

Assessment of the Bolivia Postabortion Care Community Mobilization Program

Emma Ottolenghi, M.D., *Independent Consultant, USA Team Leader*
Patricia Riveros, MPH, *Consultant, Bolivia*
Sarah Blanding, *International Development Intern, USAID/Washington*

May 2008

This study was funded by the U.S. Agency for International Development (USAID) under the terms of Leader with Associate Cooperative Agreement No. GPO-A-00-03-00006-00. Opinions expressed in this report are those of the authors and do not necessarily reflect the views of USAID.



USAID
FROM THE AMERICAN PEOPLE

the **ACQUIRE** project

TABLE OF CONTENTS

Acknowledgments	v
Acronyms and Abbreviations	vii
Executive Summary	ix
Background	1
Objectives of the Assessment	7
Methodology of the Assessment	9
Findings	13
Conclusions	25
Recommendations	27
References	31
Appendixes	
Appendix 1: Documents Reviewed	33
Appendix 2: Questions for the Assessment	35
Appendix 3: Evaluation Instruments	37
Appendix 4: Key Stakeholders Interviewed and Agencies They Represent	45
Appendix 5: Possible Criteria for Selection of Health Centers Where Comprehensive PAC Services Can Be Established	47
Appendix 6: Selected Photos of Evaluation Activities	49
Appendix 7: Sample Action Plan	51
Appendix 8: Sample Follow-Up of Action Plan	55
Appendix 9: Data from SNIS (2004-2006)	61

ACKNOWLEDGMENTS

We are very thankful to Dr. Carmen Monasterios, Community Mobilization PAC (C-PAC) coordinator, for the generous and collegial assistance she provided and for her important, knowledgeable insight about the C-PAC program and the Bolivia context in which it was implemented. The EngenderHealth Bolivia team deserves special thanks, in particular Lynn Johnson, Country Director, and Debbie Muñoz, Secretary. The C-PAC field staff we met with (coordinators and facilitators) enriched our knowledge and helped us understand their commitment and how their intense work made the program a success. And without mentioning names, thanks to all of the community group members and their leaders, the Health District Director in Santa Cruz, and all of the health center staff who agreed to our visits and contributed their valuable time to inform us, reflect with us, and show us their facilities. Our gratitude also goes to those key stakeholders we interviewed, who were quite ready to provide responses to our questions and were not averse to being quoted. Of these individuals, Luisa Rada was most familiar with details of C-PAC and gave us very rich information and details about the project.

We thank the U.S. Agency for International Development (USAID) Postabortion Care Working Group, and in particular its leader, Carolyn Curtis, for providing funding and direction for this assessment. And special thanks too go to Dr. Rocio Lara, USAID/Bolivia, for sharing her extensive knowledge of the Bolivian health care situation and for her ready availability to us during our visit.

We finally thank all those who reviewed drafts of this report, including our colleagues in Bolivia and at EngenderHealth and the World Health Organization (WHO). Their questions and comments enabled us to produce the present, final draft.

This study was made possible by the generous support of the American people through the Office of Population and Reproductive Health, USAID, under the terms of Leader with Associate Cooperative Agreement No. GPO-A-00-03-00006-00. Opinions expressed in this report are those of the ACQUIRE Project and do not necessarily reflect the views of USAID or the United States Government.

ACRONYMS AND ABBREVIATIONS

CIES	Centro de Investigación, Educación y Servicios (Bolivian NGO)
CIDEM	Centro de Información y Desarrollo de la Mujer (Bolivian NGO)
CEPAC	Centro de Promoción Agropecuario Campesino (Bolivian NGO)
COPE	client oriented, provider efficient (a method for self-diagnosis)
C-PAC	Bolivia's Community Mobilization Postabortion Care Program
DHS	Demographic and Health Survey
FCI	Family Care International
FP	family planning
GOB	Government of Bolivia
IEC	information, education, and communication
IDB	International Development Bank
IR	Intermediate Result
KAP	knowledge, attitudes, and practices
MOH	Ministry of Health
MVA	manual vacuum aspiration
NGO	nongovernmental organization
PAC	postabortion care
PAHO	Pan American Health Organization (a branch of the World Health Organization)
PROCOSI	El Programa de Coordinación en Salud Integral, a Bolivian NGO umbrella organization
PROSALUD	Protección para la Salud (Bolivian NGO)
RH	reproductive health
SEDES	Servicio Departamental de Salud
SNIS	Sistema Nacional de Información en Salud (National Health Information System)
SRH	sexual and reproductive health
SUMI	Seguro Universal Materno-Infantil (Bolivia's universal maternal-child health insurance)
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
USAID	U.S. Agency for International Development

EXECUTIVE SUMMARY

Since 1994, the U.S. Agency for International Development (USAID) has included postabortion care (PAC) as one of its programmatic priorities to reduce maternal mortality and to link couples with needed family planning (FP) and reproductive health (RH) services. The model in USAID's PAC strategy includes three components: 1) emergency treatment for complications of spontaneous or induced abortions; 2) FP counseling, service provision, evaluation and treatment of sexually transmitted infections (STIs), HIV counseling and/or referral for testing; and 3) community empowerment through community awareness and mobilization.

The USAID Postabortion Care Working Group, which has developed standardized tools for PAC programs, is moving its PAC program from being a vertical stand-alone to being an integral component of USAID's global health program. Since 2003, it has provided additional support to seven "focus" countries to test and document innovative strategies and new PAC program models. Eligibility criteria to be a focus country included Ministry of Health (MOH) commitment, USAID Mission matching funds, and plans for program sustainability once USAID/Washington Global Leadership Program funding was no longer available.

One of the USAID/Washington focus countries is Bolivia, which proposed to test a strategy for community involvement and mobilization and received an additional \$580,000 from USAID/Washington to plan, implement, and expand this program element. The Community Mobilization PAC (C-PAC) program was implemented in three diverse geographical and cultural areas, focused on periurban, Spanish-speaking communities from 2004 to March 2007; the program was implemented by CATALYST/Pathfinder from its onset in April 2004 until November 2005, when it was transferred to the Bolivian nongovernmental organization (NGO) PROSALUD, through its project, *Socios para el Desarrollo*.

The overriding goal of the Bolivia C-PAC Program was to empower the community to mobilize itself and thus help reduce maternal morbidity and mortality caused by complications of incomplete abortion (both spontaneous and induced). The main C-PAC objectives were to: 1) identify barriers to preventing unintended pregnancy and treating complications of miscarriage and abortion; 2) strengthen local capacity for meeting the health needs associated with the above and other important health-related problems; and 3) develop community plans to address the above causes of morbidity and mortality. In this program, health services participated only to the extent that they agreed to work with the community and assess changes taking place as a result of community involvement. An innovative methodology for achieving these objectives—known as the community action cycle (CAC)—was implemented. The CAC consists of five phases: 1) organizing the community by forming community groups and introducing them to the community mobilization objectives and methodology; 2) determining priority health problems and needs; 3) developing an action plan and implementing feasible solutions; 4) monitoring and evaluating those plans; and, 5) evaluating the achievements of the action plan using community-determined indicators.

The present assessment was conducted in June 2007 at the request of the USAID Postabortion Care Working Group and USAID/Bolivia. Its main purpose was to evaluate the C-PAC Project carried out by CATALYST and *Socios para el Desarrollo* in Bolivia. It is meant to provide information to interested parties in Bolivia and to key stakeholders in the USAID global PAC program, and to provide a knowledge base for replicating the program and scaling up investments in similar programs worldwide.

The assessment included a document review, interviews with key stakeholders, and visits to the three areas where the program was implemented. In intervention sites, the evaluation team met with MOH

management, health center providers, C-PAC coordinators and regional staff, community leaders, and community groups, including women and youth.

Key Findings

1. *The C-PAC program was, in large part, able to accomplish its objectives.*

The effort is commendable, given that the project was able to achieve difficult changes in both the community and health centers within a relatively short time frame. The program led to a paradigm shift in power relations between the community and health service providers. Clients and communities changed from passively accepting services to being proactive and assisting service providers to effect changes. This led to better understanding and empathy by providers and to a better response in meeting the community's needs.

- a. Community mobilization and empowerment was very effective, most notably in women and youth. Women gained self-esteem and empowerment, became very active in the community, and reported changes in the health services they received. Both women and service providers reported horizontal, respectful, and cordial relations as a result of the C-PAC program. Changes that took place included more respectful, confidential, and culturally appropriate treatment; improved client-provider communication; longer service hours; and the establishment of new services in some sites. Youth demonstrated a new sensitivity to women's health issues, particularly pregnant women's issues. Young people started assisting pregnant women, for example, by carrying their heavy burdens, and learned that pregnancy can cause complications that demand a quick response. Empowerment, (as defined by Wallerstein, 2006)¹ became an intermediate avenue for changes in the delivery of health services and was an important outcome for the women themselves.
- b. Local capacity at the community level for preventing unintended pregnancy and treating abortion complications is now in place. The program was associated with increases in participants' and their peers' knowledge related to the prevention of unintended pregnancy, symptoms of obstetric complications, when to seek care, and the right to receive free services guaranteed in Bolivia's universal maternal-child health insurance (SUMI). This increase in knowledge and community empowerment led to better awareness of pregnancy complications, a need to reduce the three types of delay that contribute to maternal mortality and morbidity, and activism to address those delays by changing established practices at health centers. We were surprised by how readily community women used explicit language to address topics (i.e., FP, abortion) that were thought by many to be too "sensitive" to bring up.
- c. Community action plans were developed, implemented, and evaluated. The development of such plans was not an easy component, because communities tended to identify many more needs than could be addressed in a short time (i.e., up to 30 were chosen in the first action cycle). Through intensive discussions using tools provided by the C-PAC staff, the communities determined several priorities, some of which included problems related to unintended pregnancy and how to prevent it, unsafe abortion, and complications from miscarriage and induced abortion. In subsequent action cycles, the community expanded beyond pregnancy and unsafe abortion to other problems and possible solutions (e.g., tooth decay, malnutrition, gender-based violence, and others).
- d. Links between the community and health services were established and strengthened. Some women (and even community leaders) stated that before the project started they did not know the location of the closest health center. Community leaders initiated meetings with district MOH directors, health center staff, and municipal officials to address newly recognized concerns and to help centers meet clients' needs. Providers reported that they were more informed of community needs and had

¹ According to Wallerstein (2006), "empowerment" can be both a process and an outcome. It can cross different issues in public health, such that interventions addressing women's, patient/family, and partnership issues can produce health outcomes such as greater self-efficacy, adoption of healthier behaviors, and/or policy changes, for example (pp. 9–14).

changed their attitudes toward clients. Clients stated that providers were more respectful and culturally sensitive, and that they made greater efforts to communicate, explain, and listen. Not all health centers and staff, however, collaborated with the program, which caused frustration in some communities.

2. *The C-PAC methodology facilitated goal achievement.*

Knowledgeable key stakeholders, health service managers, providers, and project personnel used the following adjectives to qualify the C-PAC methodology: systematic, flexible, adaptable, self-correcting, easy to replicate once learned, and easily adapted for low-literacy community members. Many participants stated that although they found the methodology difficult and laborious at first, they became much more efficient at their tasks and needed less assistance from C-PAC staff as they became more familiar with it.

3. *Men and youth were also positively affected by the project.*

Male-female communication was facilitated, and (in a reversal of accepted tradition) knowledge filtered down from the women to their husbands and adolescent children. According to the women, their limited literacy created a window of opportunity to involve their adolescent children, and doing so facilitated conversations on never-before-addressed topics, including sexuality, unplanned pregnancy, abortion, and gender-based violence. Although many men were originally opposed to their wives' involvement in group work, they became supportive after seeing how their wives became more assertive with health service providers, and sometimes joined the groups themselves. However, men never made up more than 10% of the community members who actively participated.

4. *The project and participating community groups and their leaders leveraged inkind resources.*

Examples of leveraged resources include training and other assistance offered by many nongovernmental organizations (NGOs), state agencies (such as the Santa Cruz University, a public institution), and the Pan American Health Organization (PAHO), and the donation of space, including the use of equipment and utilities, in a health district office. No funds were leveraged.

5. *The C-PAC program is not well known among agencies working in related efforts.*

Many key stakeholders—even managers of agencies working with PAC, community extension activities, and some NGOs funded by USAID/Bolivia—were unaware of the existence of the C-PAC program. One key stakeholder suggested that project may have been little known because it was a pilot project, about which information would be disseminated if effectiveness was proven.

6. *Support provided by the USAID/Washington Postabortion Care Working Group was valuable.*

The additional infusion of resources facilitated this project's large volume of work. The change in administration of the program in mid-2005 involved a shift from channeling USAID/Washington funds directly to CATALYST to providing the funds to USAID/Bolivia, which in turn transferred them to the Bolivian NGO; this was accomplished with slight delays but with little difficulty. The change actually facilitated USAID/Bolivia involvement; indeed, the USAID Health Representative we interviewed stated that *Socios para el Desarrollo* excelled at project management.

C-PAC Program Costs

Between November 2005 and March 2007, *Socios para el Desarrollo*'s budget for the C-PAC Project totaled \$380,000; these funds were spent in their entirety, covering such items as personnel and consultants, travel, equipment, materials, printing, community work and administrative costs and overhead. These were complemented by the \$200,000 budgeted to CATALYST for their PAC activities, which included the implementation of C-PAC.

Conclusions

The PAC community mobilization program implemented in Bolivia succeeded in promoting service demand and quality improvements as well as creating impressive changes in the participating communities. The program improved levels of knowledge about abortion complications and care-seeking practices; increased knowledge on preventing unplanned pregnancies; created links with health services and providers; and raised the quality of services to make them more client-friendly and culturally responsive. It deserves to be maintained and further supported by USAID to firm up its achievements and expand its reach. In addition, the program should inform USAID/Washington and its global PAC program partners about a creative strategy that proved especially effective at empowering and mobilizing the community.

Recommendations

To enhance future programming in Bolivia and globally, we offer the following eight recommendations.

