collaborative projects in geographically determined areas where the Church provides services for the community.

Some of these service arrangements involve a mixture of funding such that the SNS contributes a portion for personnel, another portion is financed by funds generated by the services themselves, and the operational and maintenance costs are assumed by the Church. In addition, the Church maintains some private services in which the SNS has no voice except to assure that procedures utilized are in accordance with official norms. Currently, the Church is promoting educational activities, as well as generating and distributing education materials on family planning, respecting the freedom of choice of each couple and promoting natural family planning methods.

The Catholic Church considers the promotion and development of women to be one of the most important areas for inter-institutional collaboration. This would help women overcome the current situation where women are not the owners of anything nor able to play the role of decision-maker. The proposal of the Church is to contribute to the education of women so that they can take on a larger role both in the house and in the greater society.

The traditional health system: Traditional medicine provides an alternative system of care for a large part of the Bolivian population, and even more so in rural areas where communities prefer their own health system.

In 1986, Bolivia became one of just a few countries in the world to legalize the practice of traditional medicine. As such, one of the most widely recognized institutions for traditional medicine is in the country, the Bolivian Society of Traditional Medicine (SOBOMETRA). SOBOMETRA works together with the formal health sector and the Bolivian Medical College to direct seminars and trainings for providers on the topics of alternative practices and the use of traditional plants (Dibbits, 1994).

Currently, the Secretariat of Health, and in particular the National Directorate for the Health and Nutrition of Women and Children, perceives the need to establish stronger ties with the traditional sector, and has therefore implemented training activities with traditional midwives (around 2,500 in the last 15 years). Traditional medicine is not completely isolated from western medicine; traditional midwives and healers encourage their patients to go to health centers for injections and surgery. Many midwives have indicated an interest in working collaboratively with doctors. Also, it is not uncommon for women to combine elements from both health system depending on the origin or cause of an illness. Thus, there are strong ties linking the two health systems, even though these links are often not formally or officially recognized.

Women, Health and Community

The analysis for this report is based on visits carried out in rural communities with at least some proximity to urban areas, such as peri-urban towns. This chapter is centred on our findings related to the impressions and reactions of community women, including leaders, on the substantive issues of women's health as well as on access to, and quality of, health services.

The women interviewed for this assessment differed on a number of social and cultural characteristics including their level of education, age, number of children, and experiences derived from their socially assigned roles. All of these characteristics contributed to their different health behaviors and perspectives on health care services. When we asked women about their health, we obtained a wide range of answers relating to the general situations they find themselves in, their quality of life, and survival strategies. Despite the diversity, we found numerous commonalties among women related to perceptions of health, needs and strategies for fulfilling those needs.

One issue that emerged clearly was that women tend to focus on the health of their children, and more generally, on the health of the family. Concerns for health are expressed only after worries related to their multiple households tasks and economic situation. Women virtually always place these other issues ahead of concerns fortheir own health.

In general, women's health is not perceived as a special problem, nor are maternal mortality and its causes given specific attention. However, in some areas where women discussed maternal mortality, they described it as a rare phenomenon, mainly affecting women who live in isolated areas and not themselves. They described it as something that "is far away from them". One union leader indicated that she was worried about the fact that "husbands don't pay attention to the health of women, they don't want to spend money on it, and besides, they don't even want them to leave their homes". Among the majority of men interviewed, maternal mortality is also not seen as a problem or if it is, it has no solution. It is not uncommon to hear the phrase "if a woman or her baby dies, it's because her time had come".

In general, we found that members of the population do not have an ample understanding of the real problems associated with maternal mortality in the country. It is not viewed as a social problem that can be prevented medically and institutionally. There seems to be a very strong focus on life and death as derived from culturally-based perceptions and religious beliefs about a divine plan. In this plan, death assumes the role of a completely natural fact of life, without reference to a person's age or the illness that ends his or her life. This may explain the fact that many maternal deaths occur in communities where health services are available.

This fatalistic perception exists in intermediate cities, in rural commu-

nities (with greatest intensity), and in peri-urban zone such as in the hillsides of the city of La Paz, heavily populated with Aymara immigrants. At one health post we visited, we were told that two blocks away a fifteen year old woman had died of postpartum haemorrhaging without ever having sought care at the health post. Another recently married woman had died without any intervention because her husband could not figure out how to describe his wife's illness to anyone.

It is also important to describe some of the views about women's health expressed by health providers. Many feel the issue of maternal mortality is of little significance. Others recognize it as a problem but not one that is prevalent in their communities. One example of this attitude emerged during a conversation with a physician who said that "maternal mortality is not a major concern because the people around here are strong". Only a few health professionals identified maternal mortality as a problem and indicated that health cannot be viewed independently of the socio-cultural context.

Just as maternal mortality was not mentioned, obstetrical emergencies were also not identified as a problem. These perceptions are products of the following circumstances: (1) the phenomenon of maternal mortality, statistically speaking, is rare; (2) health care coverage for deliveries is so low (43% according to the DHS), due partly to a general a lack of confidence in health services and the fact that access to services for women experiencing an obstetrical emergency is very limited; and (3) community information networks for spreading news of maternal care are underutilized.

Pregnancy and Childbirth

Pregnancy and childbirth are viewed as natural processes which form part of the daily lives of women; its simply another event in the context of long and difficult work lives. For this reason and because it is such a common event, most feel is requires intervention by family or community members (husbands, other relatives, or midwives) rather than the services of a doctor. Many women utilize traditional medicine; it is only when they are very ill or feel they are about to die that they resort to a doctor. This is usually in the context of an emergency or when the midwives or traditional healers cannot resolve their problems.

In addition, there are a significant number of women who turn to health services only once before they deliver, and seek no care either during the delivery or afterwards. Women only want to find out whether the baby is healthy and in a good position. This is supposed to assure a safe delivery in their homes, a culturally appropriate setting for having babies with the help of family members or midwives. Among younger women, however, there is a greater tendency to deliver in the hospital or a medical centre, and to take advantage of prenatal services.

Some women think that "when the baby is born, the womb opens up, cold enters and chills the blood"; for this reason, it is necessary to wrap oneself up well during delivery and drink warm liquids to warm the blood. This belief is in direct contrast with the conditions of medical facilities which are often not temperature controlled. Delivering with a midwife also ensures that a woman will have privacy during childbirth, whereas privacy is rarely assured

in health services. A woman delivering at home can choose the position in which to give birth. Many women prefer the squatting position to the classical gynaecological position because it is more comfortable, more familiar, and exposes the woman less to the open air.

In a majority of health facilities, gynaecological tables are available but there are no preparations made for a women who might prefer to have her baby in another position. The majority of providers demand that women have their babies on a delivery table, "for comfort and because is it less dangerous for the infant", or simply because the providers have not been trained in any other childbirth care modalities.

Other factors which contribute to the poor utilization of medical centres is the general lack of confidence in these services and embarrassment in front of doctors. Some men oppose their wives seeing a doctor because they don't "want the doctors to see the women or to treat them there". However, other husbands indicate that it is important that their wives seek medical services, even though in some instances, they cannot convince their wives to do so. It is also important to point out that at several of the sites visited, we found the tendency among women to prefer obstetrical care given by health personnel of the same gender, largely because they are ashamed to be seen by male physicians and found it uncomfortable to discuss the intimate details of their lives and sexual relationships. Some men also mentioned that they preferred their wives to be seen by women.

The interviews illustrated that besides the technical, economic and human factors that favour or negatively impact the process of seeking obstetrical care and affect health service utilization, there are other elements to consider in understanding the utilization of services including the acceptance or rejection of diverse cultural factors on the part of providers and gender preferences.

There are a number of factors related to the way in which women and men perceive quality of care. Some people told us that when they seek care, service facilities are closed, medicines are unavailable, they don't feel well cared for, or they perceive that providers are too interested in money. Another important factor is the constant turnover of physicians, a phenomenon which makes it difficult for clients to develop confidence in the services. People said, "we were used to the doctor we had before." Others insist that the information they receive is insufficient and when asked to identify which services were offered at the health facility, the majority did not have the correct information. However, some women indicated they were satisfied with or 'felt good about" the care they obtained because they were treated kindly and given the information and counselling they needed.

One of the issues frequently discussed was the cost of services. Often there is little relationship between the stated price of services and the final costs to the patients because the total bill is usually augmented by hidden costs. The accounting records at some facilities included a payment item for ambulance service which was not advertised to clients. Cost, although relatively low in the public sector, constitutes a barrier to access for a significant proportion of the population. Nevertheless, some women

consider free services to be synonymous with services of poor quality and prefer to pay for care.

Women often obtain their care at private offices because they believe the services are safer and of higher quality than the services provided by the SNS. In some respects, this is an indicator of a general mistrust on the part of women of the services provided in the public sector. They do not believe that they will have their problems resolved if they seek care. However, it is equally important to note that many women turn to the public services, without regards to the gravity or seriousness of their illness, when their experience indicates that the services are of good quality.

Family Planning

Regarding the issue of family planning, we were able to establish that women as well as men feel a need for family planning. Every place we went where the issue was discussed, even on an informal basis, people were acutely interested in learning about contraceptive options as well as the advantages and limitations of methods. One illustrative example emerged from an interview with a woman selling food at a market in an Altiplano community. When the woman was asked questions about family planning, she began to solicit information and convened other women to participate in an improvised diffusion session.

However, need and demand do not necessarily translate into an acceptance of family planning among all segments of the population; a number of cultural, religious and social factors intervene to determine and condition the practice of family planning and specifically, the use of contraceptive methods. The most important religious influence is from the Catholic Church.

We were unable to find any indication of a strong interest in the timing or spacing of births. The possibility of postponing another pregnancy was not among women's basic concerns, whereas ending the reproductive life cycle was. Once women have reached their desired family size, they then consider the possibility of pursuing a definitive family planning method. However, the 1994 DHS (ENDSA) includes some information indicating women's desire for spacing as well as for limiting births.

We observed that while the issue of family planning is of great interest in some areas, in others, enthusiasm is limited. This is consistent with the information given by providers about the reactions they obtain when they carry out family planning training or educational sessions in the community. We found, as providers have, that the greatest interest in the subject is found among the younger population and among couples who already have many children.

Union leaders highlighted the need to have information on an on-going basis because listening to a family planning message only once is not enough. "It's something new, we need to think about it again, discuss it" indicated the leaders. The general anxiety about family planning is based on the difficulties people have with the use of certain methods and the uncertainty brought about by the irregular use of some methods. The union leaders felt that physicians or nurse auxiliaries should go more often to the communities to discuss family planning ideas. This is necessary because many people have doubts about the positive and

negative effects, and the safety of the methods. These doubts are undoubtedly products of the deficient, partial or biased information available to most people.

There are a number of myths and biases related to the use of methods, such as that the Copper T IUD gets "stuck in the body or causes cancer." The pill is also viewed as having a connection with cancer and with bodily changes such as large weight gain or "drying up of the body". For some of the women interviewed, the pill is not considered a good method because it must be taken every day which is very impractical.

A number of providers feel similarly, and in some regions, also indicated that oral contraceptives were not recommendable because they can become damp and disintegrate easily. The utilization of the pill varies considerably by region. In some areas, it is the only method available, and in others, despite being available, women rarely use it. Others indicated that injections were not good for your health.

