



# Contraceptive Security in Bolivia: Assessing Strengths and Weaknesses

December 1–12, 2003

USAID/LAC/RSD-PHN  
Regional Contraceptive Security Feasibility Study

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CEASS	Center for Provisioning of Health Supplies
CIES	Center for Investigation, Education, and Services
CNS	Caja Nacional de Salud (Bolivian social security system)
CS	Contraceptive security
DDSS	Directorate of Health Services
DFID	Department for International Development (United Kingdom)
DILOS	Local health board
DINAMED	Directorate of Medicines
ENDESA	Bolivian Demographic and Health Survey
EU	European Union
FP	Family planning
FPLM	Family Planning Logistics Management
GDP	Gross domestic product
IADB	Inter-American Development Bank
ICPD	International Conference on Population and Development
INE	National Statistical Institute
IPPF	International Planned Parenthood Federation
IUD	Intrauterine device
LAC	Latin America and the Caribbean
MSD	Ministry of Health and Sports
NGO	Nongovernmental organization
PAHO	Pan American Health Organization
RH	Reproductive health
SALMI	Logistics administration system for SNUS
SEDES	Departmental Health Office
SIAL	Logistics information and administration system
SNUS	Unified National Supply System
SPARHCS	Strategic Pathways to Reproductive Health Commodity Security
SUMI	Universal Maternal and Infant Health Insurance
TFR	Total fertility rate
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development

**T**he contraceptive security (CS) assessment conducted in Bolivia reveals that the country will face several critical challenges in achieving contraceptive security in the short term. Use of modern contraceptive methods is increasing in Bolivia, but is still very low compared with other countries in the region. Bolivia's family planning (FP) program is a young one, having been established only in the early 1990s. At present, the country's economic and political situation is precarious, and the turmoil surrounding the ouster of the former government has weakened the entire government to the point that decisionmaking, for the long term, is next to impossible. Without significant support from international donors for its FP services, maintaining even the current level of family planning coverage is likely to be a challenge for the government of Bolivia.

The Ministry of Health and Sports (MSD) provides modern contraceptive methods through its network of hospitals and clinics as well as mobile brigades and community promoters, all of which provide contraceptives free of charge. The role of government in the provision of contraceptives changed very little between 1994 (27%) and 1998 (33%). During the same period, the role of pharmacies increased from 21 percent to 25 percent, private clinics and hospitals decreased from 43 percent to 32 percent, and the social security system, Caja Nacional de Salud (CNS), continued serving 8 to 9 percent of contraceptive users. The MSD purchases large quantities of essential drugs and vaccines each year but does not budget for or purchase contraceptives. The MSD does not have a definitive plan for replacing contraceptives donated by United Kingdom's Department for International Development (DFID), and at the time of this assessment, the political situation in the country as a whole and inside the MSD made short-term planning and decisionmaking complicated.

Since the mid-1990s, Bolivia has embraced a series of governmental reforms that have decentralized financial and management responsibilities in the health sector, presenting even more challenges for contraceptive security. The net result of these reforms has been the transfer of responsibility, authority, and funding for most pharmaceutical purchases to health establishments and/or municipal governments. While Universal Maternal and Infant Health Insurance (SUMI) and its predecessors have helped to guarantee that this funding is channeled to priority health interventions for women and children, local purchase of essential pharmaceuticals has increased costs and put important decisions about product selection and sourcing into the hands of individual health establishments or municipal government, which may or may not be equipped or qualified to make them.

Bolivia's method mix appears to have changed substantially since 1998, with an increase in the contribution of injectable contraceptives. The intrauterine device (IUD) has been a popular method in Bolivia, but in the past five years, IUD insertions and oral contraceptive use have not increased proportionally to other methods. Male-controlled contraceptive methods—condoms and vasectomy—are still almost nonexistent. The country's population of reproductive age and its demand for contraceptives will continue to grow and change into the next decade.

The result of the assessment suggests that achieving contraceptive security in the medium term for Bolivia will be very difficult, and current indications suggest that it is an unrealistic goal. The Bolivian government, with assistance from the World Bank, Inter-American Development Bank (IADB), UNFPA, USAID, and others, is doing a valiant job of expanding and increasing access to basic primary healthcare, but it will require at least another decade of assistance to reach isolated and culturally hard-to-reach populations with reproductive health (RH) information, quality family planning, and contraceptives.

Within the Latin America and Caribbean (LAC) region, contraceptive security has become an increasingly important issue. While USAID and many other international donors have supported family planning for more than three decades, donor investment is now declining, and contraceptive donations have been or are being phased out in many LAC countries. At the same time, the demand for contraceptives continues to grow as the region's predominantly young population passes through its reproductive years.