1. Strengthen the alliances between various NGOs and MOH services. EngenderHealth's scope of work includes the establishment and improvement of PAC services at both the national level (through service-delivery NGOs) and currently at MOH second- and third-level facilities in 48 municipalities in the departments of Santa Cruz, Beni, Tarija, and Cochabamba. Principal strategic allies include selected community-level NGOs belonging to El Programa de Coordinación en Salud Integral (PROCOSI), a Bolivian umbrella organization. We recommend strengthening alliances through the following steps:
 - Coordinate with Andean Rural Health Care, under the PROCOSI Community Health Project, to conduct operations research to test a project similar to C-PAC. To determine the effectiveness of community mobilization to increase demand of reproductive health services (including PAC), data need to be collected prior to and during intervention at participating and similar control sites; in the project being evaluated, this was not done. If there are positive results, they should be shared with other PROCOSI members working at the community level with obstetric emergencies. EngenderHealth would provide technical assistance to develop linkages between the community and health services.
 - For the municipalities under EngenderHealth RH support, we recommend establishing formal coordination between EngenderHealth PAC programs and MOH community extension efforts based on the C-PAC strategy of linking service demand and supply and, further, that comprehensive PAC services be established in a few first-level facilities. Some clinics would need only modest efforts to be able to provide these services (see criteria, Appendix 5).
 - Update health center and post providers on the national reproductive health norms related to PAC services. In almost all visited clinics, one or more providers claimed that although they had participated in manual vacuum aspiration training, such services were universally unavailable at first-level facilities because national reproductive health norms do not allow it, an assertion that turned out to be false.
 - We further recommend that USAID-funded NGOs working in clinical RH services (such as Centro de Investigación, Educación y Servicios [CIES] or PROSALUD) integrate the C-PAC program strategy in areas that receive EngenderHealth technical support. CIES is already programming community extension activities, led by Dr. Carmen Monasterios (C-PAC coordinator), that adapt the C-PAC strategy for all sexual and reproductive health (SRH) services. This effort could be developed as a modest operations research project to document changes in service demand associated with the community extension efforts based on the C-PAC methodology. Moreover, any changes in the program area can be compared with the experience of a similar site that did not participate in C-PAC activities.
 - We recommend that the self-assessment stage of the C-PAC cycle be administered not only as part of community work, but also at the participating health service delivery sites. The COPE model (which stands for "client-oriented, provider-efficient" services) could be applied to PAC services in

hospitals and health centers and could sensitize managers, providers, and support staff, who would then implement important client-focused service improvements even before the community itself intervenes.

- We recommend regular meetings with the participation of all strategic allies to keep them involved, to share work, achievements, challenges, and lessons learned, and to prevent noneffective activities from being repeated. These meetings would provide an opportunity for group thinking on improvements to the intervention as it proceeds.
 - USAID should encourage meetings of its stakeholders to share plans, process issues, and lessons learned from similar programs. Participants at these meetings should include, in addition to USAID-funded program managers, other funding agencies' representatives and MOH representatives who support the project.
2. To prevent loss of momentum, USAID should consider building more time at the end of pilot projects that have been shown to be successful. Several informants stated that a minimum of five years is needed to achieve true institutionalization of successful programs. The additional time would be used to gradually decrease support and transfer responsibilities to principal actors. If communities are to be convinced that PAC service improvement is a necessary and continuous process, they will need assistance in finding ways to mobilize their own resources to improve the chances of sustainability.
 3. We recommend that follow-up programs work with health networks to establish comprehensive emergency obstetric care/PAC services in one or two health centers meeting specific criteria (see Appendix 5); such services would include emergency treatment followed by FP counseling and services.
 4. Sustainability needs to be promoted. To that end, we recommend the following four steps.
 - Disseminating the C-PAC program design and outcomes widely among key actors, such as the MOH (central and regional/district), municipalities, major donors, health and development agencies, and NGOs/private voluntary organizations. Several key stakeholders advised that the MOH needs to be addressed separately, with a carefully considered strategy.
 - Forming strategic alliances with women's and indigenous organizations and workers' unions, among others.
 - Obtaining MOH buy-in to the C-PAC strategy and scaling it to fit MOH human and financial resources for child health and SRH programs. To achieve MOH buy-in, several strategies may need to be explored, including the following:
 - Identifying community extension champions within the MOH and forming strategic alliances with particular representatives of NGOs that enjoy the trust of the ministry.
 - Encouraging PAHO, the United Nations Population Fund (UNFPA), World Bank, and similar multinational agencies to advocate for program implementation at the central MOH level, and concurrently, working directly with regional-level (SEDES) and district-level MOH managers.
 - Engaging the involvement of other public institutions, such as the Ministry of Education, which could explore the possibility of including rural teachers in follow-up adaptations and replications of the C-PAC strategy.
 - Simplifying the C-PAC manual for direct and regular use by less-educated community groups. (*Note:* After multiple revisions based on its use, this manual was considered effective and easy to use by college-educated program facilitators). However, it included a lot of theory and had too much text to be useful for regular use by community groups.
 5. To prevent the loss of investment in training human resources and thus increase cost-effectiveness, we recommend that trained, committed staff from completed projects be offered work in other ongoing or

new USAID-funded projects with similar characteristics. Staff should be promoted and deserve fair salaries and benefits. (C-PAC field staff were hired as consultants, so while they had adequate salaries, they received no benefits.)

6. Program staff should retain a presence in the community and should gradually decrease the intensity of their involvement, until the community is fully able to continue on its own. We recommend such additional “accompaniment” time to allow communities to appropriate and replicate new methodologies for service improvement and integrate them into their regular lives. Program staff involvement should only be terminated when skills are institutionalized and the community is able to leverage resources to continue activities.

BACKGROUND

USAID Involvement in Postabortion Care

Complications from unsafe induced abortion and miscarriage remain a major cause of maternal ill health and death in many countries. In response to this problem, since 1994, the U.S. Agency for International Development (USAID) has included postabortion care (PAC) as one of its programmatic priorities to reduce maternal mortality and to link couples with needed family planning (FP) and reproductive health (RH) services.

In 2001, USAID's Bureau for Global Health commissioned a global evaluation to document the strengths and weaknesses of USAID-supported postabortion care programs. As a result of this evaluation, a strategy plan, results framework, and model for USAID PAC programs were developed in 2002–2003.

Key facets of the PAC strategy include:

- Expansion and institutionalization of PAC at the country level
- Identification of successful models through intensive work in a number of focus countries
- Compilation of research findings, documentation of the impact of PAC programs, and identification of needed further research
- Dissemination of successful models to donors and decision makers, in order to mobilize global resources to enable expansion and replication of evidence-based PAC programs
- Monitoring and evaluation throughout all Intermediate Results (IRs) in the Results Framework.

Further, the USAID Postabortion Care Working Group decided to develop standardized tools for PAC programs, to move PAC from a vertical stand-alone program to an integral component of USAID's global health program, and to provide significant additional support to a small number of focus countries to test and document innovative strategies and new PAC program models. Eligibility to be a focus country was based on maternal mortality ratios, contraceptive prevalence rates, total fertility rates, and the requirement of Ministry of Health (MOH) commitment, USAID Mission matching funds, and plans for program sustainability once USAID/Washington Global Leadership Program funding was no longer available. The seven focus countries chosen in 2003 were Bolivia, Cambodia, Haiti, Kenya, Nepal, Senegal, and Tanzania.

Bolivia: RH Context

- Population: 9.1 million (CIA, 2007)
 - 52% women; 32% of all women are of reproductive age
- Total fertility rate: 3.8 lifetime births per woman (DHS, 2003)
- Contraceptive prevalence rate/modern methods: 35%; unmet need: 23%
- Maternal mortality ratio: estimated at 290 per 100,000 live births (Unicef and WHO, 2000, adjusted):
 - 37% due to "hemorrhage during pregnancy," e.g., abortion-related complications (Ipas, 2007)
 - Striking inequities (rural/urban, indigenous/nonindigenous). In some isolated rural indigenous populations, maternal mortality ratio may reach 887 per 100,000 (PAHO 2004).
 - Key contributing factors include:
 - Lack of knowledge about and access to contraceptive services
 - Disrespectful treatment of women by providers
 - Health workers' lack of understanding about and insensitivity to traditional cultural practices
 - Poor communication between health workers and clients
 - Lack of emphasis in health policies on need to expand coverage to indigenous areas
 - 650 Bolivian women die every year from complications related to pregnancy and childbirth; 47% of these women are younger than 30 years (Rehnstrom, U., International Midwifery, UNFPA, September 2006)

Bolivia as a USAID PAC Working Group Focus Country

In 2003, USAID updated its existing PAC model by adding community empowerment through community awareness and mobilization. In fiscal year 2003–2004, Bolivia was chosen as one of two focus countries in the Latin American region because it met the selection criteria and was interested in testing a model for community mobilization for PAC. Bolivia received \$580,000 in funding from USAID/Washington’s Postabortion Care Working Group to implement this activity.

In 2004, as a result of USAID/Bolivia’s initiative and added USAID/Washington focus-country financial support, Pathfinder/CATALYST proposed and incorporated a community mobilization component into its PAC clinical program. The component was tested in selected periurban areas of El Alto in the department of La Paz (highlands) and outside the city center of Santa Cruz (eastern lowlands). When CATALYST involvement ended, the program continued under the aegis of Socios para el Desarrollo, a project of the Bolivian nongovernmental organization (NGO) PROSALUD from November 2005 through March 2007, and expanded to poor periurban areas of the city of Cochabamba (valley area).

Bolivia’s Health System

The Bolivian government has decentralized its health system into nine regions (or SEDES, in Spanish). Each SEDE has between six and 12 health districts or networks, which are managed by a network administrative unit; each network supervises multiple health centers and their associated health posts. Bolivia has a total of 1,300 primary health centers and 250 secondary-care and tertiary-care hospitals. The government has not only decentralized health management, but has also devolved funding for health and education programs. Funds, from taxes, are distributed to municipalities, which in turn reimburse facilities for covered services. Funding for programs is determined by the epidemiology of each district and by local decision making, through an annual work plan.

In 1998, the Bolivian government developed a universal health insurance plan, now designated as the Universal Maternal-Child Health Insurance plan (SUMI), which provides all maternal and child health services free of charge. Coverage for women, which includes contraception, extends throughout pregnancy and during the first six months postpartum; children are covered up to their fifth birthday. Cases of hemorrhage during pregnancy are also covered by SUMI. Although the plan has been institutionalized throughout the health system, many potential users are still poorly informed about it, and thus may avoid care because they are unable to pay for it. In El Alto, there is governmental discussion for expanding this insurance to cover additional adolescents’ sexual and reproductive health (SRH) care services.

Abortion in Bolivia

Abortion is illegal in Bolivia except when the pregnancy resulted from rape or incest, or when carrying the pregnancy to term puts the woman’s health or life in danger.² Abortion providers may be sentenced to 2–10 years’ imprisonment for performing an illegal abortion. Because of the severity of the penalties, physicians are wary of providing even legal abortions, which makes safe legal abortion essentially unavailable. It is estimated that more than 40,000 abortions occur each year in Bolivia.³

Until recently, even the word abortion was avoided, and as a result, complications of induced and spontaneous abortions were referred to as “hemorrhage in the first half of pregnancy” (in Spanish, HPME). This is the term used in MOH documents and norms for treating postabortion complications.

² This information is based on the Bolivian Penal Code.

³ [No author given] 2007 “En Bolivia se realizan 115 abortos ilegales al día.” [115 abortions are performed daily in Bolivia] *Criterios* (Mexico), April 26, cited on 4/23/2008, [http://www.criterios.com/modules .php?name=Noticias&file=print&sid=11431](http://www.criterios.com/modules.php?name=Noticias&file=print&sid=11431).

The Bolivia PAC Community Mobilization Effort

The PAC Community Mobilization PAC (C-PAC) program was implemented first by CATALYST from April 2004 to mid-2005 and then by Socios para el Desarrollo/PROSALUD through March 2007. This program aimed to reduce the three types of delays that contribute to pregnancy-related morbidity and mortality: a) delays in recognizing that there is a complication and deciding to seek care on the part of the individual, family, or both; b) delays in reaching an adequate health care facility; and c) delays in receiving adequate care at the facility. There are a variety of reasons for each delay, including insufficient financial resources, lack of transportation, unavailable or insufficiently trained staff, and insufficient supplies and infrastructure, among others. The C-PAC program was implemented in three diverse geographical and cultural areas, focused on periurban, Spanish-speaking communities.

Goals and Objectives of the C-PAC Program⁴

The central, overriding goal of C-PAC was to empower the community to mobilize itself to reduce maternal morbidity and mortality due to complications resulting from miscarriage and incomplete abortion.

The three specific program objectives are the following:

1. Identify attitudinal, social, physical, and financial barriers to the prevention of unintended pregnancy and treatment of complications of miscarriage and incomplete abortion, and educate community members about FP (including birth spacing) and PAC services.
2. Identify and strengthen local capacity for addressing the health needs associated with prevention of unintended pregnancy and treatment of complications of miscarriage and incomplete abortion, as well as other related needs, such as women's and adolescents' empowerment.
3. Develop community action plans for addressing the barriers to use of both FP and PAC services.

C-PAC Mobilization Methodology

The Bolivia C-PAC model is based on the WARMI (*warmi* = woman in Aymara) program's community action cycle, a framework for community mobilization that was developed by Save the Children in the 1990s.⁵

Each community action cycle consists of five phases (see poster below):

Phase 1. The community organizes by forming community groups to initiate the process, and the community mobilization objectives and methodology are introduced.

Phase 2 (also termed autodiagnosis). The community identifies and prioritizes problems and needs related to unintended pregnancy and miscarriage/abortion complications.

Phase 3. The community develops an action plan centered on available health services to propose solutions to priority needs that were identified. (See Appendix 7 for an example.)

Phase 4. The community implements and monitors the action plan.

Phase 5. The community and facilitators evaluate the achievements of the action plan using community-determined indicators. (See Appendix 8.)

⁴ CATALYST: Community Mobilization around Postabortion Complications in Bolivia (April 2004).

⁵ *Monasterios presentation, 2007.*



Poster of the community action cycle and its phases developed by a woman's group in El Alto. (Translation of the poster: Phase 1: Community organization; Phase 2: Identification and prioritization of needs; Phase 3: Elaboration of action plan; Phase 4: Plan implementation and follow-up; Phase 5: Participatory evaluation)

All subsequent action cycles can skip the first phase and go directly to Phase 2, using feedback from the results of the community's self-evaluation.

Sample exercises used by group members in the course of the action cycle include: a) constructing life stories, including SRH life stages and experiences of men and women (see Photo 4, Appendix 6); b) drawing a symbolic bridge depicting the present health situation and the desired situation and activities needed to reach it; c) community mapping (see Photo 3, Appendix 6) to identify the location of all health service sites, pharmacies, traditional healers, traditional birth attendants, and available transportation (buses, taxis, ambulance); d) interviewing community members using an instrument developed by group members to identify SRH problems; e) developing indicators through community participation; f) and documenting all meetings and their contents.