In general, evidence is scarce to indicate any preference for the condom outside of the demand noted at some urban centres. Some women indicate that "husbands don't like them" and men added that "they weren't used to using them" on a regular basis. Many women want and obtain a tubal ligation; they almost always choose the private sector to get it, where costs are high, adequate information is not given, and where there is little assurance of quality of care. In some cases, a medically unjustified caesarean section is performed simply in order to do a tubal ligation. Some people think that tubal ligation is slow in healing.

The use of vasectomy is practically non-existent due largely to the widely held belief that it reduces the sexual potency of its users. For other people, the condom is not an acceptable method because it is believed to reduce sexual pleasure.

During our interviews it became clear that there is a demand for injectable contraceptives in several regions. While some people indicate that injections are not good for your health, others believe the injection "cures all" and is more practical than other methods. It is considered an easily manageable method because when husbands are away, as in the case of temporary migrant groups, women can take a rest from using contraception and resume use when husbands return home. We found a wide variety of injectables in private pharmacies, including in some rural zones. The types found were PERLUTAN, Depo-Provera (offered in three varieties: one, three and six months), and MESIGYNA. Furthermore, we found that women turn to nurse auxiliaries to perform the injection, though they acquire their supplies of the method at the pharmacy.

Among the perspectives voiced, the only methods considered totally safe were natural methods as they do not harm your health or make you feel sick. Coitus interruptus, Billings and rhythm (periodic abstinence) are frequently utilized among the population. However, we found diverse interpretations on how to actually use them, some of which were technically incorrect. The information presented in the background document on the incorrect use of these methods was confirmed during the field visits, and serves to confirm once again the need for accurate information on these methods.

Although there is a strong recognition of the need for family planning, this need tends to generate a number of contradictions and conflicts in couples' relationships when decisions about use are made. There are a number of ways in which women and couples interpret, perceive and live with the use of contraceptive methods. For example, men frequently are of the opinion that women, upon using some of the modern methods, particularly the IUD, will "become crazy" and become "hotter and insatiable". Without a doubt, this perception is supported by or rooted in the position of control that men still maintain over the body and sexuality of women, and their fear that if a woman utilizes a contraceptive method, she will "get together with others". Women, however, frequently consider the IUD a very advantageous method because of its low cost, its efficacy and durability. In response to the "get together with others" worry, women say that "if things are going well with your partner, you don't need to look for another".

The constant increase in the sales of injectable contraceptives in pharmacies, and the increasing number of women who verify that they use them without medical supervision, also signal unmet need. In addition, there are other indicators of unmet demand for family planning in the public sector. One is the high frequency of induced abortion; among the people in the different areas visited, abortion is a highly visible reality of alarming magnitudes. Among providers and authorities, there is a tendency to categorize many abortions as miscarriages and attribute them to the conditions of daily life and the overextension of women in their work.

We were told of a variety of ways in which women induce a miscarriage or achieve an abortion: using their own home remedies (herbal teas, falling down, lifting heavy weights), going to a midwife, or finally having the procedure performed by a doctor. Finally, we would be remiss if we failed to mention an important health problem women often face while pregnant: mistreatment and violence from within their own families.

Despite the fact that many family planning services are offered with a low level of quality of care, we observed several examples of services which were well adapted to the living conditions of the population and had a good stock of supplies. Users of these services consistently claimed that they were very satisfied with the care.

Conclusions and Recommendations

The reproductive/maternal role socially assigned to women is one of the factors that influences the value they assign to the health of others and the well-being of the family in constrast to a concern for their own health. Many of the problems that providers and health authorities consider most pressing are not seen that same way by either women or men, and consequently, are not prioritized by the community. A good example of this is maternal mortality.

Given the preceding discussion, it is possible to conclude that the strategies women employ are both rational and logical within the sociocultural and gendered context and the reality of the available services within which the strategies are developed. For this reason, it is important to recognize and validate the strategies women have and aim to incorporate the knowledge into the better organization and delivery of services intended for them. Policies

related to the Integrated Women's Health Care Programme should take into account these needs and allow women to take an active role in the design and prioritization of activities around solving their specific health problems. If the goal is to increase the utilization of obstetrical services, the services must be more adequately tailored to the actual needs and desires of women.

Women, men and authorities all expressed the need for family planning information and services. This need manifests itself in the unregulated use by many people of injectables found in the commercial sector. Another indicator was the explicit request of people interviewed for more information about family planning and better services. We recommend that there be increased access to information and services for a greater variety of methods.

Implementation of the Integrated Women's Health Care Programme and the Law of Popular Participation

The Integrated Women's Health Care Programme and the Reproductive Health Strategy

The Integrated Women's Health Care Programme is a product of an evolutionary process designed to attend to the health needs of Bolivian women, particularly those who live in rural areas. For the benefit of women, a strategy was designed which includes the following components:

1. Prenatal, delivery, postpartum, newborn, and breast-feeding care
2. Sexually transmitted diseases
3. Cervical, uterine and breast cancer
4. Tetanus toxoid vaccination
5. Other diseases affecting women
6. Contraception

The concepts of women's health and reproductive health have evolved in such a way that in Bolivian, women are offered integrated package of services of which family planning is one important component.

This is in contrast with many other countries where family planning was developed as a vertical programme, separated from other health services, or as an isolated component within a maternal and child health programme. The notion of integrated care implemented within the public sector also contrasts with the services of some NGOs which situate family planning at the centre of their activities and programmes.

Despite the programme's short history in many communities, its implementation has already had an important impact on women who use the services. These women, until recently, were completely without access to information and services related to reproductive health.

Prenatal care, delivery, and postnatal care, including attention for newborns and the promotion of breast-feeding have always been a part of primary health care, but emphasis on these services has been stepped up in recent years in an effort to confront the problems of perinatal and maternal mortality. Focus is being placed as much on the extension of routine services such as the improvement of essential clinical care, as on activities related to the resolution of obstetrical emergencies.

Technological changes have been made in obstetrical care such as the use of ecographs and fetal monitors, but their widespread availability has not yet been achieved due to cost factors, and lack of technical knowledge and skill in some areas. While technology may not be totally necessary, it is important to note that even basic materials are not available for routine procedures. These include bags for blood transfusions and equipment for neonatal resuscitation. It is only very recently that protocols

for obstetrical and neonatal procedures have been updated, replacing outdated norms.

The wide scale introduction of contraceptives offered as part of health services coincided with the implementation of the Reproductive Health Strategy. This temporal coincidence may help explain why many providers believe that the concepts of reproductive health and family planning are synonymous. In general, however, providers have a favourable attitude towards family planning.

Some providers consider the rule which demands the taking of a Pap smear before the IUD insertion inappropriate because application of this protocol limits the potential coverage of this method. Also, the requirement could reinforce the widespread belief that the IUD causes cancer.

The concept of postpartum family planning as part of a reproductive health strategy is very new, and to date has not been completely implemented at the institutional level. During the fieldwork, however, we found instances where providers had begun to offer this service.

The existence of unmet demand for contraception and the lack of information can be illustrated by the prevalence of cases of pregnant women searching for family planning. In these cases, providers usually encourage the woman to attend prenatal care, have the baby in the health facility, and then seek family planning after the delivery. In come instances, women will submit to a caesarean, even when not warranted, with the sole intention of obtaining a tubal ligation.

The fieldwork revealed that among health providers and members of the community, there is not a uniform understanding of the variety of components that comprise the reproductive health strategy. Additionally, among providers there is not a clear understanding of the significance of women's sexual and reproductive rights.

Responsibility for health services in the public sector is divided among various entities which leads to discrepancies in the range of services offered in reproductive health. These discrepancies can be attributed, in many cases, to the philosophic or political orientation of the institutions that finance the services.

The SNS has formal agreements with Churches to offer services. The introduction of contraceptive methods within the regular health care system has generated tension between the SNS and the Catholic Church. The policy of the SNS is to respect religious beliefs on the issue of family planning, without failing to guarantee that methods are offered.

We have found that in different regions of the country, the policy of the Church not to offer artificial means of contraception manifests itself in different ways. Family planning counselling, for example, generally only includes a discussion of natural methods.

The SNS also has agreements with NGOs to develop health services, but practical and objective measures to guarantee a correct orientation about family planning have not been adopted. Many NGOs offer a broader range of methods than recommended by the SNS and use guidelines and personnel

different from what is accepted in the country.

The operational framework in which health programmes operate, including the Integrated Women's Health Care Programme and the reproductive health strategy, is largely based in the provision of clinical services. As a direct result, projects and resources are directed at building the capacity of clinical providers who largely work in health centres and hospitals.

With the exception of vaccination campaigns, and in some places the training of traditional midwives, the emphasis of the Integrated Women's Health Care Programme and the reproductive health strategy is concentrated in improving infrastructure and the greater offering of services in centres, posts, and hospitals. One consequence of this approach is that the members of the population who cannot or do not seek care at these facilities, for a variety of reasons, do not benefit from these efforts.

Programme planning currently conducted is not adequate to deliver the reproductive health strategy to the community level. In a few areas visited, nurse auxiliaries used their own initiatives to take the services to the people. But in other areas, we found that auxiliaries and community-based health promoters did not have a clear idea of the definition of reproductive health, which thus made it impossible for them to provide information to members of the community.

Little attention has been focused on providing information and organizing community-based activities for distinct sectors of the population (adolescents, prostitutes, and others). Focusing on women of reproductive age has segmented the implementation of reproductive health activities.

Emerging Tendencies with the Law of Popular Participation

All of the changes made in the relationship between the State and civil society, and especially those changes resulting from the Law of Popular Participation, have had or will have important effects on the health situation. Advancements in the educational attainment of the population, and of women in particular, will improve the health of Bolivian families and expand the coverage of services.

The 1994 Law of Population Participation provides for the transfer of ownership and administration of health services, among other services, to municipal governments. The central government maintains control over the areas of policy and human resources, although under the permanent oversight of active popular organizations. The government continues to commit resources to various social sectors, (expenditures exceed prior levels) while at the same time, apportioning a percentage of tax revenue to municipalities for future investment. All of this activity is carried out within a philosophy of transferring greater control and knowledge to municipal level governments.

The Law of Popular Participation is not merely designed to increase the fiscal resources dedicated to social areas or to make more money available for social investment in rural areas. The Law allows members of the population and their representatives the power to intervene in important decision-making. Before the Law Community Participation was a mechanism used to

complement the existing health care service delivery model and to make services function better and extend coverage. With the Law of Popular Participation, members of the population now have an opportunity to be included in the making of policy through their municipal authorities or through other local leaders.

Among health professionals and health workers, there is a great deal of optimism about the long term health benefits of the Law of Popular Participation. In Santa Cruz, Cochabamba and La Paz, providers demonstrated their enthusiasm by showing us the new equipment, infrastructure, and materials they had purchased with funds made available to the local governments.

However, there is some concern about the implementation of the Law, especially on the part of urban physicians. It is important to highlight the fact that a majority of the providers believe that an increase in municipal control of fiscal and administrative matters will give local governments a great deal of power over how services are provided in each municipality. The municipal government of Cochabamba has initiated the reorganization of the city's hospital system, and is considering the possibility of instituting a training programme as a requirement for the evaluation of health personnel.