It is in this climate that USAID and UNFPA country offices are working with host governments and nongovernmental organization (NGO) recipients to address contraceptive security. To support these efforts, USAID's Bureau for Latin America and the Caribbean (LAC/RSD-PHN) conducted a regional contraceptive security assessment to guide future policy and programmatic decisions at the regional and country levels. USAID's DELIVER and POLICY II projects implemented the assessment in Bolivia, Honduras, Nicaragua, Paraguay, and Peru. The assessment was designed to address the following issues:

- What are the priority CS issues shared by most USAID-assisted countries in the LAC region?
- What are the most promising regional interventions to address these issues?
- How should future regional assistance be structured to maximize benefits?
- What are the national-level issues that should continue to be dealt with in-country, and why are they not appropriate for "regionalization"?

These activities were initiated in July 2003 during a regional CS conference in Nicaragua designed to raise awareness about contraceptive security and stimulate dialogue. During this meeting, representatives from each participating country formed a Contraceptive Security Committee designed to take the lead on CS issues and serve as a liaison in the CS assessment in those countries that formed part of the regional study. The CS assessment was conducted in Bolivia in December 2003.

**O**f Bolivia's population of almost 9 million, more than one-third (38%) is under 15 years of age. The latest Demographic and Health Survey for Bolivia (ENDESA) was conducted in 1998. The total fertility rate (TFR) was estimated at 4.2 children per women, almost one child less than in 1989. The change in TFR, however, has only occurred in urban areas, and in rural areas the TFR remains more than 6 children per woman and has not changed in the last 10 years. The high TFR rates are linked to low contraceptive prevalence levels when compared with the rest of Latin America. In urban areas, the prevalence is 57.6 percent among women in union, and in rural areas, contraceptive prevalence is only 30 percent. These trends show that contraceptive prevalence has increased only in urban areas, and that there is now an even wider gap between urban and rural areas.

The Bolivian government's national FP program is relatively young. Until the late 1980s, Bolivia was essentially pronatalist as a result of strong anti-family planning forces within the Catholic Church and the belief that the country was, in fact, underpopulated. Attempts to introduce family planning in the 1970s and 1980s were met with stiff opposition. In the early 1970s, the Peace Corps was accused of performing coerced sterilizations and expelled. In the 1980s, the government prohibited distribution of contraceptives by NGOs. At this time, various NGOs, the National Population Council, and USAID conducted studies and workshops about the importance of family planning in reducing abortions and maternal mortality.

As a result of these efforts, in 1989, the government launched the National Plan for Infant Survival and Development and Maternal Health, which called for providing FP services in government health establishments. This plan was followed in the early 1990s by policy declarations and international agreements recognizing reproductive health as a fundamental right and establishing the National Sexual and Reproductive Health Program 1997–2002.

Bolivia's deteriorating economy and its recent political crisis are the most immediate threats to its future contraceptive security. Bolivia's population in 2003 was estimated by the National Statistical Institute (INE) at 8.9 million. About two-thirds of all Bolivians are poor and have low levels of education, health, and nutrition. In recent years, a series of economic shocks has resulted in a decrease in real GDP growth and poverty has been on the rise. This situation led to serious episodes of civil unrest in 2003 that culminated in the ouster of the elected president just two months before this assessment.





## Family Planning Services in Bolivia

The MSD provides modern contraceptive methods through its network of hospitals and clinics as well as mobile brigades and community promoters, all of which provide contraceptives free of charge. The MSD provides contraceptive services to approximately 32 percent of the population. Within the MSD at the national level, the Directorate of Health Services (DDSS) and the Directorate of Medicines (DINAMED) as well as the parastatal Center for Provisioning of Health Supplies (CEASS) are the entities most directly involved with contraceptive security. The MSD operates in a decentralized manner, with the central level sharing oversight of municipalities with the Departmental Health Offices (SEDES).

CNS, Bolivia's Social Security System, provides medical services to approximately 25 percent of the population. In 1998, the CNS was providing FP services to about 13 percent of users with technical and commodity assistance provided by USAID. Since USAID's assistance ended in 2000, the CNS no longer offers a consistent supply of contraceptive services or commodities.

