
Prepared for UNFPA

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EXECUTIVE SUMMARY

Background and Situation Analysis

UNFPA has been assisting the people and government of Sri Lanka since 1969, almost 40 years. Early on, UNFPA support was primarily for maternal health and family planning services as well as building national capacities for demographic research and training. With a current population of 19 million and a total fertility rate of 1.9, Sri Lanka is now entering the final phase of demographic transition. Sri Lanka is a lower middle-income country with a GNI of US $1,160 per capita. Most Millennium Development Goals have been met or soon will be. Regional and socio-economic disparities are significant and growing, however—and poverty remains a major challenge. Progress has been slowed by ongoing ethnic conflict, especially in the Northern and Eastern provinces, compounded by the disastrous tsunami in December 2004.

Sri Lanka has made remarkable achievements in public health, including in reducing maternal and infant mortality. Today the vast majority of births take place in health care facilities. The contraceptive prevalence rate is about 70%, with about 50% modern method use. Despite these otherwise positive indicators, high numbers of women still die from unsafe abortion. Estimates of the number of abortions range from 700-1000 per day, accounting for an estimated one-third of all pregnancies. Most abortion seekers are married women over the age of 35, which is a direct reflection of current gaps in the quality and availability of family planning services in Sri Lanka and high unmet need for family planning. Young people have limited access to reproductive health information and services. Sri Lanka is currently a low-prevalence country for HIV/AIDS, even though the country has many risk factors that could easily trigger a rapid escalation of HIV infections.

UNFPA is one of five major international agencies supporting the government of Sri Lanka in the health sector. Others are WHO, UNICEF, the World Bank, and the Japan International Cooperation Agency (JICA).

The 6th UNFPA-Supported Country Programme

The main areas of focus of the CP (2002-2007) included:

(a) increasing access to reproductive health services of underserved and vulnerable communities;
(b) supporting NGOs to address gaps in services in underserved areas;
(c) building capacities for reproductive health promotion;
(d) strengthening reproductive health in-school education; and
(e) supporting advocacy efforts targeting policy makers and planners as well as community and religious leaders.

Total UNFPA funding support during the period 2002-2007 was: Country Programme $7 million; regional youth projects RHIYA Project $1.35 million; and tsunami rehabilitation and support $8.1 million—a total of approximately $19 million.
Evaluation Purpose, Audience and Methodology

UNFPA Sri Lanka is in the process of developing its 7th cycle of programming to be implemented during 2008-2012. The main objective of this evaluation is to draw out lessons learnt during the 6th country programme and make recommendations to be considered in developing next country programme action plan. The evaluation was to highlight strengths, weaknesses and gaps, good practices, and provide forward-looking recommendations. The primary audience (intended users) for the evaluation is UNFPA: Sri Lanka country office and UNFPA Headquarters.

The evaluation took place from 2-28 July 2007. Conclusions and recommendations are based on: extensive interviews with implementing partners and other stakeholders (22 interviews with 40+ persons); field visits & interviews at project sites in 13 districts: (Kurunegala, Galewela, Polonnaruwa, Kantale, Trincomalee, Kandy, Kadugannawa, Pussellawa, Nuwaraeliya, Maskeliya, Matara, Aluthgama, and Kalutara); document review, including all project agreements and evaluations, relevant government policy and legislation, UNFPA and UN global documents, and others; and triangulation of findings from the preceding three sources.

Major Conclusions

1. Relevance to UNFPA global priorities. In general, UNFPA Sri Lanka’s 6th country programme and its components projects are quite in line with the global UNFPA mandate and its Multi-Year Funding Framework, 2004-2007. An exception is the global strategy’s/MYFF’s emphasis on results. Design and implementation of the 6th CP placed greater focus on activities than results.

2. Relevance to Sri Lanka. Overall, UNFPA’s 6th Country Programme has been very relevant to Sri Lanka’s population and reproductive health needs. UNFPA is the main international and U.N. agency supporting reproductive health in Sri Lanka. It has played a pivotal role in initiating and developing sexual and reproductive health services for adolescents in the country. Its support to population issues has contributed significantly to understanding of the implications of the demographic changes at both national and sub-national levels and strengthened the capacity of local institutions to undertake related work. UNFPA’s concern for gender equity is highly relevant in the Sri Lankan context; while many indicators for women are very good, there are also serious regional disparities and aberrations.

3. Relevance and contribution of other projects. The four unanticipated projects (two youth-focused and two tsunami) that UNFPA Sri Lanka took up during its 6th CP brought a certain amount of disruption and stress to the country office but, on the whole, the positive contributions have been important and outweighed the negatives. Both the youth-focused and tsunami response activities have been highly relevant to Sri Lanka’s needs.

The two regional youth projects, both focused on reaching adolescents and youth in out-of-school settings, introduced important innovations that broadened Sri Lanka’s approach to SRH for young people. The Reproductive Health Initiative for Youth in Asia (RHIYA) was the second cycle of an initiative in Sri Lanka to provide SRH counseling for adolescents and youth in a community setting. The Youth Friendly Services (YFS) project is the first effort in
Sri Lanka combining SRH services for youth (including counseling and condom supply) with other activities, such as computer training and entertainment, in a one-stop service.

The two tsunami projects contributed to the country programme in important several ways. They expanded the scope of UNFPA Sri Lanka’s interventions to include RH and related services in emergency/humanitarian settings and propelled UNFPA actively into a lead role on gender and gender-based violence.

4. Humanitarian/emergency support. UNFPA/Sri Lanka does have limited capacity to provide urgently needed humanitarian/emergency assistance, and UNFPA’s mandate for this work is quite clear in Sri Lanka. The critical although limited support UNFPA has provided in the IDP districts and its larger post-tsunami response are clear evidence that the country expects and UNFPA is able to mount such an operation.

5. Meeting reproductive health needs of the most vulnerable groups. Although UNFPA focuses on underserved groups, UNFPA support is spread too thin to meet the RH needs of Sri Lanka’s most vulnerable groups. At best, UNFPA could only contribute to meeting the RH needs of the most vulnerable groups in Sri Lanka. However, there is lack of clarity as to who the most vulnerable groups are. Clearly focused thinking on this matter is a necessary step to more effective programming for results.

6. UNFPA’s comparative advantage. Despite its relatively modest resources, UNFPA is well-positioned in Sri Lanka to make a difference. Its current areas of concern and engagement are national priorities. Still, to increase effectiveness and efficiency and make the greatest difference possible, it should deploy its resources and focus its support more strategically.

Effectiveness/Achievement of Results: Strengthening Reproductive Health Services

1. Unmet needs for family planning. Addressing the problem of unmet needs for family planning constitutes one of the most urgent reproductive health requirements in the country. It is essential for saving women’s lives, reducing the numbers of women who resort to unsafe abortion rather than bring an unwanted child into the world. As Sri Lanka has advanced to the ranks of a middle-income country, women still dying in abortion stands out as a black mark on the face of its otherwise successful family planning and human development programmes.

2. Quality assurance. Support to set up a functional, effective Quality Assurance System is another need in which UNFPA can play a significant role, both in terms of advocacy and technical advice.

3. Reproductive health services to underserved and vulnerable populations. Providing reproductive health services to the country’s underserved and vulnerable populations is a challenge. UNFPA has provided some support for RH services in several conflict-affected and neighbouring districts, some tea plantations, and a few remote areas. The input of UNFPA to these populations has been limited and not always to the most underserved.

4. Well Woman Clinics. Well Woman Clinics (WWCs) are an innovation that has the UNFPA brand name etched on it. The concept of screening healthy well women at community level is relatively new, requiring public education prior to its acceptance. However, while community interest is being created, the service elements need to keep pace with community expectations.
5. **STIs and HIV/AIDS.** The National HIV/AIDS Strategic Plan 2007-2011 identifies populations considered “most at-risk” for HIV and makes these the focus of the plan. During the 6th CP, UNFPA has had very minimal engagement with Sri Lankan populations most at-risk for HIV.

6. **Education and training.** UNFPA’s long-term support to education and training in reproductive health is well recognized and currently UNFPA is the main organization that supports this training. There is need now to update and rationalize both pre- and in-service training.

7. **Advocacy for reproductive health.** Overall, UNFPA seems to have had limited success in its advocacy role on important aspects of reproductive health. The advocacy role to initiate policy dialogue among the parliamentarians, provincial counselors and high-level decision-makers does not seem to have produced tangible results.

8. **Engaging the private sector.** Increasing numbers of Sri Lankans are seeking RH-related care in the private sector, mainly for STIs and HIV; those private-sector services could be enhanced to improve the overall programme.

**Effectiveness/Achievement of Results: SRH Information and Services for Adolescents and Youth**

1. UNFPA has been a pioneer in supporting sexual and reproductive health programs for young people in Sri Lanka. While the ASRH services supported by the UNFPA during its 6th country Programme may be described as comprehensive -- in the sense that all segments of young people (in-school, out-of-school, working and unemployed, boys and girls) were reached in one way or another -- the programme was also thinly spread, insufficiently targeted, inadequately results-oriented and poorly evidence-based. A more targeted and results-oriented approach focusing on underserved youth in particularly vulnerable situations is needed for developing interventions under CP 7.

2. **In-school adolescents.** As school children are the majority of adolescents in Sri Lanka and a captive group accessible through the schools, the school system provides important opportunities for promotion of sexual and reproductive health and responsibility. Reproductive health modules are now in the school curricula and a programme of counseling and peer communicators has been introduced in some schools. However, continuing resistance by conservative administrators, teachers and parents, as well as the limitations of the traditional didactic teaching methods and lack of open discussion and free flow of information between teachers and the younger generation, remains a serious constraint to effective implementation. There are no data to show an impact on behaviour.

3. **Out-of-school youth.** Adolescents and out-of-school youth are more sexually active and thus more vulnerable from the perspective of sexual and reproductive health risks than in-school adolescents, but addressing their SRH needs is extremely challenging. While several programmes have been carefully designed and implemented for many of these vulnerable young people, it is not possible to determine the effectiveness of these programmes from the existing data.

**Effectiveness/Achievement of Results: Gender**

1. Gender was conceptualised in 2001 as a cross-cutting theme in UNFPA’s 6th Country Programme, but UNFPA did not develop a comprehensive strategy to integrate gender into
all its projects and interventions. Instead, “Gender” has been compartmentalised and managed like a project in itself.

2. UNFPA nevertheless has become recognised as a leader in gender work and has achieved a good foundation during CP6 for progress toward gender-related goals that are important for Sri Lanka. This includes tackling gender-based violence, increasingly recognised as a serious issue in the country.

   Effectiveness: Cross-Cutting Concerns

1. Programme design. It is difficult to determine the extent to which UNFPA Sri Lanka considered its capacity when designing the Sixth Country Programme. The selection of operational strategies (linking partners, target groups and interventions) was generally appropriate, but UNFPA’s resources were spread too thin to achieve significant results. Achievement of results was also constrained by the programme design being activity-based rather than results-focused.

2. UNFPA partnering. Most of the governmental and NGO partners selected by UNFPA were appropriate. They contributed in different ways to achievement of specific inputs and processes. However, due to the general lack of focus on programme results, it is difficult to quantify and evaluate the specific outcomes resulting from collaboration with each of these partners. Three partners were not effective in their roles.

3. Implementation: Synergy and learning lessons. Programme components have been implemented basically as vertical projects with little synergy or lesson-sharing among them. Lesson-sharing with partners tends to concern immediate issues of programme implementation rather than analysis of outcomes and effectiveness over time.

4. Monitoring, evaluation and accountability systems. Although various forms of monitoring take place, and many mid-term evaluations and reviews have been carried out, the current approach is not adequate to enable UNFPA to demonstrate programme results. On a positive note, based on the set of mid-term evaluations and reviews, some recommended changes were made in the implementation of various projects.

   Efficiency

Detailed financial data and output data are not immediately available. Although they could be extracted from agency records, it is not possible in the context of this evaluation to reach firm conclusions about efficiency in the use of programme resources. Various factors suggest, however, that the use of resources was not the most efficient.

   Sustainability

1. There is very good likelihood that the reproductive health/family planning programme will be sustained, regardless of UNFPA support. This is less true for other programme components. On the whole, there is limited evidence that any of the adolescent sexual and reproductive health (SRH) interventions carried out under UNFPA support will have long-term continuity and lasting results upon the termination of UNFPA funding. It is probable, however, that some elements of certain interventions will continue to yield some benefits.

Major Recommendations for the 2008-1012 Country Programme

The 10 Major Recommendations
Looking holistically at Sri Lanka and its needs that are consistent with UNFPA’s global mandate, and reflecting on lessons learnt through implementation of CP6, the evaluation team arrived at 10 major recommendations for UNFPA support as it embarks on its Seventh Country Programme:

1. Meet unmet needs for contraception, to prevent abortion and save women’s lives. (Details provided in body or report.)
2. Mainstream gender throughout all UNFPA work, with emphasis on reducing gender-based violence.
3. Provide RH and related services in the conflict-affected populations in the North and East (includes youth, gender and gender-based violence, etc.).
4. Be prepared to provide RH services in emergency and humanitarian crises.
5. Develop and implement a strategy to support SRH needs of young people, particularly in vulnerable situations.
6. Be strategic in moving forward with STIs and HIV/AIDS.
7. Develop a strategy for improving and sustaining the Well Woman Clinics.
8. In re-engaging in Population and Development, support activities that directly contribute to achieving the planned results of the Country Programme.
9. Greater collaboration is essential; take a lead in responding to the call.
10. Develop a Country Programme Action Plan that is evidence-based and truly results-focused.

The Country Office should consider as a theme for the Seventh Country Programme: “Saving Women’s Lives.” The principal interventions would be:
- Meeting unmet needs for contraception, to reduce abortion and save women’s lives;
- Well Women’s Clinics – safeguarding women’s lives and tackling the main gynecological killer cancers;
- Reducing gender-based violence.

Moving “Upstream”

UNFPA Sri Lanka has repeatedly emphasized the need and intention to be more strategic and “upstream” in its programming. While this is highly appropriate, UNFPA must balance the upstream “talk” with continued strategic inputs (“walk”) at the services level; this is essential to assure the quality of services and for maintaining credibility as UNFPA moves to engage more in policy and advocacy.
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<th>ACRONYMS AND ABBREVIATIONS</th>
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<td>A/Y</td>
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<td>BCC</td>
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<td>FTZ</td>
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<td>GBV</td>
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<td>GFATM</td>
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GO  governmental organisation
GP  general practitioner
ICPD  International Conference on Population and Development (Cairo, 1994)
IDPs  internally-displaced persons
IDU  injecting drug user
IEC  information, education and communication
IUD  intra-uterine device
JICA  Japan International Cooperation Agency
LTTE  Liberation Tigers of Tamil Eelam (the “Tamil Tigers”)
MCH  maternal and child health
MLT  medical laboratory technician
MMR  maternal mortality ratio
MOE  Ministry of Education
MOH  Ministry of Healthcare and Nutrition
MSF  Médecins sans Frontiers
MSM  men who have sex with men
MYFF  Multi-Year Funding Framework
NCCP  National Cancer Control Program
NCW  National Committee on Women
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Full Name</th>
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<tbody>
<tr>
<td>NGO</td>
<td>non-governmental organization</td>
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<tr>
<td>NIE</td>
<td>National Institute of Education (under the Ministry of Education)</td>
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<tr>
<td>NIHS</td>
<td>National Institute of Health Services</td>
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<tr>
<td>NSACP</td>
<td>National STD/AIDS Control Programme</td>
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<tr>
<td>NYSC</td>
<td>National Youth Services Council (in Ministry of Sports and Youth Affairs)</td>
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<tr>
<td>OECD</td>
<td>Organisation for Economic Co-operation and Development</td>
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<tr>
<td>PDHS</td>
<td>Provincial Director of Health Services</td>
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<tr>
<td>PHM</td>
<td>public health midwife</td>
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<tr>
<td>PHWT</td>
<td>Plantation Housing and Welfare Trust</td>
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<tr>
<td>PSL</td>
<td>Population Services Lanka</td>
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<tr>
<td>RADA</td>
<td>Rehabilitation and Development Agency</td>
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<td>RH</td>
<td>reproductive health</td>
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<tr>
<td>RHIYA</td>
<td>Reproductive Health Initiative for Youth in Asia</td>
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<tr>
<td>RMU</td>
<td>RHIYA Management Unit</td>
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<tr>
<td>SDP</td>
<td>service delivery point</td>
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<td>SLAVSC</td>
<td>Sri Lanka Association for Voluntary Surgical Contraception</td>
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<td>SLIDA</td>
<td>Sri Lanka Institute for Development Administration</td>
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<tr>
<td>SRH</td>
<td>sexual and reproductive health</td>
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<tr>
<td>Abbreviation</td>
<td>Full Form</td>
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<td>TFR</td>
<td>total fertility rate</td>
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<td>TOT</td>
<td>training of trainers</td>
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<tr>
<td>UGC</td>
<td>University Grants Commission</td>
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<tr>
<td>UNAIDS</td>
<td>UN Joint Programme on HIV/AIDS</td>
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<tr>
<td>UNFPA</td>
<td>United Nations Population Fund</td>
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<tr>
<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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<tr>
<td>VDRL</td>
<td>Venereal disease research laboratory test</td>
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<tr>
<td>VOG</td>
<td>Visiting Obstetrician and Gynaecologist</td>
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<tr>
<td>WDF</td>
<td>Women's Development Federation</td>
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<tr>
<td>WFP</td>
<td>World Food Programme</td>
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<td>WHO</td>
<td>World Health Organisation</td>
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<tr>
<td>WIN</td>
<td>Women in Need</td>
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<tr>
<td>YFS</td>
<td>Youth Friendly Services</td>
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I. INTRODUCTION

I.A BACKGROUND AND SITUATION ANALYSIS

UNFPA has been assisting the people and government of Sri Lanka for almost 40 years -- since 1969, the year that UNFPA was established. This is thus a long-standing and important relationship. During the early period, UNFPA played a major role in helping Sri Lanka, then Ceylon, develop infrastructure and services for maternal health and family planning as well as building national capacities for demographic research and training. For over three decades, UNFPA provided support for contraceptive supplies, initially covering the full national requirement, assisting the country to reduce its population growth rate from a total fertility rate of over 5 to today's TFR of 1.9. UNFPA has worked closely with the government in helping build awareness of population dynamics and their significance for the country. With a current population of 19 million, Sri Lanka is now entering the final phase of demographic transition in a scenario of low fertility and low mortality. The population is expected to stabilize around 24 million in year 2030. A consequence of the above trends is a rapidly ageing population, with life expectancy at birth of around 73 years.¹

Sri Lanka is a lower middle-income country with a GNI of US $1,160 per capita. Economic growth has averaged around 5 per cent in the last decade, despite over two decades of ethnic conflict. Regional disparities are significant, however, and poverty remains a major challenge. By Sri Lankan official standards, over 40% of the population lives below the poverty line of less than $2 per day (2002 estimate).² Despite the low national TFR, significant differentials exist between socio-economic groups and among geographic areas (Sri Lanka Demographic and Health Survey, 2000).

Progress has been slowed by ongoing ethnic conflict and, most recently, the disastrous tsunami of 2004. Ethnic conflict since 1983 has resulted in the loss of an estimated 60,000 lives and displacement of a nearly one million people. Although the entire country has been affected, the Northern and Eastern provinces have experienced the most direct and severe impacts. Then, in December 2004, the tsunami hit two-thirds of the coastal belt, destroying much of the infrastructure and social fabric of the coastal communities and resulting in the loss of 40,000 lives and almost one million displaced persons. Although reconstruction is underway, progress remains uneven and renewed armed conflict is slowing the recovery phase, particularly in the Northern and Eastern provinces. Impacts of the conflict and tsunami have disproportionately affected on women and children.

Sri Lanka has made remarkable achievements in reducing maternal and infant mortality, which stand at 43 per 100,000 live births and 14 per 1,000, respectively. There is universal access to health care and the vast majority of births (95-98%) take place in health care facilities -- with exception of the conflict-affected areas where access is constrained. The contraceptive prevalence rate is about 70%, of which about 50% is modern method use. Universal access to education since early in the past century has contributed to exceptionally high school-completion and literacy rates (female literacy an impressive high of nearly 90%).

¹ Sri Lanka has the fourth fastest aging population in Asia after Japan, Singapore and Hong Kong.
² This is 22% below the poverty line according to the international standard of $1/day.

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Despite these otherwise positive indicators, disproportionately high numbers of women die from unsafe abortion. Abortion, which is illegal, is increasingly a leading cause of maternal deaths. Estimates of the number of abortions range from 700-1000 per day, accounting for an estimated one-third of all pregnancies. While some who resort to abortion are unmarried teens, most abortion seekers are married women over the age of 35, which is a direct reflection of current gaps in the quality and availability of family planning services in Sri Lanka.

Unmet need for contraception is high, calculated as 11-12%, with high discontinuation rates for some modern methods. The burden of contraceptive use falls mostly on women, with condom use at 4 per cent and male sterilization around 2 per cent compared to female sterilization of 21 per cent. Young people have limited access to reproductive health information and services, despite the increasing gap between the onset of puberty and age of marriage (average age 26 years). Teenage births are estimated to account for 9% of births nationwide and even more in conflict-affected areas and among IDP populations.

Sri Lanka is currently a low-prevalence country for HIV/AIDS. Risk factors include high internal and external migration, internal displacement and low use of condoms. STI and HIV/AIDS services remain limited.

I.B THE 6TH UNFPA-SUPPORTED COUNTRY PROGRAMME

The 6th UNFPA country programme for Sri Lanka was endorsed for a five-year period from 2002 to 2006. Following the 2004 tsunami disaster, the country programme was extended through 2007. The main areas of focus of the CP (2002-2007) included:

a) increasing access to reproductive health services of underserved and vulnerable communities;

b) supporting NGOs to address gaps in services in underserved areas;

c) building capacities for reproductive health promotion;

d) strengthening reproductive health in-school education; and

e) supporting advocacy efforts targeting policy makers and planners as well as community and religious leaders.

Five projects were developed within these areas. Subsequently the country office became a participant in two major regional youth-focused projects. In response to the tsunami disaster, UNFPA has mobilized substantial funding (vicinity of US$8 million) to respond with relief, recovery and reconstruction efforts. A concise overview of the beneficiaries, partners, geographic spread and budgets of these projects and activities is presented in Annex A. This is a useful, succinct guide for understanding the country programme. A more detailed financial overview is presented in Annex B.

The prime implementing partner from previous country programmes remained the Family Health Bureau (FHB) and the Health Education Bureau (HEB) in the Ministry of Healthcare and Nutrition. Likewise, the prime implementing partner for in-school RH education remained the National Institute of Education in the Ministry of Education. An innovation of the programme was its wide range of implementing partners, designed to access out-of-school young people in diverse settings, including factories, universities, the Army and youth clubs. Additionally, partnerships with both health and non-health NGOs and CBOs sought to increase access to reproductive health information and services in underserved communities.

Total UNFPA funding support during the period 2002-2007 is shown in Table 1.
### Table 1: UNFPA Funding Support, 2002-2007

<table>
<thead>
<tr>
<th>Country Programme:</th>
<th>$7 million</th>
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<tr>
<td>Strengthening RH services</td>
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<td>Serving RH needs of adolescents &amp; youth</td>
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<td>Advocacy for RH and Gender</td>
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<td>2 major regional youth projects:</td>
<td>$1.35 million</td>
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<tr>
<td>Reproductive Health Initiative for Youth in Asia (RHIYA)</td>
<td>$350,000</td>
</tr>
<tr>
<td>Youth Friendly Services (YFS)</td>
<td></td>
</tr>
<tr>
<td>Tsunami:</td>
<td>$8 million</td>
</tr>
<tr>
<td>$6.1 - Rehabilitation of health facilities</td>
<td></td>
</tr>
<tr>
<td>$1.9 - Psychosocial and Gender-based violence</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>Appr. $16.7 million</strong></td>
</tr>
</tbody>
</table>

Source: Expenditure estimates provided by UNFPA Country Office

### I.C EVALUATION PURPOSE AND METHODOLOGY

**Purpose, Audience and Users**

*Purpose.* UNFPA Sri Lanka is in the process of developing its 7th cycle of programming to be implemented for the next five years from 2008-2012. Lessons learnt from the 6th programme will be important and valuable for the design and implementation of the 7th country programme. UNFPA Sri Lanka has thus designed this evaluation of the country programme and other projects (2002-2007) to draw out lessons learnt and make recommendations to be considered in developing the next country programme action plan.

UNFPA Headquarters’ evaluation guidelines call for use of the OECD DAC evaluation criteria -- namely, assessment of relevance, effectiveness, efficiency, sustainability and impact. This evaluation has been designed around those criteria. Impact has not been included, however, as the country office was keenly aware that evaluation of impact would not be possible, primarily due to lack of baseline data.

The main objective of the evaluation is thus stated as “to assess the relevance, efficiency, effectiveness and sustainability of program interventions” as well as to identify program goals and strategies adopted and their effectiveness in contributing to the achievement of ICPD and MDG goals. The evaluation was to highlight strengths, weaknesses/gaps, good practices, and provide forward-looking recommendations. Specific evaluation questions (28 total) are laid out in the Terms of Reference (ToR) for the evaluation (see Annex D). To guide the reader, many of the ToR evaluation questions are indicated in small boxes throughout this report.

*Audience.* The principal audience for the evaluation is UNFPA. As judged appropriate by the country office, findings may also be shared with other donors, the government of Sri Lanka, partner agencies and relevant stakeholders.

**Evaluation Methodology**

The evaluation took place from 2-28 July 2007 (see Annexes F and G), conducted by a team that combined Sri Lankan expertise with broad global experience (see Annex E). Conclusions and recommendations are based on:

- Extensive interviews with implementing partners and other stakeholders (22 interviews with 40+ persons) (see Annexes G and H);

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Field visits & interviews at project sites in 13 districts: (Kurunegala, Galewela, Polonnaruwa, Kandy, Kadugannawa, Pussellawa, Nuwaraeliya, Maskeliya, Matale, Aluthgama, and Kalutara) (see Annex G);

Document review, including all project agreements and evaluations, relevant government policy and legislation, UNFPA and UN global documents, and others (see Annex I);

Triangulation of findings: examination of data from the above three sources to arrive at conclusions.

The 28 evaluation questions in the Terms of Reference were grouped to organize inquiry under a somewhat smaller number of 19 topics (and also to form the structure of the report).
II. FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

II.A RELEVANCE

II.A.1 Relevance to UNFPA Global Priorities

In general, UNFPA Sri Lanka’s 6th country programme and its components projects are quite in line with the global UNFPA mandate and its Multi-Year Funding Framework, 2004-2007.

Likewise the 7th Country Programme, as planned, is quite consistent with UNFPA’s new Draft Strategic Plan 2008-2011. It is based on the findings of the 2006 Common Country Assessment (CCA) and responds to the national Millennium Development Report (2004) as well as the ICPD Program of Action and CEDAW. The programme is developed within the framework of the UNDAF as well as the Multi-Year Funding Framework. It is in conformity with the National Population and Reproductive Health Policy (1998), the Women’s Charter (1993) and Sri Lanka’s Mahinda Chintana: Development Framework (2006 – 2016).

The 6th and 7th country programmes both recognise the reproductive rights of women, men and young people and the need to improve the quality of reproductive health services to address the current gaps within the overall goal of poverty reduction. Both also aim to address regional disparities and focus interventions in underserved areas of the country, in particular the conflict-affected districts and the plantations. In the 7th Country Programme, support for strengthening reproductive health care in the conflict-affected districts is provided in context of promoting equity and contributing to an improved environment for sustainable peace. The new programme also aims to up-scale (scale up) support to advance the rights of women, in particular to combat gender-based violence and facilitate the participation of women in peace-building efforts. It aims to strengthen the capacities of state and non-state actors to advance gender goals and contribute to improved oversight mechanisms and governance to protect women’s rights.

The proposed programme is consistent with the strategic directions of UNFPA and takes into account UNFPA’s comparative advantage and potential for complementarity, synergy and joint interventions with other development partners. In contrast to the 6th country programme, the new programme aims to be results-oriented and place greater emphasis on national capacity-building and sustainability.

Results? An exception is the global strategy’s/MYFF’s emphasis on results. The design and also implementation of the 6th CP placed greater focus on outputs (e.g., numbers attending a training event, numbers of schools participating in a programme) than results. This is apparent from examination of UNFPA’s logframe for CP6 (see Annex C) as well as workplans of UNFPA’s implanting partners. A consequence is that it is very difficult to determine what results or effectiveness the 6th CP has achieved. The CO now expresses intent to focus more on results; this is a very needed shift to improve effectiveness.
Population and Development

Population and development was a major focus of UNFPA activities in Sri Lanka when the programme began in late 1960s. UNFPA played a major role in the establishment of a Population Division as part of the government structure and a Demographic Research and Training Unit at the University of Colombo. UNFPA’s support to population issues contributed significantly to understanding the implications of the demographic changes at the national and subnational levels and strengthened the capacity of the local institutions to undertake such work. The DRTU has now been upgraded to a full-fledged department in the University and continues to play a key role in training demographers and undertaking demographic research in the country. The Population Division on the other hand is being dismantled due to retirement of qualified staff and lack of government funding for its activities.

The UNFPA’s 6th Country Programme did not give high priority to population and development issues. In contrast, the proposed 7th Country Programme seeks to “enhance utilization of population data and the capacity to track progress in implementing national poverty reduction strategies and MDGs using a gender and social equity lens.” As Sri Lanka now enters the final phase of demographic transition (characterized by low fertility, low mortality and a TFR of 1.9) the focus on limiting population growth is no longer relevant. However, integrating ICPD issues, population mobility and the changing age structure of the population into poverty reduction and other national development strategies -- as anticipated by UNFPA’s global strategic plan for 2008-2011 -- remains highly relevant to Sri Lanka. Part of this requirement may be addressed by proposed activities under 7th CP such as engendering the 2011 population census, a national survey on gender-based violence, better utilization of population data for development planning and strengthening institutional capacities for monitoring progress towards poverty reduction and achievement of MDGs -- aspects highlighted in both the MYFF and UNFPA’s new global strategy.

Related to population and development issues are several key RH concerns that require greater sensitivity and analysis at this time. First, concerns about upsetting the ethnic balance in the country, given ongoing social tensions, may pose obstacles to addressing unmet FP needs in some sections of the population. Second, trends in certain populations appear contrary to broader national trends and require closer scrutiny. These include demographic shifts in conflict- and tsunami-affected regions (e.g., population displacement, net out-migration, decline in age at marriage among girls in particular, and obstacles to return of IDPs) and in underserved areas including the plantations (e.g., higher fertility levels and internal and international migration in particular). A challenge lies in the fact that the 2001 population census and many of the recent national surveys did not cover parts of the Northern and Eastern Provinces due to insecurity prevailing in those areas. Third, Sri Lanka’s fast-aging population will pose many challenges for development and social welfare, challenges that have yet to be addressed in a meaningful way. These can be seen as emerging population issues in Sri Lanka as anticipated in UNFPA’s CP7 (Output 4 under Population and Development). Recommendations are set forth in section III.C below.

II.A.2 Relevance to Sri Lanka

Overall, UNFPA’s 6th Country Programme has been very relevant to Sri Lanka’s population and reproductive health needs. UNFPA is the main international and U.N. agency supporting reproductive health in Sri Lanka. It has played a pivotal role in initiating and developing sexual and reproductive health services for adolescents in the country. Its support to population issues has contributed significantly to understanding of the implications of the demographic changes at both national and
Reproductive Health

As the main agency supporting reproductive health in Sri Lanka, UNFPA's RH programme is very relevant. UNFPA has helped the government introduce several important policies and schemes. These include formulation of the National Population and Reproductive Health Policy and the action plan for its implementation, development of the Contraceptive Security Plan, introduction of the Well Woman Clinics, and the gender-based violence initiative. For more than 35 years, UNFPA provided most contraceptive supplies for the nation’s family planning programme. UNFPA is acknowledged for its flexibility of programming and response and for being able to respond quickly with support.

Relevance to Sri Lanka and strengths of UNFPA:

1. Has been vital to Sri Lanka and is recognized as a leader in RH services;
2. Sri Lanka could not have achieved the current level of services to IDP areas and underserved areas in the country (including plantations, the North and East, and the tsunami-affected areas) without UNFPA support;
3. The contraceptive security plan is excellent (computerization will enhance its relevance and effectiveness);
4. Help a great deal;
5. Has technical backstopping capacity;
6. Has capacity to undertake innovative activities;
7. Can approach different ethnic groups on sensitive topics in FP.

