WHY RURAL WOMEN USE—OR AVOID—MATERNAL HEALTH SERVICES

Insights from a Qualitative Study in Bolivia

WORLD BANK GROUP

WHY RURAL WOMEN USE—OR AVOID—MATERNAL HEALTH SERVICES

Insights from a Qualitative Study in Bolivia

WORLD BANK GROUP

CONTENTS

ACKNOWLEDGMENTS

This study, funded by the Global Financing Facility (GFF), was conducted by Ursula Casabonne (Senior Social Development Consultant) and Miriam Muller (Social Scientist) under the leadership and guidance of the World Bank's Health Team for Bolivia, Marcelo Bortman (Lead Health Specialist), and Patricia Alvarez (Senior Operations Officer). Important contributions were provided by Angela Caballero (Social Development Specialist). Field work and data systematization were conducted by a team from CIES Internacional led by Raphael Villareal Waiwa and composed of Mariela Garcia Miranda, Fernando Gonzales, and Marcelo Mercado. We thank our peer reviewers Jonna Lundvall (Social Scientist) and Mickey Chopra Micky (Lead Health Specialist) for their insightful and technical review of this study. Our deepest gratitude goes to the key informants and to the women and men who shared their personal stories with us. The opinions, interpretations, and conclusions expressed herein do not necessarily reflect the views of the World Bank, its Board of Executive Directors, or the governments they represent.

ABSTRACT

Background: Bolivia has achieved significant improvements in its reproductive health indicators in recent years. Yet the country's maternal mortality ratio, at 206 per 100,000 women in 2015, was the second-highest in the Latin American and Caribbean region after Haiti. Bolivia's indigenous women are particularly vulnerable to death from complications related to pregnancy, childbirth, and the post-partum period. In the past, there have been no studies that sought the views of health providers and users to understand and address this problem in rural indigenous communities. This study fills that gap by tapping this experiential knowledge in these communities in Bolivia and gain insights into supply- and demand-side barriers that keep women away from institutional maternal health services. Increasing their use of quality maternal care is vital to long-term goals to lower the country's maternal mortality ratio.

Methods: The study employed a descriptive qualitative design to identify supply- and demand-side factors that might restrict rural indigenous women in Bolivia from using maternal health care. To ensure geographic inclusivity, it was conducted in eight rural indigenous communities across four departments (La Paz, Santa Cruz, Beni, and Cochabamba). Semi-structured interviews were conducted in May 2019 with 15 health providers in eight health centers (six primary and two secondary). There were 42 in-depth interviews with women, 32 focus group discussions (four per community) stratified by age and gender, and 16 key informant interviews with community leaders (two per community). In addition, an assessment of quality of basic and comprehensive emergency obstetric and newborn care was conducted in each of the health facilities visited.

Results: On the supply side, significant gaps and system failures were found at the health facility level, including limited orientation services for family planning/contraception; inadequate obstetrics skills among staff in primary health facilities; inadequate supply chains that create shortages of crucial supplies and medicines in primary health centers; poor human resource management leading to staff shortages in secondary health facilities; lack of intercultural adaptation of birth practices; and mistreatment of indigenous women by health staff. On the demand side, the study found issues with community norms and attitudes concerning sexuality and contraception; women's resistance to gynecological examination by male doctors; social stigma of out-of-wedlock adolescent girls; and the high value

placed on home births. At the household and individual levels additional barriers were identified, such as women's lack of agency to autonomously define their reproductive intentions; husbands' opposition to wives being examined by male doctors; women's time poverty; women's lack of prioritization for maternal health services; and limited control over household income to pay for transport to health facilities. Overall, shortages of qualified health workers, equipment, and drugs in health facilities, coupled with poor provider-user interactions, compromise the quality of maternal care and discourage rural indigenous women from seeking it out.

Conclusions: Both supply- and demand-side influences restrain the uptake of maternal health services by rural indigenous women. Strengthening the quality of maternal health services, including provider-user interactions, is a first and foremost priority that can be combined with targeted behavior change interventions to reduce community, household, and individual constraints on women seeking maternal health services.

ABBREVIATIONS

ASUSS	*Autoridad de Supervisión de la Seguridad Social de Corto Plazo* (Supervisory Authority of Social Security at the Short Term)
BEmONC	Basic Emergency Obstetric and Newborn Care
SBS	*Subsidio Basico de Salud* (Basic Health Insurance)
BJA	*Bono Juana Azurduy* (Juana Azurduy Grant)
CEmONC	Comprehensive Emergency Obstetric and Newborn Care
DHS	Demographic and Health Survey
IEC	Information, Education, Communication
ESNUT	*Encuesta de Evaluación de Salud y Nutrición* (Health and Nutrition Survey)
GFF	Global Financing Facility
LAC	Latin America and Caribbean region
MMR	Maternal Mortality Ratio
MSD	*Ministerio de Salud y Deportes* (Ministry of Health and Sports)
PAI	*Programa Ampliado de Inmunizaciones* (Expanded Immunization Program)
SAFCI	*Salud Familiar Comunitaria Intercultural* (Intercultural Community Family Health)
SDGs	Sustainable Development Goals
SEDEM	*Servicio de Fortalecimiento de las Empresas* (Business Strengthening Service)
SEDES Beni	*Servicio Departamental de Salud* (Public Health Department on Beni Department)
SNMN	*Seguro Nacional de Maternidad y Niñez* (National Maternal and Child Insurance)
SUMI	*Seguro Universal Materno Infantil* (Universal Maternal and Child Insurance)
SUS	*Sistema Único de Salud* (Unified Health System)
SUSAT	*Seguros Departamentales de Salud* (Departmental Health Insurance)

INTRODUCTION

Globally, about 830 women die from pregnancy- or childbirth-related complications every day. Almost all of these deaths occurred in developing countries, and most could have been prevented (Alkema, et al. 2016). In recent years, Bolivia has achieved solid progress on this front, reducing maternal mortality by 38 percent to 206/100,000 live births between 2000 and 2015 (Figure 3). Furthermore, recent estimates show that it is off-track to achieve the 2030 SDG target on maternal mortality (Box 1).

This study presents the findings of an exploratory qualitative study of supply- and demand-side factors that affect the quality and utilization of maternal health services in Bolivia. Little is known about forces that constrain rural indigenous women from seeking out institutional maternal health services in Bolivia and, in particular, giving birth in a health facility. Therefore, the study aims to answer the following questions: (1) What factors shape a women's decision to access maternal health services and her perceptions about those services and birth in primary and secondary facilities in Bolivia? Specifically, what are the challenges and barriers women face in accessing maternal health services and giving birth in a health facility? What are the supply-side factors in terms of distance to facilities, quality of services there, and affordability that pose barriers to women's uptake of maternal health services?

The study was conducted as part of the World Bank-supported Health Service Delivery Network Project (2018-2023), which seeks to improve access to, and quality of, health service delivery in selected health networks, and was supported by a Global Financing Facility (GFF) grant. It employed qualitative research methodologies to identify supply- and demand-side factors that might restrict rural indigenous women in Bolivia from using maternal health care by skilled providers and to learn from community members' perceptions, experiences, and interpretations of their situations. Qualitative methods allow the capture of individual perceptions of social norms, beliefs, behaviors, opinions, intra-household community-level dynamics, and contextual factors. The study was conducted in eight communities that have high maternal mortality, located in four

BOX 1.

Reducing Preventable Maternal Mortality in the 2030 Agenda for Sustainable Development

Ending preventable maternal mortality remains an unfinished agenda and one of the world's most critical challenges. For this reason, maternal health, wellbeing, and survival remain a central goal and investment priority in the post-2015 framework for sustainable development, the Sustainable Development Goals (SDGs) launched in 2016. SDG 3, "Ensure healthy lives and promote well-being for all at all ages," has an average global target of a maternal mortality ratio (MMR) of fewer than 70/100,000 live births by 2030. The supplementary national target is that no country should have an MMR greater than 140/100,000 live births (a number twice the global target) by 2030. A special target for all countries in addition to reducing their national MMR is to end extremes of inequity between countries in this measure and to eliminate disparities in maternal mortality among subpopulations within countries.

Bolivia is off-track to achieve the 2030 SDG target on MMR, according to a 2018 study by McArthur, Rasmussen, and Yamey. To reach this conclusion, the researchers used available MMR data (from 2005 to 2015) to calculate the country's proportional annualized average rate of fall in these indicators for the most recent 10 years and then extrapolated the 10-year trend out to 2030, assuming no change in the rate of decline. The researchers then used country-level birth projections, taken from the UN Population Division's 2017 population prospects, to estimate birth-weighted global child and maternal mortality aggregates, alongside country-level trajectories for the absolute number of maternal and child deaths out to 2030. In order to meet the 2030 target, the researchers concluded that the annualized rate of decline of MMR needs to almost double from the 2005-2015 annualized rate of 3.8 to 6.9 (McArthur, Rasmussen and Yamey 2018).

departments: La Paz, Santa Cruz, Beni, and Cochabamba. On the supply side, interviews were conducted with a total of 15 health care personnel in primary and secondary health care facilities. On the demand side, 90 community members took part in focus group discussions, in-depth and ethnographic interviews, and key informant interviews in the eight communities (Figure 1). To enable analysis, the transcribed interviews were organized in an Excel spreadsheet according to a deductive definition of themes and subthemes and categories. For a full description of the methodology, see Annex 1.

For data collection and analysis, the study employs a commonly-used behavioral framework of health services utilization that distinguishes between supply-side factors, demand-side factors,

FIGURE 1.

Map of Municipalities and Communities Visited

LA PAZ

- Municipality Caranavi
  - Communities surveyed: Taipiplaya, Colonias
  - Health centers surveyed: Santa Fe (primary), Caranavi (secondary)

COCHABAMABA

- Municipality Morochata
  - Communities surveyed: Piusilla, Chinchiri
  - Health centers surveyed: Morochata (primary), Piusillas (secondary)

BENI

- Municipality San Ramon
  - Communities surveyed: Siringalito, El Carmen de Guayane
  - Health centers surveyed: San Ramon (primary), Carmen de Guayane (secondary)

SANTA CRUZ

- Municipality Porongo
  - Communities surveyed: Potrerito, Pozo colorado
  - Health centers surveyed: Porongo (primary), Montero (secondary)

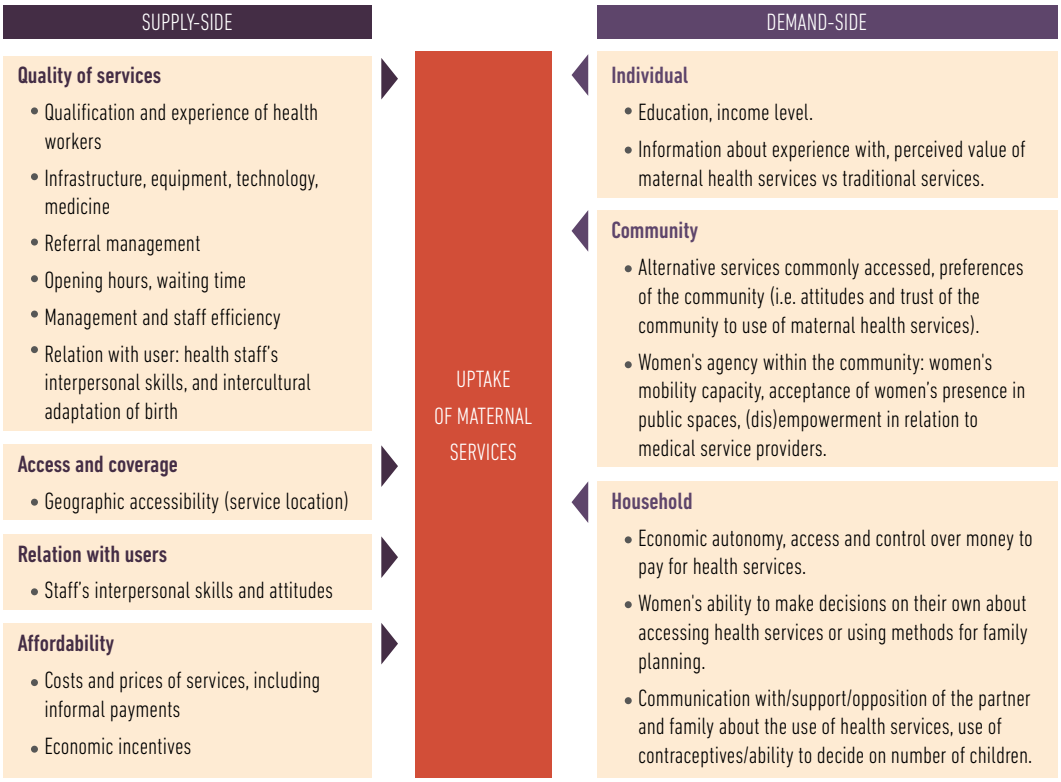
and mechanisms that affect the utilization of health services (Ensor and Cooper 2004, O'Donnell 2007, Peters, Garg, and Bloom 2008). Supply-side factors occur at the level of the health service provider and are related to the quality of care provided at the facility, such as services, availability of skilled health workers, essential equipment, and drugs. They also include aspects inherent to the health system that influence service uptake by individuals, such as the level of coverage, affordability of services, and the personal dynamics of the health service staff with users of services. Demand-side factors relate to the people the services are intended for, such as their desire and ability to use them. These factors operate at individual, household, and community levels (Ensor and Cooper 2004) (Figure 2). Individual-level factors include education, income, knowledge about the characteristics of, and need for medical treatment, and women's agency. Household and community-level factors include gender norms and expectations, women's bargaining position within the household, and other cultural or social factors that affect individual preferences.

Differentiating between demand-side and supply-side forces helps in the formulation of appropriate interventions but the two forces often interact and influence each other and should thus be addressed concurrently (James, Hanson, and McPake 2006 and O'Donnell 2007). For example, if the maternal health services offered are of low quality (a supply-side issue), this will reduce people's interest in using them (a demand-side issue). Therefore, there is a

FIGURE 2. .

Behavioral Framework for Maternal Health Services Uptake: Supply- and Demand-Side Factors

Source: Author's adaptation based on Ensor and Cooper 2004



need to address both demand and supply challenges in the maternal health system. In low-income countries in Asia (Jacobs, et al. 2012) and Africa (Kananura, et al. 2017), and among minority communities in the United States and Canada (Heaman et al. 2015, Downe et al. 2009, Johnson et al. 2011, and Scheppers et al. 2006), a large number of studies have used a similar framework to uncover supply- and demand-side factors that affect the use of maternal health services.

Following this introduction, the paper is structured as follows: Second II provides an overall picture of maternal health care outcomes and describes the Bolivian health care system. Section III describes the key findings of the qualitative research. Section IV presents the policy implications and programmatic recommendations to reduce maternal mortality in Bolivia. Annex 1 describes the methodology of the study. Annex 2 lists the research instruments, while Annex 3 maps the survey area.

2

CONTEXT: MATERNAL HEALTH OUTCOMES, THE HEALTH CARE SYSTEM, AND MATERNAL HEALTH POLICIES IN BOLIVIA

Bolivia has made solid progress in improving its reproductive health indicators, but it continues to rank among the worst in the Latin America region. In addition to significant rural/urban disparities in maternal deaths, some departments, such as La Paz, Potosi, and Cochabamba, have MMRs that are two to three times higher than in the departments of Tarija and Santa Cruz. Low usage of basic maternal and child health services, especially in rural areas, may explain why maternal, neonatal, and infant mortality have remained so high. According to the 2016 Demographic and Health Survey (DHS), key reasons that rural women cite for not using maternal health services are that health facilities are too far away and that it is not the custom to seek assistance there. While a large share of maternal deaths occur at home and enroute to health facilities (42 percent), an almost equal proportion (37 percent) occur at the health facilities themselves. This points to deficiencies in the facilities' provision of basic emergency obstetric and newborn care (BEmONC), comprehensive emergency obstetric and newborn care (CEmONC),[1] and referral management for emergency obstetric cases.

---

1 Basic emergency obstetric and newborn care (BEmONC) is critical to reducing maternal and neonatal death. This care, which can be provided by skilled staff in health centers large or small includes the capabilities for (1) administering antibiotics, uterotonic drugs (oxytocin) and anticonvulsants (magnesium sulphate), (2) manual removal of the placenta, (3) removal of retained products following miscarriage or abortion, (4) assisted vaginal delivery, preferably with vacuum extractor, and (5) basic neonatal resuscitation care. Comprehensive emergency obstetric and newborn care (CEmONC), typically delivered in hospitals, includes all the basic functions above, plus capabilities for (1) performing caesarean sections, (2) safe blood transfusion, and (3) provision of care to sick and low-birth weight newborns, including resuscitation. Guidelines jointly issued in 1997 by the World Health Organization, the UN Children's Fund, and the UN Population Fund recommended that for every 500,000 people there should be four facilities offering basic care and one facility offering comprehensive essential obstetric care. These guidelines were revised in 2009, with

Maternal Health Care Outcomes

The steady decline in maternal mortality in Bolivia in recent years (Figure 3) can be attributed to improvements in access to maternal health care services. For instance, in 2003, 57 percent of births in the country took place at health facilities. By 2016, the figure had risen to 88 percent. There were similar gains in rates of antenatal care with a skilled provider: 79 percent in 2003 compared to 96 percent in 2016 (Figure 4).

Yet the country's maternal mortality ratio, at 206 per 100,000 women in 2015, is exceeded in the region only by Haiti's (Figure 5). Bolivia also ranks high in infant and neonatal and neonatal mortality (Figure 6). Within the country, indigenous women are more likely than women in general to die from complications related to pregnancy, childbirth, and the post-partum period (Figure 7). According to the Population and Housing Census 2012, 40 percent of women aged 15 and over in Bolivia self-identify as indigenous. However, maternal deaths are overrepresented among this population at 68 percent of the total (Figure 7).

Bolivia also has a high rate of adolescent fertility and adolescent mothers account for a sizable percentage of maternal deaths. In 2016, 69 births were registered in Bolivia per 1,000 women between the ages of 15 and 19, compared to 62.8 on average in Latin America and the Caribbean (World Development Indicators). Teenage pregnancy is higher in rural areas, among women with low levels of education, and among minority ethnic groups (Figure 8). A sizable proportion of maternal deaths occur among women between the ages of 14 and 19 years (Figure 9).

Low use of basic maternal and child health services, especially in rural areas, may explain why maternal, neonatal, and infant mortality have remained at such high levels in the country as a whole, but particularly in rural areas. In rural Bolivia, just 70.3 percent of births are delivered in a health facility compared to 95.8 percent in urban areas, according to the latest Demographic Health

---

additional support from the Averting Maternal Death and Disability (AMDD) Program of Columbia University, and published in Monitoring Emergency Obstetric Care: A Handbook. The handbook details the newly revised indicators for assessing the availability, use, and quality of obstetric services. To manage obstetric complications, facilities must have multiple skilled attendants on duty 24 hours a day, seven days a week, assisted by trained support staff. To manage complications requiring surgery, facilities must have a functional operating theatre and additional support staff, and must be able to administer safe blood transfusions and anesthesia (UNFPA 2015).

FIGURE 3.

Maternal Mortality Ratio (Modeled Estimate, per 100,000 Live Births), 1990-2015

Source: World Development Indicators

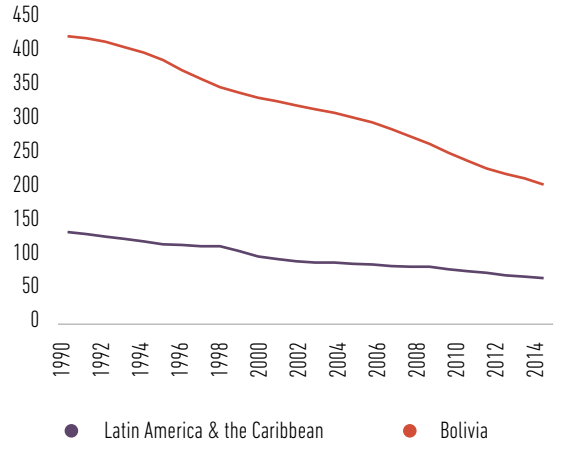


FIGURE 4.

Trends in Maternal Care (percent)

Source: Bolivia Demographic Health Surveys, 2003, 2008, 2016

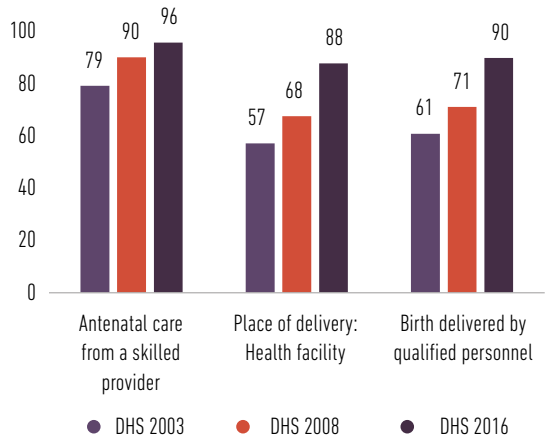


FIGURE 5.

Maternal Mortality Ratio (Modeled Estimate, per 100,000 Live Births), 2015

Source: World Bank, World Development Indicators.

FIGURE 6.

Neonatal and Infant Mortality Rate (per 1,000 Live Births), 2017

FIGURE 7.

Maternal Mortality According to Ethnicity

Source: Sistema Nacional de Información en Salud y Vigilancia Epidemiológica 2016.

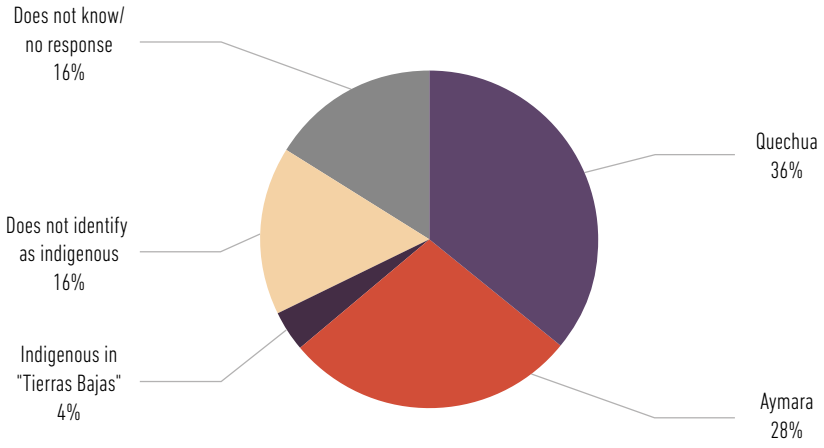
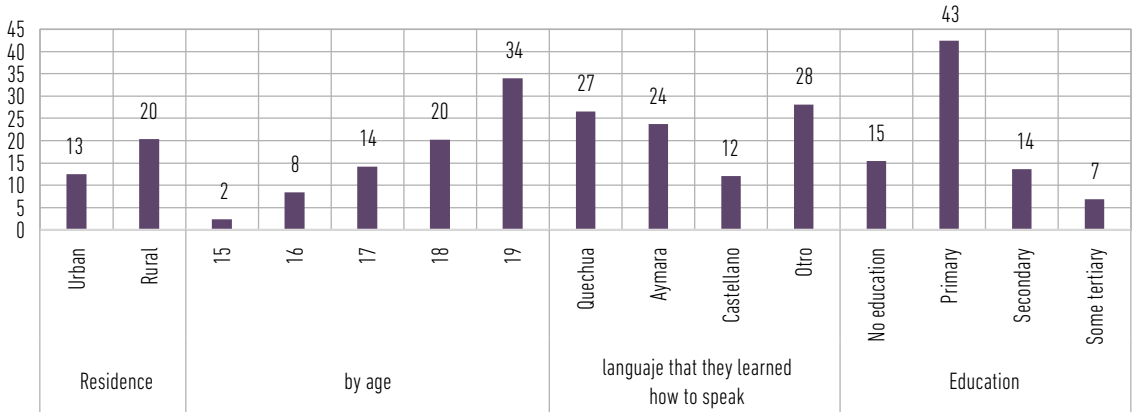


FIGURE 8.

