COUNTRY NOTE

EVALUATION OF UNFPA SUPPORT TO FAMILY PLANNING 2008-2013

COUNTRY CASE STUDY
BOLIVIA

EVALUATION OFFICE
AUGUST 2015

Evaluation of UNFPA Support to Family Planning Services 2008-2013

Bolivia Case Study Note

Evaluation Manager:

Louis Charpentier Evaluation Office UNFPA

Reference group members:

1	Maha El Adawy	UNFPA ASRO
2	Nestor Azandegbe	UNFPA WCARO
3	Elizabeth Benomar	UNFPA Technical Division, HIV and AIDS Branch
4	Louis Charpentier	UNFPA Evaluation Office – Chair
5	Rita Columbia	UNFPA Technical Division, Commodity Security Branch
6	Ezizgeldi Hellenov	UNFPA EECARO
7	Desmond Koroma	UNFPA Technical Division, Commodity Security Branch
8	Laura Laski	UNFPA Technical Division, Sexual and Reproductive Health Branch
9	Shawn Malarcher	USAID Office of Population and Reproductive Health Bureau for Global Health
10	Farah Usmani	UNFPA Programme Division, Operational Support & QA Branch
11	Josiane Yaguibou	UNFPA ESARO
12	Selen Örs	UNFPA Evaluation Office/Programme Coordinator Turkey Country Office- Ankara

Euro Health Group (EHG) evaluation team:

1	Meg Braddock	Overall evaluation team leader and Bolivia case study team leader
2	Gloria Lizárraga	National Consultant

TABLE OF CONTENTS

TABLES

FIGURES

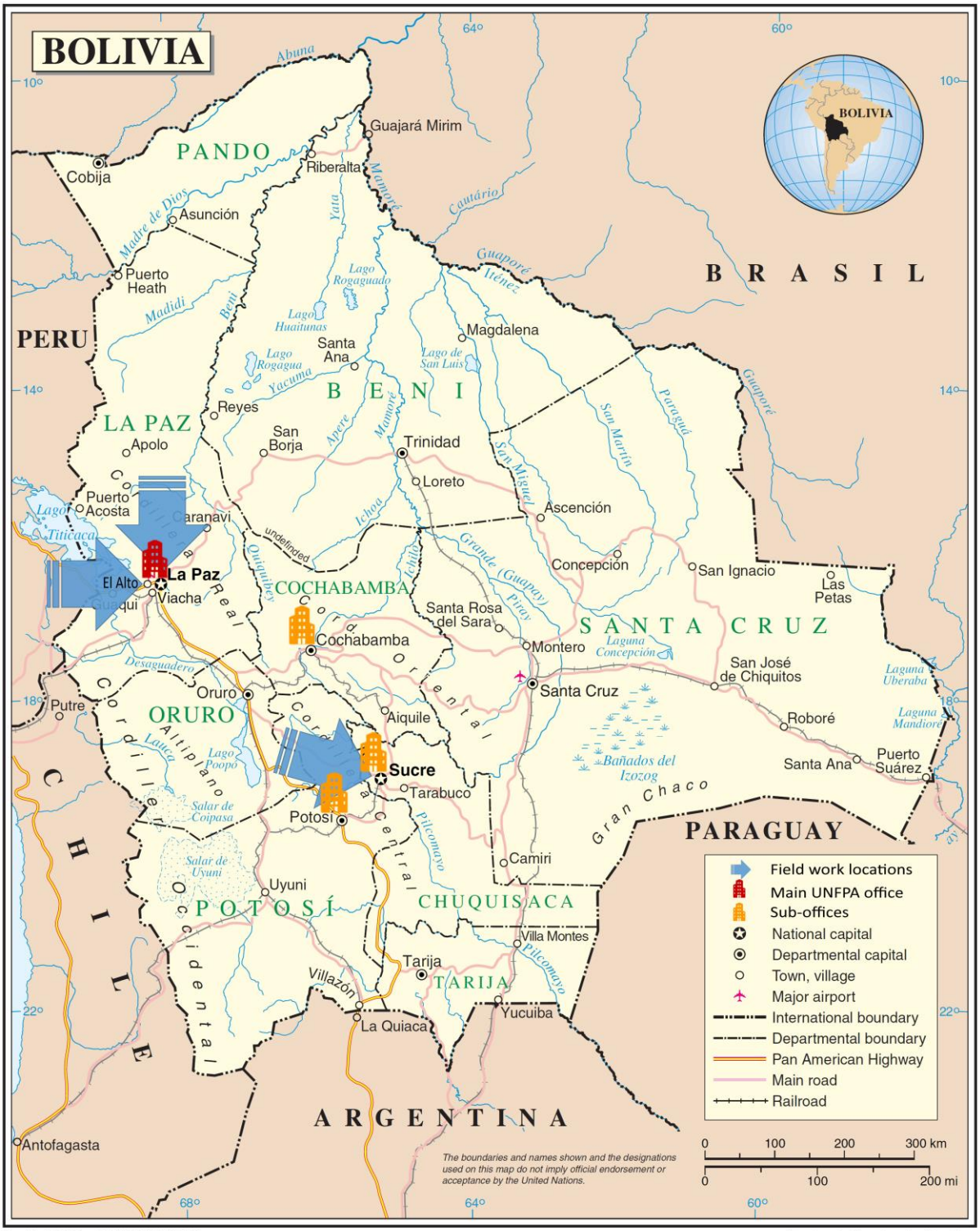
ABBREVIATIONS AND ACRONYMS

AccessRH	UNFPA procurement and information service for reproductive health commodities, census supplies and humanitarian response supplies.
AECID	Agencia española de cooperación internacional para el desarrollo (Spanish agency for international development cooperation)
AIDS	Acquired Immune Deficiency Syndrome
AYSRH	Adolescent and Youth Sexual and Reproductive Health
CA	Contribution Analysis
CAJPEA	Comité Adolescente y Joven para la Prevención de Embarazo en Adolescentes (Adolescent and Youth Committee for Prevention of Adolescent Pregnancy)
CEASS	Central de Abastecimiento y Suministros de Salud (Central Health Supplies Organisation)
CIES	Centro de Investigación Educación y Servicios (Centre for Research Education and Services)
CO	Country Office
CP	Country Programme
CPE	Country Programme Evaluation
CPR	Contraceptive Prevalence Rate
CSB	Commodity Security Branch
CSO	Civil Society Organisation
DAIA	Disponibilidad Asegurada de Insumos Anticonceptivos (Family Planning Commodity Security)
DFID	Department for International Development (UK)
DHS	Demographic Health Survey
DP	Development Partners
DRF	Development Results Framework
EC	Emergency Contraception
EHG	Euro Health Group
FCI	Family Care International
FGD	Focus Group Discussion
FP	Family Planning
FP2020	Family Planning 2020
GBV	Gender Based Violence
GPRHCS	Global Programme for Reproductive Health Commodity Security
HIV	Human Immunodeficiency Virus
HQ	Headquarters
HRBA	Human Rights Based Approach
ICPD	International Conference on Population and Development
INGO	International Non-Government Organisation
IP(s)	Implementing Partner(s)
IPPF	International Planned Parenthood Federation
IUCD	Intra-Uterine Contraceptive Device
KII	Key Informant Interview

LACRO	Latin America and Caribbean Regional Office
LGBT	Lesbian, Gay, Bisexual, and Transgender people
mCPR	Modern Contraceptive Prevalence Rate
MDG	Millennium Development Goals
MoH	Ministry of Health
MSD	Ministerio de Salud y Deportes, now called Ministerio de Salud (Ministry of Health)
MSI	Marie Stopes International
MSM	Men who have Sex with Men
MWRA	Married Women of Reproductive Age
NGO	Non-Government Organisation
PAHO	Pan-American Health Organisation
PHC	Primary Health Care
PLWHIV	People Living with HIV
PREVETS	Estudio de Prevalencia de VIH e ITS en Trabajadores Sexuales (Study of prevention of HIV and STIs amongst sex workers)
PROMESA	Programa de Mercadeo Social (Social Marketing Programme)
PROSALUD	Asociación Protección a la Salud (Association for Health Protection)
RBA	Rights based approach
RH	Reproductive Health
RHCS	Reproductive Health Commodity Security
RO	Regional Office
RRSRH	Reproductive Rights and Sexual and Reproductive Health
SAFCI	Salud Familiar Comunitario Intercultural
SEDES	Servicios Departamentales de Salud (Departmental Health Services)
SIS	Seguro Integral de Salud (Integrated Health Insurance)
SNIS	Sistema Nacional de Información de Salud (National Health Information System)
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
STI	Sexually transmitted infection
SUMI	Seguro Universal Materno Infantil (Universal maternal-infant insurance)
SW	Sex Worker
TA	Technical Assistance
TMA	Total market approach
ToC	Theory of Change
ToR	Terms of Reference
ToT	Training of trainers
UNDAF	United Nations Development Assistance Framework
UNFPA	United Nations Populations Fund
UNIMED	Unidad de Medicamentos y Tecnología en Salud (Unit for Medicines and Health Technology)
USAID	United States Agency for International Development
VMG	Vulnerable and Marginalised Group
WCARO	West and Central Africa Regional Office

WHO	World Health Organisation
WRA	Women of Reproductive Age

INTERVENTION MAP



Map No. 3875 Rev. 3 UNITED NATIONS
August 2004

Department of Peacekeeping Operations
Cartographic Section

KEY FACTS – BOLIVIA

Indicator	2014	Source of Data
Population and Development		
Population, total	10,561,887	World Bank[1]
Population growth (annual %)	1.5	World Bank[1]
Urban Population (% of total)	68	World Bank[1]
Population Density (per sq. km of land area)	10	World Bank[1]
Life Expectancy at birth, total (years)	68.3	World Bank[1]
Literacy rate, population 15+ years (%)	-	World Bank[1]
Human Development Index (HDI)	0.662 (Rank 119 out of 188)	Human Development Report[2]
Economic growth rate (GDP growth annual %)	5.5	World Bank[1]
GINI Index	-	World Bank[1]
Gender Equality and Empowerment		
Gender Inequality Index	0.444 (Rank 94 out of 155)	Human Development Report[3]
Women representation in parliament, total (%)	51.8	World Bank[1]
Violence against women ever experienced (%)	67.6	Human Development Report[3]
Employment to population ratio, 15+, female (%) (modeled ILO estimate)	62	World Bank[1]
Ratio of girls to boys in primary and secondary education (%)[4]	-	World Bank[1]
Reproductive Rights and Reproductive Health		
Adolescent fertility rate (births per 1,000 women ages 15-19)	71	World Bank[1]
Teenage mothers (% of women ages 15-19 who have had children or are currently pregnant)	-	World Bank[1]
Prevalence of HIV, both sexes (% ages 15-49)	0.3	World Bank[1]
Maternal mortality rate (per 100,000 live births)	215	World Bank[1]
Under 5 mortality rate (per 1,000 live births)	40	World Bank[1]
Contraceptive use, modern methods (%)	48.8	UN DESA[5]
Unmet need for family planning	15.1	UN DESA[5]
Births attended by skilled health staff (% of total)	-	World Bank[1]

[1] World Bank. (2016). Bolivia. Retrieved from http://data.worldbank.org/country/bolivia

[2] United Nations Development Programme. (2016). Bolivia. Retrieved from http://hdr.undp.org/en/countries/profiles/BOL

[3] United Nations Development Programme. (2016). Table 5: Gender Inequality Index. Retrieved from http://hdr.undp.org/en/composite/GII

[4] This indicator is also labeled as "*Gross enrolment ratio, primary and secondary, gender parity index (GPI)*" by the World Bank. World Bank. (2016). Bolivia. Retrieved from http://data.worldbank.org/country/bolivia

[5] United Nations. (2016). UN DESA Population Division Estimates and Projections of Family Planning Indicators. Retrieved from http://www.un.org/en/development/desa/population/theme/family-planning/cp_model.shtml

1. INTRODUCTION

Family planning (FP) is a principal focus of the work of UNFPA worldwide. This country case study is part of a thematic evaluation of UNFPA support to family planning 2008-2013, whose objective is to assess progress against past and current strategic plans and inform future decision-making and policy formulation in family planning.

1.1 Objectives of the evaluation

Purpose

The purpose of the evaluation is to assess the performance of UNFPA in the field of family planning during the period covered by the Strategic Plan 2008-2013 and to provide learning to inform the implementation of the current UNFPA Family Planning Strategy Choices not Chance (2012-2020). The evaluation will also inform other relevant programmes such as the Global Programme for Reproductive Health Commodity Security (GPRHCS) (2013-2020) and the Preventing HIV and Unintended pregnancies: Strategic Framework 2011-2015. Finally, the evaluation results will feed into the mid-term review of UNFPA current Strategic Plan 2014-2017.

Objectives

The primary objectives of the evaluation are to:

1. Assess how the framework as set out in UNFPA Strategic Plan (and revised Development Results Framework) 2008-2013 and further specified in the reproductive rights and sexual and reproductive health framework (2008-2011) as well as in the GPRHCS (2007-2012) and the Preventing HIV and Unintended Pregnancies strategic framework (2011-2015), has guided the programming and implementation of UNFPA interventions in the field of FP.
2. Facilitate learning and capture good practices from UNFPA experience across a range of key programmatic interventions in the field of FP during the 2008-2013 period to inform the implementation of both outcome 1 of UNFPA current Strategic Plan and the Choices not Chance 2012-2020 strategy; inform the GPRHCS (2013-2020) and the Preventing HIV and Unintended pregnancies strategic framework (2011-2015) as well as future programming of interventions in the field of FP.

1.2 Scope of the evaluation

The evaluation covers the period 2008-2013, taking into account information from 2014 when pertinent and necessary. It is both retrospective and forward-looking, including evaluation of past performance, analysis of lessons learnt, and conclusions and recommendations for future interventions.

The geographical scope covers all countries where UNFPA has carried out FP interventions, focussing on the 69 poorest countries with low rates of contraception use and high unmet need for FP identified by the 2012 London Summit on Family Planning and FP2020 partnership, and also covering middle income countries where FP needs are still high due to inequality of access. Data collection and case studies cover all six UNFPA regions (Eastern and Southern Africa, Western and Central Africa, Asia and the Pacific, Latin America and the Caribbean, the Arab States, and Eastern Europe and Central Asia).

All UNFPA FP interventions are included in the evaluation, including those covered by core and non-core resources and those financed through the GPRHCS. Family planning is an integral part of UNFPA interventions in maternal health, adolescent and young people's sexual and reproductive health (SRH), HIV and AIDS, gender and humanitarian support. Family planning activities in these areas are

included in the evaluation where appropriate, taking care not to duplicate work carried out in the Thematic Evaluation UNFPA Support to Maternal Health 2000-2011 (UNFPA 2012b), and the Adolescent and Youth Sexual and Reproductive Health (AYSRH) evaluation which is being carried out concurrently with this evaluation.

The evaluation covers eight principal areas of investigation:

- UNFPA support to integration of FP with other SRH services
- UNFPA efforts for coordination to ensure national ownership and institutionalisation of FP programmes
- Extent of UNFPA efforts as a broker to promote FP, with particular attention to partnerships
- Extent of UNFPA support to creation of an enabling environment
- Level of focus on the needs of the most vulnerable groups and marginalised populations
- Extent of implementation of a human-rights based approach
- UNFPA choice of different modes of engagement
- The extent to which UNFPA support for supply-side activities (including training, procurement and logistic systems) promotes rights-based and sustainable approaches and contributes to improved access

1.3 Overview

The evaluation uses a Contribution Analysis (CA) approach based on a reconstructed theory of change which is being tested through collection of data and information at different levels, and analysis of the eight evaluation areas and their associated assumptions.

There are twelve country case studies (five in-country and seven desk studies) as part of the data collection phase, which also includes review of documentation, key informant interviews (KII) at global and regional levels with UNFPA staff and other stakeholders, two on-line surveys and additional financial analysis.

The case studies are not evaluations of the FP effort in each country and do not present recommendations for on-going or future FP work. They are one important input into the data collection and analysis process for the eight areas of the UNFPA FP evaluation as a whole, and contribute to the overall evaluation through:

- Providing input from the country perspective for addressing the global evaluation questions
- Generating data for triangulation with other sources
- Contributing to identifying more clearly “how” and “why” change occurs and contributions of UNFPA to this
- Providing insights to the eight principal evaluation areas
- Identifying lessons learned across different contexts

CA was originally presented as an approach to programme design and monitoring and, to a lesser extent, to evaluation. This has left considerable freedom for evaluators to explore different approaches to operationalizing CA and the use of Theories of Change (ToC). Different approaches have been used to apply CA in evaluations which include both country or sub-programme and global or synthesis levels of analysis.

For this evaluation at country level the team has organised the country case study notes around the eight evaluation areas and has attempted to address most or all of the key assumptions in the overall ToC as they are realized (or not) at the country level. This method has the following strengths:

- It draws a clear link from the overall ToC as developed and presented in the inception report while allowing the country case studies to reflect local contexts and realities and the UNFPA response
- It allows the country case studies to include areas of UNFPA engagement and support and positive or negative results which may not have been captured in the reconstructed ToC[6]
- It simplifies the reporting of findings at country case level since it does not require the development of separate, country level ToC
- It still allows for a strong testing/challenge of the ToC at country level because it allows the evaluation team to verify the validity of key assumptions. In effect, this combines analysis of assumptions and risks (the main risks are usually that key assumptions are not realized)
- Using the common structure of the eight evaluation areas and their associated key assumptions will facilitate synthesizing the findings and conclusions of the country studies during the preparation of the overall evaluation report.

In this way the country case study notes are able to establish the link from the country level evaluation results to the overall ToC for UNFPA support to FP.

This report covers the case study in Bolivia.

1.4 Structure of the country note

Section 2 of the report outlines the case study methodology. Section 3 gives a short overview of key elements of FP in Bolivia and the UNFPA response and provides the necessary context for discussion of the specific evaluation questions and UNFPA contributions. Section 4 presents the findings of the case study along the eight evaluation areas, including progress and changes during the evaluation period and the UNFPA contribution to those changes. Section 5 presents a set of conclusions.

2 METHODOLOGY

2.1 Selection of country case studies

The five in-country case studies include three from West and Central/Eastern and Southern Africa regions, one from Asia-Pacific region, and one from Latin America and Caribbean region. The sample maximises the breadth and depth of insights into the evaluation questions and gives a broad picture of the UNFPA contribution to family planning (FP) over time in different contexts, giving insights into the country perspective on the evaluation areas, providing examples of externalities and risks and how they have been addressed, and complementing the information collected from other sources. This section summarises the process and results of country selection for visits and desk studies. A full description of the case study selection is given in the Evaluation Inception Report (UNFPA 2014a).

The selection started with a purposeful sample based on criteria which cover the dual purpose of the evaluation: looking back to assess UNFPA performance in the field of FP, and providing learning for the on-going UNFPA Strategic Plan. Criteria included poverty indices, levels of UNFPA spending and past performance in FP taking into account both change in modern contraceptive prevalence rate (mCPR) and unmet need.

From the purposeful sample, countries were selected for in-country and desk studies taking into account the following criteria, to ensure a spread and contrast in the set of case studies:

[6] The reconstructed ToC was developed in the inception phase of the evaluation, based on the pertinent UNFPA strategy documents which include family planning during the period. Expected pathways of change were identified and mapped for each of the 8 evaluation areas (see annex of inception report).

- Overall UNFPA spending per capita
- The need to include at least one country with Global Programme for Reproductive Health Commodity Security (GPRHCS) Phase 1 Stream 1 support[7]
- Availability of sufficient and sufficiently reliable data and information on past UNFPA support and the overall country context
- The need to include at least one fragile state or humanitarian situation, at least one high-population country and one or more countries with a One UN (delivering as one country) programme
- Varying degrees of government support for FP
- Changes in UNFPA modes of engagement and implementation risks
- The need to avoid concurrent implementation of in-country case studies with other UNFPA thematic and country evaluations and
- The potential of the country study to contribute to analysis of the hypotheses in the evaluation matrix.

The resulting sample is spread across the UNFPA Strategic Plan business model's four quadrants, which show need for FP interventions versus capacity to finance such interventions, although application of the sample selection criteria clearly favours countries in the quadrants representing countries with relatively higher levels of need and lower levels of financing ability (UNFPA 2013). Aside from Bolivia, the other countries selected for the field phase are: Burkina Faso, Cambodia, Ethiopia, and Zimbabwe.[8]

2.2 Selection of Bolivia as a case study

Bolivia was selected for a case study as it has characteristics regarding UNFPA support to FP that offer important insights into the country perspective on the evaluation questions in a specific context. Relevant characteristics of the country and the UNFPA country programmes in the evaluation period include:

- The country's decentralised administrative structure which has implications for national and regional budget allocations to FP
- Departmental[9] differences in the FP context and key parameters which affect UNFPA priority-setting and mode of engagement at different levels
- Participation in the GPRHCS (Phases 1 and 2)
- Variable government commitment to expanding access to FP services at departmental, municipal and community level, with opposition to FP from some political groups
- Limited number of partners and donors engaged in FP
- Important programmes for specific vulnerable and marginalised groups (VMG) including indigenous women, adolescents and sexual minorities and development of an evidence base for work with these groups.

2.3 Scope of the study and data collection methods

The country study covered all UNFPA FP work during the evaluation period: projects fully dedicated to FP as well as those in which FP activities are a component of other sexual and reproductive heatlh (SRH) projects were captured. Core and non-core funding (including funding from the GPRHCS thematic trust fund) was covered by the analysis.

[7] Stream 1 countries are those selected for priority attention by GPRHCS for multi-year, flexible and predictable funds to help countries develop more sustainable approaches to Reproductive Health Commodity Security (RCHS)

[8] See inception report for discussion of country selection.

[9] Throughout this text “department” and “departmental” refer to the administrative division below national level.

The study was carried out during March 2015 by a team of two consultants (one international and one national). UNFPA Country Office (CO) staff participated fully in the preparation of the study and logistics, internal discussions and interviews within the CO, collection and analysis of information and financial data, and in the de-briefing workshop. CO staff participated in some interviews in La Paz and in Sucre Department where appropriate, and organised visits to health facilities in peri-urban and rural areas.

Preliminary work (prior to the country visit) included:

- Collection and review of key data of Bolivia including country background; country health sector and other sectors relevant for SRH/FP; health and other SRH/FP-relevant indicators
- Desk analysis of UNFPA response in the country; overview of UNFPA interventions (2008-2013)
- Preparation of detailed timetable for interviews and other activities during the country visit (in consultation with CO).

In-country work was designed to provide input to the eight evaluation areas. Activities included briefing and de-briefing with CO staff and interviews with UNFPA staff, government officers, bilateral donors, UN agencies, national and international NGOs, health service delivery personnel and service clients, to give a balance of different points of view of UNFPA support to FP and the current context of FP programmes and services. Focus group discussions (FGDs) were held with young people, FP users and non-users, non-government organisations (NGOs) and government health providers. The team worked with CO staff to identify FP budgets and spending over the evaluation period, including FP spending within other thematic areas.

There was a field visit of two days to Sucre Department, where UNFPA has supported FP activities. The purpose of the field trips was to gain insights on rights holders' needs, duty bearers' responses and programme successes and challenges in the decentralised country context and to add context-specific examples to the overall country picture.

Data and information collected from documents, interviews, field trips and FGDs was collected in an evaluation matrix which collates data relating to each of the eight evaluation areas and their assumptions (see Annex 3). Activities and progress in each evaluation area were analysed to identify the changes which have occurred and the UNFPA contribution to those changes. At the end of the visit the team presented preliminary findings to the UNFPA CO staff for their comments and feedback which are included in the analysis in section 4 of this report.

Documents consulted are shown in the list of references (Annex 1). A list of people interviewed and FGD participants is given in Annex 2. Interview guides and FGD guides are presented in the Evaluation Inception Report (UNFPA 2014a).

Limitations on the data collected include:

- Staff turnover in key partner organisations such as the Ministry of Health (MoH), and some loss of institutional memory of events in the period under evaluation. The CO staff managed to arrange interviews with people who had been in place in key roles during the period 2008-2013, although some had moved on to new positions.
- Lack of up-to-date official statistical information on FP and reproductive health. The most recent Demographic Health Survey (DHS) was carried out in 2008. Although a new DHS was planned for 2013 it has not yet been completed, so it is not possible to identify trends. The MoH Information system (SNIS) is not considered sufficiently reliable and only provides data on the public sector service provision.

- The participants in the users FGD did not cover the full range of socio-economic characteristics which the team had requested. More FGDs would also have provided a more balanced set of information from the users' perspective.
- Detailed financial information on FP spending within other SRH projects is based on estimates by CO staff. This approach was chosen due to challenges in obtaining FP expenditure through the UNFPA financial management platform ATLAS. For the period under evaluation ATLAS did not explicitly track FP spending and did not capture all the FP spending in other SRH projects. Overall figures for FP spending in Bolivia by the MoH and other development partners are also based on estimates as FP work is often integrated with other SRH activities. Information was triangulated where possible.

3 SHORT DESCRIPTION OF FAMILY PLANNING IN BOLIVIA

Country background

Bolivia has an estimated total population of 10 million, of which 67 percent are urban. Rural areas are geographically extensive and include a wide range of environments from the high Andes plateau to the mountain regions and the tropical plains and forests in the Amazon basin. Rural areas are sparsely populated and the overall average population density for the country is 9.2 people per square kilometre. The population has a young age structure with 62 percent below 25 years of age. Population growth rate is moderate at 1.7 percent p.a., and total fertility is 3.5. The population is predominantly indigenous, major groups being Quechua (30%), Aymara (25%), mestizo (30%) and white (15%) (Index Mundi 2015). Recognition of indigenous identity has been high on the political agenda during the last decade.

Bolivia is one of the poorest countries in Latin America and the Caribbean region with an estimated gross domestic product (GDP) per capita of US$2,876 (World Bank 2015), the fourth lowest in the region after Haiti, Honduras and Nicaragua. 25 percent of the population are still below the basic need poverty line, although economic growth rates are estimated at 6.8 percent p.a. Adult literacy rates are high at 95 percent, and gender equality is still poor but improving, with an indicative 53 percent female members of parliament (data sources are shown in the Key Facts table).

The Plurinational State of Bolivia is a multi-party democracy. The present government took office in January 2015 under the leadership of Evo Morales who was first elected President in 2005. The administrative structure is decentralised with 9 departments and 339 municipalities, all with elected officials. Central government allocates budgets to the departments on the basis of population numbers, specifying the percentage to be spent in different sectors but leaving allocation and decision-making within each sector to departmental and municipal governments. Decentralised levels of government also raise their own funds through local taxes which they can allocate at their own discretion.

Health System

The Ministry of Health (MoH) (formerly *Ministerio de Salud y Deportes* (MSD)) is the central government health agency. Its functions include development of policy, norms and standards, identification of priority health areas, design of the service delivery structure and the number of health facilities at different levels, and contracting and paying health staff. At departmental level the Departmental Health Services (*Servicios Departamentales de Salud* (SEDES)) implement health services and programmes. They respond to the MoH on technical issues and to the departmental government on finance and administration matters. Health facilities including health posts, health centres and first and second level hospitals are under the financial and administrative control of municipal governments, whilst third level reference hospitals are administered by the departmental government. First and second level facilities have also been linked into a series of "networks" (*redes*

de salud) for referral and resource allocation purposes. This is a complex administrative system in which the health sector responds to more than one branch of government at each administrative level. Municipalities are responsible for procurement of supplies (including family planning (FP) methods) and can purchase through the parastatal central health supplies organisaiton (*Central de Abastecimiento y Suministros de Salud* (CEASS)) or other suppliers. Coverage of the public health sector is better in urban areas, with poor availability of services in remote rural areas.

A universal maternal-infant health insurance (*Seguro Universal Maternal Infantil* (SUMI)), was introduced in 2002 to provide a wide range of free services to women and children. Family planning was included in the SUMI in 2005. Health services including FP provided at facilities are reimbursed by central government to municipal governments on a *per capita* basis, and municipal governments cover the cost of supplies and facility maintenance. The SUMI has recently been replaced by a new national insurance scheme, Integrated Health Insurance (*Seguro Integral de Salud* (SIS)), which covers a wider range of services and includes access for all, including men and boys. Medical supplies are channelled through municipal pharmacies in the health facilities.

Major non-government employers and employment sectors including banks, the press and universities also provide health services and insurance for their workers through their own facilities (*Cajas de Salud*) and include FP services although some are not free. Health services are provided on a fee-for-services basis by non-government organisations (NGOs), the largest networks being Association for Health Protection (*Asociación Protección a la Salud* (PROSALUD)) which was formerly financed by United States Agency for International Development (USAID). (PROSALUD continues to run the contraceptive social marketing programme (*Programa de Mercadeo Social* (PROMESO)), set up with USAID support) (JSI Deliver 2014); the International Planned Parenthood Federation (IPPF) affiliate Centre for Research and Education Services (*Centro de Investigación Educación y Servicios* (CIES)) and Marie Stopes International (MSI) Bolivia, these latter two organisations specialising in sexual and reproductive health (SRH) and FP services. The number of NGOs has reduced significantly in the last few years due to increasing government restrictions and control over their activities. The private sector includes pharmacies which are the most important supplier of condoms and pills for vulnerable and marginalised groups (VMGs) such as adolescents and men who have sex with men (MSM) (Ministerio de Salud y Deportes and Programa Nacional ITS/VIH/SIDA 2010, UNFPA 2013) as well as the general population. As men have only recently been covered by the national health insurance scheme (see section 4 below), pharmacies were the normal source of purchased pills and condoms during the period under evaluation.[10] Private medical clinics provide FP services for those with capacity to pay. There is no community health worker network; communities nominate a "health secretary" whose function is coordination between health facilities and municipal government, but does not include health promotion.