Negatives include:

1. Delays in procedures and receipt of funds by partners
2. The absence of regular supervision or adequate technical guidance to the NGOs

Adolescents and Youth: Sexual and Reproductive Health

In this country where the government’s RH services have -- until recently -- been largely targeted for married women, UNFPA has played a pivotal role in initiating and developing SRH services for adolescents (defined as 10 to 19 years old) and youth (defined as 15 to 24 years old). This is highly relevant for Sri Lanka given the peaking of the A/Y cohorts in the population as of 2001, the rising age at marriage (mean age at marriage for males = 28 years and for females = 25 years), the widening gap between the onset of puberty and age at marriage, and the emergence of a popular youth culture that glorifies courtship and premarital love. Recent studies (e.g., UNICEF 2004, Silva et al 1997) indicate that, while cultural inhibitions on premarital sex continue to influence a large segment of young people, some become sexually active in a variety of ways, including male-to-female and female-to-female sex, non-penetrative male-to-female sex, and protected or unprotected casual and commercial sex (mostly male-to-female). Unwanted pregnancies, abortions, incest, suicides caused by humiliation and stigma associated with pregnancy prior to marriage have been vital to Sri Lanka and is recognized as a leader in RH services;
3. The contraceptive security plan is excellent (computerization will enhance its relevance and effectiveness);
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to marriage, as well as STIs, including HIV, are known to prevail among young people (see Annex L). Although little reliable information is currently available on these issues, they are considered important social and public health problems by at least some opinion leaders and health professionals. SRH programs supported by UNFPA are highly relevant from the angle of identifying and at least partially addressing the needs of this vitally important segment of the country’s population.

**Recommendation:**

Given the paucity of accurate information about sexual activity (and consequences of pregnancy, abortion, STIs, etc.) among young people, spanning ages 10 to 24, well-designed studies should be undertaken, following careful analysis of available information, in order to determine where the highest priority needs are concerning AYSRH and how such needs should be effectively addressed. These studies should inform ongoing and proposed interventions for A/Y, including BCC, YFS, and special programs targeting vulnerable young people in underserved communities and populations.

**Gender**

UNFPA’s concern for gender equity is highly relevant in the Sri Lankan context. While many indicators for women are very good, there are also worrisome regional disparities and aberrations. Significant among them, is the high incidence of abortion. Because abortion is illegal, women are still dying due to septic abortion -- despite this country’s excellent health network of doctors, midwives and an in-hospital delivery rate of over 95%. In the conflict-affected districts, the indicators for maternal mortality and morbidity continue to be relatively poor and contraception use remains relatively low. Early marriage is a concern and consequent under-age pregnancy is also a concern in the conflict-affected areas. A fairly significant incidence of incest is prevalent as well as widespread domestic violence. For these and many other reasons, gender priorities spelled out in UNFPA’s MYFF and in its new global Draft Strategic Plan 2008-2011 are extremely relevant to Sri Lanka. UNFPA Sri Lanka, however, has only begun the challenge of integrating gender throughout its programme. With the gender objectives laid out in the Strategic Plan 2008-2011 and in the United Nations Development Assistance Framework for Sri Lanka 2008-2012, UNFPA Sri Lanka has appropriate roadmaps clearly at hand to guide a more dynamic response to the gender challenges.

**II.A.3 Relevance and Contribution of Other Projects: Regional and Tsunami**

The four unanticipated projects (two youth-focused and two tsunami) that UNFPA Sri Lanka took up during its 6th CP brought a certain amount of disruption and stress to the country office (as staff report) but, on the whole, the positive contributions have been important and outweighed the negatives. Both the youth-focused and tsunami response activities have been highly relevant to Sri Lanka’s needs and the evolving UNFPA programme in Sri Lanka.

The Two Regional Youth Projects

The two regional projects, both focused on reaching adolescents and youth in out-of-school settings, introduced important innovations that broadened Sri Lanka’s approach to SRH for young people. The Reproductive Health Initiative for Youth in Asia (RHIYA) was the second cycle of an effort to provide SRH counseling for in Sri Lankan adolescents and youth in a community setting. The Youth Friendly Services (YFS) project is the first effort in Sri Lanka combining SRH services for youth (including counseling and condom supply) with other activities, such as computer
training and entertainment, in a one-stop service. Further detail on these two projects, including recommendations stemming from their experience, is provided below in II.C.

Reproductive Health Initiative for Youth in Asia (RHIYA)  
Under this Asia regional project, a counseling program for in-school and out-of-school adolescents and youth was established in selected underserved communities. The establishment of a counseling service for adolescents and youth (A/Y) in a community setting was an important innovation, as there were no SRH counseling programs in Sri Lanka targeted for adolescents and youth prior to the RHIYA project.5

Implementing partners were family planning and non-FP NGOs. Counselors were trained through a cascade TOT (training of trainers) method. Male and female peer educators for specific age groups were selected and trained by each counselor for the purpose of expanding knowledge among young people in general and facilitating referral of young people needing information and services, including counseling and condoms, to trained counselors. (Only a few RHIYA partners actually provided condoms, due to fear of criticism from parents and the community, and even this was not widely publicized for that reason.)

Relevance and Contributions. The relevance, appropriateness and effectiveness of RHIYA’s counselor scheme varied depending on the local context, the interest taken by the counselors and peer educators, and the attitude of young people toward divulging their personal problems and sensitive, intimate concerns to known people in the local area. The type of persons employed as counselors varied according to the partner organization. School teachers, lower-level health workers (especially Public Health Inspectors and, on the plantations, medical assistants), and certain categories of development workers (such as Samurthi Niyamakas involved in poverty reduction work at the village level) were typically selected and trained as counselors by the partner organizations.

Youth Friendly Services
Three YFS centres established on a pilot basis under UNFPA support seek to identify and fulfill the unmet SRH needs of adolescents and youth by providing clinical and advisory services in a non-threatening, enabling and pleasurable environment. The YFS approach goes beyond the more limited family life and reproductive biology curricula presented in the schools and aims at addressing needs of young people in an integrated manner. First, the centres provide frank discussion of sex and sexuality, risk-taking and risk-avoidance, offer information on contraception and contraceptive methods, and provide condoms for those who are sexually active. Second, beyond SRH, the YFSs provide entertainment and activities such as Internet access, vocational training, educational programs and libraries/reading rooms. Yovun Piyasa (“Youth Space”), established by SLAVSC in Kandy, (“Youth Space”), established by SLAVSC in Kandy, has introduced several innovations, including tuition classes,6 for attracting young people. This is in line with the UNFPA global strategy which advocates “integration of an essential package of social services for adolescents and youth that deals with a variety of issues including HIV prevention, pregnancy prevention and gender-based violence, as well as life skills development….7

The YFS project also piloted different sponsorship and institutional modalities for the three centres: one NGO (SLAVSC), one government health sector (National Institute of Health Services, NIHS), and one government non-health (National Youth Services Council, under the Ministry of Sports and Youth Affairs). It is noteworthy that the NIHS centre is not located on hospital or clinic grounds but in a very youth-friendly mid-town site.

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5 FPA provided some SRH counseling in family planning clinics, but FPA clinics catered mainly to married couples. PSL did not provide any SRH counseling to A/Y prior to RHIYA.
6 “Tuition classes” are privately organised after-school tutoring, for which parents pay a fee.
Relevance and Contributions

- Integration of SRH services with other A/Y services -- including entertainment, vocational training and internet -- creates an enabling environment where appropriate counseling and SRH services may be gradually introduced to young people.

- It may be too early to assess the relevance, contribution and effectiveness of the YFS centres, as these centres came into existence within only the past two years. Some delays in establishment of these centres and user statistics for the early period suggest that the contribution of these facilities is currently low. However, they require serious attention in view of the opportunities they present for addressing unmet SRH needs of adolescents and youth in Sri Lanka.

The Two Tsunami Projects

The two tsunami projects contributed to the country programme in important several ways. They expanded the scope of UNFPA Sri Lanka’s interventions to include RH and related services in emergency/humanitarian settings and propelled UNFPA actively into a lead role on gender and gender-based violence. They also provided support to improve national capabilities for psychosocial support interventions.

It is part of UNFPA’s new global strategy that UNFPA is to take a lead in RH in humanitarian and emergency work. UNFPA Sri Lanka had already gained some experience in humanitarian assistance through its support for RH services in conflict-affected regions (e.g., PSL work in Vavuniya and Mannar). In response to the tsunami disaster of December 2004, UNFPA built on this experience and acquired a greater significance in terms of activity, budgetary allocations and mobilization of staff. During the emergency phase (early 2005), UNFPA provided support for reproductive health kits and personal hygiene kits for women and girls. In the recovery phase, UNFPA contributed to the national health sector reconstruction plan and helped restore and rebuild 16 health facilities, addressed the psychosocial needs of tsunami victims, and launched activities to protect women and girls from gender-based violence.

In terms of financial outlays, the tsunami projects outweighed the regular RH services supported by UNFPA under its 6th CP. (See Annexes A and B.) This has had both positive and negative effects. While the UNFPA portfolio in emergency assistance and recovery expanded in keeping with the emerging post-tsunami needs, it led to some diversion from UNFPA’s core focus on strengthening RH services. Tsunami work also expanded UNFPA’s geographic focus, although given the 6th CP being spread thin, it is not clear that this was a positive development.

Restoration of Reproductive Health Services in Tsunami-Affected Districts (project LKATR201). According to readily available financial data, this project provided about US$6.1 million for reconstruction and rebuilding of damaged and destroyed health facilities in four districts (from 2005 to 2007). It also provided some of the essential transport facilities for the health staff in the affected areas (US$783,000 for purchase of 49 vehicles of various sizes). And, through NGOs, it helped to provide basic reproductive health services to some of the displaced populations.

Building Psychosocial Wellbeing among Individuals and Communities Living in Tsunami Affected Areas, with Improved Responsiveness for the Prevention and Management of gender-based violence (project LKATR031). This project (funded at...
US$1.65 million) was implemented as two quite separate parts, a psychosocial component and a gender component.

The psychosocial component

This provided support to build the capacities of the Ministry of Health to address the psychosocial needs of the affected communities. It was undertaken with the goal of harmonising and rationalising the many approaches brought into Sri Lanka by various emergency relief organizations to help victims cope with the disaster. This led UNFPA into collaboration with the mental health section of the Ministry of Health, a new partner. The main outcome is a draft guidance manual for health workers. Other strategic outcomes are documented in the 2006 Tsunami report. Nevertheless, while the need may have been clear in 2005, this is not an area of comparative advantage for UNFPA.

The gender component

Gender had been conceptualised in 2001 as a cross-cutting theme in UNFPA’s 6th Country Programme and a disparate range of concerns were to be stressed, including gender-sensitive reproductive health services, male participation in reproductive health matters, women’s rights, reproductive rights and the prevention of gender-based violence. However, UNFPA did not develop a comprehensive strategy to integrate (mainstream) gender into all its programmes and interventions and did not have funds to do so.

In 2005 in the aftermath of the tsunami, this project provided UNFPA Sri Lanka with significant funding for gender-related interventions. The objective of the gender component was to reduce the vulnerability of women and girls to sexual and other forms of violence in the context of temporary shelters, relocation and reconstruction following the December 2004 disaster. The strategy adopted focused both on strengthening the policy environment and on improving the institutional and community responses to gender-based violence (GBV). This included establishment of 27 women’s centres that provide support for women and girls at the community level in the tsunami-affected districts, the training of over 400 frontline workers on gender and GBV issues, and integration of a GBV response in the health sector through a pilot project in Matara. It also launched a GBV database and establishment of the GBV Forum, a multi-partner coordination mechanism involving state and non-state actors and concerned donors to mobilize support and promote a coherent response.

The project responded to the immediate needs and strategic interests of women through a multiplicity of interventions at both the community level as well as the national level. It responded to protection concerns of women at community level; advocated for gender-sensitive interventions in housing and livelihoods at the national level; built capacity at the National Committee on Women to integrate gender into national level relief and recovery responses and continued to consolidate work among tsunami-affected communities.

This established UNFPA as an agency centrally positioned with a comparative advantage to take a lead in gender-based advocacy and interventions, responsive and responsible for gender mainstreaming and strengthening national capacity and institutional mechanisms for increased state accountability to fulfill and protect the rights of women.

Relevance and Contributions

Clear contributions of the two tsunami projects to UNFPA Sri Lanka and the CP included:

8 Accounting data made available for this evaluation do not break out the gender component from the psychosocial component.
Establishment or confirmation among government and other agencies that UNFPA is an important contributor in meeting humanitarian and emergency crises in Sri Lanka.

The tsunami projects led UNFPA Sri Lanka, more comprehensively, into gender-related work and tackling gender-based violence. This will now be a key part of UNFPA Sri Lanka’s 7th CP.

The country office hired, for the first time, a Monitoring and Evaluation Officer to facilitate accountability in managing the suddenly-increased magnitude of funding and programming. Although the M&E Officer remains responsible only for the tsunami work, his involvement has introduced a more rigorous approach to M&E for the country office.

II.A.4 Humanitarian/Emergency Support

UNFPA/Sri Lanka does have limited capacity to provide urgently needed humanitarian/emergency assistance, and UNFPA’s mandate for this work is quite clear in Sri Lanka. The critical although limited support UNFPA has provided in the IDP districts and its larger post-tsunami response are clear evidence that the country expects and UNFPA is able to mount such an operation.

UNFPA has this capacity in reproductive health, being an experienced agency that is well respected. UNFPA support tangibly improved the quality of RH services available to populations in the affected areas. It coordinated the donor response in RH. It helped to maintain a skeleton RH service in the most difficult period and the subsequent work has helped to improve the capacity of the regular services in these districts.

UNFPA has invested in humanitarian and emergency assistance in RH a limited way. After tsunami this was upscaled. As to the sufficiency of the UNFPA investment, relative to the overall investments of some of the other UN agencies, the UNFPA support has been very modest. Within the UN system, UNFPA Sri Lanka does not have any comparative advantage in relation to humanitarian and emergency support. But in relation to RH alone, the UNFPA investment, although modest, has been significant in that it addressed the most urgent needs.

For UNFPA to engage in this type of work in the future it will need to build up its own capacity in several areas. The country office lacks an appropriate operational structure for this purpose and needs back-up support from UNFPA regional and HQ.

However, UNFPA’s experience with war- and tsunami-affected populations makes clear that there are specific RH-related issues in emergency situations (e.g., sexual abuse and GBV in IDP communities; lowering of age at marriage) that require the attention of UNFPA.

Recommendations:

1. UNFPA should build up capacity to provide humanitarian/emergency assistance in Sri Lanka. The country office should develop an appropriate operational structure for this purpose, including back-up support from UNFPA regional and HQ.

UNFPA is praised for fulfilling its plans when various other agencies did not. (They are described as “like an additional wave: they came and then went.”)
2. In humanitarian/emergency assistance, UNFPA Sri Lanka must focus on RH issues and activities that address unmet RH needs and on the needs of women for protection against gender-based violence.

3. UNFPA should not continue the psychosocial support work that seemed appropriate to take on in context of post-tsunami chaos.

II.A.5 Meeting Reproductive Health Needs of the Most Vulnerable Groups

Although UNFPA focuses on underserved groups, UNFPA support is spread too thin to meet the RH needs of Sri Lanka’s most vulnerable groups. At best, UNFPA could only contribute to meeting the RH needs of the most vulnerable groups in Sri Lanka. However, there is lack of clarity as to who the most vulnerable groups are. Clearly focused thinking on this matter is a necessary step to more effective programming for results.

In programme documents UNFPA’s target populations are variously defined as “people in underserved areas” or “underserved and underprivileged communities.” Or they are more specifically identified as: people in the North and East, in plantations (estates), and in urban slums; adolescents and youth. Sometimes they also include internally-displaced persons (IDPs), migrant workers, women working in the Free Trade Zones and Army. Most vulnerable (or most at risk) in the context of HIV/AIDS are typically stated to be CSWs, IDUs and men who have sex with men (MSM).

There appears to be no clarity, either within UNFPA or with partners, as to who really are the most underserved or vulnerable. It is noted by UNFPA and partners that certain of the country’s 26 districts are “underserved,” and that there are certain “underserved pockets” within relatively advantaged districts. Given this, programming to “underserved areas” appears somewhat random and opportunistic. But there is no mapping by UNFPA or its partners of where geographically the most underserved populations are. With regard to slums, some stakeholders say Sri Lanka’s slums are much less grim than those of India or Bangladesh and that Sri Lanka slum residents are probably much less underserved than other populations in Sri Lanka.

UNFPA typically considers plantation populations as underserved. Here too is lack of clarity and consensus. By some measures it appears that workers on the larger commercially-owned plantations are not so “underserved” but that those on the smaller “private-private” definitely are disadvantaged. Top leadership are WHO advises that UNFPA’s focus on the plantations is a “distraction” from the more important work that it should be doing, including reducing abortions by better efforts to meet unmet need for FP and dealing more directly with the consequences of the aging population.

Reproductive Health Programming for Vulnerable Populations

In reproductive health, UNFPA is recognized as one of the two leading agencies in Sri Lanka (WHO being the other) with a very long experience of working among the vulnerable populations. This confers it the legitimacy and the capacity to continue work with these populations.

UNFPA has no direct presence in the areas where the most vulnerable population groups are located. Rather, it has and continues to work with the relevant government agencies and NGOs as needed. For example, in the plantations the main partners are the Ministry of
Health and the health arm of the Plantation Housing and Welfare Trust. In the North and East, the main partner has been the Population Services Lanka (PSL) and, to a limited extent, the Ministry of Health. In the gender and gender-based violence activities, UNFPA also works with both government and NGO partners.

With regard to the support to the most needy areas, UNFPA was able to reach the appropriate needy populations in the “cleared” areas of the North and East. However, there has been a general problem of reaching the most needy in the so-called “uncleared” areas in the Vanni, and there is no way of verifying this. The shortage of health personnel in the North and East is highlighted elsewhere.

To expand and strengthen RH programs in the North and East, UNFPA should consider:

- establishing a presence (e.g., a small office co-located with UNICEF or another UN agency) in one or both of these areas in order to provide direct technical support and supervision.
- structuring support in such a manner that it will strengthen the regular institutions and personnel who will be then be able to continue the work after UNFPA support ends.

In the plantations and in some of the vulnerable areas in the South there is no need for a direct UNFPA presence as the existing institutions are able to manage the work.

Vulnerable Adolescents and Youth

In general, there is lack of clarity as to who the most vulnerable groups are. As concerns SRH, UNFPA programmes have identified the following adolescents and youth as among the most vulnerable:

1. A/Y in the conflict- and tsunami-affected areas, including IDPs,
2. A/Y in tea and rubber plantations,
3. A/Y in the coastal tourist belt (includes beach boys),
4. Young workers (mostly female) in export processing zones (free trade zones),
5. Members of the armed forces,
6. Young people in IDP communities, and
7. Growing children (especially girls) in families where the mother has gone to the Middle East/Gulf States for work.

Several UNFPA partners are well-positioned to serve some of these vulnerable groups. In fact their capacity to serve specific vulnerable groups has been an important consideration in UNFPA’s selection of partners. For instance, Population Services Lanka (PSL) has been identified as an important SRH service provider in conflict-affected regions such as Vavuniya, Mannar and Trincomalee. Similarly, the Centre for Development Alternatives (CDA) was selected for its strong connections with the plantation sector and with the army as a means of reaching out to the soldiers on the war front.

The draft HIV/AIDS strategic plan for Sri Lanka\(^\text{10}\) has identified CSWs, MSM and drug users as most vulnerable groups for HIV. Youth are definitely included in each category, although numbers are unknown. Policy-makers and programme planners must recognize that sexual risks of adolescents and youth include many issues besides HIV/AIDS, notably unwanted pregnancies, abortions, incest, and sexual abuse in general.

Recommendation:

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UNFPA should take a lead in an activity to map the underserved and most vulnerable populations in Sri Lanka. This would have at least two major benefits. First, this would allow more effective and efficient targeting of resources (not only UNFPA’s) and increase the possibility of showing results in serving the underserved. Second, intellectual leadership of this sort should be part of the Country Office’s effort to move “upstream.” It would also help counter the fears of those in the Country Office who worry that UNFPA’s image is too associated with “family planning/population control.”

II.A.6 UNFPA’s Comparative Advantage

Despite its relatively scarce resources, UNFPA is well-positioned in Sri Lanka to make a difference. Its current areas of concern and engagement are national priorities. Still, to increase effectiveness and efficiency and make the greatest difference possible, it should focus its support more strategically.

The 6th CP has been somewhat of an experiment with a broad array of partners implementing some long-standing approaches (e.g., supporting the Family Health Bureau to strengthen RH services) and some new ones under the regional and tsunami projects (e.g., youth-friendly services and the focus on gender-based violence). Some activities that figured quite prominently in the 2001-designed 6th CP have not appeared to yield great results and seem to have dropped in priority (e.g., a general focus on advocacy for RH, in contrast to more narrowly-focused advocacy as in the area of gender-based violence). With strategic development of the 7th County Programme Action Plan, the country office can fine-tune its inputs for greater results.

Based on careful analysis and general consensus among stakeholders interviewed for this evaluation, areas of greatest comparative advantage for UNFPA Sri Lanka are as follows:

Areas where UNFPA is judged to be the best-positioned of all donors:
1. Tackling abortion - to save women’s lives. No other donor is so well-positioned to do this as UNFPA.
2. Responding to RH needs of populations in emergency and humanitarian crises.
3. Responding to unmet RH needs in underserved areas.
4. Lead UN agency on gender (UNIFEM not present in Sri Lanka), tackling gender-based violence.
5. SRH outreach to youth. Given UNFPA’s prior experience in introducing RH education in schools and in providing counseling services, IEC, and BCC, it is best positioned to advance SRH services and advocacy.

Areas where UNFPA is judged to be among the best-positioned of actors:
7. Support for population studies, better data, issues of demographic transition.
8. Concerns of population aging.

Areas where UNFPA lacks comparative advantage. UNFPA does not have a comparative advantage in psychosocial support programming unless it is directly linked with RH issues.11 For instance, where accidental premarital pregnancy or other unresolved SRH problems

11 UNFPA entered into psychosocial support programming in response to the tsunami, collaborating with the Mental Health Department of the MOH. Motivation was the fact that many well-intended international agencies arrived on the scene with various approaches to disaster coping, which UNFPA (and others) judged inappropriate for the Sri Lanka.
contribute to suicides among youth, UNFPA programmes might contain a psychosocial component directly addressing the relevant issues.

Reproductive Health

UNFPA has played, and continues to play, a major role in reproductive health in Sri Lanka. This is acknowledged by the MOH, MOE and the NGOs that are currently engaged with the UNFPA. In general the government and non-governmental partners selected by the UNFPA were the appropriate ones. The Family Health Bureau is the national mandated agency for Family Health (not all of RH) service provision and, with the support of UNFPA, has led the national family planning programme over the years.

UNFPA has a clear comparative advantage in reproductive health in Sri Lanka, which results from its recognized expertise in reproductive health and long-term commitment and leadership to RH, provision of family planning commodity supplies and, most recently, the introduction and experience gained with the Well Woman Clinics.

There was a tendency until recently for UNFPA (and its inputs) to be viewed as just another “donor” (funding agency), whose technical inputs did not receive sufficient recognition from the national collaborating agencies. In fact, it is evident that the technical inputs could have been even greater if UNFPA had had a technical advisor in RH from the inception of the project. Consequently the collaborating partners of UNFPA tended to “go it alone” with regard to the work they undertook with UNFPA resources. However, during the past 2-3 years, with a RH technical advisor in place at UNFPA, there is a noticeable tendency for the local partners to make more “upstream” requests, asking UNFPA to undertake and support normative technical functions and advocacy positions in RH.

Recommendations:

1. UNFPA should consider its comparative advantage and clearly identify its RH niche in Sri Lanka, with a judicious mix of work related to policy and advocacy at national and local levels on the one hand, balanced with strategically-selected service activities on the other (e.g., Well Women Clinics), especially for the underserved and underprivileged communities.

2. When evaluating the UNFPA contribution, it is necessary to look at the gains made by or within the population that is being served by UNFPA’s various programme components, and not be confined to assessing only the contribution of the funds expended for these components (i.e., what proportion was spent for technical services compared to supplies and equipment).
II.B EFFECTIVENESS/ACHIEVEMENT OF RESULTS:
REPRODUCTIVE HEALTH SERVICES

This is the largest component of the regular budget of the UNFPA 6th CP portfolio. The project, “Strengthening Reproductive Health Services Including Vulnerable Groups and Underserved Areas” (SRL/06/01/01) was funded at approximately US$3.8 million out of the total CP6 funding of US$7 million. It was the main UNFPA contribution to the country’s reproductive health programme. The project had two main purposes, linked to planned outputs and activities. These are shown in Table 2.

Table 2: “Strengthening Reproductive Health Services”: Project Overview

<table>
<thead>
<tr>
<th>Purposes</th>
<th>Outputs</th>
<th>Activities to achieve the outputs</th>
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| 1. Increased utilization of quality RH services, particularly in the pockets of unmet need and among vulnerable groups and underserved geographic areas | 1. Increased access to quality RH, including family planning services for populations living in under-served areas and in conflict zones | For Output 1:  
- provision of contraceptive supplies  
- human resource development  
- support to enhancing quality and comprehensive RH  
- support to prevention of abortions  
- prevention of STDs including HIV/AIDS  
- operations research  
- limited support to the sterilization programme to meet the needs of older women who are resorting to abortions due to unavailability of such services  
- to meet unmet need gaps, including post-partum RH counseling |
| 2. Mobilise political and community support at national and subnational levels for effective implementation of the National Population and RH Policy and Action Plan | Increased understanding, commitment and support of parliamentarians and policy-makers as well as community leaders, mass media organisations, NGOs and senior administrators to address population, RH, HIV/AIDS and gender issues | For Output 2:  
- Technical assistance to:  
  - formulate a national strategy for ASRH, and  
  - re-establish the national steering committee for reviewing programmes to improve information and services for youth and adolescents. |

Advocacy. A strategy for advocacy efforts to improve reproductive rights and health was to be prepared in collaboration with relevant partners after a review of existing advocacy efforts.

Gender. Gender concerns are a cross-cutting theme in the project design, in line with the ICPD POA. To be stressed were gender-sensitive reproductive health services, male participation, women’s rights/ reproductive rights and prevention of gender-based violence. (See section II.D below.)
Certain components in the other projects, including the Regional and Tsunami projects, have also contributed to the development and quality improvement of RH services.

The main implementing partners of the Reproductive Health project are:

1. **Family Health Bureau (FHB)** of MOH (main partner) – improving/expanding RH services, with its Monitoring and Evaluation Unit being responsible for coordination of RH research activities.
2. **National STD/AIDS Control Programme (NSACP)** - syndromic management of STDs, training MLTs for VDRL (screening test for syphilis), and training health staff on voluntary counseling and testing for HIV in mothers.
3. **National Cancer Control Program (NCCP)** – Well Woman Clinics
4. **Health Education Bureau (HEB)** of MOH – BCC, volunteer training and production of communication materials
5. **Plantation Housing and Welfare Trust (PHWT)** – RH in plantation areas
6. **Population Services Lanka** – RH services in Mannar District

II.B.1 Unmet Needs for Family Planning

*Addressing the problem of unmet needs for family planning constitutes one of the most urgent reproductive health requirements in the country. It is essential for saving women’s lives by reducing the numbers of women who resort to unsafe abortion rather than bring an unwanted child into the world.* As Sri Lanka has advanced to the ranks of a middle-income country, women still dying in abortion stands out as a black mark on the face of its otherwise successful family planning and human development programmes. This is linked to several crucial issues, including the high rate of abortions, the increased role of abortion as a cause of maternal mortality, and the perception and perhaps fact that family planning services in the country have deteriorated in the past decade. Thus there is an obvious vacuum that needs to be filled in the area of unmet needs in family planning.

Family planning services are offered by the Ministry of Health through the Family Health Bureau. FHB is supported by three well-established NGOs (FPASL, PSL and SLAVS), who also provide mobile outreach services.

Currently the contraceptive prevalence rate stands at 70% of married couples of reproductive age, with about 50% using modern methods of contraception and about 20% still relying on natural and traditional methods for family planning. This means that almost one of every three married couples trying to prevent pregnancy depends on rhythm, withdrawal or some other “traditional” method, resulting in a greater chance of unwanted pregnancies (DHS 2000).\(^\text{12}\)

The DHS (2000) also revealed that the unmet need for FP was around 11-12%, which means that these couples are in need of contraceptive services although they do not practice a reliable method at present.

“Unmet need for family planning” is defined locally as “non-use of contraception by those who do not wish to have children at this time.” Such unmet needs have arisen as a consequence of one or a combination of the following factors:

- An insufficient number of adequately functioning family planning clinics, located conveniently, staffed by health personnel of necessary competence and offering a

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\(^{12}\)DHS 2000 is the latest DHS. The 2006 data are not available yet.
least four modern methods of contraception (usually condom, pill, injectable, and IUD);

- Poor services in conflict areas and in the underserved areas;
- Inadequate approaches developed and implemented for counseling persons relying on “traditional methods” to use a more reliable modern method;
- Poor availability of sterilization services in the government hospitals (unlike earlier years when good male and female sterilization services were both available);
- Increased needs of and demands by special groups such as youth and unmarried women;
- Inappropriate use of emergency contraception;
- Inadequate male participation in FP decision-making and use of services and methods;
- Insufficient post-partum family planning counseling, insufficient post-abortion family planning counseling, and available counseling being of generally inadequate quality;
- Married couples seeking abortion in spite of available sources of contraception and using abortion as a method of contraception; and, finally,
- Inadequate attention and commitment to this situation by UNFPA and its implementing partners, despite the fact that the problem has been recognized and action laid out in numerous programme documents (e.g., UNFPA’s 6th CP document and the MOH’s Action Plan to Implement Sri Lanka’s Population and Reproductive Health Policy During the Period 2000-2010).13

Although illegal, a significant number of abortions are being performed and induced abortion is a phenomenon that is increasingly seen within marriage, indicating that it is being used for spacing of births or for limiting family size. In 2004 it was reported that 40% of maternal deaths were due to unplanned pregnancies and pregnancies with medical contraindications, while in 2001, 8.5% of maternal deaths were due to septic abortion.

**Recommendations:** Not all the following recommendations are exclusively for UNFPA, but meeting them is necessary to address the problem of unmet needs for contraception. Meeting recommendations 1-6 should be priorities for UNFPA.

1. Stimulate national-level dialogue on policy options and strategies that could help to address the issue of high incidence of abortion.
2. Improve the quality ofFP counseling, including both post-partum and post-abortion counseling, as well as counseling for those who do not want additional children.
3. Re-establish and expand the male and female sterilization services at the base hospitals and above; also support NGOs and the private sector to provide male and female sterilization services.
4. Actively promote ofFP in post-partum wards; develop or update protocols for post-partum counseling and train staff in their application.
5. Support the experimental introduction of newer methods of contraception, such as the newer implants, IUDs, long-term injectables, and female condoms, to expand the method mix.
6. FP counselling and services should be promoted proactively and provided in the Well Women’s Clinics. The WWC Record should be modified to include information on

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13 Nowhere in programme and policy documents is any approach articulated or does there appear evidence of concrete measures to shift women and men from “traditional” to more reliable modern methods or even to counsel couples on more effective use of science-based natural family planning. For example, the Action Plan to Implement Sri Lanka’s Population and Reproductive Health Policy defines a specific “Action 4: Provide information to enable couples to use traditional methods effectively.” Responsibility for this action is assigned to, among others, the Dept. of Ayurveda. But why? Are many Sri Lankans using ayurvedic medicine or approaches for contraception? The answer appears to be no, that “traditional methods” means primarily rhythm and withdrawal.
parity, live births, still births and abortions, past or current use of FP and intention to use as relevant to the woman’s age. 14
8. Promote the use of the WHO contraceptive eligibility criteria, the WHO guidelines on medical eligibility – adapted, if necessary, to the needs of the country.
9. Ensure the availability of information and services as needed to special groups such as youth, unmarried women, and older women.
10. Ensure the availability of a full complement of emergency obstetric care (EmOC) facilities in district hospitals and above.
11. Promote and support studies on the epidemiology and the issues related to the high incidence of abortion, relating these to the unmet needs of contraception.

II.B.2 Quality Assurance System

Support to implement a functional, effective Quality Assurance System is another need in which UNFPA can play a significant role, both in terms of advocacy and technical advice. There is currently a RH quality assurance plan maintained by the FHB. However, there are many areas where this could be further improved. The QA system should strengthen its focus on FP/RH but also address maternal mortality. This is another important way to move “upstream” and reduce fear or reality of WHO or UNFPA being seen as FP only.)

Different types of quality assurance mechanisms exist at the moment. These include:
- reviews at various levels of service,
- visits by the DPDHS and the MOH to the field, with in-service training for supervision and appropriate in-service training for the field staff,
- maternal death reviews at the institutional, regional and national level and peri-natal mortality reviews,
- regular meetings of the health staff in the preventive health sector, but not in the curative sector; all of these meetings need to be further streamlined.

Recommendations:

1. Strengthen dialogue between FHB/MOH and the Provincial Health Authorities on RH quality issues and institute measures to further improve all of the above activities. For example, the HMIS could be analyzed at each level of service and necessary action initiated at that particular level itself.
2. UNFPA to strengthen its own supervision system and technical inputs to programs.
3. Quality assurance circles to be instituted at different levels of service, including the curative sector.
4. Random surveys (operations research) should be conducted of different aspects of the QA process and system. This would be an appropriate area for UNFPA support (another move upstream).