Percentage of Adolescents Aged 15-19 Who Are Already Mothers or Are Pregnant for the First Time in Bolivia, by Place of Residence, Age, Ethnicity, and Education, 2016

Source: DHS 2016.



Survey (Figure 10). The 2016 DHS survey shows that non-indigenous women gave birth in health institutions at higher rates than indigenous women.

While most Bolivian women have access to health facilities, many do not utilize them, for a broad variety of reasons, according to the DHS (Figure 11). For rural women, the main reason was that the facility was too far away (60 percent answered affirmatively), followed by lack of trust in the health facility/poor quality (12 per-

FIGURE 9.

Age at Death of Expectant Mothers, 2011

Source: Sistema Nacional de Información en Salud y Vigilancia Epidemiológica 2016.

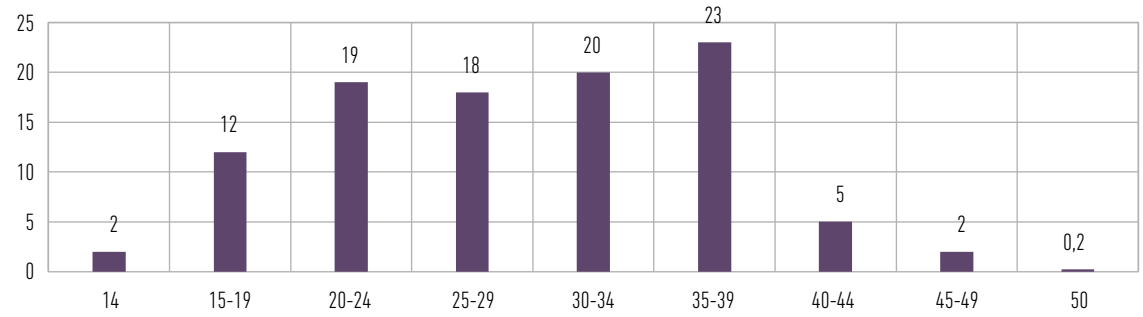
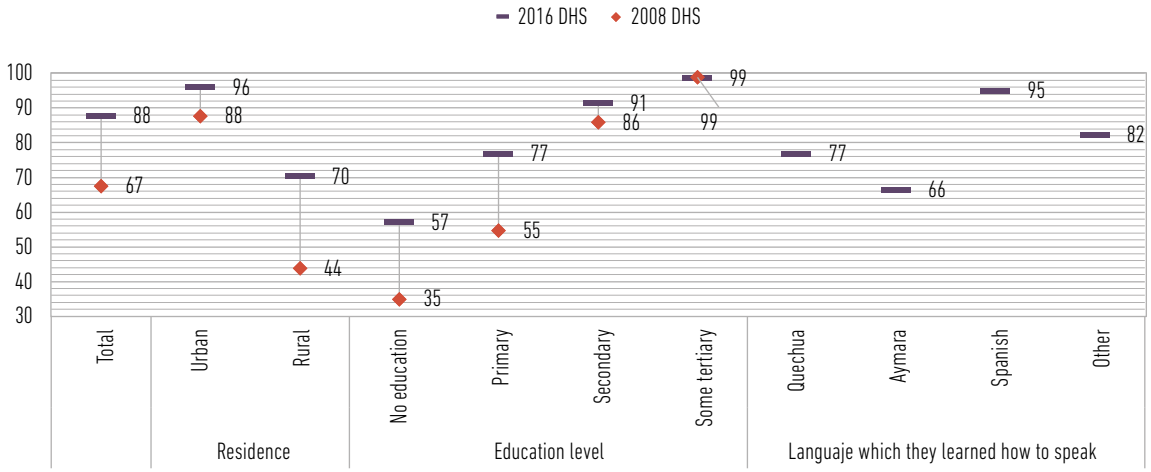


FIGURE 10.

Percentage of Live Births (in the Five Years Preceding the Survey) Delivered at a Health Facility, 2008-2016

Source: Demographic Health Surveys 2016 and 2008.



cent), and that services are too costly (11 percent).[2] In urban areas, the main reason women do not choose a health facility for birth was lack of trust in the facilities (35 percent), followed by lack of female staff there (9 percent). Furthermore, health facilities that are part of

2 These data were collected before SUS (Sistema Único de Salud) became effective. In addition, the overall conclusions from the answers may differ from those arising from qualitative data which allow surveyors to explore more in-depth the underlying decision-making of individuals rather than giving the respondents options to choose from.

FIGURE 11.

Reasons Why Expectant Mother Did Not Deliver Her Baby in a Health Center (% of Women Who Responded Yes to the Different Options for the Question: Why Did You Not Deliver in a Health Facility?)

Source: DHS 2016, ENSA 2016. Question: ¿Por qué no tuvo a (NOMBRE) en un establecimiento de salud?

the Universal Maternal and Child Insurance (SUMI)[3] were regarded as providing poor service due to long wait times (82 and 63 percent for urban and rural areas residents, respectively), unfriendly staff (51 and 44 percent), and lack of medication (30 percent and 33 percent) (see Figure 12). In rural settings, some of these results resonate with a small-scale qualitative study conducted in 2005 in Yapacani, an impoverished lowland municipality in the department of Santa Cruz. It found that the main reasons for the low rate of institutional birth were fear or embarrassment related to receiving care at a public health center, poor quality of care at the centers, travel distance, lack of money for travel or care fees, and perceptions that health care services are not necessary due to the experience of "easy birth" (Otis and Brett 2008).

While the majority of maternal deaths occur in the home (42 percent) and enroute to health facilities (17 percent), a sizeable share (37 percent) take place at a health center, pointing to deficiencies in care provided at these facilities (Figure 13). According to the 2011 National Study of Maternal Mortality, the main direct causes of maternal mortality are hemorrhage (59 percent), hypertension (19 percent), abortion (13 percent), and infections (7 percent). See Figure 14 for details.

3 Seguro Universal Materno-Infantil (SUMI).

FIGURE 12.

Reasons for Rating the Attention of a SUMI Health Facility as Poor or Average (% of Women Who Responded Affirmatively to the Different Options for the Question)

Source: DHS 2016, ENSA 2016, Question: ¿Cuáles son las razones por las que califica la atención como regular/ mala con el SUMI con la ley No. 475? (What are the reasons why you rate the attention average or bad)

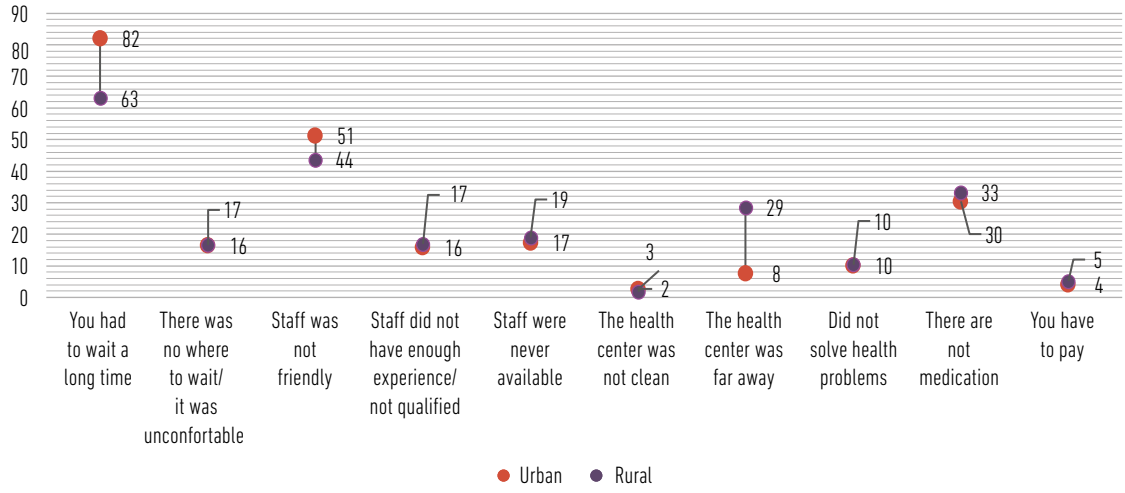


FIGURE 13.

Place Where Maternal Deaths Occur in Bolivia, 2011

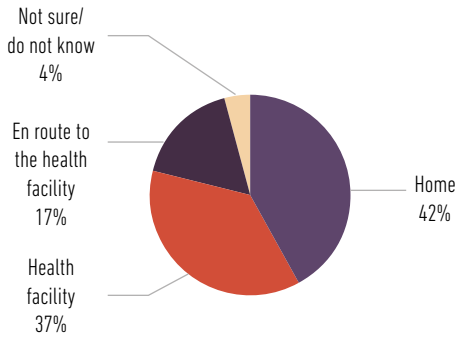
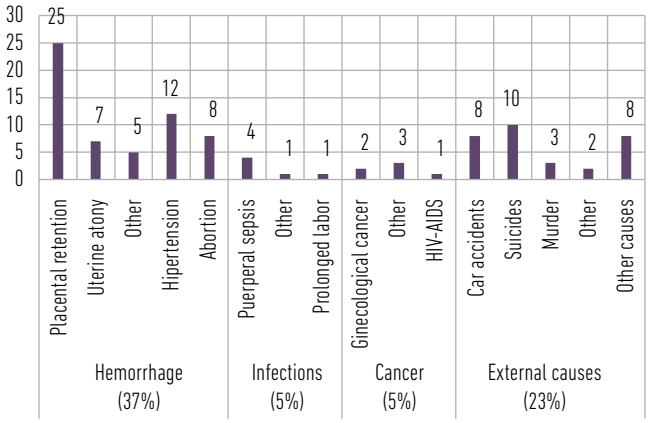


FIGURE 14.

Direct and Indirect Causes of Maternal Mortality in Bolivia, 2011



Source: Sistema Nacional de Información en Salud y Vigilancia Epidemiológica, 2016.

The Bolivian Health Care System and Maternal Health Policies

In the last two decades, the Government has enacted a series of policies specifically aimed at reducing maternal and infant mortality. Since 1997, pregnant women and children under five years old in Bolivia have been covered by publicly financed health insurance schemes that provide a free basic health care package (Box 2). These include the National Maternal and Child Insurance (SNMN) from 1997 to 1998, the Basic Health Insurance (SBS) from 1999 to 2002, the SUMI from 2003 to 2013, and the Comprehensive Health Services Benefits Law from 2014 to present (Celhay, Johannsen, Martinez, and Vidal 2019). All these schemes have provided basic maternal and child interventions, including prenatal care, skilled birth attendance, and outpatient and inpatient care for children under five. The number and complexity of covered services have increased over time.

To incentivize demand for maternal and child-care health services provided by the SUMI, the government launched the nationwide conditional cash transfer program Bono Juana Azurduy (BJA), the Juana Azurduy Grant program, in May of 2009. BJA incentivizes the use of maternal and child health services by pregnant women and children under two years old. They receive the cash only if they use select preventive health services. Enrollment in the program is voluntary and all pregnant women and under-one-year-olds not covered by the social security system are eligible. BJA pays pregnant women 50 Bs (about US$7) for each prenatal visit up to a maximum of four visits, and 125 Bs (US$18) for births assisted by qualified health personnel, whether delivery takes place at a health facility or at home. There is an additional follow-up examination within seven days of birth. For children under two years old, the program pays 120 Bs (US$17) for each health checkup in the first two years of life, up to a maximum of 12 visits (one visit every other month). With full compliance of the "co-responsibilities," covering nine months of pregnancy and the initial 24 months of the child's life, the maximum cumulative transfer amounts to 1,820 Bs (US$261) over 33 months (Celhay, et al. 2019). The enrollment rate of eligible women was approximately 33 percent between 2009 and 2012, with a decreasing trend over time (Celhay, et al. 2019). The enrollment rate of children during the same period was approximately 52 percent. According to the Health and Nutrition Evaluation Survey (ESNUT[4] by its Spanish

4 *Encuesta de Evaluación de Salud y Nutrición (ESNUT)* 2012.

acronym) 2012, the main reasons that unenrolled eligible mothers gave for their non-participation were lack of information about how to join (27.5 percent), not having the required legal documents at the time of enrollment (19.9 percent), and time costs such as long queues or long trips to health facilities (20.3 percent).

In addition, since 2015 the Ministry of Health has been providing the Universal Prenatal Subsidy (*Subsidio Universal Prenatal para la Vida*) targeting all pregnant women who have no health insurance. Beneficiaries receive food products monthly from the fifth month of pregnancy until the birth of the baby (each package is worth about Bs 300, or US$44. From October 2015 to March 2017, the benefits reached 377,574 uninsured Bolivian mothers.[5] The subsidy packages are distributed in 36 locations of the Business Strengthening Service (Servicio de Fortalecimiento de las Empresas -SEDEM) throughout the country.

BOX 2.

The Health Care System in Bolivia

More than 80 percent of Bolivia's health service delivery system (i.e. health facilities) consists of public facilities, complemented by social security (5.7 percent), private organizations (5.7 percent), NGOs (3.2 percent), churches (2.3 percent), and other smaller government entities (World Bank 2018). The breakdown is as follows:

- The public subsector, headed by the Ministry of Health, created in 1938, sets norms and standards, and formulates national policies and strategies. At the regional level, the governorships are responsible for the administration of human resources through the Departmental Health Services (Servicios Departamentales de Salud'. At the local level, municipal governments handle the administration of health facilities through the Local Health Directories (Directorios Locales de Salud)'
- The social security subsector serves salaried workers. It provides care for illness, maternity, childhood, and professional risk. It is made up of nine management entities (Health Savings Banks—Cajas de Salud—and government insurance. It is overseen by the Supervisory Authority of Social Security at the Short Term (Autoridad de Supervisión de la Seguridad Social de Corto Plazo (ASUSS), created on May 16, 2018.

5 See: https://www.minsalud.gob.bo/2390-subsidio-universal-prenatal-por-la-vida-beneficio-a-mas-de-377-mil-madres-bolivianas

- The private subsector includes insurance companies, prepaid medical companies, and non-governmental organizations.
- The traditional medicine subsector is under the responsibility of the Vice Ministry of Traditional Medicine and Interculturality, created on March 8, 2006. The Vice Ministry's purpose is to facilitate access to health programs and projects for indigenous peoples, agricultural workers, and Afrobolivians. It also seeks to facilitate equitable health care through a network of basic health establishments that have an intercultural focus, promoting the fundamental right to a dignified life. It serves approximately 10 percent of the population, especially people living in rural areas.

The National Health Sector Plan 2016-2020 (Plan Sectorial de Desarrollo Integral Para Vivir Bien 2016-2020) estimates that 65 percent of people working in health care are in urban areas and 35 percent in rural areas (31 percent of the population in Bolivia lives in rural areas). The density of government-employed health personnel is 14.1 per 10,000 inhabitants.[6] Highly qualified medical personnel are scarce. In 2015, the country had only about eight medical doctors for every 10,000 people, and five licensed nurses for every ten medical doctors. Almost half of medical specialists (45 percent) work in tertiary care, while 20 percent are in secondary, and 35 percent in primary care (World Bank 2018).

The management of health services is divided among four levels:

- At the **national level**, health policies are developed by the National Assembly of Health (Asamblea Nacional de Salud) and executed by the Ministry of Health and Sports (Ministerio de Salud y Deportes—MSD).
- At the **departmental leve**l, Bolivia's nine departments each has a Departmental Assembly of Health (Asamblea Departamental de Salud) that designs Departmental Health Plans (Plan Departamental de Salud) and administers the Health Networks (Redes de Salud).
- At the **municipal leve**l, the 339 municipalities each has a Municipal Health Board (Mesa Municipal de Salud) that administers health establishments within the municipality.

6 The World Health Organization has set a threshold of 4.45 physicians, nurses, and midwives per 1,000 people as the minimum necessary for reaching the health-related SDG targets by 2030. The largest needs-based shortages of health workers are in Southeast Asia at 6.9 million people and Africa at 4.2 million (World Health Organization 2016).

- At the **local leve**l, Local Health Committees (Comites Locales de Salud) allow for community participation in the management of health services. In 2008, the Decreto Supremo 29601 established the Unified Family, Community, and Intercultural Health System (Modelo Sanitario: Salud Familiar Comunitaria Intercultural –SAFCI) to serve as the cornerstone of healthcare nationwide based upon the principles of community participation, intersectionality, interculturality, and integrality. The SAFCI model aimed to transform the Bolivian health system by introducing primary care in an intercultural, intersectoral, and integrated manner.

Public health insurance and social protection programs include:

- **Seguro Universal Materno Infantil—SUMI—**the Universal Maternal and Child Insurance), enacted in 2003 to cover pregnant women from the beginning of pregnancy to six months after childbirth, women in childbearing age for reproductive and sexual health services, and children younger than five years.
- **Sistema Único de Salud—SUS—**the Unified Health System, created under Law N° 1069 in May 2018, to grant free health insurance to everyone who is not covered by Short Term Social Security. Health care is granted without any direct payment from users at the place or time of care.
- **Programa Nacional del Bono Juana Azurduy—BJA—**Juana Azurduy Grant to reduce maternal and infant mortality rates.
- **Subsidio Prenatal Universal**, which provides nutritional packages to expectant mothers starting from five months of pregnancy.
- **Programa Multisectorial Desnutrición Cero**, to eradicate chronic and acute malnutrition in children under five years of age, with an emphasis on children under two.
- **Seguros Departamentales de Salud**, SUSAT in Tarija, SUSA in Beni, and SUSACRUZ in Santa Cruz.

Source: World Bank, 2018, UNASUR 2012, and Leys Alvarez, Rivera Merida, and Escalante Guzman 2016, with updated information from the authors.

Adaption of intercultural birth practices is a policy aim of the Bolivian government. The Constitution of Bolivia incorporates interculturality as a core articulating principle and guarantees the right to a universal and free health care system that respects world views and traditional practices. Of special importance are Articles 18, 45, and 66 (Box 3). In 2006, the Ministry of Health's Resolution No. 0348 established cultural protocols for maternal care, including the following recommendations: rights to be accompanied by a family member, to receive the placenta, to determine body position for labor, to consume liquids and food during labor, and to avoid unnecessary practices, such as enemas, shaving, and episiotomy. To reinvigorate indigenous rural medicine and ensure its linkage and complementarity with Western medicine, the family, community, and intercultural healthcare model (SAFCI) was created by Supreme Decree No. 29601 in 2008. SAFCI places great emphasis on health promotion in the community and considers access to institutional care to be an urgent need. It is intended to assure that health services take the recipient, the family, and the community into consideration by accepting, respecting, appraising, and articulating indigenous peoples' biomedical and traditional health knowledge.

BOX 3.

The Constitution of Bolivia and Intercultural Health Practices

Article 18 establishes that:

- Every person has the right to health.
- The state guarantees the inclusion and access to health of all people, without exclusion or discrimination.
- The health system will be universal, free, equitable, inter-cultural, and participative.

Article 45 states that:

- Women have the right to safe motherhood, with vision and intercultural practice; they will enjoy special assistance and protection from the state during pregnancy, childbirth, and prenatal and postnatal periods.

Article 66 guarantees men and women the right to exercise their sexual and reproductive rights.

Source: UNFPA 2008.

However, to date the multicultural approach to providing health care to indigenous women has been applied only in several successful pilot projects by local and international NGOs (Roosta 2013). In the projects' health centers, rooms are painted in warm colors. There are wood floors, a kitchen, and two beds, one for the mother-to-be, the other for her relatives. When she is ready to give birth, she chooses the position she wants, lying on the bed or, more often, on bended knee or sitting. If a complication develops, mothers can be moved immediately to an operating room because the birthing facility is part of a hospital (Roosta 2013). While these projects are valuable, they do not as yet appear to have been replicated at a national level. In a 2015 paper, Roosta cites anecdotal evidence that most doctors in Bolivia appear not to be getting proper education on the cultural customs of the indigenous population and remain unfamiliar with traditional practices, such as how to attend a vertical birth.

In recent years, the Government of Bolivia has made a strong commitment to improving the health network system through its National Hospital Plan 2016-2020, which aims to upgrade and modernize service delivery. This is intended to address shortcomings found in assessments such as one that surveyed existing health service networks in 337 municipalities. It showed that in many places, people had no access to secondary services. For example, in the Southern Zone of La Paz network, the 750,000 inhabitants were served by only 14 health centers and only one Level 2 hospital,[7] with no access to a tertiary hospital.

7 Level 2 hospitals provide services requiring medium-level technology, including the following specialties: internal medicine, pediatrics, general surgery, obstetrics/gynecology, and anesthesiology. Other specialties may be available based on the local epidemiological profile.

III FINDINGS

Bolivia has made remarkable strides in increasing health care coverage in rural areas through the expansion of primary health care facilities, community pharmacies, the deployment of mobile health brigades, free obstetrics emergency transport, and establishment of universal insurance schemes and cash incentives for women to use modern maternal health services. Interviews with community leaders and community members revealed a widespread perception that the population has benefitted from greater access to these services. Primary health facilities are now important reference points for reproductive health, illnesses such as colds and viruses, and minor pain and minor accidents. They are able to refer people to the next level of care if necessary.

While this expansion has improved women's uptake of maternal health services, in-depth interviews with health personnel in both primary and secondary health facilities and with community members revealed important gaps and systematic failures. These included limited family planning/contraception orientation services, inadequate obstetrics skills among staff in primary health facilities, inadequate supply chains that create shortages of vital supplies and medicines in primary health centers, inadequate human resource management leading to staff shortages in secondary health facilities, lack of intercultural adaptation of birth practices, and mistreatment of rural indigenous women by health staff. The study shows that these failures reduce the demand for maternal health services.

Interviews with women and men in the communities also revealed community norms and attitudes—demand-side factors—that lower the utilization of maternal health services. These include norms around sexuality and contraception, women's attitudes regarding gynecological examination by male doctors, social stigma against out-of-wedlock adolescent mothers, and the perceived value of home births. At the household and individual levels, interviews revealed barriers related to women's lack of agency to define their reproductive intentions on their own, husbands' opposition to wives being seen by male doctors, women's time poverty, women's lack of prioritization for seeking maternal health services, and women's

limited control over household income to pay for transport to health facilities. Table 1 summarizes the supply- and demand-side factors that affect rural women's use of maternal health services. The strength of the findings is evidenced by the repeated mentions of particular barriers in the course of focus group discussions and interviews with health staff. Table 1 summarizes the key findingsof the study.

These findings at the micro level lead to a "big picture" conclusion based on interaction between the supply- and demand-side factors: low quality of maternal health services combines with community and households norms and preferences to dampen uptake of services. The result is a negative feedback loop, a vicious cycle that ultimately erodes trust in the health care system and keeps women away from it.