The parastatal procurement and distribution agency for medical supplies, CEASS was set up in 1998 to carry out procurement and distribution of essential medicines, including FP supplies. CEASS is based in La Paz with branches in the departments (see section 4.8 below).

Major problems in the public health sector which affect FP service provision include: low availability of nurses and midwives, high turnover of all medical staff especially in remote areas, and insufficient training of health workers in quality of services for different groups. Resource constraints, institutional weaknesses (e.g. in the supply chain) and socio-political obstacles within the health sector are also important limitations, as discussed in more detail in section 4.

[10] Interviews MoH, CEASS, UNFPA

Health sector spending, overseas development assistance and UNFPA contributions

Overall spending in the health sector in Bolivia was an estimated US$149 million in 2012 (WHO 2015), of which government spending accounts for about 68 percent and private spending 32 percent. Government spending includes overseas development assistance funds from donors, which represent an estimated 54 percent of total health sector spending in the period 2008-2012 (ibid.). The UNFPA Survey for the Flow of Financial Resources for Population Activities UNFPA/NIDI (UNFPA 2014b) identifies government spending of US$2.2 million on FP during 2012 and US$2.3 million in 2013 (about 2 percent of the total government health spending), which falls within the range of cost forecasts developed in 2003 by JSI/DELIVER and the Committee for Reproductive Health Commodity Security (*Disponibilidad Asegurada de Insumos Anticonceptivos* (DAIA)) (JSI Deliver and Futures Group/POLICY II 2003).

Donor funds for reproductive health (RH) and FP have fallen steadily over the period from US$17.8 million in 2008 to US$13 million in 2012 (WHO 2014). Expulsion of USAID from Bolivia in 2013 has most likely resulted in a further reduction of the total funds for that year (data for 2013 are not yet available). UNFPA FP spending (excluding commodities) is estimated at US$6.9 million for the period 2008-2012, representing about 9 percent of the overall donor RH/FP total.[11]

The Kaiser Foundation estimates (Kates, Michaud et al. 2014) of donor funds for RH and FP in Bolivia only cover the period 2009-2011 but some comparisons can be made with the WHO figures. The Kaiser Foundation estimates considerably less overall donor spending on RH and FP in the period 2009-2011 than WHO, but does identify the key donors to be USAID (65% of the total), UNFPA (15%), Japan, Spain and Denmark (6%, 6% and 4% respectively). These figures correspond reasonably well with calculations based on UNFPA and WHO estimates from the sources quoted above, which suggest that UNFPA spending on FP contributed 12 percent of the total RH/FP donations in the same period (2009-2011). Data from the UNFPA surveys of Financial Resource Flows for Population Activities (UNFPA 2013) known as the "*NIDIs*" show a much higher overall figure than WHO for the period 2008-2012, but includes all population activities as well as NGO sector donations, which are registered as a high 53 percent of the total in Bolivia in 2012. USAID stopped donating FP methods in 2009 leaving UNFPA as the only significant donor. USAID pulled out of the country completely in 2013 at the government's request.

In summary, UNFPA has had to position itself within a shifting set of key development partners including bilateral donors and major national affiliates of international NGOs. UNFPA was an important player in terms of financial contributions in the period 2008-2012, especially after 2009 when USAID stopped providing contraceptive donations. Currently UNFPA is the only significant donor in FP in financial terms, and UNFPA also provides non-financial support as discussed in section 4 below. A more detailed analysis of the UNFPA contribution is presented below.

Sexual and reproductive health and family planning

The most recent official information on SRH and FP is the 2008 Demographic and Health Survey (DHS) (Coa, Ochoa et al. 2009), the new survey planned for 2013 having been delayed. Data from the national health information system (*Sistema Nacional de Información en Salud* (SNIS)), only covers the public sector and is not considered reliable due to under-reporting: MoH epidemiologists estimate under-reporting of up to 30 percent in hospitals and 15 percent in primary health care (PHC) facilities. The 2012 census data (Instituto Nacional de Estadística 2014) may also be unreliable due to pressure by municipal governments on migrant workers to return to their place of origin for

[11] Country Office financial data (Annex 4). Commodity spending is excluded to enable triangulation of the figures with the other data sources quoted.

the census, and possible double counting of maternal mortality due to the way the questions were phrased.[12]

DHS data shows that use of modern FP stagnated at 25 percent of women of reproductive age (WRA) between 2003 and 2008, although there was a slight increase in use of traditional methods from 16 to 18 percent in the same period, and the rate of use of modern methods amongst married women and women in union reached 35 percent. The government continues to promote natural methods in health facilities. Until 2013 there were only four modern temporary methods available in the public sector, two of them being short-term (pills and condoms) and two being long-term reversible methods (intra-uterine contraceptive devices (IUCDs) and injectables). In 2013 UNFPA supported the introduction of three new methods (female condoms, implants and emergency contraceptives) that are now also available in health facilities. Use of modern methods is lowest among rural women and those with lowest educational levels.[13] The most popular methods in 2008 were IUCDs and injectables, followed by female surgical sterilization. Unmet need for FP was 20 percent, and adolescent pregnancy rates were high (88 children per 1000 adolescents nationally, and 132 per 1000 in rural areas) and rising in the period 2003-2008 (DHS, 2009). The lack of up-to-date information on FP makes it difficult to monitor priority areas and assess the results of MoH work and the UNFPA contribution, as discussed in section 4.

Maternal mortality is high at 229 per 100,000 live births (DHS 2003 estimate). More recent official data is not available as the government does not recognise the 2008 DHS figure of 310 per 100,000 live births on the grounds that the sample was too small. The World Bank estimated 230 per 100,000 live births in 2010 dropping to 200 in 2013 (World Bank 2015). Causes of maternal mortality include unsafe abortion.[14]

HIV prevalence is low at 0.3 percent, and the epidemic is concentrated amongst the lesbian, gay and transgender community (20% prevalence in transgender groups in 2008), MSM groups (2008 prevalence 12%), sex workers and their clients (0.6% prevlance in 2008), and people who live on the streets (Ministerio de Salud y Deportes nd-a). There are high reported rates of condom use amongst sex workers and transgender people, although testing overall is very low in the general population. Knowledge of HIV among youth is also low at just under 30%. Risks of increasing prevalence are related to high levels of migrant labour crossing international borders, according to the MoH. Deaths from cervical cancer in Bolivia are the highest in Latin America (26 per 100,000 women of reproductive age) and infection with condyloma amongst men and women is high (Ministerio de Salud y Deportes and Organización Panamericana de la Salud 2009).

Principal problems in SRH and FP are high maternal mortality and adolescent pregnancy, low use of modern FP methods, and high rates of cervical cancer. Illegal abortion is also an important problem but reliable statistics are not available.[15] There are also special intercultural factors that need to be

[12] People were asked if there had been a maternal death in their family, and as a result more than one family member completing separate Census returns may have identified the same death.

[13] 2008 DHS figures show that the % of women interviewed [sic] who use modern methods is 22% for those with no education and 44% for those wih higher eduction; 26% of rural women and 40% of urban women; and 20% of those living in extreme poverty compared with 41% of those in the highest disaggregated income group (Coa, Ochoa et al. 2009: 78).

[14] *"In May 1996, the Health Minister unexpectedly proposed legalising abortion to lower maternal mortality"* (Rance 2003: 24). Rance also quotes the newspaper "Ultima Hora" as claiming that *"one woman dies each day from abortion complications"* (ibid.: 28), but hard data is not provided and the overall figure for maternal mortality suggests that this would be an over-estimate.

[15] A study by IPAS identified that 775 women were investigated for illegal abortions in the period 2008-2015, and the large majority of them were poor and indigenous (IPAS 2013). The number investigated is likely to be a very small proportion of the total number.

taken into account in provision of services for indigenous groups. Indigenous groups have their specific cosmovisions (UNFPA and FCI 2008), often attaching high prestige to fertility, and a different approach is needed to ensure services are acceptable and appropriate to their needs. Low levels of demand for FP in rural areas and amongst indigenous groups are exacerbated by supply-side problems of inadequate service provision and isolation due to long distances and poor communications.[16] Relatively sparse population density has led to pronatalism and political encouragement of a higher birth rate in some geographical areas and amongst some indigenous groups whose overall numbers are declining.[17]

Government policy on family planning:

The principal laws and policies relevant to family planning are shown in table 1 below, together with the key UNFPA strategic documents for Bolivia.

Table 1: Strategic Documents related to family planning

2010- 2020	National Health Policy Strategy and Plan
2013-2017	UNFPA Country Programme Fifth Cycle
2013 to present	Integral Attention to the Continuum of Life (*Atención Integrada a Continuo del Curso de la Vida* (*Continuo de Vida)*)
2006-present	National Development Plan – PND
2008-2012	UNFPA Country Programme Fourth Cycle
2009-2015	National Strategic Plan on Sexual and Reproductive Health
2009-2015	National Strategic Plan to Improve Perinatal, Neonatal and Maternal Health
2009-2013	National Comprehensive Adolescent and Youth Health Plan
2009-2015	National Plan for the Prevention, Control and Monitoring of Breast Cancer
2009-2015	National Plan for the Prevention, Control and Monitoring of Cervical Cancer
2002-2015	Universal Maternal-Infant Insurance (SUMI)
2010	National Standard on Contraception Rules, Protocols and Procedures
2009	Political State Constitution
2008	Strategic Multi-Sector Plan: National STI/HIV/AIDS Programme 2008-2012

The right to SRH and FP is incorporated in the National Constitution of 2009 and has also been included in departmental strategic development plans. Family planning was included in MoH's first National Programme for Sexual and Reproductive Health of 1999, although norms and protocols had existed before that time, and has been included in subsequent renovations of the programme in 2004 and 2009. Since 2006 it was incorporated in the SUMI which covers free services to women and girls, and is now included in the new insurance scheme, SIS, which has a wider coverage than SUMI. It is fully integrated with other services in the current *Continuo de Vida* protocol for service provision, and FP methods are included in the national list of essential medicines (UNFPA Bolivia 2015).

Although FP is fully incorporated into the relevant laws, policies and normative documents, there are still important political and social groups who oppose it at all levels of government and in the community. This is discussed in section 4.

[16] The GPRHCS facility survey for 2014 showed that 75% of primary health care centres have at least 3 modern methods available, whilst 50% of secondary level centres have at least 5 (UNFPA 2014c). However, any people in rural areas live far from any health facility, and in existing facilities there are problems of inadequate staff training in FP provision, as discussed in section 4.

[17] Information from interviews – see Annex 3

UNFPA responses

Overview

The 4th UNFPA Country Programme (CP) 2008-2012 (United Nations 2007) covered a large part of the period under evaluation, and the 5th Country Programme 2013-2017 (United Nations 2012) is currently being implemented. Both programmes address the principal SRH priorities in the country, including politically and socially sensitive issues such as FP and work with marginalised groups.[18]

The 4th CP had a total budget of US$15 million, US$6 million from core resources and US$9 million from non-core resources. Of the three focus areas (RH, Population and Development, and Gender) the RH component had the largest share of the budget at US$8.2 million. It was aligned with the MoH intercultural, family health and community-based model of service provision and proposed increased access to quality SRH services, reduction of early pregnancies and sexually transmitted infections (STI), support for exercise of sexual and reproductive rights, and support for development of school curricula for sexuality education. All CP components gave high priority to work with adolescents and young people. The Population and Development component aimed to strengthen implementation of planning and collection and use of population data, and the gender component was focused on rights issues and reduction of gender-based violence.

The Country Programme Evaluation (CPE) of 2012 concluded that the 4th CP strengthened national efforts in addressing adolescent pregnancies, maternal mortality and violence against women. It was also concluded that the 4th CP supported public policy development, led coordinated efforts by stakeholders in sexual and reproductive health and rights (SRHR), and strengthened national capacity development in the public and NGO sectors and in social movements. Information collected on the Country Office (CO) FP work during this case study triangulates well with the overall CPE conclusions.

The 5th CP has a slightly higher budget at US$16 million, of which US$7 million are core resources and US$9 million non-core resources. Following the changes in the UNFPA Strategic Plan 2012-2013 which specifically identifies FP outcomes, FP activities are specified separately in the 5th Bolivia CP with a budget of US$4 million, but they build on the bases established by the 4th CP. The FP component proposes increased access to quality services (especially for indigenous women) and increased capacity of users to demand high quality culturally appropriate services, again focusing on indigenous women. Work with adolescents and young people is included in a special component of the CP and focuses on sexuality education and strengthening the capacity of youth organisations to work in sexual and reproductive rights using a participatory approach. The principal new element in FP is the Global Programme for Reproductive Health Commodity Security (GPRHCS).[19]

Global Programme for Reproductive Health Commodity Security

Bolivia first received GPRHCS funding in 2010 and is now participating in GPRHCS Phase 2 (2013-2017). GPRHCS funds have been used for procurement, capacity building on the supply side through strengthening CEASS and the Unit for Medicines and Health Technology *(Unidad de Medicamentos y Tecnología en Salud* (UNIMED)), service provider training, and for other training and capacity building which the CO could not support before due to lack of funds.

Following a diagnostic of CEASS in 2010, UNFPA worked with the government to develop a plan for restructuring the organisation. Using GPRHCS funds, UNFPA made three major contraceptive donations during the evaluation period, the last two being used as seed capital to establish a

[18] The principal vulnerable and marginalised groups (VMGs) in Bolivia are: young people, indigenous groups, sexual minorities, the urban poor and people living in remote rural areas.

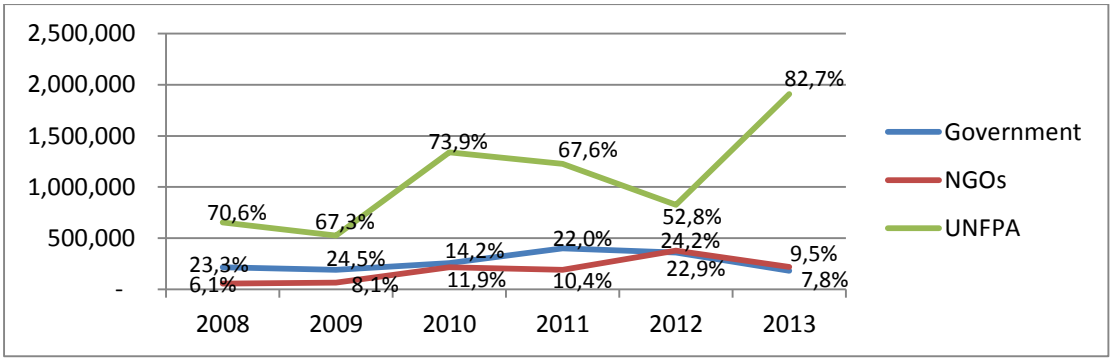
[19] GPRHCS is a multi-donor trust fund estabished in 2007. GPRHCS is a source of non-core funding for FP.

revolving fund for contraceptive purchase in CEASS.[20] It has also strengthened information systems and supply chain management. In 2013 UNFPA funded placement of long-term consultants within the organisation to strengthen its commercialisation activities and to monitor implementation of the contraceptive revolving fund. The contraceptive donations included introduction of three new FP methods – female condoms, implants and emergency contraceptives (EC). GPRHCS funds were used for some elements of programming for these new methods, including service provider training and a stakeholder conference on EC. The new methods have been included in information boards, murals and posters in the health facilities. Educational work has been carried out at political level where some groups think EC is equivalent to abortion, and at service user level, particularly for the female condom, the use of which is very different from the male condom. GPRHCS funds were also used to strengthen UNIMED in its training, monitoring and supervision of municipal pharmacies, in strengthening supply chain management systems and in development of the list of essential medicines (UNFPA Bolivia 2015). GPRHCS funds were also used for the national facility survey of FP supply and service provision (UNFPA 2014c).

Implementing partners

UNFPA has worked with implementing partners (IPs) in the public and NGO sectors including national and international NGOs and universities (see complete list in Annex 5), however its principal counterpart for SRH and FP work has been the government. During the period under evaluation, UNFPA implemented many FP initiatives itself due to lack of capacity in government, with growing participation from government and other IPs in implementation from 2010 onwards (see Figures 1 and 2).[21] UNFPA worked with the MoH and other ministries at central government level through its office in La Paz, and with departmental government, SEDES and municipalities through its departmental offices in Chuquisaca, Cochabamba and Potosí. Technical support and policy input to government at all levels are major areas of UNFPA FP work and have been financed by core funding. Projects with NGO IPs have focused on work with priority VMGs including adolescents, indigenous groups and sexual minorities mainly with funding from non-core resources.

Figure 1: UNFPA Support to Family Planning by Implementing Sectors (2008–2013)



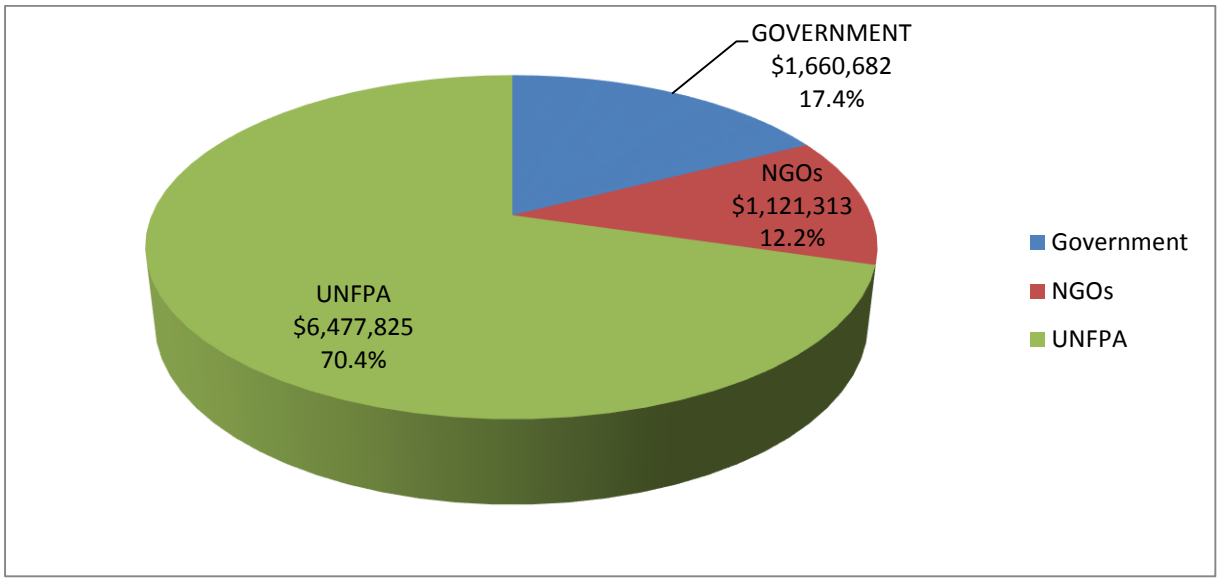
	2008	2009	2010	2011	2012	2013	TOTAL
Government	215,226	191,060	256,659	399,477	358,503	179,757	1,600,682
NGOs	56,443	63,442	215,389	189,058	378,777	218,203	1,121,313
UNFPA	652,624	524,270	1,339,698	1,226,979	825,562	1,908,692	6,477,825
	924,293	778,772	1,811,746	1,815,514	1,562,842	2,306,652	9,199,820

Source: UNFPA Bolivia Country Office

[20] Municipal governments purchase the contraceptive supplies from CEASS, which then uses the cash income to replenish its stock.

[21] Note that in 2013 UNFPA spending is high (at 82,7%) compared with previous years since it includes spending on commodities; the text above refers to non-commodity purchase family planning activities

Figure 2: Support to Family Planning, spending by implementing sector (2008–2013) (US$ million)



Source: UNFPA Bolivia Country Office

Annex 4 shows the estimated percentage of spending on FP within each project. Those with a high FP component (estimated at over 40 percent of total spending) are projects in adolescent SRH, emergency and humanitarian aid, health and sexual rights, demand promotion, access to services, and reduction in maternal mortality for indigenous women. Most projects are jointly implemented by UNFPA and the IPs. Although the public sector is the main partner in FP, the public and NGO sectors participate jointly in several major projects including adolescent SRH and rights, access to services and demand promotion which includes FP. The largest areas in terms of overall spending are adolescent SRH, SRHR, access to services, and provision of FP commodities. Availability of GPRHCS funds enabled the CO to intensify its work on the supply-side including procurement and capacity building in the supply chain, and training for service providers.

Family planning was included in the large majority of projects carried out by the CO during the period under evaluation. Annex 4 shows the estimated percentage of FP in each project. The only projects which were stand-alone FP were those funded by the GPRHCS.

UNFPA spending in family planning

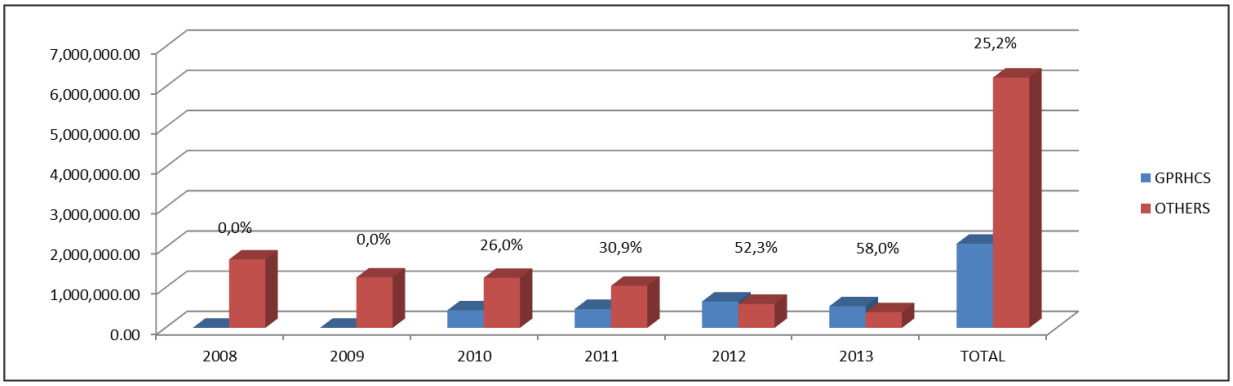
Analysis of ATLAS data shows a total of US$4.9 million specific FP spending[22] during the period 2008-2013, of which US$2 million is GPRHCS spending (41 percent of the total). The CO figure for GPRHCS spending (US$2.1 million) differs only slightly from the ATLAS total, which may be due to coding and time period differences in the databases.

The CO has estimated additional spending on FP within other SRH projects during the period under evaluation, giving a total of US$9.2 million for all FP (including GPRHCS) of which US$7 million was spent on FP activities other than commodity supply, and US$2.2 million was spent on contraceptive donations. Thirty-five percent of the total was core funding and 65 percent non-core funding (including GPRHCS funds for commodity purchase). GPRHCS non-commodity spending represented 30 percent of total FP spending over the whole period and grew steadily from 2010 to 2013. By 2012, GPRHCS non-commodity spending was the largest component of FP spending, and this position was maintained in 2013 with US$536,000 from GPRHCS and US$388,000 from other sources (see Figure 3). GPRHCS funding was used to cover a wide range of FP activities on both the supply and the demand side. The GPRHCS-funded contraceptive purchases were donated to the

[22] ATLAS codes U3 and GPRHCS (code ZZRT05)

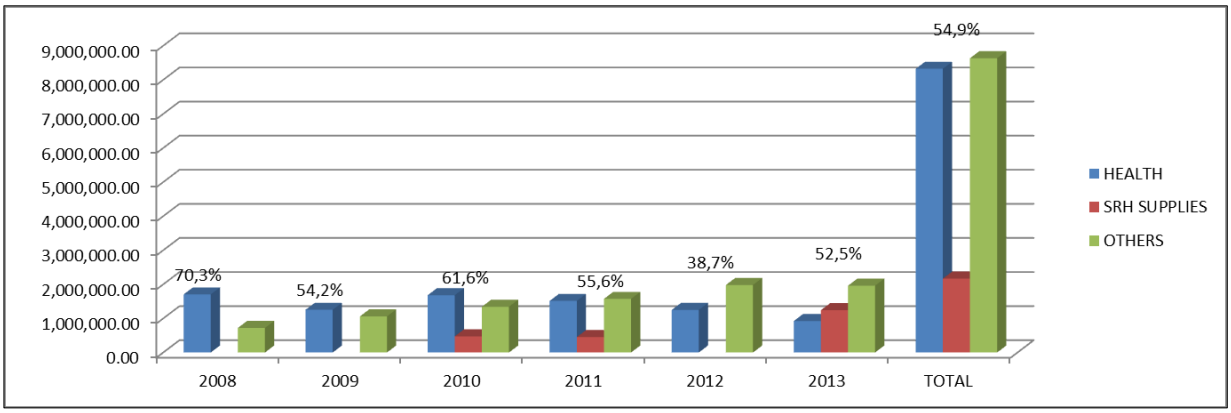
government in three tranches in 2010, 2011 and 2013 (Figure 3) and formed the seed capital for the rotating fund in CEASS. The projects which were 100 percent dedicated to FP (rather than including FP as a element of other SRH work) were funded by non-core resources (Annex 4).

Figure 3: Family planning spending comparing GPRHCS and other UNFPA funds (2008–2013)



Source: UNFPA Bolivia Country Office

Figure 4: Spending on SRH supplies compared with total CO spending on health (2008–2013)



Source: Bolivia UNFPA Country Office

Table 2 below puts the FP spending figures within the context of overall CO spending and SRHR spending. Taking into account differences due to coding processes, we can conclude that FP spending constituted about half of total UNFPA SRHR spending in Bolivia during the period under evaluation.

Table 2: UNFPA spending in Bolivia (2008-2013)

Type of spending	Amount US$ million	Source	Comments
Total UNFPA SRHR spending in Bolivia including CO institutional costs	19.8	ATLAS	Refers to all ATLAS outcome codes which may include a family planning component
Total UNFPA spending on SRHR projects	19.1	CO	Only includes project spending; excludes institutional budget
Spending on family planning dedicated projects and GPRHCS	4.9	ATLAS	Includes family planning (ATLAS U3) and ATLAS GPRHCS codes only

Total spending on family planning including: (i) family planning dedicated projects; (ii) GPRHCS and family planning components of other SRH projects	9.2	CO	Includes CO estimates of % of spending on other SRH projects which can be attributed to family planning (Annex 4)

Annex 4 provides more detail of spending on UNFPA SRHR interventions in Bolivia for the evaluation period (2008-2013), showing the FP component of other SRHR projects identified by the CO. In particulare, there are important FP components in programmes aimed at adolescent SRH and rights, gender, emergency relief, advocacy, and access to SRH services. Total spending on FP (excluding spending on commodities) was funded in approximately equal parts from core and non-core resources. It should be stressed that spending levels are only one indicator of the level of UNFPA effort, and it is important to note that much of the key UNFPA FP activities which involve on-going advocacy and capacity building with government are funded from core resources, whilst non-core resources are used for funding specific programmes with priority groups such as young people and indigenous groups.

4 FINDINGS

The country case study findings for each of the eight evaluation areas are shown in sub-sections 4.1 to 4.8 below. For each area, we first present an overview of progress and UNFPA responses in the period under evaluation, followed by an analysis of the contribution made by UNFPA. Each sub-section concludes with a paragraph relating the findings directly to the assumptions of the evaluation matrix presented in Annex 3. This approach allows the evaluation team to test the validity of the assumptions at country level, and facilitates synthesis of findings from the case studies and other data collection elements for the overall evaluation analysis and production of the synthesis report.

The findings presented build upon the information collected during fieldwork and document review; they also take into account feedback and comments from UNFPA Bolivia CO and other stakeholders. Points in the text are referenced through footnotes to the corresponding section of the Evaluation Matrix. Annex 3 shows the key data on which the analysis was based, ordered by evaluation area and by assumption.

The case study was designed to provide input and illustrative examples for the eight evaluation areas. It does not aim to assess the performance of the Bolivia CO in relation to the family planning (FP) outputs of the two country programmes which span the period under evaluation.

4.1 Integration of family planning with other sexual and reproductive health services

Q1) To what extent has UNFPA supported integration of family planning with maternal health, HIV/STI and GBV services in health plans and at primary health care level, in services for adolescents, and in emergency and humanitarian situations?
Summary of the relation between the findings and the assumptions of the evaluation matrix: • UNFPA and partners agree on the meaning and importance of service integration, and are aware that levels and types of integration vary and are contextual. • UNFPA has stimulated and supported integration at policy level and in service provision, however there are still problems in full implementation.

- There is insufficient data to come to a firm conclusion on improvements in access and service quality.