Bolivia's largest NGO FP service providers include PROSALUD (32 clinics and the country's primary social marketing effort) and the Center for Investigation, Education, and Services (CIES) (nine service delivery centers). Smaller providers such as Marie Stopes, COMBASE and others operate clinics or outreach programs in one or more areas of the country. NGOs play a significant but unquantified role in the provision of contraceptives to the public. Private clinics and hospitals perform sterilizations and insert IUDs, but most send their clients to pharmacies to obtain pills, condoms, and injectables. In 1998, 32 percent of modern FP methods were reportedly provided by private clinics.

**U**SAID, DFID, and UNFPA have all been major supporters of family planning through explicit RH programs with the public and NGO sectors. Since 2002, DFID has provided the MSD with donated contraceptives, procured through UNFPA. UNFPA provides technical assistance to the MSD as well and is currently working in nine municipalities to develop the capacity to plan and manage RH services, including contraceptive financing and logistics. USAID supports the MSD's RH program with technical assistance and is the country's largest provider of donated contraceptives. All USAID contraceptive donations, however, go to PROSALUD's social marketing program, and through PROSALUD, to a number of other Bolivian NGOs. DFID support for contraceptives will end in 2004, and USAID's support will continue through at least 2008. The Pan American Health Organization (PAHO) is also providing assistance to the government for its national laboratory and annual purchase of essential pharmaceuticals. CIES is the current affiliate of the International Planned Parenthood Federation (IPPF) and purchases most of its contraceptives from PROSALUD.

The World Bank, IADB, and European Union (EU) are also actively involved in health sector reform efforts that aim to strengthen the decentralized management and expand the coverage of all primary healthcare services. Although this should include family planning, in fact, family planning is not prominently featured in more recent reforms.

# Findings from the Contraceptive Security Assessment

The DELIVER/POLICY team used the Strategic Pathways to Reproductive Health Commodity Security (SPARHCS) Framework to guide the assessment. The key findings from each element of the framework are described below.

## Environment

Since the mid-1990s, Bolivia has embraced a series of governmental reforms that have decentralized financial and management responsibilities in the health sector. In the late 1980s, cost recovery was introduced, and revolving drug funds were established in individual health establishments. In the mid-1990s, several laws were passed that shifted tax revenues and ownership of the health infrastructure from the national level to the country's 311 municipal governments and gave the departmental prefectures control over the assignment of health sector personnel.

In 1999, Bolivia's Insurance for Maternal and Infant Health was renamed and expanded to cover 90 different services. Mandated revenues designated for the new Basic Health Insurance package doubled from 3.2 percent to 6.4 percent. In theory, the services and commodities of the National Sexual and Reproductive Health Program were also included, but donated contraceptives continued to be provided free at all levels of the health system and were not reimbursed. In 2002, the Basic Health Insurance program was renamed again, becoming SUMI, and for the first time it was established by law. An important change was that the commodities provided by the national health programs (including contraceptives) were removed from the list of services and supplies to be reimbursed by the Universal Maternal and Infant Health Insurance (SUMI). Although FP services are covered during the first six months postpartum, reimbursement rates do not include the costs of contraceptives, which have continued to be provided free by the National Sexual and Reproductive Health Program. Also in 2002, the MSD reorganized under a new health delivery model that is more compatible with the reforms mentioned above. It also integrated its multiple supply systems under a single Unified National Supply System (SNUS).

The net result of all of these reforms has been the transfer of responsibility, authority, and funding for most pharmaceutical purchases to health establishments and/or municipal governments. While SUMI and its predecessors have helped to guarantee that this funding is channeled to priority health interventions for women and children, local purchase of essential pharmaceuticals has increased costs and put important decisions about product selection and sourcing into the hands of individual health establishments or municipal governments that may or may not be equipped or qualified to make them.

## Client Demand and Use

Bolivia's fertility and contraceptive prevalence rates improved during the 1990s, but by the end of the decade, modern contraceptive use was still the lowest in Latin America. Only one quarter of women of reproductive age in union were using a modern contraceptive method at the time of the 1998 ENDESA. There are marked disparities in contraceptive prevalence and significantly higher unmet need for family planning among women living in rural areas, those residing in the altiplano, those in the lower socioeconomic quintiles, and those with little or no formal education. Unmet need for long-term FP methods is very high in Bolivia, indicating that women who feel a need to avoid future pregnancies may not have easy access—physical, cultural, or financial—to long-term contraceptive methods, including sterilization.

Bolivia's method mix appears to have changed substantially since 1998, with an increase in the contribution of injectable contraceptives. The IUD has been a popular method in Bolivia, but in the past five years, IUD insertions and oral contraceptive use have not increased proportionally to other methods. Male-controlled contraceptive methods—condoms and vasectomy—are still almost nonexistent.