Three consecutive action cycles were needed to institutionalize the community-group process in the two departments where the Bolivia C-PAC program was first introduced, La Paz and Santa Cruz. Because the C-PAC program was instituted two years later in the department of Cochabamba (in 2006), only two cycles were completed there by the program's end point. Group leaders were key to the institutionalization and appropriation of the methodology. There was a wide spectrum of leadership in this project, as in similar ones, but since much of the work was repeated in subsequent cycles, most groups eventually selected effective leadership.

Intervention Site Selection

The selection process started with the health centers, which were selected on the basis of their meeting the criteria of having expressed an interest in participating and their serving an area with very high levels of maternal morbidity and mortality. Once a health center agreed to participate, the director of the center and the program staff identified possible communities that were served by it. These communities were visited and introduced to the C-PAC intervention. If the communities expressed an interest in the program, existing community groups were approached. If no such existing groups were identified, women (and men, if they were available during the day) were gathered and groups were formed. Health centers were not substantively involved in the intervention; their participation was limited to identifying the catchment area for their services and the potential communities to participate in the program. Some clinics received a bookshelf or a cupboard, but no other material or technical incentive was provided. No training was directed

to the providers, and no new services or equipment were provided by program personnel; if any improvements occurred, they were the result of direct action by the participating communities, with financial support from the municipality. Because health centers are required to meet service targets, the possibility that they participated in the C-PAC program to help meet those targets might have served as an incentive to consent to the intervention.

OBJECTIVES OF THE ASSESSMENT

The goals of the present assessment activity include:

- Undertaking a qualitative assessment to evaluate the C-PAC program implemented by CATALYST and PROSALUD/Socios para el Desarrollo in Bolivia
- Documenting the process used for identifying groups in the initial activity and for identifying additional regions and groups to scale up to as the program progressed
- Documenting the impact on C-PAC of the funding provided by USAID/Washington's Postabortion Care Working Group
- Documenting the types and amounts of resources leveraged in the program by USAID/Bolivia and the community
- Based on this evaluation, providing recommendations to USAID/Washington's Postabortion Care Working Group for the scale-up of C-PAC programs worldwide

Assessment questions developed by USAID/Washington are presented in Appendix 2.

METHODOLOGY OF THE ASSESSMENT

A qualitative case-study approach was used to gather information and assess the Bolivia PAC community mobilization program. Information for this assessment was gathered principally through a) document review; b) telephone and face-to-face interviews with key stakeholders; and c) field visits to intervention areas in the departments of Cochabamba, La Paz, and Santa Cruz. Health center directors and providers were interviewed (in their respective centers), and individual interviews and focus group discussions were conducted with community leaders, women's and men's group leaders, women's groups, youth groups, and C-PAC program regional coordinators and facilitators.

Although it would have been desirable to obtain service data from health center providers, we were unable to do so. We were later informed by knowledgeable informants in La Paz that these data are almost impossible to obtain. Although some data on women treated for postabortion complications can be found in the National Health Information System (SNIS), the system does not always provide updated and disaggregated data at the health center level.

Assessment Team and Principal Collaborators

The assessment team was led by Dr. Emma Ottolenghi, a U.S.-based physician and consultant with extensive experience in Bolivia, PAC programs, and program evaluation. The other members of the team were Patricia Riveros, MPH, a Bolivian consultant with several years of experience in operations research programs with Population Council/Bolivia, and Sarah Blanding, a U.S.-based USAID international development intern, who observed and participated (as possible) in the evaluation. Key informants were C-PAC Program Coordinator Dr. Carmen Monasterios and Dr. Rocio Lara, Cognizant Technical Officer with USAID/Bolivia.

Development of Data Collection Instruments and Their Application

Due to time constraints, all instruments were developed exclusively in Spanish, rather than being developed first in English and then translated. Key questions were developed by the team leader before she traveled to Bolivia, and these questions were extensively revised by the team and Dr. Monasterios in the first two days of work. The instruments were pilot tested on selected informants and then revised and finalized. All instruments were comprehensive, and the team used selected questions based on their applicability to the particular respondent. Ethical standards were strictly observed in conducting interviews and focus groups by obtaining verbal informed consent before asking questions. Separate informed consent was obtained before taping any activity or photographing participants. Participants' decisions to decline to have their pictures taken or their conversations recorded were respected by the team. Sample instruments are included in Appendix 3.

Document Review

The list of documents reviewed for this assessment is found in Appendix 1.

Clinic Visits

We visited five out of the 33 intervention-area health centers and one center that did not participate in the intervention. The six centers that were visited were selected by Dr. Monasterios on the basis of their location (within a reasonable distance from the city center) and their having expressed an interest in being visited. No health center that was approached refused to be visited. In all, we were cordially received by providers and health center directors. Personnel were interviewed to obtain their opinion of service changes that could be attributed to the program and their attitudes toward those changes. We were also given an informal tour of the visited facilities. The clinics were modern, simple, and very well maintained and clean, with obviously dedicated staff.

Key Stakeholder Interviews

Nineteen key stakeholders representing 10 agencies and USAID/Bolivia were interviewed in person and/or by telephone (see Appendix 4). Verbal informed consent to be interviewed and to be quoted, if necessary, was obtained.

Interviews and Focus Groups in Periurban Intervention Areas in La Paz, Santa Cruz, and Cochabamba

Because of time constraints, Dr. Monasterios selected the C-PAC participating sites to be visited and the persons in the field to be contacted, including regional program coordinators and facilitators, taking into account their availability and the distance from where the assessment team stayed. We cannot claim that any person or group we met with is representative of the program universe, but Dr. Monasterios felt that the community leaders we met were representative of those who worked with the project.

We do not identify informants by name because they were assured of anonymity.

Table I. Evaluation activities:

Persons and groups contacted during field work for the evaluation

Person or group	La Paz	Santa Cruz	Cochabamba	Total contacts/ program totals
Regional C-PAC program coordinators	1	1	1	3/3
Regional C-PAC facilitators	2	1	1	4/8
Community participating group leaders	14	8	6	28/150
Community groups	1 group; 20 women	1 group; 13 adolescents (men and women)	2 women and 1 man	36/82
Intervention areas' health centers visited	2	1 plus one center in nonintervention area	2	5/33
MDs and RNs in centers in intervention areas	3	2	8	13
MD in nonintervention area center visited		1		1
Health district chief and staff		2		2/5
Civil society representatives		2		2
Total persons contacted during assessment				94

At Dr. Monasterios's initiative and with our approval, we were joined during some meetings by facilitators hired to work with CIES to adapt the C-PAC methodology to that agency's comprehensive RH program. These nonparticipating observers were identified as such to the individuals and groups before informed consent was obtained.

Limitations of the Assessment

This report is based on information from the documents provided and on observations of a small sample of the program universe; thus, the data are largely qualitative and anecdotal. Quantitative data come from CATALYST and Socios para el Desarrollo reports. In spite of the lack of quantitative data, we feel the picture that emerged from our visit is a reflection of the C-PAC program, and our conclusions and recommendations have been validated by knowledgeable people with whom we shared our thoughts.

This assessment was limited by the following factors:

- The time assigned for planning and conducting the assessment was very limited. Nine working days were used to plan and complete all of the activities listed above, including field visits to three cities. That we were able to conduct as much work as we did was greatly facilitated by Dr. Monasterios's assistance. She organized the field visits and convened the people we were interested in seeing and talking with.
- The program had concluded three months before our visit, and a number of staff had moved and were not available to meet with us.
- No quantitative service statistics were available at health facilities, because data collection was not incorporated into planned project activities.

For a more complete evaluation of a program of this complexity, it would have been ideal to have a team of four evaluators for a period of 15–20 days.



Women's group, El Alto, La Paz. The group leader, Doña Dominga, is at lower right, next to the facilitator, Zunilda. (Photo reprinted with permission of those shown.)

FINDINGS

As previously described, the overriding goal of the project was to empower the community to mobilize itself to reduce maternal mortality and morbidity due to complications from miscarriage and incomplete abortion. The three specific program objectives were as follow:

- Identify attitudinal, social, physical and financial barriers to the prevention of unintended pregnancy and treatment of complications of miscarriage and incomplete abortion, and educate community members about FP (including birth spacing) and PAC services.
- Identify and strengthen local capacity for addressing the health needs associated with prevention of unintended pregnancy and treatment of complications of miscarriage and incomplete abortion, as well as other related needs, such as women's and adolescents' empowerment.
- Develop community action plans for addressing the barriers to use of both FP and PAC services.

In general, we found that the C-PAC program was able to accomplish its objectives. The methodology facilitated achievement of the overriding goal—to involve and empower the community to identify and reduce barriers to the prevention of unplanned pregnancy; and, with caveats discussed below, to reduce the delays that prevent timely treatment of complications from unsafe abortion and miscarriage.

Review of C-PAC Related Documents

Combined USAID/Bolivia and USAID/Washington funding enabled the C-PAC program to train 11 field coordinators and group facilitators and to reach 82 community groups that are served by 33 health centers in five MOH Districts (health networks) in the departments of La Paz, Santa Cruz, and Cochabamba. Overall, 150 community leaders and more than 1,600 community residents in the three areas participated in the program. Of the community program participants, fewer than 10% were men and between 27% and 37% were young adults under 24 years of age.

The evaluation included a review of documents, identified in Appendix 1. According to the documents consulted, the program's achievements included the following:

Knowledge, Attitudes, and Practices Improved

To assess changes in knowledge, three knowledge, attitudes, and practices (KAP) surveys were administered to participating community members during the project. The first survey was conducted before the first action cycle began (baseline survey, N=1,602). It was administered in Santa Cruz and El Alto in October 2005 and in Cochabamba in November 2005. The final surveys (N≤1,200) took place during the third action cycle, in June and August 2006, and were conducted only in the first two departments. (The intervention could not be completed in Cochabamba due to its late start.) The results were not disaggregated by gender because the male participants were too few and were nonrepresentative. (Only men who did not work during the daytime could attend.)

Findings comparing the baseline survey (October 2005) with the last KAP survey (August 2006) show increases in:

- Knowledge of contraceptive methods (from 83% to 92%)
- Knowledge that the condom provides dual protection (from 77% to 90%)
- Awareness of the need to go to a health center without delay when faced with a pregnancy complication (from 87% to 98%)

- Use of a contraceptive method at last sexual intercourse (from 49% to 70%)
- Knowledge of the importance of communication between partners regarding sexual relations and pregnancy (from 50% to 70%)
- Belief that the health facility resolved the participant's health problem (from 32% to 73%).

However, the KAP results indicated that the program did not achieve a substantial increase in the proportion who knew which health facility to go to in the event of bleeding during pregnancy (from 47% to 53%).

C-PAC Information, Education, and Communication (IEC) Materials Were Produced

- A comprehensive facilitator's manual was developed in Spanish; it was modified during use, tested in the field, and translated into English. Many simple instruments and informational materials were developed by the facilitators to overcome difficulties that arose with the use of the manual. For example, the facilitators produced pictorial guides and checklists for the group leaders, as well as materials on nutrition and other themes requested by the groups.
- Other materials considered very useful by health providers and community leaders were a directory of private health services (with their addresses, hours, services offered, and prices, if any), and brochures with this information for each region.
- A documentary on the C-PAC program was developed by the Bolivia National State Television and the American Embassy communications department. It aired nationally in December 2005.

The C-PAC Strategy Was Adapted and Implemented Differently in Bolivia, Peru, and Kenya

The replication of the strategy in these three countries involved the following local modifications:

- In Bolivia, the model was implemented in large periurban areas and involved a broad spectrum of community members.
- In Peru, the model was implemented through a local woman's organization and the local maternity hospital.
- The model has subsequently been adapted in other countries, such as Kenya, according to local needs.

Intervention Costs

Between November 2005 and March 2007, Socios para el Desarrollo's budget for the C-PAC Project totaled \$380,000; these funds were spent in their entirety, covering such items as personnel and consultants, travel, equipment, materials, printing, community work and administrative costs and overhead. These were complemented by the \$200,000 budgeted to CATALYST for their PAC activities, which included the implementation of C-PAC. (e-mail correspondence, C. Monasterios, 14 May 2008)

Assessment Findings

The goal of "community empowerment" is prevalent in many Bolivian initiatives in health and other social programs, but it is rarely actualized due to difficulties in its definition and application, as well as in the "how" to implement it. Before initiating the C-PAC program, meetings and discussions were held with existing community groups, their leaders, municipal authorities, and service providers to obtain their buy-in with the program design and methodology. The first phase of the action cycle, community organization, is a delicate negotiation process toward arriving at a common understanding of the principal objectives of the program. The community defined its own problems and needs, initially with assistance from the facilitators, but gradually more independently. Community members were able to discuss topics that had been considered very private and taboo—RH and related problems that are behind the high maternal mortality levels in Bolivia.

The program staff, principally the facilitators, were very skilled at keeping the community groups focused on the tasks that had been agreed upon by all, namely holding discussions about the following topics: unplanned pregnancy and its prevention; unsafe abortion; how to recognize complications in the first half of pregnancy; and what needs to be done if they occur. In addition, the program design envisioned addressing problems and solutions to other priority needs that were identified by the communities.

Although consent to participate from the health centers was obtained at the start of the program, center staff were not accustomed to receiving requests and complaints from community leaders. Moreover, community leaders feared being rejected or criticized by health service staff. To overcome those fears, C-PAC program staff initially accompanied the leaders on any interactions they had with center personnel. A positive working relationship between the community and health service staff evolved once providers' fears of being observed and censured, and community leaders' fears that they would be criticized and treated disrespectfully by providers, did not materialize. After mutual respect between the communities and health service staff was achieved, both became aware of the potential mutual benefits of the C-PAC strategy, and leaders were able to collaborate directly with health service staff without support from C-PAC program staff.

Adjectives to describe the C-PAC methodology that were offered by (the few) knowledgeable informants and by community members and service providers included the following terms: systematic, flexible, adaptable, self-correcting, easy to replicate once learned, and easily adapted for low-literacy populations. However, many participants stated that they found the methodology difficult and laborious at first. They noted that because the methodology was new to them, it needed too much time and effort to master, and they also found that the meetings were initially too long (three hours). In response to these complaints, the program staff was able to plan shorter, two-hour meetings.

The exercise consisting of constructing women's and men's life stories based on their collective experiences was described by the women we met with as sad and pessimistic at first. These exercises had poor outcomes in the early cycles, because the participants had no answers to the problems described. After the third action cycle, however, the life stories were more optimistic and positive; many couples had succeeded in overcoming communication barriers, planning the number of children they wanted and the spacing between them, and seeking care when needed.