Progress and activities

Family planning has been integrated with sexual and reproductive health (SRH) services at ***policy level*** since the first National SRH Programme of 1999, and has continued to be included in the subsequent SRH plans and policy documents. It is integrated with other SRH services in the Ministry of Health (MoH) 2012 *Continuo de Vida* protocol that was developed by the MoH with support from UNFPA, UNICEF and PAHO and is now being implemented throughout the country.[23] The protocol embeds family planning (FP) in an approach which integrates health service provision through the different stages of life, and includes FP in adolescent services, maternal health, post-partum and post-abortion services.

Full integration of FP with ***HIV services*** started in 2009. Family planning is now included in the HIV service protocols and condoms are being promoted for "triple protection" against HIV and other sexually transmitted infections (STIs), unwanted pregnancy and cervical cancer. This is an innovative approach to encourage men to use condoms, taking advantage of concerns over the high rate of condyloma and cervical cancer in Bolivia and the protection which can be offered by condom use.[24] Men have not been able to get free condoms from health facilities under the national heath insurance scheme, despite extensive advocacy by UNFPA, and inclusion of condoms in the HIV and AIDS programme is an important means of providing one means of access to FP for some but not all men. The programme is focused on lesbian, gay, bisexual and transgender people (LGBT), but a 2008 survey showed that 40 percent of men who have sex with men (MSM) are bisexual and have female partners and therefore get double protection from condom use (Ministerio de Salud y Deportes nd-a). The HIV programme also carries out promotional work with the general population.

Family planning is integrated into protocols for support to survivors of ***gender-based violence*** (GBV), and methods considered appropriate for humanitarian and conflict situations[25] have been included in UNFPA emergency kits for humanitarian assistance since 2008.[26] Although emergencies in Bolivia are generally due to natural disasters rather than conflict, more commonly used FP methods such as pills and injectables are not included in the emergency kits. The methods included are male and female condoms and emergency contraceptives (ECs), which are designed to protect women from pregnancy and HIV due to sexual violence rather than provide on-going supplies for normal use.

The Ministry of Education has developed a plan to integrate ***sexuality education*** into the school curriculum at national level (*Plan Plurinacional en Educación Sexual Integral*), which provides guidance to the departmental level which is responsible for implementation. Family planning has now been integrated by the Ministry of Education into the school curriculum for sexuality education in some departments (see for example *Dirección Departamental de Educación de Chuquisaca*, 2011), but has not been fully implemented at national level.[27]

Although norms and protocols for integration are in place, implementation depends on the capacity and willingness of health staff to integrate ***service provision at facility level***. Health staff have received extensive training but the way services are integrated in practice depends on the

[23] Assumption 1.1, Annex 3

[24] Assumption 1.4, Annex 3. Condyloma is transmitted sexually and men have been interest in the message that condoms can protect against condyloma

[25] Emergency contraception to avoid unwanted pregnancy incuding pregnancy resulting from rape, and male and female condoms to prevent HIV.

[26] Assumption 1.3, Annex 3

[27] Assumption 1.3, Annex 3

management of each facility. In smaller facilities with one or two staff, the same person can provide an integrated service, but in larger facilities users are referred between departments.[28] The *Continuo de Vida* protocols have not yet been implemented in all facilities, and user perceptions of the benefits of integrated service provision in terms of access to FP and quality of services have not been evaluated yet.[29] Divergent opinions on the level of integration in public sector facilities were expressed in focus group discussions with users and visits to health facilities (see below).

Contribution of UNFPA to family planning outputs and outcomes

UNFPA has been a major contributor at national and departmental levels in the ***development of protocols*** for integration since the first national programme for SRH in 1999. More recently it has worked with the other relevant United Nations agencies (PAHO and UNICEF) on support for development of the national *Continuo de Vida* protocol, and has provided technical support to the Departmental Health Services *(Servicios Departamentales de Salud* (SEDES)*)* for development of departmental protocols for integrated service provision. National partners, MoH and the other UN agencies recognise that UNFPA played the leading role in development of the *Continuo de Vida*.[30] UNFPA worked closely with the Ministry of Education on the school curriculum for adolescents and made an important technical and financial contribution to curriculum production. UNFPA developed the new concept of "triple protection" in the HIV programme and has actively promoted integration and distribution of condoms to ensure there is a channel for men to get them free. This is an innovative contribution in a field where UNFPA has been working throughout the period under evaluation.

Although protocols for integrated services have been developed there are still ***weaknesses in implementation*** due to lack of trained staff and political will in some departments where key leaders do not support FP for religious, political or cultural reasons. UNFPA has contributed to implementation through support for training in the public sector including training of trainers (TOT) (expected to be the first step in cascade training to cover all health facility staff) and has directly supported non-government organisations (NGOs) (e.g. CIES, MSI) for delivery of integrated FP and SRH services.[31] The results and effectiveness of training in the public sector have not been measured. High staff rotation in the public sector means that in any case training has to be repeated frequently. UNFPA carries out continuous advocacy through its contacts with the MoH at central and departmental levels to overcome lack of political will for integration of FP with other SRH services.

UNFPA has advocated the integration of FP with SRH services for adolescents and has contributed to demand creation through support to departmental and national adolescent networks such as the Adolescent and Youth Committee for Prevention of Adolescent Pregnancy *(Comité Adolescente y Jóven para la Prevención del Embarazo en Adolescentes* (CAJPEA)). On the supply-side UNFPA has been instrumental in development of integrated and differentiated services for adolescents through policy and programmatic support for the MoH in staff training and development of facilities for youth-friendly service provision.[32] UNFA has also worked with the Ministry of Education at national and departmental levels to develop the sexuality education curriculum, and has provided direct support at departmental level in Chuquisaca through the UNFPA sub-office.

UNFPA has also contributed in a sustainable way to service integration through working with three universities to include FP in ***professional training curricula*** for *obstetrices* (equivalent to graduate nurses or professional midwives). The first students graduated in 2012 and teaching staff are

[28] Assumption 1.1, Annex 3
[29] Assumption 1.4, Annex 3
[30] Assumption 1.1, 1.3, Annex 3
[31] Assumption 1.3, Annex 3
[32] Assumption 5.1, 5.2, Annex 3

enthusiastic that this is a long-term contribution to service integration as the *obstetrices* will be front-line service providers who can integrate FP fully into their SRH and maternal health work.[33]

UNFPA has made an important contribution to integration of FP into SRH services, adolescent education and services, services for survivors of gender-based violence and humanitarian support services through its advocacy and its technical support for development of policies and protocols. Its contribution to implementation has included training in the public sector and financial support to NGOs for service delivery. The effect of the contribution at output and outcome levels cannot be measured in the absence of reliable data from the national health information system (*Sistema Nacional de Información de Salud* (SNIS)), or demographic health survey (DHS);[34] to date UNFPA has not developed alternative means for measuring results.

The extent of integration of FP with other SRH activities by UNFPA itself is illustrated by the spending figures shown in Annex 4. About half of overall spending goes on integrated FP-SRH projects.

4.2 Coordination and national ownership

Q2) To what extent has UNFPA successfully contributed on its own and in coordination with others to strengthening national leadership of family planning and improving sustainability?
Summary of the relation between the findings and the assumptions of the evaluation matrix: • UNFPA has actively supported mechanisms to raise the profile of family planning at national and at decentralised levels. • UNFPA and other development partners have supported national ownership, UNFPA playing a strong leadership role, but outcomes have varied in different departmental and municipal contexts. The exit of USAID makes the role of UNFPA more challenging. • UNFPA has made an important contribution to cultural and social sustainability through its empowerment of indigenous groups and adolescents. It has adapted its strategies to variability in the political environment and to the facts that government has taken leadership but not clear ownship at all levels, and is still ambiguous about FP for political reasons. Sustainability of commitment and ownership is and will be an on-going process at all levels of government.

Progress and activities

The Constitution of 2009 includes provisions for sexual and reproductive rights which opened the door for development of laws and policies for FP at national and departmental levels. Family planning was included in the universal maternal-infant health insurance scheme *(Seguro Universal Materno Infantil* (SUMI)) which has provided free services in the public sector since 2006 and is now included in the Integrated Health Insurance *(Seguro Integral de Salud* (SIS)), a broader national heath insurance scheme which has replaced SUMI. These developments demonstrate government ownership and leadership at national and departmental levels in the policy and legal environment. There is still however a ***lack of commitment*** by all political groups to fully implement the laws and policies with repercussions on government ownership at national and decentralised levels.[35]

With administrative decentralisation in Bolivia, municipal governments have an important role in resource allocation and funds flow for health services. The municipalities are responsible for purchase of contraceptives through the SUMI/SIS system, and their effective commitment to FP is

[33] Assumption 8.1, Annex 3
[34] Assumption 4.1, Annex 3
[35] Assumption 2.2, Annex 3

essential to avoid stock-outs.. To encourage government ownership at municipal level, the national MoH, with UNFPA support, has mounted workshops for the Federation of Municipal Mayors and municipality staff who are responsible for the administration of FP services, yet lack knowledge and experience and, at times, political will to promote implementation.[36]

UNFPA participates in ***coordinating mechanisms*** at national and departmental levels which bring stakeholders and development partners (DPs) together to support the government on SRH issues. The two principal mechanisms are the working group on maternal mortality *(Mesa de Maternidad y Nacimiento Seguro* (MMNS)) established in 1996 (MMNS, undated) which is led by the government and includes donors and NGOs, and the working group adolescent sexual and reproductive rights (*Mesa de Derechos Sexuales y Reproductivas)* which is formed by 54 civil society organisations. The *Mesas* include FP in their agenda, covering service provision issues and implementation of a rights-based approach. UNFPA has been a leading member of the MMNS and has supported its research on maternal mortality at national and departmental levels. It provides technical assistance for the *Mesa de Derechos Sexuales y Reproductivos*. Historically UNFPA has provided financial support for both *Mesas*, but is currently reducing its support to encourage others to do their share (UNFPA Bolivia 2015).[37]

In the period under evaluation UNFPA has also coordinated with DPs including United States Agency for International Development (USAID), Spanish Agency for International Development Cooperation (*Agencia española de cooperación internacional para el desarrollo* (AECID)), International Planned Parenthood Federation (IPPF), international non-government organisations (INGOs), national networks and NGOs, and other UN agencies on FP initiatives. Much of this work has been focused on advocating, supporting and sustaining government ownership and leadership.[38]

UNFPA contribution to results on government leadership and sustainability

UNFPA (alone and in coordination with others) has contributed to government leadership at national level through its support to the development of laws and policies that include FP provisions, most recently the 2009-2015 National Strategic SRH Plan and the *Continuo de Vida* protocol. It has provided technical input and financial support to government and, as already indicated, it has been the principal supporter of the two stakeholder coordination mechanisms (*Mesas*).[39] UNFPA has been the principal external agency promoting and supporting FP since USAID left Bolivia in 2013.[40]

Government, DPs and civil society see UNFPA as a friendly helping agency which does not impose its criteria and ideas but provides technical and material support when necessary and appropriate. This is an important achievement in the Bolivian political environment as FP is a sensitive topic which is said to have imperialist connotations, and was especially difficult during the early part of the period under evaluation when lack of national implementation capacity meant that UNFPA had to implement many programmes itself.[41]

UNFPA has contributed to the promotion of FP ownership by government at departmental and municipal levels through support to MoH workshops and training related to the decentralisation process, ensuring that FP was included and that governments at decentralised level are able to implement programmes. UNFPA has also worked with the MoH and the Federation of Municipal

[36] Assumption 2.2, Annex 3

[37] Assumption 2.1, Annex 3

[38] Assumption 2.1, Annex 3

[39] Historically, UNFPA has provided financial support for both *Mesas*, but is currently reducing its support to encourage others to do their share (UNFPA Bolivia 2015).

[40] Assumption 2.1, Annex 3

[41] Assumption 2.1, 2.2, Annex 3

Mayors to strengthen links between municipal governments and the departmental health services (SEDES) through training and workshops.[42]

Although national ownership of FP is embodied in the laws, policies and the basic health package, there is lack of commitment by the central government to promote FP. There are also important political groups that actively oppose FP at all government levels and in some communities. These include pro-natalist groups who feel that Bolivia needs a higher population, and some traditional indigenous leaders in areas where fertility is highly esteemed. UNFPA has adjusted its activities and working strategies to enable it to continue to contribute in less favourable circumstances, positioning FP as a method to reduce maternal mortality and reduce the high rate of growth of adolescent pregnancy, both of which are key priorities in Bolivia.[43] To counteract opposition which results from lack of information on the implications of early pregnancy, short birth spacing and high fertility for women and children's health, UNFPA has contributed to awareness-raising through advocacy with departmental government and training for municipalities. To promote ownership at community level, UNFPA has financed training of MoH and NGO service providers in counselling, to ensure better understanding of FP in the community. Through its work with communities and NGO development partners,[44] UNFPA has also taken the lead in support for research and service delivery programmes for key indigenous groups.

In an unfavourable political environment UNFPA has worked towards sustainability of government ownership and leadership through advocacy and technical support whenever laws and policies are renewed. This work, together with permanent support for training due to staff rotation in the public sector, is an important contribution to ensure continuation of a rights-based approach to family planning. UNFPA contributions to work with adolescents and indigenous groups have been based on empowerment of these groups (see section 4.5), which increases their social sustainability.[45] The most important contributions of UNFPA to sustainability have been in the areas of cultural/social sustainability and advocacy to reduce political opposition.

4.3 Brokerage and partnerships

Q3) To what extent has UNFPA acted as a broker at global, regional and country levels to promote family planning, acting in partnership with the public, private and non-state sector service providers?
Summary of the relation between the findings and the assumptions of the evaluation matrix: • UNFPA has been an important broker of relationships for family planning work between different ministries and levels of government, and between government and the NGOs sector; it has been selective in its support to NGOs choosing those which work in its priority areas, and which do not prejudice its neutral and apolitical position.[46] • UNFPA has a high profile and sufficient visibility at country level to broker these relations and has used its position effectively.

Progress and activities

The *Mesa de Maternidad y el Nacimiento Seguro* and the *Mesa para los Derechos Sexuales y Reproductivos* are the two principal mechanisms for in-country coordination between non-

[42] Assumption 2.2, Annex 3

[43] Assumption 2.2, Annex 3

[44] Assumption 2.2, Annex 3

[45] Assumption 2.3, Assumption 5.4, Annex 3

[46] This does not refer to the "social organisations" (in the Bolivian context this refers to indigenous and grassroots organisations), Annex 3

government stakeholders and the MoH. These mechanisms have facilitated contacts between government, DPs and civil society organisations (CSOs) and are important forums for discussion of new policies, norms and protocols. UNFPA has played a leading role in encouraging stakeholder participation in meetings, discussions and joint activities in both forums. It has also provided financial and material resources and has participated in joint research programmes, such as the current national study of maternal mortality.[47]

Within the government structure there is coordination between relevant ministries on specific areas related to FP. Development of the school curriculum on sexuality education was a coordinated effort of MoH and Ministry of Education; work on gender and sexual and reproductive rights was developed jointly by MoH and Ministry of Justice; the inclusion of population issues in national development plans was coordinated by MoH and Ministry of Planning and Development; and MoH and Ministry of Autonomy have worked together on implementation of FP at departmental and municipal levels. At departmental level the Departmental Health Services *(Servicios Departamentales de Salud* (SEDES)) coordinates with the Ministry of Education and works with CSOs in FP issues through the departmental *Mesa de Maternidad y Nacimiento Seguro*.[48]

Within the MoH there is coordination between the different programmes and agencies which include FP on their agenda (Central MoH, SEDES, HIV programme, Central Health Supplies Organisation *(Central de Abastecimiento y Suministros de Salud* (CEASS)). The HIV programme now purchases its condoms through CEASS.[49]

Contribution of UNFPA to results in brokerage and promotion of family planning

The leadership role played by UNFPA in the two coordinating forums referred to earlier is widely recognised by all members; they give UNFPA credit for linking organisations that would not otherwise have worked together to promote SRH and FP. NGOs consider UNFPA to be a key organisation to represent the forums, enabling their voice to be heard at government level ("*UNFPA knows how to support government and negotiate*").[50] It has brokered working relations between the MoH and the large FP NGOs (Marie Stopes International (MSI) and Centre for Research Education and Services *(Centro de Investigación Educación y Servicios* (CIES)) who now carry out FP training for government health staff. UNFPA has been selective in its support for NGOs to avoid prejudicing its neutral and apolitical position with the government. It has supported large SRH specialist service delivery NGOs which have capacity to work with government or to reach under-served groups, and NGOs who focus on priority groups for UNFPA such as adolescents and indigenous groups rather than those which have a political agenda.[51]

UNFPA has been a key actor in brokering and fostering joint promotion of FP by the ministries of health, education, justice, autonomy, and planning and development through working with the ministries on the school sexuality curriculum, gender equality laws, and population and development planning.[52]

UNFPA has also carried out important brokerage functions between different areas of the MoH, linking the HIV programme with the CEASS FP procurement system.[53] This increases cost-efficiency and also ensures that men (who were not eligible for FP methods under the SUMI system which only

[47] Assumption 2.1, Annex 3
[48] Assumption 3.2, Annex 3
[49] Assumption 1.3, Annex 3
[50] Interviews with NGOs
[51] Assumption 3.2, Assumption 2.1, Annex 3
[52] Assumption 3.2, Annex 3
[53] Formerly condoms for the HIV programme were not procured through the CEASS system.

covered women and children) have some access to free condoms during promotional fairs and campaigns run by the HIV programme, although they still cannot receive them directly in health facilities. UNFPA intervention and brokerage activities have accelerated the process ("*UNFPA facilitated early integration of family planning with HIV services, although the HIV programme would probably have done it themselves in the end*").[54] UNFPA has also brokered training programmes sponsored by the central MoH for municipalities to ensure the latter have the necessary information and skills to promote FP at decentralised levels. UNFPA has provided material support and carried out advocacy at municipal level to obtain acceptance of the training.[55]

UNFPA has brokered cooperation between relevant UN agencies (UNFPA, PAHO and UNICEF) that carried out joint research to inform the *Continuo de Vida* protocol. Presenting a concerted front has given the UN agencies more leverage with government to promote SRH and FP. UNFPA has also coordinated integration of FP work with the World Food Programme in humanitarian situations.[56]

There is an important gap in brokerage of public-NGO-private sector cooperation in commodity supply. USAID sponsored the Reproductive Health Commodity Security Committee (*Comité de la Disponibilidad Asegurada de Insumos Anticonceptivos* (DAIA)) which was set up in 2004. The DAIA activities were discontinued early in the period under evaluation (2008) due to changes in MoH policies (Bertrand 2011). UNFPA has not followed up the DAIA initiative[57] and the principal private sector FP provider PROSALUD (the USAID social marketing partner) has continued its work independently. Lack of joint work between government, NGOs and private sector to advance national procurement and initiate a total market approach (TMA) affects the long-term sustainability of FP programmes, as CEASS needs a larger procurement volume and market in order to obtain cheaper prices and maintain its revolving fund.[58]

4.4 Enabling environment

Q4) To what extent has UNFPA supported the creation of an enabling environment at national and community levels to ensure family planning information and exercise of rights?
Summary of the relation between the findings and the assumptions of the evaluation matrix: • UNFPA has identified key enabling factors at policy and implementation levels, but has been more successful in strengthening them at policy level. In particular, UNFPA has developed a successful strategy for acceptance of family planning at policy level. Devolution of decision-making means that there are challenges for UNFPA support to implementation in departments and municipalities that are less committed to FP. • UNFPA has supported partners for demand creation but the effectiveness of that support cannot be measured due to lack of national data.

Progress and activities

Key elements of an enabling environment in Bolivia are the legal and policy framework, the political environment and community attitude.

As discussed in previous sections the ***legal and policy environment*** are favourable for FP, but there have been problems in putting laws and policies into practice. During the period under evaluation,

[54] Key informant interview

[55] Assumption 2.2, Annex 3

[56] Assumption 1.1, Annex 3

[57] The CO reports that a new initiative to coordinate procurement and supply chain activities is currently being developed by the Regional Office LACRO.

[58] Assumption 8.5, Annex 3

the political environment has been complex due to changing levels of support for FP at different governmental levels (central, departmental and municipal) and at different points in time.[59] The political environment has been further complicated by the administrative structure and decentralisation of responsibility for implementation of health programmes including FP to departmental and municipal levels. Whilst all departments have the same basic health structure, each has autonomy in fixing programme priorities and in developing strategies to implement policy.[60]

At central government level, there has been political support for FP from some quarters but this is not generalised and there are some influential conservative and indigenous groups in the national parliament that continue to promote population growth in order to increase the population density of the country. As a result, the government does not prohibit FP but neither does it actively promote it. Similarly, some departmental governments support FP but others are at best lukewarm, and some cases have been reported of active opposition to FP by departmental governments.[61]

These ambiguous attitudes percolate down through the heath service and there has been little incentive for heath workers to actively promote FP and create demand. Health staff lack training in service provision (many cannot insert intra-uterine contraceptive devices (IUCDs) or implants) and counselling, which reduces service quality. Insufficient dissemination of information at community level has also led to negative attitudes towards health providers who promote FP ("*Community members thought the health staff were trying to stop them having children*").[62] As the political environment has been unfavourable towards CSOs, there are few NGOs apart from CIES and MSI with capacity to work on promotion and information dissemination at community level.[63]

UNFPA contributionto the development of an enabling environment for family planning information and exercise of rights

UNFPA clearly identified the key elements of an enabling environment and has been a leading protagonist of inclusion of FP in health laws and policies and in the social security scheme, but implementation has been a challenge. In the absence of full acceptance of FP at political level, UNFPA has promoted it as a means of reducing maternal mortality and teenage pregnancy, both of which are high priorities countrywide. This has been an effective strategy and has contributed to better acceptance of FP.[64] UNFPA has worked with the MoH to strengthen understanding of FP at all levels and to encourage commitment at municipal level, much of this work being carried out by the UNFPA staff at departmental level who are active in advocacy work and provide technical support. However there were and still are major problems to be overcome in service quality due largely to lack of trained staff and poor access to facilities, and in demand creation due to insufficient promotion of FP by service providers.[65]

UNFPA has contributed to FP promotion and demand creation through advocacy and training with social organisations, municipal health councils and youth organisations. However, the direct contribution of UNFPA to demand creation during the period under evaluation was limited to programmes carried out through NGOs with specific high priority groups, including adolescents and indigenous groups, and production of promotional materials for the MoH. UNFPA is now working

[59] Assumption 4.1, Annex 3

[60] Assumption 4.1, Annex 3

[61] Cases reported in interviews include public statements opposing family planning by departmental health leaders, and prohibition of provision of family planning to some small indigenous groups to maintain population numbers.

[62] Interviews SEDES

[63] Assumption 4.1, Annex 3

[64] Assumption 4.1, Annex 3

[65] Assumption 4.2, Annex 3

with the MoH to develop the National Promotion and Communications Strategy, which is specifically aimed at addressing demand creation.[66] UNFPA has financed and provided technical input for training in FP service provision and counselling to improve quality, but there is no reliable information to measure the effectiveness of this work in demand creation.[67] The most recent demographic health survey (DHS) was carried out in 2008. Furthermore, there is a high level of under-reporting in the national health information system (SNIS), and the recent census contains little information relevant to FP. Finally, information on procurement of contraceptives cannot be used as an indicator as figures are only available for the public sector, and procurement does not reflect actual levels of use.[68]

During the period under evaluation, UNFPA has focused its work on strengthening the enabling environment at policy level, with a ***limited contribution at programmatic level***. UNFPA has supported specific studies such as those of the SRH needs of adolescents and indigenous groups cited earlier. However, in common with other development partners, UNFPA has not supported development of methods to overcome the lack of reliable data at national level, and information is not available to measure results of this work or its impact on the availability of FP information and the exercise of rights to use services. Production of such data is essential for strengthening knowledge management. The GPRHCS facility surveys which started in 2014 (UNFPA 2014c) will provide some much-needed up-to-date data for decision-makers.

4.5 Vulnerable groups and marginalised populations

Q5) To what extent has UNFPA focused on the family planning needs of the most vulnerable and marginalised groups, including identification of needs, allocation of resources, and promotion of rights, equity and access?
Summary of the relation between the findings and the assumptions of the evaluation matrix: • UNFPA has carried out important work on identifying needs of VMGs and has developed good practices to address them, with a particular focus on young people and indigenous groups and taking into account cultural and societal beliefs. • UNFPA has supported programmes specifically targeting key vulnerable and marginalised groups with effective strategies to meet their needs. • UNFPA has effectively promoted reproductive rights at all levels and has supported capacity building and empowerment which improves access for VMGs. • UNFPA has pioneered and has been a lead agency in supporting active participation by VMGs in all stages of programme development. • UNFPA has not developed information on improvements in access and utilisation of services; such information/data is not available nationally from any source at present. However, information collected in the evaluation indicates that access and utilisation have improved for participants in programmes supported by UNFPA.

Progress and activities

The principal vulnerable and marginalised groups (VMGs) in Bolivia are: young people, indigenous groups, sexual minorities, the urban poor and people living in remote rural areas. These groups have difficulties accessing services and exercising their rights to FP due to distance and poor accessibility of services, stigma or service provider bias, as well as cultural and social traditions. These latter

[66] Assumption 4.2, Annex 3

[67] Assumption 4.2, Annex 3

[68] Assumption 4.1, Annex 3

especially affect access for indigenous women and young people.[69] UNFPA has supported programmes for VMGs through the public sector and NGOs, at national, departmental, municipal and community levels. Work with VMGs is one of the special strengths of the UNFPA Bolivia programme.[70] UNFPA has developed a body of research and evidence on the FP needs of VMGs, in particular adolescents and young people, indigenous groups and sexual minorities.[71]

The rights of VMGs to appropriate FP services are now widely recognised outside the government, and at all levels of the MoH.[72] However there are still important obstacles for VMGs in exercising their rights due to supply-side problems (lack of high quality accessible services adapted to their needs) and to cultural, social and traditional obstacles on the demand-side which restrict access for VMGs (for example, community censorship of FP for unmarried young people; traditional prestige for high fertility in some indigenous groups).[73] Work is now in progress in the public and NGO sectors to improve access for young people through staff training, promotion and provision of differentiated youth-friendly services, and NGOs have worked with UNFPA in development and delivery of FP programmes for indigenous groups in remote communities.[74]

UNFPA contribution to family planning needs of VMGs

UNFPA has made a major contribution to family planning work with VMGs by supporting programmes that meet their needs, ensuring high levels of participation, and having potential for scale-up. Examples include community-based programmes to improve FP for indigenous women in different parts of the country, and work with youth networks to provide FP information and advocacy training. UNFPA has raised the level of awareness of VMG rights to FP services amongst both service providers and VMGs themselves, and has identified better ways to help VMGs exercise those rights (for example, UNFPA has supported programmes which empower adolescents, indigenous women and transgender women and promote informed discussion of their rights).[75] UNFPA has developed quality research which has been recognised by professional bodies (e.g. the research team of the Bolivian Society of Gynaecologists and Obstetricians)[76] and has been widely disseminated in the country and used to advocate for better access to appropriate services by UNFPA and by VMGs themselves. Notable examples are the transsexual national women's organisation *Mesa de Trabajo Nacional* and the Adolescent and Youth Committee for Prevention of Adolescent Pregnancy *(*Comité Adolescente y Joven para la Prevención de Embarazo en Adolescentes (CAJPEA)) who are now active in advocacy for better access to quality services. There has been limited dissemination of the research results to other parts of UNFPA, although there is much that other COs could learn from experiences in Bolivia.[77]

UNFPA has been a leading actor in keeping the rights of VMGs high on the public agenda, and in supporting programmes that ensure participation by VMGs in the early stages of design and implementation thereby enabling them to take the lead themselves ("*UNFPA has helped us take the first steps so we can fly on our own*").[78] UNFPA is recognised by VMGs and other stakeholders as a leader in developing horizontal relations with VMGs and as being the first development partner to

[69] Assumption 5.1, Annex 3
[70] Assumption 5.2, Annex 3
[71] Assumptions 5.1, 5.4, Annex 3
[72] Assumptions 5.1, 5.3, Annex 3
[73] Assumptions 5.1, 5.5, Annex 3
[74] Assumptions 5.2, 5.4, Annex 3
[75] Assumptions 5.2, 5.3, 6.5, Annex 3
[76] Assumptions 5.1, 7.4, Annex 3
[77] Assumption 5.1, Annex 3. See discussion of RO role in section 4.9
[78] Assumptions 5.3, 5.4, Annex 3; Interviews with youth representatives and NGOs

"*treat them as participants not as beneficiaries*".[79] UNFPA funding and support for work with sexual minorities such as transsexual women in the organisation *Mesa de Trabajo Nacional* has provided important leverage for sexual minorities to raise funds and support on their own terms from other donors. Work with young people has included support for establishment of the young people's network CAJPEA at departmental level which later expanded its advocacy and promotion to the national level. UNFPA has also contributed to the development of differentiated services for young people in the MoH through advocacy for policy change and technical input for implementation.