The country's population of reproductive age and its demand for contraceptives will continue to grow and change into the next decade. Without significant support from international donors for its FP services, maintaining even the current level of FP coverage is likely to be a challenge for the government of Bolivia.

## Services

The MSD's National Sexual and Reproductive Health Program 2003–2007 aims to improve the physical, cultural, and financial access of hard-to-reach populations to information and services, including contraceptives. World Bank and IADB projects have allowed the MSD to add health staff and support mobile brigades designed to reach remote areas with primary healthcare, but it is not clear how much attention these programs are giving to family planning. SUMI has eliminated financial barriers to some RH interventions for poor women, but expanding access to family planning is not an explicit goal of SUMI.

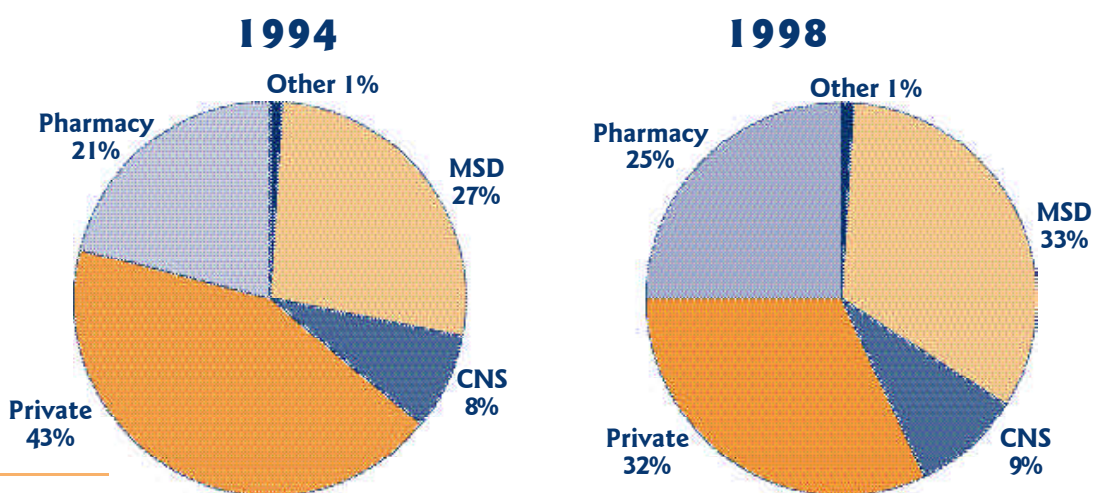
The CS assessment also revealed that many health facilities in the past have suffered from contraceptive stockouts. The logistics field study included 142 health establishments in the country's nine departments. Sixty percent of the health establishments visited had suffered a stockout of one or more contraceptive products during the first nine months of 2003.

NGO services continue to reach rural and peri-urban communities with support from international donors. However, several NGOs, including CIES, have had to close community-based programs in recent years because of high support costs. As DFID and USAID assistance to FP programs declines and if regional patterns hold true, there may be even fewer NGO FP programs targeting disadvantaged groups in the future.

## Market Segmentation

The role of government in the provision of contraceptives changed very little between 1994 (27%) and 1998 (33%). During the same period, the role of pharmacies increased from 21 percent to 25 percent, private clinics and hospitals decreased from 43 percent to 32 percent, and CNS continued serving 8 to 9 percent of contraceptive users (see Figure 1). Since 1998, MSD and NGO service statistics show that the MSD and the private pharmacies in particular have continued to increase their contraceptive market shares. They also show that the CNS's role in family planning has declined dramatically since USAID's assistance to its Reproductive Health Unit ended in 1999.

