AWARENESS Project
Bolivia Country Report
2001–2006

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The *Institute for Reproductive Health*, affiliated with Georgetown University in Washington, D.C., is a leading technical resource and learning center committed to developing and increasing the availability of effective, easy-to-use, natural methods for family planning.

The purpose of the AWARENESS Project was to improve contraceptive choices by expanding natural family planning options and developing new strategies and approaches to increase the reproductive health awareness of individuals and communities in developing countries.

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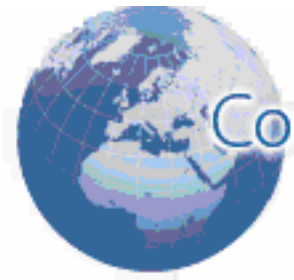
Acronyms

IEC	Information, Education, and Communication
IRH	Institute for Reproductive Health
KIT	Knowledge Improvement Tool
MOH	Ministry of Health
NGO	Non-governmental Organization
PROCOSI	Programa de Coordinación en Salud Integral
REDES	Sub-Regional Health Area
SDM	Standard Days Method®
SEDES	Departmental Health Area
USAID	United States Agency for International Development



Country Program Summary

Bolivia

IRH collaborated with the MOH and the PROCOSI (Programa de Coordinación en Salud Integral) network of nongovernmental organizations (NGOs) to integrate the SDM into public- and private sector services. As a result, in 2001, the MOH included the SDM in its national family planning (FP) norms and in 2004 added it to services covered by its public health insurance policy, thereby requiring that the method be provided free of charge to qualifying women at all MOH clinics. The MOH, key NGOs, and EngenderHealth (the USAID cooperating agency [CA] now responsible for TA to the MOH on family planning), all have integrated the SDM into their pre-service curricula, as have two auxiliary nursing programs in Trinidad and Beni departments. Efforts continue to integrate the SDM into the Cochabamba school of public health's auxiliary nursing curriculum, as this school is responsible for certifying curriculum changes for all public-sector auxiliary nursing programs nationally.

USAID/Bolivia discontinued field support to IRH after FY05, and IRH phased out activities in Bolivia by September 2006. By then the SDM was available in 270 MOH networks in six departments, and seven NGOs; over 2,100 providers had been trained; and over 14,000 couples were registered as SDM users. With a grant from EngenderHealth, IRH has continued to transfer capacity for further consolidation of SDM integration. IRH has a memorandum of understanding with ProSalud for continued distribution of CycleBeads, though procurement remains problematic. An assessment is planned for 2008 to evaluate the status of SDM services in Bolivia and determine whether additional assistance is needed.

I. Introduction

Source: CIA World Factbook 2008

Bolivia, a country of eight million people situated in the heart of South America, is one of the poorest countries in the Western Hemisphere. Its geography and ethnic composition also make Bolivia unique among the countries of the Americas. It is the only country in the hemisphere where indigenous people represent a majority of the population, and where much of the population lives in relatively inaccessible areas. During the last decade, Bolivia's population grew by about 2.6% per year. Slightly less than half of currently married women (48%) are using contraception, although only about half of these women are using a modern method.

Georgetown University's Institute for Reproductive Health (IRH) worked in Bolivia as a USAID cooperating agency between April 2001 and August 2006. IRH maintained an office in La Paz with two technical staff focused on scaling up the Standard Days Method® (SDM) through training; monitoring; supervision; creation of information, education, and communication (IEC) materials; and the distribution of supplies (CycleBeads®, provider aids, etc.). As USAID/Bolivia reduced the number of management units operating in the country, it provided no further field support to IRH after 2006. Therefore, IRH phased out activities in Bolivia as of August 2006.

Beginning in 2001, the Institute provided technical assistance to the Ministry of Health (MOH) and affiliates of the *Programa de Coordinación en Salud Integral* (PROCOSI) network of nongovernmental organizations (NGOs) to introduce the SDM into services throughout the country as well as to ensure the sustainability of current services going forward. IRH also worked closely with EngenderHealth, the cooperating agency responsible for family planning technical assistance to the MOH, to transfer capacity for providing support for the integration of SDM services.

The MOH remains committed to improving maternal and child health and reducing maternal mortality, and views expanded access to high-quality family planning services as an important strategy for achieving these goals. To help reach its objectives, the MOH included the SDM in its national family planning norms as an additional family planning choice and identified six SEDES (departmental health areas) as priority sites for training health providers and assisting them to introduce the SDM into government and NGO family planning services.