Pioneer work to empower women and increase participation in a culturally sensitive way has been carried out by UNFPA with many indigenous groups foucsing on promoting rights and access to services and serves as a model for future work.[80] For example, the regional programme carried out by FCI and jointly funded by UNFPA and AECID (described in the annex) has provided methodological models focused on high levels of participation and ownership. UNFPA work on introduction and development of a gender focus and an inter-cultural focus in its work with VMGs is recognised by stakeholders as a pioneering contribution in the national context.[81]

In the absence of reliable data on service use and user satisfaction, the impact of programmes on access for VMGs cannot be measured. However, information from interviews and focus groups suggests that access has improved. For example, young people have more information and feel more comfortable using the differentiated services, obstacles due to provider bias are being reduced for sexual minorities, and indigenous women are using FP even where traditional community attitudes or local government policy are unfavourable (see box):

> *Our parents still consider it taboo to talk to their children about sexuality*
>
> *The men still think family planning means loose living, so I don't tell my husband I'm using a method*
>
> *The best thing [about the differentiated services] was the information and knowledge of the benefits of family planning; this should be more widely promoted, everyone should have the opportunity to know*
>
> *The nurses advised me to start using family planning after my last baby was born, and I feel much more secure*
>
> *In some rural areas people are two-faced: on one hand they say family planning is good for women, and on the other they don't accept it because it goes against the Church and traditional beliefs.*[82]

UNFPA, NGOs and the MoH recognise that there are still major obstacles to overcome on the supply side, including poor availability of appropriate services and trained staff in the public sector. This is especially difficult in remote areas where many indigenous groups live due to difficulties in recruiting and retaining experienced staff.[83]

[79] Assumptions 5.3, 5.4, Annex 3
[80] Assumptions 5.1, 5.2, 5.4, Annex 3
[81] Assumptions 5.2, 5.4, Annex 3
[82] Comments from FGD with users
[83] Assumption 5.5, Annex 3

4.6 Human rights based approach

Q6) To what extent has UNFPA implemented a human rights-based approach to family planning, in particular regarding access to and quality of care, and through support from HQ and RO for a rights-based approach in country?
Summary of the relation between the findings and the assumptions of the evaluation matrix: • UNFPA, national government and NGOs partners share a common understanding of a HRBA to family planning; UNFPA and some NGO partners share a more holistic understanding including empowerment, participation and non-discrimination. • There is variability in understanding of the HRBA at departmental government level and at service provider level. • Programming incorporates human rights principles. • UNFPA has started developing evidence on HRBA for specific groups and has opportunities to expand this evidence base through analysis of its work with IPs. • Anecdotal information suggests that rights holders and duty bearers are becoming more aware of SRH and family planning rights.

Progress and activities

Discussion of a human rights-based approach to family planning has emerged in Bolivia during the last ten years. Previously it was considered a health service rather than a right, and a means to save lives through prevention of unwanted[84] pregnancies and birth spacing.[85] The right to FP is incorporated in the National Constitution and relevant MoH policies, but as discussed earlier there is an important gap between policy and practice and users' rights are not fully recognised by all public sector authorities and service providers.[86]

Although services are available in most public sector health facilities and are included in the national health insurance scheme, not all MoH and departmental health authorities support or promote FP, there is little community-based promotion, and service providers are not well trained in counselling or a rights-based approach.[87] Their capacity to offer a full range of FP methods and counsel on their relative advantages so users can take their own decisions is limited, and they do not always see access for all users to a full range of quality voluntary services as a right that should be respected. The right to access for young people, indigenous women and other marginal groups is also limited by community-level taboos and in some cases by political will.[88]

The UNFPA human rights-based approach (HRBA) to programming is described in the HRBA training manual (UNFPA 2010) and summarised on the UNFPA web page (ibid.). The HRBA to FP focuses on fulfilling the "right to health services" – that health services should be available, acceptable, accessible and of the highest possible quality, emphasising participation of rights holders and accountability of duty bearers. UNFPA Bolivia also implicitly and explicitly includes empowerment, non-discrimination and equity as elements of its HRBA to FP.[89]

Civil society has been an important ally for UNFPA in promoting rights. The leading NGO FP service providers (MSI, CIES and Family Care International (FCI)) use a rights-based approach. The *Mesa de*

[84] Although internationally these are often called "unintended" pregnancies, the term "unwanted" has been left here as it is a literal translation of the term and concept used in Bolivia.

[85] Assumption 6.1, Annex 3

[86] Assumption 6.1, Annex 3

[87] Assumption 6.2, Annex 3

[88] Assumption 6.2, Annex 3

[89] Assumptions 6.1, 5.4, Annex 3

Derechos Sexuales y Reproductivos is a network of 54 NGOs and CSOs which work in SRH and FP from a rights-based approach. They are an important voice in advocacy and promotion with the government. UNFPA has provided technical and financial support to the network and has helped improve their access to and dialogue with government.[90]

To promote a rights-based approach to FP in an unfavourable implementing environment, UNFPA has focused on empowerment of women and young people to ensure they know and understand their rights, and has provided financial and technical support for service provider training to improve service quality and raise providers' awareness of users' rights.[91] The country office has been a leading protagonist in specific projects that promote rights (e.g. FCI) and has worked jointly with the ministries of justice, education and health to strengthen a rights-based approach to their work.[92]

The MoH does not use specific indicators such as free choice of contraceptives and user satisfaction with services, which could help strengthen a rights focus in service providers' work. Some data may be available from questions in the GPRHCS Phase II surveys which are now being implemented in Bolivia.[93]

UNFPA contribution to results on a rights-based approach

UNFPA has contributed to introduction of the concept of a rights-based approach in the public sector through advocacy and promotion with government to develop a common understanding, although this is still work-in-progress. Support for UNFPA from the *Mesa de Derechos Sexuales* demonstrates civil society commitment and increases the legitimacy of UNFPA promotion of rights.[94]

UNFPA has contributed leadership and direction in rights promotion by working from both sides, empowering users to demand their rights, and strengthening the capacity of service providers to respond.[95] It has used a holistic strategy, including FP within SRH rights, and has also contributed specifically to a rights-based approach to FP through financial support, production of materials and technical input to service provider training both directly and through training of trainers (ToT). This is expected to lead to cascade training in a rights-based approach in the public sector but has not yet been fully implemented.[96] The FP and SRH programmes that UNFPA has supported through government and civil society implementing partners have included empowerment, non-discrimination, equity and access to FP as key elements, in particular in projects with VMGs.[97]

UNFPA has made an important contribution to keeping rights issues high on the public agenda through promotion and advocacy. It has carried out some important studies of a HRBA for specific groups, and has opportunities to do more on its own and through its IPs work with young people, indigenous groups and sexual minorities and survivors of GBV. However, UNFPA has not yet developed a substantial evidence base which can be used for rights promotion.[98]

UNFPA, as the only large donor and multi-lateral development partner working in FP, has been the principal contributor to promotion of a rights-based approach in the public sector. Anecdotal information from interviews with service providers and stakeholders and from focus group

[90] Assumption 2.1, Annex 3
[91] Assumption 8.1, Annex 3
[92] Assumption 6.2, Annex 3
[93] Assumption 8.1, Annex 3
[94] Assumption 6.1, Annex 3
[95] Assumption 6.2, Annex 3
[96] Assumption 8.1, Annex 3
[97] Assumptions 5.3, 5.4, Annex 3
[98] Assumption 6.3, Annex 3

discussions with users suggests that providers are developing more understanding of users' rights, and user satisfaction is increasing at least amongst specific groups which have become empowered and have benefitted from increased provider awareness.[99]

4.7 Different modes of engagement

Q7) To what extent has UNFPA adapted its mode of engagement[100] to evolving country needs in different settings, using evidence and best practice?
Summary of the relation between the findings and the assumptions of the evaluation matrix: • UNFPA has monitored changes in the country context. Where possible and within the constraints of national capacity UNFPA has adapted its mode of engagement and moved upstream. • Interventions and engagement modes support financial, political and social sustainability of advances in family planning and SRH. • UNFPA identifies and applies best practice where appropriate and feasible, taking into account the need to adapt best practices to specific contexts; UNFPA has not contributed effectively to identifying other gaps in knowledge management skills and supporting government in addressing them.

Changing country context and modes of engagement

Political and social changes outside the control of UNFPA have led to changes in the country context during the period under evaluation, as discussed in section 3. The level of political support for FP has varied through time and in different locations and levels of government. UNFPA has taken this into account and adapted its mode of engagement when and where necessary to maintain an apolitical and neutral position whilst advancing its SRH and FP agenda.[101]

Decentralisation has opened up opportunities to work at departmental and municipal levels, however UNFPA has had to adapt to the conditions and political environment in each department. Modes of engagement have also responded to the availability of additional resources such as non-core donor funds and GPRHCS funds, which have been used for a range of activities including capacity building and demand creation, as well as strengthening procurement and the supply chain.[102]

UNFPA has monitored changing needs and adapted its modes of engagement as necessary. It has moved away from its earlier role as a principal supplier of FP methods to focus more on capacity building, advocacy and technical support.[103] Capacity building and strengthening in procurement and the supply chain has included diagnostic studies and technical support to CEASS and to UNIMED, creation of the CEASS rotating fund for contraceptive purchase, support to service provider training in the public sector, and training for municipal governments in FP.[104] Advocacy has been carried out at all government levels. UNFPA is currently moving further upstream into knowledge management. Examples include research studies on the SRH and FP needs of indigenous groups and young people for input into programme design, and cooperation with the MoH in implementation of the national

[99] Assumption 6.5, Annex 3

[100] "Modes of engagement" refers to the four modes of engagement in the current UNFPA strategic plan (support for service delivery, capacity building, advocacy, knowledge management). This concept is fully discussed in the evaluation inception report (UNFPA 2014a: 14, 17).

[101] Assumption 7.2, Annex 3

[102] Assumption 7.2, Annex 3

[103] Assumption 7.2, Annex 3

[104] Assumption 8.3, Annex 3

stock-taking of contraceptives and logistic processes as a response to problems of availability of FP methods in health facilities (UNFPA Bolivia 2008a).

It has been difficult to develop knowledge management practices in the absence of reliable data. UNFPA has financed studies of specific SRH and FP priority areas (young people, indigenous groups), some proposed by the CO and others by the MoH. There is however persisting lack of data for routine monitoring and evaluation purposes as SNIS information is unreliable and there has been no DHS since 2008.[105] UNFPA has not contributed to strengthening either of these basic data bases (e.g. through improvement of the SNIS or support for national surveys such as the DHS). Knowledge management is not only concerned with creating or collecting data but also with the use of data for management and decision-making and there is still limited national capacity for this.[106]

UNFPA contribution to sustainability of family planning and SRH interventions

It is not feasible to identify the contribution of different modes of engagement *per se,* although movement away from direct support to service delivery and towards upstream activities could serve as an important model for other development partners in other contexts. In Bolivia there are no other donors working directly in FP so this move does not provide an example for others to follow.

UNFPA work to promote inclusion of FP in the basic health insurance package has been an important contribution to sustainability, as the government now covers the cost of FP supplies through reimbursement of contraceptives purchases by municipal governments. Prices could be lowered and sustainability increased if all municipalities purchased through CEASS, as a single combined national procurement could expect to attract volume discounts.[107] UNFPA is supporting CEASS in marketing and promotion but this work is still in progress, as some municipalities purchase from private sector suppliers, and others do not promote FP or actively discourage FP.[108] UNFPA has worked with CEASS to establish a ring-fenced revolving fund for contraceptive purchase using the GPRHCS-funded contraceptive donations of 2011 and 2012 as seed capital, and this will be an important contribution to sustainability. The fund can only be used for contraceptive purchases, and will be replenished by the income resulting from CEASS sales to the municipalities. This mechanism will also reinforce UNFPA moves upstream, as the government should not need to request contraceptive donations in the future.[109]

UNFPA has contributed to social sustainability of programmes through its pioneering work to develop horizontal relationships with FP users, treating them and the community as participants rather than beneficiaries. Programme participants, NGOs and the MoH recognise that empowerment is a key to social sustainability. Participants and NGO implementing agencies are now advocating wider use of this approach.[110]

[105] Assumption 7.2, Annex 3

[106] For example, data on municipalities which are not purchasing family planning methods through CEASS is needed in a format which enables SEDES to identify the problem areas and follow up. Data is supplied by CEASS but the current format is designed for stock control not for management decision-making. In the same way data on consumption of family planning methods by municipal pharmacies is not passed from UNIMED to CEASS in a format which enables CEASS to identify discrepancies between consumption and stock replenishment orders. This information would enable CEASS to identify which municipalities are buying from other suppliers.

[107] A law to set up a single combined national purchase was decreed on the day the case study visit finished, but has yet to be implemented

[108] Decision-makers were quoted in interviews as saying *"not a condom to be distributed during my term of office"*; *" we don't do family planning here as we have no gynaecologist"*.

[109] Assumption 8.3, Annex 3

[110] Assumption 5.4, Annex 3

UNFPA contributions to capacity building in the public sector through service provider training are less sustainable due to high staff rotation.[111]

UNFPA contribution to identification and application of best practices

Decentralisation of decision-making and resource allocation in Bolivia means that best practices vary between departments.[112] UNFPA has identified and implemented some best practices in FP and SRH work with adolescents and young people which can be applied nationally, such as differentiated services for adolescents, and the Committee for Prevention of Adolescent Pregnancy (CAJPEA), which started at departmental level and has been scaled up to national level. Best practices for work with indigenous groups have also been identified, documented and implemented successfully in different departments.[113]

The CO has taken advantage of its access to best practices from other countries, with support from the Latin America and Caribbean Regional Office (LACRO).[114] The most effective learning method has been through visiting staff from LACRO who have shared experiences from elsewhere and discussed with CO staff how they can be adapted and applied in the Bolivia environment. The CO has also sent people from user groups and implementing partners on study trips outside Bolivia to learn about best practices elsewhere, and participants in the evaluation's focus groups indicated that these experiences are often put into practice.

4.8 Supply-side activities

Q8) To what extent has UNFPA support for supply-side activities promoted rights-based and sustainable approaches and contributed to improved access to quality voluntary family planning?
Summary of the relation between the findings and the evaluation matrix assumptions: • UNFPA has supported training with some elements of a quality client-centred rights-based approach but there is still great need to train more staff and broaden the scope of training. • UNFPA has been instrumental in expanding the method mix in the public sector with some input to programming for the new methods. • UNFPA contraceptive donations have been used as seed capital for a rotating fund designed to be sustainable.

Progress and activities

Service provider training in all aspects of FP is an on-going activity in the MoH and more training is always needed due to a high staff turnover. UNFPA has provided technical and material support for MoH training and has brokered training for MoH by specialist NGOs who work with a client-centred rights-based approach.[115] The NGOs were subsequently contracted directly by the MoH for additional training. Service provider training supported by UNFPA has included aspects of a client-centred approach to FP provision, service quality and promotion of rights and method choice, procurement and RHCS and some counselling. However, there has been insufficient provider training in FP promotion, counselling on all methods, and insertion and removal of IUCDs and implants, which results in service provider bias in favour of other methods.[116]

[111] Assumptions 2.3, 8.3, Annex 3
[112] Assumption 7.4, Annex 3
[113] Assumption 5.5, Annex 3
[114] Assumption 7.4, Annex 3
[115] Assumption 8.1, Annex 3
[116] Assumption 8.1, Annex 3

There has been no evaluation of the impact of training on user perspectives of service quality. Anecdotal evidence from interviews and focus group discussions suggests that service providers' counselling skills are weak, many are unable to provide full information to clients and they do not fully understand clients' rights to choose a method. Few have been trained in specific counselling skills for indigenous women or adolescents, and there is often a lack of privacy for counselling in health facilities.[117] As discussed earlier, training has to be continually repeated due to high staff turnover in the public sector.

According to public sector protocols, FP consultations should be provided by a doctor. In practice this is generally observed for the first visit, while in follow-up visits, nurses or auxiliaries administer pills, condoms and injectables. UNFPA has promoted task-shifting to enable *obstetrices* (equivalent to graduate nurses or professional midwives) to provide first consultations and has successfully supported inclusion of FP in the professional curriculum in three universities. The first group of students graduated in 2012.[118]

Until 2013, only four FP methods were available in the public sector (pills, condoms, injectables and IUCDs), with tubal ligation (TL) available in hospitals and some health centres.[119] UNFPA was the prime motivator in introduction of three more methods (female condoms, implants and emergency contraception) through the public sector procurement and distribution system.[120] These methods are now available in health facilities and some programming work has been implemented, but uptake is still low. This is partly because they are still new, but there are also political obstacles for emergency contraceptives[121], technical obstacles for implants (insufficient service provider training in insertion and removal), and social obstacles for female condoms which are associated with sex work.[122]

UNFPA has strengthened CEASS in procurement and supply chain logistics by placement of technical consultants within the organisation.[123] They have worked on promotion strategies, technical and logistic management, and supervision of the revolving contraceptives fund, but the impact of their work is limited by frequent changes in CEASS top management. Financial sustainability of the government procurement and distribution system through CEASS and the revolving fund for contraceptives was discussed earlier. A greater concern for sustainability of UNFPA work through CEASS is the organisation's vulnerability to political intervention in staff appointments, which can affect its stability and the technical quality and experience of staff in key management positions.[124]

UNFPA has also provided support to UNIMED, which is responsible for quality control of medications, and storage, administration of supplies and information systems in pharmacies in the public and private sectors.[125] Municipal pharmacies supply the public health facilities and buy contraceptives from CEASS, and are a key link in the supply chain. UNFPA financial and technical support to UNIMED has also covered publication of the list of essential medicines, which now includes FP methods (UNFPA Bolivia 2015). This raises the profile and priority of FP in purchase decisions by municipal governments.

[117] Assumption 8.1, Annex 3
[118] Assumption 8.1, Annex 3
[119] MSI are currently the largest provider of TL, through mobile surgical units which work from government health centres
[120] Assumption 8.2, Annex 3
[121] There is opposition to EC from pro-life groups who consider it an abortifacient
[122] Assumption 8.2, Annex 3
[123] Assumption 8.3, Annex 3
[124] Assumption 8.3, Annex 3
[125] Evaluation Area 8, Annex 3

The CO has requested and received technical support from the LACRO GPRHCS focal point for work on the supply side, including training and management strengthening in procurement and logistic systems, and technical assistance visits. This is discussed further in section 4.9 below.

UNFPA contribution to supply-side strengthening
UNFPA has made important contributions to the supply-side, which have evolved during the period under evaluation due to changes in country context and the withdrawal of USAID as the principal provider of FP methods. GPRHCS funding has enabled a larger contribution to service provider training in FP and strengthening of the procurement and logistics systems and the supply chain.[126]

UNFPA has been the principal contributor to broadening the method mix through introduction of three new methods. Availability of the methods is the first step but take-up has been low due to lack of promotion.

There is no evidence on the impact of UNFPA contribution to improved service quality through provider training, and there are still important gaps in provider skills and understanding of a rights-based approach. Whilst staff turnover remains high, the gaps will be difficult to cover.

UNFPA has focused its supply-side support on CEASS, including development of the rotating fund for contraceptive purchase, and on support for UNIMED. Currently CEASS supplies the public sector only and is vulnerable to political intervention, so it is unclear whether this is a sustainable contribution to availability of FP methods. Funds for FP supplies are ring-fenced within CEASS, but the organisation as a whole may not be able to sustain the role of principal supplier for the public sector. If CEASS fails, the UNFPA investment in FP will clearly be affected. Overall availability of FP methods is also limited by lack of a total market approach involving the private sector and NGOs in commodity planning, procurement and distribution.[127] Implementation of a total market approach would be complex due to the decentralisation of decision-making on resource allocation and contraceptive purchasing.

4.9 Support from UNFPA Headquarters and the Latin America and Caribbean Regional Office

We have included this as a separate section because a number of the findings of the case study apply to all the evaluation questions which include an assumption on the roles of HQ and RO (questions on service integration, enabling environment, rights-based approach, modes of engagement, and supply-side activities).

Technical guidance from HQ has been predominantly provided through technical documents and training manuals. Examples include the training manual on the UNFPA human rights based approach (discussed in section 4.6), and technical guidance on integration of FP with post-partum and post-abortion services. Technical guidelines on integration and HRBA have been put into practice by the CO taking into account the characteristics and constraints of the national context.

There has been direct technical support and training from HQ Commodity Security Branch (CSB) on GPRHCS and supply-side work. CSB and procurement services in Copenhagen provide support with the logistics of donations and contraceptives procurement. Apart from the GPRHCS team, there has been little other direct contact with HQ, mostly technical support being provided by the Latin America and Caribbean Regional Office (LACRO). The CO makes specific requests for technical

[126] Assumption 8.5, Annex 3
[127] Assumption 8.4, Annex 3

support to LACRO and CSB, who also identify areas where support is needed and themselves propose technical assistance to the CO. All technical guidelines for GPRHCS from HQ and from LACRO are implemented by the CO.[128]

There has also been training and support from HQ through the RO for strengthening results frameworks at country level, including the development of stronger indicators of results and better definition and monitoring of results in FP. The CO has had support in development and use of the results framework, and in alignment of results and indicators of the strategic plan with the Country Programme Action Plan products, baseline information, targets and means of verification.

The Bolivia CO considers that it has had constant and high quality technical support from LACRO since the Regional Office was set up in 2008. Needs for support are identified by the CO and discussed with LACRO for planning purposes, with additional on-going dialogue on needs and input required from the RO. Technical support has included technical and advocacy materials on key programme areas, training for both the CO and the MoH in communications skills and in RHCS, information exchange between offices in the region, and information on best practices discussed in GPRHCS annual regional planning meetings and in visits from LACRO staff to Bolivia.[129] This technical support takes into account the national context.

The CO considers that LACRO has a good technical level in SRH and in supply-side GPRHCS-related topics, and its frequent country visits include technical support and sharing best practices. However, RO officers' time is limited and more input would have been particularly helpful at the start of Bolivia's participation in GPRHCS in 2010, when the national logistics system was weak and difficulties in strengthening the supply system were exacerbated by the complexity of decision-making systems in the decentralised national administration. LACRO has contracted specialist regional organisations such as PRISMA (a Peruvian NGO) to carry out training and technical support for supply-side activities when it has insufficient capacity to do the work itself. LACRO has also offered additional support to the government on supply-side activities but this was not accepted.[130]

Contact with HQ (including contacts for contraceptive procurement) is normally through the RO, although there is some direct contact with Commodity Security Branch (CSB) on GPRHCS issues. CSB is perceived as the principal counterpart in HQ. The CO expressed the need for a stronger direct link with Technical Division, suggesting that it does feel a need for better access to expertise such as HRBA to FP which may be available at HQ.

5 CONCLUSIONS

5.1 Different degrees of integration at policy and service provision levels

UNFPA has played an important role in advocacy and technical support to integrate family planning (FP) with sexual and reproductive health (SRH) services, HIV services, adolescent services, gender-based violence (GBV) services and emergency relief at policy and protocol level, within and outside the health sector. UNFPA has provided financial support for integrated projects, and has supported health staff training for implementation of integrated services. However, full integration and implementation of integrated service delivery protocols at facility level has not been achieved in all departments and municipalities. Neither the country office (CO) nor the Ministry of Health (MoH) have evaluated the impact of integration on family planning outputs and outcomes.

[128] Direct communication from CO, Sept 2015

[129] Interviews UNFPA Bolivia CO

[130] Interviews UNFPA, MoH, NGOs. The reasons are not clear but may have included political and bureaucratic obstacles.

▶ Origin: Evaluation question 1 (section 4.1)

5.2 Leadership in coordination of support for government ownership

UNFPA has actively supported and taken a leading role in mechanisms that contribute to government ownership and leadership at policy level, yet this needs constant reinforcement due to the influence of political groups which oppose family planning at central, departmental and community levels. Outcomes have varied in different departmental and municipal contexts. UNFPA has contributed to strengthening the link between policy and practice in family planning service delivery. UNFPA has made important contributions to political, institutional and cultural sustainability, all of which need constant reinforcement due to changing contexts.

▶ Origin: Evaluation question 2 (section 4.2)

5.3 Effective brokerage between government and other partners

UNFPA has used its position and comparative advantages well to foster relations and broker joint work between different government agencies, development partners and certain non-government organisations (NGOs) which are involved in service delivery. It has also brokered working partnerships between different government agencies such as the ministries of health and education. There are few initiatives for partnership between the MoH and the private for-profit sector.

▶ Origin: Evaluation question 3 (section 4.3)

5.4 Contributions to an enabling environment

UNFPA has identified the policy, legal and community-level factors which lead to an enabling environment for family planning and has contributed effectively to strengthening these factors at policy and community levels. UNFPA has been agile in developing advocacy strategies based on the role of family planning in reducing maternal mortality and adolescent pregnancy. There are still many political, social and cultural challenges to overcome in policy implementation and in demand creation for family planning.

▶ Origin: Evaluation question 4 (section 4.4)

5.5 Focus on participation of vulnerable groups and marginalised populations

UNFPA work with vulnerable and marginalised groups (VMGs), particularly young people, indigenous women and transgender women, has made an important contribution to identification of needs, and design and implementation of appropriate programmes which meet VMGs needs. It has promoted reproductive rights at all levels and supported empowerment and capacity building of VMGs. UNFPA has provided leadership for the public sector, other donors and NGOs in developing participatory approaches with sustainability and potential for scale-up. Although overall contribution to outputs

and outcomes cannot be measured, specific VMGs consider that UNFPA work has increased respect for their rights and improved their access to services.

▶ Origin: Evaluation question 5 (section 4.5)

5.6 Promotion of an integrated human rights based approach in a challenging environment

UNFPA has promoted a human rights-based approach (HRBA) including empowerment and participation by users as well as improvements in the quality and range of family planning services and access. UNFPA Bolivia has supported programmes with a HRBA to family planning, going beyond the concept of access to and quality of care, to include empowerment, participation, non-discrimination and equity. Understanding of this holistic HRBA is shared with some but not all partners, and has been applied to UNFPA work with VMGs and survivors of GBV. An HRBA has not been fully implemented in practice in the public sector. There is no evidence or measurable indicators to demonstrate impact of the HRBA on service quality or user satisfaction.

▶ Origin: Evaluation question 6 (section 4.6)

5.7 Difficulties in changing modes of engagement in different contexts

UNFPA has monitored and responded to changes in the national context and at departmental level. Decentralisation has complicated decisions on modes of engagement as each department has different needs. The exit of USAID from Bolivia generated additional challenges for UNFPA, which has been successful in taking the leading development partner role in family planning work. Moves upstream to knowledge management are difficult in the absence of reliable information/data for management decision-making, although UNFPA is developing an evidence base for advocacy.

▶ Origin: Evaluation question 7 (section 4.7)

5.8 Increasing support to improve service quality

UNFPA support to the supply-side has strengthened availability and promoted a rights-based approach through expanding method mix and supporting service provider training. Availability of global programme for reproductive health commodity security (GPRHCS) funds has enabled UNFPA to carry out more strengthening work at service provider level and in the commodity supply chain, including set-up of a revolving fund for contraceptive purchase. UNFPA is obliged to work through CEASS on the supply chain but the organisation is vulnerable to political intervention which affects its staff turnover, stability and technical capacity. This in turn may affect the sustainability of UNFPA supply-side work. Sustainability would be enhanced by a total market approach and inclusion of NGOs and the private sector in FP commodity planning and distribution systems.

▶ Origin: Evaluation question 8 (section 4.8)

ANNEX 1 – BIBLIOGRAPHY

Asamblea Legislativa Departamental de Chuquisaca (2015). *Una experiencia exitosa "Nuestros Derechos en e Estatuto Autonómico Departamental". Internal document*. Chuquisaca, Asamblea Legislativa Departamental de Chuquisaca.

Bertrand, Jane T (2011). *USAID Graduation from Family Planning Assistance: Implications for Latin America*. New Orleans, Tulane University School of Public Health and Tropical Medicine. Available from http://www.populationinstitute.org/external/files/reports/FINAL_LAC_Report.pdf

CEASS Fondo Rotatorio (2014). *Seguimiento Técnico y Administrativos de la Cuenta Única del Fondo Rotatorio de Insumos Anticonceptivos. PPT presentation. Internal document*. La Paz, Central de Abastecimiento y Suministros de Salud, Fondo Rotatorio de Insumos Anticonceptivos.

Coa, Ramiro, Luis H. Ochoa and MEASURE DHS (2009). *Encuesta Nacional de Demografia y Salud 2008*. Calverton, MD, MEASURE DHS, Macro International Inc. Calverton. Available from http://dhsprogram.com/pubs/pdf/FR228/FR228%5B08Feb2010%5D.pdf

Comité Nacional de Acceso Universal para la Población GBT y HSH (2010). *Acta de Reunión Extraordinaria*. La Paz. Available from http://portalsida.org/repos/Acta GBT 6 Dic 2010.pdf

de la Mora, Beatriz (2013). *Key Elements: Global Programme to Enhance Reproductive Health Commodity Security (GPRHCS) Phase II. PPT Presentation. Internal document*. New York, United Nations Population Fund.

Dirección Departamental de Educación de Chuquisaca (2011). *Plan Estratégico de Educación para la Sexualidad 2011-2015. Internal document*. Chuquisaca, Dirección Departamental de Educación de Chuquisaca.