Although the C-PAC methodology needs to be adapted to the specific culture, language, and gender of participants in different settings, as designed, it is very flexible, and the manual has built-in tools for adaptation and replication based on different groups and their needs.

Community mobilization and empowerment was very effective, most notably in women and youth. As a result of the intervention, women are now members of decision-making community organizations, including the Community Health Committees and municipal health committees. Women have been invited to attend meetings where annual health network and municipal work plans are developed, and they have incorporated their own action plan components into those plans. Community women also attend health facility monthly meetings where health statistics and targets are discussed and set.

As a result of their empowerment, women reported improvements in self-esteem, intergenerational communication, communication with their partner, and ability to modify service providers' attitudes and practices. As women learned of their rights, they insisted on eliminating the need for their husbands' permission to obtain a contraceptive method at health centers. (Even though official guidelines prevent spousal consent requirements, many providers continue to impose them.) A surprising observation is that women used explicit language to discuss so-called "sensitive" topics with us. The word abortion is no longer taboo, and sexuality, FP, gender-based violence, and adolescent sexuality were all discussed quite openly.

Women also constructed penis models out of toilet paper and glue to teach women how to use condoms; they were proud to display these to us.

“Women were enabled to demand to have their rights respected from not just providers but also their husbands.”

—Luisa Rada, key stakeholder

The program led to a paradigm shift in power relations between the community and health service providers. The second C-PAC objective considers strengthening local capacity to address health needs in PAC as well as women’s and adolescents’ empowerment. Interview results suggested changes in these areas. Clients’ interactions with providers went from being passive exchanges to being partnerships with service providers. Proactive clients were able to effect service quality improvements, including changes that led to better understanding and empathy and an improved response to community needs. These findings were emphasized by both community members and the providers we interviewed.

- The positive changes in health service delivery included more respectful, confidential, and culturally appropriate treatment; improved client-provider communication; and longer service hours in some health centers (i.e., providers were originally present for only 6–8 eight hours, even though the center was officially open for 12). In some cases, lengthened service hours resulted when the municipality hired an additional provider. Also, the health centers started offering new services—i.e., eye and dental care and cervical cancer screening and follow-up—because of community requests and negotiation.
- Demand for family planning services increased. Women reported that they knew more about FP methods and felt more comfortable requesting FP services because they were treated respectfully and not charged for the services. Despite the fact that SUMI guaranteed that FP and PAC services are offered free of charge, these services were still in very low demand. Reasons women gave for not seeking FP services were a lack of detailed knowledge about methods; shyness; and worries about privacy, confidentiality, and being treated disrespectfully. In addition, women often did not know that they qualified for government health insurance, and thus they expected to have to spend from their meager budgets on these services. Adolescent women in particular did not request RH services out of financial worries.
- Female and male group leaders reported that repeated complaints of providers’ poor treatment or absenteeism led to more than one provider’s being removed from a health center by the regional director. This fact was confirmed by the regional director.
- Interestingly, women also reported that “we learned they (i.e., service providers) are not all bad.”

Women said:

“The project gave us knowledge that **yes we can! (SÍ PODEMOS).**”

“Now we are conscious of our rights.”

“Just the words family planning used to make us ashamed and we blushed.”

Knowledge of family planning and warning signs among participants from community groups increased. The first C-PAC objective aims to identify barriers, but also to educate community members about FP and PAC services. Results from the KAP survey and the interviews suggest positive changes in this respect.

Program participants considered unplanned and unwanted pregnancy and resulting unsafe abortion to be a problem, especially for adolescent women. The reasons they gave for adolescents’ experience of unplanned

pregnancy included the lack of parent-child communication, peer pressure, and machismo, which demands that a young man prove his virility by fathering a child. They stated that young people have sex impulsively, without plans for avoiding unwanted pregnancy. With adolescent pregnancies, abortion is often sought because a pregnant adolescent is unable to face her parents or because giving birth at a young age would disrupt her future plans, including her education and career.

Women also reported that their peers resort to abortion when a new baby would worsen current financial difficulties; moreover, some women stated that husbands pressure their wives to have an abortion. Among the ways that local women induce abortion, participants mentioned that some take pills or use traditional remedies, while others attempt to interrupt a pregnancy by carrying heavy loads or deliberately taking a fall.

- Women are able to list symptoms and signs of obstetric emergencies and are clear that they need to seek care if complications occur. Community women have mapped the location of health centers and hospitals and know their transportation options. In contradiction to this assertion, however, the KAP surveys found that only half of the respondents (all of whom were involved in the intervention, including the mapping) knew which health center to use in case of an emergency. Given that few ambulances are available in these areas, using taxis and even public transportation as an alternative was discussed by the groups, despite the extra travel time and expense involved. Some interviewed leaders stated they are now sensitized to pregnancy and abortion complications and would assist a woman in reaching a health center for needed care.
- Women state they have learned about the benefits of birth spacing, available FP methods, how to use them, and where to obtain them. Although the KAP surveys showed that even at baseline 83% knew of the existence of contraceptive methods (and the proportion increased to 92% at the third KAP), women told us they had learned specific details about methods, how to use them, and their side effects. We hypothesize that the increase in method use at last intercourse found in the KAP survey results may have resulted from the C-PAC program.
- Community members are now informed about the government-provided SUMI plan, which covers all care for infants and children under age five, and pregnancy and maternity care for women, including PAC services, for up to six months postpartum and contraception for all women. Community members' awareness that "they now have rights to free services" and their knowledge of the specific services covered gave them the confidence to request RH services, including FP and antenatal care, that they had previously assumed would be too costly. Interviewed providers also mentioned that they had seen an increase in demand and were pleased that the increase affected their ability to meet targets. It should be noted that targets are not set numbers of new contraceptive users or methods supplied, but guides for expected numbers of clients to be counseled in FP and expected numbers of related services to be provided.
- Community action plans were developed and implemented. Community members successfully completed the third C-PAC objective to develop community action plans for addressing barriers to FP and PAC services. Communities were able to use the C-PAC methodology to identify health priorities and plan how they would approach service providers to help meet those priorities. Identifying problems was easy, but prioritizing them was difficult, because communities tended to identify many more needs than could be readily addressed. Program staff worked intensively with community groups to prioritize problems based on their severity, the number of persons affected, etc. In the C-PAC program, problems related to unintended pregnancy and complications from unsafe abortion and miscarriage were, intentionally, the focus of discussion. However, community groups also expressed the need to know more about a number of health-related and social topics: self-care during pregnancy; long-term consequences of unsafe abortion; the range of services offered at their health center and covered by SUMI insurance; nutrition; sexually transmitted infections; alcoholism; gender-based violence; poor couple communication and parent-adolescent child communication; and what constitutes "responsible fatherhood" (i.e., the responsibilities of a father toward his children). Many of these needs for information were followed up by community groups and their leaders initiating discussions and

obtaining assistance and training from local NGOs specializing in the chosen issues (see leveraging of resources for details). With time, these needs for information expressed by the community were expanded to obvious needs for other health services, such as dental and eye care, among others. The community, in specific cases, was able to meet with municipal officials and the health network director to request, and in some cases obtain, these additional services.

- The community evaluated its achievements at the end of each action cycle. The community constructed indicators related to their activities. These included the number of persons contacted, meetings held with health services (and the managers and providers who were present), RH training sessions provided by health service personnel, assistance from external NGOs, etc. Community groups also documented the changes that health providers made once they were made aware of the community group activities, the providers' visits to the community to discuss requested topics, the number of community members who were made aware of available services, etc. Planned activities and their progress (i.e., completed, in process, rescheduled, or dropped) were recorded in three follow-up sessions by each community.
- Links between the community, municipality, and health centers were established and strengthened based on mutual respect. Some women and even their leaders stated that before the project, they did not know where the closest health center was located. As a result of a mapping exercise that was conducted during the self-assessment stage, women now know the location of the closest health center, hospital, and clinic (NGO and other private), as well as available transportation and logistics in case of emergency. Community leaders and women's and youth group leaders initiated regular meetings with district MOH directors, health center staff, and municipal officials to address newly recognized concerns and help the health service sector meet the community's needs. These generally monthly meetings were tense at first, due to distrust between the community and providers, but with time they became cordial and participatory. Community leaders and providers became convinced of the mutual benefit these meetings offered. Providers were better informed about negative aspects of their behavior and were able to change them in response to issues identified by the community that had not been considered. Some of these changes included taking time to explain health issues and problems in clear, nontechnical language; showing increased sensitivity to cultural taboos (e.g., undressing completely); and displaying more respectful attitudes toward their clients. Clients agreed that providers had made positive changes, stating that providers now are more respectful and culturally sensitive and make greater efforts to communicate, explain, and listen.

As noted in the background section, the health system in Bolivia is decentralized, with decision making and funding assigned directly to municipalities. C-PAC group leaders met repeatedly with municipal representatives to request additional services that necessitated additional funding. Some of the requested services were added, once funding was secured to purchase new equipment and fund additional health personnel. One clinic obtained a part-time ophthalmologist, and several instituted services provided by a dental technician. One clinic we visited was able to extend its hours of operation (from 12 hours to 24 hours) by getting the health district manager's approval to hire additional staff, with funding from the municipality.

The initiative for collaboration between community groups and providers went both ways. Examples of instances in which providers requested assistance from community groups include when the community assisted its health center in planning, promoting, and holding health fairs, and when providers asked for community assistance in promoting the availability of cervical cancer screening and antenatal care. Another example of collaboration described by a community leader in Santa Cruz was how, in response to community women's urging, cervical cancer detection (Pap smears) was incorporated into the daily clinic routine. Every two weeks, a community woman acted as courier, collecting the smears from the clinic and delivering them to the cytology lab, where she picked up the previous delivery's results to be returned to the clinic. The women's group assisted in tracking and assuring follow-up of women with abnormal smears.

**“We did not know the community, nor did we know who were their leaders.”
“We achieved a model coordination with the program staff and the community
representatives.”**

—*Dra. Calvo, Red Norte (District), MOH Network Director, Santa Cruz*

On the negative side, not all health centers and their staff were responsive to the program’s request for collaboration. Some who initially had agreed to be part of the community extension effort did not participate at all, which caused anger and frustration in the community groups. Others participated in a casual and unhelpful fashion. One reason given by nonparticipating centers was that public services needed tangible incentives to participate in new strategies or activities, and since no incentives were forthcoming, they withdrew passively from the C-PAC program.

**“The methodology is unique for its potential in changing the status quo and needs more
time to consolidate achievements and transfer responsibilities.”**

—*Key knowledgeable stakeholder*

What about men and youth?

Men and youth were also positively affected by the project. Gender relations improved as communication between men and women was facilitated. In a reversal of established power relations, knowledge filtered down from the women to their husbands.

- Before the C-PAC intervention, many men prevented their wives from participating fully in group work, viewing women’s participation in the project as not good (“no es bueno”) and as a “waste of time” that took women away from home duties. After gaining experience with the project, men not only allowed women to participate, but would remind them of their meetings and encourage them to attend.
- Likewise, before the intervention, men, women, and program staff reported that although men were aware that unplanned pregnancy and unsafe abortion were a problem, they wanted to control their wives’ ability to prevent these problems through controlling their contraceptive use. However, because the KAP data could not be disaggregated by gender (since very few men participated), we are unable to verify this assertion. Women program participants became empowered and took the initiative to talk with their husbands; some men became advocates for women’s rights, allowing them to participate as equals on decisions involving the use of contraception.

Women also involved their adolescent children by requesting their assistance with reading informational material. Adolescents who were not used to talking with their mothers about sexually explicit topics acquired comfort in doing so. They eventually became active participants in women’s groups and formed a few mixed-gender groups of their own.

- Women stated that they learned how to converse with their adolescent children in a nonjudgmental and nonconfrontational manner. Interviewed youth and women expressed that the program facilitated communication between them.
- Participating youth were sensitized to women’s lives and difficulties. They helped pregnant women by carrying their heavy loads and helping with their tiring work.
- We were told that youth who participated in the program became a source of detailed RH information for their school and social peers.

“Youth contributed knowledge, adults contributed wisdom.”

—*Youth group member*

Leveraging of Resources

There was considerable leveraging of technical resources by participating groups and their leaders. A partial list of examples follows.

- The Santa Cruz district (Red Norte) MOH network director made office and meeting space, including the use of office equipment and utilities, available to the regional C-PAC coordinator and facilitators at no cost. The director was so convinced of the value of the C-PAC methodology that she took the time to attend many meetings held with community leaders, health center staff, and municipal authorities. Her presence provided an official imprimatur to these meetings, which further validated the communities' input.
- Women's groups approached many Bolivian NGOs and other agencies to request assistance and training on topics they had determined to be important. Participating groups and their specific assistance included the following:
 - Gregoria Apaza, a respected feminist NGO, provided training in leadership.
 - CIES provided contraceptive training.
 - CIDEM conducted workshops on gender violence.
 - PAHO assisted in facilitating relations between community groups and health providers.
 - The State University of Santa Cruz worked with groups to facilitate intergenerational communication skills.

No financial support was provided by the collaborating NGOs or other contributors.

The C-PAC program is very poorly known by many managers of agencies working in related efforts.

We were surprised to learn that many key stakeholders had very little information regarding the C-PAC program; these stakeholders included several who were working in USAID-funded health activities with RH services and community outreach activities, and some who were working on PAC services with other funding (e.g., Ipas and Family Care International). According to one key stakeholder, one possible reason for this may have been that project was a pilot project and, as such, information about it was not widely disseminated. The director of the sole nonparticipating health center we visited stated that he had heard of the program, but he did not know what it was and dismissed it as not applicable to the population his center served (mostly middle class).

As noted above, a documentary about the C-PAC program was developed by the Bolivian National State Television and the American Embassy communications department. It aired nationally in December 2005. No information was provided about the documentary's audiences, and we are unaware whether any of the key stakeholders we interviewed had viewed it.

Program Funding and Sustainability

Sustainability at the community level was built into the program from its inception. According to the program staff's direct observation, three action cycles with the C-PAC strategy were needed to provide the community with the skills to continue to work independently of external support on the problems they identified as priorities. Further, program organizers envisioned inclusion of the community action cycle within the process for developing the annual municipal work plan, thus allowing groups to continue their activities. According to various groups, this has indeed been the case. Without municipal support, though, some groups will be unable to continue their activities. Some committed, skilled group members and leaders stated they would not be able to continue working with the health centers because they lacked funds for transportation, photocopying of documents, and other very modest needs; they had not attempted to raise those funds. Fundraising was not established as an objective for the project, and so the implementing agency did not work with the communities to make them aware that community funds would be needed to sustain activities.