14 This was also recommended in the 2004 Review of the Well Women’s Clinic Programme (Chitramalee de Silva et al.), pp. v and 10.
II.B.3 RH Services to Underserved and Vulnerable Populations (See also II.A.5)

Providing reproductive health services to the country’s underserved and vulnerable populations is a challenge. UNFPA has provided some support for RH services in several conflict-affected and neighbouring districts, some tea plantations, and a few remote areas. The input of UNFPA to these populations has been limited and not always to the most underserved.

Plantations. The selection of the plantations and the underserved remote districts might be justifiable as the services and the vital indicators in many of these areas fall short of the national averages. However, among the plantations, it is found that many plantations that have been included in the project display indicators (such as IMR and MMR) comparable to the national levels. This does not justify many of them being identified as “underserved.”

But there are plantations that are not managed by the Plantations Trust (PHWT) which have indicators short of the national averages. These are typically the “private-private” plantations (i.e., owned by individuals rather than corporations). RH services on some of these private-private plantations are currently facilitated by small numbers of volunteers who have had one year of UNFPA-supported training and now receive a modest 3000 rupee/month travel allowance (= approx. US$27) for their outreach work (e.g., conducting health awareness in the community, providing small health services in the community, bringing mothers from remote areas to the clinic, and assisting while at the clinic). An example are the 25 volunteers, mainly Tamil, in Maskeliya District.

North and East. The Northern and Eastern provinces, while presenting many of the same issues in other underserved and vulnerable areas, have a range of serious problems not seen in other parts of the country. The main issues in the North and the East (with an estimated 2.1 million population) are:

- Deficits of all categories of health personnel: VOGs in the main hospitals, MOs in the peripheral institutions, and nurses and PHMs in all areas for RH work. The PSL recruited Community Health Promoters have been rendering a very useful service in some areas and recently MSF has placed a VOG each in Kilinochchi and Patipudirupru hospitals (Mullativu).
- Difficulties in movement to and from uncleared areas to Vavuniya and Mannar hospitals; congestion in their obstetric wards.
- More home deliveries than in other places in the country, some attended by untrained staff; the consequent need to encourage and facilitate hospital deliveries.
- MMR in 2006 estimated to be higher than the national average: 6 maternal deaths per about 3000 deliveries that year (nearly 180/1000 live births); of these a few being definitely avoidable, as they were due to delays in getting to a surgical facility.
- Family planning clinics are not attended regularly by the needy and missed opportunities for FP are many.
- The abortion rate is estimated to be high (at least in Trincomalee), but no accurate data is available.
- Non-availability of colposcopic facilities in Vavuniya Base Hospital, which requires these PAP-positive clients be referred to Colombo.
• Among the Muslim populations in the Trincomalee and Batticaloa districts, the average age of marriage is lower than the rest of the country and teen pregnancies among married girls appear to be more frequent, although there are no recorded data. Family planning coverage is also below the national level and improved FP counseling seems to be urgently needed.

• Batticaloa hospital has opened a child abuse centre called Child Protection Unit, with help from UNICEF; some ASRH education is done in Kalmunai with UNFPA and PSL support.

• PSL provides support to government in the RH services; PSL’s Community Health Promoters are the main health workers here; since early 2007 the government has continued the program as PSL has not received funds in 2007.

• One major problem for IDPs is malnutrition of mothers. There is no nutrition supplementation and the health leaders ask why the WFP and UNFPA cannot work together in this.

• In the plantations (the Estate sector) MCH services have improved, with decreases in MMR and IMR. However, these still remain high in certain smaller areas, compared to rest of country. The cluster health plan is in operation, but services to small plantations are not included.

Recommendations:

1. In collaboration with the relevant partners, formulate plans and strategies to upscale the coverage and quality of RH services to the IDPs and underserved groups. This should include immediately needed services to the IDPs and the rest of the population in the same areas and more medium-term services to restore normalcy in the RH services of these areas.

2. When selecting undeserved areas for RH programs, promote the use of explicit criteria, based on disaggregated demographic and epidemiological information. For example, among the plantations, some of the “private-private” estates need RH support rather than the corporately-owned (where vital statistics are near the national levels). This could be linked with the work being proposed for the Population Unit of the FHB, the demographic unit of the University of Colombo, and data from the Registrar General.

3. The following are recommended specifically for the North and East:
   • In collaboration with the government and the other UN and NGO partners, develop a blueprint and plan for its implementation to improve the health human resources situation in the North and East.
   • Provide for “waiting/lying in homes” either in or close to the hospitals in Vavuniya, Mannar and Trincomalee so that pregnant mothers can stay for a longer period prior to their dates of delivery.
   • Provide delivery kits to the mothers so that they can take these along when they go to hospitals for delivery.
   • Consider providing urgently-needed vehicles (a few four-wheelers and two-wheelers) for the staff to visit clinics and the IDP camps for providing essential RH services.

15 Sri Lanka had the earliest recorded “lying in homes” in the 2nd century B.C. as recorded in Mahawamsa.
• Small-scale supplies and equipment (such as test kits, chemicals and test equipment) should be made available to conduct the basic laboratory examinations, such as TPAT, HB, and proteins.

4. UNFPA is correct in being cautious about supporting volunteers, paid and otherwise. It should, however, continue the modest 3000 rupee/month travel allowance (= approx. US$27) currently paid to small numbers of volunteers serving the small “private-private” plantations, at least for one additional year while plantation health services are in transition to the MOH system (e.g., the 25 volunteers in Maskeliya District).

II.B.4 Well Woman Clinics

Well Woman Clinics (WWCs) are an innovation that has the UNFPA brand name etched on it. The concept of screening healthy well women at community level is relatively new, requiring public education prior to its acceptance. However, while community interest is being created, the service elements need to keep pace with community expectations.

In accord with its commitment to provide comprehensive reproductive health services based on the life-cycle approach, UNFPA supported establishment of 300 Well Women’s Clinics in 1996 under its 5th Country Programme to focus on health needs of women above 35 years of age. Selected services and screening tests were made available at these clinics to address non-communicable diseases that were chosen based on epidemiological evidence. Emphasis is on screening for cervical cancer and breast cancer (clinical breast exam and instructions on self-exam). The WWC programme is implemented through the MCH infrastructure at divisional (MOH) level, WWCs being held at designated facilities according to a specific schedule. The FHB is the focal point for implementing this programme, in collaboration with the National Cancer Control Program (NCCP) and the College of Pathologists (CP).

The WWC concept has been endorsed by all concerned, including the Professional Colleges, and has been a successful and significant component of the RH program.

The WWCs also create awareness and educates women about STIs, HIV/AIDS, RTIs, anaemia, nutrition and adopting a healthy life style. The extent to which they proactively promote and provide FP services, as urged in the 2004 review, is unclear.

While the WWCs are on the whole successful, some of the weaknesses relate to:

- Coverage, which is over all less than 20% of women over 35 years of age,
- Delays in the receipt of laboratory reports and provision of results,
- Call-recall: no reliable record of who did not receive the examination after referral (need to streamline this),
- Referral linkages to services for women found positive; lack of colposcopic facilities in some of the referral centres,
- No provision yet to repeat at least every 5 years,
- Absence of regular screening for RTIs,
- Different levels of training being given for the different categories of staff,
- Unlikely sustainability without UNFPA support.

16 Gynecological cancers account for about 50% of all reported cancer cases among women.

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Recommendations:

At the policy level
1. Formulate a national policy and strategy to ensure the continuity and sustainability of the WWC programme, even if and when UNFPA support is withdrawn.

At the service level
2. Streamline the existing services so as to expand the coverage, increase the efficiency of the services (by removing the bottlenecks regarding cytological services and the referral and feedback system).
3. Experiment with including methods to visualize the cervix as a substitute/alternative to pap smears in order to expand coverage. This includes training the health personnel and the provision of the essential supplies.
4. Explore the implications and possibilities of gradually building the capacity to have a centralized screening system with a centralized data-keeping mechanism.
5. Expand the RH information and services to women over 35 years but still fertile, and to peri- and post-menopausal women.

II.B.5 STIs and HIV/AIDS

STIs are an increasing problem in the country, with an estimated 200,000 new cases per year. Of these only 10-15% may be seen in government facilities, although reliable data are not available. Therefore the quality of treatment is not guaranteed and the possibility of introducing syndromic management backed up by referral has been proposed.

The National STD/AIDS Control Programme (NSACP) does sentinel surveillance of HIV/AIDS using WHO guidelines and tracks populations with risk factors such as low condom use, sexually-active young male and female CSWs, and drug users -- although the prevalence of HIV is currently low in all these groups. HIV knowledge is found to be low in rural and estate areas.

The STI/HIV sub-component of UNFPA’s RH programme aimed to strengthen the NSACP to introduce syndromic management of STDs in non-specialist clinics, train MLTs for basic laboratory tests for VDRL, and train health staff on voluntary counseling and testing for HIV in mothers. SLAVSC also participated in this work in the Central Province.

Services to provide adolescents and youth with appropriate sexual and reproductive health information and services (to protect them from the negative consequences of unwanted pregnancy and infection from STDs and HIV/AIDS) were undertaken through the Health Education Bureau (HEB) of the MOH and four other partners, which it coordinated:

- the Army medical Corps – focus on youth in the Army;
- the National Youth Services Council of the Ministry of Sports and Youth Affairs;
- University Grants Commission – focusing on students in the universities; and
- the Department of Labour – focus on young women working in the free trade zones.

*The National HIV/AIDS Strategic Plan 2007-2011 identifies populations considered “most at-risk” for HIV and makes these the focus of the plan.* (Because Sri Lanka is a low-prevalence country for HIV (prevalence < 5000 by end 2001), the Strategic Plan does...
not place much emphasis on outreach to the general population.) During the 6th CP, UNFPA has had very minimal engagement with Sri Lankan populations most at-risk for HIV. It has supported the following activities with:

1. CSWs – A small project with Community Strengths Development Foundation (CSDF), whose focus is CSWs. UNFPA is apparently now starting a CSW project that the World Bank had designed but didn’t proceed with.

2. Prisoners – A project with SLAVSC to support sexual health and HIV awareness with prisoners (6000 planned) and prison staff in two prisons (Kandy and Badulla)\(^1\). Funding was $200/year for five years (total $1,000). Described as: “Educational programs for 6,000 prison inmates.”

3. Beach boys - While not an explicit UNFPA focus, they are among the out-of-school youth addressed by the UNFPA-supported Aluthgama YFS centre.

In the 7th CP, UNFPA plans to increase STI and HIV and AIDS prevention efforts for women and young people and help to implement the HIV strategic plan in areas of comparative advantage of UNFPA. Specifically UNFPA will, in coordination with UNADS partners:

1. Develop and implement the national BCC strategy;
2. Strengthen linkages between the RH and STD programs;
3. Target prevention services for CSWs, uniformed services, out-of-school youth and migrant women.

Recommendations:

1. UNFPA should continue seeking means to act as the coordinating agency between the FHB and the NSAAP in relation to their responsibilities in STIs and HIV prevention and management.
2. UNFPA should further develop BCC approaches to promote safe sex among vulnerable and at-risk groups (CSWs, MSM, migrant women, and the military) as judged appropriate and feasible considering UNFPA's capabilities and need to be less thinly stretched under CP7.
3. With the other UN partners, develop policies and strategies to extend the information and services to groups such as young women and mothers.
4. Provide support to institute measures to prevent parent-to-child transmission (PTCT).

II.B.6 Education and Training

UNFPA’s long-term support to education and training in RH is well recognized and currently UNFPA is the main organization that supports training. There is need now to update and rationalize both pre- and in-service training. UNFPA support has helped to build the capacity of the health personnel engaged in RH work at all levels. However, many RH education and training programmes supported by UNFPA have over the years tended to become stereotyped, centralized, routine and delivered vertically, with about 150 medical officers and similar numbers of other categories being trained per year, mainly in family planning. Most of the training is of the in-service type, with insufficient input into the pre-service components. It is unlikely that this will, in any palpable way, address the unmet needs for FP in the country, neither in terms of numbers of personnel who have the required competence nor the range of skills they develop.

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19 Reproductive Health Information and Services with Focus on Out of School Adolescents and Youth through Non Governmental Organizations [PO2]. November 2001.

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Recommendations:

1. UNFPA should facilitate review and revision of the curricula of pre-service and in-service training, both in the training institutions as well as in the decentralized units, so as to rationalise the goals and objectives, content and training methods. More interactive, problem-oriented and problem-based methods need to be instituted and the appropriate teaching and learning support materials need to be developed.

2. UNFPA should provide support to build the technical capacity of the trainers and the training institutions. The possibility of availing the help of the Universities and the NIHs and using the excess capacity of some of the Regional Training Centres (e.g., Kadugannawa) should be examined. Ideally, this can be done in partnership with the WHO.

II.B.7 Advocacy for Reproductive Health

Overall, UNFPA seems to have had limited success in its advocacy role on important aspects of reproductive health. Some successes of UNFPA advocacy in RH include:

- Development of a national contraceptive security plan
- Formulation of the concept and operational strategy of Well Woman Clinics
- The pilot for hospital-based management of gender-based violence (GBV clinic in Matara)
- Introduction of new contraceptive methods, most recently successful negotiation for UNFPA provision of Implanon (long-term injectable), on a provisional basis for CP7.

The advocacy role to initiate policy dialogue among the parliamentarians, provincial counselors and high-level decision-makers does not seem to have produced any tangible results. No new significant policy decisions seem to have resulted from their engagement. It is possible that UNFPA previously had not taken up this area of work very intensively, and that it concentrated instead on “filling the gaps” and consolidating the gains in services delivery. It is also possible that UNFPA’s advocacy was not very effective because of efforts to promote “reproductive health” generally, rather than critical RH issues that intended audiences can more easily comprehend.

Recommendation:

It is crucial that advocacy efforts concentrate on critical and burning issues such as abortion, reproductive health needs of vulnerable groups, violence against women, adolescent health, reproductive health of older women, aging and male participation.

II.B.8 Balancing Roles (and Images) of UNFPA: Policy-Advocacy, Technical and Service

Often, possibly erroneously, national counterparts have tended to envision UNFPA as a FP support organization, with less recognition of its technical role. Some staff in the CO feel UNFPA has an identity crisis and ask “What strategies could the UNFPA CO adopt to avoid the identity crisis we are facing in Sri Lanka at present as a “population (birth) controlling” organization?” and add: “Progressively, family planning is becoming a sensitive issue, especially among certain religious groups and ethnic groups, thus it is pertinent that UNFPA is seen as an organization that offers much more than FP.”
**Recommendations:**

1. The Country Office should continue looking at ways to balance its policy and advocacy roles, on the one hand, with technical and service roles on the other. While developing the 7th CP Action Plan, the CO should be constantly posing the question “How do we position ourselves appropriately in the national RH and RH-related agenda to develop an identity and public image as an organization with an important technical and leadership role in RH, in addition to our service delivery function?” This relates to the CO’s desire to do more “upstream” work. (See section IV.D below.)

2. UNFPA needs to lead the UN community in the preparation of RH policies on a gender-sensitive framework, and ensure RH services to both men and women.

3. UNFPA should collaborate closely with the other UN partners, particularly WHO and UNICEF, in formulating a common agenda for RH and gender policies and services.

4. UNFPA should continue to support meeting the critical service needs in RH, particularly in FP, to ensure the quality of the services.

**II.B.9 Engaging the Private Sector**

*Increasing numbers of Sri Lankans are seeking RH-related care in the private sector, mainly for STIs and HIV; those private-sector services could be enhanced to improve the overall programme.*

The private sector (which includes private hospitals, nursing homes and independently practicing general medical practitioners), also provides MCH services to varying degrees. Although data are not available, it is known that a considerable proportion of patients with MCH needs patronize the private sector, including an estimated 10% who have their deliveries in private facilities. The Independent Medical Practitioners Association (IMPA) has been engaged by UNFPA to develop continuing education modules on STIs and HIV, and this collaboration has been successful. It lends itself for further strengthening.

The FHB’s current FP work could be further strengthened in a number of ways by improving collaboration with private-sector physicians. For example, the FHB could expand its work with important categories such as general practitioners (GPs) and NGOs, thereby capturing a segment that has a major role and potential in strengthening RH. The GPs provide a considerable volume of services in STIs (estimated to be around 70-80% of total), antenatal care, and temporary methods of family planning. The NGOs support the RH program of the government in many different ways.

**Recommendation:**

UNFPA should facilitate the engagement of the MOH and the FHB with the GPs in a more robust way to improve their knowledge and skills in reproductive health and to optimize their contribution to improving RH services.
II.C  EFFECTIVENESS/ACHIEVEMENT OF RESULTS:
SRH INFORMATION AND SERVICES FOR ADOLESCENTS & YOUTH

UNFPA has been a pioneer in supporting sexual and reproductive health programs for young people in Sri Lanka. While the ASRH services supported by the UNFPA during its 6th Country Programme may be described as comprehensive -- in the sense that all segments of young people (in-school, out-of-school, working and unemployed, boys and girls) were reached in one way or another -- the programme was also thinly spread, insufficiently targeted, inadequately results-oriented and poorly evidence-based. A more targeted and results-oriented approach focusing on underserved youth in particularly vulnerable situations is needed for under CP 7.

UNFPA-supported SRH services for adolescents and youth in Sri Lanka are illustrated below.

Figure 1: UNFPA-Supported Activities for Promotion of A/Y SRH in Sri Lanka

II.C.1  Reproductive Health Education in Schools

As school children are the majority of adolescents in Sri Lanka and a captive group accessible through the schools, the school system provides important opportunities for promotion of sexual and reproductive health and responsibility. Reproductive health modules are now in the school curricula and a programme of counseling and peer communicators has been introduced in some schools. However, continuing resistance by certain administrators, teachers and parents, and limitations imposed by the traditional didactic teaching methods and behavioural norms adopted in schools as well as the lack of open discussion and free flow of information between teachers and the younger generation remain a serious constraint to effective implementation. There are no data to show an impact on behaviour.
Given Sri Lanka’s decades-long system of universal education, school children constitute the majority of adolescents in Sri Lanka, as elaborated elsewhere in this report. As these adolescents are a captive group accessible through the normal education processes in the country, the school system provides good opportunities for promotion of sexual and reproductive health (SRH) knowledge. School attendance rates are high among both young boys and girls, except perhaps in the conflict-affected populations.

The school system in Sri Lanka has a captive audience of about 4 million young people and it has a strategic importance in affecting knowledge, attitudes and behavior of young people during their formative years. This has been one of the longest-serving partnerships of UNFPA in Sri Lanka -- nearly two decades. The focus shifted from population education to RH since ICPD. In some regards, the current project has national coverage (e.g., curriculum development and preparation of relevant educational material), but much of the UNFPA-funded activities have concentrated on 13 educational zones in some underserved areas (out of national total of 92 educational zones). Project components include training of resource persons, principals, RH teachers, teacher counselors, and peer communicators; development of teaching/learning material and establishment of a counseling service in schools.

Table 3: Persons Trained under RHE in Schools, by Year and Category

<table>
<thead>
<tr>
<th>Year</th>
<th>Principals and Administrators</th>
<th>Teacher Trainers</th>
<th>Teacher Counselors</th>
<th>Peer Communicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>2002</td>
<td>264</td>
<td>190</td>
<td>203</td>
<td>278</td>
</tr>
<tr>
<td>2003</td>
<td>464</td>
<td>198</td>
<td>240</td>
<td>312</td>
</tr>
<tr>
<td>2004</td>
<td>858</td>
<td>69</td>
<td>584</td>
<td>470</td>
</tr>
<tr>
<td>2005</td>
<td>728</td>
<td>71</td>
<td>240</td>
<td>846</td>
</tr>
<tr>
<td>2006</td>
<td>995</td>
<td>31</td>
<td>458</td>
<td>628</td>
</tr>
</tbody>
</table>

The National Institute of Education (NIE), which is part of the Ministry of Education, plays a crucial role in curriculum development, in-service training of teachers and educational administrators (See Table 3), and the development of teaching and learning material. The actual administration of schools is the responsibility of Department of Education in the central government and of provincial education departments under the purview of provincial councils. Given this administrative set up, NIE alone may not be able to bring about required change in the education system. Side by side with government schools, there are private schools and international schools catering to children from more affluent families; the state has limited influence over the curricula and educational processes in these private sector institutions.

Nearly 80% of all schools and some 85% of all school children are in the public-sector school system. As the public-sector schools are centrally administered and as NIE is
responsible for developing suitable curricula and preparing teachers to teach the relevant subjects, NIE has taken the lead in introducing RH education in public schools. NIE has had a comparative advantage in curriculum development, development of suitable reading material for school children, and in-service training of teachers to prepare them for the challenging task of teaching sensitive topics as part of the normal education activities in the schools.

Some of the key achievements of UNFPA-supported school-based interventions are as follows:

- Institutionalization of RH education within the country’s extensive school system;
- Integration of RH into school curricula in various disciplines: health science, physical education, social science, home science;
- Capacity-building in RH education (see Table 3), which has produced some excellent and exceptionally committed teacher communicators, although these appear to be the exception rather than the rule;
- Reasonably good integration with the health sector, although this could be improved, particularly in the periphery;
- Development of curricula and teaching/learning materials suited to Sri Lanka situation

NIE, however, has encountered difficulties in overcoming the resistance to RH education in schools from some principals, certain school teachers and some of the parents. At least in some areas, NIE has not received the full cooperation of the local educational authorities responsible for introducing and implementing innovations in the school system. Instead it has been left to the individual interest and initiative of school principals and teachers responsible for teaching RH and providing counseling services, rather than a systemic change completely assimilating the new RH modules.

At the same time as many government officials, school administrators, teachers and parents resist the RH curricula because they “do not want children exposed to such things,” school children are increasingly exposed to sexual matters from other sources. It is frequently stated that “very few adolescents in Sri Lanka are sexually active before marriage.” Data show otherwise (See Box 1.) The schools visited during this assessment indicated a range of emerging SRH issues among school children. These include the popularity of erotic “blue films” (pornographic movies) among boys, problems of sexual abuse and incest faced by girls (particularly in homes where the mother has gone abroad for employment), and love relationships among school children. In at least some schools, the teachers and counselors trained by NIE, as well as supplementary reading material developed by NIE, have identified these issues as important and devised some ways to address them.

In most schools, however, any kind of open discussion about these issues and identification of any effective remedies beyond normative prescriptions such as “do not fall in love until

Box 1: In a national survey of adolescents aged 14-19, 15% of school children and 36% of out-of-school adolescents admitted having a love affair with someone of the opposite sex at the time of the survey (UNICEF, 2004). Among school-going adolescents, 6.1% had experienced heterosexual intercourse. The mean age of sexual debut was reported to be 15.3 years for boys and 14.4 for girls. About 10% had experienced a homosexual relation. In the out-of-school sample 22% had experienced heterosexual intercourse. Nationally, 8 to 10% of reported pregnancies occur among teenagers. It must be noted that the SRH problems of adolescents and youth are not merely due to lack of knowledge or access to services, but due to structural mechanisms connected with wider social, economic and political dynamics in the country as a whole. An example is the incest among daughters of women who have gone to work in the Middle East/Gulf states, many of them impelled by poverty. (See Annex L.)
after you finish your education” have been prevented due to the disciplinarian environment prevailing in schools, the normative orientation of teachers, school authorities and even NIE staff, and the perceived political sensitivity to any open discussion on the relevant topics within the school environment. This, in turn, has adversely affected the efforts to promote RH education in schools.

The lack of government commitment to gradually take over responsibility for sustaining RH activities that have been established in NIE and in the schools (through financial support of UNFPA over a period of two decades) points to a serious question over the long-term sustainability of this initiative.

Other major limitations of school-based RH education are as follows:

- Program is thinly spread; only 13 out of the total 92 educational zones in the country are covered in teacher training and training of teacher counselors and peer communicators.
- Impact not clear.
- Over-sensitive to cultural inhibitions (for instance, a school play by project peer communicators advises classmates to avoid boys, postpone love and concentrate on studies).
- Over-sensitive to cultural inhibitions, sexuality issues largely untouched.
- The curricula developed cover mainly physiology and bodily changes during adolescence to the relative neglect of relevant behavioral, gender and rights issues.
- Initial opposition to RH from within the school system has been overcome to some extent through training, but many teachers continue to have difficulties in communicating effectively with their students on sexual health.
- Counselors play a useful role in some schools, but in many schools the role is not properly institutionalized.
- Peer communicators are inactive, or active in a problematic way, in some settings.

One recent innovation that has come about through UNFPA’s CP6 work with government and NGOs is the provision of SRH information and counseling to in-school adolescents at out-of-school sites. For example, SLAVSC and the Pilimatalawa Regional Training Centre have several programs for school children from nearby schools on a regular basis. This allows school-going adolescents greater opportunity for more frank and informed discussion than is generally possible in school.

**Recommendations:**

1. While effectiveness of the ongoing interventions is not clear (in spite of nearly two decades of UNFPA involvement in population and RH education in schools), given the strategic significance of public schools in reaching out to young people, UNFPA should not abandon the school system altogether but should encourage the government to take over responsibility for SRH education in the schools.

2. In regards to UNFPA’s CP6 support for RH education in schools, a proper exit strategy should be worked out in order to ensure that whatever gains have been made are not entirely lost. As regards the exit strategy, the following is recommended:

   a. A systematic assessment of work to date and how it may be used in any future interventions;
2. Assessment of curricula developed thus far to identify strengths and weaknesses from the angle of promoting responsible and safe conduct among young people;

3. Identification of any good practices within the CP6 project from the angle of preparing young people for risks and challenges; and

4. Identification of how school curricula and training programs initiated under the project may be adapted for new national-level initiatives (such as the World Bank-assisted HIV/AIDS education program in schools).

As the National STD/AIDS Control Programme moves ahead with its plans to support education on STIs and HIV/AIDS in the schools, UNFPA and NIE should ensure that the NSACP builds effectively on what UNFPA and NIE have achieved and learned.

4. Efforts to integrate SRH in the pre-service training of school teachers should be recommended by UNFPA as an alternative to the in-service methods already pursued. Suitable SRH modules must be developed for teacher training colleges. Such modules may be piloted in selected teacher training colleges preparing teachers who are likely to serve in underserved communities (e.g., Sripali Teacher’s Training college in Hatton), especially those providing Tamil language training and for those serving in the UN focus districts.

5. There is considerable scope for establishing and promoting linkages between the school system and other ongoing ASRH activities and services at the regional and district levels (such as regional training centres under NIHS, SLAVSC, YFS or even STD clinics) whereby schools serve as an outreach facility for these centres and the schools draw upon the more competent RH experts for teaching some of the sensitive and advanced topics. Where necessary, teacher counsellors may refer school children for counseling and other services available in these centres.

6. More interactive and youth-friendly teaching and learning methods -- such as theatre, puppetry, music and IT-based activities -- should be promoted for raising the awareness of school children around SRH themes. These alternative communication strategies may be more effective in overcoming the communication barriers currently evident in RH education in schools.

II.C.2 SRH Information and Services for Out-of-School Adolescents and Youth

Out-of-school adolescents and youth are more sexually active and thus more vulnerable from the perspective of sexual and reproductive health risks than in-school adolescents, but addressing their SRH needs is extremely challenging. While several programmes have been carefully designed and implemented for out-of-school youth, it is not possible to determine their effectiveness.

Adolescents and youth who have left the schools for one reason or another are a particularly vulnerable group from the angle of SRH. They include unemployed youth as well as those employed in vulnerable occupations in the security forces, free trade zones, plantations, tourist industry and other such places. They may or may not be under parental supervision. Outside parental supervision, they typically have more opportunities for casual and even commercial sex. As they are dispersed in many places and mingle freely with adults in work places, it is generally more difficult to reach them compared to the captive population of school children. The 2004 UNICEF study found that out-of-school adolescents are far more sexually active compared to school children of comparable ages.
AY SRH activities under CP6. Addressing SRH needs of out-of-school young people is a major challenge. UNFPA-supported activities under CP6 have followed two complementary and supplementary approaches. One is to provide RH information and services to this target group through a range of government agencies -- such as NYSC, Army, UGC and the Department of Labour -- that are in contact with this target group. The other is to channel information and services through several NGOs working closely with the relevant target group in community settings. The RHIYA project also built on this model to develop a community-based counseling programme side by side with provision delivery of contraceptives (condoms) to needed young people needing them. More recently, Youth Friendly Services have been established in selected areas with a view to providing necessary services, including clinical services, for young people requiring these services. From the available data it is difficult to determine how effective these programmes have been. While the programmes have been carefully designed and implemented for many of the vulnerable young people within the framework of the UNFPA country programme and regional projects, how much far they have contributed to improving young people’s SRH knowledge and practices and minimising their risks is not clear from any project-related information or national-level data. It is true that useful IEC materials have been produced and widely disseminated through several channels of communication, linking key government agencies, including HEB and FHB, health care providers, NGOs and CBOs and mass media. More recently BCC interventions have been introduced for the purpose of understanding specific behaviours that need to be fostered, modified or prevented.

There is continued disagreement among the agencies as to what messages are to be disseminated (i.e., total abstinence or safe sex) and whether condom or contraceptive use should must be openly promoted among this target population. Agencies such as the Army and the Labour Department have found it necessary to combine IEC with condom/contraceptive services. On the other hand, many other agencies have sought to promote IEC and counseling (including peer education) without explicitly promoting condom use or use of emergency contraception. Most government agencies and NGOs have carefully avoided any explicit or open promotion of safe sex practices among A/Y except where they openly deal with high-risk groups such as CSWs, beach boys, and soldiers. Issues such as RH rights, gender-based violence and other gender issues are insufficiently addressed in these activities.

As regards activating NGOs to reach out-of-school youth with appropriate SRH information and services, funds were channeled to suitable NGOs through the NGO Secretariat. Implementing partners were three family planning NGOs (Family Planning Association of Sri Lanka, SLAVSC and PSL) and some broader developmental NGOs (including Sarvodaya, Mahila Samithi and WDF). The focus was on young persons in underserved communities, such as remote rural regions, conflict-affected areas, and urban low-income communities. Strategies included training and mobilization of peer educators, youth camps, and RH services for young people, including mobile clinics in some areas and awareness-raising on HIV and STDs in general.

The Two Regional Projects

Reproductive Health Initiative for Youth in Asia (RHIYA) was an EU-funded regional project that aimed to improve the sexual and reproductive health of young people ages 10-24. It trained and deployed a large number of master counselors, counselors and peer educators. Initially a uniform set of interventions was carried out by all 9 implementing partners under the guidance of the Family Planning Association of Sri Lanka (FPASL). Although project management collected substantial information regarding numbers trained, numbers of young people who consulted counselors, and numbers who received contraceptive services...
(particularly including condoms), the reliability of the information collected is questionable due to insufficient follow-up. While a mid-term evaluation pointed to limited effectiveness and impact, a good-practice documentation in 2006 identified various practices as effective, replicable and sustainable. (See also section II.A.3 above and Annex L). Major lessons for future programming included the following:

- Innovative communication strategies (such as participatory street theatre) can play a useful role in raising community awareness about SRH issues where cultural constraints prevent direct one-to-one communication between young people and adults, including their parents and teachers.
- Integration of counseling and SRH services with other types of non-SRH services tends to enhance their effectiveness for A/Y and their appropriateness in the Sri Lanka context.

**Youth Friendly Services.** This regional pilot project established three YFS centres in three districts under three different auspices: government health system (NIHS), government non-health organization (NYSC in the Ministry of Sports and Youth Affairs), and an NGO (SLAVSC). Although these services are not yet optimally used, there is evidence of increasing popularity judging by the number of adolescents and youth visiting the centres. Among achievements during the first year of operation are: establishment of the three centres under different settings, development of minimum standards for youth friendly services, introduction of user fees for some services in SLAVSC’s centre, and integration of services. It is too early to assess the effectiveness, impact and sustainability of these centres. (See also section II.A.3 above).

**Recommendations:**

1. As UNFPA plans to move out of some of the ASRH activities for out-of-school youth, it should consider facilitating advocacy efforts aimed at evolving suitable policies that explicitly address pre-marital sex. UNFPA and other donors might jointly support a research program to establish baseline information on emerging trends in adolescent and youth sexuality. The information generated should be used to raise awareness and promote advocacy towards a more open recognition of unmet RH needs among adolescents and youth.

2. **Consensus on messages.** Effort must be made to reach a consensus on SRH messages to be disseminated to young people, male and female, in different age groups. This may be done through a series of consultations among relevant agencies (GOs and NGOs) currently engaged in SRH work among adolescents and youth in and outside the school system. UNFPA might facilitate this process with a view to strengthening on-going programmes for out-of-school youth.

2.1. **Pre-marital sex.** As UNFPA plans to move out of some of the ASRH activities for out-of-school youth, it should consider facilitating advocacy efforts aimed at evolving suitable policies that explicitly address pre-marital sex. UNFPA and other donors might jointly support a research program to establish baseline information on emerging trends in adolescent and youth sexuality. The information generated should be used to raise awareness and promote advocacy towards a more open recognition of unmet RH needs among adolescents and youth.