Faúndez, A. and M. Weinstein (2010). *INFORME FINAL: Evaluación de Medio Término de la Implementación de la "Campaña de Promoción de la Salud Materna desde una Perspectiva Intercultural y de Derechos". Eje 3 del Fondo de Cooperación AECID-UNFPA. Internal document*. Santiago de Chile, United Nations Population Fund Regional Office for Latin America and the Caribbean.

Gobierno Autónomo de Chuquisaca and SEES Chuquisaca (2013). *Plan Estratégico Departamental de Salud Sexual y Reproductiva 2013-2017. Internal document*. Sucre, Bolivia, SEDES.

Index Mundi (2015). Bolivia Ethnic groups. Available from http://www.indexmundi.com/bolivia/ethnic_groups.html

Instituto Nacional de Estadística (2014). *Un pincelazo a las estadísticas con base a datos de censos. Censo nacional de población y vivienda 2012*. La Paz, Instituto Nacional de Estadística de Bolivia Available from http://webine.ine.gob.bo/ine/sites/default/files/documentos/publicaciones/Cartilla CNPV.pdf

IPAS (2013). Human Rights Committee to Bolivia: Stop arresting women for abortion, 5 November. Chapel Hill, NC, IPAS Health, Access, Rights. Available from http://www.ipas.org/en/News/2013/November/Human-Rights-Committee-to-Bolivia--Stop-arresting-women-for-abortion.aspx

JSI Deliver (2007). *Bolivia: Informe final del país*. Arlington, VA, DELIVER for USAID. Available from http://apps.who.int/medicinedocs/documents/s18380es/s18380es.pdf

JSI Deliver (2012). Contraceptive Security Indicators Data Dashboard. Available from http://deliver.jsi.com/dhome/whatwedo/commsecurity/csmeasuring/csindicators/csindicatordashboards

JSI Deliver (2014). CS Indicator Dashboards, 2014. Arlington, VA, JSI Deliver. Available from http://deliver.jsi.com/dhome/whatwedo/commsecurity/csmeasuring/csindicators/csindicatordashboards

JSI Deliver and Futures Group/POLICY II (2003). *Disponibilidad Asegurada de Insumos Anticonceptivos en Bolivia: Evaluación de Fortalezas y Debilidades*. Bolivia, USAID. Available from http://www.rhsupplies.org/uploads/tx_rhscpublications/DOC23.pdf

Kates, Jen, and others (2014). *Mapping the Donor Landscape in Global Health: Family Planning and Reproductive Health*. Menlo Park, California, The Henry J. Kaiser Family Foundation. Available from https://kaiserfamilyfoundation.files.wordpress.com/2014/01/8541-mapping-the-donor-landscape-in-global-health-family-planning-and-reproductive-health.pdf

Ministerio de Planificación del Desarrollo and UNFPA (2007). *Bolivia: Población Territorio y Medio Ambiente: Análisis de Situación de la Población*. La Paz, Government of Bolivia and United Nations Population Fund. Available from http://www.unfpa.org/sites/default/files/admin-resource/Bolivia-Analisis-de-Situacion-de-la-Poblacion.pdf

Ministerio de Planificación del Desarrollo and UNFPA (2012). *Plan de Acción del Programa de País (PAPP) entre el Gobierno del Estado Plurinacional de Bolivia y el Fondo de Población de las Naciones Unidas – UNFPA 2013-2017*. La Paz, Government of Bolivia and United Nations Population Fund. Available from https://data.unfpa.org/downloadDoc.unfpa?docId=79

Ministerio de Planificación del Desarrollo and UNFPA Bolivia (2012). *Plan de Acción del Programa del Pais (PAPP) entre el Gobierno del Estado Plurinacional de Bolivia y el Fondo de Población de las Naciones Unidas (UNFPA) 2013-2017*. La Paz, Government of Bolivia and United Nations Population Fund Bolivia. Available from https://data.unfpa.org/downloadDoc.unfpa?docId=79

Ministerio de Salud y Deportes (2009). *Plan Estratégico Nacional para Mejorar la Salud Materna Perinatal y Neonatal en Bolivia 2009-2015*. La Paz, Government of Bolivia. Available from http://www.mariestopes.org.bo/webassets/documentos/plan_salud_materna.pdf

Ministerio de Salud y Deportes (2010). *Plan Nacional para la Salud Integral de la Adolescencia y Juventud Boliviana 2009-2013*. La Paz, Ministerio de Salud y Deportes. Unidad de Servicios de Salud y Calidad. Available from http://bolivia.unfpa.org/content/plan-nacional-para-la-salud-integral-de-la-adolescencia-y-juventud-boliviana-2009-2013

Ministerio de Salud y Deportes (2011). *Mapeo de Normas sobre Salud Materna Y Factores Culturales en Bolivia 1994-2010*. La Paz, Government of Bolivia. Available from http://bolivia.unfpa.org/content/mapeo-de-normas-sobre-salud-materna-y-factores-culturales-en-bolivia-1994-2010

Ministerio de Salud y Deportes (2013). *Atención integrada al continuo del curso de vida: adolescente-mujer en edad fértil mujer durante el embarazo, parto y puerperio-recién nacido/a-niño/a menor de 5 años-niño/a de 5 años a menor de 12 años de edad-personas adultas mayores: cuadros de*

procedimientos para el primer nivel de atención. La Paz, Government of Bolivia. Available from http://www.ops.org.bo/textocompleto/ncontinuo32458.pdf

Ministerio de Salud y Deportes (nd-a). *Estudio PREVETS, Resultados Preliminares. Internal document*. La Paz, Ministerio de Salud y Deportes, United Nations Population Fund, UNAIDS, IBIS, HIV and OPS.

Ministerio de Salud y Deportes (nd-b). *Salud Sexual y Reproductiva. Produced with financial and technical support from UNFPA, and editorial committee of the Mesa por una Maternidad y Nacimiento Seguros*. La Paz, Estado Plurinacional de Bolivia. Available from http://www.familycareintl.org/UserFiles/File/CartillaBolivia_Salud Sexual y Reproductiva.pdf

Ministerio de Salud y Deportes and Organización Panamericana de la Salud (2009). *Plan Nacional de Prevención, Control y Seguimento de Cáncer de Cuello Uterino 2009-2015*. La Paz, Government of Bolivia. Available from http://bolivia.unfpa.org/content/plan-nacional-de-prevenci%C3%B3n-control-y-seguimiento-de-c%C3%A1ncer-de-cuello-uterino-2009-2015

Ministerio de Salud y Deportes and Programa Nacional ITS/VIH/SIDA (2010). *Estudio sobre sexualidad masculina y VIH en Bolivia*. La Paz, Government of Bolivia. Available from http://www.derechoshumanosbolivia.org/archivos/biblioteca/semvbo.pdf

MMNS (nd). *Reglamento interno de la Mesa de Maternidad y Nacimiento Seguros. Internal document*. La Paz, Government of Bolivia.

Rance, Susanna (2003). Changing Voices: Abortion Talk in Bolivian Medical Settings. PhD Dissertation, University of Dublin. Available from https://www.academia.edu/7808033/CHANGING_VOICES_ABORTION_TALK_IN_BOLIVIAN_MEDICAL_SETTINGS_A_Thesis_In_Two_Volumes_VOLUME_I_A_thesis_submitted_for_the_Degree_of_Doctor_of_Philosophy_to_the

UNFPA (2010). *A Human Rights–Based Approach to Programming. Practical Implementation Manual and Training Materials. New York: UNFPA and Harvard School of Public Health*. New York, United Nations Population Fund. Available from http://www.unfpa.org/resources/human-rights-based-approach-programming

UNFPA (2012a). *Independent Country Programme Evaluation Bolivia 2008-2011*. New York, United Nations Population Fund. Available from http://www.unfpa.org/sites/default/files/admin-resource/BoliviaReport1_EN_2.pdf

UNFPA (2012b). *Thematic Evaluation. UNFPA Support to Maternal Health 2000-2011*. New York, United Nations Population Fund, Evaluation Branch, Division for Oversight Services. Available from http://www.unfpa.org/webdav/site/global/shared/documents/Evaluation_branch/Thematic Evaluations - Sept 2013/MHTE - Sept 2013/MHTE_12_12R.pdf

UNFPA (2013). *Informe de Actividades de la Consultoría "Flujo de Recursos para Actividades de Población 2012 UNFPA/NIDI". Internal memorandum 29 July 2013*. New York, United Nations Population Fund.

UNFPA (2014a). *Evaluation of the UNFPA Support to Family Planning 2008-2013. Inception report*. New York, UNFPA Evaluation Office. Available from http://www.unfpa.org/sites/default/files/admin-resource/Final inception report UNFPA support to FP.pdf

UNFPA (2014b). *Financial Resource Flows for Population Activities in 2012*. New York, United Nations Population Fund (with cooperation of Netherlands Interdisciplinary Demographic Institute (NIDI)).

Available from http://www.unfpa.org/publications/financial-resource-flows-population-activities-2012

UNFPA (2014c). *Reporting questionnaire for GPRHCS implementing countries based on indicators in the Monitoring and Evaluation Framework. Internal document for GPRHCS Phase II*. New York, United Nations Population Fund, Commodity Security Branch.

UNFPA and FCI (2008). *La Salud Reproductiva de las poblaciones indígenas de Bolivia. Internal document*. La Paz, United Nations Population Fund and Family Care International.

UNFPA and FCI (2011). *Servicios de salud materna con pertinencia intercultural: son nuestro derecho Bolivia Ecuador y Perú*. Quito, United Nations Population Fund and AECID. Available from http://lae.princeton.edu/catalog/0fwkx

UNFPA Bolivia (2008a). *Diagnóstico de la Gestión del Suministro. Internal document*. La Paz, United Nations Population Fund.

UNFPA Bolivia (2008b). *Programa del País 2008-2012. Plan de Acción del Programa del País. Plan de Seguimiento y Evaluación. Internal document*. La Paz, United Nations Population Fund Bolivia.

UNFPA Bolivia (2009a). *2009 Annual Work Plan and Monitoring Tool. Strengthening Institutions for adolescents and youth SRH*. La Paz, United Nations Population Fund Bolivia.

UNFPA Bolivia (2009b). *2009 Country Office Annual Report. Bolivia*. La Paz, United Nations Population Fund.

UNFPA Bolivia (2010). *2010 Annual Report. Bolivia*. La Paz, United Nations Population Fund.

UNFPA Bolivia (2011a). *2011 Annual Report. Bolivia*, United Nations Population Fund.

UNFPA Bolivia (2011b). *El Rol de las Parteras Tradicionales en el Sistema Unico de Salud*. La Paz, United Nations Population Fund Bolivia. Available from http://bolivia.unfpa.org/content/el-rol-de-las-parteras-tradicionales-en-el-sistema-%C3%BAnico-de-salud

UNFPA Bolivia (2011c). *Los Derechos de las Mujeres en Situaciones de Emergencias*. La Paz, United Nations Population Fund Bolivia. Available from http://bolivia.unfpa.org/content/los-derechos-de-las-mujeres-en-situaciones-de-emergencias

UNFPA Bolivia (2012). *2012 Country Office Annual Report. Bolivia*. La Paz, United Nations Population Fund.

UNFPA Bolivia (2013a). *2013 Country Office Annual Report. Bolivia*. La Paz, United Nations Population Fund.

UNFPA Bolivia (2013b). *Derechos sexuales y reproductivos de adolescentes y jóvenes; prevención, tratamientos y sanción de la violencia sexual en Bolivia. Informe de Línea de Base del municipio de Camargo. Internal document*. La Paz, United Nations Population Fund Bolivia.

UNFPA Bolivia (2015). *Inversión en Salud Sexual y Reproductiva y Planificación Familiar Marzo 2015. PPT presentation. Internal document*. La Paz, United Nations Population Fund Bolivia.

UNFPA Bolivia (nd). *Análisis de la Constitución y Funcionamiento de la CEASS. Internal document*. La Paz, United Nations Population Fund Bolivia.

UNFPA Bolivia and FCI (2013). *Foro Nacional. Anticonceptión de Emergencia en Bolivia. Internal document*. La Paz, United Nations Population Fund Bolivia and Family Care International.

UNFPA Bolivia and Ministerio de Salud y Deportes (2010). Consultoría: Diagnóstico Situacional de la CEASS y sus regionales/propuesta de reorganización. PPT presentation, 13 September. La Paz, United Nations Population Fund Bolivia. Available from http://bolivia.unfpa.org/content/consultoria-diagnostico-situacional-de-la-ceass-y-sus-regionalespropuesta-de-reorganizacion

UNFPA LACRO (2013). *Evaluación Final del Programa Regional del UNFPA para América Latina y el Caribe 2008-2013. Período Evaluado: 2008-2013*. Panama, United Nations Population Fund Latin American and Caribbean Regional Office.

UNIBOL and UNFPA (2011a). *Diagnóstico de Conocimientos Actitudes y Prácticas de Sexualidad en la UNIBOL Guaraní y Pueblos de Tierras Bajas "Apiagüaki Tupa"*. La Paz, Viceministerio de Educación Superior; Universidad Indígena Boliviana Guaraní (UNIBOL); "Apiagüaki Tupa", Pueblos de Tierras Bajas and United Nations Population Fund. Available from http://www.bivica.org/upload/sexualidad-unibol_a.pdf

UNIBOL and UNFPA (2011b). *Diagnóstico sobre Conocimientos, Actitudes y Prácticas de Sexualidad en la UNIBOL Quechua "Casimiro Huanca"*. La Paz, Viceministerio de Educación Superior; Universidad Indígena Boliviana Quechua "Casimiro Huanca" (UNIBOL) and United Nations Population Fund. Available from http://www.bivica.org/upload/sexualidad-unibol-quechua_a.pdf

United Nations (2007). *Country programme document for Bolivia*. New York, United Nations Population Fund. DP/FPA/CPD/BOL/4. Available from http://www.unfpa.org/sites/default/files/portal-document/Bolivia_CPD_2008-2012.pdf

United Nations (2012). *Final country programme document for Bolivia (Plurinational State of)*. New York, Executive Board of the United Nations Development Programme, the United Nations Population Fund and the United Nations Office for Project Services. DP/FPA/CPD/BOL/5. Available from https://executiveboard.unfpa.org/execDoc.unfpa?method=docDetail&year=2012&sessionType=SRS

Viceministerio de Igualdad de Oportunidades and UNFPA Bolivia (2009). *Encuesta Nacional de la Adolescencia y la Juventud 2008*. La Paz, United Nations Population Fund Bolivia. Available from http://bolivia.unfpa.org/sites/default/files/EncuestaJuventud2008.pdf

WHO (2014). Global Health Expenditure Database. Health System Financing Profile by country. Health System Financing country profile, Bolivia 2012, 2013. Geneva, World Health Organization. Available from http://apps.who.int/nha/database/Country_Profile/Index/en

WHO (2015). Bolivia (Plurinational State of). Country Planning Cycle Database: A World Health Organization Resource, Geneva, World Health Organization. Available from http://www.nationalplanningcycles.org/planning-cycle/BOL

World Bank (2015). GDP per capita, Washington DC, World Bank. Available from http://data.worldbank.org/indicator/NY.GDP.PCAP.CD

ANNEX 2 – LIST OF PEOPLE INTERVIEWED

NAME	TITLE
UNFPA	
Ana Angarita	Representative
Celia Taborga	Assistant Representative
Rene Alberto Castro	National Programme Officer SRH
William Michel Chavez	Coordinator GPRHCS
Tatiana Molina	Administration and Finance Associate
Walter Garrón Sara Vargas	Administrator GPRHCS
Rolando Pardo	Programme Analyst M&E
Diddie Schaff	National Adviser on Adolescence and Youth
Alejandra Alzerreca	Coordinator PIAV project
Gabriela Carrasco	Humanitarian Assistance Officer
Daniela Villarpando	Communications Officer
Sara Vargas	Programme and Management Assistant
Rolando Pardo	Programme Analysis M&E
Rolando Encinas	Officer-in-charge Chuquisaca sub-office
Juan Pablo Diaz UNFPA Sucre	Official Sucre
Claudia Resamano UNFPA Sucre	Official Sucre
MINISTRY OF HEALTH (LA PAZ, EL ALTO, CHUQUISACA)	
Gricel Alarcon	Director Epidemiology Unit
Carla Parada	Vice-Minister of Health
Carola Valencia	National Coordinator HIV Programme
Jackeline Reyes	Director Planning Unit
Amparo Morales	Executive Director CEASS
Carlos Bilbao	Consultant CEASS
José Luis Bazán	Consultant CEASS
Roberto Escobar	Chief of Technical-Logistic Unit CEASS
Haydee Padilla	Advisor in Family and Community Health and SRH
Patricia Tames	Manager of Supplies and Rational Use of Medicines UNIMED
Henrry Flores Ayllon	Coordinator of ”Continuo de Vida” programme, SEDES La Paz
Patricia Barrera	Coordinator SRH SEDES Chuquisaca
Felix Tanqara	Director of Gynaecology-Obstetric Hospital Sucre
Patricia Barrera	Chief of Nursing, SEDES Chuquisaca
Maria Huarachi	Coordinator of SRH Sucre Hospital
Elizabeth Vacaflor Barrera	Regional Coordinator CEASS Sucre
Sandra Dávalos	Coordinator ”Continuo de Vida” SEDES Chuquisaca
Dr. Maximo Ortuño	Official SEDES Chuqisaca
Patricia Calvo	CEDES Sucre
Luis Ramírez	Official SEDES Chuqisaca
Wilder Gallardo	Official SEDES Chuqisaca
Edwin Subirana	Official SEDES Chuqisaca

Grover Loayza	Director Epidemiology Unit
Elva Muñoz	Official SEDES Chuquisaca
Centro de salud periurbano "VILLA ROSARIO"	***Peri-urban health centre "VILLA ROSARIO"***
Isabel Miranda	Psychologist
Gloria Alvis	FP Specialist
Edgar Estivenson	Doctor
Claudio Hernandez	Assistant doctor
Victoria Sosa	District Health Chief
Puesto de salud rural:"LAS PALMAS"	***Rural health post "LAS PALMAS"***
Roberto Peñarrieta	Director, Doctor-surgeon
Justo Yampara	Dentist
Dora Miranda	SRH Coordinator
Magaly Robledo	Family Health Coordinator
DEVELOPMENT PARTNERS AND NGOS	
Jhony López	Executive Director CIES
Rayza Torriani	Executive Director National Working Group
Patricia Saenz	Ex-Coordinator of Promotion and Logistics USAID
Rosario Quiroga	Health Official UNICEF
Ramiro Claure	National Director Marie Stopes International Bolivia, Coordinator MSI Bolivia Sucre
Nancy Manjon	UMRPSF (NGO Sucre)
Jovanna Ordonez	Network T Sucre
Julieta Perez	Network Against gender violence
Jaime Montero	Official, CIES
Wendy Torres	Member CAJPEA
Alexia Escóbar	Coordinator FCI Bolivia
Haydee Cabrera	Manager of Social Marketing PROSALUD
Bertha Pooley	Board Member of the National Working Group on Maternity and Safe Delivery
SERVICE USERS (FGD PARTICIPANTS)	
Anastasia Cataño	Focus group participants – SRH service users
Martha Perez	
Maritza Vallejos	
Shiomara Mendoza	
Pamela Buduguez	
Odeman Reyes	
Katerina Oblitas	

ANNEX 3 – EVALUATION MATRIX

The data and information produced through the document review, and collected through interviews and focus groups during the field visit in Bolivia are presented in the evaluation matrix below. Data and information are categorized along the evaluation questions and related assumptions for verifications and support the findings analysis presented in Section 4 of the present country note.

Area of Investigation 1: Integration

To what extent has UNFPA supported integration of family planning (FP) with maternal health, HIV/STI and gender based violence (GBV) services in health plans and at primary health care level, in services for adolescents, and in emergency and humanitarian situations?

Data collection methods:
Document review
Key Informant Interviews (KII)
Focus Group Discussions (FGD)
Site visits

Assumption 1.1: **UNFPA headquarters (HQ), regional office (RO) and country office (CO) staff and in-country partners are working towards a common understanding of the meaning and importance of service integration.**	**Information sources:**
Indicators: • Knowledge generated and shared regarding nature of and lessons learned from integration interventions • UNFPA staff, partners' and users' (both women and men) perception of meaning and importance of service integration.	
There have been stronger moves to integrate FP with HIV services since 2009. Prior to that, integration was partial and procedures for integration had not been put into practice by Ministry of Health (MoH). UNFPA made an important contribution in promoting integration and speeding up the process.	MoH staff
There is good integration between FP and maternal health, HIV and adolescent programmes; UNFPA has been an important promoter of integration.	MoH staff
At service delivery level, every health unit integrates in the manner it thinks most appropriate. There are no standard protocols for integration at this level.	MoH staff

CO has participated in development of *Continuo de Vida*, the new MoH health service provision protocol. Family planning is fully integrated into services designed round client needs at different stages of life. UNFPA worked with UNICEF and PAHO on the *Continuo de Vida* Protocol for MoH, UNFPA being the principal collaborator.	MoH and UNFPA staff; (Ministerio de Salud y Deportes 2013)
At departmental level, policies for integrated services exist, and the government recognises the advantages of integration for user access to FP, sexual and reproductive health (SRH) and HIV and AIDS services.	(Gobierno Autónomo de Chuquisaca and SEES Chuquisaca 2013)

Assumption 1.2: **Country offices receive and put into practice technical guidance from HQ and ROs to support partners in delivering quality, integrated services.**	**Information sources:**
Indicators: • Number, frequency and type of technical assistance (TA) provided • RO plans address COs' needs for support in promoting service integration where appropriate • CO plans and programs reflect current technical guidance and best practices for integrated services • Evidence-based guidance developed to support the integration of FP or more in the following SRH services (in policies, plans, actual service delivery): ▪ Maternal health ▪ HIV/STIs ▪ Gender-based violence (GBV) ▪ Level of emergency preparedness to address FP needs in emergency situations ▪ Adolescent SRH (girls and boys).	Note: Additional information on this and other assumptions referring to HQ and RO will be gathered during KIIs and the internet surveys.
Family planning is integrated into post-partum and post-abortion services, CO support following technical guidance of UNFPA HQ/RO.	UNFPA and MoH staff

Assumption 1.3: **UNFPA support has been effective in stimulating service integration by in-country partners; government, civil society organisations (CSOs), private in policies, plans and actual services.**	**Information sources:**
Indicators: • Number and type of FP service providers trained on service integration	

• Number and percentage of service delivery points that offer FP integrated with other services (and acknowledge UNFPA guidance for this) • Integrated service provision included in provider training programmes (with acknowledgement of UNFPA guidance for this) • Inclusion of integrated service provision in government policies and health plans.	
UNFPA has taken a leading role in integration in the Continuo de Vida, and in the HIV programme, at policy and programmatic level. There has been support at service delivery level through service provider training in public sector. Non-government organisation (NGO) implementing partners already offer integrated services.	UN agency, MoH and NGO staff
UNFPA has worked to integrate FP with the national HIV programme as a way to make free condoms available to men, who were not able to access them in health facilities during the period under evaluation (the national insurance scheme which included FP was only available to women). UNFPA worked with the MoH to develop the innovative concept of "triple protection" through condom use (protection against HIV and AIDS, unwanted pregnancy, and cervical cancer/condyloma). This has been effective in Bolivia due to the high rate of cervical cancer. The condoms financed under HIV-programme are still not distributed to men through the health facilities, only through special events and campaigns.	UNFPA and MoH staff
It has been argued that when UNFPA supports FP as one element of integrated SRH services rather than as a specific vertical programme, the impact of UNFPA in FP itself is diluted. The same problem may occur with full integration of FP into the *Continuo de Vida* protocol – integration may lead to less specific emphasis on FP.	(UNFPA Bolivia 2009b); UNFPA staff
Methods of integration of FP with emergency services are included in the UNFPA Guidance booklet *"Los Derechos de las Mujeres en Situaciones de Emergencia"* (Women's Rights in Emergency Situations). The guide has a chapter on FP, the need to ensure FP is available, and methods to do so.	(UNFPA Bolivia 2011c)
Family planning is integrated in the school curriculum on sexuality education.	(Dirección Departamental de Educación de Chuquisaca 2011)

Assumption 1.4: **Service integration leads to improved user access and quality of services.**	**Information source:**
Indicators: • Evidence of user consultations	

• Perception of different user groups – women and men, vulnerable and marginalised groups (VMG), people living with HIV (PLHIV),[131] for whom access and quality have improved by integration.	
Users find that services are integrated and meet their needs. Users feel the quality of services is better in urban than rural areas due to better facilities and more trained staff. However, in urban areas users often have to visit several clinics within the same facility to meet all their needs, whilst in rural areas services are fully integrated because there is often only one service provider who does everything.	Service users
There is no up-to-date and reliable data on user satisfaction with services as the demographic health survey (DHS) has been delayed due to technical problems in the data collection and analysis.	UNFPA and MoH staff

Other points:	**Information sources:**
Family planning included in basic health package and national health insurance scheme. These are fully described in the MoH protocols included in the *Atención Integrada a Continuo del Curso de la Vida*, in the JSI/DELIVER review of RHCS (*Disponibilidad Asegurada de Insumos Anticonceptivos*), and in the summary presentation of UNFPA Bolivia work in FP (*Inversión en Salud Sexual y Reproductiva y Planificación Familiar*)	(JSI Deliver and Futures Group/POLICY II 2003, Ministerio de Salud y Deportes 2013, UNFPA Bolivia 2015)
Family planning is integrated into protocols for support to survivors of gender-based violence, and since 2008 UNFPA Bolivia has included contraceptives supplies in UNFPA emergency support kits for humanitarian situations.[132] Although emergencies in Bolivia are generally due to natural disasters rather than conflict, more commonly used FP methods such as pills and injectables are not included in the emergency kits.	UNFPA staff

[131] Access: availability, accessibility (distance, transport, time), affordability (willingness and ability to pay incl. opportunity cost) and socio-cultural acceptability

[132] Assumption 1.3, Annex 3

Area of Investigation 2: Coordination

To what extent has UNFPA successfully contributed on its own and in coordination with others to strengthening national leadership of family planning and improving sustainability?