C-PAC and USAID/Bolivia and USAID/Washington

- PAC is one of the three priority programs in USAID/Bolivia's RH portfolio. Bolivia's plan, developed in 2003, was to reach and mobilize communities. USAID/Washington CORE funds from USAID/Washington's Postabortion Care Working Group made this work possible.
- The USAID/Bolivia informant stated that the injection of CORE funds to implement the C-PAC program was very important in terms of the reach of the project and in terms of learning lessons for global application through the close coordination with the USAID/Washington Postabortion Care working group.
- CORE funds were transferred directly from USAID/Washington to CATALYST during the first phase of the C-PAC program. USAID/Bolivia participated actively in the development of the program from the start. Although the funds were allocated directly to the CATALYST Project, the Mission worked with USAID/Washington to develop a final proposal and to put a local project team in place. Funding to the Bolivian NGO Socios para el Desarrollo was channeled through USAID/Bolivia, which allowed for closer involvement and oversight. The changeover in financing and management structure initially caused some delay; however, with the excellent administrative support of Socios, the program soon began running smoothly and continued without further delays.
- The Bolivia C-PAC project is one community extension strategy that appears to have impacted both the demand for services and how services are delivered to clients. Although we lack quantitative data on service demand to back this up, the impact has been affirmed by community and provider informants. The precise strategy is not described in USAID/Washington's PAC model, but fits directly into the model's third component (community empowerment through community awareness and mobilization). If the C-PAC program is successfully expanded locally and replicated in other countries, it will impact the USAID Postabortion Care Global Results Framework IR 3: "State-of-the-art PAC practices supported at all service delivery levels through community empowerment via community awareness and mobilization." Specifically, conducting the C-PAC program will positively affect the following IRs:
 - IR 3.2. Number of communities with established referral systems between community and primary-, secondary-, and tertiary-care sources of PAC
 - IR 3.4. Percentage of men and women aged 15–49 who can cite one warning sign of obstetric emergency
 - IR 3.5. Number of PAC programs that meaningfully involve members of vulnerable or underserved populations in the design of programs.
- The C-PAC strategy is being adapted and used in USAID-supported programs in Bolivia. EngenderHealth/ACQUIRE's plans for Bolivia include replicating the C-PAC methodology and strategy by partnering with community-based NGOs and coordinating their support of clinic-based services with community extension through selected PROCOSI partners.
- In addition, the C-PAC model is presently being incorporated into CIES's SRH programs, with Dr. Monasterios's assistance. CIES is a moderately large NGO providing low-cost, comprehensive primary health care and is financed by USAID/Bolivia. The introduction of the C-PAC methodology into its community outreach programs will help ensure that its use in communities is more sustained.
- To date, no financial resources from other funders have been obtained for this program. It is hoped that with wider dissemination of the program's results, similar interventions funded by other sources will adopt and apply the C-PAC strategy for community mobilization.

Elements that facilitated C-PAC's achievements and thus enhanced its sustainability include the following:

- A charismatic program coordinator who was always available, was particularly talented in reaching female and male leaders as well as clinic staff, and who exhibited contagious optimism and energy
- Availability of USAID/Washington and USAID/Bolivia for consultation, support, and collaboration

- An excellently trained and committed field staff who established a relationship of trust with the community and health personnel, and who displayed creativity and initiative in developing local information, education, and communication materials
- Self-selected communities (The program enrolled only communities that expressed an interest and willingness to participate after they were informed of the program objectives, planned activities, and what was expected of them.)
- Provision of only very modest tangible incentives to participate (e.g., a pint of cooking oil), which prevented community members from becoming dependent on the program

“What they came to give us:

- **Knowledge**
- **Consciousness of our worth**
- **Learning that all providers are not evil/bad**
- **An opportunity to see the health center and its staff from within.”**

—*Women’s group members*

Challenges encountered

- In Bolivia, as in other developing countries, there is little consciousness of the importance of preventive versus curative services. Program staff had to work energetically to change the established preconception that medicine is exclusively curative.
- The methodology is initially very labor-intensive and demands a lot of effort from the community. Participating community groups needed to experience three consecutive action cycles to learn the new methodology and be able to fully apply it without external assistance; this took up to two years of activities. In Cochabamba, where the project started later and where only two cycles were completed, frustrated community informants doubted they would be able to continue the activities with health providers, since the project had not reached the level of interest needed to assure sustainability.

“Changes in attitude and behaviors don’t happen overnight.”

—*Key informant*

- Negotiations with municipal authorities were not always easy. Local authorities are not used to community involvement in matters of budgeting and at first were dismissive of community leaders. Although program staff initially had to be directly involved, community leaders were gradually fully accepted as planning partners by local officials.
- Some community groups, such as neighborhood boards, security and surveillance committees, and health worker groups, were said to be politicized and to have hidden agendas. Some were unwilling to participate and showed passive resistance by not attending meetings they were invited to. In future efforts, community groups will have to be evaluated individually on the basis of their interest in participating and be reassured that the program poses no threat to them.
- In Bolivia, as in many other less-developed countries, health center personnel such as managers and providers change frequently. This high turnover meant that program staff had to renegotiate health centers’ participation, which involves a lengthy description of the program. The extra time needed may cause significant delays in program activities.
- The principal barriers to substantive changes in service providers’ attitudes and practice habits were said to be the following:
 - *Doctors and other professionals defending their “territory” and resisting change.* Although national MOH guidelines allow “trained providers including specialists, generalists, nurses and nurse-

auxiliaries” to provide FP and PAC services, including manual vacuum aspiration (MVA), the providers we interviewed all stated that only medical doctors supplied FP methods to clients and treated abortion complications. These services are traditionally provided by specialists in obstetrics and gynecology, who are deferred to by lower-level health workers. This widespread and erroneous perception of (or lack of knowledge about) norms needs to be gently challenged and changed. Ipas has been able to work within the guidelines and has established PAC services with MVA in 56 mostly rural health centers by training 515 providers (more than 30% of whom are nurses and only 16% are obstetrician-gynecologists) and providing equipment.

- *The relatively short duration of the program.* Sufficient time (and persistence) are known to be key to bringing about attitudinal change. Although the community is currently able to make improvements in health services delivery, achievements may become diluted or disappear with the passage of time and with MOH staffing changes. Most participating community members, providers, and key stakeholders agreed that to assure that the impact of the program continues and is long-lasting, it is preferable to have *at least* five years of external support and presence.

Lessons Learned

In addition to providing quality clinical care, emergency obstetric services (including PAC) can only be successful if the community is informed and involved. The C-PAC program has highlighted a number of lessons learned in using CAC to address the third component of PAC:

- Skilled program facilitators are necessary. The program cannot be conducted through trial and error by unskilled staff.
- Program staff needs to maintain flexibility to continuously modify activities based on circumstances, context, and experiences.
- Regional managers’ buy-in is key to obtaining health care providers’ full participation with the community as an equal partner.
- Community projects are labor-intensive to establish, but once the community is empowered, the project will continue to act independently of external technical support. However, the community should not be completely abandoned until it is able to raise modest financial support or find alternative strategies (e.g., inclusion of the action cycle as part of municipal work planning) to continue program activities.
- To prevent unfounded rumors and negative propaganda, it is important to keep local authorities and local community-based organizations involved and informed.
- When community leaders are involved early in the planning process, the implementation is more fluid and successful.
- Preexisting community groups are more effective than groups that are established to address a single issue (e.g., PAC and unplanned pregnancy). Preexisting groups also may be more likely to sustain efforts to effect change after the program is over.
- Planners and implementers need to maintain flexibility in the design and time frame of activities to allow the program to reflect the existing local situation, problems, and needs. The methodology needs continuous adaptation to be effective in different cultural, literacy, and gender contexts.

CONCLUSIONS

The empowerment of women and communities resulted in substantive changes in the health service delivery system and, importantly, caused remarkable and probably lasting changes in the participants' lives. The PAC community mobilization program implemented in Bolivia was successful in promoting improvements in service demand and quality, which resulted in more culturally appropriate and client-centered services. The program deserves to be maintained and further supported by USAID to firm up its achievements and expand its reach.

The experience will inform USAID/Washington and its global PAC program partners about one creative effective strategy for accomplishing USAID's third PAC element—mobilizing the community to improve knowledge and care-seeking practices about abortion complications and pregnancy prevention, and to promote community–health service links.

A noted project shortcoming was that women who experience hemorrhage during pregnancy are instructed to seek care at their nearest health center, but clinical emergency treatment is not available at these sites, which offer only examination, stabilization, and referral to a hospital. In addition, many health centers are only open five days a week, for 6–18 hours a day. Providers informed us that women who arrive for treatment when the facility is closed are referred to the hospital by the security guard on duty. Although official guidelines state that patients seeking care must always go to their health center first and some providers stated that hospitals will not receive patients without a referral, other providers informed us that hospitals are obligated to receive all obstetric emergencies, with or without a referral from the health center. As it is now implemented, the referral protocol may pose an unacceptable risk to pregnant women by lengthening the third emergency obstetric care delay—the delay in receiving adequate treatment.

The changes promoted by the C-PAC program appear to be sustainable in participating communities. However, we are less confident that health centers, which frequently change personnel, will be able to sustain any changes made in services without a more protracted external presence and greater encouragement.

As presently structured, this project works for periurban, Spanish-speaking communities. In order to expand it for use in rural indigenous areas, it will need culturally appropriate and linguistic adaptations for specific indigenous groups, taking the manual as a base but creating new support materials.

RECOMMENDATIONS

To enhance future programming in Bolivia and globally, we offer the following eight recommendations.

1. Strengthen the alliances between various NGOs and MOH services. EngenderHealth’s scope of work includes the establishment and improvement of PAC services at both the national level (through service-delivery NGOs) and at MOH second- and third-level facilities in 48 municipalities in the departments of Santa Cruz, Beni, Tarija, and Chuquisaca. First-level services are also in the scope of work but presently not directly included (Viscarra, 2007). EngenderHealth has identified principal strategic allies, in particular selected PROCOSI-member NGOs working at the community level (e.g., the implementation group of Andean Rural Health Care/Nur University/Save the Children/CEPAC). We recommend strengthening alliances through the following steps:
 - We suggest that a pilot project be conducted in coordination with Andean Rural Health Care, the prime for the implementation group under the PROCOSI Community Health Project. The focus of the pilot would be operations research to determine feasible community PAC activities, followed by implementation and evaluation to measure the effect of the C-PAC strategy on service demand (which this program was unable to do). Once completed, the pilot’s experiences should be shared with other PROCOSI implementation groups to scale up work in community PAC. EngenderHealth would provide technical assistance to develop linkages between the community and health services.
 - For the municipalities under EngenderHealth RH support, we recommend establishing formal coordination between EngenderHealth PAC programs and MOH community extension efforts, based on the C-PAC strategy of linking service demand and supply, and further, establishing comprehensive PAC services in a few first-level facilities. Some clinics would need only modest efforts to be able to provide these services (see criteria, Appendix 5).
 - We propose that providers be updated on the national reproductive health norms related to PAC services. In almost all visited clinics, one or more providers claimed that although they had participated in MVA training, such services were universally unavailable at first-level facilities because national reproductive health norms do not allow it—an assertion that turned out to be false.
 - We further recommend that USAID-funded NGOs working in clinical RH services (CIES, PROSALUD) integrate the C-PAC program strategy in areas that receive EngenderHealth technical support. CIES is already programming community extension activities, led by Dr. Monasterios, that adapt the C-PAC strategy for all SRH services. Because information systems in NGOs tend to be more reliable than those in public facilities, this effort could be developed as a modest operations research project to document changes in service demand associated with the community extension efforts based on the C-PAC methodology. Moreover, any changes in the program area can be compared with the experience of a similar site that did not participate in C-PAC activities.
 - We recommend that the self-assessment stage of the C-PAC cycle be administered not only as part of community work, but also at the participating health service delivery sites. The COPE model (which stands for “client-oriented, provider-efficient” services) could be applied to PAC services in hospitals and health centers and could sensitize managers, providers, and support staff, who would then implement important client-focused service improvements even before the community itself intervenes.
2. We recommend regular meetings with the participation of all strategic allies to keep them involved; to share work, achievements, challenges, and lessons learned; and to prevent noneffective activities from being repeated. These meetings would provide an opportunity for collective discussion on improvements

to the intervention as it proceeds. Once located, the documentary about the C-PAC program could serve as an advocacy tool to better acquaint other agencies with the program.

3. To prevent loss of momentum, USAID should consider building more time at the end of pilot projects that have been shown to be successful. Several informants stated that a minimum of five years is needed to achieve true institutionalization of successful programs. The additional time would be used to gradually decrease support and transfer responsibilities to the principal actors. Although many felt that the C-PAC strategy would be sustainable in communities that had completed three action cycles, it is unclear that such efforts could continue without additional time or support. In fact, several groups stated that they had to discontinue meetings with clinic providers once the project ended because they lacked transportation and very modest supplies (e.g., paper to write letters to authorities and make photocopies). If communities are to be convinced that PAC service improvement is a necessary and continuous process, they will need assistance in finding ways to mobilize their own resources to achieve sustainability.
4. We recommend that follow-up programs work simultaneously with health networks to establish comprehensive emergency obstetric care/PAC services in one or two health centers meeting specific criteria (see Appendix 5); such services would include emergency treatment followed by FP counseling and services. The Global PAC Resources Guide (USAID Postabortion Care Working Group, 2007) should serve as a resource for doing this. Placing services closer to where clients live in smaller, client-friendly facilities could also increase the proportions who return for follow-up visits and those who receive other RH services, such as FP counseling and methods. EngenderHealth and CARE are implementing obstetric care networks in 10 sites, and future community PAC projects should work in the same geographic areas to ensure appropriate referrals.
5. USAID should encourage meetings of its stakeholders to share plans and process issues and lessons learned from similar programs. Participants at these meetings should include, in addition to USAID-funded program managers, other funding agencies' representatives and MOH representatives who support the project.



6. Sustainability needs to be promoted. To that end, we recommend the following four steps:
 - C-PAC's program design and outcomes should be widely disseminated among key actors such as the MOH (central and regional/district), municipalities, major donors, health and development agencies, and NGOs and private voluntary organizations. Several key stakeholders advised that the MOH needs to be addressed separately with a carefully considered strategy. Municipalities are of particular interest because administration of the Bolivian public health system has been devolved to the municipalities, which receive and distribute funds according to their self-determined priorities. Those priorities may not necessarily include abortion, even though the problem of unsafe abortion extends throughout the country.⁶

⁶ The United Nations Development Programme has now started an effort to develop formulas for municipalities and health regions and districts to analyze their own situation and to rationally select priority programs to implement and fund.