2.2. **IEC to BCC.** A shift from IEC to BCC is necessary in all programmes for out-of-school youth. This means encouraging young people to move from unsafe to safe behaviours within an evidence-based framework as the ultimate objective of the relevant interventions. As for UNFPA-supported programmes for out-of-school youth, some are still firmly anchored in the IEC framework (e.g., RH for Out of School Education of UNFPA Sri Lanka Country Programme & Other Projects Implemented 2002-2007 - DRAFT 21 Aug.)
Youth by NGOs) while others (e.g., IEC support for RH in Army, Labour Department and NYSC) have gradually moved toward a BCC model. While a diversity of approaches is not necessarily ineffective, it may be counter-productive to simply provide information without directly targeting and monitoring behaviour.

4. **Collaboration.** Collaboration and networking among NGOs and government agencies must be promoted with a view to building civil society involvement in ASRH, including advocacy and upstreaming efforts.

5. **Serving out-of-school youth.** Programmes for out-of-school youth, whether implemented by government or NGOs, must be made more gender-sensitive, rights-oriented and participatory in character. For instance, given the fact that many young people, girls in particular, are victims of sexual abuse at home, in community settings and in work places, educating about and ensuring child/youth rights must play a more significant role in RH programmes for both school children and out-of-school youth. Consultations with the intended beneficiaries are a prerequisite for developing such programmes, and active participation of the young people themselves in all stages of project development, implementation and monitoring must be ensured for greater effectiveness of such programmes.

6. **Youth Friendly Services.** Based on results of the three recently established YFS centres, YFS might be expanded to other areas, including the North and East and plantations. In addition to the current YFS sponsorship (government and NGO), other modalities of YFS sponsorship (e.g., commercial private-sector) should be explored in order to increase accessibility to diverse population groups. There is considerable scope for integrating YFS with community-based counseling services and school-based programs initiated under other UNFPA-supported projects. This should be considered for the next CP.

7. **School-based educational or extracurricular activities** should be considered to facilitate and popularize help-seeking behaviour by young people.

8. **Identified good practices.** Some innovative good practices of the RHIYA project, such as street drama and mobilisation of community outreach workers (CHPe), for reaching vulnerable and mobile populations, should be incorporated into UNFPA’s CP7.

9. **Integration with other services.** Given the still-conservative Sri Lankan social context, models of integration should be further explored with the goal of enhancing the relevance, appropriateness and acceptability of ASRH programs. Consideration should be given, for example, to integration of counseling and SRH services (e.g., provision of condoms or other contraceptives) with other already-established services for young people (e.g., health care and educational or vocational training activities).
II.D. EFFECTIVENESS/ACHIEVEMENT OF RESULTS: GENDER

II.D.1 UNFPA Gender Strategy

Gender was conceptualised in 2001 as a cross-cutting theme in UNFPA’s 6th Country Programme and a disparate range of concerns were to be stressed, including gender-sensitive reproductive health services, male participation in reproductive health matters, women’s rights, reproductive rights and the prevention of gender-based violence. However, UNFPA did not develop a comprehensive strategy to integrate gender into all its projects and interventions. Therefore gender was not effectively mainstreamed into UNFPA’s programme as a cross-cutting concern. Instead, the gender component has been compartmentalised and marginal to the country programme. “Gender” appears to be perceived as a project in itself rather than a strategic intervention to be integrated and mainstreamed throughout the programme. UNFPA nevertheless has become recognised as a leader in gender work and achieved a good foundation during CP6 for progress.

In the aftermath of the tsunami, UNFPA received significant funding for gender-based interventions that became the main focus of its gender related work. The tsunami projects helped UNFPA profile itself as an agency responsive and responsible for gender mainstreaming and strengthening national capacity and institutional mechanisms for increased state accountability to fulfill and protect the rights of women.

UNFPA can continue to more effectively use its position as the UN’s foremost agency responsible for the implementation of the ICPD Programme of Action to create synergies between gender equality and reproductive health outcomes by ensuring a commitment to integrate a gender perspective into all its programmes and partnership interventions. The Gender Equality component of UNFPA’s programme is crucially important and relevant to Sri Lanka’s population and reproductive health needs.

Power imbalances in economic and social structures. Sri Lankan society is characterised by power imbalances in economic and social structures among geographical regions, ethnic groups and between men and women. A gender policy must be grounded in the understanding that women’s health is largely determined by economic and social constraints and that it is difficult to separate reproductive rights and health from other economic, social and political rights and needs (such as income and food security, cultural practices that affect women’s autonomy and choice and peace and ethnic harmony) that impact on economically poor women’s lives.

Recommendations:

1. UNFPA must centrally identify reproductive health and rights as determinants of gender equality – and vice-versa. Failure to do so negates UNFPA’s comparative advantage and perpetuates the compartmentalisation of gender and isolates gender concerns from efforts to strengthen the reproductive health programme. The UNFPA programme should be strengthened to achieve the integration of a gendered focus on reproductive health and rights into all interventions.

2. UNFPA therefore needs to develop a gender strategy, including operational tools and an approach for effective dialogue with key government and UN partners to integrate gender equality and reproductive health.

[21] It is indicative of this – and other aspects of UNFPA positioning in Sri Lanka – that UNFPA’s major government partner in reproductive health did not speak to the evaluation team during this assessment about gender programming, but repeatedly stated the request that UNFPA provide it with vehicles.
gender and gender approaches fully into its 7th CP. Gender integration must be part of overall programme and project design, implementation, monitoring and evaluation.

3. A comprehensive gender policy and strategy (including that of UNFPA) must embody a sexual and reproductive rights framework that is grounded on an understanding of macroeconomic policies, cultural practices and conflict issues that undermine women’s autonomy and choice.

II.D.2 Advocacy to Mobilise Political and Community Support for RH and Gender

The 6th CP identified the mobilisation of political and community support at national and sub-national levels for effective implementation of the National Population and Reproductive Health Policy and Action Plan as one of two purposes to meet its overall goals. The project, Advocacy in Support of Reproductive Health and Gender (PO5), was one of the strategies of this programme area.

The output was expected to be increased understanding, commitment and support of parliamentarians and policy-makers as well as community leaders, mass media organisations, NGOs and senior administrators to address population, RH, HIV/AIDS and gender issues. An advocacy strategy for improving reproductive rights and health was to be prepared in collaboration with relevant partners after a review of existing advocacy efforts.

Conceived in 2001, this component of work was to be handled by three partner agencies: the Population Division of the Ministry of Health, the Sarvodaya Movement, and the Women’s Bureau. This programme underwent a mid-term review in 2004.

- **Population Division.** At the time of this evaluation, the Population Division at the Ministry of Health had completed the project component assigned and had ceased to exist. The Population Division was to advocate on demographic transition with parliamentarians and high-level policy makers but this appears not to have been possible. Flaws in design, unrealistic expectations and assumptions that parliamentarians may have advocated on reproductive health concerns may have been contributory factors.

- **The Sarvodaya Movement** was selected to advocate among religious and community leaders. In the first phase of implementation it focused more attention on youth leaders, providing them with information rather than tools for advocacy. Following the mid-term review, Sarvodaya began to focus its advocacy work on community-based religious leaders in 4 districts: Kurunegala, Anuradhapura, Vavuniya and Monaragala. Sarvodaya has a good network among religious leaders and is recognized for its strong inter-faith work at the community level. This programme component will end in December 2007.

- **The women’s Bureau** was responsible to carry out capacity building of women leaders at the local level so that they could advocate for RH and gender concerns. Activities were limited to single-event awareness-raising seminars spread across a large number of districts with no clearly identifiable output.

The mid-term review found that the project components were very discrete, event-based and locally-focused with no upstream work at the national level and no lateral linkages. It also found very limited understanding of advocacy among the partners. There appeared to be flaws in project design. This may have been in part – but only in part – because gender was not yet a substantive concern at UNFPA when CP6 was developed in 2001.
Following the review in 2004, it was decided to limit the RH and Advocacy project to one pilot district (Kurunegala) and to place it under supervision of the Government Agent. The project was re-conceptualised to a process-based capacity-building and mobilising of community-level women leaders to advocate for RH and gender. These activities began in late 2005.

**Outcomes:** Institutional and human resources capabilities strengthened to advocate for gender and human rights at sub-national and community levels in the one pilot district (Kurunegala). Specifically:

- RH and Gender advocacy work in 5 D/S divisions implemented through the office of the Divisional Secretary and supervised by the GA at District level;
- Outreach to community-based women’s organisations established;
- Work with regional machinery at divisional and local level, establishing strategic and long-term linkages with the health sector;
- Outreach to women leaders at the community level, including those from the Kantha Balamandalas of the Women’s Bureau;
- Community-based women leaders and Women Development Officers to the Divisional Secretariat trained together in advocacy at SLIDA;
- Engagement with secondary outreach groups of local-level religious leaders, political leaders, government officials and leaders in voluntary organizations;

**Constraints:**

- The project received no guidance from the Women’s Bureau once the project was located within the preview of the Government Agent;
- Lack of national level support required a strong district level leadership and the project was therefore quite dependent on the support and supervision provided by the GA;
- The channeling of funds through the Women’s Bureau proved inefficient, resulting in delays and constraints;
- Mid-term changes in the Ministerial portfolio with the exit of Social Services from the Women’s Empowerment Ministry negatively affected the project;

**Recommendations:**

1. The Gender/RH Programme in Kurunegala merits a review for extension at the end of 2007 to enable identification of a suitable donor through the Department of External Resources. If extended:
   a) It should develop clear process and outcome indicators.
   b) It should be located under the Ministry of Public Administration.
   c) Enhanced training can be negotiated with SLIDA.
   d) The following should be considered:
      - advocacy outreach to local-level politicians and local government members;
      - undertaking systematic research on local concerns (such as incest, early marriage and under-age pregnancy, and gendered needs of elderly) to inform evidence-based policy formulation;
      - extending the focus to cover RH concerns of older women (e.g., peri-menopausal, menopausal and post-menopausal concerns);

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22 Women Development Officers are a cadre of government officials assigned to do gender work at the divisional level. A WDO has been appointed to each Divisional Secretariat in the country.
II.D.3 Responding to Gender-Based Violence in the Aftermath of the Tsunami

This was the “Gender Component” of the tsunami project, Building Psychosocial Wellbeing among Individuals and Communities Living in Tsunami Affected Areas with Improved Responsiveness for the Prevention and Management of Gender-Based Violence in Sri Lanka. The objective of this initiative was to reduce the vulnerability of women and girls to sexual and gender-based violence in the temporary shelters and context of post-tsunami reconstruction and relocation. The strategy adopted focused on strengthening the policy environment and improving institutional and community responses to gender-based violence. The main activities included:

1. Strengthening the policy environment for the integration of gender in reconstruction activities by:
   a) Setting up a Gender Desk at the NCW
   b) Conducting a Gender Audit
   c) Establishing a Data Base for gender-disaggregated data and analysis
2. Supporting an immediate and effective response to GBV through capacity building by: Training frontline government/NGO workers
3. Strengthening capacities at community level by:
   a) Setting up Women’s Centres at the community level
   b) Building male and community accountability for preventing GBV
4. Strengthening capacity of health sector to respond to sexual and GBV by:
   Piloting integration of GBV services in a health facility
5. Strengthening multi-sectoral responses to GBV through improved coordination and integrated strategic approaches, Establishing a Gender-Based Forum as a mechanism for enhanced collaboration on GBV-related work, including sharing of resources, information and programme implementation experience.

1.a) Setting up a Gender Desk at the NCW

A Gender Desk was set up at the National Committee of Women in the immediate aftermath of the tsunami, initially to address protection concerns of women and girls vulnerable to sexual and gender-based violence in temporary shelters and camps. It gradually expanded its focus to integrate gender in the overall relief and reconstruction efforts. At the national level it liaised with the Rehabilitation and Development Agency (RADA) and TAFREN, national authorities coordinating tsunami recovery efforts. It initiated a dialogue with RADA on women’s rights to land and property and advocated for gender sensitive housing policy. The Chairperson of the NCW was also appointed to RADA’s livelihoods Advisory Council. The Gender Desk is also coordinating with the Ministry of Disaster Management and Human Rights to ensure that gender is mainstreamed and is in the process of setting up a Working Committee to develop a gender strategy for the ministry.

The NCW is the policy advisory and advocacy body to the Ministry of Child Development and Women’s Empowerment. It is bound by the National Women’s Charter and its responsibilities are defined in the Charter. The NCW is made up of independent experts and committed personnel at DS/GA level who can provide the needed direction and oversight.

- piloting the programme in one other carefully selected district with sensitive and committed personnel at DS/GA level who can provide the needed direction and oversight.
has a Chairperson responsible to implement its work. A new complement of members was appointed during the project period, some of whom are new to the work of the NCW. The Committee of Experts continues to be diverse and a strong group of gender advocates; however, the NCW’s operational capacities need to be strengthened. The NCW also has a very modest budget and small staff and needs capacity enhancement and additional recourse and logistical support to carry out its policy making and advocacy mandate.

### Outputs:
- Focused on addressing sexual and GBV in the relief phase, also in the recovery and reconstruction phases through the training of frontline workers.
- Improved protection measures in camps and temporary shelters.
- Sensitized Government Agents and senior administrators.
- Appointed Gender Focal Points at the district level.
- NCW Chairperson appointed to RADA’s Livelihood Advisory Council.
- Co-ordinates with the Ministry of Disaster Management and Human Rights to ensure that gender is mainstreamed.

### Constraints:
- Insufficient capacity to integrate gender in the tsunami recovery process.
- Unable to effectively mainstream gender into tsunami recovery process.
- Continued advocacy work on women’s land rights and livelihoods challenged with the withdrawal of RADA from Tsunami Recovery co-ordination.
- A new Chairperson has been appointed and, together with the new committee, will be challenged to ensure continuity of the work undertaken by the NCW.

#### 1.b) Conducting a Gender Audit

A Gender Audit was conducted to assess how the needs of women and girls had been responded to during the tsunami recovery process.

- The findings of the Gender Audit indicated a gender neutral response during the emergency phase and inadequate attention to needs of women and girls in the recovery process, due to lack of gender-disaggregated data and weak mechanisms for gender mainstreaming.

#### Outputs:
- Ascertained the gender dimension of the support provided during the tsunami relief and recovery phases.

#### Constraints:
- Integrating findings into national policy.
- Weak national mechanisms for mainstreaming gender.
- Lack of gender-disaggregated and qualitative data.

#### 1.c) Establishing a Data Base for Gender-Disaggregated Data and Analysis

#### Outputs:
- GBV Data Base set up by the NCW.
- Technical assistance received from the University of Colombo to design Data Base.
- Technical Officer appointed to input data.

#### Challenges:
- Capacity available at the NCW weak for establishing a national data base.
- More clarity needed about what type of data should be collected and for what purpose.
- Data base needs to be policy focused.
- Needs further mapping of data sources.
- Tools for data collection must be improved.
**Recommendations:**

1. Clarity must be established as to what data should be collected and for what purpose.
2. What type of data should be collected and for what purpose.
3. The NCW must be supported to strengthen and maintain the data base for evidence-based policy formulation and implementation.
4. Have in place a staff person who manages the Data Base project.
5. The NCW could be supported to revamp its GBV complaints unit.
6. Continue to develop and improve appropriate tools to gather the relevant data.

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**2) Training of frontline government and NGO workers**

UNFPA facilitated a series of TOTs for the transfer of capacity building skills to the local community through the development of a resource pool of 27 trainers specialized on sexual and gender-based violence (SGBV). The trainings were conducted with technical assistance from the Centre for Refugee Research, University of New South Wales, Australia. These trainers initially conducted training for frontline government and NGO workers in 6 districts and thereby strengthened district-level capacity to respond to gender and GBV issues.

Following the training, several ‘feedback and review’ meetings were held with both trainers and selected frontline workers to assess the impact as well as to respond to practical needs of the frontline workers. UNFPA also conducted an evaluation of the training program, which in general highlighted positive feedback from the trainees. Based on feedback from ‘review meetings’ and the evaluation, the training modules and techniques were revised and a more focused programme was designed and delivered to a second batch of frontline workers.

In addition, a more intensive training program was conducted to strengthen the capacity of the newly recruited Women Development Officers (WDOs). Further, to create a more supportive environment for the frontline workers to apply the knowledge from the training in their regular work, the project also conducted several orientation workshops and meetings for District Secretaries, Assistant District Secretaries, Divisional Secretaries and Assistant Divisional Secretaries to whom the frontline workers report. The training was considered very useful by frontline workers who found that the concepts introduced helped them identify and address gender concerns that they were previously unaware of.

**Outputs:**

- TOTs conducted and pool of 27 trainers established.
- 191 frontline government and NGO workers in 6 districts received SGBV training during the first phase.
- Feedback and review meetings held post training.
- An additional 215 frontline workers received more focused and improved training.
- Intensive training held for Women Development Officers.
- Orientation workshops held for Senior Officials at D/S level.

**Challenges:**

- Follow-up.
- Helping frontline workers establish and maintain lateral linkages.
- Assisting frontline workers access referral mechanisms.
- Programme institutionalisation and sustainability.

**Recommendations:**

1. Consolidate the resource pool of trainers, update their skills and training methodologies, and ensure their continued availability for UNFPA/partner training initiatives.
2. Establish a mechanism to track the impact and continued training needs of frontline workers
3. Assist frontline workers to establish lateral contacts to assist effective gender-related responses
4. Provide frontline workers with outreach materials to address gender and RH concerns of women
5. Ensure the continued engagement of frontline workers with RH and gender concerns
6. Explore possibilities of offering formal skill upgrades for frontline workers to enable job-related promotions

3.a) Setting up Women’s Centres at Community Level

Women’s Centres set up in 4 tsunami-affected districts mobilised communities to respond to gender and GBV concerns through community-based self-help groups. (The centres were established through 3 UNFPA-supported NGOs: Women in Need, the Sarvodaya Movement, and the Muslim Women’s Research and Action Forum.) They engage in the formation of women’s committees and youth groups; conduct mobile clinics (health, counselling, legal, etc); set up referral networks; conduct awareness programs on RH, gender and GBV issues; and launch advocacy campaigns on male accountability. During the latter part of the project period, Community Watch Groups were set up comprising women leaders, community leaders, Grama Niladhari, and the police, to monitor and prevent GBV in the community. The centres also serve as key sources of qualitative data collection on GBV using innovative methods to access information. The Centres’ managers are drawn from the communities in which the Centres are established and then trained in information gathering and management techniques through technical support provided by the Centre for Refugee Research, University of New South Wales, Australia.

3.b) Building male and community accountability for preventing GBV

The Centres also established programmes to engage men in the prevention of GBV and used RH as a strategic entry point to discuss issues relating to gender and GBV. They were, in fact, able to mobilize men and youth to carry out a community-based campaign against domestic violence and alcoholism. Men have also joined Community Watch Groups set up by the Women’s Centres to monitor and prevent GBV in their communities.

Outputs:
- 27 Women’s Centres established in 4 tsunami affected districts: 4 centres in Matara by Women in Need (WIN); 10 in Batticaloa and 10 in Hambantota by Sarvodaya; and 3 in Ampara by the Muslim Women’s Research and Action Forum (MWRAF)
- Centres mobilise communities to respond to gender and GBV through community-based self-help groups and other community development activities
- Community Watch Groups set up through the Centres to monitor and prevent GBV in the community
- Centres collecting data for the NCW Gender Data Base
- 32 programs held for men to sensitize them about GBV.

Challenges:
- The initial rationale for establishment of the centres no longer exists. They were conceptualised as safe houses to strengthen local coping mechanisms to respond effectively to post-tsunami psychosocial needs and reduce post-tsunami GBV but, by the time the centres became operative in 2006, the needs of the immediate

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2005 post-tsunami period no longer prevailed. The centres perform some beneficial services, but to communities in general rather than tsunami victims alone.

- Centres have evolved into safe spaces for women to share and respond to a range of needs including, but not limited to GBV
- Inability to become a multi-service facility; as a result, attracting fewer community women to visit the centre to deal with sensitive GBV concerns
- Need for capacity and focus on GBV
- The need to strengthen lateral linkages
- Enhancing male and community accountability for prevention of GBV.

**Recommendations:**

1. Consider support to a select number of Women’s Centres following a review at the end of the project.
2. If UNFPA continues support, it should work with NGOs whose mandates also include RH and GBV goals. Women in Need, with its referral facility of legal services, shelter and specialized expertise in dealing with GBV, appears best suited to continue with the Women’s Centre initiative. UNFPA should explore the possibility of piloting a Women’s Centre in Trincomalee (or a selected district in the Eastern or Northern provinces) in collaboration with WIN or a carefully selected local women’s NGO.
3. The Women’s Centres should establish linkages with and solicit support of frontline workers at the local level to address gender, RH and GBV concerns. They should explore the possibility of working with local government bodies and local politicians for policy-related advocacy.
4. The Women’s Centres should undertake systematic documentation and analysis of the nature of the gendered problems affecting women in their communities (e.g., under-age marriage, early pregnancy, the impact of pornography on GBV, and the specific needs of different ethnic communities), so that relevant evidence-based policy interventions for both RH and gender can be made.
5. The Women’s Centres should improve lateral linkages with relevant stakeholders at the level of provincial administration, the provincial health service, local and provincial women’s groups and networks, and so on.

4) Piloting integration of GBV Services in a health facility: Mithuru Piyasa

The Mithuru Piyasa (“Friendly Home”) clinic was created in the outpatient department of Matara General Hospital in June 2007 as a public health response to GBV. It encourages women who are suffering from violence or in danger of violence to ‘break the silence’ and seek help at the clinic. Mithuru Piyasa offers counseling, medical treatment and referral to other service providers and can also provide legal advice when necessary. It also offers counseling to perpetrators.

This initiative approaches GBV as a public health concern that can lead to substantial morbidity and even mortality as a consequence of physical and sexual violence. It also highlights the reproductive health consequences of GBV on the lives and well-being of women and warns of the inter-generational impact of violence.

Mithuru Piyasa has a complement of 7 trained Medical Officers and 9 nurses on its roster. They have received 3 days basic training, supported by UNFPA, in identifying GBV among women visiting the outpatient department and admissions and seem to handle them adequately. The objectives are to prevent further violence and to counsel the women as

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23 The evaluation team was able to visit two Women’s Centres run by WIN in Matara, but could not visit any centres run by Sarvodaya or the Muslim Women’s Research and Action Forum due to lack of time.
needed. While the Mithuru Piyasa team attends to the physical and psychosocial needs in the hospital itself, for other services such as legal needs, financial needs, and temporary shelter, clients are referred to the appropriate authority.

While it is obviously too early to measure the impact of Mithuru Piyasa, there is no doubt that its services are being utilised and that the staff appears very engaged in both counseling and referrals. The clinic had registered 27 cases in a little less than a month. Case histories were being documented and salient information computerized protecting the confidentiality of the patient. Although this model is mainly curative in nature -- identifying victims in hospital -- it is evident that the model at this hospital is worth further support so that a replicable, cost-efficient service delivery model can be developed. The fact that it is located in a hospital has the advantage of making the people feeling “safe” and less inhibited.

There is also a preventive component to this initiative. In addition to the hospital component, it includes training field staff (MOHs, midwives, PHIs, PHNs, etc.) as well as advocacy activities with the community to promote gender equality and prevent GBV.

The importance of a public health response to GBV. GBV requires that the problem is addressed both as a widespread human rights abuse as well as a serious public health concern. It is also a social problem which is both a manifestation of the discrimination suffered by women as well as a consequence of their subordinate status in society. The respect and credibility that society extends to health providers can also go a long way toward mitigating the occurrence and is a crucial step in preventing GBV.

However, violence against women cannot be understood or addressed in isolation from social norms and practices that reinstate women’s subordination and make them more vulnerable to violence and abuse. For instance, women’s social or economic status and dependency often makes it difficult for women to seek assistance unless they have some dependable and sustained support. GBV is rooted in both gender inequality and discrimination.

Conclusions

Addressing GBV as a public health concern helps health providers acknowledge the problem and offer support to women who are directly affected. Locating such a service in a legitimate and acceptable medical setting may also inspire confidence among women who are otherwise afraid or reluctant to publicly confront and deal with the issue of violence. The health sector can offer an important and significant response to GBV particularly in situations where the problem is considered too culturally sensitive or socially irrelevant to be acknowledged or dealt with publicly.

For communities that have no direct support mechanisms to address GBV, a health sector response affords the opportunity to confront the silence and tolerance that has long shrouded GBV. This could be a particularly effective mechanism to address GBV in culturally sensitive settings or politically dangerous ones.

Health care facilities will essentially offer services to women who have already experienced violence or are under threat of experiencing violence. While offering medical assistance, they must also be prepared to assist women deal with the consequences of the violence and possibly mitigate or prevent further violence. If not, health services may only be a palliative and women will be left with no means to deal with the often repetitive nature of GBV.

A health sector response can also use health data to highlight the magnitude of the problem, defeat cultural relativist arguments, challenge norms that justify GBV, and reframe GBV as a public health concern and human rights violation.
**Recommendations:**

1. Since the institutionalized nature of a health-sector-based response, such as Mithuru Piyasa, lends itself more easily to long-term sustainability, UNFPA should consider this an effective model to pilot in carefully selected general hospitals in at least two districts, including a hospital in the northern or eastern province.

2. A hospital-based GBV service should link with community-based services to take the response to GBV beyond the clinic and address its social causes and consequences. Strong referral mechanisms should be established with linkages between the health centre, community and other service providers, including the women’s centres and awareness and advocacy programs.

3. Training should be institutionalized so that existing and new staff are adequately prepared to address the complexities of GBV. While in-service training may be the best response to this need in the short term, the ideal approach would be inclusion in the basic curricula of all the schools of medicine, nursing, and auxiliary health services.

4. UNFPA should also explore the possibility of Mithuru Piyasa sharing the resources of the YFS also newly established at the Mathara General Hospital.

**II.D.4 UNFPA Models of Outreach to Address Gender-Based Violence**

The 6th Country Programme established three models of outreach to address gender-based violence. These are:

1. Health-sector-based response piloted at the Matara General Hospital
2. Community-based response developed through the Women’s Centres
3. Interlinked sub-national (institutional) and community response

Since gender-based violence has emerged as a major social and medical issue, it is timely to consider what should be the place of gender-based violence and psychosocial health programs in the UNFPA portfolio. The three models currently being operated have useful elements and the potential exists for the development of a more holistic functional model to prevent and control gender-based violence. It would be very useful (especially among medical professionals) to envision GBV in the nature of a non-communicable disease or a chronic socio-biomedical problem and address it in a way similar to managing any other non-communicable disease.

Dealing with gender-based violence requires a holistic approach. Determinants of violence need to be identified and appropriate responses initiated. Initiatives should work toward protecting and promoting the rights of women to be free of violence. Activities should also respond to the needs of women directly affected by GBV. They must address health concerns, social and economic challenges and legal concerns. It is also important that they address outreach and strengthen mechanisms needed at local level. Achieving results will require close links and coordinated action among facilities and services, both governmental and in the non-government sectors.

**Recommendations:**

1. UNFPA should consider integrating relevant components of these three models into the design of a future integrated (holistic) and sustainable strategic approach to
address the multi-faceted concerns of gender-based violence, RH-related gendered concerns, and the promotion of gender equality and gender equity.

2. UNFPA should consider extending the pilot project at the Matara General Hospital to one or two other hospitals in carefully selected districts, possibly in the Northern or Eastern Province. An existing facility in the Kurunegala hospital, not funded by UNFPA, could be offered technical and other support as relevant.

3. Provide continued support to a small set of Women’s Centres, selecting those where the likelihood of impact is greatest and developing plans whose results can be measured.

II.D.5 The Gender-Based Violence Forum

UNFPA is the lead UN agency mandated to address gender concerns in Sri Lanka. It therefore has an important upstream advocacy role to play in promoting and protecting women’s rights, gender equity and gender equality in the country. Sri Lanka is a signatory to all major UN conventions, including the convention dealing directly with the rights of women - CEDAW and its Optional Protocol. In addition, UNFPA has the key mandate of tracking the ICPD and the MDGs in relationship to reproductive health and rights and gender goals. The establishment of the GBV Forum is a crucial enabling mechanism for this purpose and UNFPA has a lead role as Convenor and Co-ordinator, which should be leveraged strategically.

Outputs:
- GBV Forum set up and coordinated by UNFPA
- Regular meetings conducted
- Major collaborative events facilitated

Challenges:
- Needs to have a policy/advocacy related focus
- Needs to expand membership at least to provincial/district level
- Needs to commission or access evidence-based research to promote policy advocacy

Recommendations:

1. The GBV Forum could help the NCW operationalise selected components of its Plan of Action on the Implementation of the Domestic Violence Act. Of particular importance would be tracking the enforcement of Protection Orders and the community level support needed by women who seek to access the provisions of the Act.

2. The GBV Forum should commission evidence-based research to enable appropriate and effective interventions for addressing gender-based violence.

3. The GBV Forum should consider expanding its membership to include women’s groups and networks at provincial and district level. It should also consider developing and maintaining linkages with Inter-sectoral and inter-governmental agencies such as law enforcement, justice, health and media.

4. The GBV Forum, together with the UN Gender Working Group, should advocate for the enactment of the Women’s Commission Bill (currently being scrutinized by the
II.D.6 General Recommendations

1. Gender Issues in Reproductive Health

1. Tracking mechanisms for identifying and approaching spouses/partners of STI-infected persons must be improved and sensitive methods developed to reach them for testing and treatment. This is particularly important for women engaged or coerced into sex work or sexual activity in high-risk areas such as those adjacent to armed forces transit points in the Anurahapura and Polonnaruwa districts, villages with a high armed forces presence, trading centres such as Dambulla, and Free Trade Zones.

2. Special attention must be paid to the higher rate of HIV/AIDS infection among women.

3. Social and cultural factors that define masculinity and their implications for their sexual partners, male and female, must be addressed.

4. PSL and SLAVSCF could supplement the services provided by the national health system by conducting mobile Well Women Clinics in the conflict-affected areas of the Northern and Eastern provinces and the ‘border’ villages of the Polonnaruwa and Anuradhapura districts respectively.

2. Strengthening National Gender Machinery

1. As part of its upstream work, UNFPA needs to track implementation and follow through of important gender-related initiatives. These include:
   - gender-related plans and policy directives of the Ministry of Child Development and Women’s Empowerment, such as the National Plan of Action and the Action Plan for Domestic Violence; and
   - recommendations emerging from the Engendering Criminal Legislation study and Consultation commissioned by the NCW -- one of which was to explore the possibility of liberalizing legislation on abortion in line with the Women’s Charter and initiating dialogue with relevant Health Ministry officials.

As all these policy documents emerged from a fairly inclusive consultation process, it is essential that the UNFPA’s gender programming incorporates national gender policy, wherever possible, to ensure complementarity.

2. Explore the possibility of linking with other Ministries -- the Ministry of Planning, Ministry of Justice, Media Ministry and so on -- to promote RH and GBV work.

3. Training

| UNFPA should provide technical support for the development and broad dissemination and utilisation of standardised sector-specific gender-sensitive curricula for all RH training and awareness. This should include the gendered concerns of women and men regarding condom use, the discriminatory practice of virginity testing, the prevalence and trivialising of sexual harassment, the impunity of domestic violence, the women-centred stigma attached to infertility, sub-fertility, rape, illegitimacy, how to deal with masculinity and identity related concerns of males with regard to RH behaviour and GBV. |
2. Consolidate the resource pool of trainers, update their skills and training methodologies and ensure their continued availability for UNFPA/partner training activities.

3. Training may need to be institutionalised and regularly enhanced so that current and new health-sector staff are adequately prepared to address the gender complexities of RH and GBV. While in-service training may be the best response to this need in the short term, the ideal approach would be to ensure that gender training is included in the basic curricula of all schools of medicine, nursing, and auxiliary health services. Relevant linkages and advocacy with the SLMA and other centralized training institutions should be continued.

4. Advocate to institutionalise gender training for local-level practitioners through establishment of a diploma course at regional universities – e.g. Wayamba and the Eastern University.

5. Explore the possibility of offering scholarships for the Women’s Studies Masters programme at the University of Colombo to government officials strategically placed to influence and implement gender-based policy.

6. Support the development of training and outreach materials for district-level WDOs to address gender and RH concerns of women who may not easily access reproductive health facilities based in the medical sector (e.g., young adult women who become sexually active prior to marriage as the age of marriage goes up).

7. Establish a mechanism to track the impact and continued training needs of frontline workers; explore possibilities of offering formal skill upgrades for frontline workers to enable job-related promotions.

8. Assist in building language capacity – particularly work in Tamil
II.E EFFECTIVENESS: CROSS-CUTTING CONCERNS

II.E.1 Programme Design

The current programme was designed and operational strategies set down through project agreements in 2001. Given staff turnover since 2001, it is difficult to determine the extent to which UNFPA Sri Lanka considered its capacity when developing the CP6 programme design. The selection of operational strategies (linking partners, target groups and interventions) was generally appropriate but UNFPA’s resources were spread too thin to achieve significant results.