Data collection methods:
Document review
Key Informant Interviews (KII)
Focus Group Discussions (FGD)
Site visits

Assumption 2.1: **UNFPA has developed and/or actively supported mechanisms to raise the profile of family planning in coordination with other FP/SRH stakeholders at** • **Global** • **Regional** • **National levels.**	**Information sources:**
Indicators: Type of existing and emerging coordination mechanisms at each level with evidence of UNFPA support and FP-relevant contents of meetings and initiatives.	
UNFPA, United States Aid for International Development (USAID) and Department for International Development (DFID) were principal donors in FP in the 1990s and early 2000s. They maintained close working relations although their approaches were very different, with UNFPA working to support government ownership whilst USAID developed parallel systems through non-government implementing agencies (e.g. PROSALUD). ("*UNFPA has been a friendly helper to government and encourages government leadership at departmental level*" – FGD Sucre). All three organisations worked with Ministry of Health and Sports (MSD) and municipalities to get FP included in basic heath package. UNFPA picked up the supply-side work when USAID stopped providing FP in 2009, but did not push for continuation of the reproductive health and commodity security (RHCS) *(DAIA)* committee which disappeared. During the period under evaluation, UNFPA has worked with USAID (with the DELIVER programme and social marketing programme), Spanish Agency for International Development Cooperation *(Agencia española de cooperación internacional para el desarrollo* (AECID)), indigenous groups and International Planned Parenthood Federation (IPPF) in FP service delivery.	(JSI Deliver and Futures Group/POLICY II 2003); UNFPA and Development Partner staff
Principal Coordination groups are:	(UNFPA Bolivia 2009b);

• *Mesa Nacional de Maternidad y Nacimiento Seguros*: this is the principal coordinating group, headed by the government. Its ToR were expanded in 2008 to include SRH. It is currently preparing a report on maternal mortality. It discusses all the new plans, norms and protocols and provides technical input to government. At departmental level, UNFPA has been an important promoter of the *Mesa*, which has been the best way to get government and CSO together. Structural changes in government and rotation of government personnel affect the functionality of the mesa and it needs constant support to keep it functional. • *Mesa de Derechos Sexuales y Reproductivas* incudes 54 NGOs. The *Mesa* provides political support to UNFPA, demonstrating to government that UNFPA does put forward the views of civil society in negotiations. • The *Mesas* complement UNFPA advocacy work. UNFPA works alone where it can, calling on support and back-up from the *Mesas* when appropriate. Other coordinating groups with less focus on FP are: • Grupo Intersectorial de revision del Plan de Juventudes (inter-sectoral group for revision of the youth plan) • Grupo Tecnico de Genero del sistema de las Naciones Unidas (United Nations Technical Group on Gender) • Grupo Interagencial de Salud (Inter-Agency Health Group) • Comite Interagencial de Genero (Inter-Agency Gender Group) • Mesa Tecnica de Cooperantes en VIH SIDA (Working Group of Cooperation in HIV/AIDS) • Comite Interagencial de Educacion (Inter-Agency Education Committee) • Grupo de Socios para Bolivia (GruS) (Group of Partners for Bolivia)	UNFPA, NGO and departmental government staff (MMNS nd) (Ministerio de Salud y Deportes nd-b)
Since USAID left Bolivia, UNFPA has been the principal external cooperation organisation working in FP. UNFPA works with other organisations in the forums listed above. The government is not willing to accept donor-driven programmes, or any pressure or imposition of ideas, especially those which come from outside Bolivia. There is also government antipathy towards NGOs, as government feels that many NGOs receive resources which should go to government and do not wish to accept government controls.	UNFPA, DP, NGO and MoH staff
The government had no administrative experience when it first took power, and sought technical support from organisations such as UNFPA. The government has always been the principal UNFPA implementing partner (IP). UNFPA also considers NGOs as allies and has worked with them directly as well as contracting them as trainers to strengthen government capacity. The *Mesa de Derechos de SR* includes many NGOs and CSOs and gives important support from civil society to UNFPA advocacy.	UNFPA staff
UNFPA works in coordination with MoH together with other relevant United Nation funds and programmes (UNICEF and PAHO) to carry out studies on HIV and AIDS in high-risk groups (e.g. prevention of sexually transmitted infections (STI) – *PREVETS*). The PREVETS study included FP.	(Ministerio de Salud y Deportes nd-b)

Assumption 2.2: **UNFPA and other donors (including those influenced by UNFPA advocacy) have effectively supported national governments to assume ownership of FP-related policies and programmes.**	**Information sources:**
Indicators: • Existence of national FP policy and programme (separate or integrated with other SRH areas) • National budget allocations to FP • Number of other major donors actively supporting national ownership of FP, (on their own account or as a result of UNFPA advocacy).	
UNFPA has worked with the ministries of health and education, with municipal governments and social organisations to develop institutional SRH plans, and has trained personnel. This supports government leadership but unless training is repeated frequently, its impact on service quality may not be sustainable due to high staff turnover.	(UNFPA Bolivia 2011b); UNFPA, MoH and DP staff
UNFPA has provided support for government in policy and programming and to fill capacity gaps. If UNFPA takes a too strong leading role, it detracts from government leadership; government has now taken control of policy development and programme planning, some of which were formerly led by development partners (DPs). UNFPA is now seen as a supporting partner which presents no challenge to government control and leadership.	UNFPA and MoH staff
UNFPA has used regular resources for its policy-related work and other initiatives to support government capacity and programmes. Through its close relationship with government, UNDP has a comparative advantage for these types of work.	CO financial data; UNFPA staff
The government has taken leadership but has not taken clear ownership of FP at all levels and is still ambiguous about it for political reasons. Parliamentarians are divided in their opinions, and some indigenous groups think high fertility is prestigious. The government has never prohibited FP at policy level, but in periods when political opposition to FP has been strong, the government has stopped promoting it at service delivery level. UNFPA strategy has been to approach FP as a key factor to reduce maternal mortality, to reduce the rate of adolescent pregnancy and to reduce rates of cervical cancer and condyloma (this latter gave rise to development of the innovative triple protection strategy for condom promotion).	UNFPA, MoH, DP and NGO staff
Decentralisation of decision-making on resource use means that UNFPA has needed to work with municipalities in promotion and repositioning of FP. UNFPA contributed to inclusion of FP in the universal maternal-infant insurance (SUMI), which was an important step forward. UNFPA has also worked with MoH to mount workshops on FP for municipality staff who have the responsibility but little knowledge or experience.	UNFPA, MoH and NGO staff
Central government is in a weak position to promote FP, as the departmental health services (SEDES) respond to autonomous regional governments rather than central government. Central government does some direct work with health units though this should not be the case.	MoH staff

At municipal level, directors of heath units have to negotiate with municipal government for allocation of funds for FP methods.	
UNFPA has worked with government at all levels to promote FP as a means of reducing maternal mortality. This is a strategy which has worked at departmental and national levels in terms of policy and norms, although there are no statistics to prove it has been implemented effectively (in the absence of an up-to-date DHS, there are no reliable statistics to demonstrate and increase in FP).	Staff of SEDES Sucre, UNFPA staff
UNFPA has supported government in development of a wide range of policies in SRH which include FP; development of policies for special groups, including adolescents and young people, indigenous groups, VMGs, and people living with HIV (PLWHIV); and development of norms and protocols.	(Ministerio de Salud y Deportes 2009, Ministerio de Salud y Deportes and Organización Panamericana de la Salud 2009, Ministerio de Salud y Deportes 2010)

Assumption 2.3: **Programmes are culturally/socially, institutionally and economically sustainable in different national contexts**	**Information sources:**
Indicators: • Trends in modern contraceptive prevalence rate (mCPR) • Percent of FP provided by the public, NGO and private sector • Government spending as per cent of total expenditure on FP • Evidence of participation by CSOs (including end user groups, VMGs) and private sector in FP policy, planning and accountability mechanisms at national level.	
UNFPA has worked on policy, supply-side and promotion. None of these will be sustainable without additional input, because (a) the government is not in favour of FP and does not promote it, (b) training has to be repeated frequently because of high staff turnover and (c) UNFPA will have to advocate for FP when policies are renewed.	NGO staff
UNFPA has worked with AECID and NGOs in research and programmes for indigenous groups (at national and regional levels). These programmes are appropriate for the needs of indigenous groups and therefore should be culturally sustainable. The programmes have been integrated into municipal planning processes and have been proposed as models for scale-up by the MoH.	NGO staff; (UNFPA Bolivia 2009b, Faúndez and Weinstein 2010, Ministerio de

	Salud y Deportes 2011, UNFPA Bolivia 2011a)

Area of Investigation 3: Brokerage and Partnership

To what extent has UNFPA acted as a broker at global, regional and country levels to promote family planning, acting in partnership with the public, private and non-state sector service providers?

Data collection methods:
Document review
Key Informant Interviews (KII)
Focus Group Discussions (FGD)
Site visits

Assumption 3.2: **At the country level, UNFPA COs brokered partnerships between public agencies, CSOs and private sector entities to promote FP and its integration with other SRH programmes.**	**Information sources:**
Indicators: • Other stakeholders and partners recognise the comparative advantages of UNFPA, its positioning and its potential contribution at global, regional and country levels, and respond to UNFPA initiatives in bringing them together • UNFPA participation and role in policy forums, networks and other partnership mechanisms at global, regional and country levels.	
UNFPA brokered joint activities of large specialist SRH NGOs and government, including service providers training carried out for government service providers by the specialist NGOs. It has not used its brokerage capacity to promote better relations between MoH and other NGOs whose focus and *modus operandi* are less compatible with the UNFPA family planning agenda, or between MoH and the private sector. UNFPA worked with relevant ministries to broker joint programmes with MoH which include FP. It has worked with the Ministry of Education on inclusion of comprehensive sexuality education in the school curriculum and with the Ministry of Justice on development of the Youth Law *(Ley de Juventud)*.	(UNFPA Bolivia 2008a, UNFPA Bolivia 2009b, UNFPA Bolivia 2010, UNFPA Bolivia 2011a, UNFPA Bolivia 2012, UNFPA Bolivia and FCI 2013)

	UNFPA, NGO, MoH and other government staff Service users
UNFPA carried out the Study of Population and Territory with the Ministry of Development Planning. The study integrates FP in discussion of development, focusing on stagnation in the level of unmet need, level of awareness of FP and reduction of maternal mortality. The current country programme (CP) action plan agreement with the same ministry explains the legal and policy framework of FP in more depth, as well as summarising previous CP SRH and FP achievements.	(Ministerio de Planificación del Desarrollo and UNFPA 2007, Ministerio de Planificación del Desarrollo and UNFPA 2012)
UNFPA has not brokered relations between government, CSOs and "social organisations" (in the Bolivian context, this term refers to indigenous and grassroots organisations). There is currently a missing link between the Parliamentarians' Forum on Sexual and Reproductive Rights *(Foro Parlamentario de Derechos SR)*, CSOs and social organisations.	NGO staff
UNFPA is good at leveraging finance from other development partners. It has more access to information, expertise, finance and decision-makers than the non-government implementing partners (IPs) and CSOs.	NGO staff; Service users
UNFPA has opened doors for NGOs to work with other donors.	Service users
UNFPA has been a key actor in coordinating and integrating the work of different organisations, due to its holistic approach which includes training, supplies strengthening, research and a focus on human rights.	Service users
UNFPA has worked with the Ministry of Education at departmental level to produce sexuality education curricula.	(Dirección Departamental de Educación de Chuquisaca 2011)

Assumption 3.3: **The visibility of UNFPA is sufficiently high at global, regional and country levels to bring together potential partners to increase commitment to FP.**	**Information sources:**
Indicators: • Other stakeholders and partners recognise the comparative advantages of UNFPA, its positioning and its potential contribution at global, regional and country levels, and respond to UNFPA initiatives in bringing them together	

• UNFPA participation and role in policy forums, networks and other partnership mechanisms at global, regional and country levels.	
The MoH, NGOs and departmental governments recognise UNFPA as the leading organisation in the FP field. UNFPA has convened FP meetings and conferences such as the Emergency Contraceptive Conference (*Foro Nacional Anticonceptión de Emergencia en Bolivia*) and convenes the *Mesa de Maternidad y Nacimiento Seguros* at departmental level. UNFPA has brought together partners within government (MoH, Ministry of Education and Ministry of Justice) to work on FP -related issues of comprehensive sexuality education and the Youth Law. It has also brokered joint work between government and NGOs for training service providers.	MoH, NGO and departmental government staff; (UNFPA Bolivia and FCI 2013) MoH, UNFPA and NGO staff

Area of Investigation 4: Enabling Environment

To what extent has UNFPA supported the creation of an enabling environment at national and community levels to ensure family planning information and exercise of rights?

Data collection methods:
Document review
Key Informant Interviews (KII)
Focus Group Discussions (FGD)
Site visits

Assumption 4.1: **UNFPA has identified key enabling factors in different country contexts and developed effective interventions to strengthen these.**	**Information sources:**
Indicators: • Identification of enabling factors in CO annual reports • Interventions in CO plans at the national and community levels designed to strengthen the enabling environment. • Evidence of enablers being strengthened at national and community levels (e.g. political commitment, community support) • Evidence of how enablers have facilitated strengthened FP information and services.	

UNFPA has identified enabling factors at policy level and has strongly supported policy reform in all aspects of SRH and FP.	(JSI Deliver and Futures Group/POLICY II 2003, United Nations 2007, UNFPA 2012a, United Nations 2012) UNFPA, MoH and DP staff
The National Constitution and *Plan Estratégico Nacional de SSR 2009-2015* affirm sexual and reproductive rights. UNFPA has made important technical and financial contributions to the SRH plan and national norms and protocols since the 1990s and continues this work. There were many problems in working with government in 2008 due to frequent changes of personnel in key positions.	(UNFPA Bolivia 2008a, UNFPA Bolivia 2009b, UNFPA Bolivia and FCI 2013, UNFPA Bolivia 2015); MoH staff
UNFPA supported development of the National Constitution and all relevant plans in the health sector to ensure they incorporate sexual and reproductive rights norms and provisions.	(UNFPA Bolivia 2008a)
Ranking of enabling environment factors for RHCS and community-based interventions for FP in the 2012 and 2013 reports showed that UNFPA had identified that for reproductive health commodity security (RHCS), the policy and legal frameworks were largely in place, but there were some gaps in institutional factors and resources. For community-based interventions there were inadequate resources, policy and legal frameworks were weaker, and institutional capacity was lacking. Institutional capacity, and policy and legal frameworks were rated one grade lower in 2013 for both RHCS and for community-based interventions. As the difference is small, this may have been subjective rather than reflecting significant deterioration.	(UNFPA Bolivia 2012, UNFPA Bolivia 2013a)
There are major differences in opinion on FP within the government party itself, with 30 percent of members of Parliament (MPs) associated with anti-FP fundamentalist churches. UNFPA has focused on advocacy for FP as a way of saving lives (through reducing maternal mortality).	UNFPA and NGO staff
The legislative framework is favourable, policies are in place and there are norms and protocols for FP. UNFPA has helped raise government awareness to give FP priority status. It has also contributed to development of the policy framework for social determinants of FP and related issues (youth issues, sexual violence). However, good legal and policy frameworks are not enough. As the government is not clearly in favour of FP there is no promotion, and FP use is thought to be stagnant. The problem now is implementation, especially at departmental and municipal levels where staff are not motivated to promote FP. It is difficult to motivate health facility staff, and the MoH does not have direct line management due to the decentralised structure. At departmental level, the SEDES responds to MoH for norms and technical orientations, but is administratively subordinate to the autonomous regional government.	UNFPA, MoH, departmental government and NGO staff; Health service providers; Service users

UNFPA has worked with the MoH to strengthen the municipalities understanding the importance of FP, but the structural arrangements for decentralised decision-making mean that implementation of norms is in the hands of departmental and municipal governments rather than the central MoH. MoH and departmental health staff consider that government has not promoted FP sufficiently, but at health centre level staff say they do promote it, and users agree.	
There are serious problems of data availability; there has been no DHS since 2008 and the alternative sources of data are partial and unreliable (national health information system (SNIS), special studies). Problems with the SNIS registers mean that MoH has unreliable data on service delivery for its planning and monitoring. This is a major obstacle to identification of factors which affect FP uptake. UNFPA and all other stakeholders are very aware of the problem, and are eagerly awaiting publication of the new DHS.	UNFPA, MoH, departmental government and NGO staff; Health service providers; Service users
There are new restrictive laws on NGOs which have made the legal environment hostile rather than enabling. The new laws require NGOs to provide additional information to government on funding, funding sources and activities, and will lead to tighter control over NGOs by the government.	NGO staff
Cultural factors are a major problem in creation of an enabling environment. In rural areas, people often think the health staff want to stop them having children; the government is pro-natalist and instructs heath staff not to offer FP to indigenous groups with small populations. In rural areas, MoH has switched strategy and uses reduction in maternal mortality as an entry point for FP. This is also the UNFPA strategy.	UNFPA, NGO and departmental health staff
UNFPA studies and research have been effective tools for NGOs in promoting FP. The government has not disseminated the studies widely and UNFPA has not identified their impact on policy.	MoH, NGO and departmental health

Assumption 4.2: **UNFPA has successfully supported partners at country and community levels to improve demand creation and access to services, thus enabling people to exercise their rights better.**	**Information sources:**
Indicators: • Improved service use and FP uptake (esp. where unmet need is high and by VMGs) • Change in unmet need of different groups	

• Access barriers reduced, equity improved • Increased responsiveness to the needs of VMGs.	
UNFPA has worked with some NGOs to strengthen service delivery, and has worked with government to support service provider training which may lead to demand increase. In the period under evaluation, UNFPA did not work directly on demand generation although it did some work at community level with VMGs – see below. UNFPA is now supporting the government in the development of a national promotion strategy.	(UNFPA Bolivia 2008a, UNFPA Bolivia 2009b, UNFPA Bolivia 2010, UNFPA Bolivia 2011a); UNFPA staff
Low demand is not a price issue; the central health supplies organisation (CEASS) has lowered the price of contraceptives purchased by municipalities, and services are free to users at health facility level. However, users do not have sufficient information to demand services, and health providers do not promote FP.	MoH staff; (UNFPA Bolivia and Ministerio de Salud y Deportes 2010)
Insufficient demand creation, and poor quality orientation and counselling are the key problems in Bolivia. UNFPA has done some training, but the effectiveness of the training on demand creation and quality of services and counselling cannot be specifically identified, as other factors also affect demand. For example, some health facility staff make special efforts to get out into their communities to promote FP and monitor all users, but this is due to personal conviction and interest of facility directors, and is not the normal practice throughout the country. UNFPA has concentrated its effort with MoH at policy level rather than at service delivery level.	UNFPA and NGOs staff
There is a large demand for condoms, emergency contraception and other methods in the NGOs and private sector. The private sector sells more condoms than CEASS, and many users (especially young people) prefer to use the pharmacies for privacy and for quick service with no need for clinical consultations. During the period under evaluation, men could not access free condoms in the public sector.	Departmental MoH staff, MoH and UNFPA staff; (UNFPA 2013)
The government is not interested in demand creation; it is pro-natalist and lacks political will to promote FP. Some departmental SEDES chiefs make their opposition to FP very clear.	UNFPA and NGO staff

Assumption 4.3: **HQ and ROs have supported COs in identifying needs, creating an enabling environment and promoting demand and access in different contexts.**	**Information sources:**
Indicators: • Frequency and nature of technical assistance (TA) visits and communications with focus on factors related to creation of enabling environment and promoting demand and access.	

This note applies to all the questions on HQ and RO input: LACRO has provided constant and high quality TA on Global Programme for Reproductive Health Commodity Security (GPRHCS) and on SRH, and has helped generate non-core funding for the CO. TA incudes: • Discussion of needs and key programme areas • Technical materials useful for lobbying government, such as the documents and videos available on the LACRO website http://lac.unfpa.org/en • Communications training and how to deal with the press • Training for MoH and for UNFPA • Open line for support and consultations. TA needs are identified by the CO and discussed with RO. RO has good technical level and provides information from other countries on technical advances and best practices, for example for SRH and GBV work in emergency settings. HQ provides procurement support, but otherwise communications are through RO. CO would like a stronger link with Technical Division on other aspects of FP, such as technical developments in contraception. Currently the main counterpart in HQ is Commodity Security Branch (CSB).	UNFPA staff (UNFPA LACRO 2013)

Area of Investigation 5: Vulnerable and Marginalised Groups

To what extent has UNFPA focused on the family planning needs of the most vulnerable and marginalised groups, including identification of needs, allocation of resources, and promotion of rights, equity and access?

Data collection methods:
Document review
Key Informant Interviews (KII)
Focus Group Discussions (FGD)
Site visits

Assumption 5.1: **UNFPA globally and at country-level performs situation analyses to identify needs, challenges and rights violations forms, and identifies good practices on how to address these.**	**Information sources:**

Indicators • Evidence of gender-sensitive needs assessment of target groups for UNFPA supported interventions including identification of rights violations • Availability of accurate and sufficiently disaggregated data for targeting most vulnerable and marginalized groups • HQ/RO TA visits to support assessment, design, implementation, monitoring (including results-oriented monitoring) and evaluation of interventions to address the needs of VMGs • Evidence that good practices have been identified and disseminated.	
UNFPA has worked to identify needs of young people and indigenous groups. It has financed the following needs assessments of both groups: • UNFPA has supported studies with indigenous groups which have focused on understanding their perceptions of FP and maternal health, and obstacles to their use of services (*Diagnóstico de Conocimientos Actitudes y Prácticas de Sexualidad en la Guaraní y Pueblos de Tierras Bajas; Diagnóstico de Conocimientos Actitudes y Prácticas de Sexualidad en la Tierras Quechua,* both carried out by the national Indigenous University, UNIBOL). Obstacles include distance, costs, discrimination, lack of confidence in health personnel, and women's inability to leave their families. Understanding and evidence from the studies was used to contribute to formulation of intercultural policies in MoH to improve access of indigenous groups to SRH services. • UNFPA supported an MoH study of masculinity and HIV in Bolivia (*Estudio sobre sexualidad masculina y VIH en Bolivia*) which aimed to understand their behaviour and risk factors. The study found that men who have sex with men, gays, bisexuals and transsexuals are the groups most affected by HIV and AIDS and the most vulnerable. They under-value their level of risk and rarely use condoms, and their access to services is restricted in both urban and rural areas due to insufficient services and discrimination (p.15). • UNFPA supported the National Survey of Youth and Adolescents (2008) The high quality of the research supported or carried out by UNFPA is recognised by national experts, including the research team of the Bolivian Society of Gynaecologists and Obstetricians.	(UNIBOL and UNFPA 2011a, UNIBOL and UNFPA 2011b) (UNFPA and FCI 2008, UNFPA 2012a) (Ministerio de Salud y Deportes and Programa Nacional ITS/VIH/SIDA 2010: 15) (Viceministerio de Igualdad de Oportunidades and UNFPA Bolivia 2009)
UNFPA has developed norms for attention in SRH, including FP for indigenous. These norms have been adopted by MoH as part of the Ministry's Intercultural Family and Community Health Model.	(UNFPA Bolivia 2009b)
UNFPA financed studies of cultural norms in maternal health, which showed that the public sector bases its programmes and activities on western medical criteria with little reference to the indigenous cosmovision. Studies were carried out in the Quechua and Guaraní indigenous groups.	(UNIBOL and UNFPA 2011a)
An MoH study of gay, bisexual, and transsexual groups shows they are still discriminated against and stigmatised in service provision, and have poor access to services. This study was on HIV, not FP.	(Ministerio de Salud y Deportes and Programa

	Nacional ITS/VIH/SIDA 2010)
The regional programme implemented in collaboration with AECID has given UNFPA leadership in intercultural SRH work and has raised SRH awareness of indigenous organisations and leaders. The studies and projects with indigenous women have given these groups more voice and skills to participate in planning and programme monitoring, but this is still limited to specific groups and geographical locations which have benefited from the programme. UNFPA has carried out studies on the role of traditional birth attendants working with indigenous women (for example: *Las Compañeras en el Alumbrar. Dejando la penumbra en el arte obstétrico Bolivia 1837-2012*) The high quality of this research has been recognised by expert national researchers. The research has been disseminated at regional level and have potential for wider dissemination in countries whose indigenous groups have different needs from the rest of the population.	(UNFPA and FCI 2011) Staff of NGOs (UNFPA 2012a)
UNFPA has conducted analysis of needs and risk behaviours of adolescents, young people and indigenous groups including: the "National Survey of Adolescents and Youth" which indicates that 52 percent of adolescents have received some sexuality education but only one third have been informed about reproductive rights and sexual violence (p.77). The average age of initiating sexual relations is 17 years, and only one third claim to have used contraception in their first relation, with 57 percent of sexually active adolescents not using methods at all (p.81). Most adolescents use public sector health services; only 50 percent of them are satisfied with the SRH services which they receive. As only one-fifth of adolescents are salaried workers most service users are beneficiaries of the health insurance cover of their parents, who accompany them to medical consultations (p.75). As adolescents prefer privacy for SRH consultations this represents a significant barrier. Differences in the health service needs of indigenous groups resulting from their world view are discussed in depth in the "Mapping of Maternal Health Norms and Cultural Factors in Bolivia 1994-2010." The document illustrates the problems which arise in different perceptions of pregnancy and childbirth which make the standard norms and protocols inappropriate for attention to indigenous women (for example, the dominance of biomedical criteria in western medicine do not coincide with indigenous concepts of pregnancy and childbirth; and the importance of fertility in indigenous culture is underestimated by western medical training and practice). As a result the State objective of providing the same services to all groups does not meet the needs of indigenous women.	(Viceministerio de Igualdad de Oportunidades and UNFPA Bolivia 2009) (UNFPA and FCI 2011)

UNFPA leads on work with young people and adolescents and has done work through NGOs with other groups, such as sex workers (SW) and PLHIV, which focus on increasing access to information and services.	NGOs and MoH staff

Assumption 5.2: **UNFPA allocates resources to effective and targeted programming for the most vulnerable and marginalised groups.**	**Information sources:**
Indicators: • Number and type of programme interventions targeted to VMGs per cent of total budget allocations to partner activities which focus on VMGs.	
VMGs (in particular rural and indigenous women and young people) is a major focus of CO work. Work with indigenous women has included research on their needs, support for advocacy with MoH by indigenous groups, and activities aimed at empowerment. Work with young people has covered the same areas and has focused on participation and empowerment.	(UNFPA Bolivia 2009b, UNFPA Bolivia 2010, UNFPA Bolivia 2012) UNFPA, departmental MoH and NGO staff
Other VMGs such as transsexuals are targeted in HIV programmes implemented by NGOs rather than in FP programmes.	NGO staff; (UNFPA Bolivia 2009b)
UNFPA has made major efforts to improve the SRH of adolescents, and has promoted and supported development of differentiated services by the MoH. This work is described in all the CO annual reports and is clearly summarised in the new report format of 2012.	UNFPA and MoH staff; (UNFPA Bolivia 2012)
There has been no analysis of the effectiveness of programmes for VMGs, although data on access and use of services will be available when analysis of the 2014 DHS is completed (expected in 2015). Other stakeholders recognise UNFPA as the leader in work with adolescents.	UNFPA, MoH and NGO staff; (UNFPA Bolivia 2013a)
UNFPA has supported organisations which promote VMG rights through material support, assistance in networking and advocacy.	(Comité Nacional de Acceso Universal para la Población GBT y HSH 2010)

Assumption 5.3: **UNFPA promotes reproductive rights and supports capacity development to remove barriers and improve access, quality and integration of FP services with other services for the most vulnerable and marginalised groups.**	**Information sources:**

Indicators: • Rights of, and services for VMGs actively promoted in advocacy strategies with specific attention to gender issues • Type of capacity building interventions to address service barriers and improve access for, and enable exercise of rights by the most disadvantaged groups.	
Rights of VGMs are firmly integrated in the National SRH Strategic Plan 2009-15 and the Strategic Plan to Improve Maternal, Perinatal and Neonatal Health 2009-2013. For example, the latter includes "application of models which promote respect, dialogue, acceptance and complementarity between mothers and service providers", promotion of "coordination between community agents, midwives and traditional medical workers", and "application of the Ministerial Resolution number 0496 on intercultural attention to births" (p.33). UNFPA provided technical support to government in drafting these plans.	(UNFPA 2012a); UNFPA and MoH staff
UNFPA has been a pioneer of the rights based approach (RBA) with indigenous groups, *not* considering them as beneficiaries but as people with rights to appropriate and culturally acceptable services. This has led to a high level of participation. UNFPA has provided technical support to MoH to put the international conventions on rights of women and indigenous groups ratified by Bolivia into practice. These include: • Convention on the Elimination of all Forms of Discrimination Against Women (New York 1979, ratified by Bolivia in 1989); • The Consultative Convention on the Fund for Development of Indigenous Peoples of Latin America and the Caribbean (Madrid 1992, ratified by Bolivia in 1993); • The UN Declaration on the Rights of Indigenous Peoples (New York 2007, ratified by Bolivia 2007).	UNFPA, MoH and NGO staff; Service users
In the case of some indigenous groups, service delivery staff have been explicitly instructed by municipal or departmental government not to provide women with FP, as a way to promote population increase.	NGO staff

Assumption 5.4: **UNFPA actively encourages VMG to participate in programme planning, implementation and monitoring and VMG receive capacity building to this end.**	**Information sources:**
Indicators: • Evidence for gender sensitive participation by VMGs • Evidence for UNFPA support for training in participation.	
The Political Constitution of the State of 2009 outlines the establishment of a *"Unitary Social Plurinational Community-Based Law State"*, and sets out the constitutional foundations of "*Better Lives for All*" as the ultimate goal of development. Interculturality is proposed as *"an instrument for harmonious, balanced cohesion and coexistence between peoples and nations"*, with respect for differences and in equal conditions. It also contains principles and norms to advance the exercise of human	(United Nations 2007, United Nations 2012, UNFPA 2014b)

rights, specifically sexual and human rights for all citizens, both male and female (Country Programme Evaluation (CPE) p.29). Mechanisms for participation by indigenous groups in planning and implementation of health programmes as well as monitoring within the framework of the new Constitution include affiliation to social movements and grass-roots organisations.	
UNFPA has included participation of indigenous groups in programme design implementation and monitoring since 2008. Important examples are the work carried out at regional level with AECID (see above) and the UNFPA-financed projects implemented by Family Care International (see financial table).	UNFPA and NGO staff; (UNFPA Bolivia 2008a)
UNFPA has provided financial and advocacy support to promote inclusion of young people in policy dialogue and programming on youth issues including SRH. This work with the Adolescent and Youth Committee for Prevention of Adolescent Pregnancy *(Comité Adolescente y Joven para la Prevención de Embarazo en Adolescentes* (CAJPEA)) started at departmental level and has now been scaled up to national level. Young people are satisfied with the opportunity to participate and feel empowered, but the effectiveness of participation in improving the alignment of programmes to needs has not yet been measured.	NGO and MoH departmental staff; Young people; (UNFPA Bolivia 2012)
UNFPA has supported work with VMGs in capacity building for participation and this has enabled them to participate more. UNFPA took the lead on this work with transsexual women through the "*Mesa de Trabajo Nacional*" organisation, and now other donors encourage participation. UNFPA has strengthened the leadership capacity of VMGs who are now able to design their own programmes and have been successful in seeking resources themselves. UNFPA has also promoted horizontal programme design and implementation with indigenous groups, and with young people. It has given them the means and skills to develop and control their own programmes through participation and training in programme design and management. This is a sustainable approach. In Sucre, it has helped develop young people's leadership in SRH, and methods and structures for participation and leadership have been scaled up to national level.	NGO staff, CSO networks and departmental health staff
UNFPA has supported campaigns to identify and implement the perspective of VMG in programme design, and has documented results. For example, the mid-term review of the regional maternal health programme for indigenous women carried out in cooperation with AECID found that the programme was highly effective due to women's empowerment and strengthening of indigenous social and grass-roots organisations, and had enabled progress to be made in achieving an intercultural rights-based programme	(Faúndez and Weinstein 2010)
UNFPA has supported detailed studies of VMG needs which take into account their cultural and social environments, their perspectives on sexual and reproductive health rights (SRHR), the obstacles they face in accessing services and their needs for training, education and capacity building. Studies of young people were described above. Studies on indigenous women have been carried out in conjunction with national universities.	(UNIBOL and UNFPA 2011a)

Assumption 5.5:	**Information sources:**

Access to and utilization of services by VMG, according to their sexual and reproductive intentions, has improved.	
Indicators: • Documented evidence on improved VMG access and utilization of services (link with area 1 - integration) • VMG user (women and men) satisfaction with service access and quality.	
There is no quantitative data available on access to FP services for different VMGs, although it is well documented that access for adolescents and young people is restricted by social attitudes as well as service provider bias. Access for indigenous women is also limited by cultural factors including their perception of the need for outside support in childbirth and their unwillingness to leave their families to travel to health facilities. Information from interviews indicates that awareness of poor access is growing and MoH, UNFPA and other development partners, in particular NGOs, are working to improve it.	Service providers; NGO staff; (Ministerio de Salud y Deportes 2010)
Obstacles to access to SRH services for indigenous women include the lack of trained staff in remote and rural areas and poor referral systems (p.13).	(UNFPA 2012a); Health service providers
The provisions of the SUMI and a government scheme to provide material benefits and cash to encourage birth *spacing ("Bono Juana Azurduy")* did not take into account indigenous attitudes towards childbirth and fertility. High fertility is esteemed by indigenous groups and it is expected that women will have their children in quick succession. As a result, almost all indigenous women were automatically excluded from the scheme, as eligibility was restricted to women with few children and long intervals between births.	NGO, UNFPA and MoH staff

Area of Investigation 6: Rights-Based Approach

To what extent has UNFPA implemented a human rights-based approach to family planning, in particular regarding access to and quality of care, and through support from HQ and RO for a rights-based approach in country?