Despite the optimism for long term benefits of the new Law, everyone realizes that the administrative mechanisms necessary for implementation of the Law are, as of yet, not complete. In the interim, the operation of some programmes, many of which are still in the development stage, could be jeopardized. We found some cases where money had not been allocated for services, even though health centres had handed over resources to local authorities. The lack of funds will result in an interruption in the administration of critical health services.

Up to this point, investments made by local governments in the health sector have been concentrated in the acquisition and maintenance of capital facilities, whether infrastructure or equipment, for hospitals and health centres. Supplies and maintenance are supported directly from payments made by clients for services. From a financial standpoint, the investment appears to make sense. However, there has been a significantly uneven allocation and utilization of resources.

The fees collected at most service facilities, including in urban areas, rarely cover completely the basic costs of care. Still, in accordance with the Law, local government funds need to be utilized for the infrastructure needs of a wide variety of services, not just those related to health. It is therefore reasonable to expect local government officials to hope that health services become self-sustaining to limit their dependency on local funding; all of the local officials we interviewed indicated that this would be the ideal situation. However, it is dangerous to expect that the entire burden for financing health services can be absorbed by the facilities themselves with income from such a precarious source as user fees.

We detected a dilemma faced by local government in choosing between improving existing infrastructure and building new structures, with the latter generally receiving greater priority. Decisions on capital investment, however, are generally not based on levels of coverage or the current utilization of

existing services. It is thus necessary to have some guidelines for making appropriate decisions. Local officials will have to take into consideration the difference between current and potential utilization rates (subutilization); the range of other public health facilities available in the locality or municipality; to whom the infrastructure of the facilities belongs; and the possibilities for cooperative agreements between service providers.

It is also important to point out that the financing mechanisms discussed above, while logical from a economic point of view, have larger implications for the health sector than for others. They affect the range of services available, cost, and accessibility. It is not clear, for example, whether local officials will be open to providing funds for non-tangible activities such as training and community outreach.

From a public health standpoint, such activities can have a great impact on reaching objectives for improving reproductive health. But none of the health centres visited had used the funds from the local government for anything other than infrastructure or the purchase of large equipment. Additionally, resources have been invested in hospitals and health centres, leaving the smaller health posts without funding.

The increase in available funds for local governments resulting from the Law of Popular Participation allows officials a considerable degree of flexibility in defining, supporting or augmenting health activities to best respond to the local needs. This is especially true in urban centres where good possibilities exist for improving cost-effectiveness and efficiency within health services. Hence, the Law of Popular Participation represents a valuable opportunity to expand and/or reinforce reproductive health services at the local level. However, this opportunity is one whose fruition ultimately depends on two factors: recognition on the part of local authorities of the high priority of women's health, and the capacity of district health authorities to assume the role of defender of women's health to the local level. Unfortunately, interviews both with community leaders and providers suggested that neither the health of women nor reproductive health specifically are perceived as crucial health issues.

In addition, we noted that the implementation of processes for participatory planning, needs assessment, and monitoring is not being accomplished in some communities. In various sites visited, the municipal annual operating plan and budget were developed by the mayor without the participation of the town council or other local organizations. In several areas visited, especially capital cities, the formation of both local groups designed to collaborate with and advise leaders (*Organizacions Territoriales de Base or OTBs*) as well as monitoring committees is far behind schedule. Moreover, the majority of mayors we interviewed felt that health services should be self-sustaining. Yet, in various places, health personnel were not able to mobilize funds at service delivery sites. Or when funds were generated, they could not be used at those sites; instead they had to be delivered to the local health authorities who then must reallocate them.

Conclusions and Recommendations

It is still unclear what the impact of the new financing system on access to health services will be, but a great deal

will depend on the readiness of local governments to allow health centers to maintain control over the use of the funds generated by their services.

We found a divergence of positions in regards to this issue. For example, in some communities, health centers have a large degree of flexibility in the use of the funds they generate which allows them to purchase medical supplies and subsidize the costs of some services (including medication) for those who cannot pay. In other communities, the interference of local officials in the management of funds is seen as an obstacle to subsidizing services, especially in areas where the health centers must purchase their supplies from central distributors, known as *Unidad Regional de Suministros* or *URES*.

We detected an urgent need to make uniform the financing and accounting processes used, utilizing procedures and principles compatible with the SAFCO Law (a finance control regulation). This is to satisfy the financial expectations of the municipalities and to move towards a more efficient system of distribution of funds so they can be best utilized to benefit the population.

In recognition of the complexity of human resource issues, there is a need to train not only health workers but also the municipal employees and the community in order to appropriately respond to local needs. Collaboration with representatives of civic organizations is crucial to this process. The need for this training was confirmed through our discussions with civic and municipal leaders; many lacked sufficient information to consider a gender focus in identifying problems, to recognize the basic components of reproductive health, or to regard maternal mortality as a significant problem. The following are specific recommendations:

Raise the awareness among providers that all components of reproductive health care are equally important and necessary. Also, emphasize the diffusion of the concepts of reproductive and sexual rights.

Do not expect that changes in existing health services will bring reproductive health closer to the community. Creative strategies for taking the concept and services to the people are essential.

Define at a local and regional level the functions, activities and tasks that each member of a health team should provide for reproductive health services. External feedback and retraining are important in the educational process and will help ensure greater efficacy.

Accelerate the process of decentralization for training procedures using a technically-based framework and a system of follow-up, supervision, and evaluation.

Support the organization and maintenance of the network of nurse auxiliary schools, involving regional authorities, and facilitate the incorporation of continuing education activities so as to assure a constant interface between training and service delivery.

Spell out a process of education for the general population and municipal leaders using IEC strategies which are planned and implemented in accordance with local norms.

Continue to support the process of curriculum change within Schools of Medicine and Nursing, and the reinforcement of ideas in post-graduate training.

Utilization of Services, Access and Quality of Care

In this chapter, we describe women's health services offered by the Secretariat of Health (SNS). Given the objectives of the assessment, we have focused special attention on pregnancy, delivery, postpartum and family planning services as viewed within a larger context of reproductive health.

Health services for women are offered within a complex system of care comprised of health posts, health centres and hospitals. The system is currently undergoing some transition. At the core of the network of health services is the community health promoter (Responsable Popular de Salud or RPS). In certain communities, one or two RPSs are working, while in others trained traditional midwives are available. Some settings have both type of provider while others have none.

The next level of services is offered at health posts, which are managed by nurse auxiliaries. In general, these posts provide inpatient care, including prenatal and postnatal services, and home childbirth care. For the most part, it is the nurse auxiliary who performs these services, although occasionally a recently graduated doctor performing a year of social service is available.

The next level of care is provided at health centres. Normally, health centres are staffed by a nurse auxiliary and a recently graduated physician; occasionally a registered nurse is also available. Some health centres have physicians trained specifically in family planning including IUD insertion. The majority of the centres we visited had contraceptive supplies.

Health centres and posts in the service delivery network refer patients with more complex problems to a district hospital. Referral problems include obstetrical emergencies and family planning services not otherwise available at the local level. Contraceptive methods are generally offered at district hospitals but the range of methods available at each service delivery site depends on a number of factors, including the availability of methods and whether or not the district hospital has a gynaecologist or other physician trained in reproductive health and IUD insertion.

At the level of the health centre and post, the majority of doctors available are those who are recently graduated from medical school who must perform a year of social services (*año de provincia*) before obtaining their diploma. This leads to a problem with continuity of care among medical personnel because providers are changing on a yearly basis. This is largely the case with physicians but also to some extent among nursing staff as well.

District level hospitals have a greater variety of providers, including a permanent physician, and depending on the facility, specialists in obstetrics and gynaecology, recently graduated doctors, interns in their last year of medical school, registered nurses, and nurse auxiliaries. At this level, the capacity to resolve obstetrical complications and perform caesarean sections is variable, depending on the availability of human resources as well as materials, equipment, and infrastructure.

The next level of care beyond the district level is available at regional hospitals, which are typically able to provide tertiary reproductive health care. In addition, various NGOs offer reproductive health services, independent of, or in conjunction with, the public sector.

Currently, the Integrated Women's Health Care Programme places a strong emphasis on the concept of reproductive health and has incorporated family planning counselling in some service delivery sites. Some health promoters and nurse auxiliaries at health posts and centres offer counseling for all the methods available while others only discuss natural family planning. And in a few posts and centres, auxiliaries distribute pills and condoms.

In order to initiate oral contraceptive use, a medical exam is required; however, nurse auxiliaries can be in charge of follow-up care. Women seeking an IUD insertion need to be referred to those health centres with trained physicians. Providers at the health post/centre level can assist women who want to use an injectable method (Depo-Provera or a monthly injectable) which they obtain at pharmacies. Injectable contraceptives are not yet available in the public sector.

Training in reproductive health within the Integrated Women's Health Care Programme has received a great deal of attention in the last few years. Additionally, reproductive health has been incorporated into the curriculum of medical and nursing schools. An externally funded training course which lasts five days and includes a module on contraceptive technology has been directed at physicians (especially those recently graduated) and nurses. At the postgraduate level, training in reproductive health for nurses has been initiated and it is now possible to obtain a specialization in this field.

Recently, reproductive health training has been integrated into the curriculum of nurse auxiliary schools. Furthermore, a 10 day course is available for those nurse auxiliaries who graduated previously to the inclusion of reproductive health in their curriculum. The Secretariat of Health also has agreements with NGOs whereby the NGOs provide training in reproductive health to auxiliaries.

Overall, the SNS has a strong interest in education and outreach to communities. However, the health care system continues to operate under a clinical model of care. Access to services is facilitated for married women of reproductive age with little regard for providing care to other groups such as men and adolescents.

Utilization of Women's Health Services

The service delivery system for health care is underutilized, especially in rural areas. This pattern of subutilization has been documented in national statistics through annual reports of the National Health Information System (SNIS) and clearly observed during our field visits. Of the regions visited, the lowest level of utilization was observed in the Altiplano, followed by Los Valles and Los Llanos.

The number of deliveries performed in health facilities is lower than would be expected given the number of women who obtain prenatal care in SNS clinics. This confirms our earlier observation that many women utilize

prenatal services to check the position of the fetus with the intention of ultimately delivering at home.

Access

Access is an important factor affecting utilization. The traditionally recognized components of access, (distance, time and money), all critical. In addition, access is related to the socio-cultural context as well as gender-related issues.

Distance: The urban population, which constitutes 58% of the total population, has relatively easy access to health services. Additionally, in rural areas, a considerable proportion of the population lives in small towns which have a district hospital or health centre. Other people live in communities with good accessibility to a health post or centre but not to a hospital.

However, those who live in remote areas, and who are dispersed in those areas, do not have easy access to health services because roads are so poor and/or it is difficult to obtain transportation. Ambulances, if they exist at all, are scare, not well maintained, and are not free to the patient. A system of radio communication has contributed somewhat to reducing the difficulties associated with distance.

Cost: Another important barrier to obtaining health services is cost. Both providers and service users mentioned that direct costs as well as the incidental costs of obtaining care (transportation, housing, food, etc.) were problematic. Moreover, women mentioned that it is impossible to estimate what the total charge of care will be because costs for medication and other procedures are added to the final bill. This creates anxiety because on the one hand, there are always "informal costs" to care while on the other hand, tests and procedures which are or perceived by the community to be unnecessary are ordered.