Operational strategies. The Country Office has asked: Did UNFPA select
- the right partners?
- the right geographical areas?
- the right target groups?
- the right interventions for the target groups?

The operational strategies set down in the 2001 project agreements preceded along two main avenues.

1. With long-time partners -- to continue work along largely established lines (e.g., Family Health Bureau at the MOH, UNFPA’s primary partner during 35-plus years, and the NIE for UNFPA-supported education in the schools). Here target groups were largely the same as in previous country programmes: married couples (FHB) and in-school children (NIE).

2. New initiatives – e.g., with the Army and Labour Department to reach out-of-school youth.

The right partners? Most of the partners have been appropriate. Exceptions are discussed in the following section.

The right geographical areas? UNFPA has prioritised underserved areas (loosely defined) and tsunami-affected areas, but beyond this has not clearly defined a geographic focus.

Target groups? CP6’s main target groups have been: married women of reproductive age, in-school adolescents, out-of-school youth, people in the conflict-affected areas, people in underserved areas, including plantations. Following the 2004 tsunami came additional target groups: tsunami victims and women experiencing gender-based violence. These are all appropriate target groups for UNFPA.

But there have been additional target groups whose appropriateness is more questionable; it appears these were funded because an NGO that UNFPA wanted to support wanted to assist direct activities at these target populations. Three examples emerge from the project documents. First, the project agreement for "RH for Out of School Youth" included a sub-contract to “help HelpAge Sri Lanka, or other selected NGO, to create awareness of a ‘Voluntary Home Care Service Programme’ for training youth and social service workers in Home Care to provide services to needy elders.” Allocated for this was $10,000. It appears

25 The midterm evaluation of UNFPA’s CP6 project with NIE reported: “The project...is an on-going phase of a [UNFPA-supported] programme implemented by the MOE and the NIE over three decades. The programme shifted its focus from Population Education in the 1970s and 1980s to Family Life Education, to Reproductive Health Education in Schools and in the current phase to Adolescent Reproductive Health in Schools” (Jayaweera, 2004, p.1).
to have been the only activity in CP6 targeted to the elderly. A second target population receiving very minimal support were urban slum residents in Colombo (Saravodya, through PO2). A third were prisoners (SLAVSC), again $10,000.

**Right interventions for the target groups?** The major interventions have all been appropriate, in principle, for the target groups. Several, however, have had limited effect due to limited resources being thinly spread, and for additional reasons described above in sections II.A, II.B and II.C. One UN stakeholder described UNFPA’s involvement in the conflict-affected areas as very weak, saying “RH needs of women in conflict areas and tsunami areas have not been adequately served. The tsunami evaluation reports showed this. We have not learned our lessons.”

**Design Weaknesses**

- **Trying to do too much with too little**
  Considering the above elements, the answer to the question “Were operational strategies adequate to achieve programme results?” is that none of the strategies was totally inappropriate, per se, but that UNFPA was trying to do too much with too little. Furthermore, UNFPA was also tackling some areas where results are very difficult to achieve – in any country:
  - Providing health services to people in conflict/war zones, and
  - Persuading teenagers to abstain from pre-marital sexual activity when the average age of marriage has already gone up to the mid-20s.

- **Lack of clarity in project documents**
  Many UNFPA project agreements, like the CP6 logframe itself (see Annex C), lack the clarity needed to achieve measurable results. For example, the project agreement for “ARH in Schools” states: “…there is much to be done to make reproductive health education more accepted in the school system so that the school going adolescents to be better informed on reproductive health issues and thereby improve their reproductive health status.” As evaluators we ask: What are these school kids supposed to do to “improve their reproductive health status”? The document also states: “These adolescents need appropriate reproductive health information and services (emphasis ours) to meet their specific needs and to protect them from the negative consequences of unwanted pregnancies and infection from STDs and HIV/AIDS.” The Project Workplan includes two Outputs. One is increased RH awareness. The second is: “Improved access to quality RH services including counseling.” However, under Activities (to achieve the Outputs), all are focused on an awareness objective. The services objective is (1) not even clearly stated, and (2) there is not one single activity linked to services. As evaluators we ask: “Was there ever a genuine intent to improve access – of these school children – to reproductive health services? If so, what would those services be, given that school children are not supposed to be personally in need of reproductive health services (contraception, abortion, safe motherhood).

All the above shortcomings are more issues of design than of implementation.

**Recommendation:**

For CP7, UNFPA should be very clear as to what it truly wants to achieve – and believes it can achieve with its available resources. In developing the CP7 Action Plan, it should consider limiting its support to objectives that are more likely to be achieved (e.g., reducing unmet need for contraception), or to areas of greatest need.

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II.E.2 UNFPA Partnering

In general, the governmental and NGO partners selected by UNFPA were appropriate. Most had the correct positioning for undertaking the work assigned to them. They contributed in different ways to achievement of specific inputs and processes. However, due to the general lack of focus on programme results, it is difficult to quantify and evaluate the specific outcomes resulting from collaboration with each of these partners. Three partners, the NGO Secretariat, the Women’s Bureau, and the University Grants Commission were not effective in their roles.

UNFPA is one of five major international agencies supporting the government of Sri Lanka in the health sector. Others are WHO, UNICEF, the World Bank, and the Japan International Cooperation Agency (JICA). UNFPA CP6 partners included government and non-governmental agencies. Government partners include the Ministry of Health, Ministry of Education, and Ministry of Women’s Affairs. NGO partners include the main FP service providers in the country (FPASL, PSL and SLAVSC) as well as NGOs with broad development agendas (e.g., Sarvodaya, the Centre for Development Alternatives (CDA) and Women’s Development Federation (WDF).

Key strengths of UNFPA’s partnership strategy:

- Diversity of partners covering different sectors, different approaches and different regions in the country;
- Consensus on most key issues;
- Networking among partners.

Weaknesses of the partnership strategy:

1. Role of intermediary agencies in channeling funds;
2. Limited role in advocacy for policy;
3. Limited capacities of some of the partners;
4. Unhealthy competition among partners in some instances;
5. Dependency of most partners on UNFPA support;
6. Limited collaboration with other big agencies supporting the health sector.

The NGO Secretariat and the Women’s Bureau were not effective vehicles for supporting (or even just channeling funds) to the regional projects. Neither agency played a role in either guidance or monitoring. A lack of ownership and interest hindered implementation of project work. University Grants Commission (UGC) was ineffective and inefficient as a vehicle to provide SRH to students in Sri Lanka’s universities.

National Institute of Education. UNFPA’s use of NIE for in-service training of school personnel on ARH is questionable and has produced only geographically limited results at best. UNFPA began family life education (FLE) curriculum revision work with NIE back during UNFPA’s 4th or 5th country programme. This was appropriate given NIE’s mandate for overseeing and updating curricula of the national school system. NIE may have done a competent job earlier on of integrating ARH into the school curricula, but the decision to continue on with this long-time partner, now using it to train personnel in the districts, appears inappropriate for at least two reasons. First, NIE does not have the Department of Education mandate for training and, second, NIE is not a devolved agency with representation outside Colombo. Various stakeholders stated that a more appropriate
partner might have been the Department of Education which does have offices at sub-national levels, including the Teachers’ centers at the zonal level which are under the Department of Education.

There is no firm evidence that exclusion of any stakeholder had negative impacts on UNFPA’s programme. However, some stakeholders suggest it was negative that the Department of Education was left out from in-school ARH implementation while UNFPA continued with its many-year partner, NIE. It is also said that Plan International should have been more actively involved in the A/Y SRH sector.

Closer collaboration. If there could have been closer collaboration among the main partners - government, UNFPA WHO, UNICEF and the NGOs -- a greater synergy may have been achieved. The main responsibility for this of course must lie with the government, but the partners could also have worked more closely together.

Partnering in Reproductive Health

The main implementing partners for UNFPA’s reproductive health component are:

1. The Family Health Bureau, in the MOH is the national mandated agency for Family Health, including much but not all of RH, UNFPA’s principal partner. FHB is responsible for the government’s family planning programme which has had major UNFPA support for improving access and quality. FHB is also responsible for Monitoring and Evaluation as well as overall coordination of RH research.

2. National STD and AIDS Control Project/Programme (NSCAP) of the MOH. The UNFPA inputs have been relatively small in this area, as the NSCAP has received considerably large funds from the World Bank and now from the GFATF. However, UNFPA work with the vulnerable and at-risk groups is recognized as an input to develop strategies for use among such groups.

3. Health Education Bureau (HEB) of the MOH. The HEB undertook the production of IEC (later transformed to BCC) communication support materials, and training of health personnel at the subnational level. HEB served the needs of both the government and non-government partners. The materials produced are of good quality and relevance to the communication needs of the programme.

4. National Cancer Control Program (NCCP), is partner for the Well Woman Clinics. Initially it the NCCP was the main partner for examination of the PAP slides and for some of the training of the health personnel. Now the College of Pathologists supports the cytology work, which has helped to reduce the delays due to the increased volume.

5. Plantation Housing and Welfare Trust (PHWT) – conducted some of the work related to improving RH in plantation areas.

6. Population Services Lanka. Provides RH services in the challenging, conflict-affected northern district, Mannar, through training and deployment of volunteers, improving antenatal care, and direct delivery of contraceptive services to people in this conflict-affected area.

Partnering in Gender Work

UNFPA has had to work with three entities at the national level and to devise a creative synergy at the local level between public administration and the national gender machinery. This has been an evolving process (as reflected in PO5). The three national gender agencies are: the Women’s Bureau, the Ministry of Women’s Affairs (currently structured as the Ministry of Child Development and Women’s Affairs), and the National Committee on
Women (NCW) has also been characterised by partnerships with several women’s NGOs.

The Women’s Bureau was established in 1978 and placed within the Ministry of Planning. In 1983 a separate Ministry of Women’s Affairs was established and the Women’s Bureau was placed within its purview. A comprehensive Women’s Charter was adopted in 1993 and The National Committee on Women (NCW) was appointed to oversee its implementation. While the Ministry of Women’s Affairs and the Women’s Bureau are governmental bodies, the NCW is meant to be an independent body of experts serving in their private capacity, with a full-time Chairperson, Executive Director and Secretariat. Over the years the Ministry of Women’s Affairs has been invested with and divested of other portfolios ranging from Teaching Hospitals to Social Services and is currently in charge of Child Development. During the tsunami it was also in charge of Social Services, burdening it with a range of responsibilities. However, gender concerns have tended to be marginalised in the national policy-making, implementing and monitoring structures. In addition “women’s affairs” is not a devolved subject, which results in further marginalisation and confusion at local levels of administration.

UNFPA has worked most effectively with the NCW, strengthening its capacities to mainstream gender into the tsunami relief and recovery process and to help establish a GBV database, which is an ongoing project. Although the NCW has the fewest financial resources among the three national gender agencies, the NCW currently has a strong complement of gender experts in different fields of competency and can be consulted independently as well. Its Chairperson, however, has just resigned and this may pose problems for the continuity of work. Continued work with the NCW will be crucial, specifically: to assist it in developing the GBV database, to assist with the implementation of the Plan of Action on the Domestic Violence Bill, and to help implement the National Plan of Action on Women.

The Women’s Bureau is the implementing body of the Ministry of Child Development and Women’s Affairs and has an extensive network of locally-based women’s associations. They are a crucial recourse for community-level interventions and could be accessed through the Women Development Officer (WDO) responsible for gender work at the Divisional Secretariats. Divisional Secretaries and Government Agents are also important partners in gender work in the periphery.

The NGO, Women in Need (WIN), has been an excellent partner in establishing the Women’s Centres, given WIN’s substantive experience and expertise in addressing GBV concerns at both the national and local level. WIN’s mandate has been compatible with that of the UNFPA’s gender and GBV work. The partnership with the Muslim Women’s Research and Action Forum was also important in the context of the need to work with Muslim women in the Ampara district. However, its mandate is not focused on GBV and thus it may be less compatible with UNFPA’s programmatic goals. Sarvodaya has an extensive community network and was a useful partner in the context of the tsunami intervention. However, it does not have a strong gender focus and its capacity is uneven at the local level. It may not be the most effective partner to ensure UNFPA’s gender and GBV goals. However, its work with religious leaders and its inter-faith work make it a potential “partner of partners” in the future.

Recommendations:

1. UNFPA should re-asses and weigh all partnerships for determine where effectiveness and impact greatest.

2. For gender work, government ministries not currently UNFPA partners but which should be considered for CP7 include:
• The Ministry of Planning - for policy-level advocacy;
• The Ministry of Public Administration - for the Kurunegala gender/RH work; and
• The Ministries of Health, Justice, Law Enforcement, Media, Local Government - for advocacy work.

II.E.3 Implementation: Synergy and Learning Lessons

Programme components have been implemented basically as vertical projects with little synergy or lesson-sharing among them. Lesson-sharing with partners tends to concern immediate issues of programme implementation rather than analysis of outcomes and effectiveness over time.

Many CO staff say there not been much synergy among the programme components. Interviews with staff indicate that synergy that is achieved happens on an ad hoc basis, with few mechanisms that require or even encourage synergy. “Activities that should be programme components are viewed and implemented as projects,” said one staff member. A most clear example is the gender component which (as noted above in section II.D.1) has been compartmentalised and dealt with largely as a free-standing project rather than a strategic intervention to be integrated and mainstreamed throughout the programme.

In 2004 the country office commissioned a substantial series of mid-term reviews and evaluations (see Annex I). These produced various useful recommendations, many of which constituted lessons learnt that were incorporated into the subsequent period of implementation. Beyond that, lessons learnt tend to be incorporated in an ad hoc manner by individual programme managers. These lessons concern primarily processes of ongoing implementation rather than an effort to stand back and take a long hard collective analytic objective look at what is being achieved in various programme areas (e.g., meeting the goal of improving the quality of family planning services). However, there is no systematic process and no person designated for this responsibility (as an M&E Officer might be).

There has been some sharing of lessons learnt, but it appears that this is confined mainly to immediate experiences of programme implementation -- for example, during quarterly, semi-annual and annual reviews, or periodic steering committee meetings. There has been much less assessment and lesson-sharing concerning technical outcomes and achievements.

In the area of A/Y SRH, for example, lack of coordination prevails at various levels. For instance, while both UNFPA and UNICEF are involved in interventions in the school system, no serious discussion appears to have taken place between them for coordination of their activities. It is very possible there has been duplication of services and related inefficiencies in training of counselors and peer educators under various projects. Replication of pilot projects without ensuring sustainability and application of lessons learnt is a concern even in the assessment of YFS supported by UNFPA.

In RHIYA, UNFPA shared the lessons with lead partner FASL and other partners in the project. The partners were also encouraged to learn from each other. For instance, when street theatre was found to be effective in the plantations under CDA, effort was made to disseminate it to other partners. The diffusion was not successful, however, as other partners did not take it seriously.

In the gender area, in contrast, UNFPA's RH and Advocacy project appears to have effectively shared lessons of its mid-term review, which resulted in comprehensive re-
conceptualising. The tsunami gender-related projects appear to have been effectively monitored by designated staff with regular visits and consultations with partners and a significant degree of lesson sharing and response.

II.E.4 Monitoring, Evaluation and Accountability Systems

Although various forms of monitoring take place and numerous mid-term evaluations and reviews have been carried out, the current approach is not adequate to enable UNFPA to demonstrate programme results. On a positive note, based on the set of mid-term evaluations and reviews, some recommended changes were made in the implementation of various projects (e.g., in the “ARH in School” project).

UNFPA itself has not established any formal monitoring, evaluation or accountability systems or mechanisms and it has no M&E specialist for the country programme or staff member tasked with such M&E responsibilities. With the advent of the tsunami projects, an M&E specialist was hired for that purpose; he was not assigned responsibility for the core of the country programme, however, as it was judged best to wait for the new (7th) CP before changing the established work patterns.

The logframe for the overall Country Programme is problematic (see Annex C). It was developed by the Country Office in response to UNFPA headquarters; government partners did not participate in its development. It lacks indicators that would permit tracking of UNFPA results and does not constitute a tool of any sort for monitoring progress. Baseline data are not stated or made clear for some of the “objectively verifiable indicators.” (For example, “Decrease of unmet need for family planning from current level by 10%” or “Number of SDPs offering a choice of at least 4 contraceptive methods continuously.”)

Despite lack of systems, various monitoring and accountability measures are in place. These include the following:

1. Each project officer monitors her or his programme individually. This includes dialogue with implementing partners, review of their workplans and reports, and field visits when progress in implementation is reviewed and discussed.

2. The CO conducts internal performance reviews of the CO workplans.

3. Implementing partners are required to submit quarterly reports along with their request for the next tranche of funding; they also submit annual and final reports. These reports tend to be descriptions of activities and processes (outputs) – rarely of outcomes. Their quality varies. Some are quite thorough in describing a new activity (e.g., establishment of the Women’s Centres). Others tend to focus on training activities and numbers of participants in the training. The responsible project officer receives these and, if there are issues, discusses issues with the representative. There is no formal review process.

4. Most implementing partners have some form of monitoring. Quality varies. Some INGOs have quite rigorous standards while others are very ad hoc. Some partners attempt to evaluate at least the immediate results of a training activity through use of a pre- and
post-test (e.g., SLAVSC) but this appears to be the exception. Some collect “monitoring” data but do not use this information productively for programme management.\textsuperscript{27}

5. An Annual Progress Review Meeting takes place with the External Resources Department of the Ministry of Finance in first quarter of each year. All partners participate and report their progress. The UNFPA project officers reportedly meet with partners in advance. There are also regular, three- and six-monthly reviews of the programmes of work with the different stakeholders.

6. There are no accountability systems as such and accountability is not a concept that is well understood (i.e., who should be accountable to whom?). Audits are conducted every year, however, with scrutiny becoming especially close following the large influx of tsunami funding. Internal performance reviews of the CO workplans are audited annually as are the financial and progress reports submitted by the implementing partners.

It appears difficult to monitor programme expenditures. Data are not readily available that provide an overview of budget and expenditures for either the programme or for each project. The Atlas accounting system (instituted in 2004 for some U.N. agencies) apparently cannot readily provide such data. Staff have access to Atlas on their computers, but it does not provide updates on expenditures vis-à-vis budgets. When the evaluation team asked for expenditure data, UNFPA could not provide it. (The Expenditure Summary 2002-2007, Annex B, was finally generated manually, after several tries.) The Planning Directorate (DDG for Planning) of the MOH also notes that it has not been possible to obtain expenditure data from UNFPA, which the Directorate has sought for inclusion in its annual Progress and Performance Report.

**Recommendations:**

1) Develop and implement a monitoring and evaluation system for CP7. The M&E system should be based on the new single harmonized M&E system being developed for the UN system, reportedly to be phased in beginning January 2008, but should also coordinate with the systems of UNFPA’s major government partners. Recruit a staff member to serve as Monitoring, Evaluation and Design Officer.\textsuperscript{28} Get commitment of staff and partners to the system.

2) Where possible, establish baseline data for interventions against which progress can actually be monitored.

3) If possible, refine the financial system to be able to generate up-to-date budget and expenditure data. Consider the model of WHO Sri Lanka, which is reported to be very satisfactory in this regard.

### II.E.5 Reproductive Health Policy

UNFPA’s main policy contribution has been to support development of the Population and Reproductive Health Policy in 1998, followed by its Action Plan. Other

\textsuperscript{27} For example, in the RHIYA project a monitoring mechanism collected periodic information about the number of young people visiting each counselor within a stipulated period, but the information collected was rarely cross-checked and rarely used for monitoring purposes. While RHIYA was a regional project, this is indicative.

\textsuperscript{28} It is recommended that UNFPA consider inclusion of Design in the title, to emphasize that the goal of M&E is to feed findings back into design and fine-tuning of interventions.
contributions have been more at the technical and operational levels. These included: the policy directions of the contraceptive security plan, the decision to initiate the Well Woman Clinics, expansion of the trial introduction of newer contraceptive methods — an improved long-term implant (Implanon), improved female condom and newer IUDs -- and, most recently, the hospital-based Gender-Based Violence Clinic in Matara.

A/Y SRH. UNFPA has played a catalytic role in mainstreaming A/Y SRH issues and concerns in Sri Lanka. In partnership with relevant government authorities and NGO partners, UNFPA has contributed to the following outcomes:

1. Development of a draft ASRH policy; this is yet to receive formal official recognition and support;
2. Introduction of RH in the school curricula;
3. Raising awareness among health workers at various levels about A/Y SRH issues.

Recommendations:

7.1. UNFPA should support the government to review and (if necessary revise) the current policies related to abortions, RH-related services to youth, and operational policy issues to address the problem of unmet needs of contraception.

8.2. A/Y SRH policy in Sri Lanka must address the following issues:

- Abortions,
- Teenage pregnancies,
- Reported increased incidence of STIs including HIV among A/Y,
- Sexual abuse, including incest,
- SRH rights of young people,
- What messages and services must be provided to young boys and girls at various ages?
II.F  EFFICIENCY

Detailed financial data and output data do not exist that would permit reaching firm conclusions about efficiency in the use of programme resources. Many factors suggest, however, that the use of resources was not the most economical. The new Atlas accounting system does not give necessary data for judgment about efficiency. Although the Country Office was able to manually generate some expenditure data (see Annex B), these do not give a detailed enough picture on amounts invested. As stated in various sections above, outputs are unclear and most results not measurable. There is no UNFPA Sri Lanka M&E system to provide such data.

Factors that appear to have contributed to less-than-efficient use of resources include:

- CP6 being activity-focused rather than results-focused;
- Involvement of numerous NGOs with minimal capacity to monitor;
- Sub-optimal synergy among programme components;
- Sub-optimal collaboration among the main partners: government, UNFPA WHO, UNICEF and the NGOs;
- Possible/likely of duplication of effort;
- War and related disturbances prevented implementation of some activities and made others difficult in the conflict-affected regions;
- Substantial programme resources went for vehicles. (Of the total budget of $12.7 million for RH support 2002-2007, nearly $6.6 million went to provide commodities, equipment and vehicles and $4.6 million for construction, leaving only $1.5 million for other areas. Furthermore, it was repeatedly noted that some vehicles did not reach their intended users, but were kept by higher-level officials/politicians; the same is reported for some laptop computers; this prevented their intended use at the grassroots level);
- Much of the investment in A/Y SRH has gone into training programs whose effectiveness is not evident from available data;
- Some important areas, such as establishment of an evidence base for A/Y SRH interventions, have not received enough attention (neither in the current or even proposed new CP);
- Channeling funds through the NGO Secretariat, Women’s Bureau, and University Grants Commission;
- Being spread thin;
- Lack of clarity as to which underserved areas and populations are the priority.

Gender work was negatively affected by several external factors. These included:

- Changes in government resulting in new appointments to key Ministries and Departments which adversely affected the continuity of work.
- Dependency on individual officials in the absence of sufficient capacity and interest within government institutions; this is also detrimental to efficient implementation of collaborative projects – e.g., at the National Committee on Women.

29 Health officials in the North, for example, report that a vehicle donated for use in Kilinochchi is still being used by the MOH in Colombo despite all efforts of the intended recipients. This is an issue that requires attention. This also supports the intent of the CO to not provide vehicles during CP7.

Q: Were programme resources (human, technical, financial, equipment) used most economically to achieve the given outputs?
Q: Were operational strategies adequate for the most economical use of resources?
Q: What internal and external factors influenced the implementation process?
Shifts in policy direction – e.g., Mahinda Chinthanaya and the emphasis on family and children, which may constrict women’s autonomy interests.

On-going conflict and security constraints.

The government requirement that an external donor agency, such as UNFPA, must fund NGOs through an intermediary, the NGO Secretariat, was a major damper on efficiency -- especially as the Secretariat was shifted among three different ministries during the implementation period.

While CO procedures appear to have kept most inputs proceeding at an acceptable pace and schedule, CO staff, and some stakeholders, point to several instances of delay, including:

- Project activities for which funds and authorisation had to pass through the NGO Secretariat or the Women’s Bureau;
- The tsunami projects

This question is difficult to answer as there is no way to make any comparison. UNFPA’s accounting system has only very gross categories which do not permit a clear understanding of the use of resources. Secondly, as UNFPA is only one of numerous agencies, including the government, that finance most activities, it is difficult to isolate the effects of UNFPA’s resources. As stated above, if there had been closer collaboration among the main partners – government, UNFPA, WHO, UNICEF and the NGOs -- greater efficiency might have been achieved. With regard to the A/Y SRH programmes, stronger linkages among both projects and partners could have enhanced their efficiency.

Recommendations:

1. Develop an evidence base and a results-oriented approach for UNFPA’s 7th CP.
2. Increase coordination of activities with other UN partners and multilateral agencies.
3. Encourage and facilitate the sharing of resources wherever possible among different UNFPA supported activities.
II.G SUSTAINABILITY

Nothing in the official document authorizing the UNFPA Sri Lanka Sixth Country Programme refers to sustainability. Nor do the individual project agreements demonstrate concern for sustainability. The closest the programme authorisation document comes is a paragraph (29) on capacity building.

Improving Reproductive Health Services

UNFPA support over the years has helped make it possible for the national RH programme to reach a stage where the core elements can now be sustained at a basic level in the event of a reduction or discontinuation of UNFPA support. A critical element is the contraceptive security plan that is now in the process of being established and the fact that the government is committing nearly all the resources needed for contraceptive supplies.

Nevertheless, UNFPA withdrawal from RH in Sri Lanka at this time would be extremely unfortunate. It is clear that further UNFPA support is needed for a variety of very important reasons. First, it is central to UNFPA’s ICPD commitments that abortion should be safe. In Sri Lanka, unsafe abortion is still common and septic abortion is still killing women. UNFPA can play a major leadership role in tackling this issue through strategic improvements in the family planning programme. Further, RH quality issues, the need for strengthening some of the innovative programs initiated by the UNFPA in the past two to three years, and the need to support some of the newer and emerging priorities in the underserved and conflict areas require UNFPA engagement in RH for a longer period of time.

Another sustainability issue concerns UNFPA partnership with other UN agencies. There seems to be potential for greater synergy in certain areas of UNFPA work if it could collaborate more closely with other UN agencies with an eye on ensuring complementarity and sustainability. There is good opportunity for joint programming among the UN partners: UNFPA, UNICEF, and WHO with UNDAF. Programs in underserved areas and estate areas can benefit from this. There is scope to do so particularly in the gender and GBV work, adolescent SRH, and in counseling services to youth and adults. UNICEF is also engaged in certain programmes such as the Youth Friendly Services in which UNFPA and UNICEF can have a closer working partnership.

Some of the other programmes being implemented with government and NGO partners would be difficult to sustain unless UNFPA support is continued. Among the NGOs, PSL, and to a lesser extent WIN, seem best placed to continue their work with alternate resources. It seems likely that most of the other partners would struggle to continue their RH work in the absence of UNFPA support. Nearly all of them seem to lack other sources of support at the moment. What must be examined is what additional value they bring, the comparative advantages that they possess, and what they can do that the government cannot. It seems clear that UNFPA should undertake its RH work mainly through the government system (which is strong except in the North and East) and strengthen it to address RH priorities, rather than develop a parallel system with NGOs. However, in some

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Q: Did the programme design include strategies to ensure sustainability?

Q: Are the programme or its components likely to have lasting results upon the end of UNFPA funding?

Q: Are there signs that specific programme systems, processes, or approaches will be/have been adopted or funded by national implementing partners upon the end of UNFPA funding?
of the newer areas -- such as adolescent SRH, gender and GBV -- NGO partnerships seem required.

Sustainability is an inherent problem in most of the activities and uncertainties exist. However, the following will add to the likelihood of lasting results:

1. The increased RH technical capacity of medical personnel at different levels of services. This is especially so in family planning and in the WWCs where the training is almost entirely through UNFPA support.
2. The government commitment to fund and provide the country's contraceptive supplies means it is no longer donor-dependent for contraceptives.
3. The contraceptive security plan will add to the sustainability of family planning provision.
4. The technical materials produced by the HEB, NIE and other partner agencies will help to continue some programme elements.
5. The transport provided to health staff for providing RH services and supervision will help sustain this work after UNFPA support ends.

SRH Information and Services for Adolescents and Youth

On the whole, there is limited evidence that any of the A/Y SRH interventions carried out under UNFPA support will have long-term continuity and lasting results upon the termination of UNFPA funding. There is, however, some potential for sustainability of some elements of the various projects.

RH education in schools. RH-related curricula introduced in the schools and some of the supplementary readings produced as part of the project can have a lasting effect even after the project has ended, provided that there is continued support for RH education from within the education sector. Sustainability of the school counseling and peer communication activities launched through NIE will be questionable on the completion of the project -- especially when the current generation of peer communicators leave school and when trained staff retire.

A similar fate awaits the counseling programmes initiated under PO 2 and RHIYA. There is, however, some evidence that health workers and teachers trained for counseling services under these projects have incorporated the newly acquired counseling skills in their regular duties in relation to adolescents and youth. As for the RHIYA street theatre developed within CDA as a low-cost strategy for community mobilization in ASRH, there is little evidence that it can continue without outside support even among those already involved in street theatre. Sustainability of YFS centres is also questionable unless the centres introduce a user fee system at some point in their development.

Elements likely to continue upon the end of UNFPA funding include:
- The school curriculum in RH, and related educational material;
- IEC material developed;
- Draft Adolescent SRH policy for Sri Lanka;
- Competencies in IEC and BCC;
- NGO-government networks.

Gender

Sustainability is a crucial issue with regard to the gender-related interventions that UNFPA has launched or otherwise supported during CP6. The GBV Forum has active participation
of many stakeholders, involves very little cost, and would continue without UNFPA involvement. Other initiatives need ongoing support.

- The National Committee on Women needs continued support for the gender database. It will also need technical assistance for implementation of the Domestic Violence Plan of Action and the National Plan of Action for Women.

- Most of the 27 Women’s Centres are likely to wither and disappear without continued financial support from UNFPA and a strategic decision will have to be made about which centres UNFPA will continue to support. WIN is interested and will attempt to access external funds to carry on with its work in Matara if UNFPA funding is not available.

- The Kurunegala programme can be continued with external support and UNFPA could attempt to facilitate this.
III. MAJOR RECOMMENDATIONS FOR THE 2008-1012 COUNTRY PROGRAMME

The 7th country programme will comprise three components: (a) reproductive health; (b) gender equality; and (c) population and development. According to country office plans, gender will also be mainstreamed throughout the programme and advocacy will be an integral strategy within each component.

With some aspects of family planning seemingly remaining sensitive with political, social and religious overtones, and with even certain obstetricians expressing concern regarding UNFPA working mainly in the family planning mode, the proposed expanded agenda of the UNFPA in the next programme cycle will help ensure its image acquires a wide RH and gender dimension.

III.A THE 10 MAJOR RECOMMENDATIONS

Looking holistically at Sri Lanka and its needs that are both consistent with UNFPA’s global mandate and of greatest relevance to the country, and reflecting on lessons learnt through implementation of CP6, the evaluation team arrived at 10 major recommendations for UNFPA support as it embarks on its Seventh Country Programme. They are as follows. (These 10 priorities are followed by a few additional recommendations not covered in section II above.)

#1 Meet unmet needs for contraception, to prevent abortion and save women’s lives. This should be an explicit objective of the Action Plan and additional planned output of CP7. It can be paired with the planned Output 1: “Enhanced capacity of national health system to improve quality and demand for comprehensive reproductive health services.” Output 1, however, sounds like the same-old same-old bureaucratese typical of official documents but not inspiring commitment to action. With so many stakeholders emphasizing that the #1 reproductive health problem in Sri Lanka is abortion and that UNFPA is the agency best-positioned to tackle it, there needs to be strong direct language to galvanise the needed action.

Essential interventions include: ([too duplicative with section II.B.1 [3]. harmonize?])

| (3)[1] | Ensure method choice: at least four methods in each facility. |
| (4)[2] | Work with the Family Health Bureau and the College of Obstetricians to revive and strengthen sterilization services. |
| (6)[3] | Ensure the quality of counseling services, including post-partum and post-abortion family planning. |
| (6)[4] | Explore introduction of new method(s) of contraception (e.g., newer implants). |
| (7)[5] | Pay special attention to underserved areas. |
| (8)[6] | Increase male participation in family planning. |
| (9)[7] | Get data on epidemiology of abortion, but do not wait for such data before moving ahead. Such data may be needed for eventual debate on legalization. |
| (10)[8] | Use Women’s Centres as partners for addressing contraception, unmet needs, counseling, and male responsibility. |
Support measures to help sexually-active unmarried women gain access to effective contraception as needed.

Seek approaches for streamlining, harmonising, and rationalising technical support services (e.g., training and capacity building, materials development, methodologies, logistics, etc.)

**Saving Women’s Lives.** The Country Office should consider as a galvanising theme for the Seventh Country Programme: “Saving Women’s Lives.” The principal interventions would be:

- Meeting unmet needs for contraception, to reduce abortion and save women’s lives;
- Well Women’s Clinics – safeguarding women’s lives and tackling the main gynecological killer cancers;
- Reducing gender-based violence.

All three are intervention areas where measurable results could be achieved.

**#2** Mainstream gender throughout all UNFPA work, with emphasis on reducing gender-based violence.

(1) Develop a model for tackling gender-based violence in all aspects, bringing in all relevant government and non-government partners.