II. Activities and Accomplishments

Between 2004 and 2006, IRH worked to integrate the SDM into public and private-sector services by following five strategic objectives. These included: building capacity, expanding access, assuring quality, building political support, and creating awareness and demand. The following section details IRH activities as they related to each of these five objectives.

A. Research

Bolivia has been the host country for a number of IRH-led studies, including:

- Study to test strategies to strengthen providers' technical competence to offer natural methods of family planning,
- Operations research study to look at improvements in training and monitoring systems as a strategy to strengthen quality of NFP services at MOH facilities,
- Pilot study of the SDM,
- Efficacy trial of the SDM,
- Long-Term Follow-Up study of the SDM

Study to test strategies to strengthen providers' technical competence

Strategies tested in this study included establishing clear eligibility criteria for the Calendar – Rhythm method and training providers in their use; developing and distributing job aids for providers and materials for clients; and training providers in how to follow procedures and use tools. The study was conducted with public and private sector providers and completed in 2001. The study showed that if providers had simple protocols and appropriate materials, they could provide good quality services.

OR study of improvements in monitoring systems

The study examined the effect of adding natural methods to the topics included in training activities, and to the areas to be checked in supervision visits. This study was a joint effort between IRH and CARE; it was conducted selected sites in the northern and eastern areas of the country, and was completed in 2001. The main finding was that training providers in the calendar method prepared them to competently provide it to their clientele. The strategy allowed CARE to expand the availability of natural methods to new areas of the country.

Pilot study of the SDM

This was a short term study to examine the feasibility of teaching the SDM in a brief counseling session, and the feasibility of correct use by typical clients of public programs. It was carried out over four months in 1999, with some 20 couples in one site in Potosi, with the collaboration of CARE. The key findings were that MOH providers could teach the SDM to their clients, that women easily understood how to use the method; and that couples were able to use the method correctly, including avoiding unprotected intercourse during fertile days. Results concurred with those from two other countries (Peru and the Philippines). These findings warranted the implementation of a full efficacy trial.

SDM Efficacy Trial

Women from one site (urban and peri-urban Trinidad, in Beni) used the SDM for up to one year, as part of a multisite, prospective trial conducted in 2000-2001 to determine the use efficacy of the method. Additional sites were in the Philippines and Peru. The key finding was that the method was effective (the overall study found the method was 95% effective with correct use). These results prompted the MOH to accept IRH's offer of TA to introduce the SDM to regular services in Bolivia.

SDM Long-Term Follow-Up Study

Health policy makers are concerned about high discontinuation rates among FP users in general. This was a study to obtain information about long-term continuation rates among SDM users, and about method efficacy beyond the first year of use. Couples who had participated in the SDM efficacy trial were invited to participate in a continuation study. Most accepted, and used the method for up to two more years during 2001-2003. Key results were that continuation rates were high (67% after two years in this study, which was actually 36 months of method use), and that efficacy in years two and three was also high (94.8 and 96.6% respectively, figures that include both correct and incorrect use).

B. Build capacity

In order to create local capacity for sustainable SDM services, IRH worked closely with the MOH; key NGOs; USAID's family planning cooperating agency, EngenderHealth; and educational institutions to integrate the SDM into their pre-service curricula. The following provides a general overview of IRH's work in these areas.

Public Sector **–** In coordination with the departmental branches of the MOH known as SEDES, IRH trained family planning providers on the SDM in the following departments: Beni, Chuquisaca, La Paz, Oruro, Pando, Santa Cruz, and Tarija. The SEDES are each divided into varying numbers of smaller management units known as REDES. IRH staff worked closely with individual REDES to create institutional capacity to sustain quality SDM services. To accomplish this goal, the project chose a team of SDM facilitators within each RED based on their special interest in the SDM and willingness to train new providers and offer supervision and technical assistance to those already trained.

The following table breaks down the number of REDES that received training in each department or SEDES in relation to the total number of REDES.

Table 1: Training by MOH Administrative Region and Sub-Region (2002–2006)

Department or SEDES	REDES with Trained Personnel
Chuquisaca	3 of 6
La Paz	5 of 5
Oruro	3 of 3
Pando	3 of 3
Santa Cruz	4 of 4
Tarija	2 of 2
TOTAL	20 of 23

The total number of MOH providers trained exceeds 800, and the cumulative number of SDM users reported from 2002 to 2006 by the public sector, which has a relatively weak reporting system, is more than 3,000.