Only a few of the establishments we visited offered the clientele the chance to find out about the costs of the different services through posters or by direct information from providers. In others where a poster was visible, the information was incomplete and did not reflect "hidden costs".

Cost often dictates which kinds of services women seek. For example, in obstetrics, many women attend prenatal care in public sector facilities because it is free but prefer to deliver their child at home (delivery is not free in the public or private sector). Of course, as mentioned earlier, there are also a number of cultural beliefs about delivery which contribute to the situation.

The lack of prenatal care is seen as an important public health problem and many providers are using strategies to motivate women into obtaining prenatal care and having their delivery under medical supervision. For example, discounts for delivery are offered to women who attend 4 prenatal visits; other centres offer a discount of 75% off the cost of having a home delivery if it is done with supervision. Some hospitals offer material incentives to women who enroll in prenatal care.

The impact of cost on the accessibility of family planning is slightly more difficult to quantify. In general, there appears to be a correlation between price and methods chosen, both in the health services and pharmacies. In the

latter case, for example, pharmacists told us that the cheapest brands of pill, NORIDAY and MINIGYNON which are available through a social marketing strategy, sell more than any other brand of pill. Similarly, providers indicate that the popularity of the IUD relative to other contraceptive methods has a great deal to do with its greater cost-effectiveness.

Cost can be a limiting factor when it renders services inaccessible, but its influence varies depending on certain socio-cultural factors. For example, some people feel that anything that is offered free with no payment expected is *ipso facto* of low quality. The idea that what is most expensive is the best is reinforced within private medical practice. The statement made by a man we interviewed is illustrative. He said "a private doctor told me there are three types of IUDs: one that costs 20 Bolivianos which is provided in the hospital and it not very good, another that costs 40 Bolivianos and is so-so, and the kind that he provided which costs 60 Bolivianos and is the best. And that nice little doctor is the one who my wife goes to because I only want the best for her." The IUD offered in the public sector was the TCu380-A, the best IUD currently available.

The cost of care in the private sector is generally higher than in the public sector. Many patients prefer the private sector, however, because they believe it to be of better quality. Another important consideration is that the providers are more permanent in the private sector, while in the public sector, doctors performing their year of social service are constantly changing.

A few local initiatives have begun to develop alternative payment system for essential services in the public sector. Thus far, these limited efforts have been able to partially eliminate cost barriers without providing services completely free of charge.

Time: In rural areas, we found that clients do not need to have an appointment to receive care at health facilities. In some places, there are specific days on which reproductive health care is offered, and in general, these days coincide with market days. This allows providers to attend to people from distant communities, taking advantage of their business-related trips to the centre of a town.

Without a doubt, the time women need to get to health services is an important determinant in coverage rates. The majority of women have very little free time to go for care because of their overload of both paid and domestic work. In urban areas, arriving at a health centre may not take as long but waiting times at the services are longer than in rural areas. At the majority of sites visited, the routine is "first come, first served". The wait at hospitals can be two hours or more.

Some procedures, for example, an IUD insertion, require quite a bit of time and persistence. A woman has a consultation, receives counselling, has a Pap test done and waits for the results. Once she has the results and there are no apparent problems, she must wait until her next menstrual period for the IUD insertion.

Quality of Care

In the area of quality of care, our discussions were guided by the following questions: 1) What is understood by the term "quality of care"? What are some of the funda-

mental aspects of the definition? 2) What do providers consider good quality of care, do they practice it, and do they consider the needs and perspective of the users? and 3) Is the principle of free choice always applied?

The Secretariat of Health has highlighted quality of care as one of the basic elements necessary to achieve good implementation of health policies and strategies, and to obtain user satisfaction. The objective of providing high quality family planning service is specifically established in the *Plan Vida,* which also prioritizes attention to gender perspectives in public sector services. During our fieldwork, we observed the development of human resource training plans which incorporate the concept of quality in technical training. As a way to improve recordkeeping and supervision in reproductive health programmes, the PROISS project has implemented a quality of care model in more than 200 urban centres.

In an effort to analyse the situation of quality of care in Bolivia for this assessment, the elements proposed by Bruce (1990) were utilized with some modification. These criteria were also applied to the observation of obstetrical care where pertinent. The criteria used were: interpersonal relations, privacy, counselling, information, referral mechanisms, freedom of choice, and community outreach.

As with many issues of reproductive health, the concept of quality of care is relatively new in the context of the facilities we visited. This may explain the fact that for many providers, a full understanding of reproductive health care has not yet been attained. Similarly, an integrated concept of quality of care has not been developed and gender perspectives are practically nonexistent. Providers relate the concept of quality of care to a variety of issues including: improvement of infrastructure, humane treatment, privacy, reasonable waiting time, and counselling. We only found a few cases where providers referred to a complete and integrated focus on women as an element of quality care.

It is important to note that the lack of clarity surrounding the concept of quality of care also flows from the fact that emphasis in some services has largely been placed on increasing coverage rather than on *how* services are offered.

Interpersonal relations: Interpersonal relations constitute one of the fundamental elements of quality of care. Clearly, this element should not only be analysed on the level of client-provider interactions, but also include an understanding of the socio-cultural context in which services function.

Respect is a key ingredient of good interpersonal relations; respect means accepting and recognizing the other person they way they are. Generally, interpersonal relations are carried out within a context of social, cultural and gender imbalance. Most physicians are educated in a system which rejects cultural identities or in which some cultures are automatically associated with poverty and ignorance. In a number of the sites we visited, physicians indicated that women do not seek services because "that's how they are, ignorant," without questioning whether the real reason had to do with something they did not like about

the services provided. Some nurse auxiliaries also perpetuate discrimination, but others who provide services to those who are often discriminated against strive to understand their culture and attempt to get close to women to understand their needs.

At some service delivery sites, efforts have been made to accommodate the needs of women and respect their cultural norms. We observed this in particular at some of the institutions run by religious organizations. These services concentrate their efforts in offering prenatal, delivery, and postpartum care, as well as education and services for natural family planning methods (and occasionally the pill). It's very rare that these service sites offer the IUD.

At many church-owned service delivery sites, patients are treated very humanely, without discrimination, in a familial atmosphere. The relationship between body and soul is emphasized, which is important for legitimizing the beliefs held by some users. Continuity of care is greater in these services as well because of a lower rate of staff turnover. In general, the use of indigenous language by health personnel facilitates the acceptance and use of formal health services.

We also found some examples of good quality of care at SNS health posts where providers expressed great concern for how they took care of patients and how the patients felt. For example, one doctor in her year of social service felt she was very motivated in her work and that "quality of care for me means that the people receive the best care I can give them, that the patients trust me, and above all, that the patients like to come here and don't think it's so terrible to go to the doctor."

When we talked with service users and community members about interpersonal relations, we obtained a wide variety of responses. Some indicated they were satisfied with the treatment and care they received, while others were critical. There was general agreement that interpersonal relations between providers and clients need to be improved. For users, it is fundamental that they be able to put their trust in providers, services, and the system to help them resolve their health problems and other needs.

Various community members suggested that the trust level in services was very low or nonexistent. This mistrust emanates from the feeling that the medications prescribed and the operations performed are unnecessary; prices are very high and not related to the services requested; and the doctor that the community liked was changed, making it very difficult to develop a relationship with a new doctor each time. However, these attitudes depend on the situation or context. We found examples where people felt well cared for and understood within a short period of time of the arrival of the new physician. One woman who was at the health post for a prenatal visit said she had never felt as comfortable as she did now with the current doctor, who seemed to be truly interested in her. Her friends, sisters, and her mother were now coming to use the services.

In addition, we found some cases where language did not consti-tute a barrier because providers spoke the local language and thus created a more trusting and acceptable relation-ship with the users.

In some of the urban hospitals we visited, users indicated that they did not feel satisfied with the care due to the long waiting times, short consultation session, and a lack of communication on the part of the doctor. What was most often emphasized was the poor treatment given by all types of providers.to women who arrive with an incomplete abortion

Privacy: We found that the issue of privacy was taken seriously in almost all service delivery sites. Health posts offer a greater degree of privacy than hospitals because in the former, there are fewer personnel and generally better attention paid to maintaining privacy. Even in posts with the most precarious conditions for offering services, exam rooms with doors are separated from waiting rooms.

For some providers, privacy is one of the most important elements in quality of care and they take great care in assuring that private changing areas and adequate smocks or gowns are available. It is important to point out that privacy is much more than having a good physical space. For some women, it also means not being forced to share a room with others. For others it is related to the position in which they are in during childbirth, a position which does not force them to "expose themselves".

Counselling and information: Counselling and information giving are two intertwined elements of quality of care. In general, neither of the two is very well implemented in obstetrical care and family planning services. Supportive educational materials are not available, especially in rural areas. We found some regional differences; in some places, counselling is more informative and the staff is better trained to offer it. A good example is in Valle Alto in Cochabamba where the entire staff has received training--this includes the non-technical personnel such as the custodians and drivers who are often good sources of informal counselling. Likewise, in some cities, service delivery sites have a complete and even complex system for counseling. However, the impact of such initiatives has not yet been measured because they are so new.

In general, we were not able to find evidence among providers of the concept that counselling should be centred on the needs of the woman. Counselling generally does not facilitate a better understanding for women of their bodies, or sexual and reproductive rights which could help them make informed health decisions. In those places where auxiliaries provide counselling, there is no evidence of any type of coordination between the information they provide and that given by the physicians during the consultation. Counselling is directed at pregnant women and their children, and rarely towards adolescents, men or couples.

At some health centres, there exists a confusion between counselling and information giving, as some think mere information is enough. When counselling is provided in the services run by religious sectors, it is sometimes biased. Information giving is often limited to the handing out of pamphlets which are rarely read.

Referrals: We found virtually everywhere we went that the referral system did not necessarily correspond to expected standards. Among the problems with the system is the fact that doctors make arbitrary decisions about where to send patients while the

capacity of service sites to resolve problems varies considerably.

We found one extreme case where a doctor at a moderately equipped health centre sent all her patients to the hospital in the neighboring community. Other doctors who work in the public sector channel patients to their private practice. The poor referral system reduces quality as well as the prestige of public health ser-vices. In addition, adequate referrals are often hindered by a lack of ambu-lances or transportation in general. In the case of acute obstetrical complications, this lack of referral mechanisms is contributing to the lack of progress in reducing maternal mortality.

Choice: The freedom of choice is an important element of quality obstetrical and family planning care, above all when we look at issues of method mix or the choice of a childbirth position. In general, we found that the concept is not well understood by providers, despite the fact that many indicated that free choice is an important component of quality and that women should have the right to choose.

In regard to family planning, providers often influence the opinion of women or couples on certain methods and perpetuate a series of myths about them. Also we found that providers decide the best method for a woman or couples based on the perception that "they don't know, they aren't able to decide, they are ignorant." Furthermore, some providers avoid broaching the subject of family planning among those women with low levels of education.

At most service delivery sites, a spouse must give permission for an IUD insertion or a tubal ligation. Another barrier restricting choice, however, is the mere lack of supplies or appropriate training of providers. This causes the couple or the woman to seek services from private providers or pharmacies. Those who go to pharmacies are unlikely to have access to follow-up care or at a minimum, assurances that they will receive instruction on how to use hormonal methods properly.