(2) Develop and implement a strategy that links national-level advocacy with community-based initiatives (e.g., a small number of carefully-selected Women’s Centres that can “give flesh” to the advocacy efforts).

**#3** Provide RH and related services in the conflict-affected populations in the North and East (includes youth, gender and gender-based violence, etc.).

**#4** Be prepared to provide RH services in emergency and humanitarian crises.

**#5** Develop and implement a strategy to support SRH needs of youth outside of school.
The focus is out-of-school youth but also serving in-school youth in non-school locations. Actions may include:

- Help the government finalise, appropriately, and then develop an implementation strategy for the National Youth Policy. It must recognize that the situations of young adolescents (10-13) are very different from those of older teens and young people in their 20s.
- Seek innovative ways of working with youth. Then seek ways to institutionalize.
- Strengthen the existing services and monitor their progress and, hopefully, impact.
- The YFS initiative should be expanded to selected underserved areas and vulnerable communities, including the North and East.
- Explore options with the private sector. This might include support for more effective management and marketing, or encouraging corporate social responsibility (CRS) to support a YFS centre on a pilot basis.
- Youth-friendly RH services should be integrated with community-based counseling services and also serve school-going adolescents (as SLAVSC is doing in Kandy).
- Pursue BCC with a clear focus on whether efforts are achieving outcomes or likely to do so; BCC is not a silver bullet.
- Learn lessons from the international experience. But recognize that there are no easy answers and no country has found the perfect formula for getting results and going to scale (upscalesing).
• Piggy-back on current high-level commitment for HIV/AIDS education/IEC/BCC. Phrase UNFPA’s interest vis-à-vis youth as SRH, not just RH – which makes many in the HIV/AIDS community think RH has nothing to do with them. This is essential for forming the bridge between FHB and NSACP.

**#6 Be strategic in moving forward with STIs and HIV/AIDS.**
The most at-risk populations that are the focus of the National HIV/AIDS Strategic Plan 2007-2011 are not where UNFPA has greatest comparative advantage. (See III.B below.)

**#7 Develop a strategy for improving and sustaining the Well Woman Clinics.**
In addition to their importance in addressing the main gynecological cancers, support for the Well Woman Clinics allows UNFPA to retain credibility at the service delivery level while working upstream; they also diffuse the “FP only” image about which the CO is concerned.

**#8 In re-engaging in Population and Development, support activities that directly contribute to achieving the planned results of the Country Programme.**
This is important for shifting from an activity-focused programme to being results-focused.

**#9 Greater collaboration is essential; take a lead in responding to the call.**
Many stakeholders emphasise that better collaboration is needed for better results. Help develop effective mechanisms for collaboration: among UN agencies; among UN agencies and relevant government agencies; and among UN agencies, government and NGOs/INGOs. One goal of collaboration should be effective identification of comparative advantage and a clear, clear division of labor.

**#10 Develop a Country Programme Action Plan that is truly results-focused.**
This requires a logframe with baseline data and measurable targets, developing mechanisms for synergy, lesson sharing, monitoring and evaluation. It also requires additional consultation up-front with key partners to bring them on board. (For example, partners need to understand that UNFPA’s #1 priority is reducing abortion and saving lives by meeting unmet need for contraception – not just providing vehicles.)

### III.B STI and HIV/AIDS Prevention for Women and Young People

UNFPA has identified this area as a priority for CP7. This section, following on #6 above, sets forth additional findings and suggestions related to how UNFPA might proceed.

The HIV/AIDS draft strategic plan for Sri Lanka has identified CSWs, MSM and drug users as most vulnerable groups for HIV. Young people are definitely in each category, although numbers are unknown. The CP6 does not directly serve any of these designated highly vulnerable groups, with the exception of one small activity with an NGO (Community Strengths Development Foundation, CSDA) that is reported to focus on sex workers. UNFPA may not be well positioned to serve any of these three vulnerable groups. On the other hand, using available data and monitoring information, UNFPA can determine which vulnerable groups it might reach most effectively during its 7th CP.

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32 UNFPA is praised by numerous stakeholders for the series of consultations it conducted in early 2007 for developing the Seventh Country Programme. This might be a platform for going forward.


34 UNFPA’s work with CSDA was mentioned to team only by David Bridger of UNAIDS.
Recommendations:

4.1. UNFPA must work strategically with partners in developing suitable strategies for STI and HIV/AIDS prevention among adolescents and youth.

5.2. Promote integration of SRH, including STI and HIV prevention, into the in-service training of teachers in colleges of education through the relevant section of the Department of Education.

6.3. If resources allow, introduce and develop BCC strategies in the Army, FTZ work force and other categories of young workers, including three-wheel drivers and migrant workers.

7.4. Use the experience and knowledge already accumulated with out-of-school youth to develop programmes for them via NYSC and suitable NGO partners; IEC and BCC strategies that have been recognized as effective should be adopted for this purpose.

IIIC GENDER EQUALITY

UNFPA has identified this area as a priority for CP7. This section, following on #2 above, sets forth additional findings and suggestions related to how UNFPA might proceed.

UNFPA can more effectively use its position as the United Nations’ foremost agency responsible for the implementation of the ICPD Programme of Action to create synergies between gender equality and reproductive health by ensuring a commitment to integrate a gender perspective into all its programmes and partnership interventions. The Gender Equality component of UNFPA Sri Lanka’s programme is crucially important and relevant.

The proposed outputs and envisaged outcomes of the Gender Equality component of UNFPA’s 7th CP are:

<table>
<thead>
<tr>
<th>Goal area</th>
<th>OUTPUTS proposed</th>
<th>OUTCOMES envisaged</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender-Based Violence</td>
<td>1. Strengthened capacity of government, NGOs and CBOs to prevent and respond to gender-based violence; 2. Strengthen the national capacity and institutional mechanisms for increased state accountability to fulfill and protect the rights of women.</td>
<td>1. Strengthen institutional mechanisms; 2. Empower the community to strengthen the rights of women.</td>
</tr>
<tr>
<td>Rights of Women and Girls</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The Outputs proposed are insufficient to achieve the Outcomes expected. The second Outcome requires empowerment of communities to strengthen the rights of women. Proposed Outputs are inadequate to achieve this Outcome. It should be noted that Output 1 addresses gender-based violence but does not extend to protect the rights of women.

If Outcome 2 is retained (as it should be) a third Output will have to be defined.

Further, the UNFPA Outcomes must centrally identify reproductive health and rights as determinants of gender equality. Failure to do so negates its comparative advantage and only serves to marginalise gender concerns in reproductive health programmes and interventions or compartmentalise gender work.
The UNFPA programme design (including formulation of outputs and outcomes) could be strengthened to achieve two substantive dimensions of gender equality that are central in UNFPA’s niche and comparative advantage:

- Promoting the integration of a gendered focus on reproductive health and rights into all project and programme interventions;
- Addressing sexual and gender-based violence.

III.C.1 Gender-Based Violence

**Planned output:** Strengthened capacity of government, non-governmental and community organizations to prevent and respond to gender-based violence

4.1. The NCW must be supported to improve, strengthen and maintain the database for gender disaggregated data with its initial focus on GBV for evidence-led policy formulation and implementation of the Domestic Violence Act.

4.2. UNFPA should consider integrating relevant components of its community-based and health sector initiatives in the design of a holistic model, with a sustainable strategic approach to prevent and address gender based violence.

4.3. Continued support should be offered to a strategically selected small number of Women’s Centres (following a review at the end of the project period ensuring that the mandate of NGOs supported to establish or continue Women’s Centres is compatible with RH and GBV goals of UNFPA).
   - UNFPA should explore the possibility of piloting a Women’s Centre in Trincomalee (or a selected district in the Eastern or Northern provinces) in collaboration with WIN or a suitable local women’s NGO.
   - Women in Need, with its specialized expertise in addressing GBV and its referral facility of legal services and shelter, is best positioned to continue with the Women’s Centre initiative and should be further supported.

4.4. Since the institutionalized nature of health sector-based responses such as Mithuru Piyasa lend themselves more easily to long-term sustainability, UNFPA could consider this an effective model to pilot in carefully selected General Hospitals in at least two districts, including a hospital in the Eastern or Northern provinces. A link with community based models, such as the Women’s Centres, will also help take the response to GBV beyond the clinic to address its social causes and consequences.

4.5. The Gender/RH Programme at sub-national level in Kurunegala merits a review for extension at the end of 2007 and to determine whether financial support exists enable the identification of a suitable donor through the Department of External Resources. (but are there any possible candidates?? If not, must revise or delete this rec.)

4.6. The GBV Forum needs to have policy/advocacy related focus. It could assist the NCW operationalize selected components of its Plan of Action on the Implementation of the Domestic Violence Act. The GBV Forum should consider expanding its membership to include women’s groups and networks at provincial and district level.

III.C.2 Rights of Women and Girls

**Planned output:** Strengthen national capacity and institutional mechanisms for increased state accountability to fulfill and protect the rights of women and girls.
UNFPA must centrally identify reproductive health and rights as determinants of gender equality and develop a gender strategy and operational tools to integrate gender and gender approaches into its country programme, including its RH components.

The UN Gender Working Group, together with the GBV Forum, should advocate for the enactment of the Women’s Commission Bill.

UNFPA should track:

a. implementation of the gender-related plans and policy directives of the Ministry of Child Development and Women’s Empowerment (such as the National Plan of Action and the Action Plan for Domestic Violence);

b. the recommendations emerging from the Engendering Criminal Legislation study and Consultation (commissioned by the NCW), one purpose of which was to explore the possibility of liberalising legislation on abortion in line with the Women’s Charter and initiating dialogue with relevant Health Ministry officials.

All of these policy documents emerged from a fairly inclusive process of discussion and consultation. It is thus essential that the UNFPA’s gender programming incorporates national gender policy, where possible, to ensure complementarity.

Strategies to address unintended pregnancy and abortions must incorporate a rights-based response (in addition to the health-sector response) by assisting in advocacy processes for the liberalising of abortion laws.

III. D POPULATION AND DEVELOPMENT

UNFPA has identified this area as a priority for CP7. This section sets forth findings and suggestions related to how UNFPA might proceed.

Addressing life-cycle implications of the demographic transition. Sri Lanka’s success in family planning has made it possible that zero population growth will be achieved within 25 years -- by 2031 at 21.9 or 22 million. Today Sri Lanka has a favourable age-structure for development with decreasing dependency ratios. But with the rapid ageing of the population, care of the elderly and their health care needs will soon become major issues. An immediate implication will be the large numbers of older women who will require services of different types. With structural changes and needed changes in provider competencies, resources needed will increase.

International migration will also become important (1.5 million Sri Lankans outside) and will continue with social and related problems.

A/Y SHR. Given the paucity of accurate information about sexual activity (and consequences of pregnancy, abortion, STIs, etc.) among young people spanning ages 10 to 24, well-designed studies should be undertaken, following careful analysis of available information, in order to determine where the highest priority needs are concerning AYSRH and how such needs should be effectively addressed. Even the most recent (2005) DHS has very limited information on AYSRH. The next DHS (2010) should include more on AY SHR.

Recommendations. In addition to UNFPA’s planned output (increased availability and utilization of sex- and age-disaggregated population data), the following are recommended.
1. Promote the increased availability and utilization of sex- and age-disaggregated population data at district and division levels.

2. Expand technical support for the 2011 census to address some of the gaps in demographic data, with special emphasis on conflict- and tsunami-affected regions and other underserved areas.

3. Develop capacities in relevant agencies (including the Department of Demography at the University of Colombo, the Department of Census and Statistics, and the Ministry of Healthcare and Nutrition) to enable them to monitor population dynamics in Sri Lanka from the angles of health, development, poverty reduction and equity, gender analysis and advocacy.

4. Capacity should be further developed to undertake the policy-oriented analyses needed for addressing important current and evolving issues, including demographic transition concerns such as aging and the feminisation of ageing, youth issues, and needs of women and families resulting from internal and international migration. Consider support for macro- and micro-level studies and analyses and small-sample qualitative studies on adolescent sexuality and gender-based violence.

5. UNFPA should also consider reviving or replacing the lapsed Population Division (e.g., at an apex level potentially in the National Planning Division/Department [[Malathi which??]]). In addition, UNFPA should consider supporting placement of a Senior Advisor at the National Planning Division/Department [[which??]] to strengthen national planning capacities and address gender and population issues at the apex level.

6. Consider support for a series of workshops for mainstreaming relevant population and development issues and identifying relevant policy options in relation to emerging demographic issues such as aging, migration, and aspects of demographic transition.

III.E PROGRAMME DESIGN AND MANAGEMENT

III.E.1 Moving “Upstream”

UNFPA Sri Lanka has repeatedly emphasized the need and intention to be more strategic and “upstream” in its programming. While this is highly appropriate, UNFPA must balance the upstream “talk” with continued strategic inputs (“walk”) at the services level; this is essential to assure the quality of services and for maintaining credibility as UNFPA moves to engage more in policy and advocacy.

A question for UNFPA is its upstream contribution. Following are some considerations.

1. Guidelines. UNFPA has discussed a role in the area of guidelines. Currently WHO is recognized as the U.N. agency with this capacity and role. UNFPA would not want to challenge or try to replace the role of WHO in this regard. However, UNFPA might cooperate with WHO to develop or standardize application of the global guidelines to make them context-specific and applicable to Sri Lanka.

2. Research. Given the paucity of reliable data in the RSH sector, UNFPA could initiate and sponsor some strategically chosen and well-designed studies. These might be in the nature of operations research and be part of the Population and Development component above. But, for UNFPA to play an upstream role, UNFPA must strategically manage the launching, implementation and announcement of results to visibly demonstrate its leadership and technical capacity in these matters (not just, for example, contributing a sum of money to the upcoming census).
3. More immediate and programme-related measures to develop an evidence base for policy and advocacy. The UNFPA CO intends to engage more actively in advocacy and policy dialogue. But on what basis? The Sri Lankan evidence base is weak. ICPD declarations do not carry great weight with Sri Lankan decision-makers in the face of all other and much closer-to-home priorities. Two approaches could be productive at this time in providing UNFPA with an evidence base from which to engage in advocacy and policy dialogue:

a. Strategic implementation of activities at the service delivery/community level.

Continued support for a small number of strategically-selected Women’s Centers could provide – with good monitoring and fine-tuning of implementation – yield persuasive evidence to back up UNFPA advocacy and leadership related to gender-based violence.

Continued support for the already launched Youth-Friendly Services might -- with good monitoring and fine-tuning of implementation – yield needed insights on how to provide effective SRH messages to young people and thereby back up UNFPA advocacy and leadership related to SRH for adolescents and youth.

b. Producing a series of short (4-6 pages maximum) policy briefs on critical issues in reproductive and sexual health in Sri Lanka. Titled something like Understanding Realities: Reproductive and Sexual Health in Sri Lanka, this could be an excellent vehicle for putting forth UNFPA technical leadership in these matters. UNFPA might consider developing and issuing these jointly with WHO. Given the prevailing absence of good data on the one hand, and the swirl of myths and gross generalizations on the other (e.g., youth people in Sri Lanka are not sexually active), this series could be extremely valuable in putting forth what is known and where the gaps are. Such a series could include the following topics (some of which are controversial and some of which merely beg to have information succinctly presented for decision-making):

- Meeting unmet needs for contraception
- Abortion
- Adolescent reproductive and sexual health
- At-risk adolescents (this one could really help establish UNFPA’s role in STIs/HIV)
- Sexually-transmitted infection
- Gender-based violence, including violence against women
- Health of women over 30
- Challenges of aging

Key elements in each brief to include identification of:
1. Relevant cultural traditions and norms + changing context and behaviours
2. Main existing data shedding light
3. Data needs

UNFPA has a good basis for some of these briefs in work it has already commissioned. For example, the Thematic Evaluation of Adolescent Reproductive Health Needs and Services in Sri Lanka is an excellent document that begs for a summary of its 31 pages and wide dissemination thereof of key findings. Important findings on other topics could be produced by partners as part of the exit strategies for their work conducted under CP6.

Recommendations:

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1. For a few priority interventions, develop guidelines for Sri Lanka that fine-tune the WHO guidelines to the immediate country context. In addition, UNFPA should consider generating guidelines in important areas where none exist.

2. Continue the implementation of a few strategically-selected Women’s Centres and the already-launched YFS in such a way as to provide evidence and support UNFPA engagement in advocacy and policy dialogue on related matters.

3. Launch a series of policy briefs (e.g., *Understanding Realities: Reproductive and Sexual Health in Sri Lanka*) on priority SRH topics that: (a) unpack myths and generalizations; (b) identify clearly what is known and what is not known; and (c) identify priority data needs.

4. Take leadership in conducting a mapping of “underserved areas” to bring clarity and increase effectiveness and efficiency of programming.

III.E.2 Local Accountability/Advisory Board for UNFPA

Who does the country office turn to for well-informed supportive advice? As the country office seeks, appropriately, to move upstream, who does it consult for supportive non-invested advice? Partners can’t give this, as they are invested. The CST and HQ are far, far away. UNFPA’s current Representative is well-liked and well-respected by UNFPA’s partners – but she will be leaving. While CO staff are highly competent in their own areas of responsibility, who has the global country-wide picture after her departure? Thus the following recommendation:

- The Country Office should bring together an informal board of a small number of high-level well-respected persons who believe in the UNFPA mission and its contribution to the people of Sri Lanka: friends of UNFPA, but very knowledgeable ones. Their task, for CP7, would be to oversee UNFPA’s transition from activity-focused to results-focused over the next 5 years, providing supportive guidance to the Country Office staff. This might be chaired by the Secretary of Health, but it must not be or become bureaucratic.
ANNEXES

A. UNFPA 6th Country Programme and Other Projects 2002-2007: Overview
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D. Terms of Reference for this Evaluation
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F. Evaluation Methodology
G. Evaluation Schedule and Itinerary
H. Major Contacts /Persons Interviewed
I. Principal Documents Reviewed
J. UNFPA’s Multi-Year Funding Framework 2004-2007-- Relevant Highlights
K. Profile of Adolescents and Youth in Sri Lanka
L. Reproductive Health Initiative for Youth in Asia (RHIYA)

<table>
<thead>
<tr>
<th>UNFPA Projects</th>
<th>Targeted Beneficiaries</th>
<th>Implementing Partners</th>
<th>Districts</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Strengthening reproductive Health Services</strong></td>
<td>Married Couples</td>
<td>Family Health Bureau, National Cancer Control Programme, Plantation Human Development Trust, National STD AIDS Control Programme</td>
<td>Colombo, Matara, Nuwara Eliya, Jaffna, Mannar, Vavuniya, Puttalam, Anuradhapura, Polonnaruwa, Badulla, Monaragala, Ratnapura, Kegalle</td>
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<tr>
<td>PO1 ($2.9 million budget)</td>
<td>Women 35yrs + Health Providers</td>
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<tr>
<td></td>
<td>Estate Sector, IDPs, Private Practitioners</td>
<td></td>
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<tr>
<td><strong>Involvement of NGOs in Reproductive Health</strong></td>
<td>NGOs</td>
<td>NGO Secretariat</td>
<td>Gampaha, Kandy, Hambantota, Ampara, Trincomalee, Puttalam, Badulla, Monaragala, Ratnapura</td>
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<td>P02 ($300,000 budget)</td>
<td>Out of School Youth, IDPs</td>
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<tr>
<td></td>
<td>Married Couples, Women and Girls, Women</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Information, Education and Communication in Reproductive Health</strong></td>
<td>Health providers and mass media, Uniformed service personnel, Youth, University Students</td>
<td>Health Education Bureau, Ministry of Labour, National Youth Services Council, University Grants Commission, Sri Lanka Army</td>
<td>Colombo, Gampaha, Matale, Nuwara Eliya, Galle, Jaffna, Vavuniya, Batticaloa, Puttalam, Anuradhapura, Polonnaruwa, Monaragala, Ratnapura</td>
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<tr>
<td>P03 ($384,000 budget)</td>
<td></td>
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<tr>
<td><strong>Support for Adolescent and Reproductive Health in Schools</strong></td>
<td>Teachers, Secondary school students</td>
<td>National Institute of Education</td>
<td>Colombo, Kalutara, Nuwara Eliya, Mannar, Trincomalee, Kurunegala, Puttalam, Anuradhapura, Monaragala</td>
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<td>P04 ($400,000 budget)</td>
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<td><strong>Advocacy for RH and Gender</strong></td>
<td>Policy makers and planners, Religious Leaders, Youth</td>
<td>Women’s Bureau, Population Division</td>
<td>Colombo, Gampaha, Vavuniya, Kurunegala, Anuradhapura, Polonnaruwa, Monaragala</td>
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<tr>
<td>P05 ($500,000 budget)</td>
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### Regional & Tsunami Projects

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<thead>
<tr>
<th>Regional: Reproductive Health Initiative for Youth in Asia (RHIYA)</th>
<th>Youth, Adolescents, School Leavers</th>
<th>Sarvodaya, Centre for Development Alternatives, Samasewaya, Family Planning Association, Vinidha</th>
<th>18 districts</th>
</tr>
</thead>
<tbody>
<tr>
<td>($1 million budget)</td>
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<tr>
<td><strong>Regional: Youth Friendly Services</strong></td>
<td>Youth, Adolescents, School Leavers</td>
<td>National Youth Services Council, National Institute of Health Services, SLAVSC</td>
<td>3 districts</td>
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<td>($350,000 budget)</td>
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<td><strong>Tsunami Reproductive Health Project</strong></td>
<td>Tsunami affected population</td>
<td>UNOPS</td>
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<td>($6.2 million budget)</td>
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<tr>
<td><strong>Tsunami Psychosocial and Gender Project</strong></td>
<td>Women and Girls, Health Providers</td>
<td>Directorate of Mental Health Services, University of Colombo, National Committee on Women, Women in Need, Sarvodaya, Muslim Women’s Research and Action Fund</td>
<td>Colombo, Kalutara, Galle, Matale, Hambantota, Batticaloa, Ampara, Trincomalee</td>
</tr>
<tr>
<td>- Psychosocial component</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Gender component</td>
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<td></td>
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</tr>
<tr>
<td>($1.9 million budget)</td>
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### Annex B. UNFPA EXPENDITURE SUMMARY, 2002-2007

#### Summary: All Projects Of 6th Country Programme

<table>
<thead>
<tr>
<th>PROJECT</th>
<th>EXPENDITURE (USD)</th>
<th>TOTAL</th>
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<tbody>
<tr>
<td>PO1 - Strengthening Reproductive Health Services</td>
<td>$981,332.00</td>
<td>$3,803,338.60</td>
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<tr>
<td>PO2 - Involvement of NGOs in Reproductive Health</td>
<td>$64,197.00</td>
<td>$257,769.31</td>
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<tr>
<td>PO3 - IEC in Reproductive Health</td>
<td>$62,042.00</td>
<td>$473,206.30</td>
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<tr>
<td>PO4 - Support for Adolescent RH in Schools</td>
<td>$72,038.00</td>
<td>$400,790.94</td>
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<td>P05 - Advocacy and Gender</td>
<td>$61,697.00</td>
<td>$451,647.25</td>
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#### PO1 - Strengthening Reproductive Health Services ($2.9 million initial budget)

<table>
<thead>
<tr>
<th>PROJECT</th>
<th>EXPENDITURE CATEGORY</th>
<th>EXPENDITURE (USD)</th>
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</tr>
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<td>$35,328.31</td>
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<td>Subcontracts</td>
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<td>Contraceptives</td>
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<td>Miscellaneous</td>
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<td>Sub Total</td>
<td>$981,332.00</td>
<td>$3,803,338.60</td>
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#### PRO2 - Involvement of NGOs in Reproductive Health ($300,000 initial budget)

<table>
<thead>
<tr>
<th>PROJECT</th>
<th>EXPENDITURE CATEGORY</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
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<td>3,698.00</td>
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<td>1,733.38</td>
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<td>28,704.04</td>
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<td>70,855.47</td>
<td>4,351.65</td>
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#### PRO3 - Information, Education and Communication in Reproductive Health ($384,000 initial budget)

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<th>PROJECT</th>
<th>EXPENDITURE CATEGORY</th>
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<th>2003</th>
<th>2004</th>
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<td>Subcontracts</td>
<td>29,826.00</td>
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<td>17,605.61</td>
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<td>Training</td>
<td>13,962.00</td>
<td>27,273.00</td>
<td>3,601.32</td>
<td>(5,348.63)</td>
<td>14,310.79</td>
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<td>Equipment</td>
<td>5,263.00</td>
<td>7,956.00</td>
<td>48.54</td>
<td>1,794.22</td>
<td>55.41</td>
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<td>15,117.17</td>
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<td>Contraceptives</td>
<td>-</td>
<td>-</td>
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<td>-</td>
<td>-</td>
<td>-</td>
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<td></td>
<td>Miscellaneous</td>
<td>10,286.00</td>
<td>15,779.00</td>
<td>34,167.32</td>
<td>(7,352.95)</td>
<td>16,469.07</td>
<td>17,430.09</td>
<td>86,778.53</td>
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<td>Sub Total</td>
<td>62,042.00</td>
<td>97,987.00</td>
<td>81,276.83</td>
<td>43,588.96</td>
<td>124,856.56</td>
<td>63,004.95</td>
<td>473,206.30</td>
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### P04 - Support for Adolescent and Reproductive Health in Schools ($400,000 initial budget)

<table>
<thead>
<tr>
<th>PROJECT</th>
<th>EXPENDITURE CATEGORY</th>
<th>EXPENDITURE</th>
<th>TOTAL</th>
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</thead>
<tbody>
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<td>SRL02P04</td>
<td>Personnel</td>
<td>1,429.00</td>
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<td>Subcontracts</td>
<td>3,393.00</td>
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<td></td>
<td>Training</td>
<td>36,252.00</td>
<td>153,226.49</td>
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<tr>
<td></td>
<td>Equipment</td>
<td>22,191.00</td>
<td>153,226.49</td>
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<td></td>
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<td></td>
<td>Sub Total</td>
<td>72,038.00</td>
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### P05 - Advocacy and Gender ($500,000 initial budget)

<table>
<thead>
<tr>
<th>PROJECT</th>
<th>EXPENDITURE CATEGORY</th>
<th>EXPENDITURE (USD)</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
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<td>SRL02P05</td>
<td>Personnel</td>
<td>7,706.00</td>
<td>122,824.43</td>
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<td></td>
<td>Subcontracts</td>
<td>35,238.00</td>
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<td></td>
<td>Training</td>
<td>18,172.00</td>
<td>33,761.46</td>
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<td></td>
<td>Contraceptives</td>
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<tr>
<td></td>
<td>Miscellaneous</td>
<td>581.00</td>
<td>41,188.61</td>
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<td></td>
<td>Sub Total</td>
<td>61,697.00</td>
<td>451,647.25</td>
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## Annex C. LOGFRAME: UNFPA SI LANKA 6TH COUNTRY PROGRAMME

<table>
<thead>
<tr>
<th>HEIRARCHY OF AIMS</th>
<th>OBJECTIVELY VERIFIABLE INDICATORS (OVIs)</th>
<th>MEANS OF VERIFICATION</th>
<th>AVAILABLE OR NOT</th>
<th>RISKS/ASSUMPTIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Goal</strong>&lt;br&gt;To have contributed to the improved reproductive health (RH) status and increased gender equity and equality</td>
<td>• Decrease in MMR by 25% from current FHB estimated level of 60 per 100,000 livebirths  &lt;br&gt;• NNMR reduced from 13 per 1000 live births to 9  &lt;br&gt;• TFR maintained at current level of 2.1  &lt;br&gt;• Gender related development index (GDI) increased from 2000 level of 0.727  &lt;br&gt;• Gender empowerment measure improved from 2000 level of 0.039</td>
<td>FHB Annual Reports  &lt;br&gt;Registrar General  &lt;br&gt;DHS  &lt;br&gt;UNDP Human Development Report  &lt;br&gt;UNDP Human Development Report</td>
<td></td>
<td>• Continued Government commitment to RH program including human and financial resources  &lt;br&gt;• Political stability, peace, law and order and security situation improves / does not worsen  &lt;br&gt;• DHS will be repeated in 2005</td>
</tr>
<tr>
<td><strong>Purpose</strong>&lt;br&gt;To have contributed to increased utilisation of quality RH services particularly in the pockets of unmet need and among vulnerable groups and underserved geographic areas</td>
<td>• Decrease of unmet need for family planning from 12% to 8% or less by 2006  &lt;br&gt;• CPR increased from baseline DHS rate of 67% for 2001 to 75% by 2006  &lt;br&gt;• Increase of modern methods of contraception by 25% in the selected districts and DDHS areas by 2006  &lt;br&gt;• Population coverage of eligible women screened at WWC increased to 25% in districts selected for support by 2006  &lt;br&gt;• Maintain the HIV sero-prevalence rate of less than 1%</td>
<td>DHS  &lt;br&gt;DHS  &lt;br&gt;RH MIS  &lt;br&gt;Surveys  &lt;br&gt;RH MIS  &lt;br&gt;NGO records</td>
<td>Trained staff retained in the health sector  &lt;br&gt;Government commitment to meet counterpart contribution  &lt;br&gt;DHS will be repeated in 2005  &lt;br&gt;Full resources available from donor sources  &lt;br&gt;The government continues the cafeteria approach to family</td>
<td></td>
</tr>
<tr>
<td>In the general population</td>
<td>Surveillance reports</td>
<td>Motivated staff</td>
<td></td>
<td></td>
</tr>
<tr>
<td>---------------------------</td>
<td>----------------------</td>
<td>-----------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of women treated annually in hospital for complications of abortions in selected underserved districts</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RH MIS</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| To have contributed to increased mobilisation of political and community support at national and subnational level for effective application of the National Population and RH Policy and Action Plan, particularly for family planning, prevention and management for RTIs, STDs, HIV/AIDS, gender concerns, adolescent sexuality and reproductive health and ageing. |
| Official public statements in support of RH issues by parliamentarians, social leaders NGOs government officials and key policy makers at national level increased by 10% each year |
| Increased mass media dissemination of information in support of RH and gender related issues |
| There is no national or community opposition for the promotion of RH issues and gender equality |

### Outputs

#### 1.1 Increased access to quality RH, including family planning services for populations living in underserved areas and in conflict zones.

- No of MOH in selected districts / geographic areas offering a choice of at least 4 contraceptive methods continuously

- No of acceptors of emergency contraception at national level and in the selected DDHS areas annually from 2003 – 2006

- National clinical standards protocols and guidelines for quality of care assurance in RH

| FHB routine MIS |
| NGO records |
| DPDHS records |
| FHB records |
| NGO records |
| DDHS records |
| Survey (to be built into the component projects) |
| Training reports |

| Continued flow of UNFPA approved funds |
| Uninterrupted adequate supplies of a range of contraceptives procured and distributed |
| Sustained commitment and support of stakeholders |
services developed, reviewed and modified where appropriate and implemented to the satisfaction of clients

- 15% increase from the 2001 levels of women receiving key items of RH care e.g. VDRL screening during pregnancy, antenatal care registration before three months gestation, family planning counselling in selected areas for support by 2006

- 20% increase from the 2001 level of older men and women (over 40 years) who have completed their family size accessing family planning services including sterilisation by 2006

- New acceptors of condoms increased annually in the underserved geographic areas (HIV prevention and prevention of unwanted pregnancy)

- All WWC in the districts selected for UNFPA support provide pap smears and follow-up by 2005

- Number of women adequately counselled following GBV in selected districts

<table>
<thead>
<tr>
<th>RH MIS</th>
<th>RH MIS and DPDHS/DDHS records</th>
<th>RH MIS</th>
<th>NGO records</th>
<th>Availability of multi-bi funding</th>
<th>Availability of multi-bi funding</th>
</tr>
</thead>
</table>

...Continued below
## 1.2 Increased awareness of sexual and reproductive issues, including responsible and gender sensitive behaviour among adolescents and youth. Improved access to quality RH services including counseling

- Increased knowledge of RH issues among unmarried youth in the age group 15-24
- Increased knowledge of the availability of counselling services among unmarried youth in the age group 15-24

### KAP surveys of adolescents  
- Project records and NGO records  
- Local authorities and parents in selected areas are willing to endorse ARH education in and out of school  
- Teachers are committed to address ARH education in their daily work  
- Endorsement of local authorities for the outreach programme for youths  
- MOH support for ARH services

## 2. Increased understanding, commitment and support of parliamentarians and policy makers as well as community leaders, mass media organisations, NGOs and senior administrators to address population, RH, HIV/AIDS and gender issues.