TABLE 1.[8]

Study Findings at-a-Glance

DIMENSION	FINDING
	SUPPLY-SIDE FACTORS
Affordability	Health care services are free including ambulance transfers. BJA and *Subsidio Universal Prenatal* have incentivized pre-natal visits. However, some women don't benefit from these programs due to difficulties in signing up and other administrative barriers.
	For remote residents, a trip to a far-away health facility can impose out-of-pocket costs that strain household budgets.
Accessibility	Visited communities had overall strong coverage of maternal health in terms of prenatal visits, immunization, and institutional birth.[8]
	Free ambulance services in all health posts have benefited people except those living very remotely. Some ambulances are poorly equipped, however.
Quality	Primary health facilities lack a systematic contraceptive orientation program (continuum of services)
	Referral: Problems with healthcare referral create excess demand in secondary facilities.
	Infrastructure: Equipment and medical supplies are insufficient, especially in primary health facilities.
	Staffing: Obstetric skills of medical staff in primary health facilities are inadequate. Secondary facilities suffer shortages of on-call medical and specialized medical staff.
	Relationship with users: Medical professionals may show rude, disrespectful, and judgmental attitudes toward patients and make no effort toward intercultural adaptation of birth practices.

8 In selected communities which were chosen because research team members could reach them by road, study participants did not cite accessibility to health services as a strong barrier. However, the research team is aware that this may be due to selection bias, because 60 percent of rural women cited distance to the closest health facility as the reason why they did not deliver their baby in a health center.

DIMENSION	FINDING
	DEMAND-SIDE FACTORS
Community norms and attitudes	Social norms around sexuality and contraception discourage women from interacting with medical staff members, especially men.
	Women often oppose gynecological examination by medical doctors.
	Out-of-wedlock adolescent pregnancy remains stigmatized.
	There is strong community engagement and outreach in health promotion.
	Indigenous customs often favor home births.
Household and individual-level factors	Women have low agency in the household, such as autonomy to access maternal health services and exercise reproductive control, and have little access to economic resources.
	Women lack free time and give low priority to attending maternal health services.
	Illiteracy and language barriers constrain use of health care facilities.

Supply-Side Factors

Enhanced Affordability of Maternal Health Services

Health practitioners and rural residents deemed that overall health care access has improved since the introduction of the Universal Health Insurance (SUS) in May 2018. Health services are free for the user, including ambulance transportation, consultation, medications, laboratory tests, and ultrasound exams.[9] Most materials and services are purchased from the municipality using an assigned public fund. Other supplies, such as vaccines and ferrous sulfare, are provided by Ministry of Health programs.

> *"I know that delivering a baby costs around 300 Bs for a private doctor. Here it is free. Now they even pay you the Bono Azurduy. It helps."*
>
> From a focus group discussion with women 18-40 years old, Community Colonia, Municipality of Caranavi, Department La Paz

Some women and men said they had registered for SUS. Because it is a newly established health insurance, few community members have used it. Those who knew about it claimed that most consultations and services were free of charge and some required a co-pay of 5 Bs. Community members also relayed that the costs of traditional health care providers were now higher. For instance, labor and delivery services provided by traditional midwife cost around Bs 300 (US$43).

> *"Now there is no cost, I have paid nothing. Before you had to pay 500-700 Bs. Now you only pay when you see a private doctor."*

9 SUS replaced SUMI and increased the package of offered services to overall health care.

-Woman, 32 years old. Community Siringalito, Municipality of San Ramon, Department of Beni

"Maternity costs are now covered by the SUMI. You don't pay anything. You just pay when you have to buy something outside when there are no medicines in the hospital."
-From a focus group discussion with women 40 years or more, Community Pozo Colorado, Municipality of Porongo, Department of Santa Cruz

"Birth and delivery are covered by SUS, which has just come out. It covers everything, women and children. Even the medicines are paid for by the insurance."
-Women, 27 years, Community Pozo Colorado, Municipality of Porongo, Department of Santa Cruz

"We pay the midwife 290 Bs for each birth and delivery" conducted at home.
-Woman, 27 years, Community El Carmen de Guacayane, Municipality of San Ramon, Department of Beni

Health providers and women in rural communities agree that the BJA and the Universal Prenatal Subsidy have incentivized women to go to prenatal checkups. Both of these voucher programs have personnel who visit health centers according to a schedule, to try to increase participation. Staff in primary health facilities also mentioned their own efforts to motivate women to seek prenatal care—identifying pregnant women, linking them to their local health facilities, and offering them gift baskets and prizes for showing up.

"Now the young women, since they know they're pregnant, end up at the hands of doctors.
-From a focus group with women 40 years and older, Community El Carmen de Guacayane, Municipality of San Ramon, Department of Beni

"I went to the checkup because I liked listening to the beating of the baby's heart with the ultrasound—for nothing else. Now it's more because we get a grant. If you miss some prenatal checkups, the amount will decrease. I did them all. Now, women mostly go to prenatal checkups because they are interested in getting the money. After the baby is born, the grant is given to the baby. You have to take the baby to the health center for checkups on a regular basis if you want the grant, 150 Bs every two months."
-From a focus group with women between 18-40 years of age, Pozo Colorado Community, Municipality of Porongo, Department of Santa Cruz

However, some conditions inhibit enrollment in health insurance and voucher schemes. Women may find it difficult to sign up for the voucher programs because they don't understand which documents they will need, or don't have the documents. Other barriers include illiteracy and distance to health centers and offices for collecting the cash transfers.

> *"The Bono helps mothers comply with the prenatal checkups. [Some] are upset when the payment doesn't come, or they have problems, like their name is spelled wrong—technical issues. Other problems some pregnant mothers face is the travel distance that limits their collection of the subsidy, their lack of education. Many mothers do not know how to read or write."*
> -Health worker, primary health facility, Municipality of Morochata, Department of Cochabamba

> *"Around twenty percent of women don't go [to checkups]. In my village, there are several women who get their certificate and they don't go to the prenatal checkups. They might go one time, but then they stop going until the last one. In the last days of their pregnancy, they start worrying about their baby. They might not have certain documents and in the health center, they are always asked for certain documents."*
> -From a focus group with men 40 years of age and older, Community Taipiplaya, Municipality of Caranavi, Department of La Paz

Another barrier facing women is out-of-pocket costs. While health care is generally free, health providers mentioned two costs that patients often incurred. One is the purchase of brand-name medicines. Insurance generally pays only for generic medications. While doctors cannot prescribe brand medicines, they nonetheless make their views known that some from certain trusted laboratories are of better quality, and this often compels patients to go buy them. The second cost is the fee for treatment when patients arrive at a secondary or tertiary medical facility without a referral from a primary health doctor.

> *"We have a protocol here. A patient cannot come to the hospital without a referral from the [primary] facility. And if they want to come [anyway], and there are many who do, we tell them they have to pay, because they are going against the proper process."*
> -Health worker, secondary health facility, Montero, Department of Santa Cruz

> *"Here in San Ramon, they don't want to operate, but if you pay them, they will. For example, in the birth of my son I paid 500 Bs for a C-Section. When it is a normal birth, you don't pay anything."*

-Women, 30 years, Community of Sinringality-Palmasola, Municipality of San Ramon, Department of Beni

Improved Accessibility and Remaining Challenges

There is a widespread perception among community leaders and citizens in communities that the population at large has benefitted from greater access to health services. Primary health facilities are now important reference points for reproductive health, illnesses such as colds and viruses, minor pain, and minor accidents, and can refer patients to the next level of care. In all communities that researchers visited, women highlighted the importance of having medical professionals in the community, for safe birth and care of the newborn. This care provides security and confidence that any complications during childbirth will be dealt with, whether related to the mother or the child. Informants also noted with approval the possibility of immediate transfer to a Level 2 hospital if needed, thanks to ambulances that are free of charge. In San Ramon, participants said that women in nearby communities would move near the primary health facility of the municipality weeks in advance to anticipate emergencies and avoid complications. In Porongo, women reported that the primary health facility was comfortable and that they had confidence in the medical staff who on occasion would call at homes for prenatal checkups if women could not go to the facility. In Morochata, some women preferred to move to the city of Cochabamba and give birth there in case they had complications. They highlighted the cleanliness and hygiene of the secondary health facilities.

> *"They take good care of us They give us our medicine on time and two days [after giving birth] we are discharged from the hospital and we return home. I went to the health center because my husband didn't know how to deliver the baby at home. There could be complications and you might need a doctor. Some 17 years ago all babies were delivered at home, but not anymore. There are no longer midwives in this area."*
>
> -Woman, 23 years old, Community Potrerity, Municipality of Porongo, Department of Santa Cruz

Health providers deemed that cost-free ambulance rides in particular have improved accessibility to the health centers, except for people in remote communities connected by poor roads. Before the introduction of the SUS in 2018, ambulance rides often resulted in surprise costs to patients. On the other hand, issues remain with regards to low-quality equipment in ambulances.

> *"Ambulances are not well equipped. The transfer is very difficult. Our ambulances often don't have a stretcher for the patient and seats for the health personnel. Sometimes the family of the patient sends their own mattress, which needs to be dragged from the ambulance."*
> -Health staff member, secondary health facility, Municipality of Caranavi, Department of La Paz

Notably, for remote poor households the trip to the nearest health facility imposes substantial costs, in the range of Bs 20-200 (US$0.30-US$3.00). Women reported that distance and cost of transportation were key barriers to going for prenatal checkups, especially in communities in the municipalities of Caranavi and San Ramón.

> *"Some women mostly don't go because of transportation, because they don't have money for the outbound and for the return, and in town it is complicated to eat, where to stay."*
> -From a focus group with women between 18-40 years of age, Community El Carmen de Guacayane, Municipality of San Ramon, Department of Beni

For women who live in remote locations, the long distance to the health facility poses a risk that their babies will be born enroute. This seemed to be not at all an exceptional experience. Sometimes laboring women gave birth while walking to the next health center when there was no option for a ride. Other times, births occurred in ambulances. Several women reported that because this had happened to them personally they preferred for subsequent pregnancies to stay home and give birth there. This shows that homebirth sometimes is a very rational preference.

> *"Pedro, his wife had her baby in the middle of the road there in Pouyuri…There had been bad weather, the ambulance hadn't gotten there, and so they'd headed out on the road in the rain. She said to her husband 'I can't stand it anymore, stop.' And as soon as she opened, the little person came out. He cut the cord and turned the cord two times. She gave birth in the middle of the road. Later the ambulance arrived and brought her to the health center."*
> -From a focus group with men 18-40 years old, Community Siringalito, Municipality of San Ramon, Department of Beni

> *"For me to come to [Taipiplaya town] from where I live is three and a half hours and you have to come on foot. One time I was in labor and I had the baby in the middle of the trip to town. Therefore from then on, I decided to have the babies at home."*

-From a focus group of women 40 years and older, Community Taipiplaya, Municipality Caranavi, Department of La Paz

Lack of Quality in Maternal Health Services

While primary health facilities offered comprehensive services for pregnant women, the study identified a number of shortcomings, including in provision of family planning and contraception guidance. The comprehensive services offered included prenatal consultation, basic laboratory, vaginal birth deliveries, administration of tetanus vaccine, provision of ferrous sulfate and folic acid, and provision of contraception. Although all health facilities visited provide contraception, several lacked guidelines, standards, and protocols to carry out family planning and provision of contraception in a systematic fashion. Instead, contraceptive counseling was provided by general practitioners or gynecologists during patient visits. Whether or not this occurred depended largely on the predisposition of health personnel. These personnel reported having adequate supplies of contraceptives, though sometimes there were delays in receiving them.

Infrastructure, Medical Equipment, and Supplies

Health providers noted shortages of medical equipment, notably in primary facilities. While the "bricks and mortar" infrastructure of primary health facilities was in good shape—some were new, and others had been refurbished and expanded—health providers pointed to serious shortcomings in basic medical equipment for birth and delivery, such as temperature management systems in the delivery room, neonatal resuscitation bags, incubators and radiant warmers for newborn reception, and oxygen gear. Delivery rooms in primary health facilities that researchers visited often seemed in a precarious state, with very old equipment in poor condition. But most primary facilities did have ultrasound equipment and a laboratory to conduct basic pregnancy tests.

Health providers also spoke of shortages of medical supplies for delivery and obstetric complications. While most facilities had oxytocin, many did not have magnesium sulfate pre-eclampsia and eclampsia. In some municipalities, the shortage of essential medicines and supplies was due to financial problems that the municipality faces.

> *"Magnesium sulfate? No, currently we don't have any. It is finished. We are waiting for payment by the municipality. There is a delay."*
>
> -Health staff member, primary health facility, Santa Fe, Caranavi

For the most part, secondary health centers were well-equipped with operating rooms, transfusion units, and delivery rooms. In one secondary hospital, health personnel noted that the equipment to sterilize medical and surgical supplies had not been working and their backup equipment had stopped functioning too. For the extraction of placental remains or incomplete abortions, both hospitals used instrumental curettage and manual vacuum extraction. Health personnel mentioned that an NGO[10] had trained medical staff in these techniques and provided equipment for these procedures.

Women reported lack of privacy in the antenatal and labor wards, particularly during vaginal and abdominal exams, with problems including lack of curtains to separate women from other patients. The antenatal and labor/delivery wards were sometimes located in common or public areas. Some women were forced to share beds with other women in labor. Women expressed desire to be shielded from other patients, male visitors, and staff who were not attending them while they were in labor and, particularly, during physical exams. They felt that such exposure was undignified, inhumane, or shameful.

> *"One is going to get a cure and all the people come in there, nurses, cleaning staff, cooks, everyone. One doesn't have any privacy, the privacy of doctor and patient."*
> -From a focus group with women 40 years and over, Community Potrerito, Municipality of Porongo, Department of Santa Cruz

Personnel Management and Efficiency

Lack of coordination between local service providers can undermine overall care effectiveness. Primary facilities were not coordinating their community canvassing—such as sending outreach workers to identify women in need of prenatal care—with local midwives. This canvassing was done through mobile health brigades from SAFCI and Mi Salud and the Programa Ampliado de Inmunizaciones (PAI) and nursing staff from the health centers. When asked if they coordinated with local midwives, health personnel said there was no such interaction.

The study identified problems with basic obstetric care skills and equipment in primary health facilities. Medical staff reported difficulties in handling birth and delivery complications due to inadequate skills and equipment. Instead, staff preferred to refer patients to secondary health facilities, especially with ambulance rides more readily available. In one primary facility, however, staff reported

10 IPAS (www.ipas.org)

handling most high-risk patients and labor and delivery complications on the spot. This center has grown in complexity of services on the initiative of its own medical staff due to its remote location (none of the neighboring municipalities has secondary health centers with Comprehensive Emergency Obstetric and Newborn Care services). Staff members set up a room for surgical procedures including cesarean sections and blood transfusions even though they had no anesthesiologist or a transfusion unit, and resolved emergencies that they felt would otherwise have ended in death. But it is important to note that these services should be conducted only at secondary facilities that are equipped for them, not at primary facilities that lack the proper equipment and infrastructure. Concerning postpartum care, all primary care facilities provide postpartum care and some carried out visits to women they had identified as having given birth at home.

Referral System

Rising numbers of referrals have contributed to excess demand in secondary facilities, some of which lack specialized doctors. This sometimes results in secondary health facilities rejecting patients, according to staff in primary health facilities.

> *[The hospital] lacks human resources and space…Patients are in the halls, on stretchers. Sometimes we have the situation that obstetrics has to send patients to surgery looking for beds. They put women and men in internal medicine [beds]. The situation is serious, and the level of staff remains the same. People want quality, but quality cannot be given."*
> -Health staff member, secondary health facility, Municipality of Montero, Department of Santa Cruz

Health personnel noted that primary health centers have not established referral committees, which by policy must have community representatives among their members. Staff at primary facilities reported that often refer patients to a secondary facility at the slightest risk of complications, so as to prevent emergencies. Referrals often occurs because primary facilities lack equipment and medicine that they are supposed to have.

Health providers cited problems that patients face when they are turned away from secondary[11] or tertiary facilities. Referrals can be rejected due to administrative problems in filling out forms, or because doctors disagree with the health assessment of a doctor

11 The Bolivian Ministry of Health has established regulations that dictate the functions of the primary and secondary health facilities. See Ministerio de Salud y Deportes 2013, Ministerio de Salud y Deportes 2014.

in a lower-tier health facility. Referral is often not justified, staff said, or the diagnosis is incorrect. But frequently it is simply because of lack of space in hospitals. Staff in secondary health facilities say they are overloaded, and that their facilities receive patients referred even from municipalities that are not under their jurisdiction.

> *"The problem is in the secondary health facility, the reception [of a referred patient]. That is the big problem we have, and I think it will continue to exist. There is no immediate reception. Even when the severity of the patient's condition is seen, there is no immediate reception. I do not know if there are communication problems, space limits, misdiagnosis."*
> -Health staff member, primary health facility, Municipality of Porongo, Department of Santa Cruz

> *"Even normal deliveries they refer them to us, even when it is just a little bit complicated, but here it comes out normal. We need to reinforce what type of births should be handled by the primary health center."*
> -Health staff member, secondary health facility, Municipality of Montero, Department of Santa Cruz

> *"I believe they are justified [to refer]. The majority of the health personnel in the area do not have many means: there is no operating room, there is no laboratory. I think they fear that dystocia could occur."*
> -Health staff member, secondary health facility, Municipality of Caranavi, Department of La Paz

> *"With first-time mothers, they always refer them. {In the primary health center], there are young doctors doing their practical training. They don't feel confident to treat a first-time mother."*
> From a focus group with women 18-40 years old, Community Potrerito, Porongo, Department Santa Cruz

Hours of Operation

Staff shortages were raised as an issue of severe concern in both primary and secondary facilities. Such shortages impeded having medical professionals cover on-call schedules and emergency care, especially specialist physicians. While secondary health facilities are open 24 hours a day, every day of the year, and have established on-call schedules for physicians, it remains a challenge to find physicians to actually cover those schedules. The primary centers are open 12 hours a day, usually from 8 a.m. to 8 pm. Some primary health facilities have arranged to have some staff on-call at night and on weekends but continue to face challenges to make this work.

> *"There is the 24-hour emergency service where there are two nurses and a general practitioner and the specialist doctor is on call. They do not do 24 hours, but they are available on-call. Say two in the morning, four, three, they have to go for emergency care that's needed, according to the specialty. But now in emergency care, we attend over 50 patients. They come from Mapiri, Tipuani, Teoponte. They don't go to the primary health centers, they come [to us] directly, and they make the flow higher. We need more medical staff here."*
>
> -Health staff member, secondary health facility, Municipality of Caranavi, Department of La Paz

Primary health staff described problems with ambulances running late and lacking proper equipment to care for patients being transported. Patients can suffer serious complications during these trips.

> *"In case of an emergency, it takes time to reach Porongo, and then time to reach the hospital of referral."*
>
> -Health staff member, primary health facility, Municipality of Porongo, Department of Santa Cruz

Relationship with Users

Mistreatment of Women by Health Staff

A person who goes to the doctor or hospital has a right to expect to receive appropriate treatment and respect, including consideration of his or her cultural beliefs, practices, and values. A healthcare staff member who speaks disparagingly about an expectant mother's health practices sends a message of disrespect, resulting in disempowerment of the woman. At other times, the message is indirect and unintentional, resulting from a complex range of failures at the provider level. These include insufficient staffing, inadequate supply chains, poor physical conditions, and policies and practices specific to the facility. Bad experiences can create low expectations of future care at facilities, eroding women's trust in the health system and predisposing them against seeking service there in the future.

A strong theme emerging from interviews with health care staff and rural women alike was mistreatment of women in health facilities during childbirth. Some female participants reported feeling shamed by health workers who made inappropriate comments and were verbally aggressive. Women feared mistreatment by the medical staff because of their lack of hygiene. Such experiences led to anger and sadness, affecting their willingness to seek institutional care again. Those experiences may be shared informally with oth-

ers, who then stay away out of fear of encountering similar behavior. Mistreatment of female patients was acknowledged by several medical staff interviewed for this study.

> *"Some women are afraid to go to the hospital. They are afraid of the doctors because the doctor scolds them and even treats them like filthy pigs. They prefer to treat themselves with medicinal plants or to give birth in their homes because they receive more attention from their relatives."*
> -Woman, 33 years old, Community Colonia, Municipality Caranavi, Department of La Paz

> *"We are afraid of the doctor. One time, I decided to go, acting very boldly. I said to my family 'I will go have a checkup.' There, the doctor says, 'In any case, are you afraid of [undressing] for your husband? That's how you have to be'. From that day on, I never went back to the doctor's office."*
> -From a focus group with women between 18 and 40 years old, Community Colonias Municipality of Caranavi, Department of La Paz

> *"No, they didn't treat me well. The doctor who attended me scolded me. He said, 'Endure it!' Is it your first child? You should already know how it is to deliver."*
> -Focus group with women 18-40 years old, Taipiplaya, Municipality of Caranavi, Department of La Paz

> *"I prefer female doctors, because they have more patience, as they know motherhood. My first birth was with a female doctor. She knows what one feels. She has been a mother. Instead, the male doctor treated me badly. That man! He would say: 'Macha' you were to do it [have sexual relations], Macha you will deliver that baby!' Those doctors are brutes."*
> -From a focus group with women between 18-40 years of age, Community Pozo Colorado, Municipality of Porongo, Department of Santa Cruz

> *"It is the treatment of medical staff towards patients that needs to improve. We are also working on that here in the hospital. We are still working, we are still talking about this".*
> -Medical doctor, secondary health facility, Municipality of Montero, Department of Santa Cruz

Adolescent unmarried women are special targets of insensitive comments because many community members view pregnancy and childbirth as appropriate only within marriage. This was reported, by key informants, more frequently in communities of Porongo and San Ramón. Mistreatment and lack of social support

leads many pregnant young women to skip prenatal appointments, though they often do deliver their children in health centers.

> *"I was about to turn 15. The nurse was the one who treated me badly because I remember she would tell the other nurses. 'No! This girl will not have a cesarean, no! It has to be normal, so she learns.' And mother told the nurse: 'Madam, what is the matter with you? You are a woman, have you not been a mother?' The nurse said: 'No! You are to blame, how can you let your daughter get pregnant at this age? She is a child.' And then the doctor came, and they sent me to the operating room, and I delivered the baby by cesarean."*
>
> -Woman, 24 years old, Community Potrerito, Municipality of Porongo, Department of Santa Cruz

Another aspect of women's disempowerment vis-a-vis health care providers was lack of privacy and potential breaches in patient-doctor confidentiality, especially by health professionals who lived in the same community. Women from smaller communities where health staff were native said they worried that these people would disclose private and medical information to other community members. Sometimes this lack of trust was so great that the women chose to skip prenatal checkups in the local health centers and deliver their babies in more remote facilities.

> *"The doctor comes from this community, so sometimes one is afraid to go and see this acquaintance and then bump into her in the street…She could talk about your situation with other people. That is scary. It is better to go somewhere else than to come here. She knows you have had an illness, and she can talk about the infections that you have contracted or something like that."*
>
> -From a focus group with women 18-40 years old, Community Taipiplaya, Municipality of Caranavi, Department of La Paz.