Overall, then, we cannot conclude that there is true free choice in Bolivia. Choice is limited by several factors including the availability of methods, nonexistent or inappropriate counselling, and the cost of methods.

In the area of childbirth, we found that at most rural service delivery sites, when women use health services, they are allowed to have their husband or other relatives present during labour but not always during delivery itself. This is not true of urban facilities, where the accompaniment of family members is rarely permitted during any phase of childbirth. The position in which a woman delivers is almost always imposed on her; women are not asked which position they would prefer. At some service delivery points, the delivery tables are very uncomfortable. When doctors were asked if they would let a woman have her baby while seated or squatting, they said they would permit it if the women brought "something" to put on the floor, but never indicated what that something might be or where it could go in the room.

Community outreach: Community outreach is an element in quality of care because it can dictate the ability of the system to confer services and information (appropriate constellation of services) as well as provide

mechanisms with which the population can make decisions to protect their health and obtain services to resolve their health problems.

Health promoters, traditional midwives, nurse auxiliaries, and to a limited extent doctors, are currently offering community-based education. Nurse auxiliaries receive instruction on how to perform this task as part of their regular training. Community-based activities have been broadened with the implementation of the Reproductive Health Strategy. However, there is ample evidence of the need and demand for more of this type of work.

Our observations indicate that community outreach has only been partially implemented; in the area family planning, it is poor or non-existent. This is in spite of the fact that nurse auxiliaries are trained and interested in doing it.

Conclusions and Recommendations

One of the major problems inhibiting access to services is the insecurity and ambiguity related to the total cost. This suggests that prices should be published and enforced. Given that the country now has the SAFCO law, which is being extended to include the health sector, it is important to adapt new rules for financing and accounting within services. Prices charged to the client are just one element of this. A first step could be the introduction of receipts in order to document all transactions and sales, but ultimately, each service delivery point will have to be responsible for balancing its accounts.

In spite of the fact that there are some logistical problems, the distribution of contraceptive methods within the network of services is efficient, although not necessarily so for all medications. Practically all health facilities have at least two or three methods, including the IUD.

Interpersonal relations need to be improved as does general quality of care. Respect, as well as intercultural and gender-based dialogue, need to be strengthened. Norms for quality of care and counselling should be developed. These should include an emphasis on free choice in relation to contraceptive methods, the position in which a woman can deliver a baby, and other practices valued by the community.

The concept of respect for the needs of users and for cultural traditions of each ethnic groups should be included in University-level training. It would be helpful to fully identify and diffuse information on the knowledge, attitudes and practices of the different ethnic groups in the country so that a process of dialogue can be initiated with the goal of strengthening intercultural and gender relations. The curriculum for physician education should include sociological and anthropological perspectives, together with a focus on gender. Students should be offered the opportunity to learn native languages and traditional medicine practices.

On-going training in all aspects of reproductive health should be included in guidelines for human resource development at the local level. Under Article 16 of the Law of Popular Participation, municipalities have a critical role to play in assuring that investments are made in training programmes.

Counselling on the method mix should be related to the true availability of methods and include the possibility of being referred to a health centre or hospital for some methods. In large urban hospitals with high levels of demand, it is essential that a space be made available to conduct counselling as well as personnel specifically assigned to offering it. When these conditions are not available, counselling does not occur or is poorly administered. Good counselling plays a key role in increasing the access of women and couples to family planning.

In the regions where we detected an unmet demand for injectables, we would recommend a strategy for introduction of the method within the public sector which includes systematic research. This introductory effort should not only strengthen the delivery of injectables but improve quality of care in the provision of all methods.

The mere existence of clinical services is insufficient for reducing maternal mortality and for offering integrated services to women. We recommend that a systematic study be undertaken in conjunction with community members which examines appropriate ways to execute a community outreach programme. This is part of an effort to find creative strategies for taking reproductive health to the people in a way which responds to their real needs and expectations.

Technical Capacity

The assessment of technical quality was carried out using a list of criteria developed during the preparatory fieldwork. A general description of each item is followed by key observations, especially where we found some unusual characteristics within or between regions.

Prenatal Care

Materials: We found, almost without exception, that service delivery points had available at least the minimum level of essential equipment and material for obstetrical care: stethoscope, fetal stethoscope, blood pressure gauge, scale, and obstetrical measuring tape. However, at some facilities, personnel complained that either the scale, the blood pressure gauge or both was broken or inaccurate.

The perinatal clinical history card deserves a special mention. It is available at almost all the facilities we visited and in the majority of cases, is being filled out by the staff. Nevertheless, it appears that neither the health workers nor other personnel utilize the tool for its intended purpose. Decisions are not made based on the instructions printed on the card. The card is seen as a requirement or routine registration mechanism rather than an instrument for selecting the appropriate actions to be taken during the prenatal period, especially where a high risk pregnancy is identified.

Characteristics of prenatal care: Following the Secretariat of Health's guidelines, prenatal care is generally available on demand. Waiting times vary; they are longest at large urban hospitals (between 1 and 3 hours) and shorter at rural service sites. However, in the rural setting where personnel is scarce, waiting times can be much worse when the physician or nurse is out making a house call or has another commitment. At a few locations we found that prenatal care was not available all the time because services are organized on different days of the week, limiting prenatal care to twice or three times a week.

Women initiate prenatal care at different stages in their pregnancy, but the national average indicates that a significant percentage (55%) initiate care in the fifth month or later. There is also a fairly significant percentage of women who only receive one prenatal visit and few pregnant women (30%) attend the four recommended consultations. Women in Santa Cruz on average go to the most prenatal visits while women in La Paz the least.

In the majority of cases, all of the clinical activities that should be carried out in a prenatal exam are performed in accordance with established norms, including blood pressure measurement, weight, uterine height, and fetal heart beat and blood pressure. However, little attention is paid to the quality of the measurements or to communicating with patients. This is due in part to the fact that the time of an average consultation is very short. Complementary laboratory exams are only conducted in referral hospitals because other facilities only have the materials for some tests or do not have any materials at all.

The most serious deficiency found was that of low coverage for tetanus toxoid vaccine among women of reproductive age, including pregnant women. There has not been a systematic effort to educate either the public or providers about the importance of the vaccine. Women we interviewed did not understand the significance of the vaccine, nor the disease itself, even though we were told that the incidence of tetanus is increasing at service delivery sites in rural Santa Cruz.

As discussed previously, the underutilization of the perinatal obstetrical card results in a lack of emphasis placed on the detection of high risk pregnancies. This in turn has meant that a system of efficient referral of these cases has not been implemented. In general, women are referred to a better equipped health facility only if they experience complications during delivery. Very few women receive inpatient care during pregnancy.

Delivery and Postpartum Care

Availability of materials and supplies: In general, there is an adequate supply of basic materials at health facilities. The vast majority of service delivery points have sterilized delivery packets, instruments, and essential medicines for delivery. However, there are some facilities that did not have essential medication for deliveries. Several hospitals are able to maintain a stock of essential medicine only by making consignment agreements with the commercial sector. Generally there are no special materials available for attending deliveries in non-gynaecological positions.

Disinfection/sterilization norms for materials are generally followed, yet some deficiencies remain. At virtually all service delivery points visited, we found problems with the disposal of needles and other sharp objects which could have been contaminated.

One major problem is with the availability of blood; only more complex hospitals have it and there are no controls in place to assure that blood is not infected with the hepatitis B virus or HIV.

Treatment of patients: Personalized and humane care for patients is variable depending on the type of service. However, we were able to detect some common attributes among services.

The majority of physicians are trained in normal delivery and in the maintenance of reasonably good levels of asepsis. However, a significant proportion of doctors have not received instruction in how to attend deliveries in the positions traditionally used by some women. This is due in part to a lack of emphasis in the curriculum of medical schools but also to an authoritarian attitude expressed by many providers which tends to lead to the rejection of cultural views and traditions other than those held by providers.

In most cases, family members are allowed to accompany a woman during labour, and women can be mobile during this period. Permission for husbands or other family members to approach the delivery room is generally very limited. This is not due to a lack of space or dressing gowns but rather, as mentioned above, the attitude of doctors who are committed to following

the technical norms they learned where they were educated. For example, at the maternity ward of Percy Boland hospital in Santa Cruz, husbands are not allowed in the delivery room because it is a training hospital and there are usually already several people in the room. The husband is seen as a disturbance to the other professionals.

The bringing of food to patients is generally acceptable; at some rural hospitals, it is a necessity because the facilities lack the resources to provide meals to patients. In many cases the pregnant woman is accompanied by her entire family when she goes to the hospital to deliver; this implies that the patients' family is responsible for feeding several people during her stay.

The team observed that, in some areas, the premature rupture of membranes during delivery was practised and oxitocins were occasionally administered. There appeared to be some reticence to recognize that analgesics are used routinely; the majority of physicians said they did not administer them. However, the team felt that this may not reflect actual practice The norms of the SNS currently in effect recommend that a rigorous evaluation of the risks and benefits of using analgesics during labour be carried out.

One interesting finding we made was that doctors have different medical practices for obstetrical care based on where they have studied medicine. Many have studied in neighboring countries (principally Chile and Brazil) or at different Bolivian universities. Each location appears to teach different practices and as such, each doctors follows different norms depending on where he or she was educated. The Secretariat of Health (SNS) through the National Directorate for the Health and Nutrition of Women and Children has initiated a process of review and development of a number of practice guidelines for all levels of care.

Capacity to Resolve Obstetrical Emergencies

For the most part, the surgical capacity installed at higher level health centres is sufficient with regard to equipment and basic materials. However difficulties remain for facilities in the resolution of obstetrical emergencies requiring a caesarean. The operating rooms in district hospital, with a few exceptions, are deficient. Several of the supporting hospitals at the district level do not have surgical capabilities due to a lack of infrastructure, trained personnel, or both. One critical issue we encountered is a dearth of personnel at the district level trained in the administration of spinal anaesthesia. There is a critical lack of anaesthesiologists, particularly in rural areas. Even in urban areas, lack of funding for anaesthesiologists and the low salaries paid to them in the public sector create a serious shortage.

As was already mentioned, control over the blood supply for lower level service facilities is very poor and a potentially serious problem. Likewise, in higher level facilities, an uncontaminated blood supply is not guaranteed because there are no donor directories.

Another problem found at less complex facilities is the lack of containers for blood and the inability to label them. Thus, even if a donor is available, a transfusion may not take place because of the lack of equipment. We were told that in some areas there is culturally-based resistance to donating because blood is considered sacred.

Local referral systems varied in their capabilities. There appears to be a tendency toward very late detection of pregnancy complications, which frequently leads to the delayed referral of difficult cases. This contributes to the high rate of maternal mortality; some deaths could be avoided if patients were transferred to a better prepared hospital earlier on the pregnancy or delivery. In Santa Cruz, for example, more than half of maternal deaths occur among women who are referred from other facilities and arrive at the regional hospital already near death.

Problems with referrals are not limited to the district level; there are serious deficiencies among the majority of reference hospitals as well. There is a lack of personnel, materials, and laboratory support for treating obstetrical emergencies.

Finally, we found a general tendency of providers to pay more attention to the mother than the newborn.