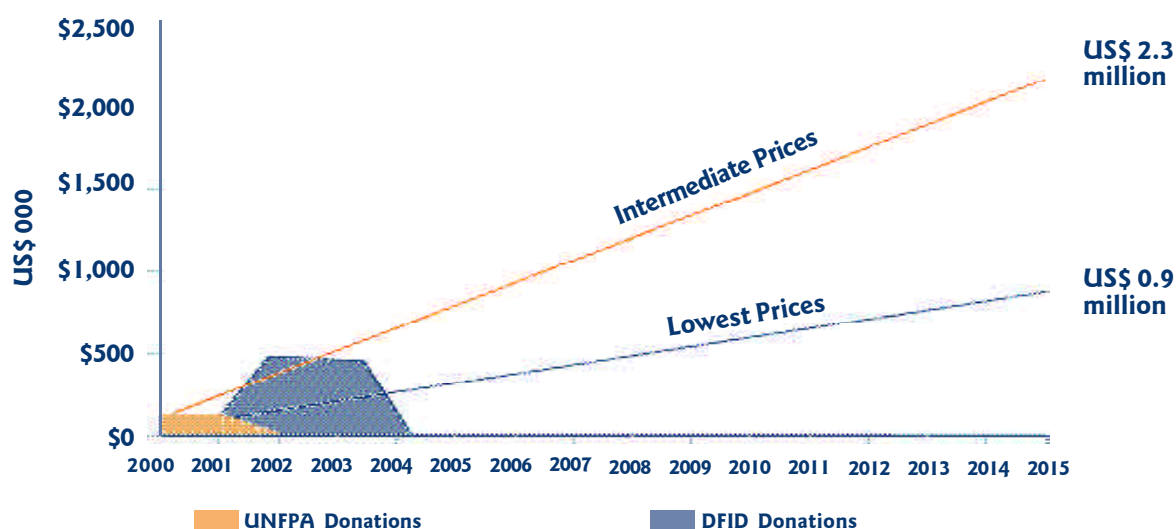
**Figure 1. Changes in Sources of Contraceptives and Condoms, 1994 and 1998**



Source: ENDESA 2 years

Both private medical establishments and commercial pharmacies have an important niche among higher and middle income groups, who are able to pay for the FP services and contraceptives that they receive. PROSALUD's social marketing program has greatly increased the role of commercial pharmacies in family planning while also making a reliable supply of contraceptives available to other NGOs at very favorable prices. Commercial contraceptive brands are somewhat limited in Bolivian pharmacies and are more costly than the vast majority of Bolivians are able to afford. A major obstacle to expanding the future role of pharmacies is the fact that most are located in urban areas. As such, although they play an extremely important role among those with the ability to pay, they are not accessible to the hard-to-reach rural and peri-urban populations, who have the highest continuing unmet need for family planning and the least ability to pay for contraceptives. In addition, the expansion of the commercial sector is mainly due to the support provided by PROSALUD through subsidized products marketed by local distributors, which makes the future expansion vulnerable once donations from USAID start decreasing.

**Figure 2. MSD Contraceptive Funding Gap, 2000-2015**



## Financing

The MSD has not yet budgeted for nor purchased contraceptives. The MSD purchases large quantities of essential drugs and vaccines each year, but these purchases do not include contraceptives. The MSD does not have a definitive plan for replacing DFID-donated contraceptives, and at the time of this assessment, the political situation in the country as a whole and inside MSD made short-term planning and decisionmaking complicated.

UNFPA, DFID, and USAID are Bolivia's primary sources for contraceptives. From 1998 to 2001, UNFPA donated approximately US\$125,000 in contraceptives to the MSD per year. Beginning in 2002, DFID began providing the funding for these donations and UNFPA moved into managing the procurement. The value of DFID's contraceptive donations in the past two years has been over US\$450,000 per year. DFID/UNFPA will continue to provide funding for contraceptives in 2004, and then its assistance is expected to end. The total value of USAID's contraceptive donations averaged US\$380,000 per year from 1998–2000, and then jumped to US\$1.1 million annually over the past three years. USAID's current donations are to PROSALUD only, for its social marketing program. USAID does not have a phase-out plan for its assistance to PROSALUD but anticipates that its commodity donations will continue at about \$1 million per year through at least 2005.

When DFID donations end in 2004, unless other funding is secured, it is likely that the MSD will face a serious contraceptive funding gap. At low contraceptive unit prices, the financial projections prepared during this assessment indicate that the ministry's total requirement in 2005 will be approximately US\$300,000. Because of population growth and continued increases in the use of modern contraceptive methods, this requirement could be as much as US\$900,000 per year by 2015, again at low unit prices. At intermediate prices, the requirement would more than double (see Figure 2).

Bolivia has more varied options over the short and long term than most countries in the region because of its highly decentralized health system and the existence of parastatal, NGO, and commercial procurement agents that are either currently importing or ready to import contraceptives and condoms. Future funding for contraceptives will probably come from some combination of the following sources: the National Treasury budget; SUMI/Dialogo 2000 funding at the municipal level; World Bank, IADB, or EU loans and credits; UNFPA and/or other bilateral donor projects; employers and employees through the social security system; cost recovery and revolving drug funds in government and NGO health establishments; and contraceptive purchases by individuals in pharmacies and other commercial outlets.