Private Sector **–** In the private sector, IRH collaborated with a number of NGOs from the USAID-supported PROCOSI network. The following chart identifies key NGO partners and their geographic coverage areas:

Table 2: Training Coverage by NGO Partner (2002–2006)

NGO	Coverage Area
APSAR	Cochabamba
APROSAR	Oruro
CIES	all departments except Pando
CRECER	Cochabamba, Chuquisaca, La Paz, Oruro, and Potosí
PROSALUD	La Paz and El Alto

The SDM proved to be a popular option in the method mix of these NGOs, with a cumulative total of nearly 8,000 users. IRH trained over 500 providers in the private sector, 489 of whom were actively offering the SDM at the time of this report. The project created a cadre of SDM trainers within each NGO in order to ensure sustainable services over the long term. IRH also provided partners with electronic versions of all necessary materials to reproduce as needed, including training manuals, counseling guides, and job aids.

EngenderHealth **–** IRH worked closely with EngenderHealth, the USAID cooperating agency in Bolivia that assumed responsibility for providing technical assistance to the MOH on all family planning methods, including the SDM. IRH provided EngenderHealth with detailed reports of all activities implemented regarding the SDM as well as the different methodologies used for the training of trainers and providers. The project team also transferred stocks of training materials, provider materials—including supervisory tools—and CycleBeads. In August 2005, IRH trained key EngenderHealth staff on the SDM and accompanied these individuals as they provided trainings to give feedback and support. EngenderHealth and IRH put an agreement in place so that technical assistance could be provided going forward.

Pre-service Training **–** Two auxiliary nursing programs in the departments of Trinidad and Beni included the SDM in their pre-service training curricula.

C. Expand Access

IRH partnered with the NGO PROSALUD to establish a distribution system for CycleBeads for both the public sector and NGOs in six departments. As part of this partnership, IRH provided ProSalud with CycleBeads, and ProSalud will:

- inform service delivery organizations of the availability of CycleBeads from ProSalud at no cost to the organizations, and explain to them how to request them from ProSalud
- respond to service delivery organizations' requests for CycleBeads by shipping them out at no cost to organizations
- include CycleBeads in the list of commodities purchasable from a fund earmarked for FP commodities in general, and purchase them when the current stock runs low

This partnership will help ensure the availability of CycleBeads after IRH closed its country office.

In addition, PROSALUD will continue to offer the SDM and CycleBeads in its 32 pharmacies in six departments.

D. Assure Quality

In order to ensure quality services, IRH worked closely with local partners to integrate a provider supervision tool known as the Knowledge Improvement Tool (KIT) into their programs. KIT consists of 28 questions that allow a trainer or supervisor to evaluate provider competence and knowledge for offering the SDM and to identify areas of weakness. Once these are identified, the trainer/supervisor can provide feedback and support to improve skills in deficient areas. Partner NGOs and the MOH's REDES have incorporated KIT in their programs and actively use it as a supervisory tool for SDM providers. Their experience has been very positive and they report that KIT is a useful, economical alternative to a complete follow-up training.

E. Build Political Support

The MOH included the SDM in its norms in 2001 and, in 2004, added it to the menu of services covered by the MOH's public health insurance policy, the *Seguro Universal Materno Infantil*. This means that the SDM is provided free of charge at MOH clinics to women who qualify. This was a key step to making the SDM more widely available throughout the country, as it now must be provided at all MOH facilities.

IRH presented the results of the partnership's efforts at an end-of-project conference in early 2006. This served as an opportunity to highlight the results of efforts in Bolivia and underscore the SDM's importance as an addition to the method mix.

F. Create Awareness and Demand

One of the final pieces missing from the Bolivia program is a concerted communication strategy to increase awareness of the SDM. IRH implemented an IEC strategy in three cities, La Paz, Santa Cruz, and Tarija. This strategy spurred increased demand for the method by informing the public that this reliable option exists and is widely available, while simultaneously motivating providers to be more disposed to offer the SDM as a viable family planning option for their clients. This activity was of particular importance because, until that point, almost no work had been done to promote awareness of the SDM.

Formative research guided the design of the campaign, including an assessment of potential clients' attitudes towards and awareness of natural contraceptive methods in general and, specifically, of the SDM. This approach helped identify factors limiting SDM use in Bolivia; these included lack of awareness and misconceptions regarding natural family planning. In addition, the research served to identify appropriate strategies for overcoming these obstacles.