Lack of Intercultural Adaptation of Birth

A key finding of the study was a lack of intercultural adaptation of local birth practices. Very few of the health personnel at the surveyed primary or secondary health facilities were aware of the norm of intercultural birth, nor did they report receiving training in intercultural birth practices. None of the health centers had made infrastructure or equipment adaptations for intercultural birth. A key barrier reported by health staff is that medical schools do not offer training in intercultural birthing practices. Another barrier relates to the ingrained prejudice against these practices within the medical

profession in Bolivia, despite official policies promoting them. In the traditional medicine unit of the Public Health Department on Beni Department located in Trinidad, Bolivia, one interviewee described the infrastructure that a health center would need to adapt to intercultural births:

> *"If we want to say that a hospital offers intercultural birth practices as indicated by the norm, the correct thing would be for the hospital to have three spaces for traditional ancestral medicine. The first would be the delivery room with intercultural adaptation. The second would be an external consultation room, and the last would be a space for the pharmacopeia that would provide the natural and traditional medicines to all patients who need it."*
> -Medical staff member, SEDES Beni

Health staff in primary facilities said they know the communities they serve have midwives, but said they have no communication with them. When asked whether the medical staff had any interactions with local midwives who helped women deliver at home—for instance, to help the midwives in case of emergency or to identify pregnant women—staff members recalled that a few years earlier such efforts had been made, but no longer.

> *"On one occasion, we had identified [midwives] but this was left aside with the changes of the SAFCI doctors. They were doing that job of trying to identify them and certify those who provided adequate care." Interviewer "How long ago was that, doctor?" Respondent: "It was about three years ago. Now, we only know that they exist, but we have not identified who they are."*
> -Medical doctor, primary health facility, Municipality of Morochata, Department of Cochabamba

In secondary health facilities, staff were often unfamiliar with or uninterested in intercultural birth practices, and consequently there was no cultural adaptation during deliveries. With rare exceptions, births in these facilities are attended in the supine position.[12] Hospitals generally have no norm as to whether family members can enter the delivery room. Medical staff decide according to their own criteria. Some allow family members, but most do not. One reason mentioned for this was that when serious complications occur, family members who witness the event might be more likely to bring legal actions against the medical staff.

> *Interviewer: "In the last three months, have births been attended in an upright position? Squatting position? How many?" Re-*

12 In this position, the legs are separated, flexed, and supported in raised stirrups.

spondent: "No, only in the lithotomy position."
-Medical doctor, secondary health facility, Municipality of Montero, Department of Santa Cruz

"The disadvantage [of having family members in the delivery room] is for the doctor. There are sometimes critical moments that have to happen with the baby, in the case of neonatal depression,[13] for example. [The family members] see everything, and you can be legally charged, hence there is a bit of apprehension among medical professionals."
-Medical doctor, secondary health facility, Municipality of Montero, Department of Santa Cruz

Women reported feeling a loss of autonomy when they were not allowed to incorporate some of their safe traditional birthing practices. Women commonly reported a lack of supportive care and feeling removed from decisions about their childbirth, such as being denied food and herbal infusions brought by their relatives during labor. Another frequent complaint was that they were confined to prone positions rather than being allowed upright ones, such as walking or standing. Some women preferred to deliver in a squatting or kneeling position. They resented feeling forced to deliver in undesirable or humiliating positions that rendered them passive. Though women often wanted a birth companion, such as a family member or husband, on hand, many were denied their companion of choice. This left them feeling disempowered, frightened, or alone during their delivery. Maintaining other safe traditional practices, such as retaining the placenta for burial, was important to women. Denial of these practices may be an important barrier to women seeking facility-based delivery or quality supportive care.

"Here the doctor does not return the placenta to you. What do they do with it? We need to put the placenta in the earth, very clean. We bury it."
-From a focus group with women 40 years and older, Community Piusilla - San Isidro, Municipality of Morochata, Department of Cochabamba

"In the case of my sister-in-law's delivery, they didn't want to deliver it the way it's done here. They deliver the babies lying down. She always had had her babies standing up or in squatting position. She asked to have it like that. But… they forced her

13 Neonatal depression is a term to describe the condition of any newborn showing a prolonged transition from intrauterine to extrauterine life, in the immediate postnatal period.

[to have the baby lying down] and she pushed almost half a day."
-From a focus group with women 18-40 years old, Community Taipiplaya, Municipality of Caranavi, Department of La Paz

"Nothing, they don't let you have herbal infusions, like chamomile tea. They don't allow it."
-From a focus group, women 40 years and older, Community Taipiplaya, Municipality of Caranavi, Department of La Paz

"Home remedies are forbidden while the woman is in the hospital. Secretly, one can take them in, but they are forbidden. They do not allow you to massage her. For me, it is not right to forbid that. For me, it is discrimination against those people who have a lot of knowledge, long-time experience in delivering babies."
-From a focus group with men 18 to 40 years old, Community El Carmen De Guacayane, Municipality San Ramon, Department of Beni

Demand-Side Factors

Community Norms and Attitudes

Social Norms around Sexuality and Contraception

Social norms and taboos around sexual and reproductive health present a barrier to interaction between women and medical staff. These norms also inhibit counseling and delivery of contraceptives to young sexually active men and women, contributing to teenage pregnancy.

"Some families are still very closed or conservative and do not talk openly about sexuality. That is why we sometimes stumble on those barriers of their culture."
-Medical staff member, primary health facility, Municipality of Morochata, Department of Cochabamba

"Young people…do not come to pick up contraceptives due to embarrassment. They are told that it is free, but it seems that they are too embarrassed, or they worry, what would their mom or dad say?"
-Medical staff member, primary health facility, Municipality of Porongo, Department of Santa Cruz

Interviewer: "Is [the high rate of teenage pregnancy] a problem with the health staff, with the availability of contraceptives or educational materials?" Respondent: "No, in fact, we have material to show them and they can see the contraceptive methods.

It is primarily that they feel embarrassed. They do not want to see. They act uninterested, that there is nothing to worry about. Because supposedly they don't do it, they don't have sexual relations, they don't know how [pregnancy] happens. So, in my opinion, it is the embarrassment and the fear that young people have."

-Medical staff member, primary health facility, Municipality of Morochata, Department of Cochabamba

Women's Attitudes Regarding Gynecological Examination by Doctors

Interviews with rural women revealed strong anxiety about male doctors providing routine prenatal checkups and gynecological examinations. During the examination, women are in an extremely vulnerable situation. Apart from the physical discomfort, gynecological examination involves exposure of intimate parts of the body. Very often women experience embarrassment about undressing, cleanliness, and vaginal odor. The feelings are all the stronger when the gynecologist is male.

"When I was four months pregnant, I decided to go to the health center for my first checkup. But if I had known the doctor was a man, I would have turned back."

-From a focus group with women between 18-40 years of age, Siringalito Community, Municipality of San Ramon, Department of Beni

Male doctors "look at me with such a mean, dirty look."

-Woman, 27 years old, Community Chinchiri, Municipality of Morochata, Department of Cochabamba

With my first daughter, I had to go to prenatal checkups, but I didn't go because I was embarrassed that they would see my belly there when I still wasn't showing. When I was four months pregnant, I just started to go, but I would ask who was attending that day and if they told me it was a male doctor, I would leave. I didn't want to go for checkups with male doctors because I was embarrassed about being undressed in front of them."

-From a focus group with women aged 18-40, Community Siringalito, Municipality of San Ramon, Department of Beni

The Social Stigma of out-of-Wedlock Adolescent Pregnancy

Interviews with women and men revealed a strong social stigma against unmarried adolescent pregnancy. Unwed teenage mothers are seen as immoral and out of control, flawed in some basic way. The stigma isolates them from local society. Women who became

pregnant as unmarried teenagers said they resisted going to the primary health facility due to fear and shame of people finding out.

> *"I went when I was three months pregnant even though I was afraid of going to the health center. I had never been to the health center. I was just 17 years old. My mom brought me here. They did a blood test and other analysis. Afterward, I wasn't afraid."*
> -Woman, 20 years old, Community Piusilla, Municipality of Morochata, Department of Cochabamba

> *"When I got pregnant with my first daughter I was still in school, pre-prom… It was so bad. I told him, and we went to a clinic in Santa Cruz and it was confirmed that I was pregnant. [I didn't go to the primary health center of Porongo] for fear that people would find out, as it was the first time. I brought all the ultrasound to the doctor [at the Porongo center] and I did my prenatal checkups here."*
> -Woman, 23 years, Community Potrerito, Municipality of Porongo, Department of Santa Cruz

> *"My niece had her baby in the High Beni [mountainous part the Beni department]. We didn't know she was pregnant, because she always hid it. That day, the only one in the house was my father-in-law and my niece said, 'it hurts me.' When she went to urinate, right there she had her baby. My father-in-law had to help her, cutting the umbilical cord. She had hidden [her pregnancy] by wearing big sweaters. She was 18 years old."*
> -Woman, 28 years old, Community Colonia, Municipality of Caranavi, Department of La Paz

Community Engagement and Outreach in Health Promotion

On the positive side, the study found that engagement by community groups and leaders in health care promotion improved awareness of the importance of maternal health and led more women to seek out care in local facilities. Community leaders can be strong intermediators between community members and health providers. They can help increase trust in the health care system. In some communities, health promotion work done by local authorities and civil society organizations has increased women's use of maternal health services. In the municipalities of Morochata and San Ramón, participants spoke approvingly of the work of mobile brigades that periodically visited their communities. In Caranavi, work conduct-

ed by mothers clubs[14] was mentioned as important in providing information and guidance to women on reproductive health. In the municipality of Morochata, an ambulance driver was mentioned as a key point of contact and intermediator between community members and the primary health center's staff. As a Morocharta native, he knew how to navigate the narrow roads effectively, but his role went beyond transport. His social connections with virtually everyone in the community helped increase their familiarity with facility-based delivery and build trust in it.

In a meta-evaluation of community engagement interventions for health promotion, Cyril et al. (2015) find they can increase uptake of health services. Community engagement helps to ensure social acceptance of health programs, enables cultural adaptation of the interventions, and enhances the relevance of promotion messages. This overcomes cultural and access barriers, and encourages local people to engage. It creates community validation, an important factor in collectivist indigenous cultures.

Home Birth Customs

While institutional births have become more prevalent in recent years, in all of the surveyed communities participants said they were familiar with home births. Almost all women over 40 and some under 40 had given birth in their homes, attended often by their husbands and sometimes by midwives. For women, home births implied warm care from family members, closeness and attention of the husband, massages, warm drinks and soup, warm baths, and burial of the placenta. They had great confidence in their intuition and innate abilities during childbirth. The idea of delegating decisions to health center staff was unsettling to these women, all the more so if their ideas about health care were not understood or respected. Health centers were seen as cold, desolate places both physically and emotionally. Women saw it as crucial to have a loved one at her side, particularly her husband, during birth and believed that absence of such support could result in problems, even fatal complications.

> *"I saw that before, they attended differently, all-natural. Everything is pure medicinal plants. For example, when the child was born, the children gave them chamomile to clean their belly, or anise. In the hospital, they do not give anything."*

14 Mothers clubs typically had 30-40 members. They were originally established to distribute food provided to Bolivia by the United States Agency for International Development. These clubs later shifted their emphasis to disseminate health education (Aguilar, Schaeffer and Spain 1988).

-From a focus group with women aged 18-40, Community Potrerito, Municipality Porongo, Department Santa Cruz

"You have to disinfect your hands with alcohol. When you are having labor pains, there is tea that you take that is like medicine and helps in having the baby. When the baby is born, they cut the umbilical cords with scissors. From the belly button, I have measured four fingers and I have cut it. From there you tie it with disinfected gauze. Some of them are bathed, and others are not, depending on whether the mother wants to have the baby bathed that moment. You also have to make a tea to give the baby some chamomile and anise to clean his stomach because sometimes they swallow the phlegm. Three teaspoons are given. Then you have to take care of the mother, you have to bathe her with warm water, whatever she wants. She is also given a chamomile or lemongrass infusion or with a little bit of alcohol, that helps to stop the bleeding. At the time the baby is born, sometimes everything comes out, or sometimes it takes five to ten minutes for the placenta to come out. If it doesn't come out, you beat a raw egg, add a little salt, and that is given to the woman, which provokes dilation for the placenta to come out. The woman has to take care of herself for a few weeks, stay home, give herself baths, and take home-remedies, stay home until slowly the bleeding stops."

-Woman, 35 years old, Community Siringalito, Municipality of San Ramon, Beni Department

"When I had my first daughter, my husband and my father helped to deliver the baby. For the second, my mother-in-law helped out in addition to my husband, as always."

-From a focus group with women 18-40 years of age, Community Potrerito, Municipality Porongo, Department of Santa Cruz

"My mother had a baby at home. I would see how they attended mothers in a different way, all natural. Everything was with medicinal plants. For example, when babies were born, they would clean their tummies with chamomile and anise infusions. In the hospital, they don't allow you to do that."

-Woman, 23 years old, Community Potrerito, Municipality Porongo, Department of Santa Cruz

Women's Agency and Decision-Making Power within the Household

The widespread awareness of the importance of prenatal care has strengthened autonomous decision-making among women to seek out maternal care services when they become pregnant. Women, alone or sometimes accompanied by their partners or other family members, attend health facilities to confirm their pregnancies and after this confirmation, they start their prenatal controls. Most men interviewed expressed support for their wives using maternal health services.

> *At first signs of pregnancy "she buys the pharmacy pregnancy test. If she doubts, she automatically goes to the medical center to have a blood test. Automatically they have free care, laboratories, everything. I advise my wife to go to the doctor. Sometimes a family member advises that women go to do family planning."*
> -From a focus group with men between 18-40 years old, Community El Carmen De Guacayane, Municipality Of San Ramon, Department Of Beni

In a few cases, especially among older cohorts (40 years and above) that reside in remote locations, women experienced a lack of agency within the household concerning seeking maternal health services. This was manifested in several ways: controlling behavior by the husband to limit her mobility, male decisions against use of birth control, lack of financial resources, and a husband's opposition to a woman seeing male doctors due to jealousy. However, these limitations were sporadic and limited to specific groups of women.

> *"Some men want their wives to be in the house, to not leave. Men think that women are there for cooking, cleaning, to iron for them, to sleep with them. If women get pregnant, well, they don't consider [attending maternal health services] to be important."*
> -From a focus group with women, 40 years and older, Community El Carmen De Guacayane, Municipality of San Ramon, Department of Beni

> *"Sometimes husbands are mean. They are jealous. They say that women go to the hospital because they want to be with a doctor."*
> -Woman, 32 years, Community Siringalito, Municipality of San Ramon, Department of Beni

When asked about family planning, most women said these decisions were always made jointly with their husbands. Making

autonomous decisions about using contraception and about reproductive preferences might generate irreparable family conflict and cause mistrust and mistreatment on the part of husbands, according to some interviewees. Participants said that if women hid contraceptive use, their husbands would lash out and accuse them of having extramarital affairs.

Similarly, participants reported that women's limited control over household income and assets often constrains their utilization of maternal health services. As contributory family workers, women lack financial autonomy and control over cash of their own to pay for transportation and other out-of-pocket costs. This financial dependence can prevent women from using maternal health services.

Individual-Level Barriers that Lower Demand for Services

Women's lack of time due to heavy work responsibilities was a key factor preventing them from using maternal health services at faraway facilities. Furthermore, interviews with older women (aged 40 and above) suggested that they did not make a priority of attending prenatal checkups. This was either because they lacked knowledge of the checkups' importance or downplayed their own level of risk based on prior positive experiences with home delivery. In other words, if a woman gave birth at home to her first child without complications, going to a facility for subsequent births could be viewed as unnecessary or illogical.

> *"They don't have time. They work harvesting coca or tending to their quinoa crop. They consider that they waste their time and money coming to the health center for their prenatal checkups, and then they just appear when they are in labor to give birth."*
> -Male leader, 62 years, Community Taipiplaya, Municipality Caranavi, Department of La Paz

> *"[Pregnant women] don't have time to come. The doctors come late and then the women stop coming to their checkups. They spend time working. They lack time."*
> -From a focus group with women 40 years and older Community Piusilla - San Isidro, Community Morochata, Department of Cochabamba

For the older cohort of women, use of reproductive health services may be hampered by language barriers and their often low level of education. However, this did not feature prominently in the

interviews. Overall, there was a marked difference in the level of schooling between the younger (below 35 years of age) and the older (more than 40 years) women who were interviewed in the communities. Most members of the younger cohort had some secondary education, whereas most of the older were illiterate, with just a few years of primary education or none at all. It was noteworthy that most members of the younger cohort had dropped out of school due to teenage pregnancy. Younger women interviewed in the Municipality of Porongo had a greater tertiary rate of instruction than women in the other municipalities because of the proximity of Santa Cruz city. Language as an access barrier was particularly notable in the Municipality of Morochata (Cochabamba Department) where the Quechua language predominates for all age groups and health staff members have little proficiency in it. In the Municipality of Caranavi, residents of the Taipilaya community are generally migrants from the highlands and valleys of La Paz, Oruro, Potosí, Chuquisaca, and Cochabamba, and thus are bilingual, speaking Quechua-Spanish and Aymara-Spanish. In Porongo, due to the opening of roads in recent years to the city of Santa Cruz, the population is becoming more and more bilingual.

Discussion

The analytical framework provides a useful tool to enable policymakers and health planners to conceptualize and identify the constraints to women's uptake in maternal health services, based on a behavioral model that contains both supply- and demand-side determinants. To recap, demand-side determinants are factors at the individual, household, or community level that influence demand for services. Supply-side determinants are aspects of maternal healthcare provision such as geographic accessibility, affordability, and quality of service supplied.

The study shows that the most important reason that women don't seek maternal services is the low quality of those services, a supply-side factor. This amplifies pre-existing negative attitudes in the community and households towards maternal service, a demand-side factor (Figure 15). In other words, initial negative attitudes towards institutional maternal care are intensified by fear and lack of confidence in the health care system and mistreatment of women by health personal. As the interviews showed, women's experiences were marred by shortages of qualified medical staff, high staff turnover, lack of medicines and functioning equipment, and mistreatment by health professionals. These realities generated distrust in primary health facilities, lowered demand for services,

and pushed women to search for alternative services. Beyond the perception of poor quality of services, the interviews revealed basic differences between services offered by government and the cultural practices and preferences of women and communities. Perceived cultural insensitivity and failure to incorporate culturally appropriate practices and adapt the setting to meet rural women's birthing preferences further dampens demand.

> *"Those who have the possibility go to private doctors or hospitals in the city because here the medical attention is awful."*
> -Female community leader, 38 years old, Community Potrerito, Municipality of Porongo, Department of Santa Cruz

> *"My cousin didn't go to the health center to give birth to her baby because she was afraid. She died of childbirth complications in 2015."*
> -Woman, 19 years old, Community Chinchiri, Municipality of Morochata, Department of Cochabamba

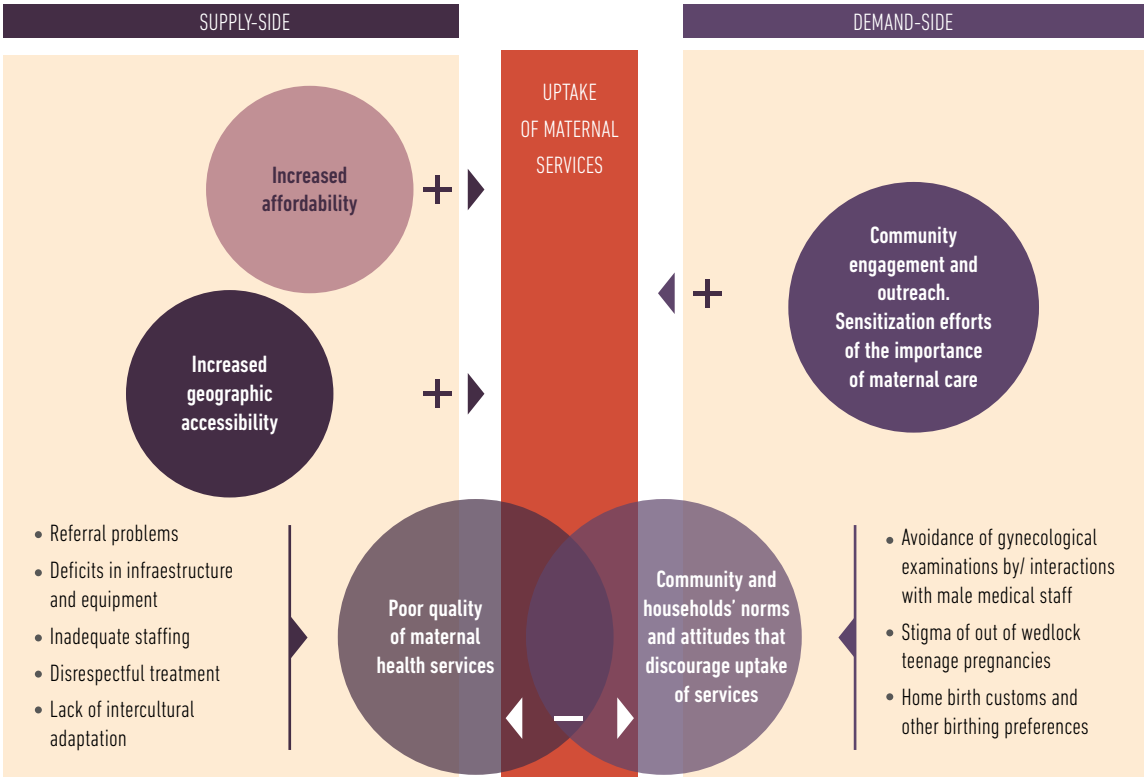
> *"In the hospital in San Ramon, the attention is terrible. The doctors and nurses are very careless."*
> -Woman, 21 years old, Community Siringalito, Municipality of San Ramon, Department of Beni

> *"In the health center here, there are normal deliveries. Sometimes the deliveries go well and other times they don't. Sometimes the babies die. There are some doctors who are good and treat you well, and sometimes they are awful."*
> -Woman, 23 years old, Community Siringalito-Palmasola, Municipality of San Ramon, Department of Beni

This is the first qualitative study to document the views both of maternal health care providers and users of their services in selected rural and indigenous communities in Bolivia. The sample size—15 health service providers and 90 users in eight communities in various locations—ensured that we captured a broad range of perspectives. Study limitations relate mainly to the sample selection and the qualitative nature of the data collection. While qualitative research yields insights into people's thoughts, attitudes, and behaviors, the findings cannot be generalized to a larger population. Many of the findings resonate with those of prior quantitative surveys. For example, Figure 11 presents Demographic and Health Survey findings for why rural expectant mothers did not deliver their babies in health centers. But there was not a total match between that study's findings and this one's. For instance, in the qualitative study the issue of lack of road accessibility did not feature as a key barrier to the uptake of maternal health services. This is because one of the criteria

FIGURE 15.

Supply- and Demand-Side Interactions for Maternal Health Services



for selecting the study sites was that they had road connections so that the field work team could reach them by public transport.

The study did not collect information on wider aspects of the health care system. It did not address issues such as strategic management, overall governance, policy framework, and financing, but rather zeroed in on front-line aspects of maternal healthcare provision, at the level of primary and secondary- hospitals. For the analytical framework, we assume that sound policies are in place for the health sector overall, that relevant legislation is enforced while a steady supply of consumables and funds is provided, and that monitoring and supervision proceed regularly. These principles should enable the public health sector to operate at a basic level. However, supply-side deficits that the study identified may have developed because of suboptimal performance of the overall health system. Therefore, there is a need to consider these underlying factors to provide a fuller picture of key challenges.