## Procurement

The most reliable source of government funding for contraceptives over the long term is likely to be some combination of SUMI and HIPC/Dialogo 2000 funding, administered by the local health boards (DILOS) through municipal health accounts. However, SUMI law would have to be changed to include all women of reproductive age for this funding to become available. If such a change is made, it will effectively transfer responsibility for contraceptive purchasing from the central MSD level to the municipalities and health establishments.

The current system for essential drug purchasing at the local level has been credited with making medicines more available in health facilities, but it is also more expensive than it should be and not as carefully supervised as all acknowledge it should be. According to the current purchasing regulations, for all purchases over Bs100,000 (US\$1 = Bs7.90), a price proposal must be obtained from CEASS. If CEASS's proposal is equal to or less than a proposal made by a private provider, the contract must be awarded to CEASS; if not, the purchaser may choose another supplier. Putting contraceptive purchases in this system would be dangerous because it could result in unacceptably high contraceptive prices, decisions that are not consistent with national development and/or health policies, problems with product selection and quality, and the overstocking and/or understocking of products in health establishments because of local resource constraints and inadequate forecasting and management skills in health establishments and municipalities.

The most cost-effective procurement option available to the MSD at the time of the assessment was procurement through one of the reimbursable procurement services offered by UNFPA, IPPF, or PAHO. CEASS's current agreement with PAHO for reimbursable procurement sets the precedent either for purchase through that agreement or for signing another agreement, for example, with UNFPA, that is specifically established for contraceptive procurement. Because international procurement through PAHO and UNFPA is a lengthy process, other national procurement options should also be explored.

PROSALUD's successful social marketing program has been generously supported by USAID and, as a result, it is in a good position to begin purchasing contraceptives with its substantial funding reserve. This reserve will allow PROSALUD to negotiate and establish relationships with suppliers that it will need in the future to ensure stable pricing and distribution rights. It will also allow the NGO to increase the prices it charges its clients more gradually than would have been possible if this cushion did not exist. In general, the NGOs that purchase contraceptives from PROSALUD have accepted cost recovery and been able to take advantage of PROSALUD's favorable prices to establish their own revolving fund for contraceptive supplies.

## Logistics Management

John Snow, Inc. (JSI)/Family Planning Logistics Management (FPLM) started working with the NGO community in Bolivia in 1992 to introduce a contraceptive logistics information and administration system (SIAL). In 1996, this effort was expanded to include the MSD. Overstocking and wastage of donated contraceptives had become a serious problem for the MSD in the 1990s, largely because donors were purchasing and the MSD was allocating products using population-based forecasts. The contraceptive SIAL was developed by consolidating and simplifying existing supply registers and reports and adopting a consumption-based approach to contraceptive forecasting, procurement, requisitioning, and allocation of available supplies.

The contraceptive SIAL has not only had an important effect on contraceptive logistics but has also served as the basis for SNUS and its administrative system, SALMI. A major step in the MSD's logistics management was achieved when the Basic Health Insurance package adopted the contraceptive SIAL for the management and tracking of all pharmaceutical supplies included under that ambitious program.

The two most important problems with the SIAL have been the lack of resources for its monitoring, supervision, and on-the-job reinforcement of the SIAL training, and for the distribution of contraceptives. At health establishments, there is very little logistics-related monitoring and supervision. As such, errors go undetected and are simply passed on from health establishments to the regional and central levels. Because the central level does not systematically monitor or consolidate information from the SIAL or have a team assigned to keep the SIAL up-to-date on a regular basis, MSD contraceptive forecasts are still being generated with incorrect information, and distribution is too often based on products available in the central and regional warehouse versus quantities requisitioned. These problems are responsible for stockouts in some cases and overstocking in others. Lack of vehicles, fuel, and personnel to distribute supplies from the regional offices to the municipal and health establishment levels makes contraceptive distribution to health establishments an ad hoc exercise that is often ineffective. Raising the awareness of the municipalities and engaging their help with the transport of contraceptives will be important in the future.

In 2002, with the conversion of Basic Health Insurance to the current SUMI, the MSD integrated its multiple supply systems and created SNUS. The contraceptive SIAL was again adopted as the basis for this newly integrated system. As of 2003, all contraceptive logistics functions in the public health system are carried out in an integrated fashion under SNUS.