Data collection methods:
Document review
Key Informant Interviews (KII)
Focus Group Discussions (FGD)
Site visits

Assumption 6.1: **UNFPA staff and key partners have a shared understanding of the meaning and importance of a rights-based approach to FP.**	**Information sources:**

Indicators: • Identification of definitions/descriptions of rights-based approaches • Perception of UNFPA and partners' staff of the meaning and importance of the rights-based approach.	
The CP documents and CPE suggest that the government and UNFPA share a definition and it is widely discussed, but this does not triangulate with other evidence.	(United Nations 2007, UNFPA Bolivia 2011a, United Nations 2012)
Discussion of RBA has emerged in the last ten years. Previously, FP was considered a heath service rather than a right; it was justified as a means to save lives through reduction of maternal and infant mortality through better birth spacing and fewer early pregnancies. Government did not promote FP, although it was not refused if users requested it. A rights-based approach (RBA) was not used in service provision or training.	UNFPA staff
UNFPA has worked with civil society partners in the *Mesa de Derechos Sexuales y Reproductivos* to claim rights and carry out advocacy for an RBA through periodic meetings and representations to MoH and other areas of government.	UNFPA and NGO staff; (UNFPA Bolivia 2009a)
There is a contradiction between the inclusion of the right to SRH and FP in the constitution, and the need to respect the rights of indigenous people not to accept it. The need to respect the views of different segments of the Bolivian population places the government in an ambiguous situation. The strategy adopted by the government and UNFPA has been to promote FP as a strategy to support the right to life (through reduction of maternal mortality).	MoH and UNFPA staff
Although SRH rights are included in the constitution, in practice it is still difficult to ensure that they can be fully exercised. At departmental level, UNFPA has supported government publications which explain the SRH rights included in the constitution indicating how these rights are in turn incorporated into the departmental statutes which were developed on the basis of the constitution.	MoH and NGO staff; (Asamblea Legislativa Departamental de Chuquisaca 2015)
UNFPA has supported the work of MoH to promote the "*Bono Juana Azurduy*" (which provides material benefits and cash to promote child-spacing), through production of booklets which emphasise rights to FP. As discussed in section 5 above, the conditions of the "*bono*" exclude many indigenous women from receiving the benefits.	(Ministerio de Salud y Deportes nd-b)

Assumption 6.2: **UNFPA programming incorporates human rights principles in the assessment, design, implementation and evaluation of FP program interventions.**	**Information sources:**
Indicators: • Evidence of a rights-focused needs assessment, quality assurance mechanisms, participatory processes, and accountability mechanisms within programs • Evidence of attention to barriers and protocols for addressing coercion	

• User satisfaction with FP access and quality (men, women, VMGs).	
There is a strong emphasis on a RBA in UNFPA work in Bolivia, and in methods of implementing it. UNFPA has formed alliances with civil society through participation and support for the *Mesa de Derechos Sexuales y Reproductivos* whose main focus is rights.	UNFPA and NGO staff
In practice, there are taboos and attitudes in the community and amongst service providers which restrict the right to access to and quality of services for all groups (for example, attitudes towards premarital sex, restrictions on decision-making by women and the importance placed on fertility in traditional societies). The discourse is rights-based but this is not always put into practice. There is service provider bias and unwillingness to promote FP due to lack of knowledge or motivation of service providers, or due to instructions from health management. The government has pro-natalist policies.	UNFPA and NGO staff; Service users
UNFPA has advocated with government for a RBA, but there are still restrictions on access to a full range of quality FP services, and empowerment and participation of user groups, especially VMGs, is limited.	NGO and MoH staff
UNFPA and partners have carried out national and regional projects to promote the sexual and reproductive rights of indigenous groups. These projects have produced publications which explain the legal framework and RBA to FP information and services	(UNFPA and FCI 2011)

Assumption 6.3: **UNFPA is developing a body of evidence and lessons learned regarding human rights-based approaches for FP.**	**Information sources:**
Indicators: • Identification of evaluation and research and/or briefs on lessons learned related to human rights-based programming.	
UNFPA and IPs have carried out several studies of indigenous groups and adolescents which include FP, and these are used in programme design and advocacy.	UNFPA staff

Assumption 6.4: **COs receive and put into practice technical guidance from HQ and ROs to support rights-based FP.**	**Information sources:**
Indicators: • Number, frequency and type of TA provided • RO plans address capacity gaps and support needs of COs, and ROs provide timely support • CO strategies and programmes reflect current technical guidance and best practices for rights-based FP.	
This and other assumptions on RO and HQ support and technical guidance are consolidated in section 4.9 of the report.	

Assumption 6.5: **Rights holders consider that duty bearers understand their rights to FP and SRH**	**Information sources:**
Indicators: • User satisfaction with FP availability and quality (men, women, VMGs)	
Users in rural health facilities do not feel they receive sufficient counselling and consider that FP is not promoted.	Service users
There is insufficient information available on the different methods.	Service users
Users in urban areas are more satisfied with the level of information and counselling they receive at facilities; they feel that health staff understand their rights to FP with freedom of method choice.	Service users
Adolescents and young people feel they are disadvantaged by lack of information and service provider bias as well as community and family level taboos on discussion of sexuality and FP.	Service users
UNFPA has designed and supported projects and programmes which have empowered VMGs including adolescents, sexual minorities and indigenous women, and supported them in understanding their rights to FP. This has led to better access to services for adolescents, higher levels of participation in and ownership of processes of programme design and implementation by transsexuals, and better access to FP services for indigenous women.	NGO staff and CSO networks

Area of Investigation 7: Modes of Engagement

To what extent has UNFPA adapted its mode of engagement[133] to evolving country needs in different settings, using evidence and best practice?

Data collection methods:
Document review
Key Informant Interviews (KII)
Focus Group Discussions (FGD)
Site visits

Assumption 7.1: **HQ and ROs provide support and TA to COs to identify and adapt to changing needs over time.**	**Information sources:**
Indicators:	

[133] "Modes of engagement" refers to the four modes of engagement in the current UNFPA strategic plan (support for service delivery, capacity building, advocacy, knowledge management). These modes of engagement have been included in the ToC diagranm and discussion in section 3.2.1

• Number of visits and TA input from ROs and HQ to collection and analysis of evidence on changing needs in FP engagement • Other activities (staff workshops, training, etc.) conducted by HQ and ROs) to support program innovation and/or incorporation of best practices into programs.	
RO support to all evaluation areas is discussed separately in section 4.9 of the report.	

Assumption 7.2: **UNFPA COs monitor changes in country context and needs over time and adapt their mode of engagement and programme development accordingly.**	**Information sources:**
Indicators: • Evidence of continued monitoring of country context and needs • Evidence collected and analysed on the appropriateness of the mix • Change of engagement modes used over time • Existence and frequency of coordination on engagement modes with national stakeholders and development partners.	
UNFPA has had to adapt to a volatile political environment in the period under evaluation, with large fluctuations in the level of political and central government support for FP. The political agenda in health has been more important to leaders than the technical agenda, and there have been phases of stagnation with little progress in SRH or FP. Modes of engagement have had to take this into account.	UNFPA, NGO and MoH staff
Formerly UNFPA played an important role as a supplier of FP methods. During the period under evaluation UNFPA moved upstream with greater emphasis on advocacy and technical support, although commodity supply has remained important. Throughout the period under evaluation UNFPA has supported development of evidence bases for FP, including the work on VMGs cited in evaluation area 5 above (VMG). UNFPA has also implemented knowledge management activities in response to the lack of reliable information on FP discussed earlier. For example, in 2008 UNFPA and MoH carried out the National Inventory of Contraceptives and Analysis of Logistic Processes. Information gathered for regular reports on GPRHCS Phase II ("Reporting questionnaire for GPRHCS implementing countries based on indicators in the monitoring and evaluation framework") will also provide a contribution of up-to-date and regular information to share with government for better knowledge management.	(JSI Deliver and Futures Group/POLICY II 2003, UNFPA Bolivia 2008a, UNFPA 2014b) UNFPA staff
There was a window of opportunity for UNFPA to promote human rights based approach (HRBA) in 2008 with the new indigenous discourse of the government, which is based on a human rights perspective. UNFPA took up the opportunity with in-depth work on SRH and FP needs of indigenous groups cited earlier.	(UNFPA Bolivia 2009b); UNFPA, MoH, and SEDES staff

In 2009 UNFPA anticipated a move towards more technical strengthening of the government, and this was expected to be an opportunity for UNFPA to engage effectively in technical support. In practice the political agenda in health remained strong, and UNFPA adapted its mode of engagement to the political context, seeking entry points which were appropriate in the political context (for example, emphasising the importance of FP to reduce maternal mortality). Decentralisation policies were seen as an opportunity for more work at municipal and SEDES levels in 2009, and this has been taken up by UNFPA departmental offices.	
The FP programme has adapted to changes in the context during politically volatile periods in specific geographical areas. Many MPs and rural community leaders are members of fundamentalist sects which oppose FP, and where these groups have gained political control, UNFPA has emphasised non-controversial elements of its programme (e.g. commodity supply, reduction of maternal mortality).	UNFPA; Development Partners' staff
UNFPA has had to take over the role formerly taken by USAID as "commodity provider of last resort". It has used this position to promote reproductive health commodity services (RHCS) with government leadership, carrying out a diagnostic of CEASS and developing a programme to strengthen the existing public sector supply structure and its sustainability *("Diagnóstico Situacional de la CEASS y sus regionales: propuesta de reorganización")*.	UNFPA and Development Partners' staff; (UNFPA Bolivia and Ministerio de Salud y Deportes 2010)
Lack of information is an acute problem for FP in Bolivia and is an obstacle to better knowledge management. DHS 2008 data is the only credible database for FP (MoH itself says the SNIS figures are not reliable), and data from the 2014 DHS is still being processed. In the period between DHS, UNFPA has carried out studies of specific groups (see examples in section 5 of this matrix on VMG) and of the supply chain system (cited above). Strengthening of SNIS information on commodity supply is included in the GPRHCS phase II activity plan (2013-2017).	(Coa, Ochoa et al. 2009, de la Mora 2013); MoH and NGO staff;
Modes of engagement have also responded to the availability of new resources such as GPRHCS. GPRHCS funds are used for a wide range of activities which are not limited to commodity security (for example, FP education and promotion). The CO includes all FP activities in its GPRHCS reporting, and GPRHCS has provided resources for UNFPA to carry out activities which were in the country programme but could not be implemented prior to GPRHCS due to lack of funds.	UNFPA staff CO financial data
Knowledge management is not only about creating or collecting data but is also about the use of data. There is limited national capacity for this, and existing data on service use in the SNIS is unreliable.	UNFPA staff; (UNFPA Bolivia 2010, UNFPA 2012a)

UNFPA has worked in knowledge management on its own and in partnership with the MoH and NGOs. For example, it has developed and disseminated studies on indigenous women's and adolescents' needs for FP (cited above), and has supported the MoH in a situation analysis for development of the HIV/AIDS programme ("*PREVETS*").	UNFPA and MoH staff; (UNIBOL and UNFPA 2011a, UNIBOL and UNFPA 2011b, Ministerio de Salud y Deportes nd-a)
UNFPA has not contributed effectively to identifying gaps in knowledge management skills and supporting government in addressing them. Information and supervision systems do not facilitate information flow for problem identification or decision-making. For example, CEASS information formats are designed for inventory control rather than management decision-making. Municipalities who do not order FP methods "*because they don't have a gynaecologist*" could be easily identified by CEASS, but not SEDES who are responsible for problem-solving and remedial measures.	MoH staff
Knowledge management programme includes situation analyses, for example "Analisis de la Situacion de la Poblacion en Bolivia: Poblacion, Territorio y Medio Ambiente" developed in coordination with the Ministry of Planning and Development, and used as an input to discussions between UNFPA and the government on the design of the 2013-2017 CP.	(UNFPA Bolivia 2011a)

Assumption 7.3: **UNFPA interventions and engagement modes support country moves towards increased sustainability of FP and SRH interventions.**	**Information sources:**
Indicators: • Evidence of change in engagement modes supporting moves towards sustainability • Percent of overall FP financial needs covered by national budget • Allocation of funds to FP in medium and long-term health sector plans.	
UNFPA has worked with CEASS on organisational development and marketing, and has contracted long-term national consultants to strengthen these areas within the organisation. In order to increase the sustainability of commodity supply, UNFPA carried out successful advocacy to include FP in the national SUMI insurance scheme. SUMI provides FP methods free of charge to users, and municipalities purchase replacement stocks. (Under the decentralised financing system municipalities receive budgets from the central government for health infrastructure and supplies; the system is therefore equivalent to having a central government budget for contraceptive purchase, provided the municipalities allocate their funds to FP supplies). UNFPA funds have been used as seed capital for setting up a revolving fund for contraceptive purchases in CEASS in order to increase sustainability.	UNFPA and MoH staff; (UNFPA Bolivia 2015)

Advocacy and capacity building for young people and other VMG is based firmly on empowerment and participation in order to increase cultural and social sustainability. UNFPA work has enabled participants to acquire the skills and experience necessary to design their own programmes and do their own advocacy and fund-raising.	MoH, NGO and IP staff

Assumption 7.4: **UNFPA identifies and applies good practice at country, regional and global levels.**	**Information sources:**
Indicators: • Results-oriented monitoring and evaluation systems are in place and inform programming • Evidence of good practices identified with attention for rights and gender issues • Examples of application of good practice at country, regional, global level.	
There are limitations in applying best practices from elsewhere, as each country context is so different. Regular visits from RO staff are used to transfer experiences and best practices. Personal visits enable RO experts to adapt their input to take into account the country context and local needs. GPRHCS regional meetings are used to share experience and best practices.	UNFPA staff
UNFPA and partner organisations have disseminated reports of its work with indigenous groups at regional level.	
Autonomous regions share information and experiences through regular meetings in the central MoH but UNFPA has not had a direct input to identification of best practices in the meetings.	MoH staff
There are lessons to be learnt for UNFPA in comparing modes of engagement in different countries with similar political-administrative structures. The potential role for UNFPA depends on the degree of decentralisation of government decision-making.	MoH and UNFPA staff
UNFPA is strong on research and development of evidence and technical justification for FP. The quality of its research is recognised at national level by key partners (Obstetrician/Gynaecologist Society of Bolivia).	NGO and MoH staff
In Bolivia, the UNFPA departmental offices do not take autonomous decisions but the CO expects them to adapt best practices and apply them in their department where appropriate.	UNFPA staff

Area of Investigation 8: Supply-side Activities

To what extent has UNFPA support for supply-side activities promoted rights-based and sustainable approaches and contributed to improved access to quality voluntary family planning?

Data collection methods:
Document review
Key Informant Interviews (KII)
Focus Group Discussions (FGD)
Site visits

Assumption 8.1: **Provider training supported by UNFPA is client-centred, quality-focused and promoting rights and freedom of choice in FP.**	**Information sources:**
Indicators: • Nature of training programmes offered by MoH and other partners • Behaviour change communication and client counselling included in training, including gender perspectives.	
There has been financial and technical support from UNFPA for MoH staff training on FP methods and on logistics in five departments.	(UNFPA Bolivia 2008a)
Municipal and health network (*redes de salud)* SRH plans were developed in a participative manner and implemented in 2011, following the MoH *Salud Familiar Comunitario Intercultural* (SAFCI) guidelines. The *redes* are clusters of primary and secondary health facilities, and have been set up to strengthen referral systems and improve access to different levels of services. This participative planning method has been adapted by the Health Promotion Unit in the MoH, and will be replicated in municipalities, seeking complementarity between the health networks and social networks at community level. UNFPA has provided material and technical support to the MoH planning process.	(UNFPA Bolivia 2011a)
The slow sales of FP to municipalities in 2011 was thought to be due to lack of staff training in FP at municipality level, so UNFPA started a training programme. Demand creation is being addressed through service provider training and RHCS. UNFPA is currently participating in development of the MoH FP promotion strategy.	(UNFPA Bolivia 2011a)
Training in procurement and in FP service provision was carried out for MoH staff and service providers. Training for MoH staff in elements of RHCS are included in the 2013-2017 plan.	(Ministerio de Planificación del Desarrollo and UNFPA Bolivia 2012, UNFPA Bolivia 2013a)
Staff training is needed to start eliminating service provider bias in favour of specific methods. Staff are not trained or motivated to promote FP. They neither have the information nor the skills available for counselling, nor for administration of some methods such as intra-uterine contraceptive devices (IUCDs).	MoH and NGO staff

Doctors are the FP providers – although task-shifting may be possible there is a shortage of nurses in Bolivia. UNFPA has tried to address this through support for training nurse midwives.	
UNFPA is working on supply through CEASS, but the key problem is the lack of promotion of FP at service provider level. This is due to apathy, lack of interest, or lack of focus on FP by the health and regional authorities. UNFPA has done provider training, but there are obstacles at service delivery level due to lack of staff training and lack of a promotion strategy for FP.	UNFPA, NGO and MoH staff
Service provider training is done at all levels and includes counselling on all methods including natural methods. There is a contradiction for MoH in respecting right to choose and not advising people that natural methods are not reliable.	MoH staff and service providers
There is general agreement that service providers are weak on counselling and that many do not provide full information to clients. They do not understand women's right to choose a method. They do not understand how to counsel indigenous women. There is often no privacy in counselling areas in facilities.	NGO and MoH staff
Use of GPRHCS funds for capacity building is being reduced in phase II of the programme, although this is the priority in Bolivia.	UNFPA staff
GPRHCS Phase II surveys include important questions on quality including method mix, service provider training, stock-outs, implementation of HRBA and access for young people.	(UNFPA 2014c)
Capacity building has included diagnostics of CEASS, and studies of the supply system and its functioning and capacity, starting at central level and going down through departments and municipalities to health facility level.	(UNFPA Bolivia 2008a, UNFPA Bolivia 2008b)
Training has been carried out for MoH by large specialist SRH NGOs which were later contracted directly by MoH and/or requested to provide additional training on a voluntary basis.	NGO, UNFPA and MoH staff

Assumption 8.2: **UNFPA support to procurement promotes availability of a wider method mix.**	**Information sources:**
Indicators: • Range of methods procured by UNFPA, development partners and national governments • Range of methods available at service delivery points for all user groups.	
Use of IUCDs is diminishing	(JSI Deliver and Futures Group/POLICY II 2003)
UNFPA supported the National Forum on Emergency Contraception (EC), has promoted EC with municipalities and at all levels in the MoH, and has distributed learning and promotional materials. UNFPA was instrumental in getting EC introduced into the public sector in 2012. UNFPA (in alliance with the national forum participants which include NGOs and national professional organisations) has been looking for ways to get the laws and norms actually put into practice.	(UNFPA Bolivia and FCI 2013); UNFPA and MoH staff

The female condom, implants and EC were added to the four existing methods available in the public sector (pills, male condoms, injectables and IUCDs) in 2012. UNFPA was the driving force behind this, offering the new methods to the MoH, providing the commodities and supporting staff training (doctors, nurses and ToT) for service provision with new methods and logistics. UNFPA also supports MoH in technical monitoring of the new methods to ensure that health staff are providing counselling and technically correct service to users.	(UNFPA Bolivia 2012) UNFPA and MoH staff
Municipalities control spending on FP methods and their availability in health facilities. Family planning is included in the *Seguro Universal Materno infantil* (SUMI), and methods are provided free of charge to all women aged 5-60, but not to men (condoms are distributed to women). Men can get free condoms through the HIV programmes. There used to be four methods available in SUMI (pills, condoms, injectable, IUCD); the mix has now increased to seven methods thanks to the offer of three new methods (EC, implants, female condoms) by UNFPA in 2012 (see above). Municipalities are the key actors in FP supplies, but some departments are also starting their own insurance systems which will include men, in addition to expansion of the national insurance system (SIS).	(Bertrand 2011) UNFPA and MoH staff
Demand for the three new methods is low – female condoms are not easy to promote, implants still have only a small market segment, and the church/conservative government members oppose EC.	Development Partners and MoH staff
MoH still considers natural methods as legitimate FP methods and incudes them as an eighth option.	NGO and MoH staff and service providers
Although UNFPA has contributed to expanding the availability of a wider mix, many service providers have not been fully trained and many still do not know how to insert IUCDs.	MoH, NGO and UNFPA staff
Young people prefer to use pharmacies for purchasing FP methods, as they provide quicker service and a higher level of privacy.	MoH staff (UNFPA Bolivia 2013b)

Assumption 8.3: **Strengthened procurement and logistics systems and related health system improvements are designed to be financially sustained by national governments.**	**Information sources:**
Indicators: • Trend in FP methods (as percentage of MoH budget) • Trends in contributions by other development partners • Value-for-money in method mix, which meets user needs (men and women, adolescents, VMGs).	

UNFPA works or will work in three areas on the supply side: • CEASS – distribution, sales, introduction of new methods • UNIMED – logistic system, control of pharmacies • SNIS – information systems (programmed for 2013-2017).	(Ministerio de Planificación del Desarrollo and UNFPA Bolivia 2012)
CEASS revolving fund for contraceptives was created in 2010, using a large UNFPA contraceptive donation of four methods to cover all national needs as seed capital. The national shortfall which prompted the request to UNFPA was due to new tax on imported donations. The donations were distributed to departmental CEASS but few were purchased by municipalities. The ring-fenced revolving fund in CEASS which can only be used for contraceptive purchase is a model which GPRHCS has used elsewhere. UNFPA carries out regular monitoring of CEASS and its administration of the revolving fund.	(UNFPA Bolivia 2010); (UNFPA Bolivia 2011a) (CEASS Fondo Rotatorio 2014)
CEASS considers that lack of demand is a marketing problem. It is also due to incorrect and incomplete implementation of policy due to lack of motivation at decentralised departmental and municipal levels.	MoH and UNFPA staff
There are contraceptive stocks in CEASS at central and regional levels, and in the health facilities, but there is insufficient demand. CEASS has lowered prices every year for the last three years but sales are practically price-insensitive, indicating that the problem is a lack of demand. This means that UNFPA will have to work more effectively with MoH to stimulate demand and to include the NGOs and private sector which can also raise demand. This has implications in terms of regionalising the work, as demand is created at municipal level. There is no total market approach to demand and supply of FP in Bolivia although the previous RHCS committee *("Disponibilidad Asegurada de Insumos Anticonceptivos")* was moving in that direction with inclusion of the NGOs in forecasting and planning.	(UNFPA Bolivia and Ministerio de Salud y Deportes 2010)
In 2006, CEASS lost many of its experienced staff and deteriorated rapidly. In 2008 UNFPA carried out a consultancy to diagnose the strengths and weaknesses of CEASS. Weaknesses were identified in many areas, and the consultancy made proposals for reorganization and systems strengthening. CEASS was reorganised in 2011 to address the weaknesses which had been identified and to improve most aspects of the supply chain including processes of procurement, stock-holding, warehousing, distribution and financial administration.	(UNFPA Bolivia nd); (UNFPA Bolivia and Ministerio de Salud y Deportes 2010, UNFPA Bolivia 2011a)
Sustainability depends on the municipalities allocating funds for FP purchases. UNFPA is supporting MoH workshops to raise the awareness of FP at municipal government level.	(UNFPA Bolivia 2012)

UNFPA is supporting work on the revolving fund for contraceptive purchase as a means to achieving financial sustainability. The "*monetarización*" of FP methods (putting a price on the donation, to be paid by municipal governments from their heath budgets) and the revolving fund is a way of getting the government to contribute public sector funds. CEASS sells to municipalities, which receive their funds from the central government, so the net result is equivalent to a government budget line. In this case it is more likely to be sustainable, as the funds which flow back to CEASS have been ring-fenced and can only be used for contraceptive purchase to replace stock. In an earlier attempt at a revolving fund, the income was diverted into purchase of more urgent medicines.	UNFPA, MoH and DP staff (UNFPA Bolivia and Ministerio de Salud y Deportes 2010)
It is more difficult to work on capacity building in supply with government than with other sectors due to high staff rotation, but UNFPA sees this as the only sustainable way.	UNFPA staff
UNFPA has banked on working with CEASS but it is a high-risk strategy as CEASS is politically vulnerable and technically weak. The local government in El Alto where the central office is located considers CEASS a municipal property and wants to take it over, which would lead to risk of political incidence in appointments of key staff. Municipalities are not obliged to buy from CEASS and many do not. CEASS does not get information from the software system that generates orders (although the information is available in UNIMED). Such information would enable it to identify which municipalities are under-ordering and take appropriate promotional action.	MoH staff
UNFPA is still covering contraceptive shortfalls in Bolivia but is trying to work towards sustainability through the revolving fund. The path to sustainability has pitfalls arising from the decentralised government structures. There is no consolidation of orders from municipalities, and therefore it is difficult to procure cost-efficiently.	UNFPA and MoH staff
Attitudes and awareness of decision-makers, procurement and distribution channels, and logistics systems vary between countries (as do questions of national independence) so no one model will suit all countries. UNFPA and the MOH consider that an appraisal by an expert GPRHCS team at start of support would help direct UNFPA resources the best way in the national context.	UNFPA and MoH staff
UNFPA support in Bolivia has consisted of: • Donation of contraceptives and development of the revolving fund • Capacity building for CEASS (consultants, training) • Strengthening of commercialisation strategies (this has proved difficult with products like female condom and EC, but easier for implants). As a result of strengthening by UNFPA, CEASS is now able to do its own procurement, which it plans to do through the UNFPA procurement and information service for reproductive health commodities (AccessRH) this year.	UNFPA and MoH staff; (JSI Deliver 2012)

DFID pulled out of contraceptive purchase for Bolivia in 2001 and USAID pulled out in 2005 as a result of policy and priority changes in UK and USA overseas development.	UNFPA staff (Bertrand 2011)
USAID was effective in running the supply chain but did not invest in capacity building. UNFPA has concentrated more on capacity building and is therefore supporting sustainable change.	NGOs, CEASS La Paz (JSI Deliver 2007)
The revolving fund is designed for sustainability. Profits will be used to strengthen CEASS. At present CEASS can only sell to the public sector and there are even restrictions on public sector sales (UNFPA had to advocate with government to allow sale of condoms to the HIV programme). CEASS would be more financially viable if it could sell to NGOs and the private sector but this would require a change in its statutes. Until NGOs and the private sector are incorporated, a total market approach (TMA) will not be possible and it will be difficult to reach sustainability.	UNFPA and MoH staff
The USAID social marketing programme increased the participation of the pharmacies as FP suppliers. They were an important segment (in urban areas only), and are still a key supplier of condoms as many people (especially young people) prefer to purchase anonymously in the pharmacies.	(JSI Deliver and Futures Group/POLICY II 2003); MoH and NGO staff
DAIA was making progress on inclusion of NGOs and the private sector in planning but disappeared when USAID left. UNFPA and other partners did not take it forward as the government saw it as a system imposed by USAID.	NGO, UNFPA and MoH staff
An HIV programme study of condom sales showed that the private sector sells more condoms than CEASS.	MoH staff; (UNFPA Bolivia 2013a)

Assumption 8.5: **HQ provides appropriate support to CO level in capacity building and procurements**	**Information sources**
THE GPRHCS official in the RO has provided useful support but his time is limited. The contraceptive supply situation in Bolivian prior to GPRHCS was chaotic with poor capacity in CEASS and a complex decision-making system focused on municipalities for contraceptive purchases. There was need for timely support from a central/regional GPRHCS team to help develop a strategic roadmap and design effective interventions. This process would have been quicker with additional specialist input.	UNFPA staff
The RO has offered much-needed support which the government has not accepted due to reluctance to accept input from foreign organisations. LACRO has provided training and has contracted consultant organisations from elsewhere in the region for systems development and training.	UNFPA and NGO staff

GPRHCS funds have enabled the CO to carry out many activities on the demand and supply side which it could not finance before. These include service provider training, advocacy, and supply-chain capacity building.	(UNFPA Bolivia 2015)

ANNEX 4 – SRHR AND FAMILY PLANNING EXPENDITURE (2008-2013)*

PROJECT	IMPLEMENTING PARTNERS	CORE/ NON-CORE	2008	2009	2010	2011	2012	2013	TOTAL SPENDING 2008-13 SRHR INCL FAMILY PLANNING	% FAMILY PLANNING OF TOTAL SPENDING	TOTAL FAMILY PLANNING SPENDING
			SPENDING PER YEAR SRHR INCL. FAMILY PLANNING								
BOL3G102: Active Participation by Women	NGO, UNFPA	CORE	2						2	30%	**1**
		NON-CORE	43	83					126	30%	**38**
BOL3R205: Adolescent project	UNFPA, GOVT	CORE	35	28					63	40%	**25**
		NON-CORE	1.013	134					1.147	40%	**459**
BOL4A11A: Administration and coordination	UNFPA	CORE	145	127	140	151	179		742	20%	**148**
		NON-CORE									
BOL4A12A: Additional resources Bolivia	UNFPA	CORE									
		NON-CORE	8	23					31	10%	**3**
BOL4G11A: Gender equality and human rights	GOVT, UNFPA	CORE	5	84	49	56	8		202	10%	**20**
		NON-CORE									
BOL4G21A: Gender equality	UNFPA	CORE	142	153	189	224	235		943	10%	**94**
		NON-CORE		113					113	10%	**11**
BOL4G22A:Gender equality and human rights	GOVT	CORE	56						56	10%	**6**
		NON-CORE									
BOL4G31A: Emergencies	UNPA, NGOS	CORE			68	18			86	40%	**34**

* Values in '000 USD.