V

CONCLUSIONS AND RECOMMENDATIONS

The study shows that both supply- and demand-side factors affect women's uptake of maternal health services. On the supply side, the study revealed key gaps in the quality of care given at health facilities: lack of qualified staff, inadequate equipment, medical supplies and drugs, substandard basic emergency obstetric and newborn care, a weak referral system, lack of cultural adaptation of birth practices, and poor provider-user interactions. Thus, a key take-way of this study is that improving the quality of care at health centers and hospitals should be a priority to generate greater demand for institutional maternal care. On the demand side, the study found barriers stemming from social norms at the household and community levels. These include women's and husbands' opposition to gynecological examination by male doctors, the stigma of out-of-wedlock adolescent pregnancy, women's lack of control over income and other economic resources, and women's lack of time and prioritization of attending maternal health services. Thoughtful strategies that match supply to demand, coupled with targeted efforts to affect behavior change, cultural norms, and practices are needed to improve the quality of obstetric care for women in Bolivia and encourage women in reproductive ages to use it. Table 2 outlines suggested interventions to improve women's reproductive health outcomes, based on the study's findings. A short description follows each recommendation.

TABLE 2.

Possible Interventions to Improve Women's Uptake of Maternal Health Services

Supply-side and demand-side constraints to the uptake of maternal health services	Recommendations	Entities responsible
IMPROVE GEOGRAPHIC ACCESSIBILITY AND ACCESS TO SERVICES		
• Technical/administrative issues that prevent women from registering for and using the services • Travel distances that impose unaffordable financial costs on remote residents • Lack of information among rural residents concerning maternal health care services	• Establish mobile outreach services, and peripheral health units.	MoH, SEDES.
	• Encourage women to make individual birth preparedness and complication readiness plans.	Local health providers
	• Provide counseling and information.	Local health providers
IMPROVE THE QUALITY OF HEALTH SERVICE		
• Lack of systematic contraceptive orientation in primary health facilities • Problems with the health care referral system that create excess demand in secondary health facilities • Shortages of medical equipment and supplies especially in primary health facilities • Inadequate obstetric skills of medical staff in primary health facilities, shortages of on-call medical staff and specialized medical staff in secondary health facilities	• Provide family planning and contraceptive counseling.	MoH, SEDES and Local health providers
	• Upgrade the functionality of emergency obstetric and neonatal care services.	MoH, SEDES.
	• Improve infrastructure and equipment at secondary health facilities.	MoH, SEDES.
	• Improve supply chains to reduce medical supply shortages.	MoH, SEDES.
	• Improve the referral system.	
TAILOR PROVIDER RESPONSES TO THE SPECIFIC NEEDS OF USERS		
• Rude, disrespectful, judgmental treatment from medical professionals toward patients • Lack of intercultural adaptation of birth practices	• Improve client-provider interactions through training of health policy-makers on patient-centered and respectful care principles.	MoH, SEDES, and Local health providers
	• Implement intercultural adaptation of birth.	

Supply-side and demand-side constraints to the uptake of maternal health services	Recommendations	Entities responsible
INTERVENTIONS TO CHANGE COMMUNITY AND HOUSEHOLDS NORMS AND ATTITUDES TO INCREASE UPTAKE OF MATERNAL HEALTH SERVICES		
• Women's attitudes against gynecological examination by medical doctors • Stigma of out-of-wedlock adolescent pregnancy • Women's lack of agency and autonomy to access maternal health services, exercise reproductive control • Low economic resources of women • Women's heavy work load and tendency not to prioritize attending maternal health services	• Provide chaperones during gynecological examination by male doctors.	
	• Organize community communications campaigns on family planning, pregnancy, safe delivery, and postpartum care.	Civil society organizations in coordination with health facilities and municipalities
	• Build public trust in health care institutions through education sessions targeting men and interpersonal communication programs.	Civil society organizations in coordination with health facilities and municipalities
	• Address stigma of premarital sex and adolescent pregnancy at the (1) individual level through intrapersonal interventions including education, counseling, and values affirmation targeting women who experience reproductive stigma, (2) community level through educational approaches and communication campaigns, and (3) health provider level through training health staff to challenge pervasive stereotypes of teen mothers and to advocate for services and policies that reduce adolescent stigmatization and marginalization.	Civil society organizations in coordination with health facilities and municipalities

Improving Geographic Accessibility and Access to Services

Geographic accessibility has been significantly improved in recent years, as seen in this study, but it remains a constraint on women trying to reach maternal health services. Specific recommendations concerning this issue are grouped below into (1) mobile outreach and peripheral health units, (2) birth preparedness and complication readiness plans, and (3) outreach, counseling, and information.

Mobile Outreach Services and Peripheral Health Units

Taking maternal services to remote communities, rather than requiring women to make long and costly trips to clinics, could greatly increase those services' effectiveness. This could be accomplished by funding more mobile units to visit outlying communities, and by bolstering the capabilities of fixed health facilities that do exist in those places.

Birth Preparedness and Complication Readiness Plans

Women will be safer if they plan in advance for birth place and complications. During prenatal visits, primary health staff could work with women in local communities to develop such plans (Freyermuth and Sesia 2009). Birth plans set out decisions on delivery location, transportation, out-of-pocket expenses, and what to do in case of complications or other unforeseen events. In understandable language, plans help pregnant women and their families recognize the signs and symptoms of obstetric urgency, identify in advance the nearest medical resolution unit that operates 24 hours, 365 days a year, how far it is from home, and how to get there. Likewise, plans can decides about a medical transfer, and who will take care of the children when the couple moves to the hospital.

Outreach, Counseling, and Information

Some women, especially those living in remote locations and who have a low level of education, avoid formal maternal health care because they lack information about its advantages, how to register, and what documents are required. Targeted communication and outreach efforts can bring this information to this group of women. Information can also be disseminated through local newspapers, radio, and television. A key group to target is adolescent girls. Community groups such as mothers clubs and schools that adolescent girls attend can also be important sources of information about maternal health services.

Engaging community groups and leaders in health care promotion and outreach was found in this study to improve women's uptake of institutional maternal care. Community leaders are strong intermediators between community members and health providers and help to increase trust in the health care system. In some coun-

tries, health promotion work by local authorities and civil society organizations has been shown to improve women's use of maternal health services. For example, an education and outreach initiative in Malawi reported a three-fold increase in the use of hospitals or clinics for postpartum care and a doubling in delivery care (Gennaro, et al. 2001).

In a meta-evaluation of community engagement interventions used for health promotion, Cyril et al. (2015) found it had multiple positive effects on uptake of health services. Community engagement helps ensure the cultural adaptability and acceptability of health programs, and enhances the relevance of health promotion messages. This works to overcome cultural and access barriers, and encourage participant engagement. It enables community validation, an important engagement factor in collectivist indigenous cultures.

Improving the Quality of Maternal Health Service

Most importantly, the study identified specific deficiencies in the quality of care in primary and secondary health facilities. High-quality care requires trained personnel working in well-equipped facilities offering services appropriate to the needs of the local population. In primary health facilities, the study found no systematic family planning and contraceptive orientation, shortages of trained personnel and appropriate equipment, inadequate supplies of drugs and supplies, and poor functionality of emergency obstetric and infant care, which resulted in the too-frequent referral of women to higher-level facilities. Secondary health facilities ideally have modern operating rooms, transfusion units, and emergency services, operate 24 hours a day, and can deal with most of the obstetric complications they receive. In fact, the ones surveyed in the study had inadequate numbers of specialized doctors, old infrastructure, and poor equipment. They often struggled with excess demand and patient congestion.

The following recommendations grow from the current research under a broad agenda of strengthening the quality of service. Specific recommendations concerning this issue are grouped below into (1) family planning and contraceptive orientation, (2) functionality of obstetric and infant emergency care in primary health centers, (3) infrastructure and equipment in secondary-level health facilities, and (3) the referral system.

Strengthen the delivery of family planning and contraceptive counseling services.

Family planning and the delivery of contraception were not systematically carried out in the health centers visited and were instead provided on a demand basis. More monitoring and supervision should be conducted to ensure that men and women in reproductive ages receive this vital service. Preventing teenage pregnancies should be a key priority. Special outreach programs in sex education for adolescent girls and boys and timely, confidential access to information, counseling, and delivery of contraceptives in schools and other appropriate venues would all serve to help this vital objective.

Improve the functionality of basic emergency obstetric and neonatal care services.

Basic emergency obstetric and infant care in primary health centers critically needs improvement in health practitioners' skills, equipment, medical supplies, and medicine supply chains. These centers are intended as the point of entry for prenatal care and deliveries. Hence, a system-wide assessment should be carried out to determine their gaps in reproductive health provision. This could be done through an interviewer-administered, facility-assessment questionnaire for the officer in charge of each facility, which could be adapted from the instrument used for this study (Annex 2). The assessment results should be followed by action plans to improve this emergency care in primary health facilities. Possible steps could include after-hours phone coverage or extended or 24-hour opening times at certain sites.

To reduce risks in managing obstetric emergencies, primary health facilities in urban and peri-urban areas should focus on prenatal care while deliveries should be concentrated in secondary care facilities. But in rural areas where secondary care is not close enough for safe referrals, primary care facilities should be improved so they can offer safe conditions for difficult deliveries. This means better infrastructure, staff training, and equipment. For those cases that they nonetheless can't handle, they will need neonatal transport incubators, oxygen, and ambulances.

Upgrade second-level health facilities in terms of infrastructure and equipment.

Secondary health facilities severely need renovation and new equipment. To foster this goal, the Hospital Plan for Bolivia, launched in 2015 by the Ministry of Health, has set ambitious goals to provide the country with new secondary- and tertiary-level hospitals. In urban and peri-urban areas, secondary health facilities and maternities are to handle almost all deliveries and all high-risk pregnancies from rural areas. The Hospital Plan will create 33 level 2 and level 3 hospitals[15] of that will support obstetric networks in all nine departments.

Strengthen the referral system.

The referral system requires patients to first care in a primary facility and then be referred to an appropriate higher level if the need arises. Qualified health personnel are tasked with advising on transfers and overseeing the process. The referral system should ensure cost-effective and optimal use of health services to the advantage of both patients and the health system. However, standard procedures for referrals often break down. The study indicates that disregard of the referral system is common at primary facilities and is associated with their low quality of basic emergency obstetric and newborn care and inadequate medical supplies and medical equipment, as well as lack of referral committees. Congestion at higher-level health facilities is the frequent result. To combat this problem, clinical guidelines for prenatal, labor, and delivery care need to be updated and include well-defined algorithms to timely identify high-risk pregnancies. The referral system requires clearer standards based on clinical conditions as well as distances to be traveled and capacities of receiving facilities. Improved management of referrals, including supervision and feedback mechanisms, potentially holds the greatest promise for effectively curbing this problem.

Improve provider responses to meet the specific needs of users.

The crucial bottleneck preventing women from greater access to maternal health services in rural Bolivia was related to interactions between poor quality of service and women's preferences that health

15 A level 2 hospital is a local hospital that include limited number of medical services/specialties (Pediatry, Internal medicine, OB/Gyn, Surgery and anesthesia. A level 3 hospitals are regional and include many other medical services

facilities ignored. Recommendations are grouped as follows: (1) client-provider interactions and (2) intercultural adaptation of birth.

Improve client-provider interactions.

Improvements to quality of care need not only ensure access to timely, safe, and effective treatment but must also protect and promote women's rights to dignified and respectful care. The World Health Organization's quality of care framework for mothers emphasizes the need for good communication, respect, dignity, and emotional support (World Health Organization 2016).

A large proportion of women in the study reported that treatment by health providers was often rude, rough, and abrupt, making them feel discouraged. Providers also offended clients by failing to ensure privacy and confidentiality, by making clients wait, and being unwilling to answer their questions. Adolescents reported that stigmatizing attitudes and behaviors by providers were major barriers to them seeking out services.

In order to improve client-provider interactions, health staff should undergo instruction on culturally sensitive and respectful health care as part of their overall training. Such instruction would address social and cultural perceptions, emphasizing the importance of reproductive health more generally and addressing provider preconceptions, biases, and attitudes (EngenderHealth 2003). Training programs increasingly stress the importance of providers counseling clients so as to ascertain and cater to their unique needs and that providers should ensure that their own beliefs or biases do not interfere (Kim, et al. 2000). Many types of aids for this job, such as checklists, flip charts, decision-making algorithms, and information education communication (IEC) materials can help providers improve the quality of interactions (DFID 2010). Furthermore, published evaluations in several countries show that "facilitative" or "supportive" supervision and feedback mechanisms can improve the quality of service (Moran et al. 2014, Kim, Rimon et al. 1992, and Combary, Newman, and Glover 1999). Although interventions aimed at improving supervision act only indirectly on client-provider interactions, these studies documented improvements in technical skills among providers when delivering services, communications styles that were more client-focused and less authoritarian, and higher client satisfaction. Finally, health policymakers should be trained in principles of patient-centered and respectful care. Social accountability mechanisms to improve respectful care should be piloted, monitored, and assessed to develop tailored quality improvement plans for health facilities.

Interventions to improve client-provider interventions should address the needs of adolescent girls and address health staff's stigma towards them when they are pregnant out of wedlock. Health providers should undergo training in interpersonal skills that stress respectful and dignified treatment of adolescent girls and how to communicate with them in a confidential manner, and without a moralizing attitude. This training should include interpersonal skills to negotiate and intervene in conflicts between young clients and parents while upholding an ethical obligation to protect the clients' integrity and autonomy (Kim and White 2018). Health workers and counselors should also be well-versed on contraceptive options.

A final recommendation to improve provider-user interaction is have chaperones in the room during gynecological examinations by male doctors. This could encourage women to use maternal health services and attend prenatal centers. It would also provide husbands with greater reassurance there would be no improper conduct by male doctors (Yanikkerem, et al. 2009).

Strengthen intercultural adaptation of birth.

As previous studies have found, this study concludes that differences between the cultures of providers and users are a major issue in service delivery. The World Health Organization (WHO) recommended supporting culturally-appropriate maternity care services as a means of improving maternal health (World Health Organization 2003). Culturally-appropriate services—providing care that takes account of the preferences and aspirations of individuals and the cultures of their communities—are an important component of quality of care.

A systematic review of culturally appropriate birth interventions in other countries found that women and other stakeholders had generally positive views toward them (Jones, Lattof and Coast 2017). In the Peruvian Department of Ayacucho, a cultural adaptation of birth and delivery implemented in 2000 improved women's experience of childbirth and made them feel well-attended (Gabrysch, et al. 2009). Women who had used the service reported in interviews that they felt comfortable in the delivery room, gave birth in their own clothes, had their husbands present, and received the placenta. Gabrysch et al. (2009) wrote that "simple changes such as respecting certain preferences or language or allowing the company of relatives can have a massive impact both on service satisfaction and use." In an indigenous antenatal clinic in Brisbane, Australia, women reported being generally satisfied with the cultural adaptation of birth services. A much higher proportion of women (92 percent) felt

mostly understood and respected by staff in the intervention clinic than in other hospital locations, and they approved of the clinic location and care arrangements (Kildea, et al. 2012).

Renewed efforts to train professionals and implement cultural adaptation of birthing services could encourage service uptake, an important step in improving maternal health. The SAFCI model provides an opportunity for real progress in this area. However, strong political will is needed if this is to be carried through. In addition, the program will need effective mechanisms to ensure that Indigenous women are consulted and can influence the development of policies and initiatives. This renewal of efforts could be led by the Vice Ministry of Traditional Medicine (see Box 2).

Reflecting on the experience of cultural adaptation of birth interventions, Jones, Lattof, and Coast (2017) identify key themes in facilitators and barriers to implementation. Firstly, community participation is vital in understanding problems with existing services and potential solutions, and in the development and implementation of interventions. For example, one intervention in Australia established women's reference groups to discuss, promote, and support an enabling model of care (Health NSW 2005). Secondly, respectful, person-centered care should be at the core of these interventions. Employing staff members who shared linguistic and/or cultural backgrounds with target groups was the most common strategy. Interventions also sought to build relationships and trust with target groups through friendly, non-judgmental, culturally-sensitive, and respectful interactions, an empowering approach giving women choices. Studies reported that improvements in interpersonal interactions were at the core of intervention success. Thirdly, cohesiveness is essential between culturally-appropriate services and other health services that women and their families encounter along the continuum of care through pregnancy until after birth. For example, a lack of cohesiveness inhibited an intervention concerning prenatal nursing case management for Mexican-American women in Oregon (Thompson, et al. 1998). Staff in implementing facilities worked to ensure that women received culturally appropriate care there but had little control over other services that their clients might receive elsewhere.

Interventions to change social norms and attitudes at the community and household levels

As seen in this study, community and household norms sometimes impede women from accessing maternal health services. Husbands may not want their wives to have gynecological examinations by male doctors, or adolescents may be too ashamed due to stigma of premarital sex and pregnancy to obtain contraceptive counseling or go to prenatal checkups. Behavior and normative change approaches at the community, household, and individual levels can help increase uptake of maternal services. These interventions are grouped into three categories: (1) community-level communication campaigns, (2) building trust in health care institutions through education sessions targeting men, and (3) addressing the stigma of adolescent pregnancy.

Organize community-level communications campaigns.

Community-level communications campaigns have proven successful in improving knowledge, changing social norms, and, to some extent, changing behavior. A meta-analysis of 39 family planning campaigns implemented between 1986 and 2001 found that exposure to campaigns greatly increased knowledge of contraceptive methods, interpersonal and partner communication, approval of family planning, and intentions to use and actual use of contraceptives (Snyder, Diop-Sidibe and Badiane 2003). Another assessment, examining entertainment and education programs, found that exposure to dramas on radio and TV was associated with increased contact with reproductive health providers, greater use of family planning, and decreased family size desire (DFID 2010). In Egypt, the Mabrouk ("Congratulations") program used a multi-pronged communication strategy—including television, radio, variety shows, information booklets, and group wedding celebrations—to inform newlyweds about family planning, pregnancy, safe delivery, and postpartum care. The program also conveyed messages on key decisions regarding having children, spousal communication, and appropriate birth spacing. It especially aimed to address social taboos around communication and discussion of reproductive health issues and the stigma related to contraceptive use among young people. Mabrouk is credited with increasing contraceptive use among young couples with one child from 20 percent in 1995 to 50 percent in 2005 (Salem, et al. 2008).

Build trust in health care institutions through interpersonal communication programs and education sessions targeting men.

The health system should work to further involve men in encouraging women's interaction with maternal health services. As the study showed, some men already do this, but there is potential for many more to follow suit. This could be encouraged through a wide array of interventions such as partner counseling, education sessions, community-based communication campaigns or edutainment efforts targeted at male audiences (Jennifer McCleary-Sills 2012). Interpersonal communications programs can encourage male partners by increasing their understanding of the importance and benefits of reproductive health services. The programs can impart negotiation and communication skills that help empower young women and men in their interactions with each other. Most interpersonal communications programs address gender issues not just through skill building, but through messages that question traditional masculine and feminine roles, have content aimed separately at men vs women, and advocate for women's rights and health. These interventions aim to seed attitudinal and normative change. In Guatemala, an education and health promotion intervention used a peer-to-peer approach in which couples spent time counseling and educating other couples to better understand health issues affecting women and children (Schooley, et al. 2009). Several studies have found a positive association between spousal communication and the use of contraception (Bawah 2002, Link 2011, Shattuck et al. 2011, and Tumlinson et al. 2013).

Combat the stigma of adolescent pregnancy.

The study found that unmarried adolescent mothers are frequently dismissed, scorned, and discriminated against. Stigmatizing practices harm the adolescent mother by heightening her social isolation and creating barriers to seeking maternal health services. Addressing the stigma of extra-marital teenage pregnancy can be tackled at the individual, community, and provider levels. Individual-level interventions could include education, counseling, and values affirmation. Interventions targeting the broader community could include education which incorporates critical thinking about the alignment of social expectations, lived experiences, and related stigma (Cook, et al. 2014). At the provider level, staff members can conduct outreach activities at local schools with the goal of preventing unwanted

pregnancies (some facilities are already doing this) and treat young unmarried mothers who come into the facilities with respect. Restoring dignity in healthcare settings requires health staff to challenge pervasive stereotypes of teen mothers and advocate for services and policies that reduce their stigmatization and marginalization.

The recommendations presented here all seek to incentivize women's uptake of maternal health services by addressing supply- and demand-side factors alike in the short and medium terms. Strengthening the quality of maternal health services, including provider-user interactions, is a first and foremost priority for interventions. Once the quality of services has substantially improved, these efforts can combine with behavior change interventions aimed at community, household, and individual factors that constrain women from seeking maternal health services. Demand-side interventions will only succeed if supply is also improved. While we focus on interventions that can help in the short term, effort is needed too toward goals that will take considerable time, such as building female autonomy and women's control of income. The improvement of transport services and road conditions will also aid in the timely accessing of maternal care services.

While the literature on supply- and demand-side barriers to the uptake of maternal health services is large, the literature on interventions that can bring the barriers down is small. Looking ahead, health care will benefit from more evaluations on the impact of these interventions, as well as meta-analysis of existing evaluations. The resulting knowledge could help open the way for Bolivia's rural and indigenous women to make greater use of maternal care. That would be a big step toward achieving one of the country's most important development goals, reduction in the mortality rates for mothers and infants.

BIBLIOGRAPHY

Aguilar, Ana María, Curt Schaeffer, and Peter L. Spain. 1988. "Bolivian mothers clubs as media: Building on community-based networks." Journal of Rural Health. 4 (1): 23-28.

Alkema, L., D. Chou, D. Hogan, S. Zhang, A.B. Moller, and A. Gemmill. 2016. "Global, regional, and national levels and trends in maternal mortality between 1990 and 2015, with scenario-based projections to 2030: A systematic analysis by the UN Maternal Mortality Estimation Inter-Agency Group." Lancet. 387 (10017): 462-74.

Alvarez, Francisco, Mart Leys, Hugo Rivera Merida, and Giovanni Escalante Guzman. 2016. "Primary health care research in Bolivia: Systematic review and analysis." Health Policy and Planning. 31: 1140128.

Bawah, A.A. 2002. "Spousal communication and family planning behavior in Navrongo: A longitudinal assessment." Studies in Family Planning. 33 (2): 185–194.

Berhe, Abadi, Achenef Muche, and Getachew Fekadu. 2018. "Birth preparedness and complication readiness among pregnant women in Ethiopia: A systematic review and meta-analysis." Reproductive Health .15 (182).

Celhay, Pablo A., Julia Johannsen, Sebastian Martinez, and Cecilia Vidal. 2019. Can Small Incentives Have Large Payos? Health Impacts of a National Conditional Cash Transfer Program in Bolivia. (forthcoming). Economic Development and Cultural Change.

Combary, Perle, Candy Newman, Koffi Glover et al. 1999. "Study of the effects of technical supervision training on CBD supervisors, performance in seven regions of Ghana." Chapel Hill:: Technical Report 7, Prime.

Cook, Jonathan, Valerie Purdie-Vaughns, Ilan Meyer, and Justin Busch. 2014. "Intervening within and across levels: A multilevel approach to stigma and public health." Social Science & Medicine . 103: 101-109.

Cyril, Sheila, Ben Smith, Alphia Possamai-Inesedy, and Andre M. N. Renzaho. 2015. "Exploring the role of community engagement in improving the health of disadvantaged populations: A systematic review." Global Health Action. 8.

Dawson, Margaret, Bev Phillips, and Sandra Leggat. 2012. "Effective clinical supervision for regional allied health professionals: The supervisor's perspective." Australian Health Review. 37 (2): 262-267.

