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STATE OF THE PRACTICE BRIEF

Meeting the Millennium Challenge: Women and Their Families Can Survive and Thrive Through Expanded Access to Family Planning

Ensuring contraceptive availability and increased use at the decentralized level is now Bolivia's development challenge.

DELIVER, 2006

Field visit to a Ministry of Health and Sports municipal pharmacy in Llalagua, Potosí, to apply a logistics indicator assessment tool and contraceptive physical inventory

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Contraceptive security has been achieved when individuals have the ability to choose, obtain, and use quality contraceptives whenever they need them.

Bolivia has some of the most alarming socioeconomic indicators in Latin America, with 42 percent of the population living below the international poverty line of U.S.$2 per day.[1] The country is divided into nine departments and 327 municipalities, and 36 percent of the population resides in rural areas. The population in 2004 was nearly 9 million, with an estimated annual growth rate of 1.6 percent.[2] Approximately one-half of Bolivians are indigenous, who speak primarily Aymara, Quechua, and Guarani, and more than one-third of the population is younger than 15 years of age.[3] Many Bolivians reside in remote and difficult-to-reach areas and therefore face major challenges to accessing basic health services.

Furthermore, women in Bolivia experience deep inequity, with significantly lower literacy rates and income-generating capacity than men have achieved. As a result of these inequities, poverty, and limited access to health services, the maternal mortality rate is one of the highest in the Latin America and Caribbean region (229 per 100,000 live births).[4] Yet, despite these challenges, important progress has been made recently to improve the lives of Bolivian women and their families in the years to come.

For example, in 2000, the Bolivian government signed the United Nations Millennium Declaration, committing to cut maternal mortality by three-quarters and reduce child mortality by two-thirds by 2015. While much work must be done to achieve these goals, a recent upswing in contraceptive use has helped lower maternal and child mortality rates and alleviate economic strains on women and their families.

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No Product? No Program. Logistics for Health

In spite of barriers to access, the overall contraceptive prevalence rate (CPR) increased from 48 percent in 1998 to 58 percent in 2003, while use of modern methods also increased from 25 percent to 35 percent, suggesting that Bolivian women and men have increasingly embraced the importance of planning their families. Consequently, unmet need for family planning (FP) shrank from 26 percent in 1998 to 23 percent in 2003, and total fertility rate (TFR) dropped significantly from 4.8 to 3.8 children per woman (although rural TFR remained extremely high, at 5.5 children per woman). Among women in union of reproductive age, the intrauterine device is the most commonly used method (17 percent of total use), and an increase in use of injectables appears to be a major contributor to the recent CPR rise, which grew from 3 percent of total use in 1998 to 14 percent in 2003.[5]

In past years, family planning champions throughout the government have fought hard to establish a solid policy and legal framework for family planning. For instance, in 1999, the Ministry of Health and Sports (MOH) launched a strategic poverty reduction plan that identified sexual and reproductive health, including family planning, as a priority program. In broader terms, in 1995, the Government of Bolivia carried out a series of health-sector reforms aimed at expanding health care and empowering all levels of the public health sector by creating a national health insurance system and decentralizing management responsibilities to municipal health districts.

The main family planning service providers in Bolivia are the MOH; the government-run health insurance clinics (*cajas de salud*); nongovernmental organizations (NGOs) such as PROSALUD and the Center for Investigation, Education, and Services; and private pharmacies. PROSALUD is the main social marketing organization, with a network of 32 clinics, mobile units, and health promoters scattered throughout the country.

Historically, all family planning methods distributed in Bolivia by the public sector have been donated. For several decades, the U.S. Agency for International Development (USAID) was the primary donor of contraceptives to NGOs, while the United Nations Fund for Population Assistance (UNFPA) was the main donor to the public sector. Today, USAID donates only to PROSALUD, who in turn sells contraceptives to other NGOs, and local governments. Beginning in 2001, the Department for International Development (DFID) of the United Kingdom was the major donor to the MOH, a role it held through 2005. Today, the public sector receives donated methods from UNFPA, which acts as a procurement intermediary of donated contraceptives from the Japan International Cooperating Agency (JICA), which replaced DFID. Although JICA has committed funding through 2006 and the MOH plans to partially finance contraceptives in 2006, the country, to date, lacks a formal phaseout plan for donated contraceptives, and the extent to which donors are committed to continue donations is unclear.

Although Bolivia still depends on free contraceptives from donors, a number of recent practices have set the foundation for preparing for eventual donor phaseout. Bolivia must now meet the challenge of building on this base to ensure that women and men have access to the contraceptives they will need in the future. Without political commitment, Bolivia may suffer dire setbacks in continuing to secure the health of its women and children.