PROJECT	IMPLEMENTING PARTNERS	CORE/ NON-CORE	2008	2009	2010	2011	2012	2013	TOTAL SPENDING 2008-13 SRHR INCL FAMILY PLANNING	% FAMILY PLANNING OF TOTAL SPENDING	TOTAL FAMILY PLANNING SPENDING
			SPENDING PER YEAR SRHR INCL. FAMILY PLANNING								
		NON-CORE			108	326			434	40%	**174**
BOL4G32A: Justice	UNFPA, GOV, NGOS	CORE				59	10		69	20%	**14**
		NON-CORE									
BOL4G41A: Response to gender-based violence	UNFPA, GOV, NGOS	CORE	16	30	40		20		106	10%	**11**
		NON-CORE									
BOL4G42A: Gender-based violence	UNGPA, GOV	CORE		52	56	25	39		172	10%	**17**
		NON-CORE									
BOL4G43A: Gender-based violence	UNFPA	CORE	30						30	10%	**3**
		NON-CORE									
BOL4P13A: Communication advocacy and CENDOC	UNFPA	CORE			94	112	88		294	30%	**88**
		NON-CORE									
BOL4P22A Adolescent rights policies	UNFPA, GOV, NGO	CORE				5	16		21	40%	**8**
		NON-CORE				900			900	40%	**360**
BOL4P22A: Prefectures	UNFPA, GOV	CORE		13	63				76	10%	**8**
		NON-CORE									
BOL4P31A: Population and Development	UNFPA	CORE	140	159	154	173	233		859	10%	**86**
		NON-CORE					34		34	10%	**3**
BOL4P33A: Socio demographic information	UNFPA, GOV, UNIV	CORE	101	145	222	168	206		842	15%	**126**
		NON-CORE			42	3			45	15%	**7**

PROJECT	IMPLEMENTING PARTNERS	CORE/ NON-CORE	2008	2009	2010	2011	2012	2013	TOTAL SPENDING 2008-13 SRHR INCL FAMILY PLANNING	% FAMILY PLANNING OF TOTAL SPENDING	TOTAL FAMILY PLANNING SPENDING
			SPENDING PER YEAR SRHR INCL. FAMILY PLANNING								
BOL4R11A: Health and sexual rights	UNFPA, GOB	CORE	277	350	381	377	411		1.796	85%	**1.527**
		NON-CORE	45						45	85%	**38**
BOL4R12A: Promotion of health demand	GOV	CORE	35	1					36	85%	**31**
		NON-CORE									
BOL4R13A: Promotion of health demand	GOV, UNFPA, NGO	CORE	108	95	57	14			274	50%	**137**
		NON-CORE									
BOL4R14A: Sexuality education	UNFPA, GOV	CORE		31	47	17	80		175	10%	**18**
		NON-CORE									
BOL4R21A: Access to SRH services	UNFPA, GOV, UNIV	CORE	130	177	53	51	22		433	20%	**87**
		NON-CORE									
BOL4R23A: Exercise of sexual rights	UNFPA, GOV	CORE			103	96	60		259	30%	**78**
		NON-CORE									
BOL4R31A: Access to SRH services	GOV, UNFPA, NGOS	CORE			6				6	85%	**5**
		NON-CORE			436	468	653		1.557	100%	**1.557**
BOL4R41A: Demand and utilisation of services	GOV, UNFPA	CORE	30	47					77	50%	**39**
		NON-CORE									
BOL4R51A: Security for adolescents	UNFPA	CORE			7	18			25	40%	**10**
		NON-CORE		131	182	21			334	40%	**134**
BOL4R52A: HIV prevention in adolescents	UNFPA, NGOS, GOV	CORE			40	70	25	12	147	50%	**74**

PROJECT	IMPLEMENTING PARTNERS	CORE/ NON-CORE	2008	2009	2010	2011	2012	2013	TOTAL SPENDING 2008-13 SRHR INCL FAMILY PLANNING	% FAMILY PLANNING OF TOTAL SPENDING	TOTAL FAMILY PLANNING SPENDING
			SPENDING PER YEAR SRHR INCL. FAMILY PLANNING								
		NON-CORE			28			26	54	50%	**27**
HUM6R15A: Field emergency support fund	UNFPA	CORE									
		NON-CORE				18			18	40%	**7**
RLA6G21A: Regional network of indigenous people	UNFPA, NGOS	CORE									
		NON-CORE	15	38	64	104			221	30%	**66**
RLA6P41A: Address strategic emerging population	UNFPA	CORE									
		NON-CORE	1	38	24	23			86	10%	**9**
RLA6R11a: Enabling policy environment	UNFPA	CORE									
		NON-CORE	23						23	10%	**2**
RLA6R12A: RH/SRH and essential SRH package	UNFPA	CORE									
		NON-CORE	6						6	40%	**2**
RLA6R13A: Strengthening community networs	UNFPA	CORE									
		NON-CORE	3						3	10%	**0**
RLA6R22A: Reduction of indigenous maternal mortality	UNFPA, NGOS	CORE		54	133	71			258	50%	**129**
		NON-CORE									
RLA6R41A: HIV prevention and SRH	UNFPA	CORE									
		NON-CORE		25	17	27			69	20%	**14**
RLA6R51A: Strengthening youth SRH	GOV, UNFPA, SOCIAL ORGANISATIONS	CORE									
		NON-CORE		181	189	260	1		631	40%	**252**

PROJECT	IMPLEMENTING PARTNERS	CORE/ NON-CORE	2008	2009	2010	2011	2012	2013	TOTAL SPENDING 2008-13 SRHR INCL FAMILY PLANNING	% FAMILY PLANNING OF TOTAL SPENDING	TOTAL FAMILY PLANNING SPENDING
			SPENDING PER YEAR SRHR INCL. FAMILY PLANNING								
BOL5A100: PCA	UNFPA	CORE						212	212	40%	**85**
		NON-CORE									
BOL5U301: Access to SRH services	GOV, UNIV, NGPS, UNFPA	CORE						219	219	85%	**186**
		NON-CORE						469	469	100%	**469**
BOL5U302: Demand for SR rights	GOV, UNIV, NGPS, UNFPA	CORE						131	131	50%	**66**
		NON-CORE						66	66	100%	**66**
BOL5Y503: Social organisations	GOV, UNIV, NGPS, UNFPA	CORE						182	182	10%	**18**
		NON-CORE						278	278	10%	**28**
BOL5U504: Sexual violence	GOV, UNIV, NGPS, UNFPA	CORE						142	142	10%	**14**
		NON-CORE						185	185	10%	**19**
BOL5U605: Adolescents and young people	GOV, UNIV, NGPS, UNFPA	CORE						199	199	10%	**20**
		NON-CORE						366	366	10%	**37**
BOL5U606: Sexuality education	GOV, UNFPA	CORE						166	166	10%	**17**
		NON-CORE									
BOL5U707: Data availability	GOV, UNIV, UNFPA	CORE						230	230	10%	**23**
		NON-CORE									

PROJECT	IMPLEMENTING PARTNERS	CORE/ NON-CORE	2008	2009	2010	2011	2012	2013	TOTAL SPENDING 2008-13 SRHR INCL FAMILY PLANNING	% FAMILY PLANNING OF TOTAL SPENDING	TOTAL FAMILY PLANNING SPENDING
			SPENDING PER YEAR SRHR INCL. FAMILY PLANNING								
											TOTAL FP SPENDING
TOTAL CORE SPENDING ON SRHR INCLUDING FP			1.252	1.546	1.902	1.705	1.632	1.327	9.364		**3.234**
TOTAL NON-CORE SPENDING ON SRHR INCLUDING FP			1.157	766	1.090	2.150	688	1.390	7.241		**3.782**
TOTAL SPENDING ON FAMILY PLANNING COMMODITIES (NON-CORE)					474	453		1.241	2.168		**2.168**
TOTAL SPENDING SRHR AND FAMILY PLANNING			2.409	2.312	3.466	4.308	2.320	3.958	18.773		**9.183**

Source: CO Financial data

The information presented in the above table was shared by the UNFPA country office in Bolivia. Under the guidance of the UNFPA Evaluation Office, the country office in Bolivia identified projects in support of family planning – those fully dedicated to family planning as well as those in which family planning activities were mainstreamed – and reported the amount spent (annually) under each project. Project expenditure was disaggregated into core and non-core funding. The country office was then asked to estimate the percentage (%) of the project in support of family planning – 100% in cases where projects were fully dedicated to family planning and an estimated percentage for projects in which family planning activities were an aspect of the project (mainstreamed). The type of implementing partner (NGO, government and/or UNFPA) – information also provided by the country office - is captured in the table, as well.

The above approach was chosen due, primarily, to challenges in obtaining family planning expenditure through the use of the UNFPA financial management platform (Atlas). For the period under evaluation, the UNFPA financial management platform did not explicitly track family planning expenditure and, when it did so, did not capture all/the full range of family planning expenditure. Prior to 2011, there was no dedicated family planning project outcome code within Atlas. Instead, activities advancing family planning were embedded in other projects, posing significant challenges to capturing family planning expenditure. In 2012 this changed: reflecting a shift in UNFPA outcomes, a dedicated family planning project outcome code was introduced in Atlas (the U3 code). While this contributed to an improved ability to track family planning expenditure, the code does not capture expenses corresponding to family planning activities that are mainstreamed/ included within other interventions, with the attendant challenges remaining.

As mainstreaming poses particular challenges to accurately identifying the entirety of projects and activities in support of family planning in Atlas, and subsequently, in determining the amount spent in support of family planning, country offices – deeply familiar with the specifics of a project - were requested to report on family planning expenditure. A degree of subjectivity exists in, inter alia, selecting family planning projects and estimating/assigning the percentage of a project dedicated to family planning (in cases where the activities have been embedded). However, the country office is best positioned to address this, offering a sound determination based on intimate knowledge of a project and its implementation.

The country office was provided with two guidance notes: one focusing on which activities should be considered family planning and the other on estimating percentages. On the former, guidance listed the expenses that should be considered expenditure in support of family planning, including projects with a U3 code, projects funded through the Thematic Fund for Reproductive Health Commodity Security, expenses incurred to strengthen information systems pertaining to family planning or expenses incurred to create enabled environments for human-rights family planning.

A typology/percentage guidance note was also provided. This note listed activities - under different Strategic Plan (2014-2017) outputs - that can be considered to have a family planning component, with the corresponding suggested percentage included. While this was offered as a tool to support the country office, the country office was encouraged to offer the percentages that best reflected the actual expenses related to family planning in Bolivia.

ANNEX 5 – IMPLEMENTING PARTNERS

Implementing Partner	Project ID and Title	Project ID and Title (continued)
Gobierno Municipal El Alto	BOL3R205: Adolescent project	
Gobernación Potosi	BOL4G22A: Gender equality and human rights	
Ministerio Salud	BOL4R21A: Access to SRH services	
Prefectura Beni	BOL4G42A: Gender based violence BOL4R11A: Health and sexual rights BOL4R12A: Promotion of health demand	
Gobierno Municipal Santa Cruz	BOL3R205: Adolescent project	
Gobernacion Chuquisaca	BOL4G22A: Gender equality and human rights	
INE	BOL4P33A: Socio demographic information	
Prefectura Cochabamba	BOL4R12A: Promotion of health demand	
Gobernacion Chuquisaca	BOL4G42A: Gender based violence BOL4P22A: Adolescent rights policies (Title 1) or Prefectures (Title 2) BOL4R11A: Health and sexual rights BOL4R14A: Sexuality Education BOL4R23A: Exercise of sexual rights BOL4R31A: Access to SRH services RLA6R51A: Strengthening youth SRH	
Ministerio Salud	BOL3R205: Adolescent project	
Gobernación Potosi	BOL4G42A: Gender based violence BOL4P22A: Adolescent rights policies (Title 1) or Prefectures (Title 2) BOL4R11A: Health and sexual rights BOL4R14A: Sexuality Education BOL4R31A: Access to SRH services RLA6R51A: Strengthening youth SRH	
SEDUCA Santa Cruz	BOL3R205: Adolescent project	
MINISTERIO JUSTICIA	BOL3R205: Adolescent project	
Ministerio Salud	BOL4R11A: Health and sexual rights BOL4R31A: Access to SRH services RLA6R51A: Strengthening youth SRH	
Policia Nacional	BOL3R205: Adolescent project	
Ministerio Educacion	BOL4R14A:Sexuality Education	
Universidad Mayor de San Andres La Paz	BOL4P33A: Socio demographic information	
Gobierno Municipal El Alto	RLA6R51A: Strengthening youth SRH	
Policia Nacional	BOL4R11A: Health and sexual rights RLA6R51A: Strengthening youth SRH	
FISCALIA GENERAL	BOL4R31A: Access to SRH services	
Universidad Autonoma Juan Misael Saracho Tarija	BOL4R21A: Access to SRH services	
Universidad San Francisco Xavier de Chuquisaca	BOL4R21A: Access to SRH services BOL4R31A: Access to SRH services	
Gobierno Municipal de La Paz	BOL3R205:Adolescent project BOL4P44A: Older Adult	

MINISTERIO JUSTICIA	BOL4G11A: Gender equality and human rights BOL4P44A: Older Adult BOL4P22A: Adolescent rights policies (Title 1) or Prefectures (Title 2) RLA6R51A: Strengthening youth SRH	
Ministerio de Salud y Deportes	BOL4R11A: Health and sexual rights BOL4R31A: Access to SRH services RLA6R51A: Strengthening youth SRH BOL5U301: Access to SRH services	
Instituto Nal. de Estadistica	BOL4P33A: Socio demographic information	
Gobierno Autonomo de Chuquisac	BOL4G42A: Gender-based violence BOL4P22A: Adolescent rights policies (Title 1) or Prefectures (Title 2) BOL4R11A: Health and sexual rights BOL4R23A: Exercise of sexual rights BOL4R31A: Access to SRH services RLA6R51A: Strengthening youth SRH BOL5U301: Access to SRH services BOL5U302: Demand for SR rights BOL5U504: Sexual Violence BOL5U605: Adolescents and young people	
Gobierno Autonomo de Potosi	BOL4G42A: Gender-based violence BOL4P22A: Adolescent rights policies (Title 1) or Prefectures (Title 2) BOL4R11A: Health and sexual rights BOL4R31A: Access to SRH services RLA6R51A: Strengthening youth SRH BOL5U301: Access to SRH services BOL5U302: Demand for SR rights BOL5U504: Sexual Violence	
Ministerio de Educación	BOL4R14A: Sexuality Education BOL5U606: Sexuality Education	
Ministerio de Justicia	BOL4G11A:Gender equality and human rightsBOL4P44A: Older AdultBOL4P22A: BOL4P22A: Adolescent rights policies (Title 1) or Prefectures (Title 2)BOL4G41A: Response to gender-based violenceRLA6R51A: Strengthening youth SRH BOL5U503: Social and Indigenous OrganizationsBOL5U504: Sexual ViolenceBOL5U605: Adolescents and young people	
Universidad Autonoma Juan Misael Saracho Tarija	BOL4R21A: Access to SRH services BOL5U301: Access to SRH services	
Universidad San Francisco Xavier de Chuquisaca	BOL4R21A: Access to SRH services BOL5U301: Access to SRH services	
Gob.Autonomo Deptal. Cochabamb	BOL4G42A: Gender-based violence BOL4R11A: Health and sexual rights BOL4R23A: Exercise of sexual rights BOL4R31A: Access to SRH services RLA6R51A: Strengthening youth SRH BOL5U301: Access to SRH services BOL5U302: Demand for SR rights BOL5U504: Sexual Violence	

FISCALIA GENERAL BOLIVIA	BOL4G32A: Justice BOL4R11A: Health and sexual rights BOL5U504: Sexual Violence	
Unidad Analisis Polit.Soc/Econ UDAPE	BOL4P11A: Evaluación Renta Dignidad BOL5U707: Data availability	
Gob.Autonomo Municipal de La P	RLA6R51A: Strengthening youth SRH	
Universidad Nacional de Siglo	BOL4R21A: Access to SRH services	
UMSA-CIDES Postgrado	BOL4P33A: Socio demographic information BOL5U707: Data availability	
DIR. DEPTAL EDUCACION CHUQUISAC	BOL4R14A: Sexuality Education BOL5U606: Sexuality Education	
DIR. DEPTAL EDUCACION POTOSI	BOL4R14A: Sexuality Education	
Gob. Autonomo Dptal La Paz	BOL4R31A: Access to SRH services BOL5U301: Access to SRH services	
GOB. AUTONOMO MUNICIPAL CAMARG	BOL4P22A: Adolescent rights policies (Title 1) or Prefectures (Title 2) BOL5U504: Sexual violence BOL5U605: Adolescents and young people	
GOB. AUTONOMO MUNCIPAL SOPACHUY	BOL4P22A: Adolescent rights policies (Title 1) or Prefectures (Title 2) BOL5U504: Sexual violence BOL5U605: Adolescents and young people	
GOB. AUTONOMO MUNICIPAL TOMINA	BOL4P22A: Adolescent rights policies (Title 1) or Prefectures (Title 2) BOL5U504: Sexual violence BOL5U605: Adolescents and young people	
GOB. AUTONOMO MUNICIPAL UNCIA	BOL4P22A: Adolescent rights policies (Title 1) or Prefectures (Title 2) BOL5U504: Sexual violence BOL5U605: Adolescents and young people	
GOB. AUTONOMO MUNICIPAL LLALLAG	BOL4P22A: Adolescent rights policies (Title 1) or Prefectures (Title 2)	
GOB. AUTONOMO MUNICIPAL TUPIZA	BOL4P22A: Adolescent rights policies (Title 1) or Prefectures (Title 2) BOL5U504: Sexual violence BOL5U605: Adolescents and young people	
Gob. Autonomo Municipal de Viac	BOL4P22A: Adolescent rights policies (Title 1) or Prefectures (Title 2) BOL5U504: Sexual violence BOL5U605: Adolescents and young people	
GOB.AUTONOMO MUNICIPAL DE SUCR	BOL4P22A: Adolescent rights policies (Title 1) or Prefectures (Title 2)	
GOB.AUTONOMO MUNICIPAL COROICO	BOL4P22A: Adolescent rights policies (Title 1) or Prefectures (Title 2) BOL5U504: Sexual violence BOL5U605: Adolescents and young people	
Ministerio de Autonomias	BOL5U605: Adolescents and young people	
STUDIES CENTRE FOR RURAL D MEX	BOL5U605: Adolescents and young people	

FAMILY CARE INTERNATIONAL -BOL	BOL4R11A: Health and sexual rights BOL4R31A: Access to SRH services RLA6G21A: Regional network of indigenous people RLA6R22A: Reduction of indigenous maternal mortality BOL5U301:Access to SRH services BOL5U302: Demand for SR rights BOL5U504: Sexual violence	
CENTRO DE DESARROLLO - BOL	BOL3G102: Active Participation by WomenBOL4R13A: Promotion of health demand	
Asoc de Concejalas de Bolivia	BOL4G41A: Response to gender-based violence BOL5U302: Demand for SR Rights BOL5U503: Social and Indigenous Organizations	
Catolicas por el Derecho-BOL	BOL4G11A: Gender equality and human rights BOL4P44A: Older Adult BOL4P13A: Communication advocacy and CENDOC BOL4P22A: Adolescent rights policies (Title 1) or Prefectures (Title 2) BOL4R13A: Promotion of health demand BOL4R31A: Access to SRH services BOL5U605: Adolescents and young people	
Mesa de Trabajo Nac VIH-BOL	BOL4P22A: Adolescent rights policies (Title 1) or Prefectures (Title 2) BOL4R41A: Demand and utilisation of services BOL4R52A:HIV prevention in adolescents BOL5U503: Social and Indigenous Organizations	
Conf. Nal de Mujeres Campesina	BOL5U302: Demand for SR rights BOL5U503: Social and Indigenous Organizations	
Centro De Investigacion Educae CIES	BOL4G31A: Emergencies	
FUNDACION CUERPO DE CRISTO	BOL4R52A: HIV prevention in adolescents	
CONSORCIO BOLIVIANO DE JUVENTU	BOL4P22A: Adolescent rights policies (Title 1) or Prefectures (Title 2) RLA6R51A: Strengthening youth SRH	
Fundación Igualdad LGBT	BOL4R52A: HIV prevention in adolescents	
CARE INTERNATIONAL BOLIVIA	BOL4R21A: Access to SRH services BOL4R31A: Access to SRH services RLA6R51A: Strengthening youth SRH	
Marie Stopes Intl Bolivia	BOL4G32A: Justice BOL5U301: Access to SRH services BOL5U504: Sexual Violence BOL5U605: Adolescents and young people	
Vision Mundial Bolivia	RLA6G21A: Regional network of indigenous people	
Asociación Psinergia	BOL4P22A: Adolescent rights policies or Prefectures	
CENTRO GREGORIA APAZA	BOL4P22A: Adolescent rights policies (Title 1) or Prefectures (Title 2) BOL5U503: Social and Indigenous Organizations BOL5U605: Adolescents and young people	
ASOC. CIVIL DES.SOCIAL Y PROM.	BOL4P22A: Adolescent rights policies (Title 1) or Prefectures (Title 2) BOL4P31A: Population and Development	
RED NAL. TRABAJADORAS INFO Y CO	BOL4P22A: Adolescent rights policies (Title 1) or Prefectures (Title 2)	

Fund. Comunidad Productores COM	BOL4P22A: Adolescent rights policies (Title 1) or Prefectures (Title 2)	
Oficina Juridica para la Mujer	BOL4P22A: Adolescent rights policies (Title 1) or Prefectures (Title 2) BOL5U504: Sexual Violence BOL5U605: Adolescents and young people	
UN POPULATION FUND	BOL3G102: Active Participation by Women BOL3R205: Adolescent project BOL4A11A: Administration and Coordination BOL4A12A: Additional Resources Bolivia BOL4G11A: Gender equality and human rights BOL4P44A: Older Adult BOL4P22A: Adolescent rights policies (Title 1) or Prefectures (Title 2) BOL4G21A: Gender Equality BOL4G31A: Emergencies BOL4G32A: Justice BOL4G41A:Response to gender-based violence BOL4G42A: Gender-based violence BOL4G43A: Gender-based violence BOL4P11A: Evaluación Renta Dignidad BOL4P13A: Communication advocacy and CENDOC BOL4P31A: Population and Development BOL4P33A: Socio demographic information BOL4R11A: Health and sexual rights BOL4R13A: Promotion of health demand BOL4R14A: Sexuality education BOL4R21A: Access to SRH services BOL4R23A: Exercise of sexual rights	BOL4R31A: Access to SRH services BOL4R41A:Demand and utilisation of services BOL4R51A: Security for adolescents BOL4R52A:HIV prevention in adolescents BOL5A100:PCA BOL5U301:Access to SRH services BOL5U302:Demand for SR rights BOL5U503: Social and Indigenous Organizations BOL5U504: Sexual violence BOL5U605: Adolescents and young people BOL5U606: Sexuality education BOL5U707: Data availability HUM6R15A: Field emergency support fund RLA6G21A: Regional Network of Indigenous People RLA6P41A:Address strategic emerging population RLA6R11A: Enabling policy environment RLA6R12A: RH/SRH and essential SRH package RLA6R13A: Strengthening Community Networks RLA6R22A: Reduction of indigenous maternal mortality RLA6R41A: HIV prevention and SRH RLA6R51A: Strengthening youth SRH

ANNEX 6 – DETAILED KEY FACTS

Indicator	2012	2014	Source of Data
Population and Development			
Population, total	9,599,916	10,561,887	World Bank[1]
Population, aged 0-14 (% of total)	34	33	World Bank[1]
Population, aged 15-64 (% of total)	60	61	World Bank[1]
Population, ages 65+ (% of total)	6	6	World Bank[1]
Population growth (annual %)	1.6	1.5	World Bank[1]
Urban Population (% of total)	67	68	World Bank[1]
Population Density (per sq. km of land area)	9	10	World Bank[1]
Life Expectancy at birth, total (years)	67	68.3	World Bank[1]
Literacy rate, population 15+ years, both sexes (%)	94	-	World Bank[1]
Youth Literacy rate, population 15-24, both sexes (%)	99	-	World Bank[1]
Human Development Index (HDI)	0.675 (Rank 107 out of 187)	0.662 (Rank 119 out of 188)	Human Development Report[2]
Human Development Classification (very high, high, medium, low, upper middle, high)	Medium	Medium	Human Development Report[134]
Total GDP at market price (current US$)	27,084,497,540	32,996,187,988	World Bank[1]
Economic growth rate (GDP growth annual %)	5.1	5.5	World Bank[1]
GINI Index	46.7	-	World Bank[1]
Multidimensional Poverty Index (MPI), HDRO specifications	0.089	0.097	Human Development Report[3]
Government Effectiveness			
World Bank CPIA Quality of Public Administration rating (1=low to 6 = high)	3.0	3.0	World Bank[1]
UNFPA: Need and Ability to Finance			

[134] United Nations Development Programme. (2016). Country Classification. Retrieved from https://pharmacoepi.org/pub/1c08ab60-2354-d714-5192-9cc81d38354f

UNFPA country quadrant	-	Orange	UNFPA Strategic Plan[135]
Gender Equality and Empowerment			
Gender Inequality Index	0.474 (Rank 97 out of 148)	0.444 (Rank 94 out of 155)	Human Development Report[3]
Women representation in parliament, total (%)	30.1	51.8	World Bank[1]; Human Development Report[3]
Violence against women ever experienced (%)	-	67.6	Human Development Report[3]
Employment to population ratio, 15+, female (%) (modeled ILO estimate)	62	62	World Bank[1]
Ratio of girls to boys in primary and secondary education (%)[4]	0.99	-	World Bank[1]
Reproductive Rights and Reproductive Health			
Fertility rate, total (births per woman)	3.1	-	World Bank[1]
Adolescent fertility rate (births per 1,000 women ages 15-19)	73	71	World Bank[1]
Teenage mothers (% of women ages 15-19 who have had children or are currently pregnant)	-	-	World Bank[1]
Prevalence of HIV, female (% ages 15-49)	0.1	0.1	World Bank[1]
Prevalence of HIV, male (% ages 15-49)	0.2	0.2	World Bank[1]
Maternal mortality rate (per 100,000 live births)	230	215	World Bank[1]
Under 5 mortality rate (per 1,000 live births)	43	40	World Bank[1]
Contraceptive use, modern methods (%)	-	48.8	UN DESA Population Division Estimates and Projections of Family Planning Indicators[5]

[135] United Nations Population Fund. (2015). UNFPA Strategic Plan. Retrieved from https://webcache.googleusercontent.com/search?q=cache:PBcjL1D-HDYJ:https://www.unfpa.org/sites/default/files/about-us/Annex%25204%2520(funding%2520arrangements).docx+&cd=1&hl=en&ct=clnk&gl=ca

Unmet need for family planning (number of married or in-union women aged 15 to 49 who want to stop or delay childbearing but are not using a method of contraception, %)	-	15.1	UN DESA Population Division Estimates and Projections of Family Planning Indicators[5]
Demand for family planning satisfied (% of total demand for family planning among married or in-union women aged 15 to 49 that is satisfied)	-	81.3	UN DESA Population Division Estimates and Projections of Family Planning Indicators[5]
Births attended by skilled health staff (% of total)	-	-	World Bank[1]
Antenatal care (any skilled provider)	-	-	World Bank[1]