Family Planning

There is a great deal of variety in the level of training of physicians in family planning. Even among those who said they had received instruction, many harbour a series of attitudes that reflect preconceived notions about contraceptive methods and family planning in general. A majority of physicians are not well educated in most aspects of contraceptive technology. This means that access to methods is often dependent on the preferences, prejudices or knowledge of physicians. Most providers have not internalized or incorporated into their work the concepts of counselling and free choice. However, among those physicians trained in family planning, there is general consensus that it is extremely important to broaden the range of methods available to the public, especially injectables. Only Depo-Provera was mentioned by name.

Obviously, the weakness in technical capacity among most medical personnel is reflected in the low level of acceptance of contraception by the population and relative acceptance of some methods over others.

Surgical sterilization deserves special mention here. Many physicians are willing to practice tubal ligation, but are unable to because they do not have the assistance of an anaesthesiologist. Others have not learned the mini-laparotomy technique which can be performed under local anaesthesia, and is highly successful especially in the postpartum period. Materials to perform a minilaparotomy are also lacking. This means that tubal ligations cannot be carried out even in cases of high obstetrical risk, an indication accepted by the Secretariat of Health.

Equipment and supplies are available for offering a limited number of contraceptive options: the IUD, the pill, and condoms. We found that a normal Pap test result was required of all women before an IUD insertion was performed, which serves as a barrier to the use of the method. This norm was established four years ago when a broader range of contraceptive options was introduced into the public sector. The new norms, which have not yet been published, will not contain this requirement.

Family planning counselling is not available at most service delivery points due to a lack of trained staff. Doctors are generally not inclined to perform

counselling duties. Among those counsellors who are trained, most are well prepared in giving advice but have a poor understanding of the technical aspects of contraception. Because they have good communication techniques they are able to guide women into electing a method of their choice. However, they are often unable to allay the fears and doubts women have about methods. Because many of the counsellors come from the same cultural context as the users, they have been exposed all of their lives to the same taboos and preconceived notions about contraception. Without a good technical knowledge counsellors often do not have the necessary tools to dispel the strongly rooted beliefs they encounter.

One example, which we found among the counsellors we interviewed in Santa Cruz is, is that almost all counsellors believe that the IUD increases the risk of cancer. Those staff trained in counselling do not use their expertise in other areas of reproductive health outside of family planning.

The absence of educational materials for family planning in virtually all of the service delivery sites we visited was striking. All of the counselling providers referred to this lack as a serious impediment to their work. At a few sites, nurses or auxiliaries had created their own instructional materials using local resources.

Sexually Transmitted Diseases

We found major deficiencies in the area of STD services. Because STDs are part of another entity within the Secretariat of Health, the Integrated Women's Health Care Programme does not have jurisdiction over this area. Coordination between the divisions in the SNS is very poor.

The most frequently encountered STDs within SNS facilities are: syphilis, gonorrhoea, trichomoniasis, genital warts and bacterial vaginosis caused by gardernella.

The materials necessary for diagnosis, treatment and epidemiological registration of STDs are not adequate. Educational materials including posters from WHO, which could be very useful for diagnosing these diseases without laboratory resources, are not available. Virtually the only materials available in sufficient quantities is penicillin benzathine, which is used more or less indiscriminately and thus precipitates the creation of antibiotic resistance.

The current situation basically leaves women without any preventive or curative care for STDs. Syphilis and gonorrhoea, which are more difficult to diagnose in women without laboratory backup, largely go undiagnosed and treated.

The service delivery system lacks the capacity to detect and perform follow-up of infected partners. Treatment or referral for STDs is virtually nil because laboratories do not exist in areas with the highest prevalence. Personnel are only able to detect STDs using their clinical knowledge, and in the best of conditions, using VDRL. Medications for treatment are not available either, which means that doctors must write prescriptions and patients obtain the treatment through private pharmacies. The SNS only has a laboratory to perform STD cultures in the city of La Paz due to restricted resources for purchasing reactives.

HIV/AIDS detection by ELISA is not carried out except in cases where the potential carrier strongly suspects he/she is infected. This service is only available at two centres in the country (Santa Cruz and La Paz); positive tests are confirmed in Brazil. On an institutional level, the SNS has made a few hospital wards available for the treatment of AIDS patients, but most of its energy in the area has gone into the diffusion of information and the promotion of preventive measures. This includes the promotion of condom use.

Detection of Cervical and Uterine Cancer

Within the framework of the Integrated Women's Health Care Programme, detection and control of cancer in women is an important component. Still, activities as of yet have not been able to reduce the high rates of cervical and uterine cancer estimated at 154 per 100,000 women ages 35 to 64 in Bolivia.

There have been some advancements in the introduction of cytology laboratories and cervical cancer centres in some of the regional hospitals. This first phase was designed to guarantee the quality of cytological diagnosis. Norms and procedure have been defined in coordination with the scientific community. The *Caja Nacional de Salud* (Social Security), has made cobalt therapy available free of charge for women with detected cancers. However this does not solve eliminate other barriers to care (transportation, housing, etc.).

At several sites visited, materials for taking Pap tests were not available nor were the appropriate materials for sending a sample to the laboratory. Little effort is given to what is often an impossible task: locating patients with positive results. Women are asked to return to the clinic to retrieve their results, which in cases of a negative test leads to unnecessary visits to the health centre. Coverage for the test is currently low and it is not clear that the health system is prepared to process the number of new samples which may result if Pap campaigns are successful.

Conclusions and Recommendations

The SNS should:

Broadly diffuse information on the norms for using the clinical history card, and if possible hold workshops at the local level on its utilization and processing by computers in hospitals.

Motivate physicians in the detection of high obstetrical risk during prenatal care in order to allow for timely referral of cases to more highly specialized centres.

Create or comply with the norms that already exist in the area of referrals for obstetrical complications.

Revise the national classification for high risk pregnancy.

Consider organizing a regional and local subsystem for maintenance and removal of equipment such as scales, stethoscopes, refrigerators and others, based on the availability of personnel such as drivers at the district and regional level.

Strengthen the application and registration of tetanus toxoid vaccine during pregnancy.

Train physicians for childbirth delivery in alternative positions, but first ensure that there is acceptance of intercultural diversity and practices at the institutional level.

Create a national level effort to improve the availability and quality of the blood supply.

Broaden the range of contraceptive options available. The majority of physicians interviewed believe that at a minimum, the injectable should be incorporated into the existing method mix.

Eliminate the unjustified requirement of a normal Pap test result before an IUD insertion which constitutes a barrier and limits the use of this method.

Train physicians in the performance of postpartum minilaparotomy for tubal ligation and/or the use of spinal anaesthesia. This could solve many contraceptive problems, especially among women at high obstetrical risk.

Train providers in the administration of spinal anaesthesia, which will enhance the ability of services to resolve obstetrical emergencies.

Improve technical training for counselling providers though reinforcement courses specifically directed at eliminating taboos. The use of culturally appropriate reasoning and arguments should be stressed.

Administrative Capacity

Human Resources

Availability of personnel: Clinical personnel at SNS health facilities include physicians, nurses (registered and auxiliary), dentists, nutritionists and biochemists. In many rural areas, the Secretariat of Health has trained voluntary community health promoters (RPS); in some cases NGOs support these workers financially. In the cases where the SNS has an agreement with the Church to provide services, both share the responsibility of payroll for health personnel.

There is a general perception among providers, some leaders and members of the population that there is a lack of staff at SNS health centres. Our fieldwork did not have the capacity to detect whether this was a reality or not. However, our work did indicate that there is a lack of nurse auxiliaries for developing community outreach activities. Home visits carried out by auxiliaries are infrequent in the areas we visited. This is because one auxiliary often has the responsibility of providing services and information to a large number of communities, some of which are very distant from the home of the nurse. When the only auxiliary nurse is in the field or otherwise absent, the health post remains closed and no care is available to the community.

Assignment of personnel to different areas of the country based on population size or need does not appear to be taking place. We found cases where health centres claimed to offer 24 hour obstetrical care, but where in reality, the physician is not available at night or during meal hours. In other instances, a doctor is present but does not have an assistant and cannot perform some important interventions for obstetrical care.

Most of the district hospitals we visited had neither an ObGyn nor a pediatrician on staff. As noted above, there is a general lack of professionals trained in some procedures including caesarean section. The absolute number of physicians in Cochabamba, for example, is sufficient but a lack of anaesthesiologists impedes the available doctors from performing caesareans and other minor operations. This is also the case at the maternity centre of the Percy Boland hospital in Santa Cruz and the Women's Hospital in La Paz.

The SNS tries to work within the concept of a service delivery network, which includes collaboration with private clinics and those run by NGOs. In one region in Santa Cruz, for example, private physicians perform surgeries at the SNS hospital, registering their activities and generating income for the hospital. Yet in Cochabamba, in various places, private practitioners offer reproductive health services including obstetrical care and family planning in facilities in much worse conditions than those of the hospitals and posts of the SNS. This is not an uncommon occurrence and in these cases, SNS hospitals could take advantage of their superior facilities, generate funding, and improve their reputation by inviting private providers to collaborate and perform some

procedures in the SNS hospitals.

Job descriptions and training: In the last two years, considerable advances have been made in the establishment of national level training programmes in reproductive health for physicians and nurses. In spite of this progress, we found that there is still some incongruence between staff training and their corresponding job descriptions and defined responsibilities.

Some providers who have been formally trained for example, have problems applying their technical knowledge to actual practice. The application of knowledge and skills to practice is limited to some extent at an operational level by certain ambiguous norms. The power given to physicians often impedes nurses and nurse auxiliaries from carrying out functions such as delivery care and IUD insertions, even when they have been adequately trained to do so.

Another staffing problem faced by hospitals is poor continuity of activities due to high rates of staff turnover. In Bolivia, a large percentage of professional personnel in rural hospitals is comprised of physicians and nurses performing their obligatory year of social service in the community (*año de provincia).* This circumstance has direct implications for the quality of reproductive health services. As mentioned above, medical and nursing school curriculums include reproductive health training; however, the technical competence of any provider ultimately depends on practical experience. Thus the rotation of medical personnel in hospitals implies an annual influx of novice providers which can compromise the quality of care given at these facilities.

One solution to this problem would be to enable nurse auxiliaries working at health posts to offer reproductive health care. This could improve the provision of services to isolated areas and represent a critical step in assuring that rural men and women have immediate access to the services they need. In contrast to rural physicians and nurses who are constantly rotating, nurse auxiliaries often come from the same community where they work and in some cases, are paid a salary by the local population. We found several nurse auxiliaries who are extremely dedicated to their work and their communities.

Unfortunately, despite the commitment and desire to offer a wide range of reproductive health services on the part of nurses and auxiliaries, national norms still restrict their ability to do so, especially in offering modern contraceptives.

Job performance: Given the current deficient nature of the selection and hiring process for personnel--similar to that of the lack of defined roles for different levels of care and type of staffing-- it is virtually impossible to evaluate job performance. The new norms should be spelled out during the implementation of the new health care model.

We encountered numerous cases in which the staff was found to be insufficiently trained in their multiple responsibilities. This is likely due, at least in part, to the lack of competency exams or merit reviews for staff. Another factor may be that the only requirement to obtain the position is to

be a graduate of medical or nursing schools.

Staffing problems greatly impact on the capacity of services to solve health problems. The lack of technical competency of staff creates an under-utlization of available supplies and medical equipment available, and masks the growing need for newer and better devices.