- Fully functioning National Co-ordination Committee on Population and Development and recommendations implemented  
- Advocacy strategy developed  
- Advocacy strategy in place  
- Statements by parliamentarians, media etc  

### Periodic reports of NCCP  
- Document available  
- Advocacy materials on various RH issues including gender issues and prevention of HIV/AIDS  
- Hansard  
- Press statements  

### Commitment of parliamentarians and policy makers to broader population, RH and gender issues

Annex D. TERMS OF REFERENCE (TOR) FOR THIS EVALUATION

1. Title:

2. Background:
UNFPA Sri Lanka country office has been operating in Sri Lanka for more than 30 years to improve the reproductive health of people in Sri Lanka. The 6th UNFPA country program for Sri Lanka was endorsed for a five year period from 2002 to 2006. Following the Tsunami disaster that struck the country in December 2004 and the emergency situation that followed, the UNFPA country program was extended till end 2007. The main areas of focus of the CP (2002-2007) included:

(a) increasing access to reproductive health services of underserved and vulnerable communities;
(b) supporting NGOs to address gaps in services in underserved areas;
(c) building capacities for reproductive health promotion;
(d) strengthening reproductive health in-school education; and
(e) supporting advocacy efforts targeting policy makers and planners as well as community and religious leaders.

Five projects have been developed within these areas which fall under the country programme, together with two regional and two tsunami projects. Reproductive Health Initiative for Youth in Asia (RHIYA) and Youth Friendly Services (YFS) are the two regional projects implemented in Sri Lanka. RHIYA was implemented in 18 districts through 8 partner agencies and ended in Sep 2006. The YFS Project was operationalized in three districts using three different settings i.e. government health, government non-health and NGO setting. Under the tsunami projects, one project is divided into two key components: psychosocial and gender, which aims to enhance the wellbeing of individuals and communities living in tsunami affected areas. In addition, the tsunami reproductive health project has been developed for the reconstruction of MOH offices and hospitals in tsunami affected areas.

3. Evaluation purpose and users
The Sri Lanka country office is in the process of developing its 7th programming cycle to be implemented for the next five years, 2008-2012. Lessons learnt from the 6th country programme are important for the design and implementation of the next country programme. The UNFPA Sri Lanka country office is planning to conduct an evaluation of the country programme and other projects to draw out lessons learnt and make recommendations which would be considered in developing the next country programme action plan.

The evaluation findings and recommendation will be utilized by UNFPA Sri Lanka, UNFPA Headquarters, donors, government of Sri Lanka, partner agencies and relevant stakeholders.

4. Evaluation objectives and questions
The main objective of the CP evaluation is to assess the relevance, efficiency, effectiveness and sustainability of program interventions as well as to identify program goals and
strategies adopted and their effectiveness in contributing to the achievement of ICPD and MDG goals. The evaluation should highlight strengths, weaknesses/gaps, good practices, and provide forward looking recommendations. The following are specific objectives and evaluation questions:

**Relevance**

1. Is UNFPA’s programme appropriately positioned to meet the RH needs of the most vulnerable groups in Sri Lanka?
2. Is the UNFPA’s programme & projects in line with UNFPA mandate and Multi-Year Funding Framework (MYFF)?
3. What is the relevance and contribution of regional and other projects to the country program?
4. Has UNFPA Sri Lanka considered its capacity when developing the programme design?
5. What are the strengths and weaknesses of UNFPA partnering strategy?
6. Does UNFPA Sri Lanka have the capacity to provide humanitarian/ emergency support?
7. If yes has UNFPA sufficiently and appropriately invested in humanitarian/ emergency assistance in where support is needed?
8. While considering the small size of the programme, and given its scarce resources, has UNFPA positioned itself within the local country context in areas where it can make the most difference? (Draw out UNFPA’s areas of comparative advantage)

**Efficiency**

1. Were programme resources (human, technical, financial, equipment) used most economically to achieve the given outputs?
2. Were operational strategies adequate for the use of resources most economically?
3. How did accountability structures of the national implementing partners (government and non-government) influence economic use of resources?
4. Could alternative use of resources have produced the same results?
5. What was the timeliness of inputs and outputs? What are the internal and external factors which influenced the implementation process?

**Effectiveness**

1. Were programme results achieved? with reference to achieved outputs and its likely contribution to the achievement of outcomes?
2. Were operational strategies adequate to achieve programme results?
3. What were constraining and facilitating factors and the influence on the achievement of results?
4. Was there sufficient synergy among the various programme components? Did regional and other projects contribute to and reinforce achievement of programme results?
5. Did UNFPA’s network of partners support achievement of programme results? Were strategic stakeholders that influenced the programme negatively left out?
6. Are the current monitoring, evaluation and accountability systems adequate to enable UNFPA to demonstrate programme results?
7. Were these systems adequately used to adjust programme strategies to changing policy and programme contexts and needs in the course of programme implementation?
8. Did UNFPA incorporate lessons learnt into programme interventions to improve implementation and program results? Were the lessons learnt shared between UNFPA and its partners?
9. Were the planned geographic area and target group successfully reached?
10. What is the UNFPA’s contribution for policy changes in RH and related issues in the country?
11. To what extent has UNFPA assistance contributed to the longer-term goals for the advancement of human rights and gender equality in the context of Sri Lanka?
12. What positive and possibly negative long-term effects on vulnerable groups has UNFPA assistance had over the programme cycle.

**Sustainability**
1. Did programme design include strategies to ensure sustainability?
2. Are there signs that programme systems, processes, approaches will have been adopted or funded by national implementing partners upon ended UNFPA funding?
3. Is the programme/project likely to have lasting results upon its termination?

5. **Methodology**
The consultants will design the evaluation methodology required to respond to evaluation objectives in collaboration with the Country Office and other key evaluation stakeholders. The methodology should specify the following:

- Key information sources - identification of evaluation stakeholders (UNFPA staff, partner agencies, programme beneficiaries)
- Sampling approaches for different data collection methods, including area and population/stakeholders to be represented, procedures to be used and sampling size
- The level of precision required
- Data collection instruments
- Types of data analysis
- Reference indicators and benchmarks where relevant.

6. **Evaluation team composition**
The team will comprise of up to five evaluators, both international and local. The evaluators will be selected by UNFPA Sri Lanka office in consultation with CST & HQ.

The members of the evaluation team should be competent in the evaluation of similar type of programmes particularly in developing countries and preferably have a background in the following specialized areas:
- Reproductive health
- Adolescent reproductive health
- Gender, gender based violence
- Emergency/Humanitarian support

They should also possess analytical skills (gender analysis skills would be desirable), process management skills, data management and facilitation skills.

**Evaluator’s tasks (team members and leader)**

Examples of tasks:
- Read background documentation
- Contribute to design of the evaluation methodology
- Conduct field level data collection
- Contribution sections of the evaluation report related to his/her expertise
- Participate in interim and final briefings
- Ensure full stakeholder participation in the evaluation process

Additional tasks of the team leader:
- Guide other team members in order to complete the work in accordance with the terms of reference;
- Ensure that the individual members work as a team.

The evaluation team will work under the direct supervision of the UNFPA country representative for Sri Lanka who will provide necessary information and guidance for planning of the evaluation. UNFPA Sri Lanka will provide relevant documents and information for pre-reading.

**Schedule:**

- **Twenty Six days in the month of July 2007**
  1. Three days preparation time for evaluators at home location
  2. One day for planning and methodology development in Sri Lanka CO
  3. One day for meetings with UNFPA Sri Lanka staff
  4. Three days for meetings with UNFPA partner agencies and other stake holders
  5. Three days for collecting other relevant data and data triangulation
  6. Six days in the field for beneficiary meetings
  7. One day debriefing and a presentation to the UNFPA Sri Lanka office
  8. One days for preparation and presentation to key stakeholders
  9. One day for finalizing finding
  10. Six days for report writing

**8. Work plan**

- Finalization of the concept note and TOR: Completed
- Selection of evaluators: Completed
- Pre-mission preparation: 1st June – 1st July 2007
- Draft report: By 26th July 2007

**9. Procedures and Logistics**

UNFPA will provide logistical support and arrange meetings and field visits as and when requested by the team.

Evaluators will be expected to work 6 days a week.

Travel to field sites and security clearance will be arranged.

UNFPA also will make available office space, local translators, interviewers. However, evaluators are expected to bring their own laptops.

**10. Expected services and products to be delivered**

A final evaluation report written in English which has followed the tasks specified and thereby achieved the objectives outlined above.
An executive summary, providing a synopsis of the findings, together with the overall recommendations.

11. Payment
Standard UNFPA rates.

12. Background Documents for pre-reading
- Population and Reproductive Health Policy
- Adolescent Health Policy
- Women’s Charter and Plan of Action
- Country Program Documents and log frame (2008)
- Sub-programs and Projects
- Annual Reports
- Oversight Mission report (DOS 2006)
- RH Quality of Care Thematic Evaluation (2005)
- Adolescent Health Thematic Evaluation (2005)
- Well Women’s Clinic Evaluation (2004)
- CST Mission Reports
- RH In-school Education Project Evaluation (2005)
- Capacity Assessment of NGO Partners (2006)
- Multi-Year Funding Framework (2007)
- Reproductive Health Assessment (2007)
- Gender Assessment (2007)
- Adolescent Reproductive Health Assessment (2007)
- RHIYA project document
- RHIYA annual and project reports
- YFS project document
- YFS annual and project reports
- Tsunami project documents
- Tsunami project reports
Annex E.  PROFILES OF THE EVALUATION TEAM MEMBERS

Dr. Barbara Pillsbury (team leader) is a medical anthropologist specialized in program design, management, and evaluation with more than 25 years of experience internationally in reproductive and women’s health issues, especially family planning and HIV/AIDS. She has worked in all regions of the world, with both government and non-governmental organizations, including WHO, UNFPA, UNICEF, USAID, the World Bank, IPPF, and the Rockefeller, Hewlett, Ford, and Gates foundations. Dr. Pillsbury has worked with UNFPA in China, Uganda and New York. She wrote and produced for UNFPA ‘Reproductive Health and Women’s Empowerment: Links Throughout the Life Cycle’ (2000) and was a team member for the thematic evaluation, ‘Implementing the Reproductive Health Vision: Progress and Future Challenges for UNFPA’ (1999).

Dr. Palitha Abeykoon (serving as reproductive health specialist for the evaluation) is currently Advisor to the Ministry of Health and Senior Policy Advisor to the World Health Organization in Sri Lanka. He retired a few years ago from the WHO where he was the Director of Health Systems Development and Health Technology and served as the Regional Advisor in developing Human Resources for Health for South East Asia. Prior to joining WHO, he served as Senior Lecturer in Community Medicine and the Director of Medical Education in the Peradeniya Medical School. Dr. Abeykoon holds a medical degree, a Master of Public Health from Harvard University and a Master of Medical Education from University of California.

Professor Kalinga Tudor Silva (adolescent and youth specialist for the evaluation) serves as Professor of Sociology and Dean, Faculty of Arts, University of Peradeniya, Sri Lanka. He served as the Secretary of the Asia-Pacific Network of the International Forum for Social Sciences in Health (APNET) from 2000-2002 and as the Executive Director, the Centre for Poverty Analysis, Colombo, during 2002. In recent years he has held visiting appointments in University of London, University of Connecticut Health Centre, Bowdoin College, and University of Madras. He is the author of several publications on ASRH, including “Youth and sexual risk in Sri Lanka” (International Centre for Research on Women, Washington DC, 1999) and “Case Studies from Rhiya: Good Practices in Education and Communication” (EU/UNFPA, Paris, 2006).

Kumudini Samuel (gender specialist for the evaluation) is a Director at the Women and Media Collective in Colombo. She has worked on women’s rights, human rights and peace and conflict related issues since the 1980s and has been a founding member of several important Sri Lankan women’s coalitions and networks. She has written and researched on a range of women’s rights concerns, including reproductive health and rights of women affected by conflict in Sri Lanka. Ms. Samuel was appointed to the Sub-Committee on Gender Issues constituted to advise the plenary of the peace process in 2002 and is active internationally on women’s and peace issues, representing Sri Lanka in that global dialogue.
**Annex F. EVALUATION METHODOLOGY**

**Purpose and Audience/Users**

**Purpose.** UNFPA Sri Lanka has designed this evaluation of its 6th Country Programme and other projects (2002-2007) to draw out lessons learnt and make recommendations to be considered in developing the next (7th) Country Programme action plan. The evaluation was to highlight strengths, weaknesses and gaps, good practices, and provide forward-looking recommendations.

**Audience.** The principal audience and users for the evaluation are UNFPA: Sri Lanka country office (main intended user) and UNFPA Headquarters. As judged appropriate by the country office, findings may also be shared with other donors, the government of Sri Lanka, partner agencies and relevant stakeholders.

**Evaluation Methodology**

UNFPA Headquarters’ evaluation guidelines call for use of the OECD DAC evaluation criteria -- namely, assessment of relevance, effectiveness, efficiency, sustainability and impact. This evaluation has been designed around those criteria. Impact has not been included, however, as the country office was keenly aware that evaluation of impact would not be possible, primarily due to lack of baseline data.

The main objective of the evaluation is thus stated as “to assess the relevance, efficiency, effectiveness and sustainability of program interventions” as well as to identify program goals and strategies adopted and their effectiveness in contributing to the achievement of ICPD and MDG goals. Specific evaluation questions (28 total) were laid out in the Terms of Reference for the evaluation (see Annex C).

The evaluation took place from 2-28 July 2007 (see Annexes E and F), conducted by a team that combined Sri Lankan expertise with broad global experience (see Annex D). Conclusions and recommendations are based on:

- Extensive interviews with implementing partners and other stakeholders (22 interviews with 40+ persons) (see Annexes F and G);
- Field visits & interviews at project sites in 13 districts: Kurunegala, Galewela, Polonnaruwa, Kandala, Trincomalee, Kandy, Kadugannawa, Pussellawa, Nuwaraeliya, Maskeliya, Matara, Aluthgama, and Kalutara (see Annex F);
- Document review, including all project agreements and evaluations, relevant government policy and legislation, UNFPA and UN global documents, and others (see Annex H);
- Triangulation of findings: examination of data from the above three sources to arrive at conclusions.

**Structuring the inquiry (and report)**

The 28 evaluation questions in the Terms of Reference were grouped to organize inquiry under a smaller number of key questions (and also to form the structure of the report). From previous experience, members of the evaluation team knew that organising findings around the DAC evaluation criteria would be problematic, as inevitably most of the findings about the performance of the Country Programme would fall under the Effectiveness heading. Further, the DAC criteria would not easily allow the team to focus their reporting around...
UNFPA’s major programme areas. They thus judged it most appropriate to group the 28 evaluation questions under a somewhat smaller number of important topics, thus 19 topics (as follows) rather than 28 “independent” questions:

- Relevance – 5 topics
- Effectiveness – 8 topics
- Efficiency – 3 topics
- Sustainability – 3 topics

An advantage of this organization is that it enabled the report to summarize UNFPA achievements (or shortcomings) under UNFPA’s main programme areas: reproductive health, RH information and services for adolescents and youth, and gender.

The 19 topics – still adhering to the DAC criteria of relevance, effectiveness, efficiency, and sustainability – were laid out with the 28 evaluation questions from the TOR grouped under them, indicated by bullets.

**Constraints and Limitations**

Due to the seniority of the team members, previous commitments, and delayed air flights, the full team was only together for about two thirds of the time period of the evaluation. In addition, while the team agreed with the importance placed by the Country Office on making a formal presentation to stakeholders on findings of the evaluation, the time needed for preparation and presentation to stakeholders cut seriously into the short period the team had for draft this report. The use of the DAC structure and the fact that there were 28 questions to be answered presented an additional challenge (in contrast to a TOR, for example, with only 5 to 10 major questions). Among other consequences, it is for these reasons that not all 28 TOR questions are fully answered from the perspective of each of the three programme areas.
### Annex G. EVALUATION SCHEDULE & ITINERARY

#### Overview

<table>
<thead>
<tr>
<th>Dates</th>
<th>No. of days</th>
<th>Activity</th>
<th>Responsibility</th>
<th>Place/Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jun 25 – Jun 30</td>
<td>3</td>
<td>Pre-reading</td>
<td>UNFPA SL to send pre reading documents to consultants 3 weeks before evaluation starts</td>
<td>Evaluators to study documents in their home country</td>
</tr>
<tr>
<td>Monday Jul 2</td>
<td>½</td>
<td>Planning</td>
<td>Evaluation team and UNFPA management; Asela, Lankani to organize the meeting</td>
<td>UNFPA PO</td>
</tr>
<tr>
<td>Monday Jul 2</td>
<td>1½</td>
<td>Meetings with UNFPA staff</td>
<td>Appointments to be made in the planning meeting Staff members are to keep the dates free See attachment I</td>
<td>UNFPA PO</td>
</tr>
<tr>
<td>Wednesday Jul 4 - 6</td>
<td>3</td>
<td>Meetings with partners and stake-holders</td>
<td>Evaluators to select organizations and people Asela &amp; Lankani to organize meetings See attachment II for meeting schedule</td>
<td>Partners’ offices UNFPA PO</td>
</tr>
<tr>
<td>Saturday Jul 7</td>
<td>1</td>
<td>Gathering other relevant information &amp; documents</td>
<td>Asela &amp; Lankani to provide necessary logistical support</td>
<td>UNFPA</td>
</tr>
<tr>
<td>Sunday Jul 8</td>
<td>1</td>
<td></td>
<td>Free Day</td>
<td></td>
</tr>
<tr>
<td>Monday Jul 9 – Sat</td>
<td>5</td>
<td>Field visits</td>
<td>Evaluators to select organizations and people Asela &amp; Lankani to organize meetings (See attachment III for meeting schedule)</td>
<td>Places mentioned in the attachment</td>
</tr>
<tr>
<td>Saturday Jul 14</td>
<td>1</td>
<td>Gathering other relevant information and documents</td>
<td>Asela &amp; Lankani to provide necessary logistical support</td>
<td>UNFPA</td>
</tr>
<tr>
<td>Sunday Jul 15</td>
<td>1</td>
<td>Field visits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Monday Jul 16</td>
<td>1</td>
<td>Meetings with UNFPA staff and partners</td>
<td>Evaluators to select organizations and people See attachment III for meeting schedule</td>
<td>Places mentioned in the attachment</td>
</tr>
<tr>
<td>Tuesday Jul 17</td>
<td>1</td>
<td></td>
<td>Evaluators to select organizations and people</td>
<td>UNFPA PO &amp; CO</td>
</tr>
<tr>
<td>Dates</td>
<td>No. of days</td>
<td>Activity</td>
<td>Responsibility</td>
<td>Place/Remarks</td>
</tr>
<tr>
<td>Thurs. Jul 18, 19</td>
<td>1</td>
<td>Finalizing findings</td>
<td>Evaluators</td>
<td>UNFPA PO</td>
</tr>
<tr>
<td>Friday Jul 20</td>
<td>1</td>
<td>Discussion with UNFPA staff</td>
<td>Evaluators to prepare the presentation in the morning and debrief in the afternoon</td>
<td>UN conference room</td>
</tr>
</tbody>
</table>

#### RAET23 Aug.

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Staff member</th>
<th>Key area</th>
<th>Place/Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Saturday Jul 21</td>
<td>2</td>
<td>Report writing</td>
<td>Evaluators</td>
<td>UNFPA PO</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Preparation of statement to stake-holders</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sunday Jul 22</td>
<td>1</td>
<td>Free Day</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Monday Jul 23</td>
<td>1</td>
<td>Presentation to stake-holders</td>
<td>Evaluators - Secretary - Organizing the meeting, venue and invitations</td>
<td>Cinnamon Grand Hotel (Tentative)</td>
</tr>
<tr>
<td>Tuesday Jul 24 - Friday Jul 27</td>
<td>4</td>
<td>Report writing</td>
<td>Evaluators</td>
<td>UNFPA PO</td>
</tr>
<tr>
<td>Saturday Jul 28</td>
<td></td>
<td>Submission of draft report</td>
<td>Evaluators</td>
<td>UNFPA Rep.’s office</td>
</tr>
<tr>
<td>Friday Aug 10</td>
<td></td>
<td>Submission of UNFPA comments</td>
<td>UNFPA management</td>
<td>To team leader with copies to members</td>
</tr>
<tr>
<td>Friday Aug 17</td>
<td></td>
<td>Submission of final report</td>
<td>Evaluators</td>
<td>Via Email to UNFPA Rep.</td>
</tr>
<tr>
<td>By Aug 31st</td>
<td></td>
<td>Dissemination of final evaluation report to stakeholders</td>
<td>Asela and Lankani</td>
<td>UNFPA, all stakeholders</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Total days for evaluators</td>
<td>26</td>
</tr>
</tbody>
</table>

**Evaluation schedule – Attachment I**

**Meetings with UNFPA staff members**

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Staff member</th>
<th>Key area</th>
<th>Place/Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monday Jul 2</td>
<td>2.00-4.00</td>
<td>Lubna</td>
<td>Overall</td>
<td>Rep’s office</td>
</tr>
<tr>
<td></td>
<td>4.00-5.30</td>
<td>Malathie</td>
<td>Overall (specific attention to advocacy, BCC)</td>
<td>AR’s office</td>
</tr>
<tr>
<td>Tuesday Jul 3</td>
<td>9.00-11.30</td>
<td>Chandani</td>
<td>NPO (RH)</td>
<td>PO</td>
</tr>
<tr>
<td></td>
<td>11.30-12.30</td>
<td>Navani</td>
<td>Former NPPP</td>
<td>PO</td>
</tr>
<tr>
<td></td>
<td>12.30-1.30</td>
<td>LUNCH</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1.30-3.30</td>
<td>Rizvina</td>
<td>Program coordinator (Gender) Bimali-GBV Forum Facilitator</td>
<td>PO</td>
</tr>
<tr>
<td></td>
<td>3.30-5.00</td>
<td>Jayan</td>
<td>Program Coordinator (Psychosocial) Gameela Project Advisor (Psychosocial)</td>
<td>PO</td>
</tr>
<tr>
<td></td>
<td>5.00-6.00</td>
<td>Malathi</td>
<td></td>
<td>PO</td>
</tr>
<tr>
<td>Tuesday Jul 17</td>
<td>8.45-10.00</td>
<td>Priyan Finance &amp; Admin Officer</td>
<td>Finance, Admin</td>
<td>CO</td>
</tr>
<tr>
<td>10.00-12.00</td>
<td>Rizvina Program coordinator (Gender) Bimali GBV Forum Facilitator (Kum)</td>
<td>Gender, GBV</td>
<td>CO</td>
<td></td>
</tr>
</tbody>
</table>

...Continued
### Evaluation schedule – Attachment II

**Meetings with partners and stakeholders**

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Person/s to be met</th>
<th>Organization</th>
<th>Place/Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wednesday</td>
<td>9.00-10.00am</td>
<td>Dr Kanthi Anyarathne Deputy Director</td>
<td>HEB</td>
<td>UNFPA PO</td>
</tr>
<tr>
<td>July 4</td>
<td>10.30-11.30am</td>
<td>Mr. Agostino Borra</td>
<td>WHO</td>
<td>WHO</td>
</tr>
<tr>
<td></td>
<td>12.30-1.30pm</td>
<td>Directors</td>
<td></td>
<td>UNFPA PO</td>
</tr>
<tr>
<td></td>
<td>1.30-2.00</td>
<td>LUNCH</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2.00-3.00</td>
<td>Ms JoAnna Van Gerpen, UNICEF REP</td>
<td>UNICEF</td>
<td>UNICEF</td>
</tr>
<tr>
<td></td>
<td>3.15-4.30pm</td>
<td>Dr. V. Karunarathne Director</td>
<td>FHB</td>
<td>FHB</td>
</tr>
<tr>
<td>Thursday</td>
<td>9.30-10.00am</td>
<td>Ms Indrani Sugathadasa Secretary</td>
<td>Ministry of Women’s Empowerment</td>
<td>Ministry</td>
</tr>
<tr>
<td>Jul 5</td>
<td>10-10.30am</td>
<td>Ms Namanie Gunasekera Director</td>
<td>Women’s Bureau</td>
<td>Ministry</td>
</tr>
<tr>
<td></td>
<td>10.30-11.30am</td>
<td>Ms S Sumanasekera Chairperson</td>
<td>NCW</td>
<td>Ministry of WE</td>
</tr>
<tr>
<td></td>
<td>12.30-1.30pm</td>
<td>Dr Ajith Mendis DG</td>
<td>Ministry of Healthcare</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td></td>
<td>1.30-2.30</td>
<td>LUNCH</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2.45-4.00</td>
<td>Dr Y. Anyaratne, Director</td>
<td>NCCP PD</td>
<td>UNFPA PO</td>
</tr>
<tr>
<td></td>
<td>*3.15-5.30</td>
<td>Mr. G. Wanasekera, ED</td>
<td>FPA</td>
<td>UNFPA PO</td>
</tr>
<tr>
<td>Friday</td>
<td>9.00-11.00am</td>
<td>Prof. J. Wickramaratchige, DG, Project</td>
<td>NIE</td>
<td>NIE</td>
</tr>
<tr>
<td>Jul 6</td>
<td>11.45-12.15</td>
<td>Dr Nimal Edirisinghe, Director</td>
<td>NSACP</td>
<td>NSACP</td>
</tr>
<tr>
<td></td>
<td>12.30-1.30pm</td>
<td>Mr Douglas Nanayakkara Director</td>
<td>NGO Secretariat</td>
<td>UNFPA PO</td>
</tr>
<tr>
<td></td>
<td>1.30-2.30</td>
<td>LUNCH</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2.45-4.00</td>
<td>Mr A. Nanayakkara</td>
<td>ED PSL</td>
<td>UNFPA PO</td>
</tr>
<tr>
<td>Tuesday</td>
<td>9.30-10.30</td>
<td>Dr Kahandaliyanage Secretary –MoH</td>
<td>MoH</td>
<td>MoH</td>
</tr>
<tr>
<td>Jul 17</td>
<td>10.30-11.30am</td>
<td>Dr S.M. Samarage DDG (Planning)</td>
<td>MoH</td>
<td>MoH</td>
</tr>
<tr>
<td></td>
<td>11.30-12.30</td>
<td>Dr, Dula de Silva DDG (Public Health)</td>
<td>MoH</td>
<td>MoH</td>
</tr>
<tr>
<td></td>
<td>12.00-1.00</td>
<td>LUNCH</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1.30-2.30</td>
<td>David Bridger</td>
<td>UNAIDS</td>
<td>UNAIDS</td>
</tr>
<tr>
<td></td>
<td>2.45-4.00</td>
<td>V. Anyaratne Executive Director</td>
<td>Sarvodaya</td>
<td>UNFPA PO</td>
</tr>
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</table>

### Evaluation schedule – Attachment III

**Field visits**

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Person/s to be met</th>
<th>Organisation</th>
<th>Place/Remarks</th>
</tr>
</thead>
</table>

---

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Activity</th>
<th>Location</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monday, Jul 9</td>
<td>5:30 am</td>
<td>Leaving to Kurunegala/Galewela</td>
<td></td>
<td>Night stay in Kurunegala</td>
</tr>
<tr>
<td>Monday, Jul 9</td>
<td>8:30</td>
<td>Meeting with the District Secretary – Kurunegala and Project staff (Palitha, Kumi)</td>
<td></td>
<td>Kachcheri/Advocacy for RH &amp; gender project</td>
</tr>
<tr>
<td>Monday, Jul 9</td>
<td>9:30</td>
<td>Meeting with zonal education officials, teachers, counselors and students (Barbara, Tudor)</td>
<td>NIE</td>
<td>In a school in Galewela</td>
</tr>
<tr>
<td>Monday, Jul 9</td>
<td>10:30</td>
<td>Leaving to Polonnaruwa from Kurunegala</td>
<td></td>
<td>3 hours drive</td>
</tr>
<tr>
<td>Monday, Jul 9</td>
<td>11:30</td>
<td>Leaving to Polonnaruwa from Galewela</td>
<td></td>
<td>LUNCH on the way</td>
</tr>
<tr>
<td>Monday, Jul 9</td>
<td>2:00</td>
<td>Meeting with DPDHS, MOMCH, Planning Officer and staff</td>
<td>MoH</td>
<td>DPDHS Office, Polonnaruwa</td>
</tr>
<tr>
<td>Monday, Jul 9</td>
<td>3:00</td>
<td>Visit STD clinic - Polonnaruwa</td>
<td>MoH</td>
<td>STD Clinic, Polonnaruwa</td>
</tr>
<tr>
<td>Monday, Jul 9</td>
<td>5:00</td>
<td>Leaving to Habarana</td>
<td></td>
<td>Night stay in Habarana</td>
</tr>
<tr>
<td>Tuesday, Jul 10</td>
<td>7:00</td>
<td>Leaving to Trincomalee</td>
<td></td>
<td>2 hours drive</td>
</tr>
<tr>
<td>Tuesday, Jul 10</td>
<td>8:30</td>
<td>Meet Trincomalee DPDHS at the Kantale MOH Office</td>
<td>MoH</td>
<td>Kantale</td>
</tr>
<tr>
<td>Tuesday, Jul 10</td>
<td>9:30</td>
<td>Visit FP clinic/primary health care clinic</td>
<td>MoH</td>
<td>Kantale</td>
</tr>
<tr>
<td>Tuesday, Jul 10</td>
<td>11:30</td>
<td>Meeting with PSL, MOH – Muttur and DPDHS – Trincomalee</td>
<td>MoH, PSL</td>
<td>DPDHS Office Trincomalee</td>
</tr>
<tr>
<td>Tuesday, Jul 10</td>
<td>12:30 – 3:00</td>
<td>Meeting with Secretary of the Ministry of Health – Northern Provincial Council - POHS - North, POHS - East, DPDHSs from Trincomalee, Vavuniya, Mannar, Kilinochchi, Mullaitivu</td>
<td>MoH</td>
<td>Welcome Hotel Trincomalee</td>
</tr>
<tr>
<td>Tuesday, Jul 10</td>
<td>2:30</td>
<td>Meeting with front-line workers trained by NCW (Barbara, Kumi)</td>
<td>NCW</td>
<td>Kachcheri, Trincomalee</td>
</tr>
<tr>
<td>Tuesday, Jul 10</td>
<td>4:30</td>
<td>Leaving to Habarana/night location</td>
<td></td>
<td>2 hours drive</td>
</tr>
<tr>
<td>Wednesday, Jul 11</td>
<td>10:00</td>
<td>Leaving to Kandy</td>
<td></td>
<td>Night stay in Habarana</td>
</tr>
<tr>
<td>Wednesday, Jul 11</td>
<td>1:30</td>
<td>Visit YFS center – Kandy SLAVSC (RHIYA partner, YFS partner, PO2 partner)</td>
<td>SLAVSC</td>
<td>SLAVSC Office</td>
</tr>
<tr>
<td>Wednesday, Jul 11</td>
<td>5:00</td>
<td>Leaving to night location</td>
<td></td>
<td>Night stay in Kandy</td>
</tr>
<tr>
<td>Thursday, Jul 12</td>
<td>8:30</td>
<td>Visit STD Clinic - Kandy</td>
<td>MoH</td>
<td>General Hospital, Kandy</td>
</tr>
<tr>
<td>Thursday, Jul 12</td>
<td>10:00</td>
<td>Leaving to Kadugannawa</td>
<td>MoH</td>
<td>Regional Training Center</td>
</tr>
<tr>
<td>Thursday, Jul 12</td>
<td>12:00</td>
<td>Leaving to Pusselawwa</td>
<td>MoH</td>
<td>NYC</td>
</tr>
<tr>
<td>Thursday, Jul 12</td>
<td>2:00</td>
<td>Meeting with CDA (RHIYA partner)</td>
<td>CDA</td>
<td>CDA Office and field</td>
</tr>
<tr>
<td>Thursday, Jul 12</td>
<td>4:00</td>
<td>Leaving to Nuwara Eliya</td>
<td></td>
<td>Night stay in Nuwara Eliya</td>
</tr>
<tr>
<td>Friday, Jul 13</td>
<td>8:00</td>
<td>Leaving to Hatton</td>
<td></td>
<td>Night stay in Nuwara Eliya</td>
</tr>
<tr>
<td>Friday, Jul 13</td>
<td>9:30</td>
<td>Visit a FP clinic, estates and health facilities in Maskeliya (Barbara and Maskeliya)</td>
<td>MoH</td>
<td>Maskeliya</td>
</tr>
<tr>
<td>Time</td>
<td>Activity</td>
<td>Location</td>
<td>Team</td>
<td></td>
</tr>
<tr>
<td>--------</td>
<td>--------------------------------------------------------------------------</td>
<td>---------------------------</td>
<td>-------</td>
<td></td>
</tr>
<tr>
<td>9:30</td>
<td>Meeting with zonal education officials, teachers, counselors and students (Tudor)</td>
<td>NIE Maskeliya</td>
<td>Team 1</td>
<td></td>
</tr>
<tr>
<td>12:30</td>
<td>LUNCH</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1:00</td>
<td>Meeting with DPDHS, district health team including MOMCH, PHDT</td>
<td>MoH Office Maskeliya</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4:30</td>
<td>Leaving to Colombo/ Hotel</td>
<td>Maskeliya</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>3.5 hours drive via Ginigathhena route</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sunday</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2:00</td>
<td>Leaving to Matara</td>
<td></td>
<td>Team 1</td>
<td></td>
</tr>
<tr>
<td>12:30</td>
<td>LUNCH</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1:00</td>
<td>Meeting with DPDHS, district health team including MOMCH, PHDT</td>
<td>MoH Office Maskeliya</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4:30</td>
<td>Leaving to Colombo/ Hotel</td>
<td>Maskeliya</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>3 hours drive to Galle; Night stay in Galle</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Monday</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7:30</td>
<td>Leaving to Matara</td>
<td></td>
<td>Team 2</td>
<td></td>
</tr>
<tr>
<td>8:30-9:30</td>
<td>Meeting with NCW district coordinator</td>
<td>NCW Kachcheri – Matara</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9:30-11:30</td>
<td>Visit to Matara hospital GBV center Meeting with center staff</td>
<td>MoH District General Hospital Matara</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Visit women’s centers in Matara Meeting with center managers and women’s centers district coordinator WIN Polhena, Malimbada</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2:30-4:30</td>
<td>YFS center - Aluthgama Meet NIHS director and her staff at the YFS center</td>
<td>MoH 2.5 hours drive from Matara LUNCH on way</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4:30</td>
<td>Leaving to Colombo/ Hotel</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Evaluation team will be accompanied by Asela & Lankani from 8th – 13th Asela & Lankani from 15th – 16th