- Strategic alliances need to be established with women’s and indigenous organizations and workers’ unions, among others.
 - MOH buy-in to the C-PAC strategy must be obtained, and the program should be scaled to fit MOH human and financial resources for child health and SRH programs. (Although community mobilization is a government priority, all key stakeholders considered it to be the weakest element of MOH programs, and as the C-PAC program is now structured, it is probably beyond the ministry’s capacity, due to its labor intensiveness and cost.) To achieve MOH buy-in, several strategies may need to be explored, including the following:
 - Identifying community extension champions within the MOH and forming strategic alliances with particular representatives of NGOs that enjoy the trust of the ministry
 - Encouraging PAHO, the United Nations Population Fund, World Bank, and similar multinational agencies to advocate for program implementation at the central MOH level, while working directly with regional- (SEDES) and district-level MOH managers
 - Engaging the involvement of other public institutions, such as the Ministry of Education, which could explore the possibility of including rural teachers in follow-up adaptations and replications of the C-PAC strategy
 - The C-PAC manual, after multiple revisions based on its use, was effective and considered easy to use by college-educated program facilitators. However, since it includes a lot of theory and has too much text, the manual would need to be simplified for direct use by less-educated community groups.
7. To prevent the loss of investment in trained human resources and thus increase the approach’s cost-effectiveness, we recommend that trained, committed staff from completed projects be offered work in other ongoing or new USAID-funded projects with similar characteristics. Staff should be promoted and deserve fair salaries and benefits. (C-PAC field staff were hired as consultants, with adequate salaries but no benefits.)
 8. Program staff should retain a presence in the community and gradually decrease the intensity of their involvement until the community is fully able to continue on its own. We recommend such additional “accompaniment” time to allow communities to appropriate and replicate new methodologies for service improvement and integrate them into their regular lives. Program staff involvement should only end when skills are institutionalized and the community is able to leverage resources to continue activities.
 9. Public health programs in general should consider use of the CAC to address health issues in general. The methodology encourages problem solving and participation, thus enhancing health-seeking behavior in general. As was demonstrated here, outcomes in C-PAC were not just PAC-focused but reached beyond to extend into other areas of health (e.g., cervical cancer testing).

REFERENCES

Central Intelligence Agency (CIA). 2007. *CIA world factbook*. Washington, DC.

Bolivia. DHS. 2003.

Ipas. 2007.

PAHO. 2004.

Rehnstrom, U., International Midwifery, UNFPA, September 2006.

Socios para el Desarrollo. 2006. *Programa Comunitario PAC Annual report*. La Paz.

UNICEF and WHO. 2000.

USAID Postabortion Care Working Group. 2007. *Postabortion care global resources: A guide for program design, implementation, and evaluation*. Washington, DC: USAID and Health Communication Partnership. Accessed at www.postabortioncare.org/.

Viscarra, 2007.

Wallerstein, N. 2006. *What is the evidence of effectiveness of empowerment to improve health?* Copenhagen: WHO Regional Office for Europe. Accessed at www.euro.who.int/Document/E88086.pdf.

APPENDIX I: Documents Reviewed

- Bolivia MOH: Norms and Protocols for Postabortion Care (2004)
- Carmen Monasterios, M.D.: USAID/W and APHA 2005 PowerPoint presentation
- Carmen Monasterios, M.D.: e-mail correspondence
- CATALYST/Pathfinder Community Mobilization around Postabortion Complications in Bolivia proposal (April 2004) and the June 2004 CATALYST Quarterly Report
- CATALYST: Compilation Document describing PAC lessons learned in community mobilization in Bolivia, Peru and Egypt and Scale-up of PAC programs in these three countries
- Luisa Rada, E. García and A. Saravia: Sistematización de la Metodología PAC Comunitario-Informe Final: PROSALUD/Socios para el Desarrollo and USAID/Bolivia, 2007
- Socios para el Desarrollo/PROSALUD: 2005 Annual PAC-C Report and Executive Summary prepared by consultant Ms Luisa Rada
- Socios para el Desarrollo and USAID/Bolivia: Community PAC program Facilitators' Manual (2006)
- Socios para el Desarrollo: Programa Comunitario PAC, Annual report 2006
- USAID PAC Strategy Paper (2004)
- USAID/Bolivia Post-abortion Care Program (July 2003)
- USAID/B: Program Description of Community Post-Abortion Care/Socios and Salud (Bolivian NGO later re-named Socios para el Desarrollo) (September 2004)

APPENDIX 2: Questions for the Assessment

1. How did the activities completed by the project compare with what was stated in the overall and specific objectives of the program? Identify the objectives that were not met and indicate why the objective could not be met.
2. How has the project strengthened the local capacity for addressing the health needs associated with unintended pregnancy and the treatment of complications related to miscarriage and incomplete abortion? What types and amounts of resources were leveraged in the program?
3. Identify how this program has impacted on the community's knowledge of family planning and PAC services.
4. How have project activities influenced the delivery of family planning and post abortion care services and other services at the community health centers or other facilities identified by the communities? Please identify any increases in FP usage and PAC service at these facilities that may be attributed to this program.
5. What project aspects are considered the most and least valuable to the various constituent groups involved? (e.g., community leaders, focus group members, USAID mission, health facilities, health networks, grass roots community members, community; MOH, other stakeholders)?
6. What methodologies developed during the project are or can be applied in USAID's central and field PAC programs. How are they being applied?
7. What has been the contribution of the Bolivia PAC Community Mobilization activity to the revised USAID PAC model's third component of community empowerment through community awareness and mobilization? How can the successful strategies of the community PAC program be incorporated into ACQUIRE/Bolivia to improve access to clinical PAC services?
8. How did the organization, management, and finances influence the accomplishment of the project? Has the investment of CORE funds paid off in terms of global learning? The project had a fast start-up; how did this affect the organization and implementation of activities? Was the budget sufficient to complete the planned activities and obtain the results? Was the investment on behalf of USAID worthwhile? Project management began with a U.S. organization, and later was transferred to a local NGO, how did this affect implementation? Was the manner of investment appropriate (i.e., work with a local organization). What are the implications for other countries?
9. What aspect of the method of choosing focus countries and providing funding to Bolivia was considered the most and least valuable to USAID/Bolivia? What has been the added value of the financial support and technical assistance provided by USAID/Washington's Postabortion Care Working Group on postabortion care community mobilization in Bolivia?
10. Based on this assessment, please provide recommendations to USAID/Washington's Postabortion Care Working Group for the scale-up of postabortion care community mobilization programs worldwide. What are the lessons learned and recommendations?
11. What examples can be gleaned from project implementation to show the effectiveness of the community PAC mobilization?

APPENDIX 3: Evaluation Instruments

In this appendix, we will only include three of the six instruments. Those three are the guides for interviews with key stakeholders; for focus group discussions with women's groups; and for interviews with clinic providers. The remaining three instruments are variations on the clinic provider questionnaire.

Entrevista para financiadores y tomadores de decisiones (Key Stakeholders)

Fecha: ____/____/2007

Nombre _____ Cargo _____

Institución _____ Municipio _____ Departamento _____

Entrevistador _____

CONSENTIMIENTO INFORMADO. LEER TEXTUALMENTE

Buenos días/tardes. PRESENTARSE CADA UNA.

Somos asesoras independientes contratadas por la institución EngenderHealth que trabaja en Bolivia y otros países para apoyar en programas de salud reproductiva. Estamos realizando un estudio/evaluación de los logros del programa que se llevó a cabo entre el 2004 y Abril del 2007 con apoyo de las instituciones Pathfinder/Catalyst y luego Socios Para el Desarrollo/PROSALUD sobre la estrategia de participación y movilización comunitaria y promoción del dialogo entre la comunidad y los servicios de salud en la prevención y atención de las HPME o PAC comunitario. Nos agradecería entrevistarlos por no más de media hora. Sus opiniones son muy importantes para poder formular recomendaciones de cómo mejorar los servicios tanto en Bolivia como en otros países. Asumimos que su participación es totalmente voluntaria. Siéntase libre de hacernos preguntas, de rechazar responder a las preguntas que le hacen sentir incomodo/a, y de terminar esta entrevista cuando usted lo considere. Seguramente usted se da cuenta que en algunos casos podríamos identificarle como la/el originaria/o de opiniones. Si desea que alguna información que usted nos proporciona quede confidencial y anonima, por favor, puntualize este su deseo y lo cumpliremos.

Si tiene alguna inquietud o pregunta sobre esta entrevista, por favor, contacte a la Dra. Lynn Johnson, Directora de EngenderHealth en Bolivia

Esta de acuerdo en ser entrevistado?

Podemos empezar conociendo su área de trabajo y su participación en el desarrollo e implementación del programa PAC comunitario:

1. ¿Cuánto tiempo trabaja usted en esta institución? _____
2. ¿Cuáles son sus responsabilidades? _____
3. ¿Conoce usted el programa en detalle? Si No
4. ¿Cuál fue su participación en el diseño del programa? _____
5. ¿Cual fue su participación en la implementación del programa? _____
6. ¿Sintió que CATALYST en primer lugar y Socios para el Desarrollo/PROSALUD después tomaron en cuenta sus opiniones y sugerencias? _____
7. ¿Que tan colaborativo fue el proceso de diseñar las estrategias y metodologías? _____
8. ¿Quiénes estuvieron involucrados en este proceso? _____

Ahora, me gustaría conocer los alcances del programa:

9. Este programa se basa en una estrategia que fue originalmente utilizada en Bolivia hace 20 años denominada WARMI. ¿Esta usted familiarizado/a con esa estrategia? Si No
10. Sabe usted si existe una interrelacion explicita entre el PAC clinico y el PAC comunitario en las regiones donde trabajo el proyecto de PAC comunitario?
11. ¿Piensa que la estrategia basada en la participación activa de la comunidad funcionó para mejorar la atención a mujeres con emergencias obstétricas, en particular las HPME? Si No
12. ¿Qué cambios en los servicios respondieron a la necesidad sentida de la comunidad y opinión de las y los líderes? _____
13. ¿Se incrementó la cobertura de los servicios? Si No
14. ¿Mejoraron los horarios de atención? Si No
15. ¿Mejoró la calidad de atención? Si No
16. Explique por favor _____
17. ¿Cuáles elementos del programa funcionaron muy bien? _____
18. ¿Cuáles elementos no funcionaron y por qué? _____
19. ¿Se cambió algo en el diseño para responder a esto? _____
20. ¿Qué lecciones aprendidas son aplicables a futuros proyectos, tanto en Bolivia como en otros países en vías de desarrollo? _____
21. En resumen, ¿cuáles fueron los mayores éxitos del programa y cuáles fueron sus mayores limitaciones? _____
22. ¿El programa es replicable tal como fue implementado? Si No
23. ¿Se piensa extender este programa a otros departamentos o municipalidades en el futuro inmediato?
Si No
24. Sin asistencia externa, ¿se puede seguir con los servicios de los establecimientos de salud tal como fueron implementados durante el programa? Si No
25. ¿Se ha logrado otro tipo de apoyo técnico o financiero durante la implementación del programa? Explique por favor _____
26. ¿Se ha logrado otro tipo de apoyo técnico o financiero para seguir/replicar/ampliar este programa dentro del país? _____
27. ¿Qué considera usted que se debería hacer en forma diferente? _____
27. ¿Qué considera usted que se debería mantener? _____
28. ¿Usted cree que este programa ha contribuido al cumplimiento de la misión de su institución?
Si No
29. Describa por favor _____
30. ¿Puede sugerirnos otros proyectos o metodologías de servicios que incluyen un trabajo conjunto entre la comunidad y los establecimientos de salud? _____

Para ONGs internacionales:

31. ¿Se piensan aplicar las estrategias y metodologías en programas en otros países en los que ustedes trabajan?

¿Puede detallar lo que planifican? _____

32. ¿Piensan utilizar asistencia técnica de parte de agentes claves de este programa boliviano? _____

AGRADEZCA AL/LA ENTREVISTADO/A

Guía de grupos focales para la comunidad

Fecha: ____/____/2007

Tipo de grupo (M-mujeres, H-hombres, A-adolescentes) ____ # de participantes ____

Municipio _____

Departamento _____

Moderador _____

Apoyo _____

PREVIAMENTE A LA REALIZACIÓN DEL GRUPO FOCAL, PEDIR EL CONSENTIMIENTO INDIVIDUAL DE CADA PARTICIPANTE, LEYENDOLE TEXTUALMENTE LA SIGUIENTE DECLARACIÓN:

Buenos días/tardes (PRESENTARSE). Venimos a visitarles contratadas por la agencia EngenderHealth que trabaja en Bolivia y muchos otros países apoyando servicios de salud reproductiva. Estamos realizando un estudio/evaluación que nos permitirá mejorar los servicios de atención a las mujeres que tienen una emergencia de hemorragia durante un embarazo en los centros de salud de este municipio y de otros lugares tanto dentro, como fuera de Bolivia. Deseamos preguntarles algunas preguntas para tener sus opiniones y consejos. Como su comunidad y grupo de mujeres trabajó mucho para llegar a los servicios de salud y asegurar que estos podían responder a sus necesidades, las opiniones de la comunidad son muy importantes para que podamos formular recomendaciones de cómo mejorar los servicios. Toda la información que nos proporcionen será tratada por nosotras como estrictamente confidencial, y en ningún momento utilizaremos el nombre de esta comunidad ni mencionaremos nombres que los/as identifiquen a ustedes ni a nadie. Sugerimos que ustedes también mantengan confidencialidad sobre las opiniones de sus compañeras. Su participación es totalmente voluntaria y su rechazo no les causará ninguna repercusión negativa. Siéntanse libre de hacernos preguntas, de rechazar responder las preguntas que le hacen sentir incómodos/as, y de terminar esta entrevista cuando ustedes lo considere. También, si no recuerdan de algún detalle, no se preocupen; simplemente no necesitan responder. ¿Le gustaría hacernos algunas preguntas? ¿Está de acuerdo en participar en esta entrevista?

Esta sesión no durará más de una hora. Si tienen alguna pregunta o duda sobre esta reunión, por favor contactense con la Dra. Lynn Jonson, Directora de EngenderHealth en La Paz.

¿Está de acuerdo en participar?