## Policy

Bolivia was a signatory to the 1994 International Conference on Population and Development (ICPD) Program of Action, and family planning is mentioned as a priority in the government's Poverty Reduction Strategy Paper. Nonetheless, the assessment concluded that Bolivia's legal/policy framework was not as conducive to contraceptive security as it might be. This was because the proposed National Sexual and Reproductive Health Program 2003–2007 was pending approval at the time of the CS assessment, and the new minister's position on family planning was not known;<sup>1</sup> the SUMI insurance

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<sup>1</sup> The Sexual and Reproductive Health Program plan was approved in February 2004, after this assessment, and we understand that the MSDs new leadership is supportive of the program.



package restricted the financing and provision of free contraceptives to the postpartum period, when few women actually practice contraception; performance contracts, which are one of the mainstays of decentralization and recent health reforms in Bolivia, did not include FP targets or indicators; and although municipal health accounts and revolving drug funds were seen as the most likely alternative for financing and purchasing contraceptives, the regulatory framework required to permit the municipalities to play this new role was not in place or being planned.

## Leadership and Commitment

At the time of the assessment, the MSD lacked the leadership and the long-term perspective required to make a number of critical decisions that needed to be made to guarantee contraceptive availability in government health facilities once DFID funding ends. Municipal leadership in relation to reproductive health was also found to be weak. If municipalities are to assume even partial responsibility for the future planning, financing, and purchase of contraceptives under SUMI, as has been proposed, they will require considerable awareness raising, training in forecasting and financial planning, and logistics support. They will also require a regulatory framework to guide their procurement options, product selection, purchasing, and so forth.

## Coordination

Bolivia has a strong tradition of public and private sector coordination around RH issues. The work of the contraceptive logistics committee in the 1990s was important in the development of streamlined contraceptive information and administration systems for use by both NGOs and the government. Since the late 1990s, the work of the multisectoral Sexual and Reproductive Health Forum (Foro de Salud Sexual y Reproductiva) has been extremely important in terms of advocacy and the development of national RH norms and standards; information, education, and communication materials; and the National Sexual and Reproductive Health Program. Coordination around the topic of contraceptive security was given a boost in 2003 when a team of Bolivians from the MSD, UNFPA, USAID, and the NGO community participated in the regional CS conference in Nicaragua. After the conference, a multi-agency CS Committee formed. Led by the MSD's Director of Health Services, the committee met regularly in the latter part of the year and was one of the principal clients of this assessment. The political problems in late 2003 in Bolivia had a negative impact on the CS Committee members as well as on the ability of the ministry to lead the committee's work.

# Recommended Strategies and Next Steps

## Strategy 1.

**Advocate for RH policies at the national level that improve access and help to guarantee a sustainable supply of contraceptives and condoms as donor funding declines.**

- Advocate for approval of the National Sexual and Reproductive Health Program 2003–2007 (subsequently approved in February 2004) and modification of the SUMI law to include the provision of FP services and contraceptives to all women of reproductive age. In addition, a FP indicator should be added to the performance contracts that are a mainstay of decentralization in the health sector.
- Provide information and technical support to the MSD's leadership to facilitate the policy changes mentioned above and other decisions related to contraceptive security. Always present the need for contraceptive security in the context of national development goals, such as maternal and infant mortality reduction.
- Use the 2003 ENDESA findings as they become available to update and disseminate the analysis contained in this report. Also, perform a secondary market segmentation analysis on the 2003 ENDESA dataset to pinpoint socioeconomic, geographic, and other inequities in access to and use of modern contraceptive methods. Make this analysis available to promote improved market segmentation.

## Strategy 2.

**Identify sustainable contraceptive funding sources to replace donor assistance and financing, and put procurement policies and systems in place that ensure a continuous supply of low-cost, high-quality products and reduce barriers to access by the poor.**

- Develop formal donor phaseout or phase-down plans. Engage the MSD and international donors—DFID, USAID, and UNFPA—in the development of two plans, one for the public sector and one for the private sector. Set realistic targets based on anticipated funding, and measure progress.
- Move quickly to establish a system of municipal financing linked to SUMI with central level procurement of contraceptives at low cost. This will require a ministerial decree permitting municipalities and health establishments to purchase contraceptives using SUMI and revolving drug funds and sell contraceptives to clients not covered by SUMI. DFID must also provide permission for CEASS to sell donated contraceptives to municipalities and health establishments. Use proceeds from contraceptive sales to establish and capitalize a contraceptive revolving fund at the national level.

- Begin to purchase contraceptives at the central level in the most cost-effective way possible. Include a budget item for the purchase of contraceptives in CEASS's 2005 Annual Operational Plan.
- Sign a Memorandum of Understanding between UNFPA and the government of Bolivia that will permit CEASS to use UNFPA's reimbursable procurement mechanism for purchase of contraceptives at low cost, or use the government's existing agreement with PAHO to purchase contraceptives with the annual purchase of essential drugs.
- Secure stop-gap funding from the National Treasury and others if this is necessary to prevent stockouts in government health establishments during the phase out of DFID support, modification of policies, and establishment of the revolving contraceptive fund/supply.
- If contraceptives become scarce in the public sector, target or focus the distribution of free products—whether through SUMI, the national program, or both—on Bolivia's most vulnerable populations (e.g., rural areas, individuals and families with limited resources, etc.).