**Team 1:**
1. Barbara
2. Tudor
3. Asela
4. Mansoor (Translator)
5. Herath (Driver)

**Team 2:**
1. Palitha
2. Kumi
3. Lankani
4. Gamini (Driver)
Annex H. MAJOR CONTACTS /PERSONS INTERVIEWED

### UNFPA staff

<table>
<thead>
<tr>
<th>Name</th>
<th>Designation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ms. Lubna Bazi</td>
<td>UNFPA Country Representative</td>
</tr>
<tr>
<td>Ms. Malathi Weerasinghe</td>
<td>Assistant Country Representative</td>
</tr>
<tr>
<td>Dr. Chandani Gayewicka</td>
<td>National Program Officer – RH</td>
</tr>
<tr>
<td>Ms. Rizvina De Alwis</td>
<td>Program Coordinator – Gender</td>
</tr>
<tr>
<td>Mr. Jayan Abeywickrama</td>
<td>Program Coordinator – Psychosocial</td>
</tr>
<tr>
<td>Dr. Ganeela Samarasinghe</td>
<td>Project Advisor – Psychosocial</td>
</tr>
<tr>
<td>Mr. Anula Kalulamusinga</td>
<td>Monitoring and Evaluation Officer</td>
</tr>
<tr>
<td>Ms. Bimal Almarasekara</td>
<td>GSV Forum Facilitator</td>
</tr>
<tr>
<td>Mr. Priyan Perera</td>
<td>Finance and Admin Officer</td>
</tr>
<tr>
<td>Ms. Lankani Sikurajapathy</td>
<td>Program Assistant</td>
</tr>
</tbody>
</table>

### Stateholders/Partners: Other UN Agencies

<table>
<thead>
<tr>
<th>Name</th>
<th>Designation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr. Agostino Borra</td>
<td>WHO representative</td>
</tr>
<tr>
<td>Dr. Aberra Bekie</td>
<td>UNICEF, Chief of Health &amp; Nutrition</td>
</tr>
<tr>
<td>Dr. Sapumal Dhanapala</td>
<td>Asst. Project Officer, Maternal and Child Health</td>
</tr>
<tr>
<td>Mr. David Bridger</td>
<td>UNAIDS, Country Representative</td>
</tr>
</tbody>
</table>

### Stateholders/Partners: Government, Colombo

<table>
<thead>
<tr>
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<tr>
<td>Dr. Asha Mendis</td>
<td>Ministry of Healthcare &amp; Nutrition, Dir. General</td>
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<tr>
<td>Dr. Anula Kothalawansa</td>
<td>Secretary, MoH</td>
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<tr>
<td>Dr. Vinesha Karunarathne</td>
<td>Director, Family Health Bureau, MoH</td>
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<tr>
<td>Dr. Sarath Samarasinghe</td>
<td>DDG (Planning), MoH</td>
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<tr>
<td>Dr. Dula de Silva</td>
<td>DDG (Public Health), MoH</td>
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<tr>
<td>Dr. Karitha Anurathne</td>
<td>Director, Health Education Bureau, MoH</td>
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<tr>
<td>Dr. Nimal Edirisinghe</td>
<td>HSACP, Director</td>
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<tr>
<td>Dr. Y. Anurathne</td>
<td>National Cancer Control Program, Director</td>
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<tr>
<td>Ms. Indrani Sugathadasa</td>
<td>Min of Child &amp; Women’s Empower, Secretary</td>
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<tr>
<td>Ms. Namie Gunasekara</td>
<td>Women’s Bureau, Director</td>
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<tr>
<td>Ms. S Sumanasekera</td>
<td>National Committee on Women, Chairperson</td>
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<tr>
<td>Prof. J. Wickramasinghe</td>
<td>NIE, Director General</td>
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<tr>
<td>Mr. Nawaratnam</td>
<td>Project Director</td>
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<tr>
<td>Mr. Abdulla Wahid</td>
<td>Former Project Director</td>
</tr>
<tr>
<td>Dr. Lalitha Batabawdees</td>
<td>Former Project Director (after Mr Wahid)</td>
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<tr>
<td>Mr. N.G. Kulatnane</td>
<td>Min of Labour Relations &amp; Manpower, Nat’l Inst.</td>
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<tr>
<td>Prof. M.T.M. Jiffrey</td>
<td>University Grants Commission, Member</td>
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<tr>
<td>Directors</td>
<td>Army, NYSC</td>
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### Stateholders/Partners: NGO

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<th>Name</th>
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<tr>
<td>Mr. Gamini Wanascker</td>
<td>Family Planning Assn, Executive Director</td>
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<tr>
<td>Mr. Atula Nanayakkara</td>
<td>Population Services Lanka, Executive Director</td>
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<tr>
<td>Mr. Sun Brassiyakumudy</td>
<td>Project Director, Population Services Lanka</td>
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<tr>
<td>Dr. Manil Fernando</td>
<td>Plantation Human Development Trust, Head</td>
</tr>
<tr>
<td>Dr. Vinya Anurathne</td>
<td>Sarvodaya, Executive Director</td>
</tr>
<tr>
<td>Ms. Vimala Nanayakkara</td>
<td>Sarvodaya Women’s Centre, Project Director,</td>
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### FIELD VISIT, 9-16 JULY 2007:

**Kurunegala District Secretariat - 9th July 2007**

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Mr. J. C. T Bulumulla
District Secretary Kurunegala

Ms. Sugani Peethawadu
Project Coordinator Kurunegala

Ms. Pradeepa Jayasinghe
Women's Development Officer, Divisional Secretary Division (DS) Weerambudugala

Ms. Niluka Saneeewani
WDO – DS – Kurunegala East

Ms. Nadeema Galakkadawila
WDO – DS – Ehetuwewa

Mr. Sagara Herath
Social Service Assistant DS - Ehetuwewa

Mr. Wasantha Rodrigo
Social Service Assistant DS Maho

Ms. Thushari Padmakanthi
Volunteer DS – Weerambudugala

Gallewala CP/GL/ Pattiwela Junior School – 9th July

Mr. U.C. Ranathunga
Principal

Mr. Tudor has this name
Counselor

CP/GL/ Makulugaswewa M.V. School – 9th July

Ms. A.P.G. Vineetha
Principal

Mr. H.G. Dayaratoa
Public Health Inspector

Mr. Tudor has this name
Counselor

Kantale MOH - 10th July 2007

Dr. Erandi Weerasekera
Assistant Medical Officer of Health, Kantale

Dr. E.A.C. Edirisinghe
Assistant Medical Officer of Health, Kantale

Mr. B. H. Jayantha
Public Health Inspector, Kantale

Ms. D. G. Somawathie
Public Health Nursing Sister, Kantale

Vendrasanpura Primary Health Centre - 10th July 2007

Ms. W. A. Nandewathie
Public Health Midwife, Vendrasanpura

Ms. G. K.C. Neelangani
Public Health Midwife, unit 2-3

Ms. G. K.C. Neelangani
Public Health Midwife, unit 4

DSDHS Office Trincomalee - 10th July 2007

Dr. G. Ganagunalan
Deputy Provincial Director of Health Services (DPDHS) Trincomalee

Dr. S. Thevarajan
Provincial Director of Health Services (PDHS) Eastern Province

Dr. S. Arulkumaran
Medical Officer/Planning Trincomalee

Mr. Suriyamurthy
Project Manager Population Services Lanka

Trincomalee: Luncheon Meeting with Provincial Directors of Health Services (PDHSs) and DPDHSs, Northern and Eastern Provinces – 10th July 2007

Dr. Komaravetpillai
Secretary Health Northern Province

Dr. W. Nandakumar
PDHS, Northern Province

Dr. K. Aravinda
Acting, DPDHS, Mannar

Dr. M. Mahendran
DPDHS, Vavuniya

Dr. T. Sathiyamoorthy
DPDHS, Kandy

Dr. S. Thavarajan
PDHS, Eastern Province

Dr. G. Ganagunalan
DPDHS, Trincomalee

Dr. S. Arulkumaran
Medical Officer/Planning Trincomalee

Trincomalee: Frontline Workers – 10th July 2007

Dr. Adikari
Executive Director

Sri Lanka Association for Voluntary Surgical Contraception and Family Health (SLAVSC), Kandy – 11th July 2007

Dr. Adikari
Executive Director
<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
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<tr>
<td>Mr. Ashoka Ekanayake</td>
<td>Manager (Finance)</td>
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<tr>
<td>Mr. Justin Jayasuriya</td>
<td>Programme Officer</td>
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<tr>
<td><strong>STD Clinic Kandy General Hospital - 12th July 2007</strong></td>
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<tr>
<td>Dr. Ganga Pathirana</td>
<td>Medical Officer (MO) STD</td>
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<td><strong>Regional Training Centre, Kadugannawa - 12th July 2007</strong></td>
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<tr>
<td>Dr. Aruna Rajapakse</td>
<td>Medical Officer of Health (MOH) Yatinuwara</td>
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<tr>
<td>Mr. B.S. Baskaran</td>
<td>Project Coordinator</td>
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<td>Mr. Roshan Perera</td>
<td>Project Coordinator</td>
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<tr>
<td>Dr. R. B. Ekanayake</td>
<td>MO Training</td>
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<tr>
<td>Ms. M. A. A. Nissanka</td>
<td>Nursing Tutor</td>
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<td>Ms. M. C. Moragasanwadda</td>
<td>Nursing Tutor</td>
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<td>Ms. T. P. P. Hamyakanthi</td>
<td>Nursing Tutor</td>
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<tr>
<td>Mr. W. Wasantha Dhamasena</td>
<td>Planning and Programme Officer</td>
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<td><strong>Centre for Development Alternatives (CDA), Melfort Estate (RHIYA Partner) - 12th July 2007</strong></td>
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<tr>
<td>Ms. Kanthi Jayawardene</td>
<td>Estate Medical Assistant</td>
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<tr>
<td>Mr. Ramesh Nagendren</td>
<td>Project Manager CDA</td>
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<td>Mr. Ravi Chandran</td>
<td>Project Coordinator CDA</td>
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<tr>
<td>Mr. Gayan Kithari</td>
<td>Peer Educator</td>
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<td>Mr. Roshan Dharmadasa</td>
<td>Peer Educator</td>
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<td>Mr. Shivaraj</td>
<td>Peer Educator</td>
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<td>Ms. Chandra Devi</td>
<td>Peer Educator</td>
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<td>Ms. Kalchavei</td>
<td>Peer Educator</td>
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<tr>
<td><strong>Joseph Tamil Maha Vidyalaya School - 13th July 2007</strong></td>
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<tr>
<td>Mr. T. Salchirananadan</td>
<td>School Principal</td>
<td></td>
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<tr>
<td>Ms. Jevarani</td>
<td>Teacher – RH Counselling</td>
<td></td>
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<tr>
<td>Ms. S. Udayarani</td>
<td>School Teacher</td>
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<tr>
<td>Mr. P. Logeswaran</td>
<td>Teacher - in charge of discipline</td>
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<tr>
<td>Ms. Subanthali</td>
<td>Peer Counselor</td>
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<td>Ms. Pavithra</td>
<td>Peer Counselor</td>
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<td>Mr. M. Robinson</td>
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<td>Mr. N. Mohanageeva</td>
<td>Peer Counselor</td>
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<tr>
<td><strong>DPDHS Office, Nuwara Eliya - 13th July 2007</strong></td>
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<tr>
<td>Dr. Nihal Weerasooriya</td>
<td>DPDHS Nuwara Eliya</td>
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<tr>
<td>Dr. Thilina Wijeythunga</td>
<td>Medical Officer, Maternal &amp; Child Health</td>
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<tr>
<td>Mr. B. V. D. Lasanga</td>
<td>Planning and Programme Officer</td>
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<td><strong>Matara Kacheria - 16th July 2007</strong></td>
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<tr>
<td>Mr. J. Pathirana</td>
<td>Director Planning</td>
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<td>Ms. Dhammika</td>
<td>Assistant Director Planning</td>
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<tr>
<td>Ms. M. L. Maleka</td>
<td>Development Officer</td>
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<td><strong>GBV Centre, Matara General Hospital - 16th July 2007</strong></td>
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<tr>
<td>Dr. D.C.W. Wadanaambe</td>
<td>Doctor Health Education</td>
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<tr>
<td>Dr. E.W. Palitha</td>
<td>MO/GBV Centre Coordinator</td>
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<tr>
<td>Ms. P. Amarasinghe</td>
<td>Nursing Officer</td>
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<td>Ms. K. Hettirachchi</td>
<td>Nursing Officer</td>
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<td>Ms. K. C. R. Premodathra</td>
<td>Nursing Officer</td>
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<td>Ms. W. A. Indrani</td>
<td>Nursing Officer</td>
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<td>Ms. K. S. T. Malani</td>
<td>Nursing Officer</td>
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<td><strong>Polhena Women’s Centre, project of Women in Need (WIN) - 16th July 2007</strong></td>
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<tr>
<td>Ms. K. H. Shanthalatha and Ms.</td>
<td>Centre Managers</td>
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</table>
Ms. E. A. E. Chandrakanthi | Women's Centre Coordinator Matara District
---|---
Ms. A. M. Makawila | WIN Head Officer Women's Centre Coordinator

**Malimba Women's Centre - project of Women in Need (WIN) - 16th July 2007**

| Ms. Priyanka Munasinghe | Centre Manager
---|---

| Ms. B. L. Buddhika | Centre Manager
---|---

**NIHS; and YFS, Aruthgama - 16th July 2007**

| Dr. Ms. | NIHS, Director of YFS Centre Managers (3)
---|---
| Dr. (Ms.) Shiromali Pissanayake | NIHS/MOH Doctor serving the Centre
| Dr. (Mr.) | NIHS/MOH Doctor serving the Centre

**Other:**

| Dr. Priamilla Senanayake | Global Forum for Health Research, Chairperson
---|---
| Prof Swarna Jayaweera | Centre for Women’s Research Sri Lanka
Annex I. PRINCIPAL DOCUMENTS REVIEWED

UNFPA Documents

Executive Board of the United Nations Development Programme and of the United Nations Population Fund

Minutes of the Annual Programme Review Meeting of the UNFPA Supported Country Programme and Projects
2007  Colombo, 27 April.

2006  Colombo, October.

2007  Colombo, January.

United Nations Population Fund, Executive Board

United Nations Population Fund
2006  Case studies from UNFPA & partners (©)

Other programme documents

UNFPA Project Agreements:

Agreement Between the Government of Sri Lanka and The United Nations Population Fund


Project Document Between the Government of Sri Lanka and The United Nations Population Fund


2001  Reproductive Health Information and Services with Focus on Out of School Adolescents and Youth through Non Governmental Organizations. (PO2). November.


European Commission and UNFPA, EU/UNFPA Repro H Initiative for Asia, Phase II.

Evaluations and Reviews:


Chitramalee de Silva et al. 2004 Review of the Well Women’s Clinic Programme. April.


Other evaluation reports

Sri Lanka, Government Documents:

Policy and planning documents:


Ministry of Women’s Affairs, National Committee on Women 1993 Women’s Charter (Sri Lanka).


• Adolescent Health Policy
• Population and Reproductive Health Policy

Project Reports:

Ministry of Social Service and Social Welfare

Other
New South Global International Projects and National Centre in HIV Social Research, University of New South Wales.

RHIYA Project
2006  Island of Change (Reproductive Health Initiative for Asia). New Delhi, IPPF South Asia Program Office (with EU and UNFPA).
2006  We’ve Got a Right to Know: Good Practices in Education & Communication. EU/UNFPA Reproductive Health Initiative for Asia. Brussels: UNFPA RHIYA Central Unit.

Silva, K.T. et al.

UNICEF

World Health Organization, Country Office for Sri Lanka
UNFPA’s Multi-Year Funding Framework 2004 – 2007 is the UNFPA’s global medium-term strategic plan. Its aim has been to strengthen the Fund’s contribution to implementation of the ICPD Programme of Action, in the context of poverty reduction. A goal of the MYFF is to ensure that “all couples and individuals enjoy good reproductive health, including family planning and sexual health, throughout life”. In line with this, UNFPA was to contribute to meeting existing and emerging RH challenges. The MYFF takes cognizance of the most relevant niches for UNFPA and the newer issues that have emerged which UNFPA is best placed to address.

UNFPA recognizes that, to advance the ICPD agenda, it must forge a common understanding of RH and rights and promote their application in different cultural settings. UNFPA would move from simply implementing projects to a greater leadership and more proactive role in national policy development. Instead of merely attempting to improve RH of the most disadvantaged groups through time-limited projects and funding, UNFPA was to put emphasis on a broader resource base for these outcomes. This requires that UNFPA addresses underlying barriers that limit equity and equality, including gender discrimination.

In RH under the MYFF, UNFPA is to:
- emphasize women’s control of their reproductive decisions,
- increase access to services and female-controlled methods,
- promote greater male participation,
- put emphasis on adolescents and youth with regard to preventing HIV and early pregnancies,
- promote various preventive interventions in STIs and HIV,
- help strengthen family planning to avoid unintended and unplanned pregnancy,
- ensure trained attendance at delivery,
- make available emergency obstetric care to further reduce maternal mortality and morbidity, and
- work with relevant agencies to ensure the integration of RH, including sexual health and rights, into emergency preparedness and relief operations.

Results and indicators. The MYFF promotes results-based management but recognizes that mainstreaming this could take some time. The challenge is to ensure that UNFPA resources are fully aligned toward reaching the MYFF and ICPD goals while responding to national priorities.

Under the MMFF, UNFPA is to use appropriate goal-level indicators to capture the progress and results of these comprehensive RH investments. Two of the key indicators were to be MMR and HIV prevalence among 15-24 year-old pregnant women. UNFPA will also use the under-5 mortality rate which reflects the IMR, the socio-economic environment and gender bias. Unmet need for FP will reflect UNFPA’s work in reproductive commodity security and support for women’s RH choices.

Annex K: PROFILE OF ADOLESCENTS AND YOUTH IN SRI LANKA

Adolescents and youth (10-24 age group) comprised 28.1% of Sri Lanka’s population in 2001 (Population Census 2001; De Silva, Somanathan and Eriyagma 2003). This age cohort reached a peak of 5.3 million in 2001 compared to 4.8 million in 1981, but is expected to contract in the years ahead due to the demographic transition currently taking place in the country. A bulk of the young population is undergoing education in the country’s widespread education system. School enrollment ratios are high (92.1% of males and 93.4 of females) in the 10-14 age group, but decline to 51.2% of males and 54.8% of females in the 15-19 age group and 3.6% of both males and females in the 20-24 age group (Department of Census, 2001). The category, out-of-school youth, includes employed (the garment industry and security forces being the largest employers of young females and males respectively), vocational trainees and unemployed. There has been a sharp rise in the age at marriage among both males (mean age at marriage 28.3) and females (mean age at marriage 24.6) as a combined effect of educational processes, demographic change, changing youth aspirations and high levels of unemployment among educated youth in particular.

Both males and females are customarily expected to abstain from sex until marriage, with a more rigid code that includes requiring new brides to prove virginity at marriage (including the tradition of checking the blood-stained cloth or sheet). Customary taboos on pre-marital sex, however, have encountered severe challenges in recent years due to the rising age at marriage and increased gap between menarche and marriage, social change, mobility of youth (including displacement due to war and tsunami), weakening of parental supervision as young people increasingly go out for education, work and social events, impacts of global electronic and printed media, and increased acceptance, popularity and glorification of courtship and premarital love in the emerging youth culture (Basnayake 1986, 1988, Silva et al. 1997).

In a national survey of adolescents aged 14 to 19 (school-going and out-of-school) conducted by UNICEF in 2004, 15% of school children and 36% out-of-school adolescents admitted having a love affair with a member of the opposite sex at the time of the survey (UNICEF 2004). Among school-going adolescents, 6.1% had experienced heterosexual intercourse. This ranged from 2.2% for girls and 13.9% for boys. The mean age of sexual debut was reported to be 15.3 years for boys and 14.4 for girls. While 43% had their sexual debut with lovers, some 11% of those reporting heterosexual intercourse had their first sexual experience with a commercial sex worker. In the school-going sample, 10.2% (18.2% of boys and 3.6% girls) had experienced a homosexual relation. In the out-of-school sample 22% (28% boys and 17% girls) had experienced heterosexual intercourse. More than half the heterosexual partners were lovers, while 12% reported that their sex partners were commercial sex workers. As regards homosexual experiences, 9% of out of school adolescents (13% boys and 6% girls) reported such experiences. These data indicate that adolescents may be increasingly becoming sexual active in spite of the continued stress on preserving female virginity until marriage.

In a research project titled “Youth and Sexual Risk in Sri Lanka”, Silva et al (1997) examined the sexual behaviours of a sample of unmarried youth, consisting of 313 university students (mean age 25) and 303 young people from an urban low-income community in Kandy (mean age 21 years). In this study nearly 55% of community youth and some 44% of university undergraduates admitted having love partners at the time of the survey. However, a vast majority of girls (76%) and a high proportion of boys (65%) considered it necessary to preserve the virginity of the girl and prove it at marriage as expected by social custom. However, this did not preclude premarital sexual activity altogether. The unmarried young people surveyed reported a range of sexual behaviours, including kissing (reported by 51%).
touching (32.8%), interfemoral sex (24.1%), other forms of non-penetrative sex (17.5%) and penetrative vaginal sex (8.9%). More boys than girls reported each of these behaviours. Some 6 to 8% of young males opted to visit sex workers or other casual partners, including older women, for penetrative sex. Only 15% of these males had used condoms in their last encounter with such partners.

Thus adolescents and youth are not only a significant segment of Sri Lanka’s population, but their sexual and reproductive health needs deserve close attention in reproductive health policies and programmes in the country in the light of available evidence.

Specific Public Health Concerns of Adolescents and Youth with a Focus on SRH

A number of public health concerns with particular reference to adolescents and youth have surfaced at the national level in recent years. Alcohol and drugs have emerged as a significant problem among young males in particular socio-economic environments, such as urban low-income communities and plantation enclaves (Silva & Bulankulame 2003). In UNICEF’s 2004 survey, substance abuse among adolescent out-of-school boys aged 14-19 was found to be quite high, with 25.2% currently smoking, 29.2% currently taking alcohol and 10.7% reporting ever-use of heroin.

In recent years Sri Lanka has reported one of the highest suicide rates in the world (45 per 100,000 in 2000), with peak suicide rates invariably reported among adolescents and youth with unresolved problems relating to love, sex and unwanted and shameful pregnancies often implicated in attempts (Silva 2000). Violent youth uprisings -- such as youth insurrections in Southern Sri Lanka during 1971 and 1987-1989 and the rise of LTTE as a violent force in Northern Sri Lanka since 1983 -- indicate further manifestations of a “widespread youth unrest” fueled by frustrations of a sense of deprivation and feelings of social and political exclusion among Sinhala and Tamil educated youth from underprivileged backgrounds.

Nationally 8 to 10% of reported pregnancies occur among teenagers. Even though there is a rise in age at marriage nationally, early marriage and teenage pregnancies tend to be on the increase in conflict-affected and tsunami-affected IDP communities. Unwanted pregnancies among unmarried young females have been a cause for concern from both reproductive health and mental health angles (Rajapakse 2000, Rajapakse and De Silva 2002). Such pregnancies being considered shameful and disgraceful to the entire family, abortions are often used as a means to save face. With abortion being illegal, many young females facing this problem are compelled to go for unsafe abortions. The mental agony caused by such pregnancies and the difficulty in coping with them have led to suicide in some situations. Young females in dysfunctional families where the mother is employed abroad and children are at the mercy of an abusive and alcoholic father, have been particularly vulnerable to incest and other forms of sexual abuse (Silva, Herath & Athukorala 2002). Young female workers in the free trade zones, young girls in IDP camps and war-affected areas in general, and young women employed as domestic help in Sri Lanka and abroad are also among the victims of various forms of harassment, including sexual abuse.

The SRH problems of adolescents and youth in Sri Lanka are thus not merely due to lack of knowledge or lack of access to services, but due to structural mechanisms connected with wider social, economic and political dynamics in the country as a whole.

There is no accurate information regarding prevalence of STDs and HIV/AIDS among adolescents and youth, but the numbers are significant. Of the reported 838 HIV-positive cases in Sri Lanka as of December 2006, almost 20% were in the 10-29 age group. Six percent were in the 10-24 age group (51 persons, 29 males and 22 females) and about 12%
were in the 25-29 age group (106 persons, 59 males and 47 females). There is some evidence that the ratio of women and young people infected with HIV has increased in recent years. How far this is indicative of an actual trend in infections and how far this may be an artifact of who goes for testing -- for purposes such as overseas employment -- is not clear from available sources.

Available data indicate that many adolescents and youth do not consider themselves at risk for HIV or other STDs. As of now, avoidance of shame and guilt associated with loss of virginity and pregnancy before marriage appear to be more important than avoidance of STDs, including HIV/AIDS, where principles guiding the actual behavior of adolescents and youth are concerned. Their sexual and reproductive health concerns must be assessed in the light of these crucial issues.

SRH Services for Adolescents and Youth

With the participation of UNFPA and other donors, a variety of strategies has been adopted for promoting SRH. They include IEC, counseling, dissemination of life skills and limited provision of contraceptive services, primarily condoms. Sri Lanka’s education system, with its captive adolescent and youth population of nearly 4 million, has been tapped as the primary means of reaching this target group. In addition, the National Youth Services Council (NYSC) and a variety of NGOs have been mobilized as a means to reach out-of-school adolescents and youth whose numbers range from 1.5 to 2.5 million (Department of Census 2004). Various branches of the Ministry of Health, traditionally involved in promoting MCH, have been mobilized for the purpose of integrating adolescent reproductive health to their existing programmes firmly established throughout the country and for providing technical support to the Ministry of Education, NYSC and the NGOs where necessary for developing IEC material, policies and coordinating mechanisms and the like. The NGO involvement, led by FPA, includes national NGOs like Sarodaya and regional NGOs such as SLAVSC.

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Senanayake, Pramilla & Silva, K.T.
Silva, K.T.
Silva, K. T. et al.
Silva, K.T. & Bulankulame, I.
Silva, K.T., Herath, D. & Athukorala, V.
Tambiah, Yasmin
UNICEF
Annex L: REPRODUCTIVE HEALTH INITIATIVE FOR YOUTH IN ASIA (RHIYA)

Reproductive Health Initiative for Youth in Asia (RHIYA) was an EU-funded regional project covering seven countries in South and Southeast Asia which aimed to improve the sexual and reproductive health of young people aged 10-24. The project was implemented from 1998 to September 2006 through 9 partner agencies37 in 312 Family Health Worker divisions (lowest health sub-division in the country) in 18 districts in Sri Lanka. The total cost of the project in Sri Lanka was estimated to be $1.03 million.

The districts and FHW divisions were chosen on the basis of the level of SRH vulnerability of adolescents and youth and proximity and accessibility of available services. The project was implemented throughout the districts of Mannar, Vavunia and Jaffna, considering that they were directly affected by the war and that a vast majority of the population in these three districts had experienced devastation and displacement caused by the war. In the rest of Sri Lanka project coverage was thin and rather scattered, reaching merely 224,000 out of an estimated adolescent and youth (A/Y) population of 5 million.

The main activities consisted of the following:

- Information/education/communication to increase the awareness of society as a whole concerning A/Y sexual and reproductive health issues, and to promote healthy behaviour with a focus on relevant gender issues;
- The provision of quality services, from counselling and prevention to primary care, including HIV/AIDS prevention, management of sexually transmitted infections, and access to condoms.38
- Capacity building to develop civil society and non-governmental organisations, public sector and local community partnerships to provide youth-friendly information and reproductive health services.

A large number of master counselors (one per district) and counselors (one per selected FHW Division), and peer educators were trained using a cascade method of training. For the most part, training of trainers (TOT) and refresher training was conducted by under a visiting expert from India with inputs from local resource persons as well.

A total 340 counselors were trained. The total cost of the project was estimated to be $1.03 million.

In Sri Lanka the project underwent many shifts and turns as the staff at the top changed at critical junctures. RHIYA was implemented in Sri Lanka in two phases: phase I from 1998 to 2001 and phase II from September 2003 to September 2006. During phase I and much of phase II, a uniform set of interventions was carried out by all implementing partners under the guidance of the Family Planning Association of Sri Lanka (FPASL), identified as the lead institution. Training of counselors and peer educators and mobilising them for SRH counseling and services for A/Y in underserved communities were the main activities implemented. In June 2005 a change in management change was introduced with the

37 The 9 partners were: the Family Planning Association of Sri Lanka (FPASL), SLAVSC, Population Services Lanka (PSL), Centre for Development Alternatives (CDA), Sarvodaya, Vinivida, Society for Prevention of Cancer and AIDS, Sama Sewaya and Lanka Mahila Samithi.
38 Only a few RHIYA partners actually provided condoms. Even when they did make them available, this was not widely publicized due to fear of criticism from parents and the community.
establishment of the RHIYA Management Unit (RMU) to take over the management functions carried out by FPASL up to that time.

Since the management change, some partner organizations introduced innovative approaches to improve SRH knowledge of young people in addition to besides the training of counselors and peer educators. These innovative approaches included development of street theatre and the RHIYA fair (Ean exhibition of RH related art work and posters by young people) for raising community awareness about ASRH in the plantation communities (under the Centre for Development Alternatives in Kandy) and establishment of multi-purpose Community Health Promoters in IDP communities in conflict affected regions such as Mannar and Vavuniya (under Population Services Lanka).

Assessment of Effectiveness

It is difficult to determine how effective the project has been in serving the SRH needs of adolescents and youth in the selected areas. The mid-term evaluation pointed to limited effectiveness and impact. The extent to which young people at risk actually consulted counselors and peer educators established by the project on SRH issues is not clear from the available information.

Even though the Project Monitoring Unit (RMU) developed a monitoring mechanism that collected substantial periodic information regarding numbers trained, the number of young people visiting each counselor within a stipulated period, and numbers who received contraceptive services (principally condoms), the reliability of the information collected is questionable due to insufficient follow-up. The information collected was rarely cross-checked and rarely used for monitoring and management purposes.

With the available data it is difficult to determine how effective the project has been for improving SRH of adolescents and youth in the selected areas. In the field visits it was found that some of the counselors trained under this project had good skills and provided a useful service to A/Y, particularly those in vulnerable situations. There is also some evidence that young people were more willing to consult counselors who had integrated counseling to existing non-SRH services they provided for young people.39 This meant that, as young people had other “normal” reasons to visit these service providers, they were not stigmatized by others as people with SRH problems.

During the project period, the counselors were paid a small monthly allowance. After this was terminated, many of the trained counselors ceased to operate. This raises serious questions about long-term sustainability of activities/projects of this nature.

While the mid-term evaluation pointed to limited effectiveness and impact, a good-practice documentation on RHIYA carried out in 2006 identified the following good practices as effective, replicable and sustainable (UNFPA 2006):

- Street Theatre and RHIYA Fair (implemented through CDA)
- Reaching Mobile and Vulnerable Groups (by PSL)
- Local Level Advocacy (by PSL)
- Capacity Building (by the RMU)

Among these good practices, participatory street theatre developed in the tea plantations was identified as most innovative and effective in that it was popular with young people, built

39 This included Estate Medical Assistants trained by CDA, Community Health Promoters employed by PSL in conflict-affected communities, and some school teachers and Public Health Inspectors trained as counselors by other NGOs.
on the cultural heritage of plantation workers of Indian origin, was effective in raising parental awareness about the SRH problems faced by their children, and facilitated the use of counseling services established by the RHIYA project.

Conclusions:

- It is very important for young people to have access to counseling on matters of reproductive and sexual health. However, given the continuing cultural taboos on premarital sex and resulting communication barriers, efforts to provide SRH counseling in community settings may not be very effective unless they are built into an existing non-SRH service that caters to young people. Integration of counseling and SRH services with other types of non-SRH services tends to increase their acceptability in the Sri Lanka context.

- Innovative communication strategies, such as participatory street theatre, can play a useful role in raising community awareness about SRH issues where cultural constraints prevent direct one-to-one communication between young people and adults, including their parents and teachers.