HEALTH REFORM AND DECENTRALIZATION EMPOWER LOCAL LEADERS TO GIVE REPRODUCTIVE HEALTH THE ATTENTION IT DESERVES

The decentralization of Bolivia's government (which includes all sectors), began in 1994 and has considerably changed the organization of health services. Most important, municipalities have been afforded a greater role in both financing and management of health facilities. Decentralization has also served to formalize citizen participation in planning and oversight of public health care services. This civil society participation is essential in getting services to the most vulnerable populations and bridging major disparities in health service provision in years to come.

In addition, the government instituted the National Public Health Insurance Policy (SNMN) in 1996, guaranteeing free access to a government-financed package of 32 basic health services. In 1998, the

SNMN became the Basic Health Insurance System (SBS); financing was increased, and the insurance package was expanded to include 92 services. This national insurance scheme created an opportunity to decentralize financing of health interventions by earmarking central funds to be transferred to municipalities (initially 2.7 percent for SNMN, then 5.4 percent for SBS and 10 percent as of 2005). Although, to date, contraceptives have not been purchased by municipalities, this is an important step that will help secure government funding for contraceptives when donations cease.

Moreover, advocacy meetings have been carried out at the municipal level to share information with local leaders, especially women, about the importance of securing funding for contraceptives. Because municipalities have their own budget, women leaders have increased access to decision makers and have an ability to influence policy decisions from the local level. Furthermore, these advocates can help deepen access and bridge geographic, cultural, and language barriers to provision of quality health services, a major challenge in many remote regions of the country. Increased participation by women and other civil society members will help guarantee the basic services that Bolivian law assures them.

UNIVERSAL MOTHER AND CHILD HEALTH INSURANCE LAW GUARANTEES ACCESS TO HEALTH CARE AND FAMILY PLANNING

In 2002, an unprecedented initiative—the Universal Mother and Child Health Insurance Law (SUMI) No. 2426—was passed by the Bolivian Congress to further strengthen a policy framework with an already favorable attitude toward achieving contraceptive security (CS). The law mandates universal and free health services for mothers during six months postpartum and for children less than five years of age. Because public-sector clinics are required to charge for all other services, this law guarantees that all new mothers, however poor, will have access to the health care services they need, including family planning. SUMI is more powerful than previous ministerial policy initiatives; it is a legislative decree that cannot easily be revoked. Furthermore, in December 2005, the Congress enacted Law No. 3250, broadening free reproductive

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Council women leaders in a municipal health management workshop to raise awareness about contraceptive security in Potosí, Bolivia

health care coverage (including family planning) to all women of reproductive age and mandating procurement of quality contraceptives through municipal governments.

These laws solidify the right of Bolivian women to reproductive health services and create a legal platform from which they can demand the services they need to plan their families. These legal measures will go a long way to protect the health of Bolivian women and children into the future.

POLITICAL CHAMPIONS BUILD FAVORABLE POLICY FRAMEWORK FOR SUSTAINED CONTRACEPTIVE SECURITY

The Bolivian government's Sexual and Reproductive Health Program was established in the early 1990s. Since then, key policies have been approved, including the National Reproductive Health Plan 1997–2002. Furthermore, in 2004, the MOH demonstrated political commitment to family planning by approving the 2004–2008 National Reproductive Health Plan. Such an explicit plan exists in few countries in the region and demonstrates the importance the MOH attributes to family planning as a means of achieving overall poverty reduction and maternal and child health goals. The main objective of this plan is to reduce unmet need for family planning by 30 percent during 2004–2008. The plan also aims to provide a broad range of contraceptives and improve the quality of family planning service provision at all MOH health care facilities.

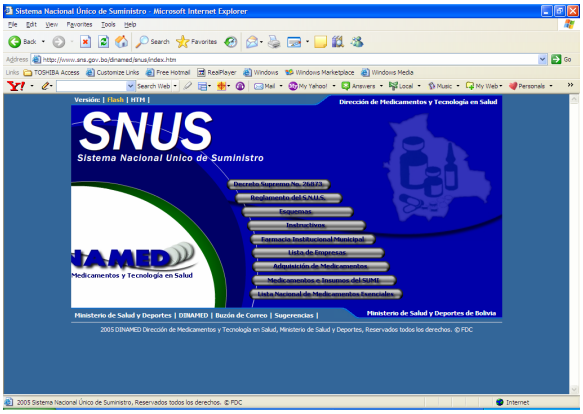
Additionally, in 2003, Bolivia formed a national Contraceptive Security Committee, with participation from public, private, and NGO sectors, indicating

widespread commitment to FP throughout all sectors of the country. The MOH also developed a draft long-term Contraceptive Security Strategy and Implementation Plan in 2005, which needs to be reviewed and considered by the new government.

This plan, if carried out under MOH leadership, and with participation from NGOs, civil society, universities, and donors, will serve as a catalyst for maintaining historic gains as well as taking first steps toward reaching the most vulnerable populations in need of family planning services. Such a committee will serve its purpose only if contraceptive security remains a priority of the MOH and other sectors, including civil society.