¿Aceptan que se graben las conversaciones?

LAS SIGUIENTES PREGUNTAS SE FORMULARÁN SOLO AL GRUPO DE PERSONAS QUE ACEPTARON PARTICIPAR GRABANDO LA SESIÓN.

Generalidades:

- Número de personas en el grupo, el foco de trabajo grupal y el tiempo de existencia
- Las razones por las que el grupo decidió involucrarse
- Cuánto tiempo han estado trabajando con el proyecto
- ¿Se siguen reuniendo con los médicos/as y enfermeros/as del servicios de salud desde que se terminó el proyecto (en el 2007)?
- ¿De qué conversan durante estas reuniones?

Sobre la metodología del auto-diagnóstico:

- ¿Habían hecho algo así anteriormente al proyecto?
- ¿Les costó mucho aprender a hacer este trabajo?
- ¿Fue útil esta metodología para causar cambios positivos en ustedes mismas? ¿Pueden dar algún ejemplo?
- ¿Les gustó la metodología de este trabajo?
- ¿Además del uso del autodiagnóstico con relación a emergencias en el embarazo, han usado/siguen utilizando la misma técnica para mejorar otros servicios? ¿Cuáles?
- Desde que ya no están acompañadas por personal del proyecto, ¿siguen ustedes discutiendo otros problemas y apoyando para tener resoluciones a estos problemas?
- ¿Pueden darnos algún ejemplo?

Sobre los conocimientos:

- ¿Las mujeres de esta comunidad acuden a control prenatal? ¿Dónde?
- ¿Dónde dan a luz las mujeres que viven en esta comunidad?
- ¿Qué complicaciones pueden ocurrir durante el embarazo?
- ¿Cómo se sabe si se trata de una complicación peligrosa?
- ¿Adónde va o a quién consulta primero una mujer con complicaciones? Y si no encuentra solución, ¿adónde va?
- ¿A que distancia queda el centro de salud más cercano? ¿Y el hospital más cercano?
- ¿Existe la disponibilidad de una ambulancia u otro medio de transporte para llegar al servicio si se presenta una complicación del embarazo?
- ¿La comunidad apoya a mujeres con emergencias para llegar a los servicios de salud?
- ¿Se pueden evitar las complicaciones del embarazo? ¿Cómo?
- ¿Qué puede causar una pérdida de embarazo en los primeros meses?
- ¿Les han hablado de los métodos anticonceptivos para retardar o evitar un embarazo? ¿Quién les ha hablado sobre este tema?
- ¿Qué piensan ustedes de los métodos de planificación familiar?
- ¿Dónde se pueden conseguir estos métodos? ¿Están siempre disponibles?
- ¿Qué pueden hacer los hombres para apoyar a las mujeres con complicaciones o necesidades de salud?
- ¿Recomiendan ustedes que se dé orientación a solo mujeres, a solo parejas, o a solo hombres?
- ¿Cuánto tiempo debería esperar una pareja para volver a embarazarse después de perder un embarazo?

Sobre los servicios de salud y cambios que han notado como resultado del trabajo hecho por su grupo:

- Antes del proyecto de PAC comunitario, ¿se podía acudir al centro de salud con una emergencia en el embarazo? Si no existían estos servicios, ¿adónde iban las mujeres?
- ¿Qué ideas, materiales o recursos fueron aportados por ustedes y su comunidad?
- ¿Cuál fue el papel de las/os líderes mujeres y hombres de su comunidad?
- Cuando ustedes trabajaron con el proyecto, ¿se sintieron escuchadas/os y respetada/os por las personas que trabajan en servicios de salud?
- ¿Los servicios estaban disponibles a todas horas?
- ¿Qué cambios han notado ustedes en los servicios que se ofrecen como resultado del proyecto del que hablamos y de la intervención de grupos como ustedes?
- ¿Se ofrecen más servicios? ¿Los horarios son más amplios? ¿La calidad es mejor? ¿Cómo?
- ¿Existen algunas sugerencias que ustedes dieron para mejorar los servicios que no se han considerado? ¿Por qué no se hicieron esos cambios?
- ¿Cuáles cambios que ustedes implementaron dieron muy buenos resultados?
- ¿Cuáles cambios no dieron buenos resultados?
- ¿Qué nos recomiendan para llevar a cabo este tipo de trabajo en otros lugares?
- ¿Tienen alguna pregunta para nosotros?

¡MUCHAS GRACIAS!

Entrevista para proveedores de salud

Fecha: ____/____/2007

Centro de salud _____ Municipio _____ Departamento _____

Entrevistador _____

CONSENTIMIENTO INFORMADO. LEER TEXTUALMENTE

Buenos días/tardes. PRESENTARSE CADA UNA.

*Estamos como asesoras independientes contratadas por la institución EngenderHealth que trabaja en Bolivia y muchos otros países para apoyar en programas de salud reproductiva. Estamos realizando un estudio/evaluación de los logros del programa que se llevó a cabo con apoyo de las instituciones Pathfinder/Catalyst y luego Socios Para el Desarrollo/PROSALUD sobre la estrategia de participación y movilización comunitaria y promoción del dialogo entre la comunidad y los servicios de salud en la prevención y atención de las HPME o PAC comunitario. Nos agradecería entrevistarles por no más de media hora. Sus opiniones son muy importantes para poder formular recomendaciones de cómo mejorar los servicios tanto en Bolivia como en otros países. Queremos enfatizar que se está evaluando el proyecto de PAC comunitario implementado en este centro, y **no** al personal de salud.*

Su participación es totalmente voluntaria y su rechazo no causará ninguna repercusión en su trabajo y empleo. Siéntase libre de hacernos preguntas, de rechazar responder las preguntas que le hacen sentir incomodo/a, y de terminar esta entrevista cuando usted lo considere. También, si no se recuerda de algún detalle, no se preocupe; simplemente no necesita responder. Esta entrevista es confidencial; no anotaremos su nombre ni ningún dato que pueda identificar a usted o al centro de salud. ¿Le gustaría hacernos algunas preguntas? ¿Está de acuerdo en participar en esta entrevista?

Si usted esta de acuerdo, nos gustaría también conocer su centro y realizar un corto recorrido en las áreas donde las mujeres que acuden con HPME reciben servicios. ¿Nos permite?

Si desea contactarse con alguien después de esta visita, por favor llame a la Dra. Lynn Johnson, Directora del proyecto EngenderHealth en Bolivia.

Muchas gracias.

SI LA PERSONA ACEPTA, CONTINUE CON LA SIGUIENTE PREGUNTA; DE LO CONTRARIO, AGRADÉZCALE A LA PERSONA POR SU TIEMPO Y TERMINE CON LA ENTREVISTA.

1. ¿Cuál es su profesión? _____
2. ¿Qué cargo ocupa en este centro de salud? _____
3. ¿Cuánto tiempo desempeña su cargo en este centro de salud? _____
4. ¿Recibió capacitación formal sobre cuidados obstétricos? Si respuesta afirmativa, ¿cuándo?
Si No Antes del proyecto Durante el proyecto
5. ¿Recibió capacitación formal sobre el manejo de emergencias obstétricas? Si resp. afir., ¿cuándo?
Si No Antes del proyecto Durante el proyecto
6. ¿Recibió capacitación formal sobre el manejo de HPME? Si respuesta afirmativa, ¿cuándo?
Si No Antes del proyecto Durante el proyecto
7. ¿Recibió capacitación formal sobre orientación en planificación familiar? Si resp. afir., ¿cuándo?
Si No Antes del proyecto Durante el proyecto

8. Después de las capacitaciones formales, ¿ha recibido reciclaje en estos temas, y cuándo?
 Si No ¿Cuándo? _____
9. ¿Cree que se encuentra capacitado/a para prestar los servicios mencionados? Si No
10. ¿En qué temas de salud sexual y reproductiva le gustaría recibir más capacitación? _____
11. ¿Recibió capacitación en la técnica de AMEU? Si No
12. ¿Se siente capaz de realizar un AMEU? Si No
13. ¿Tiene conocimiento de la existencia de servicios sobre HPME en este centro y otros cercanos que se hayan ofrecido antes del proyecto de PAC comunitario? Si No

Las siguientes preguntas se refieren a los cambios que se realizaron en este centro durante el proyecto de PAC comunitario que se implementó entre el 2004 y Abril del 2007

14. ¿Hubo cambios en la infraestructura, equipos, materiales, etc.? ¿Cuáles fueron estos cambios?
15. ¿Qué servicios se ofrecen ahora que no se ofrecían antes del proyecto? _____
16. ¿Hubo mejoras en la calidad de los servicios ofrecidos (no solo servicios de SR sino todos los servicios)? ¿Nos puede dar ejemplos? _____
17. ¿Cambiaron los servicios para adolescentes mujeres y hombres? ¿Nos puede dar ejemplos?
18. ¿Cambiaron los servicios para hombres? ¿Nos puede dar ejemplos? _____
19. Sobre los cambios que usted ha observado, ¿piensa que los grupos organizados de la comunidad tuvieron algo que ver? ¿Cómo? _____
20. ¿En la actualidad, ustedes mantienen reuniones regulares con líderes de las comunidades? ¿Con qué frecuencia?
 Si No Frecuencia _____
21. ¿Ustedes acuden a reuniones de grupos de mujeres? ¿Cuándo fue la última vez? _____

Las siguientes preguntas se refieren a la implementación del proyecto...

22. En general, ¿usted cree que el proyecto ha mejorado los servicios? Por favor, describa _____
23. ¿Con qué obstáculos se encontraron durante la implementación del proyecto? _____
24. ¿Cómo mejoraría usted los servicios que existen hoy para mujeres con HPME? _____
25. ¿Desde que terminó el proyecto, han habido algunos cambios, tanto positivos como negativos, en los servicios?
 ¿Cuáles? _____

AGRADEZCA AL/LA ENTREVISTADO/A

APPENDIX 4: Key Stakeholders Interviewed and Agencies They Represent

Note: We have permission to provide the following names because prior to the interview, these individuals gave verbal informed consent to be interviewed and quoted, if necessary:

1. USAID/Bolivia—Rocio Lara
2. USAID/Washington—Carolyn Curtis
3. EngenderHealth—Lynn Johnson
4. EngenderHealth—Marjorie Viscarra
5. EngenderHealth—José del Barco (formerly Clinical Director, Pathfinder/CATALYST)
6. PROSALUD—Luis Fernández (formerly with CATALYST and Socios para el Desarrollo, Director)
7. Socios para el Desarrollo—Luis Fernandez
8. Socios para el Desarrollo—Liliana Medinacelli
9. Ipas—Malena Morales
10. FCI—Alexia Escobar
11. PROCOSI—Ignacio Carreño
12. PROCOSI—Oscar Gonzáles
13. PROCOSI—Cristina Rentería
14. CIES—Jonny López
15. CIES—José Luis Alfaro
16. Pathfinder/CATALYST—Gladys Pozo
17. Bolivia Ministry of Health, Gerencia de Red Norte Santa Cruz—Patricia Calvo
18. Carmen Monasterios—Technical Director of the C-PAC program. Now working with CIES on application of C-PAC methodology to comprehensive RH programs.
19. Independent consultant—Luisa Rada

Dr. Oscar Viscarra (UNFPA/B) and Dr. Ibelize Segovia (PAHO) were not interviewed due to their time constraints.

APPENDIX 5:

Possible Criteria for Selection of Health Centers Where Comprehensive PAC Services Can Be Established

We have recommended that one or two health centers associated with each hospital be selected to provide comprehensive PAC services.

Sample selection criteria could include the following:

- Expressed interest from District Director, Clinic Director, and providers
- Appropriate infrastructure
- Dedicated space with reliable lighting, water supply, and visual and auditory privacy
- Services available 24 hours, seven days a week
- Providers trained in counseling, MVA, FP, infection prevention, and referral, and available at all times
- At least two complete MVA instrument sets
- All necessary equipment and supplies for infection prevention and FP methods available in treatment/recovery room
- Referral/counter-referral system and monitoring and supportive supervision provided by associated hospital
- Management information system to record services provided, referrals, follow-up visits, etc.

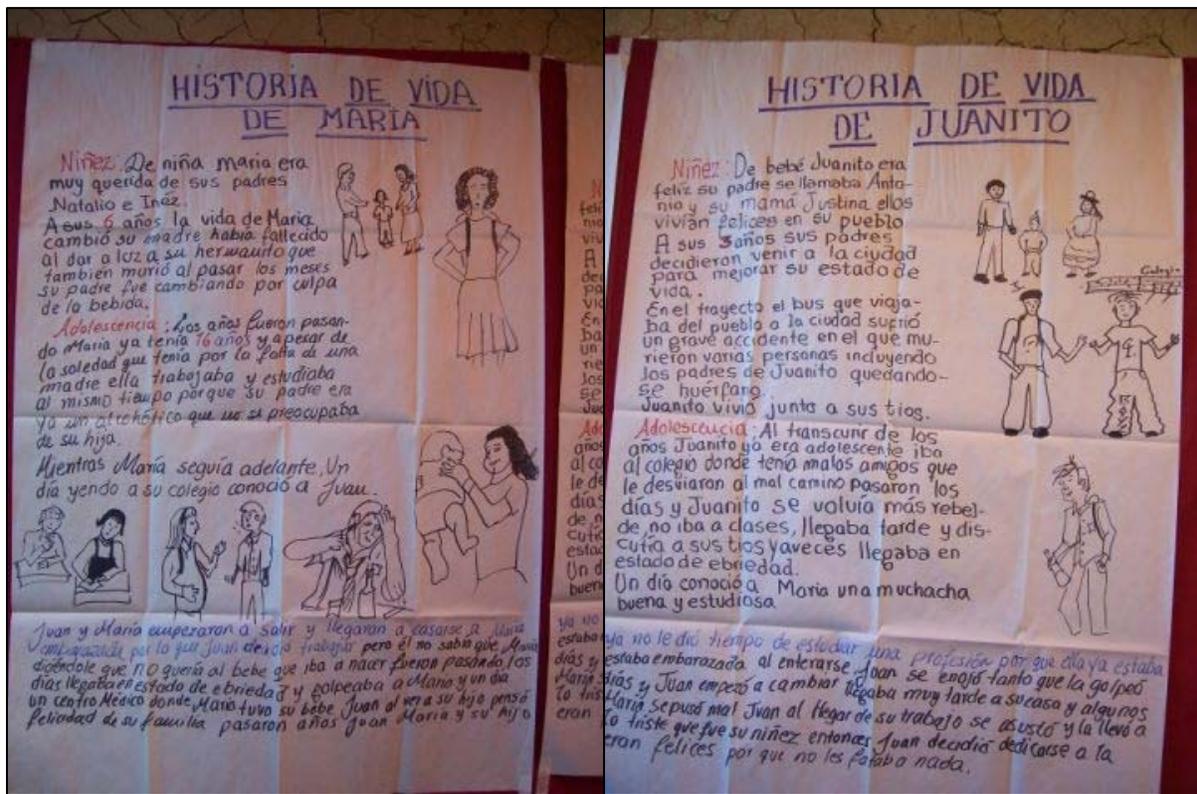
APPENDIX 6: Selected Photos of Evaluation Activities