DFID. 2010. "Improving Reproductive, Maternal and Newborn Health: Reducing Unintended Pregnancies Evidence Overview A Working Paper." London: Department for International Development.

Downe, S., K. Finlayson, D. Walsh, and T. Lavender. 2009. "'Weighing up and balancing out:' A meta-synthesis of barriers to antenatal care for marginalised women in high-income countries." BJOG. 116: 518–29.

EngenderHealth. 2003. Comprehensive Counseling for Reproductive Health: An Integrated Curriculum (Participants Handbook). New York: EngenderHealth.

Ensor, Tim, and Stephanie Cooper. 2004. "Overcoming barriers to health service access: Influencing the demand side." Health Policy Planning. 19: 69–79.

Freyermuth, Graciela, and Paola. Sesia. 2009. La Muerte Materna Acciones Y Estrategias Hacia Una Maternidad Segura. México : Centro de Investigaciones y Estudios Superiores en Antropología Social, Comité Promotor por una Maternidad sin Riesgos en México.

Gabrysch, Sabine, Claudia Lema, Eduardo Bedriñana, Marco Bautista, Rosa Malca, Oona Campbell, and Jaime Miranda. 2009. "Cultural adaptation of birthing services in rural Ayacucho, Peru." Bulletin World Health Organization. 87: 724–729.

Gennaro, Susan, Daima Thyangathyanga, Rose Kershbaumer, and Joyce Thompson. 2001. "Health promotion and risk reduction in Malawi, Africa, Village Women." Journal of Obstetric, Gynecologic and Neonatal Nursing. 30: 224–30.

Health NSW. 2005. NSW aboriginal maternal and infant health strategy evaluation: Final Report 2005. New South Wales.

Heaman, Maureen, Wendy Sword, Lawrence Elliott, Michael Moffatt, Michael Helewa, Heather Morris, Patricia Gregory, Lynda Tjaden, and Cook Catherine. 2015. "Barriers and facilitators related to use of prenatal care by inner-city women: Perceptions of health care providers." BMC Pregnancy and Childbirth .15 (2).

Jacobs, Bart, Por Ir, Maryam Bigdeli, Peter Leslie Annear, and Wim. Van Damme. 2012. "Addressing access barriers to health services: An analytical framework for selecting appropriate interventions in low-income Asian countries." Health Policy and Planning. 27 (4): 288-300.

Jennifer McCleary-Sills, Allison McGonagle, Anju Malhotra. 2012. Women's Demand For Reproductive Control: Understanding and Addressing Gender Barriers . Washington DC: International Center for Research on Women.

Johnson, A.A., B.D. Wesley, M.N. El-Khorazaty, J.M. Utter, B. Bhaskar, and B.J. Hatcher. 2011. "African American and Latino patient versus provider perceptions of determinants of prenatal care initiation." Maternal and Child Health Journal. 15.

Jones, Eleri, Samantha R. Lattof, and Ernestina Coast. 2017. "Interventions to provide culturally-appropriate maternity care services: Factors affecting implementation." BMC Pregnancy Childbirth. 17 (267).

Kananura, Rornald, Suzanne Kiwanuka, Elizabeth Ekirapa-Kiracho, and Peter Waiswa. 2017. "Persisting demand and supply gap for maternal and newborn care in eastern Uganda: A mixed-method cross-sectional study." Reproductive Health. 14: 136.

Kildea, Sue, Helen Stapleton, Rebecca Murphy, Natalie Billy Low, and Kristen Gibbons. 2012. "The Murri clinic: A comparative retrospective study of an antenatal clinic developed for Aboriginal and Torres Strait Islander women." BMC Pregnancy Childbirth. 12 (159).

Kim, Bora, and Kate White. 2018. "How can health professionals enhance interpersonal communication with adolescents and young adults to improve health care outcomes? Systematic literature review." International Journal of Adolescence and Youth. (2).

Kim Young-Mi, Jose Rimon et al. 1992. "Improving the Quality of Service Delivery in Nigeria." Studies in Family Planning. 23 (2): 118-127.

Kim, Young, Fitri Putjuk, Endang Basuki, and Adrienne Kols. 2000. "Self-assessment and peer review: Improving Indonesian service providers' communication with clients." International Family Planning Perspectives. 26 (1): 4-12. V.

Link, C.F. 2011. "Spousal communication and contraceptive use in rural Nepal: An event history analysis." Studies in Family Planning. 42 (3): 83–92.

McArthur, John W, Krista Rasmussen, and Gavin Yamey. 2018. "2018. How many lives are at stake? Assessing 2030 sustainable development goal trajectories for maternal and child health." BMJ: London.

Ministerio de Salud y Deportes. 2013. "Norma Nacional de Caracterización de establecimientos de Salud de 1er Nivel." Documentos Técnicos Normativos, La Paz. Accessed October 2019. https://www.minsalud.gob.bo/images/Libros/DGSS/ursc/redes/dgss_redes_Inivelseguro.pdf.

Ministerio de Salud y Deportes. 2014. "Norma Nacional de Caracterización de Hospitales de Segundo Nivel, Capítulos I- Capitulo XVII." Documentos Técnicos Normativos, La Paz. Accessed October 2019. https://www.minsalud.gob.bo/images/Documentacion/redes_salud/normanacional85.pdf.

Moran, Anna, Julia Coyle, Rod Pope, Dianne Boxall, Susan Nancarrow, and Jennifer Young. 2014. "Supervision, support and mentoring interventions for health practitioners in rural and remote contexts: An integrative review and thematic synthesis of the literature to identify mechanisms for successful outcomes." Human Resources for Health. 12 (10).

O'Donnell, Owen. 2007. "Access to health care in developing countries: Breaking down demand side barriers." Cadernos de Saude Publica. 23: 2820–34.

O'Rourke, Kathleen, Lisa Howard-Grabman, and Guillermo, Seoane. 1998. "Impact of community organization of woman on perinatal outcomes in rural Bolivia." Rev Panam Salud Publica. 3 (1).

Otis, Kelsey, and John A. Brett. 2008. " Barriers to hospital births: Why do many Bolivian women give birth at home?" Rev Panam Salud Publica. 24 (1): 46-53.

Peters, D.H., A. Garg, and G. Bloom. 2008. "Poverty and access to health care in developing countries." Annals of the New York Academy of Sciences. 1136: 161–71.

Romero, Lisa M., Dawn Middleton, Trisha Mueller, Lia Avellino, and Rachel Hallum-Montes. 2015. "Improving the Implementation of Evidence-Based Clinical Practices in Adolescent Reproductive Health Care Services 2." Journal of Adolescent Health. 57 (5): 488–495.

Roosta, Manigeh. 2015. "Madres indígenas enfrentan más de tres demoras: Los desafíos de la interculturalidad en salud." Journal of the Selva Andina Research Society. 6 (2).

Roosta, Manigeh. 2013. Salud Materna en Contextos de Interculturalidad: Estudio de los pueblos Aymara, Ayoreode, Chiquitano, Guaraní, Quechua y Yuqui . La Paz: CIDES-UMSA, OMS, OPS/OMS & UNFPA .

Salem, R., J. Bernstein, T. Sullivan, and R. Lande. 2008. Communication for Better Health. Baltimore, MD: Johns Hopkins Bloomberg School of Public Health.

Scheppers, Emmanuel, Els van Dongen, Jos Dekker, Jan Geertzen, and Joost Dekker. 2006. "Potential barriers to the use of health services among ethnic minorities: A review." Family Practice. 234: 325–348.

Schooley, Janine, Christine Mundt, Pascale Wagner, Judith Fullerton, and Mark O'Donnell. 2009. "Factors influencing health care-seeking behaviours among Mayan women in Guatemala." Midwifery 25 (4): 411-21.

Shattuck, D., B. Kerner, K. Gilles, M. Hartmann, T. Ng'ombe, and G. Guest. 2011. "Encouraging contraceptive uptake by motivating men to communicate about family planning: The Malawi Male Motivator Project." American Journal of Public Health. 101 (6).

Sistema Nacional de Información en Salud y Vigilancia Epidemiológica. 2016. "Estudio Nacional de Mortalidad Materna 2011 Bolivia: Resumen Ejecutivo." La Paz.

Snyder, Leslie, Nafissatou Diop-Sidibe, and Louise Badiane. 2003. A Meta-Analysis of the Effectiveness of Family Planning Campaigns in Less Developed Countries." Paper presented at the annual meeting of the International Communication Association.

Thompson, M., M.A. Curry, and D. Burton. 1998. "The effects of nursing case management on the utilization of prenatal care by Mexican-Americans in rural Oregon." Public Health Nursing. 15 (2): 82-90.

Tumlinson, K., I.S. Davis, J.T. Speizer, J.C. Fotso, P. Kuria, and L.H. Archer. 2013. "Partner communication, discordant fertility goals, and contraceptive use in urban Kenya." African Journal of Reproductive Health. 17 (3): 79.

UNASUR. 2012. Sistemas de Salud en Suramérica: desafíos para la universalidad, la integralidad y la equidad. UNASUR.

UNFPA. 2008. "Promoting Equality, Recognizing Diversity Case Stories in Intercultural Sexual and Reproductive Health among Indigenous Peoples." UNFPA.

UNFPA. 2015. "Setting standards for emergency obstetric and newborn care." Accessed November 2019. https://www.unfpa.org/resources/setting-standards-emergency-obstetric-and-newborn-care.

World Bank. 2018. "Project Appraisal: Bolivia Health Service Delivery Network Project." Washington DC: World Bank.

World Health Organization. 2016. "Health Workforce Requirements for Universal Health Coverage and the Sustainable Development Goals Geneva." Human Resources for Health Observer Series No 17, Geneva: World Health Organization.

—. 2011. "RMNCH Continuum of care." Accessed November 2019. https://www.who.int/pmnch/about/continuum_of_care/en/.

World Health Organization. 2016. "Standards for improving quality of maternal and newborn care in health facilities." Geneva: World Health Organization. https://www.who.int/maternal_child_adolescent/documents/improving-maternal-newborn-care-quality/en/.

World Health Organization. 2003. Working with individuals, families and communities to improve MNH. Geneva: World Health Organization.

Yanikkerem, Emre, Meral Özdemir, Hilal Bingol, Ayşe Tatar, and Gülten Karadeniz. 2009. "Women's attitudes and expectations regarding gynaecological examination." Midwifery. 25 (5): 500–508.

ANNEX 1. METHODOLOGY

Data Collection

Data were collected using semi-structured face-to-face interviews, focus group discussions, and ethnographic interviews based on the guides presented in Annex 2. To uncover supply-side factors affecting reproductive health outcomes, the research team conducted 15 in-depth interviews with personnel from primary and secondary health facilities. In addition, a rapid assessment was conducted on the functionality of basic emergency obstetric and newborn care (BEmONC) in the visited primary health facilities and comprehensive emergency obstetric and newborn care (CEmONC) in the secondary facilities. The interview guide for health personnel contained a set of closed questions, followed by open-ended questions aimed at understanding the perspective of health service providers. On the demand side, for each of the eight communities visited, four focus group discussions per community (a total of 32) stratified by age and gender (see Table A1.1 below) were carried out to gather insights into local attitudes and norms with regards to women's reproductive health and childbirth. Also, four to five in-depth face-to-face interviews per community (a total of 34) were conducted with women of reproductive age (18-40 years old) to uncover and generate deep and textured understanding of women's experiences and perceptions of constraints to accessing reproductive health services. The research team also conducted ethnographic observations with one of the women interviewed per community, which helped to provide information about the daily life and behaviors (social and cultural) of women of reproductive age (18-40 years old). Finally, in-depth interviews were conducted with community leaders and authorities to understand key supply- and demand-side barriers that women in their communities face that lead to high maternal mortality ratios.

The research instruments used open-ended questions to allow participants to respond in their own words, rather than directing them or requiring them to choose among fixed responses, as quantitative methods do. Open-ended questions can evoke responses that are meaningful and culturally salient to the participant, unanticipated by the researcher, rich and explanatory. Field work was conducted by a team of local health and social research experts and took place in May 2019. The interviews were performed in the interviewee's language.

Community and Participant Selection

The study employed purposeful criterion sampling to obtain information-rich data from health care professionals and users. Eight communities in four departments (La Paz, Santa Cruz, Beni, and Cochabamba) were selected to be geographically inclusive following a two-step process. The first step consisted of selecting municipalities included in the World Bank-supported Health Service Delivery Network Project (2018-2023) that had high maternal mortality and health care facilities with maternal services. This resulted in the selection of four municipalities: Caranavi, Porongo, San Ramón, and Morochata. The second step was the selection of communities (two per municipality). These were chosen jointly with municipal authorities based on the criteria of distance, number of inhabitants per community, existence of a female population of childbearing age (women between 15 and 40 years old), an child population of up to two years of age, and road links that would allow field researchers to reach the community by public transport. In terms of the distance criterion, for each municipality, a community close to the capital was selected and another that was remote but had road access. See Table A1.2 below.

The visited communities vary in characteristics with regards to cultivation and population. For instance:

- The communities in the Caranavi municipality (La Paz) cultivate mainly fruit and coca. Their people are largely migrants from various areas of Bolivia. A mixture of cultures and customs predominates. Houses are scattered and remote and access roads are precarious.
- Large quantities of fruit are grown in Porongo (Santa Cruz). The people interviewed work in the cultivation and harvest of the fruit, or in caring for the estates. Proximity to the city has allowed some residents to take other jobs there, including as domestic servants.
- In the communities of San Ramón (Beni), people largely support themselves through subsistence agriculture (cassava, banana) and the raising of animals. They engage in hunting and fishing. They also work temporarily for landowners and ranchers.
- In Morochata (Cochabamba), the main activity is the production of potatoes for commercial sale in cities.

The sample consisted of a mix of focus group discussions, individual in-depth interviews, and key informant interviews in

each of the selected communities. Given the focus on reproductive health, the age range of individual participants was defined as between 18 and 40 years.

TABLE A

Sample Information

	SUPPLY-SIDE		DEMAND-SIDE							
Municipality (Department)	Health facilities	Personnel interviews	Communities visited for user interviews	Focus group discussions				Demand-side ethnographic interviews with individuals	Individual in-depth interviews	
				Individuals						Community key informants
				Women		Men		Women	Women	Community leaders
				18-40	40+	18-40	40+	18-40	18-40	
Caranavi (La Paz)	Caranavi: Secondary health facility	Doctor Nurse	Taipiplaya	1	1	1	1	1	4	2
	Santa Fe: Primary health facility		Colonias	1	1	1	1	1	4	2
Porongo (Santa Cruz)	Porongo: Primary health facility	HF Manager HF Head nurse Doctor on duty	Potrerito	1	1	1	1	1	5	2
	Montero: Secondary health facility	Hospital Director Hospital Doctor	Pozo Colorado	1	1	1	1	1	4	2
San Ramón (Beni)	San Ramon: Primary health facility	Responsible for HF Doctor	Siringalito	1	1	1	1	1	4	2
	Carmen de Guacayane: Primary health facility	Responsible for the health facility	El Carmen de Guacayane	1	1	1	1	1	5	2
Morochata (Cochabamba)	Morochata: Primary health facility	Responsible for HF Doctor	Piusilla	1	1	1	1	1	4	2
	Piusillas: Primary health facility	Doctor Nurse auxiliary	Chinchiri	1	1	1	1	1	4	2
TOTAL		15		88	8	8	8	8	34	

The team garnered support from local authorities and community leaders before starting field work. For interviews and focus groups that covered the demand side, door-to-door recruitment was carried out for study participants. The team sought women and men in the age range required for focus groups. Since the communities consisted of a small number of families, only one participant from each household was selected for focus groups, so that each group

was made up entirely of people from different families. Research participants were summoned to a specific place in the community (the school, a house, a meeting house, or some other place where people felt comfortable gathering) and at a designated time, taking into account the work schedules of the community. In several cases the focus groups were carried out at night, when people arrived back from work, mainly in agriculture. Individual interviews were generally conducted in the house of the interviewed person or in a nearby place, always providing for the privacy and comfort of the people.

Field work lasted four weeks (one week per municipality). Field work in each municipality included time in the city (La Paz, Santa Cruz, Beni and Cochabamba) and then in the municipality (Caranavi, Porongo, San Ramón and Morochata). The field work team had one Quechua-speaking researcher. That language was particularly relevant in the municipality of Morochata (Cochabamba).

TABLE B

Community Information

Municipality (department) / health network	Ethnic group	Community	Type of health facility	Nearest health facility	Distance to the nearest primary health center	Distance to the nearest secondary health center
Caranavi (La Paz) / Health Network: Caranavi	Quechua, aymara, mestizo	Taipiplaya	Primary health center	Hospital Caranavi (secondary health facility)	40 km. from Taipiplaya to Caranavi	4 hours
		Colonias	Doesn't have	Primary health center of Taipiplaya	From 2 to 6 hours walking From 30 minutes to 3 hours by vehicle	
Porongo (Santa Cruz) Health Network: Andrés Ibañez	Mestizo y quechua migrations	Potrerito	Mobile brigade once a week	Primary health center of Porongo	5 km. from Potrerito to Porongo	40 minutes
		Pozo Colorado	Mobile brigade once a week	Primary health center of Porongo	10 km. from Pozo Colorado to Porongo	
San Ramón (Beni) Health Network: San Ramón	Itonamas	Siringalito	Doesn't have	Primary health center (with in-patient facilities)	25 km. from Siringalito to San Ramón (30 minutes walking in normal conditions	5 to 6 hours depending on the road conditions during the rainy season
		El Carmen de Guacayane	Primary health center	Primary health center (with hospitalization) in San Ramón	40 km. from El Carme de Guacayane to San Ramón (1 hour by road in normal conditions)	
Morochata (Cochabamba) Health Network: Quillacollo	Quechua	Piusilla	Primary health center	Primary health center (with hospitalization) in Morochata	10 km. from Piusilla Morochata (20 minutes, rugged road)	3 hours
		Chinchiri	Primary health center	Primary health center (with hospitalization) in Morochata	14 km. from Chinchiri to Morochata (40 minutes, rugged road)	

Data Analysis

The interviews were recorded and transcribed verbatim for analysis. Patterns in attitudes and responses were identified and coded in an Excel matrix which included inductive and deductive codes. Both of these were based on the analytical framework that guided the research (Figure 2) and on newly emerging themes which emerged during a workshop by field workers and researchers with access to the transcripts. The themes were compared between men and women in the different age groups, and among different locations. Tentative themes developed from the analytical process were compared with others to check for validity. All data were analyzed in Spanish and relevant quotes were translated into English.

Ethical Considerations

The qualitative study embedded several ethical protection measures. Data collection proceeded with subjects' informed consent. Data were collected and stored with no personally-identifying attributes. All computer files were password-protected to ensure confidentiality.

Limitations

The methodology used in the study has the following main limitations that should be considered when interpreting the findings:

- *Potential selection bias:* Participants selected for the interviews and focus group discussions were not randomly chosen.
- *Quantification of findings being outside the scope of the study:* The study used qualitative methods to obtain in-depth insights into perceived and actual gender and social norms. Qualitative analysis allows the identification of key issues, but the extent to which any of the identified issues applies to the larger population cannot be quantified by this exercise.
- *Level of health care system.* The study focused primarily on the front-line service delivery aspects of the maternal health care at the level of primary and secondary hospitals and on constraints at the individual, household, and community levels to women's utilization of institutional maternal health services. The study did not collect information on broader challenges that the health care system faces concerning such issues as strategic management, overall governance, and policy framework.

ANNEX 2. RESEARCH INSTRUMENTS

1. GUÍA DE ENTREVISTA A ESTABLECIMIENTOS DE SALUD DE PRIMER NIVEL

FORMULARIO 1

ENTREVISTA AL PERSONAL DEL ESTABLECIMIENTO DE SALUD

Centros y Puestos de Salud de Primer Nivel

(Aplicar la entrevista al director o responsable y a otro personal de salud que entrega servicios de salud materna)

Fecha (Día/Mes/Año): | | | |

Entrevistador: Lea lo siguiente:

Buenos días/tardes. Me llamo .....y estoy realizando entrevistas a personal de salud para un estudio sobre salud materna. Este estudio se hace en apoyo a los programas del ministerio de salud. La información recolectada servirá para mejorar la atención en los servicios de salud. Quiero resaltar que no es una evaluación de desempeño del personal de salud. En el estudio estamos siguiendo los estándares de ética para la investigación con seres humanos, por lo que le pido que lea el formulario de consentimiento informado y nos dé su aprobación. (entregar el formulario "consentimiento informado").

Para contar con su participación y colaboración hemos solicitado los permisos respectivos al MINISTERIO DE SALUD, SEDES y la coordinación de la red.

Entrevistador: LEA LO SIGUIENTE

Ahora le voy a hacer preguntas relacionadas con el servicio de salud. Si usted considera que debería participar alguna otra persona(s) que trabaja(n) en este establecimiento de salud, por favor solicite su presencia durante la entrevista.

Municipio: Comunidad:	
Tipo de establecimiento (de acuerdo al SNIS):	
Puesto de salud ..... 1 Centro de salud 2	Centro de salud con camas 3
Nombre del establecimiento de salud:	

Número de proveedores de salud que trabajan en el establecimiento de salud:	
Auxiliares de enfermería N°: _____ Sanitarios N°: _____ Enfermeras N°: _____ Médicos generales N°: _____	Médicos especialistas (especifique) .....N°: _____ .....N°: _____ .....N°: _____ Médicos tradicionales (especifique) .....N°: _____ .....N°: _____ Otros .....
Nombre del entrevistado (a):	Cargo:

ATENCIÓN INTEGRAL A LA MUJER NO EMBARAZADA *Pregunte si lo siguientes servicios están disponibles en el establecimiento de salud (PUEDE LEER LOS SERVICIOS DE SALUD)*		
No	PREGUNTA	COMENTARIOS/ OBSERVACIONES
1	Orientación nutricional	
2	Salud oral – Servicio de odontología	
3	Orientación en métodos anticonceptivos	
4	Provisión de métodos anticonceptivos	
5	Prevención de ITS/VIH-SIDA	
6	Toma de PAP	
7	Administración de hierro con ácido fólico	
8	Aplicación vacuna TT según esquema	
9	¿En el ES tiene y está disponible la norma: "Atención integrada al continuo del curso de la vida - parte 2: mujer en edad fértil-mujer durante el embarazo, parto y puerperio"?	
10	¿El personal de salud del establecimiento ha sido capacitado en esta norma de atención? ¿Cuántos? ¿Cuándo?	
11	¿Ha tenido problemas para ofrecer servicios de salud sexual a las mujeres en edad fértil no embarazada y adolescente? ¿Cuáles fueron estos problemas? EXPLORAR: ¿Personal?, ¿Disponibilidad de insumos y medicamentos?, ¿Material educativo?, ¿Otros?	
12	¿Hubo problemas de parte de las personas, familiares, comunidad? EXPLORAR: ¿accesibilidad?, ¿costo?, ¿participación?, ¿demanda?, ¿costumbres?, ¿otros?	