Another issue related to insufficient training of personnel relates to the treatment of patients. We were told of many situations in which SNS staff discriminated against some patients, expressed disrespect for and disinterest in their problems, verbally and physically abused clients, and forced them to wait excessively long for a visit. Both the quality of the personnel as well as the treatment they afford the population contribute to a lack of credibility and appreciation for health services expressed by members of the community. These attitudes towards services profoundly affect coverage levels as well as the network's ability to detect and resolve obstetrical emergencies.

Activity Planning and Programming

Currently, the National Secretariat of Health has an inadequate capability to program, organize, and supervise the efficient use of resources intended to meet the objectives of integrated women's health care at the regional and local levels. It is difficult to even obtain information on the underlying objectives at these levels; those goals defined at the national level are not sufficiently disaggregated to meet local needs.

In the last few years, several advances in the organization of local health activities have been made. However, priority is still placed on obtaining easily quantifiable objectives with less attention to qualitative changes which cater to the perceived needs of users such as clinic hours, home visits, and humane childbirth care.

The Law of Popular Participation demands a more complex yet more useful process for programming services/events at the municipal level. This system permits local health services to focus their attention on their most urgent needs. This autonomy has the potential to make activities related to reproductive health more feasible.

With the cooperation of a variety of national, regional, and local sectors and institutions, local and regional strategy planning workshops have been conducted with the objective of defining goals and local activities for reducing maternal, infant and under-five mortality. These workshops are intended to establish links between national norms of health care for women and children and the participatory process of policy definition at the local level. During 1994 and 1995, the process has permitted the interested actors in the health sector (health personnel, community organizations, and municipal governments) to learn and understand the objectives of national policies, and to develop ways the carry them out in a participatory manner.

Organization of Local Health Services

Even though we did not investigate this area in depth, we were able to observe

that the organization of local health services is a matter requiring review and fundamental adjustment given the existence of such a diversity of providers, distinct local realities, and financial arrangements with donors. This diversity makes it extremely difficult to ensure that efforts are not being duplicated.

Through agreements with the government, church organizations and NGOs offer services that in many instances have a comparative advantage over the public sector. Private entities are able to make their own decisions about the use and control of resources, and plan accordingly for optimal utilization of services. These institutions have the potential for better utilization than public sector facilities. However, in reality, many NGOs services are poorly designed and underutilized. The high degree of freedom contributes to a lack of coordination with other sectors.

In the area of financing, the Church and other NGOs have greater agility in their management processes (including payroll) and can therefore assure better motivation of their personnel. On the other hand the SNS, as a normative institution, must place a great deal of energy into coordinating and reaching consensus, supported by the participation of community groups. Given the existing situation, it seems advisable that district level authorities be empowered with the capacity to set guidelines and to establish and evaluate a true network of services instead of maintaining a hierarchical relationship with the SNS. This would help to respond to current conditions and strengthen each entity in the network to improve the utilization of its resources.

Supervision, Evaluation and Monitoring

Coherence between these three components, supervision, evaluation, and monitoring is vital for a successful system of feedback and adjustment. The weaknesses in the supervision system results from the same conditions that affect the entire service delivery system, namely poor roads, lack of transportation, a scarcity of funds to offer per diem to supervisors, and insufficient training.

Some service delivery systems financed by foreign donors or NGOs have been able to overcome the above-mentioned difficulties. However, the concept of supervision is still very diffuse, especially in the understanding of the objectives and the contents of a supervisory visit. We perceived that supervision visits conducted do not utilize the opportunity to jointly identify and resolve problems at the service level nor to establish an in-service training process. The absence of technical elements and clear objectives in the supervision is equally notable.

Additionally, given the series of conditions that make supervision with regularity difficult, visits should be done with several service delivery points at the same time. This would facilitate an exchange of information between providers on important matters such as preferences for certain contraceptive methods, demand for contraception, complications encountered with their use, etc.

In other cases, indirect supervision via monitoring will allow focused attention to areas with the greatest needs. When

monitoring is carried out, it is almost always focused on management. Supervision is based on quantity and distribution of services and not on qualitative measures such as technical competence or service-giving. This finding reinforces the perception of the central coordination team of the Integrated Women's Health Care Programme that it is necessary to involve specially trained physicians from regional hospitals in the process of supervision at the local level.

In regards to monitoring, significant advances have been made using the information from the *SNIS* (National Health Information System). This system allows for the collection of health data including the correlation between supplies administered and number of users. In general, the data is analysed to identify coverage levels, but not ultimately used to make decisions on the control of supplies and equipment. Indicators could potentially be used to clarify staff output/efficacy with the intent of programming personnel schedules in a more rational way for meeting client needs.

The concept and practice of evaluation is very new at the local level. In cases where evaluations are performed, they are done to satisfy the requirements of donor agencies. Periodical evaluations have not succeeded in generating ideas for adjustments in the administration of services.

Finally, we should mention the issues of quality control and user protection. Currently, there are very few opportunities for the system to insure that personnel are performing well, even in urban areas. There is no internal system for guaranteeing that supplies and equipment are appropriately used, or that income generated from the sale of services is controlled. It is possible that with the Law of Popular Participation, mechanisms will be developed to reduce cases of inefficiency and negligence in the administration and management of health services.

Logistics and Supplies

As mentioned earlier, we found that basic supplies were generally available at service delivery sites for attending childbirth, although there were some problems with the availability of sterilized packets and surgical gowns. Condoms and contraceptive pills (MINIGYNON) are on hand in the majority of SNS health posts, centres and hospitals visited by the team. In addition, the Copper T 380A IUD is available at many facilities, although in some there is still no provider trained in IUD insertion.

The system for ordering family planning supplies is generally good, although the team noted some limitations with the stock of pills. On the other hand, materials needed to perform Pap tests was not available in many facilities.

The team visited two regional supply centres, *Unidad Regional de Suministros* or URES. Two distinct lines of medications exist within the URES system: one intended for special programmes includes free medications which are distributed by those individuals in charge of regional programmes. The other, which includes low priced essential medicines, is directly distributed by URES. Attempts are made by URES to maintain a stock of some medications in only one of the two lines in order to avoid any conflicts arising between free and for-charge items.

Essential medicines are distributed to district health facilities and in some cases, directly to smaller health areas. The resources for the payment of these deliveries can be obtained from funds from the sale of services to the population, resources of the municipality, or moneys resulting from special projects such as PROISS, PSF and others. In the case of Santa Cruz, for example, each year the Regional Secretariat of Health orders a certain supply of family planning methods and turns them over to the district health authorities. Every three months thereafter, depending on need, districts order supplies directly from URES. URES then takes responsibility for making sure the items arrive at the district level, or in some cases, the district health officer goes directly to the city of Santa Cruz to pick them up.

Another way to purchase medications and supplies is on credit in quantities of no more than 5,000 Bolivianos (approximately US$ 1,000). The cost to the consumer of essential medicines is 5% of their value which helps slightly to defray costs to the health system.

The URES in Cochabamba accepts the return of medications that are near their expiration date or that have not been used, including contraceptive pills. The Central Storage Facility (CEASS) in La Paz has the same system. Pills and IUDs are considered part of both the essential medications/ supplies line as well as the special programme line. Each Tu380A IUD carries with it a cost of 6.30 Bolivianos (US$ 1.20) while each cycle of pills costs 1.85 Bolivianos (US$ 0.35). The same pill and IUD brands are offered through both types of procurement mechanisms.

Essential medicines are sold at a price to the district level; another price is charged to the facilities in the smaller health zones, and another to the client, each time with a slight elevation. It appears that little flexibility in the purchase of medications is given to patients who do not have resources. Some supplies are free to the consumer including pills, condoms, and IUDs if they are part of a special programme. However, the client must pay for the consultation and insertion of the IUD. In addition, many facilities require pill users to consult with the doctor in order to simply obtain a new cycle.

There is a widespread belief that condoms and pills provided by the SNS are of low quality or past their expiration date. Perhaps as a consequence, we found in our clinic visits that other lines of contraceptives, from the commercial sector or donors, were in stock along side the SNS essential medicine supply of methods. This could imply a higher cost to the consumer (presuming that all methods are priced at the level of the commercial supplies) and a deviation from SNS care norms.

Other Service Providers

The *Caja Nacional de Salud* (Social Security) provides services and contraceptives in a different way than the SNS. The *Caja* acquires its own medications and supplies at the national level and then distributes them directly to its various regional offices, which then distribute the supplies to their respective clinical facilities. However, some medications and programme-specific items (refrigerators, vaccines and antibiotics) are received directly through

programmes of the SNS. The national level *Caja* procures its contraceptives from direct donations.

Several of the NGOs working in Bolivia offer vaginal foaming tablets, foams, injectables, various brands of pills, condoms and the Copper T IUD, as well as tubal ligation in some cases. Some of these organizations receive their supplies directly from international donors such as USAID, Pathfinder, and others. In other instances, for example in Cochabamba, URES distributes contraceptives to an umbrella NGO organization called *ASONGS,* which then assumes responsibility for assuring that supplies are distributed to its affiliates. Generally, URES does not directly provide medications from special programmes to the NGOs but will offer essential medicines to them on the condition that these organizations are regular buyers and obtain more than one item of medication.

Private pharmacies, especially urban ones, have several brands of pills, condoms and two to three brands of injectables (Depo-Provera, PERLUTAN and MESIGYNA). Pills cost between 3.50 to 35.00 Bolivianos (US$ 0.70 to 7.00), with the exception of Diane 35 which can cost up to 70 Bolivianos (US$ 14.00) per cycle. The price of condoms ranges from 0.50 to 2.00 Bolivianos (US$ 0.10 to 0.40). Depo-Provera 150 mg costs approximately Bs 17.00 (US$ 3.40) while a pregnancy test costs Bs 35 (US$ 7.00). Our team found that some pharmacies offer hormonal regulation products such as LUTOGYNESTRIAL (Bs 7.00 or US$ 1.40) as a "pregnancy test", but members of the population buy it hoping it will provoke a miscarriage.

Traditional midwives, who attend approximately 10% of deliveries nationwide, provide pieces of cloth, towels, soaps, thread, herbs and other items on an individual basis. Those midwives trained by the SNS use special delivery packets which contain a diaper, two pieces of gauze, two strands of thread, a razor blade, and a piece of soap. In addition, they receive a bag with extra items including a small scale, a soap dish with soap, a small box of razor blades, and extra gauze bandages.

The provision of delivery packets, including ones especially designed for deliveries attended by family members, is not part of the regular supply system, although it is provided free of charge and carries with it the stipulation that the user return the information about the birth to the health centre.

Educational Materials

The SNS has been able to achieve a widespread distribution of posters on reproductive health. At the moment, however, most of the SNS facilities, especially those in rural areas, lack educational materials including flip-charts, videos and other items to conduct group sessions and individual counselling. Additionally, there is some doubt as to the adequacy of materials for different socio-cultural settings and regions.

Providers complained about the absence of educational materials or where available, the small quantity of them. They also objected to the use of messages and illustrations which are unfamiliar within local customs. Local initiatives to develop materials have also been limited, although we found some centres where providers had created educational materials appropriate for the local population. In one

area we visited in Cochabamba, the community runs its own television channel and is anxiously waiting the arrival of educational videos from the Secretariat of Health. This sort of local effort is likely to be widespread.