### Strategy 3.

#### **Encourage local governments, DILOS, civil society networks, and communities to advocate and build capacity for planning, financing, and delivering RH services.**

- Clarify the role of the municipalities and DILOS in planning, financing, and monitoring FP services and contraceptives.
- Expand UNFPA's current efforts to raise awareness of RH issues among municipal governments and DILOS. Inform them of the expected decline in contraceptive donations; strengthen their capacity to plan, manage, and finance FP services; and work with them to include FP requirements in their annual operational plans.
- Include civil society and other organizations in planning, monitoring, and advocating for improved RH services and contraceptive security.

### Strategy 4.

#### **Develop a more rational market segmentation in which the government focuses on those who are least likely to be able to pay for FP commodities, social marketing reaches the middle socioeconomic groups, and the commercial sector attends to those who have the ability to pay.**

- Perform an in-depth market segmentation analysis using the new 2003 ENDESA to better understand the current structure of the contraceptive market (i.e., the characteristics of those obtaining contraceptives from different public and private sector sources). Based on the results, develop a plan that builds on the comparative advantages of the public and private sectors.
- Develop strategic alliances with contraceptive and condom manufacturers that will lead to more rational market segmentation (e.g., provide subsidized or free products in rural areas and primarily commercial products in urban areas).

- Have PROSALUD begin purchasing Depo-Provera in 2004 and increase the quantities purchased in subsequent years as USAID donations decline. This will allow PROSALUD to establish necessary agreements with the manufacturer/distributor and adjust its sales prices over time based on actual costs.
- Have PROSALUD and NGOs begin to purchase other contraceptives and condoms in 2005; gradually increase purchases over time.
- Work closely with CNS and ensure the provision of FP services through the social security system. Include the CNS in the CS Committee.

### Strategy 5.

**Ensure that adequate quantities of all required contraceptives are available in all health establishments at all times. Effectively manage contraceptives under the newly integrated supply system, SNUS.**

- Continue to introduce and strengthen SNUS at all levels.
- Improve the capacity of municipal level DILOS and network managers to forecast contraceptive and other medicine needs through special training and other skills-building activities.
- Ensure that all necessary registers, reporting forms, and inventory control tools are available in health establishments and medical stores and that staff have been trained to use them.
- Provide continuous training on SIAL to counteract the frequent rotation of personnel, and improve the quality of logistics information for all products.
- Improve the distribution of contraceptives and other donated medicines and supplies by encouraging municipal governments to include transportation funds in their budgets or providing transport to move these products from the regional CEASS stores to health establishments.
- Increase the frequency and improve the quality of supervision by assigning logistics officers at the regional level (in the SEDES).
- Clearly define the responsibilities of municipalities and health establishments in relation to the management of logistics information and the distribution of medicines and supplies. Impress upon contact persons from the local to national level that it is their responsibility to manage supplies and provide the information that is vitally important for projecting and procuring contraceptives and other medicines.
- Motivate authorities at all levels of the health system to take concrete action to solve problems with the contraceptive supply and the supply of other medicines and medical supplies when such problems occur.

### Strategy 6.

**Reduce the high unmet need for family planning and increase the use of modern contraceptive methods among individuals who are not currently being reached with information, care, and contraceptives.**

- Approve, operationalize, and implement the National Sexual and Reproductive Health Program, which has as its objective reaching those who, for reasons of geography, culture, or language, are not currently being reached.
- Ensure that World Bank-supported efforts to expand primary healthcare in rural communities (i.e., through mobile brigades and contracting additional health workers) includes explicit FP indicators and performance targets.
- Support the efforts of municipalities and NGOs to expand their RH work in rural communities, in the altiplano, among the urban poor, and with youth in urban and rural areas.

### Strategy 7.

**Improve coordination so that government authorities, private sector representatives, and international donors are working together to meet the country's contraceptive needs in the face of declining donor contributions.**

- Continue to work through the CS Committee to support the MSD.
- Expand the committee's work with support from the international donor agencies and NGOs to include awareness raising and strengthening of municipal governments.
- Continue the MSD's leadership of the CS Committee and its coordination of the many stakeholders involved in sexual and reproductive health.