ATENCIÓN A LA MUJER EMBARAZADA Pregunte si los siguientes servicios están disponibles en el establecimiento de salud (lea los servicios de salud):		
13	Búsqueda activa de embarazadas y recién nacidos a través de visitas domiciliarias por personal de salud o técnicos de atención primaria en salud.	
14	Identificación de embarazadas y recién nacidos a través partera tradicional y otros prestadores de salud tradicional para recomendar su referencia.	
15	Llenado de la Historia Clínica Perinatal y el Carnet Perinatal	
16	¿El ES utiliza la Historia Clínica Perinatal? ¿Tiene el sistema informático de la historia? ¿Cómo se utiliza la información que proporciona sobre riesgo en el embarazo, parto y puerperio?	
17	¿Se evalúa y determina el riesgo durante el embarazo? ¿Qué procedimiento se sigue en éste ES, cuando se detecta alto o mediano riesgo obstétrico?	
18	¿El laboratorio del ES realiza las pruebas básicas que se deben hacer a las embarazadas?: Determinación de hemoglobina, examen de orina, albuminuria, prueba para sífilis, VIH, glicemia.	
19	¿En el ES se hace ecografía obstétrica? ¿Tiene el ES quién sepa interpretar estos exámenes?	
20	¿En el ES se hacen los controles para el Bono Juana Azurduy (BJA)?	
21	¿En el ES se hacen los controles para el Subsidio prenatal?	
22	¿Se hacen capacitaciones sobre hábitos saludables dirigidas a las embaraza das que son beneficiarias del BJA?	
23	¿Se elabora el Plan de Parto y Nacimiento Seguros, para cada embarazada que llega al servicio? ¿Puede mostrarme alguna Historia clínica de mujer embarazada que contenga el Plan de Parto y Nacimiento Seguros?	
24	¿Se da apoyo institucional a las organizaciones comunitarias/ sociales para la conformación de los Comités de Transporte de Emergencias?	
25	¿En el ES Ha tenido algún tipo de dificultades para ofrecer los servicios descritos a las mujeres embarazadas? EXPLORAR: ¿Personal?, ¿Disponibilidad de insumos y medicamentos?, ¿Material educativo?, ¿Otros?	
26	¿Ha habido factores que han facilitado su trabajo, para ofrecer estos servicios? ¿Cuáles?	
27	¿Considera que se puede mejorar la implementación del Bono Juana Azurduy y el subsidio prenatal? ¿Cómo? ¿Tiene alguna sugerencia?	

ATENCIÓN EN SERVICIO DEL PARTO NORMAL Solicite la presencia del personal que atiende a mujeres embarazadas, realice una visita a las salas de parto. Verifique lo siguiente:		
No	PREGUNTA	COMENTARIOS/ OBSERVACIONES
28	¿La sala de partos cuenta con una estufa que funciona?	
29	¿El establecimiento de salud cuenta con Oxitocina? ¿Cómo ha sido la disponibilidad del medicamento en los últimos 6 meses?	
30	¿Dispone de sulfato de magnesio? ¿Cómo ha sido la disponibilidad del medicamento en los últimos 6 meses?	
31	¿El establecimiento de salud cuenta con suero fisiológico/ suero Ringer en infusión de 1 litro y equipo para venoclisis?	
32	¿La sala de partos cuenta con un balón de oxígeno con oxígeno y manómetro?	
33	¿La sala de partos cuenta con una bolsa de reanimación neonatal (AMBU u otra marca)?	
34	¿La sala de partos tiene un área de recepción del recién nacido, con fuente de calor?	
35	¿En la atención del parto, se utiliza y llena el partograma? (Verifique en dos historias clínicas si cada una tiene el partograma llenado)	
36	¿En el ES se practica el rasurado del pubis de las parturientas?	
37	¿En el ES se coloca enema rutinariamente antes del parto?	
38	¿En la atención del parto normal se realiza el manejo activo del alumbramiento? Solicite le describa en qué consiste	
39	¿En la atención del parto normal se realiza la ligadura tardía del cordón umbilical? Solicite le describa en qué consiste	
40	¿Ha tenido problemas con la atención de partos? ¿Cuáles? ¿Con que frecuencia? ¿Por qué?	
41	¿En el área de influencia del ES, se realizan partos en domicilio, atendidos por familiares o parteras?	
42	¿Por qué cree que las mujeres o sus familias deciden tener el parto en domicilio?	

ATENCIÓN DEL PARTO COMPLICADO		
43	¿El ES, tiene capacidad (personal, destreza, conocimiento, equipo e insumos) para administrar antibióticos parenterales?	
44	¿El ES, tiene capacidad (personal, destreza, conocimiento, equipo e insumos) para administrar anticonvulsivantes parenterales?	
45	¿El ES, tiene capacidad (personal, destreza, conocimiento, equipo e insumos) para administrar oxitocina parenteral?	
46	¿El ES, tiene capacidad (personal, destreza, conocimiento, equipo e insumos) para la extracción de productos retenidos (AMEU y/o LUI)?	
47	¿El ES tiene por lo menos un equipo de AMEU en buenas condiciones?	
48	¿El ES, tiene capacidad (personal, destreza, conocimiento, equipo e insumos) para la extracción manual de la placenta?	
49	¿El ES, tiene capacidad (personal, destreza, conocimiento equipo e insumos) para realizar parto vía vaginal asistido (extracción por aspiración y/o fórceps)?	
50	¿En el último trimestre se ha realizado alguno de éstos procedimientos?: administración de antibióticos; de oxitocina; Sulfato de magnesio; extracción de restos placentarios ¿Cuáles? Con que frecuencia se ha realizado cada uno o alguno de éstos procedimientos?	
51	¿Ha tenido algún problema en la atención de los embarazos complicados? ¿Cuáles han sido estos problemas?	

ADECUACIÓN CULTURAL DE LOS SERVICIOS		
52	¿Usted habla el idioma local? Especifique qué idioma.....	
53	¿Usted u otro personal del ES ha sido capacitado en los últimos 2 años en la adecuación intercultural de los servicios de salud?	
54	¿Usted sabe si se han realizado cambios en los horarios del ES a solicitud de las comunidades?	
55	¿En la farmacia, hay herbolaria tradicional medicinal?	
56	¿Tiene usted normas o protocolos de atención de madres y recién nacidos culturalmente apropiados para su zona?	
57	¿Usted sabe si en las comunidades de su zona hay médicos tradicionales, naturistas y/o parteras?	

58	¿Los médicos tradicionales, naturistas y/o parteras, están acreditados? ¿Cuántos médicos tradicionales? ¿Cuántos naturistas? ¿Cuántas parteras?	
59	¿Se han hecho cambios en la infraestructura o funcionamiento del ES para adaptarse a la cultura local? En el área de salud materna, ¿en qué consistieron los cambios?	
60	¿Se ha adquirido o modificado el equipamiento para adaptarlos a la cultura local? ¿En el área de salud materna, qué específicamente?	
61	¿De qué manera el personal de salud aplica prácticas para asegurar una atención culturalmente adecuada durante el embarazo, parto y postparto? ¿Qué prácticas culturales se han adaptado para la atención del embarazo, parto y postparto? Deme ejemplos concretos por favor	
62	¿El personal del ES pregunta a la mujer embarazada la posición en la que quiere tener su parto? ¿Usted pregunta a la mujer embarazada la posición en la que quiere tener su parto?	
63	¿En los últimos 3 meses se han atendido partos en posición vertical? ¿En cuclillas? ¿Cuántos?	
64	Estos partos ¿son frecuentes o raros? ¿Usted ha atendido partos en servicio que no fueron en la mesa de partos?	
65	¿El personal de salud pregunta a la mujer embarazada si desea que algún familiar le acompañe en su parto? ¿Usted pregunta a la mujer embarazada si desea que algún familiar le acompañe en su parto?	
66	¿En el ES se permite la presencia de un familiar o la persona que la parturienta elija en la sala de partos?	
67	¿En su criterio cuales son las ventajas o desventajas de permitir la presencia de un familiar en la sala de partos? ¿Por qué?	
68	¿Qué se hace en el ES cuando la parturienta o su familia pide dar a la mujer a alimentos o líquidos caseros? ¿Se permite? ¿Se prohíbe? ¿Por qué?	
69	¿En su criterio cuáles son las ventajas o desventajas de permitir que se dé a la parturienta alimentos o líquidos caseros traídos por los familiares? ¿Por qué?	

REFERENCIA Y RETORNO DE MUJERES GESTANTES		
70	¿Este establecimiento de salud tiene conformado un Comité de referencia y contra-referencia?	
71	¿En el año 2018, se ha realizado alguna referencia de mujeres embarazadas con complicaciones desde este ES a otros centros?	
72	¿A qué establecimiento de salud, refiere este centro? Nombre y municipio: Distancia en Km: Modo de transporte:	
73	¿Las referencias se han hecho utilizando el formulario de referencia?	
74	¿De las referencias realizadas, cuantas aproximadamente retornaron, con el formulario de contra referencia o retorno?	
75	¿El año 2018 y estos meses de 2019, ha recibido referencias por asuntos relacionados con la salud sexual o reproductiva de mujeres u hombres, realizadas por personal de la comunidad? (Responsable Comunitario de salud, médico tradicional, Partera)	
76	¿Aproximadamente, cuántas referencias hechas por personal comunitario, recibió?	
77	El personal comunitario hizo las referencias utilizando el formulario de referencia	
78	¿Usted llenó el formulario de retorno cuando la persona volvió a la comunidad?	
79	¿Ha tenido problemas con las referencias hacia un nivel superior? ¿Cuáles?	
80	¿Ha tenido problemas con las referencias recibidas de la comunidad? ¿Cuáles?	
81	¿De qué medios de transporte disponen las familias para el traslado de emergencias?, (disponibilidad costo, feriados, noches)	
82	¿Aproximadamente cuánto cuesta la referencia de una emergencia obstétrica? ¿Quién paga estos costos?	
83	¿Cuánto cuesta el traslado en ambulancia? ¿Cuál es la disponibilidad?	
84	¿Qué procedimientos pre referencia, se siguen habitualmente? (comunicación, estabilización, transporte)	
85	Desde su perspectiva y experiencia ¿Dónde ocurren las principales demoras de atención?: Familia, comunidad, establecimiento de salud, transporte al 2do nivel, recepción y manejo en el 2do nivel.	

CONFORMACIÓN Y FUNCIONAMIENTO DE LA ESTRUCTURA SOCIAL SAFCI Y EQUIPOS COMUNITARIOS DE SALUD		
86	Usted, como responsable del establecimiento de salud, ¿conoce a las Autoridades Locales de Salud (ALS) de las comunidades con las que trabaja el ES?	
87	¿Este ES tiene un Comité Local de Salud funcionando?	

INFORMACIÓN ESTADÍSTICA Solicitar la presencia del estadístico del ES o la jefa/ responsable de enfermería			
	Indicadores y variables	N/ %	Observaciones
88	Cobertura de control prenatal, con 4 controles prenatales		
89	Cobertura de administración de sulfato ferroso y ácido fólico a mujeres embarazadas		
90	Cobertura de parto institucional en servicio		
91	Cobertura de parto institucional en domicilio		
92	Cobertura de control postparto por personal calificado, en domicilio		
93	Cobertura de control postparto en el ES		

2. GUÍA DE ENTREVISTA A ESTABLECIMIENTOS DE SALUD DE SEGUNDO NIVEL

FORMULARIO 2: HOSPITALES

ENTREVISTA EN ESTABLECIMIENTOS DE SALUD DE SEGUNDO NIVEL

Fecha (Día/Mes/Año): | | | |

Entrevistador: Solicite entrevistar al director del establecimiento de salud de 2do nivel

Lea lo siguiente:

Buenos días/tardes. Me llamo .....y estoy realizando entrevistas a personal de salud para un estudio sobre salud materna. Este estudio se hace en apoyo a los programas del ministerio de salud. La información recolectada servirá para mejorar la atención en los servicios de salud. Quiero resaltar que no es una evaluación de desempeño del personal de salud. En el estudio estamos siguiendo los estándares de ética para la investigación con seres humanos, por lo que le pido que lea el formulario de consentimiento informado y nos dé su aprobación. (entregar el formulario "consentimiento informado").

Para contar con su participación y colaboración hemos solicitado los permisos respectivos al MINISTERIO DE SALUD, SEDES y la coordinación de la red.

Entrevistador: LEA LO SIGUIENTE

Ahora le voy a hacer preguntas relacionadas con el servicio de salud. Si usted considera que debería participar alguna otra persona (s) que trabaja en este establecimiento de salud (obstetra, informático), por favor solicite su presencia durante la entrevista.

Municipio: Ciudad:
Nombre del establecimiento de salud:
Número de proveedores de salud que trabajan en el establecimiento de salud:

Auxiliares de enfermería N°: _____	Anestesiólogo N°: _____
Médicos generales N°: _____	Otros (especifique): _____
Médico pediatra N°: _____	_____
Médico obstetra N°: _____	_____

SERVICIOS DE EMERGENCIA EN HOSPITALES DE REFERENCIA Indague la disponibilidad y accesibilidad de los servicios		
No	PREGUNTA	COMENTARIOS/ OBSERVACIONES
1	¿En este hospital se hace transfusión de sangre?	
2	¿Este hospital tiene una unidad transfusional acreditada?	
3	¿Este hospital tiene quirófano?	
4	¿El servicio de esterilización funciona adecuadamente? ¿Por qué si o por qué no?	
5	¿En el último mes se ha hecho alguna cirugía obstétrica?	
6	¿El ES, tiene capacidad (personal, destreza, conocimiento, equipo e insumos) para administrar anticonvulsivantes parenterales?	
7	¿El ES, tiene capacidad (personal, destreza, conocimiento, equipo e insumos) para la extracción de productos retenidos (AMEU y/o LUI)?	
8	¿El ES tiene por lo menos un equipo de AMEU en buenas condiciones?	
9	¿Cuál es el procedimiento de preferencia para la extracción de restos placentarios?	
10	¿El ES, tiene capacidad (personal, destreza, conocimiento equipo e insumos) para realizar parto vía vaginal asistido (extracción por aspiración y/o fórceps)?	
11	¿En el último trimestre se ha realizado alguno de estos procedimientos? ¿Qué procedimientos? ¿Aproximadamente cuantos de cada uno de los nombrados?	
12	¿Este hospital tiene ecógrafo funcionando?	
13	¿En el hospital hay personas que sabe manejar el ecógrafo?	
14	¿El personal de salud del hospital, sabe interpretar las radiografías y las ecografías?	
15	¿El hospital atiende las 24 horas todos los días? ¿Cómo es la organización para las guardias fuera del horario habitual de atención? ¿Y feriados? ¿Con que personal cuenta el ES para las guardias y atención de emergencias en noches, feriados y fines de semana?	

16	¿Cuáles son los principales problemas relacionados a la atención de la emergencia obstétrica? Personal entrenado, equipos, insumos, medicamentos, otros	
17	¿Existen problemas para realizar transfusión de sangre? ¿Cuáles?	
18	¿Existen problemas relacionados al quirófano? ¿Cuáles?	
19	¿Qué medidas ha tomado para solucionar esos problemas?	

SERVICIOS DE SALUD Pregunte si lo siguientes servicios están disponibles en el establecimiento de salud (puede leer los servicios de salud)		
20	Atención del parto normal	
21	Atención del parto complicado (instrumental)	
22	Operación cesárea	
23	Atención postnatal – puerperio	
24	Atención de recién nacidos enfermos	
25	Hospitalización de mujeres por complicaciones del embarazo	
26	Terapia intermedia para mujeres con complicaciones obstétricas	
27	Asistencia respiratoria (respirador) para mujeres con complicaciones obstétricas graves	
28	Terapia intermedia para recién nacidos con enfermedad grave	
29	Asistencia respiratoria (respirador) para recién nacidos con enfermedad o complicaciones graves	
30	¿Cuáles son los principales problemas para la oferta de servicios de calidad en este ES?	
31	¿Ha tenido problemas con la provisión de servicios de terapia intensiva e intermedia? ¿Cuáles?	
32	¿Qué elementos de la prestación de servicios tendría que mejorarse? ¿Por qué? ¿Cómo?	

REFERENCIA Y RETORNO DE MUJERES GESTANTES		
33	¿En el año 2018 y el primer trimestre de 2019, el hospital ha recibido referencias de mujeres embarazadas desde otros establecimientos de salud?	
34	Aproximadamente, ¿cuántas referencias de complicaciones obstétricas se recibieron en este primer trimestre de 2019?	
35	¿Usted diría que la mayoría de las referencias recibidas estaban justificadas? ¿Por qué si o por qué no?	

36	En su criterio, ¿cuáles son los principales problemas en las referencias de emergencias obstétricas que hacen los centros y puestos de salud?	
37	¿De las referencias recibidas, cuantas retornaron al establecimiento de salud de donde fueron enviadas, con el formulario de contra referencia o retorno?	
38	¿En este primer trimestre de 2019, se ha realizado alguna referencia de pacientes desde este hospital a otros centros de mayor complejidad?	
39	¿Las referencias se han hecho utilizando el formulario de referencia? ¿De las referencias realizadas, aproximadamente cuantas retornaron, con el formulario de contra referencia o retorno?	
40	¿En su criterio, cuáles son los principales problemas en las referencias de emergencias obstétricas que este hospital hace a centros de mayor complejidad?	
41	¿Ha recibido referencias hechas directamente desde la comunidad? ¿Quién o quienes hacen las referencias desde la comunidad?	
42	¿Ha recibido emergencias obstétricas que llegan directamente al hospital (sin el formulario de referencia)? ¿Qué conducta se sigue en estos casos? ¿Por qué?	

ADECUACIÓN CULTURAL DE LOS SERVICIOS		
43	¿Usted habla el idioma local? Especifique qué idioma.....	
44	¿Usted u otro personal del ES ha sido capacitado en los últimos 2 años en la adecuación intercultural de los servicios de salud?	
45	¿Usted sabe si se han realizado cambios en los horarios del ES a solicitud de las comunidades?	
46	¿En la farmacia, hay herbolaria tradicional medicinal?	
47	¿Tiene usted normas o protocolos de atención de madres y recién nacidos culturalmente apropiados para su zona?	
48	¿Usted sabe si en las comunidades de su zona hay médicos tradicionales, naturistas y/o parteras?	
49	¿Los médicos tradicionales, naturistas y/o parteras, están acreditados? ¿Cuántos médicos tradicionales? ¿Cuántos naturistas? ¿Cuántas parteras?	

50	¿Se han hecho cambios en la infraestructura o funcionamiento del ES para adaptarse a la cultura local? En el área de salud materna, ¿en qué consistieron los cambios?	
51	¿Se ha adquirido o modificado el equipamiento para adaptarlos a la cultura local? ¿En el área de salud materna, qué específicamente?	
52	¿De qué manera el personal de salud aplica prácticas para asegurar una atención culturalmente adecuada durante el embarazo, parto y postparto? ¿Qué prácticas culturales se han adaptado para la atención del embarazo, parto y postparto? Deme ejemplos concretos por favor	
53	¿El personal del ES pregunta a la mujer embarazada la posición en la que quiere tener su parto? ¿Usted pregunta a la mujer embarazada la posición en la que quiere tener su parto?	
54	¿En los últimos 3 meses se han atendido partos en posición vertical? ¿En cuclillas? ¿Cuántos?	
55	Estos partos ¿son frecuentes o raros? ¿Usted ha atendido partos en servicio que no fueron en la mesa de partos?	
56	¿El personal de salud pregunta a la mujer embarazada si desea que algún familiar le acompañe en su parto? ¿Usted pregunta a la mujer embarazada si desea que algún familiar le acompañe en su parto?	
57	¿En el ES se permite la presencia de un familiar o la persona que la parturienta elija en la sala de partos?	
58	¿En su criterio cuales son las ventajas o desventajas de permitir la presencia de un familiar en la sala de partos? ¿Por qué?	
59	¿Qué se hace en el ES cuando la parturienta o su familia pide dar a la mujer a alimentos o líquidos caseros? ¿Se permite? ¿Se prohíbe? ¿Por qué?	
60	¿En su criterio cuáles son las ventajas o desventajas de permitir que se dé a la parturienta alimentos o líquidos caseros traídos por los familiares? ¿Por qué?	

INFORMACIÓN ESTADÍSTICA Solicitar la presencia del estadístico del ES o la enfermera responsable del ES			
	Indicadores y variables	N/ %	Observaciones
61	Cobertura de control prenatal, con 4 controles prenatales		
62	Cobertura de administración de sulfato ferroso y ácido fólico a mujeres embarazadas		
63	Cobertura de parto institucional en servicio		
64	Cobertura de control postparto en el ES		

65	Proporción de cesáreas (N cesáreas/ N total de partos)		
66	Número de Hemorragias de la primera mitad del embarazo, tratadas en el año 2018		
67	Número de casos de preeclampsia y eclampsia, tratadas en el año 2018		
68	Número de mujeres con sepsis puerperal, tratadas en el año 2018		
69	Letalidad hospitalaria: número de muertes maternas en los 2 últimos años		

Fin de la entrevista

CONSENTIMIENTO INFORMADO PERSONAL DE SALUD

INCIDENCIA DE FACTORES CULTURALES EN LOS ÍNDICES DE MORTALIDAD MATERNA EN BOLIVIA

CONSENTIMIENTO INFORMADO: PERSONAL DE SALUD QUE TRABAJA EN ESTABLECIMIENTOS PÚBLICOS DE SALUD

Buenos (días, tardes), estamos realizando una entrevista a personal de salud que proporciona servicios de salud a mujeres embarazadas y no embarazadas.

- El objetivo de este estudio es "Explorar cuáles son los factores socio culturales que inciden en el acceso efectivo a servicios de salud de calidad, para el diseño de intervenciones que permitan incrementar el uso de servicios de salud reproductiva."

Para empezar, quiero informarle que la entrevista dura aproximadamente 60 minutos. En este estudio estamos aplicando un protocolo de ética para la investigación con seres humanos, que consiste en lo siguiente:

1. CONFIDENCIALIDAD: la información que usted nos proporcione será confidencial, en ningún documento, publicación o base de datos aparecerá su nombre. Incluso al firmar usted puede utilizar solo su nombre o apellido o incluso sus iniciales.
2. VOLUNTARIEDAD: Su participación en el estudio es completamente voluntaria, no se le castigará ni premiará de ninguna forma si acepta o rechaza participar.
3. SEGURIDAD: El estudio está basado en una entrevista personal y observación de las condiciones de los establecimientos de salud, por lo que no tiene ninguna consecuencia dañina para su salud.
4. BENEFICIO: Estamos llevando a cabo este estudio porque los resultados nos ayudarán a entender el problema y proponer soluciones para mejorar el acceso de las personas a servicios de salud de calidad.

¿Está usted de acuerdo en que le haga una entrevista?	SI	NO
NOMBRE	FIRMA	
¿Está usted de acuerdo en que grabe la entrevista?	SI	NO

Fecha (Día/Mes/Año): | | | |

3. GUÍA DE ENTREVISTA A MUJERES

Guía de entrevista 2 – Mortalidad Materna

Mujeres

DURANTE EL RECLUTAMIENTO ENTREGAMOS UNA CARTA DE CONSENTIMIENTO EN LA CUAL SE DETALLAN LOS OBJETIVOS Y PROCEDIMIENTOS DE LA INVESTIGACIÓN.

Buenos días/buenas tardes,

En esta ocasión estamos visitando la comunidad, para aprender sobre temas que son de interés para toda la población; conversaremos con varias personas, sobre temas que son muy importantes para todos.

Como se les comentó anteriormente, vamos a hablar sobre temas de salud, específicamente sobre aquellos aspectos que tienen que ver con el acceso a servicios de salud de calidad y su influencia en la maternidad, queremos escuchar sus experiencias y opiniones porque serán de mucha ayuda para poder apoyar en la mejora.