In general, the scanty availability of written materials (flip-charts, posters, pamphlets) is also reflected in the availability of other IEC activities including the posting of signs, the making of public announcements, and the holding of discussions. These, if systematically organized and well positioned, could greatly improve the utilization of services. We found some service delivery sites which did not have a single announcement about women's health. In the newer and very well maintained centres, there is a tendency to avoid hanging anything on the walls in order to keep them pristine; usually no other space is available for education/communication materials.

Conclusions and Recommendations

The current reorientation of the government and hence the health system places the local level in a key position for creating activities to improve integrated health care for women. This implies strengthening the administrative capacity of municipalities and intermediate levels of administration of health services. Human resources (personnel) are seen as the central elements in bringing about this change; this will be achieved through a definition of their roles and competencies as well as through improvements in training and effort.

Although certain advances have been made in the training of personnel in the offering of reproductive health services, there is still no clear definition of their roles and functions at the operational level.

We have highlighted the fact that despite the important role of the auxiliary nurse in providing reproductive health services, there is a discrepancy between this reality and the support given by regional authorities for the improvement of nurse auxiliary schools. Hence, schools cannot possibly respond in an efficient manner to the need to train this important member of the health personnel.

The role of registered nurses in offering reproductive health services is also unclear, especially in relation to delivery care and IUD insertions. Currently, a post-graduate course in maternal and child health is being developed for nurses.

In addition, intense attention should be paid to supporting efforts which improve the capabilities and utilization of nurse auxiliaries and traditional midwives for childbirth care and family planning.

Regarding supplies and medications, we realize that the situation is more complex than we could appreciate during this assessment. There is a certain irrationality in the concept of having different lines of medication, essential medicines and those of special programmes. Ultimately, many health services wind up obtaining supplies from the commercial sector where the prices are much higher than those of either of the public sector lines.

It is important to be able to rely on well qualified personnel to assure a high quality of service provision. Perhaps the SNS should examine the current

distribution of staff, both in absolute numbers as well as by specialty, to guarantee that the reproductive health needs of the population are being satisfied appropriately and in a timely manner. Training initiatives could be extended to all personnel, including administrative staff, to attain more integrated and consistent care.

Given that the vast majority of nurses and auxiliaries are women and that many users prefer to be attended by women, it is important that nurses and auxiliaries be trained in counselling and other essential functions such as the offering of contraceptives and obstetrical care. This recommendation is further supported by the simple fact that frequently, the nurse or auxiliary is the only available resource in isolated regions and in areas with few resources to support any other providers.

New norms need to be created for assigning clearer job responsibilities to health workers. These need to be respected by all levels of health authorities as well as by the staff members themselves, so that more responsibility is assigned specifically for women's health care. Assigned duties should be recognized by the community of service providers to assure a coherent and consistent offering of services.

Regional initiatives for distributing educational materials adapted to the needs and sociocultural characteristics of communities must be supported. Research needs to be conducted to determine the most widely utilized methods of communication among the population (for example, radio programmes, television, community-based communication programmes, etc.)

The procedures for supervision, monitoring and evaluation need to be improved at both the national and regional level.

It is essential to highlight that one of the most important conclusions of this assessment is that the underutilization of SNS facilities and the poor imagine they have in the eyes of the community is in part the responsibility of the personnel. Special attention must be paid to making sure that staff are knowledgeable, are well chosen, that they provide good, professional treatment to the patients, and are motivated and committed.

Overall Conclusions and Recommendations

Conclusions

a) The implementation of the *Plan Vida* has had a positive impact on the health services directed at women, impacts which are both quantitative and qualitative. It has consolidated the concepts of integrated care with a reproductive health strategy.

b) The conditions under which women's health care are delivered have improved relative to the information found from a literature review carried out as the first stage of this research.

c) The concept of reproductive health, despite formal recognition, has not been completely diffused or accepted by either intermediate level health authorities, service providers within the SNS, or other institutions. The concept is also not well understood by other civil authorities nor by the target population.

d) There is an underutilization of obstetrical services, including antenatal and delivery care due to a series of barriers which prevent women from seeking care. Services do not conform to their cultural norms, are too expensive, or are difficult to access. Another important factor in the underutilization of available services is the population's lack of confidence in them.

e) In spite of the progress made, access to family planning services is still restricted in many areas because of a lack of adequately trained personnel, lack of available supplies, cost, and the location of services.

The range of contraceptive options available to the population through the SNS is virtually restricted to three: pills, condoms, and the IUD. Access to tubal ligation is difficult because the SNS does not have clear norms on its utilization, while injectables are only available in the commercial sector. This increased the possibility for improper use of injectable methods because a follow-up care is not provided.

f) The lack of access to reproductive health services in the public sector compels women to utilize a variety of strategies to obtain these services, including the use of private practitioners, other institutions, and traditional medicine.

g) Women, men and civil authorities interviewed all expressed concern over the unsatisfied demand for family planning services and information in the country. One example of unmet demand is illustrated in the growing use of injectable methods obtained directly from the commercial sector.

h) Even in areas where there are no restrictions on access to contraceptives, services are still underutilized. This is due, at least in part, to the fact that women perceive the services to be of low quality and inappropriate given their cultural norms. In addition, rumors about the risks associated

with contraceptive use are abundant.

i) Quality of care in contraceptive services is poor, especially in the area of counselling and free choice of methods. In general, trained counsellors are very well prepared in offering general advice but are not sufficiently knowledgeable in technical aspects of contraception to dispel myths and calm the fears of potential users.

j) There is a need to remove some contraceptive methods from the market whose safety has not been tested or where lower dose substitutes that pose fewer risks to women are available.

k) Resources for educational materials and other forms of mass media are scarce.

l) In general, the technical capacity of the service delivery points, at least at the lower levels, is fairly adequate. However, we found deficiencies in specific areas which require attention. For example, physicians are not trained in delivering babies in positions other than the gynaecological one and availability of anaesthesia is restricted thus limiting the availability of caesarean sections and tubal ligations. A referral system, within the district and to the outside, has not been adequately instituted.

m) The political evolution of the country, especially the issuing and implementing of the Law of Popular Participation, has opened up an important opportunity to stimulate a process of quality improvement within health programmes. This is so because the Law offers the possibility for the health sector to recuperate greater resources.

This opening can be taken advantage of if local health authorities can effectively negotiate the appropriation of funds in sufficient quantity for the health sector, and utilize the funds towards the priorities of the population they are trying to serve.

The risk involved, however, comes from the fact that at the local level, leaders are not yet trained in identifying the most urgent needs of the population and are not yet able to define, plan, and execute programmes which benefit the population.

n) At the central level, there is a certain degree of difficulty in advancing the implementation of initiatives prepared by the technical sector because the political sector takes too long to approve them or fails to approve them all together.

o) Current human resource policies are inadequate. One direct outcome is the high turnover of personnel, principally physicians, which results in the compromised quality of services and a lack of trust in services on the part of the population.

p) The distribution system for supplies suffers from a series of defects that lead to a lack of equipment and supplies for family planning and other activities at the service delivery level. Medications and other supplies are commonly out of stock at facilities which thus forces the population to utilize private sector services.

q) Resources for health care originate from such a variety of sources and

difficulties arise on many occasions when the priorities of the agencies that provide funds are different from those of the National Secretariat of Health. This can interfere in the implementation of official policies and programmes. This diversity, which also creates problems with coordination, has other consequences such as the concentration of funds in certain areas considered attractive by donors and a duplication of efforts between the SNS and other entities in the same area.

r) The lack of an adequate supervision system has created deficiencies in the evaluation and monitoring of both obstetrical and family planning services.

s) The participation of women in the identification of priorities, planning, preparation, and execution of projects has been scarce at local, regional, and national levels.

t) The undervalued role of women is, in general, an important limitation to the recognition of the importance of women's health issues.

Despite the fact that reproductive health services are directed fundamentally towards women, women do not have a voice in decision-making about their design or implementation. Consequently, gender perspectives are not considered and services are not appropriate for their needs.

Recommendations

a) The implementation of the Law of Popular Participation, which increases the power of regional and local health levels, makes it essential to train local leaders in how to negotiate the appropriation of funds for programmes and how to administer resources in an efficient manner. In addition, the central level should be available to offer technical assistance to regional and local levels in preparing and implementing projects. The specific recommendation is to try to implement technical and administrative training programmes at these levels and make changes in the administrative structure such that the central level can better support intermediate level authorities in obtaining and utilizing available resources for programmes which benefit health.

b) As the assessment of the current situation indicates, there is a need to design and implement a human resources policy which allows for the improved distribution of available personnel, especially physicians. This would permit doctors to stay in one location for a longer period of time and therefore create greater continuity and quality of services to a population which can then build trust in the provider. This should translate into a more suitable utilization of service delivery capacity.

c) Institutions offering training for providers in reproductive health should be strengthened and supported. Strategies for broadening coverage and for dissemination of information provided should be explored. In the area of training for nurses and auxiliaries in family planning counselling, more emphasis should be placed on understanding the technical aspects of contraceptive methods.

d) Physicians and other professionals need to receive training in obstetrical care which focuses attention on offering high quality services while respecting the values of different cultures and ethnic groups.

e) The method mix available at health services needs to be expanded to better meet demand. This could reduce the number of women who obtain their methods directly from the pharmacy where they run the risk of receiving inadequate advice. This can give rise to incorrect use, reduced efficacy, or a greater possibility of complications which result from poor use or use by women who have contraindications to the method.

f) Guidelines for reproductive health services, especially family planning, need to be revised and published to make them consistent with the currently accepted standards for eligibility criteria for contraceptive methods. Requirements for the use of methods should also be revised to reduce unnecessary barriers to the use of contraception without reducing the level of quality of the services offered.

g) The SNS must normalize and supervise the use of some contraceptive methods which are not yet available in public health services but are available in the private sector without a process of introduction. This is especially important for two injectables: Depo-Provera (trimester injection) and MESIGYNA (monthly injection).

h) Efforts should be made to promote and implement community outreach programmes to provide culturally appropriate information and services in reproductive health.

i) Explore the validity and feasibility of the use of mass media for the diffusion of reproductive health information and education to the population.

j) Improve mechanisms for coordinating the utilization of resources provided by international donor agencies, both in the public as well as the NGO sector.

k) The National Secretariat of Health (SNS) should make an effort to assure that the activities of the Integrated Women's Health Care Programme are consistent with the promises made by the Government at the InternationalConference on Population and Development in Cairo, 1994 and the Fourth World Conference on Women in Beijing, 1995.

l) Better utilization of existing contraceptive methods should be promoted in the programme while strengthening education on the use of natural methods.

m) Encourage the removal from the market any methods which are not offered within the SNS programme but are available in the private sector (pharmacies).

n) Consolidate politically the National Coordinating Committee within the framework of the National Reproductive Health Strategy and the technical sub-committees.

o) Initiate and promote research in reproductive health with an emphasis on service delivery and operations research, principally in

the following areas: the introduction of contraceptive methods; training plans and strategies; user perspectives; community outreach strategies; culturally appropriate modules for hospital delivery care; and evaluation of referral hospitals.

p) Encourage the more active participation of women in the planning, management, and implementation of reproductive health services, allowing for the incorporation of gender perspectives and the recognition of women's health related strategies. This will contribute to improvements in service delivery.

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