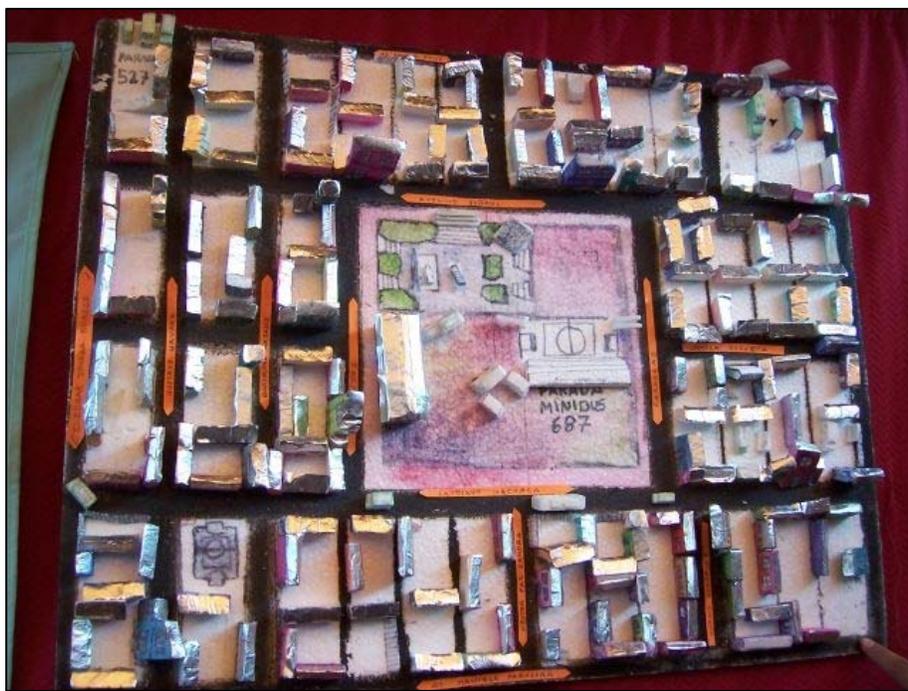
Poster with pictorial list of birth preparation needs for an expectant couple, produced by a women's group



Group leaders (and some of their children) who participated in a focus group at the evaluator's invitation



“Life stories” of a young man and woman constructed by a women’s group



A community map constructed out of cardboard and Styrofoam

APPENDIX 7: Sample Action Plan

Santa Cruz

Action Plans for the First Action Cycle

ANITA LEIGUE HEALTH CENTER

SUMI

Problem	Who are affected?	What is the root of the problem?	What do we hope to achieve?	How are we going to resolve the problem?	Intervention	With what?	Person responsible	Period Date	
Lack of information on SUMI services (22)	Pregnant women and children below the age of 5	Lack of interest, low level of education, because attention is not good in the health centers.	That the neighbors know about the SUMI services, to prevent complications during and after pregnancy, prevent illness in children below the age of 5.	Invite the director of the health center to a meeting to give them information on the community action plan and schedule training workshops on the SUMI in the community. The meeting will be held on 09/09/04, in the health center, at 11: 00	Health center director Head of nursing	A letter	The letter will be written by Nordy Paz	07/09/04	07/09/04
							Delivered by	08/09/04	08/09/04
							The meeting will be held on	09/09/04	09/09/04
							Those responsible for the meeting are: Braulio, Carmen, Isabel, María J. and Rosario.		

TRAINING

Problem	Who are affected?	What is the root of the problem?	What do we hope to achieve?	How are we going to resolve the problem?	Intervention	With what?	Person responsible	Period Date	
Parents and children do not communicate enough about sexuality. (22)	Young people, adolescents and parents	Because the parents work. They are not interested and do not care about giving information to their children.	Good communication between parents and children to prevent unwanted pregnancies, abortions and alcoholism.	Schedule training workshops for parents and children with specialized staff	Students in the 5th year of psychology	A letter	Braulio will write the letter to the psychologists	18/09/04	20/09/04
		Because parents and children do not know how to talk about sexuality.		The workshop will be held on 09/10/04 in the health center at 17:00.			The letter will be delivered by Braulio.	30/10/04	
		Design a poster on communication between parents and children.		Nordy			30/10/04	30/10/04	

COMMUNITY

Problem	Who are affected?	What is the root of the problem?	What do we hope to achieve?	How are we going to resolve the problem?	Intervention	With what?	Person responsible	Period Date	
The neighbors do not know about the health annual work plan. (22)	All of the neighbors	The leaders do not say when the meetings for the annual work plan are to be held. The annual work plan is used for their personal benefit. Community leaders' political differences.	The majority of the neighbors knows about and participates in the annual work plan sessions to contribute to solving needs and problems.	Invite Dr. Patricia Calvo to give a workshop on the annual work plan. Tentatively set for 18/09/09	Director of the North Metropolitan Network	A letter	The letter will be written and delivered by Braulio Tarqui Those in charge of interviewing Dr. Calvo are: Nurdy Braulio Isabel Place: North Network, at 08:30	08/09/04	08/09/04
The community does not support its leaders. (22)	All of the community	Because the leaders do not give out information, are politically influenced, are not trusted because they work for their interests.	The community supports its leaders and participates in solving the problems facing the community	Schedule a meeting with the community representatives so that together they can look for solutions. The meeting will be scheduled for September 12 in the office at the neighborhood football pitch at 09:00.	Neighborhood Board Popular Health Committee	A letter	Sr. Braulio already sent the letter to the leaders. Date of meeting	01/09/04	01/09/04

APPENDIX 8: Sample Follow-Up of Action Plan

POCHOLA TRAPERO HEALTH CENTER

Health Center

PROBLEM	ACTIVITY	STAGE			OBSERVATIONS AND COMMENTS	NEXT STEPS	INDICATOR
		NS	O	F			
RESOLVE We do not have a public health center in the Los Tusequis neighborhood. (18) (Re)	We will organize a meeting for Monday 09/13/04 at 19:00 in the Neighborhood Board meeting room with the community, the Neighborhood Board, the Subalcaldía, the North Health Network and the church.		X		The meeting went on as planned but unfortunately the authorities invited did not attend. The meeting was rescheduled but again the authorities did not attend, (only the president of the UV attended.) stating that they were busy with the mayor's political activities.	The leader will invite the representatives again after the elections have been held, provisionally the second week of January 2005.	A quarterly meeting will be held with the authorities. List of participants and minutes of the meetings.

PROBLEM	ACTIVITY	STAGE			OBSERVATIONS AND COMMENTS	NEXT STEPS	INDICATOR
		NS	O	F			
RESOLVE The health center is only open 12 hours a day and there is no attention on Saturdays or Sundays (7) (Re)	The first step is to hold a meeting with all of the community to analyze strategies that will help to increase the opening hours. The meeting will be held on September 30 in premises on the plaza in the Odontólogos neighborhood at 20:00.			X	The meeting was held as scheduled. Dr. Teresa Flores (SEDES) and Dr. Paniagua (Alcaldía) told the participants that the regulations did not allow two centers close to each other could not be open 24 hours a day. But they did commit to having another doctor on the staff.	The leaders and the popular committee sent a letter to the SEDES to request the doctor for the Pochola Trapero health center. This will be followed up at the monthly meetings with the health center.	12 meetings a year will be held. 1 more doctor at the Pochola Trapero health center.

SUMI

PROBLEM	ACTIVITY	STAGE			OBSERVATIONS AND COMMENTS	NEXT STEPS	INDICATOR
		NS	O	F			
DECIDE Not enough known about the SUMI (17) (D)	A meeting on September 10 with the director of the center to schedule training workshops first for the mothers' club and later for the Candia school. Provisional date - 09/17/04			X	The training activity was held with the young people and adolescents from the school (30 students) but not with the mothers' club as they had already done this activity before the scheduling.	The leaders and the facilitator will write up a training program to be presented to the head of the center and the director at the next meeting on January 24, 2005	2 educational sessions per group.

PROBLEM	ACTIVITY	STAGE			OBSERVATIONS AND COMMENTS	NEXT STEPS	INDICATOR
		NS	O	F			
DECIDE Many women do not know what the benefits of the SUMI are and we do not know our health rights. This is why some women prefer to go to the pharmacy instead of the health center. (8) (D) (R)	First we will organize ourselves as residents and then we will invite those in charge of the health center so that they can guide us. We will have a meeting on 09/01/04 at 06:30.		X		The meeting was held as agreed but there were not enough women to organize the mothers' club and so, at the request of the participants, it was decided to hold the educational sessions and that same day we prepared a schedule for the training workshops.	The leaders and the facilitator will write up a training program to be presented to the head of the center and the director at the next meeting.	2 educational sessions per group.

TRAINING

PROBLEM	ACTIVITY	STAGE			OBSERVATIONS AND COMMENTS	NEXT STEPS	INDICATOR
		NS	O	F			
RESOLVE The residents do not know about their health rights and responsibilities. (7) (Re)	A poster on health rights will be put up in the health center.			X	The poster on users' rights was made by the auxiliary nurse. Also the need to hold training workshops on this topic in the community was noted.	The leaders and the facilitator will write up a training program to be presented to the head of the center and the director at the next meeting.	50 people trained in user rights and responsibilities.

PROBLEM	ACTIVITY	STAGE			OBSERVATIONS AND COMMENTS	NEXT STEPS	INDICATOR
		NS	O	F			
RECOGNIZE Lack of complete information on methods of contraception (17) (R)	Use the meeting with the director of the health center to request and schedule training workshops.		X		The director of the Pochola Trapero health center, Dr. Lenny Sancches undertook to carry out educational activities with the support of the leaders. The leaders and the facilitator will coordinate the scheduling of the educational activities.	The leaders and the facilitator will write up a training program to be presented to the head of the center and the director at the next meeting.	Hold 12 educational sessions. List of participants.

PROBLEM	ACTIVITY	STAGE			OBSERVATIONS AND COMMENTS	NEXT STEPS	INDICATOR
		NS	O	F			
DECIDE Young couples do not know about family planning methods or the SUMI services (18) (D)	Request workshops from Dr. Jorge Torrico León (private practice) on contraception and the SUMI for the young people at the Josefina Bálsamo school The date for the first workshop has been tentatively set for 10/01/04. If the doctor can not help us, we will ask for support from the Pochola Trapero health center		X		The director of the Pochola Trapero health center, Dr. Lenny Sancches undertook to carry out educational activities with the support of the leaders. The leaders and the facilitator will coordinate the scheduling of the educational activities.	The leaders and the facilitator will write up a training program to be presented to the head of the center and the director at the next meeting.	Hold 12 educational sessions. List of participants.

PROBLEM	ACTIVITY	STAGE			OBSERVATIONS AND COMMENTS	NEXT STEPS	INDICATOR
		NS	O	F			
RECOGNIZE Couples and young people do not know how to prevent pregnancy because there is a lack of counseling on methods of contraception (8) (R)	Request that the director of the health center hold educational workshops for the community to prevent unplanned pregnancies		X		The director of the Pochola Trapero health center, Dr. Lenny Sancches undertook to carry out educational activities with the support of the leaders. The leaders and the facilitator will coordinate the scheduling of the educational activities.	The leaders and the facilitator will write up a training program to be presented to the head of the center and the director at the next meeting.	Hold 12 educational sessions. List of participants.

PROBLEM	ACTIVITY	STAGE			OBSERVATIONS AND COMMENTS	NEXT STEPS	INDICATOR
		NS	O	F			
RECOGNIZE Women do not know signs of danger during pregnancy and put the life of their child at risk (8) (R)	Request that the director of the health center hold educational workshops for the community to talk about these issues and replicate them		X		The director of the Pochola Trapero health center, Dr. Lenny Sancches undertook to carry out educational activities with the support of the leaders. The leaders and the facilitator will coordinate the scheduling of the educational activities.	The leaders and the facilitator will write up a training program to be presented to the head of the center and the director at the next meeting.	Hold 12 educational sessions. List of participants.

COMMUNITY

PROBLEM	ACTIVITY	STAGE			OBSERVATIONS AND COMMENTS	NEXT STEPS	INDICATOR
		NS	O	F			
RESOLVE The residents do not attend neighborhood meetings (7) (Re)	This will be discussed at the meeting on 09/30/04 at 20:00 in the plaza in the Odontólogos neighborhood where meetings will be scheduled to solve the main problems facing the community.			X	The meeting was held as scheduled; the representatives undertook to work more together and invited the residents to participate in the meetings held by the neighborhood board or the popular health committee.	The community representatives undertook to participating in the monthly meetings at the Pochola Trapero health center	11 meetings a year.

PROBLEM	ACTIVITY	STAGE			OBSERVATIONS AND COMMENTS	NEXT STEPS	INDICATOR
		NS	O	F			
DECIDE Lack of coordination among the grass roots organizations of the Los Tusequis neighborhood(18) (D)	At the meeting on 09/13/04 we will tell our leaders that we want to work together to benefit the neighborhood.			X	The meeting was held as scheduled; the representatives undertook to work more together and invited the residents to participate in the meetings held by the neighborhood board or the popular health committee.	The community representatives undertook to participate in the monthly meetings at the Pochola Trapero health center	11 meetings a year.

APPENDIX 9:

Data from Sistema Nacional de Informacion en Salud (SNIS)

33 health facilities involved in the C-PAC program

Type of visit	% increase from 2004 to 2006
Antenatal care (new visit, before fifth month of pregnancy)	27.5%
Antenatal care (new visits, after fifth month of pregnancy)	9.4%
Total, new antenatal clients	18.2%
New clients, men	34.0%
New clients, women	35.0%
Return clients, men	25.0%
Return clients, women	7.0%
Institutional births	26.6%

Note: The above increases in service demand may be attributed to a number of factors, including the C-PAC program; however, we have no data from comparable sites without an intervention to assert that the C-PAC program was responsible for them.

The data shown here were provided by Dr. Rocío Lara, of USAID/Bolivia.