Todas las actividades que realizamos tienen un fin investigativo y de análisis. En ningún momento difundiremos sus nombres. Todo lo que puedan comentarnos será muy importante para la investigación; de la misma manera visitaremos otras comunidades.

INTRODUCCIÓN

1. ¿Para comenzar, podría decirme su nombre (solo su nombre) y cuántos años tiene?
2. ¿Cuál es su nivel de instrucción?
3. ¿Hace cuánto tiempo vive en la comunidad?
4. ¿Con quién o con quienes vive? (indagar si es familia nuclear o extendida y cuántos miembros viven en el hogar) ¿cuántos son hombres y cuántas son mujeres?
5. ¿Todos los miembros del hogar proceden de la misma comunidad? Es decir, ¿nacieron acá o alguno viene de otra comunidad?
6. ¿Tiene hijos? ¿Cuántos hijos tiene? ¿de qué edades son sus hijos?
7. ¿Consideran que pertenecen a alguna etnia o cultura específica?

ASISTENCIA AL SERVICIO DE SALUD

8. ¿Qué es lo primero que hacen cuando una persona de la familia presenta una enfermedad? (esperamos descripción de distintas situaciones)
    a. ¿A dónde acuden en las distintas situaciones (distintas enfermedades)? Proporcione algunos ejemplos.
    b. ¿De qué depende en cada situación?
9. ¿Acuden a instituciones de salud por controles de salud? Es decir, ¿sin estar enfermos o enfermas?

a. ¿Quiénes (de los miembros de la familia) acuden sin estar enfermos? ¿Por qué será así?

b. ¿Quiénes (de los miembros de la familia) acuden solo estando enfermos? ¿Por qué será así?

c. ¿Quiénes (de los miembros de la familia) no acuden ni estando enfermos? ¿Por qué será así?

10. Hablemos ahora de las mujeres en particular. ¿En qué ocasiones acuden al servicio de salud/hospital? ¿Por qué? Como deciden ellas si van o no al servicio de salud/ al hospital? ¿Quiénes les aconsejan?

PERCEPCIONES SOBRE SALUD MATERNA

11. Las mujeres, ¿cómo se enteran que están embarazadas?

12. ¿Qué es lo que sabe de los controles prenatales? ¿Usted hizo (o haría) sus controles prenatales? ¿por qué si o por qué no?

    a. ¿Las mujeres de esta comunidad realizan los controles prenatales? ¿por qué si o por qué no? ¿Qué son los controles prenatales?

    b. ¿Las mujeres que realizan sus controles prenatales, acuden solas o acompañadas al centro de salud? ¿Quién las acompaña?

13. ¿Qué otros cuidados tienen las mujeres embarazadas? ESPERAR RESPUESTAS ESPONTANEAS Y PROFUNDIZAR CADA RESPUESTA

    SI NO MENCIONA RESPUESTAS SIMILARES A INCISOS a, b, c, d ENTONCES PREGUNTAR Y PROFUNDIZAR.

    a. ¿Cómo es su alimentación? ¿y cómo tiene que ser su alimentación?

    b. ¿Qué actividades realizan en su casa?

    c. ¿Las mujeres embarazadas trabajan?

    d. ¿Qué cuidados asumen sus familias?

PREGUNTAS SOBRE EL PARTO

14. Las mujeres embarazadas, en esta comunidad ¿Dónde dan a luz?

    a. ¿Dónde prefieren dar a luz? Centro de salud, hospital, en la casa (indagar según lo que saben) ¿Por qué esa es su preferencia normalmente? ¿Qué es que no les gusta en … (MENCIONAR OPCIÓN QUE NO ES LA PREFERIDA)? ¿Qué es que lo que les gusta en (MENCIONAR OPCIÓN QUE ES LA PREFERIDA)? [INDAGAR SOBRE LAS RAZONES QUE INFLUYEN SU DECISION]

    b. ¿En quién o en quienes confían las personas de la comunidad para la atención del parto? ¿por qué será así? (INDAGAR POR QUÉ CONFÍAN EN UNO U OTRO) ¿Y en quién no confían? ¿por qué?

15. ¿Cómo son los partos usualmente en esta comunidad? (Indagamos sobre el parto en institución de salud o el parto en casa)

16. ¿Cómo son los partos en la institución de salud más cercana? ¿Qué ha escuchado sobre partos allí?

(INDAGAR: ¿Se permite la presencia de un familiar durante el parto? / prácticas/ tratamiento / adecuación cultural/ costos)

17. ¿Ha sabido de complicaciones en el parto? ¿Qué tipo de complicaciones?
    a. ¿Qué se hace en caso de presentarse complicaciones?
    b. ¿Quién atiende las complicaciones en el parto?

CONOCIMIENTO SOBRE MORTALIDAD MATERNA

18. ¿Usted sabe qué es la mortalidad materna?
    a. ¿Usted tiene conocimiento sobre casos de mortalidad materna que hubieran ocurrido en la comunidad?

       Si conoce casos, preguntar:

    b. ¿Por qué ocurrieron?
    c. ¿Dónde ocurrieron?
    d. Esos casos de mortalidad materna, ¿pudieron haberse evitado? ¿Cómo pudieron haberse evitado? (Indagar sobre cada respuesta)
    e. ¿Qué acciones tomo la comunidad o la institución de salud después de ocurridos esos casos de mortalidad materna?

PERCEPCIONES A FUTURO

19. ¿Qué tendría que pasar aquí en la comunidad para que ya no existan casos de muerte materna?
    a. ¿Qué les hace falta o que necesitan las mujeres? (mujeres en general)
    b. ¿Qué es lo que necesitan las mujeres embarazadas?
    c. ¿Qué les hace falta o que necesitan los hombres?
    d. ¿Qué es lo que le falta al centro de salud/hospital?
    e. ¿Qué es lo que le falta al personal de salud?

SOLO A MUJERES QUE SON MADRES

20. USTED ES MAMÁ, PEDIMOS QUE NOS CUENTE SU EXPERIENCIA DEL EMBARAZO, PARTO Y POSPARTO ¿Cómo se enteró de su embarazo?
21. ¿Cómo fue la experiencia de su embarazo? Cuéntenos por favor.
    a. ¿Qué es lo primero que hizo?
    b. ¿Acudió al médico? ¿Por qué sí? ¿Por qué no?
    c. ¿Usted recibió orientación sobre el embarazo? ¿Qué tipo de orientación? ¿Dónde? ¿De quién?
    d. ¿Recibió atención prenatal? ¿Dónde y por qué? (Por qué no en institución en caso de que no escogió eso - identificar las barreras)

e. ¿Hay algo que ahora usted cambiaría de cuando estaba embarazada? Es decir, algo que haría o algo que ya no haría.

22. Cuénteme la historia de su parto. ¿Cómo fue? ¿Dónde? ¿Por qué ahí? ¿Cómo decidió a donde iba dar a luz? ¿Quién le aconsejó?
    a. ¿Hay algo que cambiaría del momento del parto? ¿Por qué?
    b. ¿Qué le aconsejaría usted a una mujer embarazada?
23. ¿Usted sabe si hay casos de muerte materna en su comunidad? Cuéntenos por favor. [INDAGAR Y PRECISAR POSIBLES RAZONES]
24. ¿Cómo se siente usted como mujer, al conocer casos de mortalidad materna?
25. ¿Quiere agregar alguna opinión que no hayamos tomado en cuenta?

¡Muchas gracias!

4. GUÍA DE ENTREVISTA LÍDERES Y AUTORIDADES

Guía de entrevista 1 – Mortalidad Materna

Líderes y autoridades de la comunidad

DURANTE EL RECLUTAMIENTO ENTREGAMOS UNA CARTA DE CONSENTIMIENTO EN LA CUAL SE DETALLAN LOS OBJETIVOS Y PROCEDIMIENTOS DE LA INVESTIGACIÓN.

Buenos días/buenas tardes,

En esta ocasión estamos visitando la comunidad, para aprender sobre temas que son de interés para toda la población; conversaremos con varias personas, sobre temas que son muy importantes para todos.

Como se les comentó anteriormente, vamos a hablar sobre temas de salud, específicamente sobre aquellos aspectos que tienen que ver con el acceso a servicios de salud de calidad y su influencia en la maternidad, queremos escuchar sus experiencias y opiniones porque serán de mucha ayuda para poder apoyar en la mejora.

Todas las actividades que realizamos tienen un fin investigativo y de análisis. En ningún momento difundiremos sus nombres. Todo lo que puedan comentarnos será muy importante para la investigación; de la misma manera visitaremos otras comunidades.

INTRODUCCIÓN

1. Para comenzar, ¿podría decirme su nombre y el cargo que ocupa en la comunidad?
2. ¿Cuántos años tiene?
3. ¿Cuál es su nivel de instrucción?
4. ¿Hace cuánto tiempo vive en la comunidad?
5. ¿Su procedencia es esta misma comunidad? Es decir, ¿nació en esta comunidad?
6. ¿Considera que los habitantes de esta comunidad pertenecen a alguna etnia o cultura específica?

ASISTENCIA AL SERVICIO DE SALUD

7. Háble me de la atención de salud en la comunidad. ¿tienen centro de salud? ¿hospital?
8. ¿Qué hacen las personas de la comunidad cuando se presenta una enfermedad? (INDAGAR)
    a. ¿acuden a las instituciones de salud?
    b. Además de las instituciones de salud, ¿acuden a otros lugares? (Indagamos sobre medicina alternativa, etc.)
    c. ¿Por qué acuden a estos otros lugares? (de que depende que vayan a uno o a otro lugar
9. Háble me de las instituciones de salud.

a. ¿Cuántas instituciones de salud corresponden a esta comunidad?

b. ¿Cómo es la atención en estas instituciones?

c. ¿Quiénes acuden más a las instituciones de salud? ¿Por qué?

PERCEPCIONES SOBRE SALUD MATERNA

10. ¿Qué es lo que hacen las mujeres de la comunidad cuando están embarazadas? Cuenten qué es lo que hacen ustedes de la experiencia de su último embarazo (ESPERAMOS RESPUESTAS A LOS INCISOS a, b, c ESPERAMOS QUE RELATEN LO QUE SABEN Y SUS PERCEPCIONES. SI NO ES ASI, ENTONCES INDAGAMOS CON LAS SIGUIENTES PREGUNTAS, PROFUNDIZAR EN LAS RAZONES QUE LAS MOTIVAN A ACTUAR ASÍ)

    a. ¿Las mujeres saben que pueden acudir a la institución de salud durante su embarazo?

    b. ¿Acuden a la institución de salud?

        i. ¿Quién decide si debe ir al centro de salud? (ella, su esposo)

    c. ¿Las mujeres de la comunidad realizan los controles prenatales?

    d. ¿Cuéntenos como es aquí en la comunidad cuando una mujer está embarazada?

11. PARA LOS CASOS EN LOS QUE LAS MUJERES ACUDEN AL CENTRO DE SALUD: ¿Qué beneficios implica para las mujeres, la prestación de servicios de salud durante el embarazo?

    a. Las mujeres que realizan sus controles prenatales, ¿acuden solas o acompañadas al centro de salud? ¿Quién las acompaña? ¿Por qué van solas/acompañadas?

    b. Las mujeres que no van al centro de salud: ¿Por qué no lo hacen? ¿Cuáles son sus beneficios? ¿Cuáles son sus desventajas?

PREGUNTAS SOBRE EL PARTO

12. ¿Cómo son los partos usualmente en esta comunidad? (Indagamos sobre el parto en institución de salud o el parto en casa)

    a. ¿Dónde prefieren dar a luz las mujeres de la comunidad?

        i. Centro de salud, Hospital: ¿Por qué en el centro de salud?

        ii. En la casa (indagar según lo que saben), ¿Por qué prefieren dar a luz en la casa?

    b. ¿Cómo es la atención de los partos en la institución de salud? (SI NO SURGEN RESPUESTAS INSISTIMOS. Por ejemplo: permite la presencia de un familiar durante el parto? (Indagamos sobre el involucramiento de la pareja o miembros de la familia para el momento del parto), otras situaciones que podría mencionar.

13. Como líder/autoridad, ¿usted intercede entre la mujer embarazada, su familia y la institución de salud? ¿Cómo y en cuales casos?

14. ¿Se presentan complicaciones en el parto, aquí en la comunidad? ¿Qué tipo de complicaciones? Cuéntenos por favor.

15. ¿Cómo proceden en esta comunidad cuando se presentan complicaciones en el parto?
    a. ¿Quiénes acompañan a la mujer que se encuentra en esta situación?
    b. ¿Quiénes la apoyan? ¿Quiénes la cuidan? ¿Quiénes toman decisiones e ese momento? Cuéntenos por favor.

CONOCIMIENTO SOBRE MORTALIDAD MATERNA

16. ¿Tiene conocimiento sobre casos de mortalidad materna (durante el parto) que hubieran ocurrido en la comunidad?
    a. ¿Por qué ocurrieron esos casos de mortalidad materna?
    b. ¿Dónde ocurrieron esos casos de mortalidad materna? (centro de salud, hospital, otro)
    c. Esos casos de mortalidad materna, ¿pudieron haberse evitado? ¿Cómo pudieron haberse evitado?
    d. ¿Qué acciones tomó la comunidad después de ocurridos los casos de mortalidad materna?
        i. Por el hecho ocurrido
        ii. Para evitar casos en el futuro
    e. ¿Qué acciones tomó la institución de salud/hospital después de ocurridos esos casos de mortalidad materna?

PERCEPCIONES A FUTURO

17. ¿Qué es lo que hace falta en la comunidad para mejorar la situación de las mujeres para que tengan un mejor embarazo?
    a. ¿Cómo se puede trabajar en favor de las mujeres?
    b. ¿Qué se necesitaría para que los hombres apoyen más a sus esposas?
    c. ¿Qué se necesitaría para que las mujeres embarazadas reciban más apoyo de su familia? ¿y de la comunidad? ¿y del establecimiento de salud?
    d. ¿Qué le hace falta al centro de salud/hospital?
    e. ¿Qué le hace falta al personal de salud para atender mejor a embarazadas?
18. ¿Qué es lo que hace falta en la comunidad y en el centro de salud para mejorar la situación del parto?
    a. ¿Qué se necesitaría para mejorar la situación de las mujeres en situación de parto?
    b. ¿Qué se necesitaría para que las mujeres en situación de parto tengan el apoyo de sus familias? ¿de la comunidad? ¿del establecimiento de salud?
    c. ¿Qué le hace falta al centro de salud? ¿Y al personal de salud?

19. ¿Qué es lo que hace falta para prevenir y evitar casos de muerte materna en la comunidad?
20. ¿Quiere agregar alguna opinión que no hayamos tomado en cuenta?

¡Muchas gracias!

5. GUÍA DE GRUPOS FOCALES (HOMBRES Y MUJERES)

Guía de grupo focal – Mortalidad Materna

Hombres y Mujeres

DURANTE EL RECLUTAMIENTO ENTREGAMOS UNA CARTA DE CONSENTIMIENTO EN LA CUAL SE DETALLAN LOS OBJETIVOS Y PROCEDIMIENTOS DE LA INVESTIGACIÓN.

Buenos días/buenas tardes,

En esta ocasión estamos visitando la comunidad, para aprender sobre temas que son de interés para toda la población; conversaremos con varias personas, sobre temas que son muy importantes para todos.

Como se les comentó anteriormente, vamos a hablar sobre temas de salud, específicamente sobre aquellos aspectos que tienen que ver con el acceso a servicios de salud de calidad y su influencia en la maternidad, queremos escuchar sus experiencias y opiniones porque serán de mucha ayuda para poder apoyar en la mejora.

Todas las actividades que realizamos tienen un fin investigativo y de análisis. En ningún momento difundiremos sus nombres. Todo lo que puedan comentarnos será muy importante para la investigación; de la misma manera visitaremos otras comunidades.

NOMBRE
EDAD
NIVEL DE INSTRUCCIÓN
(SE REGISTRARÁ EN UNA FICHA DE REGISTRO DE GRUPOS FOCALES)

REGLAS DE PARTICIPACIÓN: Apagar celulares, hablar fuerte, no hay opiniones correctas o incorrectas deben decir lo que realmente piensan, respetar las opiniones de las otras personas.

ROMPEHIELO

INTRODUCCIÓN

1. ¿Hace cuánto tiempo viven en la comunidad?
2. ¿Con quienes viven en su hogar?
3. ¿Todos los miembros del hogar proceden de la misma comunidad? Es decir, ¿nacieron acá o alguno viene de otra comunidad?
4. ¿Tienen hijos? ¿Cuántos hijos? ¿De qué edades?
5. ¿Consideran que pertenecen a alguna etnia o cultura específica?

A. ASISTENCIA AL SERVICIO DE SALUD

6. ¿Qué es lo primero que hacen las personas de la comunidad cuando un miembro de la familia presenta una enfermedad?
    a. ¿A dónde acuden? ¿por qué sí?, ¿Por qué no?
    b. ¿De qué depende que acudan a este lugar?

7. En la comunidad ¿cuentan con instituciones de salud? Háblenme de las instituciones de salud.
    a. ¿Cuántas instituciones de salud atienden a esta comunidad?
    b. ¿Cómo son las instituciones de salud aquí en la comunidad? ¿en qué horarios atienden? ¿y cuánto cuesta ir al centro de salud?
    c. ¿Cómo es la atención en estas instituciones? (preguntar sobre la atención del personal de salud, actitud, predisposición)
    d. ¿Quiénes acuden más a las instituciones de salud? ¿Por qué?
8. Además de las instituciones de salud, ¿acuden a otros lugares? (Indagamos sobre medicina alternativa, etc.)
    a. ¿Cuándo van a estos otros lugares? En qué situaciones.
    b. ¿Por qué van a estos otros lugares?
9. Las mujeres, ¿En qué ocasiones acuden al servicio de salud/hospital?
    a. ¿A qué lugar van primero? ¿de qué depende?

B. PERCEPCIONES SOBRE SALUD MATERNA

10. ¿Qué es lo que hacen las mujeres de esta comunidad cuando están embarazadas? Es decir:
    a. ¿Cómo saben que están embarazadas?
    b. ¿Acuden al centro de salud para saber del embarazo? ¿Por qué? ¿o acuden a otro lugar? ¿Por qué? (¿cómo es que deciden ir a uno o a otro lugar? ¿alguien les aconseja?)
    c. ¿Realizan sus actividades con normalidad?
    d. ¿Asumen cuidados especiales?
11. ¿Las mujeres de esta comunidad realizan los controles prenatales?
    a. ¿Cómo deciden hacerlos o no?
    b. ¿Quiénes si y quienes no? ¿por qué?
    c. ¿Qué es lo que saben ustedes de los controles prenatales?
    d. ¿Las mujeres que realizan sus controles prenatales, acuden solas o acompañadas al centro de salud? ¿Quién las acompaña? ¿por qué van así?

C. PREGUNTAS SOBRE EL PARTO

12. Las mujeres embarazadas, en esta comunidad ¿Dónde dan a luz?
    a. ¿Dónde prefieren dar a luz? Centro de salud, hospital, en la casa (indagar según lo que saben) ¿Por qué? ¿Por qué esa es su preferencia normalmente? ¿Qué es que no les gusta de...? (MENCIONAR OPCIÓN QUE NO ES LA PREFERIDA)
    b. ¿En quién o en quienes confían ustedes para la atención del parto? ¿por qué será así? (Indagar por qué confían en uno u otro) ¿en quiénes no confían? ¿por qué?

13. ¿Cómo son los partos usualmente en esta comunidad? (Indagamos sobre el parto en institución de salud o el parto en casa)
14. Como son los partos en la institución de salud más cercana. ¿Qué ha escuchado sobre partos allí?

    (Indagar por: ¿permiten la presencia de un familiar durante el parto? / prácticas/ tratamiento / adecuación cultural/ costos)

    a. ¿Qué piensan de eso?
15. ¿Ustedes saben que pueden existir complicaciones en el parto? ¿Qué tipo de complicaciones?

    a. ¿Qué se hace en caso de presentarse complicaciones?
    b. ¿Saben de complicaciones ocurridas en la comunidad? Cuéntenme por favor. (nos referimos a complicaciones y si mencionan casos de mortalidad materna, pasamos directamente a la siguiente pregunta)

D. CONOCIMIENTO SOBRE MORTALIDAD MATERNA

16. ¿Tienen conocimiento sobre casos de mortalidad materna que hubieran ocurrido en la comunidad?

    a. ¿Según lo que saben, por qué ocurrieron esos casos de mortalidad materna?
    b. ¿Dónde ocurrieron esos casos de mortalidad materna? (centro de salud, hospital, otro)
    c. ¿Esos casos de mortalidad materna, pudieron haberse evitado? ¿Cómo pudieron haberse evitado? (Indagar sobre cada respuesta que surja)
    d. ¿Qué acciones tomo la comunidad después de ocurridos los casos de mortalidad materna?

        i. Por el hecho ocurrido

        ii. Para evitar casos en el futuro

    e. ¿Qué acciones tomó la institución de salud/hospital después de ocurridos esos casos de mortalidad materna?

E. PERCEPCIONES A FUTURO

17. ¿Qué es lo que hace falta en la comunidad para prevenir y evitar casos de muerte materna?

    a. ¿Qué les hace falta a las mujeres?
    b. ¿Qué les hace falta a los hombres?
    c. ¿Qué le hace falta al centro de salud/hospital?
    d. ¿Qué le hace falta al personal de salud?

F. RELATO DE LAS MUJERES QUE YA SON MADRES

SI A LO LARGO DEL GRUPO FOCAL LAS MUJERES NO HABLAN DE LA EXPERIENCIA DE SU MATERNIDAD, ENTONCES EN ESTA SECCION PREGUNTAR SOBRE SU PROPIA EXPERIENCIA

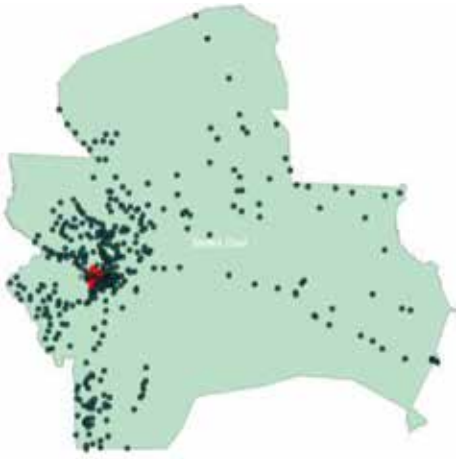
18. A las que son mamás, vamos a preguntarles sobre su experiencia personal:
    a. Cuéntenos sobre su embarazo...
    b. Ahora háblenos del parto...
    c. Y del posparto...
    d. ¿Hay algo más que quisieran compartir sobre su experiencia?
19. ¿Quieren agregar alguna opinión que no hayamos tomado en cuenta?

¡Muchas gracias!

ANNEX 3. GEO MAPPING OF HEALTHCARE FACILITIES IN SELECTED MUNICIPALITIES THAT WERE PART THE STUDY
(MARKED IN RED)

San Ramon Municipality, Beni Department

Porongo Municipality, Santa Cruz Department



Caranavi Muncipality, La Paz Department

Morochata Municipality, Cochabamba Department

Note: the dots represent health facilities.
Source: Portal GeoBolivia – Infraestructura de Datos Espaciales del Estado Plurinacional de Bolivia.
http://geo.gob.bo/portal/


WORLD BANK GROUP