A community health worker uses a pictorial flipchart to help teach the Standard Days Method.

While generating demand for the method is important, it is also necessary to focus on providers to ensure that they are actively, and effectively, offering the SDM in addition to other contraceptive methods. As such, researchers interviewed MOH providers to assess their attitudes and perceptions. This information informed the design of the portion of the informational campaign directed at this key constituency.

The campaign combined the distribution of SDM educational and promotional materials at MOH clinics and at community events, the use of promotional radio spots, and community-based awareness building through the use of health promoters and the integration of SDM talks into the activities of different civic groups. A team of experts developed and validated specific campaign messages, with significant input and support from IRH.

In order to measure the IEC campaign's impact on SDM awareness, behaviors, and use, IRH implemented a baseline and endline evaluation in all three sites. Both stages of the evaluation included a home survey, provider interviews, and endline interviews with clients of health services.

III. Future Plans

IRH discontinued activities in Bolivia in August 2006. At that time, the SDM had been positioned as a sustainable part of the method mix. EngenderHealth now provides any additional support needed locally. As a result of the mission's interest in consolidating programs and reducing the number of management units, EngenderHealth assumed responsibility for the SDM in Bolivia. IRH provided training and strategic guidance to EngenderHealth, which now has the responsibility for technical leadership in SDM in the country. It would be appropriate to conduct an evaluation of the status of the SDM in Bolivia a year after the end of AWARENESS Project activities there.

IV. Lessons Learned

Key lessons from the Bolivia experience are:

- Including the SDM in the norms of the national family planning program was essential for developing collaborative relationships with health officials at various levels of the decentralized health system.
- Political support for the SDM helped validate the training and motivate providers.
- NGOs can complement the work of the public sector in increasing access to services.
- Working with the public sector required flexibility due to the program's changing focus, the government's process of decentralization, changes in personnel, and ongoing training needs.
- There is widespread support for the SDM in both the public and private sectors, and many believe that making the method available will improve informed choice and the quality of family planning services.

"The SDM has helped both me and my partner. We had to learn to communicate to be able to use the method correctly." **-SDM User**

Another essential lesson is that IEC should be conducted at a relatively early stage in the method introduction process. The project put a heavy emphasis on capacity building, which is important,

but the availability of services must be balanced with demand generation. Providers can be trained and supplies on hand, but if the public is largely unaware that the option exists there will be relatively few users of the method.

V. Challenges Remaining

Trained staff: Many organizations report having staff who have received some type of training in the SDM , but technical competence of this personnel has not been assessed in recent years. The SDM has not been incorporated into the training or updating activities of most organizations (or they do not carry out such activities regularly). Although in general organizations report significant turnover rates for clinical personnel, new personnel have not been trained in the SDM.

The SDM is not included in the teaching curricula and activities of enough professional schools (nursing, medicine) to ensure that new health professionals will be knowledgeable in the method.

Availability and quality of services: Availability of SDM services is contingent on availability of trained and competent personnel. The high turnover rate may affect actual availability of services. Quality of SDM services is not known. Lack of technical updates and reinforcement of training may be affecting the quality of said services.

Availability of CycleBeads: Availability of CycleBeads wherever SDMservices are available needs to be verified. The logistics system designed by IRH, USAID and ProSalud for commodity distribution is yet to be implemented. ProSalud is addressing the issues of distributing CBs and eventually procuring them. These will be tested when service delivery organizations actually start requesting them and ProSalud's stock runs low.

IEC/Community outreach: There is awareness that the SDM needs to be included in these activities in order for demand to increase. While some organizations now include the SDM in some IEC activities, most materials do not yet include it. This will be corrected when new materials are produced or printed. Not all organizations are implementing community outreach activities.

Supervision / Monitoring /Evaluation: Inclusion of the SDM is very spotty. Supervisors already have numerous aspects to check for in the limited time they actually spend doing supervision. Organizations need clarity about what aspects could be included in routine supervision activities.

Collection of service statistics and other information: Collection of service statistics and other information is very spotty. Not all facilities or sites record, keep track of or submit numbers of SDM users. The method is not included in forms or other components of all organizations' MIS. Many of the providers or sites that do record some type of information about SDM users do so by manually adding the method to their forms, or in separate log books, etc. Not all managers know if or how such information is eventually aggregated at a regional, national or organizational level.