LOGISTICS MANAGEMENT IS ELEVATED TO THE FOREFRONT OF BOLIVIA'S PUBLIC HEALTH SYSTEM

In 2002, acknowledging that continuous and reliable product availability is essential to achieve the goals of the Universal Mother and Child Health Insurance Law, the Bolivian Government created the Unified National Commodity Supply System (SNUS) through Legislative Decree No. 26873. This is one of the most outstanding accomplishments in institutional-izing logistics management by any government in the Latin America and Caribbean region. In addition to making supply chain management a priority, the decree establishes the Logistics Management Information System (SIAL) as a component of the National Health Information System (SALMI).



Main screen of the Bolivia National Unified Commodity Supply System (SNUS)

This system will provide urgently needed up-to-date information about the use of medicines and contraceptives at all facilities. As a subcomponent of this supply chain management initiative, the MOH, with USAID assistance, has worked to automate the SIAL and integrate it into the SALMI. Although all facilities will not be automated, the tool is expected to facilitate and improve logistics management at the local level.

The first phase of this process has successfully validated and integrated software within the network of municipal pharmacies. The second phase, providing training workshops in software application for municipal pharmacy staff, will be made final by the end of August 2006. In addition, the MOH has begun to develop an interactive automated module to improve on-the-job training activities. This tool aims to orient local staff to the logistics information system, the automated system, and the overall national commodity supply system. Furthermore, several universities have incorporated SNUS–SALMI content into their preservice training curricula. As in other Latin American countries, the MOH recognizes that quality logistics management information deepens transparency and strengthens internal controls.

In terms of product availability, a recent logistics study carried out in MOH facilities revealed that contraceptives are available approximately 80 percent of the time, depending on the facility level (health post, health center, municipal pharmacy, or hospital).[6]

LOGISTICS MANAGEMENT CONCEPTS ARE INCORPORATED INTO NURSING CURRICULUM

Each element of CS contributes in unique ways to strengthening the capacity of service providers to deliver quality family planning services. Institutionalizing logistics management training within the country's public health and academic institutions is an important and targeted contribution toward achieving contraceptive security.

In most developing countries, the most commonly used approach to training is a "trickle-down" method. While it is a cost-effective strategy, this approach is less sustainable than others because of high turnover and dilution of information from one level to the next.

A new strategy, carried out by the Gabriel René Moreno University in Santa Cruz in 1997, with technical assistance from USAID, introduced logistics training content into the nursing program curriculum. This initiative was the start of a series of efforts and advocacy meetings about linkages between product management and quality of care. As a result, directors of universities wholeheartedly endorsed the proposal to include logistics coursework in nursing programs. For several years, consensus-building meetings were held with the universities of Bolivia to determine content, approaches, and tools to be included in logistics management curriculum. Today, Bolivia is the only developing country that has a permanent logistics curriculum for nursing students. By 2005, approximately 545 nursing program students from nine universities across the country had graduated with advanced training in supply chain management concepts.

CHALLENGES AND NEXT STEPS

Despite continued commitment in recent years to achieving CS, a call to action is needed to deepen several key aspects of CS in Bolivia in years to come. First, leaders must identify effective strategies for institutionalizing logistics management in a decentralized setting; in particular, management must ensure that central norms exist and are applied at local levels. In addition, although Bolivian law guarantees health services to all women and children, steps must be taken to translate these laws into action. The MOH will need to concentrate on dramatically expanding the availability of contraceptives in all service delivery points and at all levels of care, especially those located in the most vulnerable and hard-to-reach regions.

Second, sources of funding in anticipation of future phaseout of donations need to be identified by the government. Not only should sufficient funds be allocated but also a cost-effective procurement mechanism and a source of quality commodities must be identified, and arrangements must be made to avoid gaps in services once donations are no longer available.

Third, awareness-raising initiatives at the local level are essential to secure municipal funding for contraceptive procurement and ensure municipalities access to cost-effective sourcesof contraceptives once they begin to procure commodities for themselves (this should include centralized negotiation of prices).

Finally, the Contraceptive Security Committee needs to regroup and actively assume its role in order to facilitate CS throughout the health sector (including among NGO and commercial providers) by adjusting the implementation plan to a decentralized and ever-changing political landscape. Through invigorated participation and coordinated leadership, political champions, civil society advocates, association members, NGO leaders, and women, men, and their families can protect the gains achieved in family planning over the last decade and help meet Bolivia's Millennium Development challenge during the next ten years.

ENDNOTES

1. World Bank. 2006. "World Development Indicators." http://devdata.worldbank.org/wdi2006/contents/index2.htm.
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3. Instituto Nacional de Estadística. May 2006. "Datos Demográficos." http//www.ine.gov.bo/.
4. National Institute of Statistics, et al. 2004. *Bolivia 2003 Demographic and Health Survey, Final Report* (Spanish). Calverton: ORC Macro/MEASURE DHS+.
5. See note 4.
6. Logistics Indicators Assessment Tool, implemented in 2005.

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