THE UNFPA SEVENTH COUNTRY PROGRAMME OF ASSISTANCE TO SRI LANKA (2008-2012)

Evaluation Report
UNFPA, the United Nations Population Fund, is an international development agency that promotes the right of every woman, man and child to enjoy a life of health and equal opportunity. UNFPA supports countries in using population data for policies and programmes to reduce poverty and to ensure that every pregnancy is wanted, every birth is safe, every young person is free of HIV, and every girl and woman is treated with dignity and respect.

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EVALUATION REPORT OF THE
UNFPA SEVENTH COUNTRY PROGRAMME OF ASSISTANCE TO SRI LANKA (2008-2012)

Submitted to
UNFPA Sri Lanka Country Office
by
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November 2011
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# Abbreviations and Acronyms

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<th>Description</th>
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<tr>
<td>ASFR</td>
<td>Age Specific Fertility Rate</td>
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<tr>
<td>ASRH</td>
<td>Adolescent Sexual and Reproductive Health</td>
</tr>
<tr>
<td>AWP</td>
<td>Annual Work Plan</td>
</tr>
<tr>
<td>BCC</td>
<td>Behaviour Change Communication</td>
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<tr>
<td>CDO</td>
<td>Community Development Officer</td>
</tr>
<tr>
<td>CEDAW</td>
<td>Convention on Elimination of all forms of Discrimination Against Women</td>
</tr>
<tr>
<td>CENWOR</td>
<td>Centre for Women’s Research</td>
</tr>
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<td>CO</td>
<td>Country Office</td>
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<tr>
<td>COAR</td>
<td>Country Office Annual Report</td>
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<tr>
<td>CP</td>
<td>Country Programme</td>
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<td>CPAP</td>
<td>Country Programme Action Plan</td>
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<td>CPE</td>
<td>Country Programme Evaluation</td>
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<td>CPR</td>
<td>Contraceptive Prevalence Rate</td>
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<td>CRC</td>
<td>Convention on the Right of the Child</td>
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<tr>
<td>DCS</td>
<td>Department of Census and Statistics</td>
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<td>CSDF</td>
<td>Community Strength Development Foundation</td>
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<td>CSO</td>
<td>Civil Society Organization</td>
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<tr>
<td>DEVAW</td>
<td>Declaration on Elimination of Violence Against Women</td>
</tr>
<tr>
<td>DTRU</td>
<td>Demography Training and Research Unit</td>
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<tr>
<td>FHB</td>
<td>Family Health Bureau</td>
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<tr>
<td>FP</td>
<td>Family Planning</td>
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<tr>
<td>FPASL</td>
<td>Family Planning Association of Sri Lanka</td>
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<td>GAVI</td>
<td>Global Alliance for Vaccine Initiative</td>
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<td>GBV</td>
<td>Gender-based violence</td>
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<td>GDI</td>
<td>Gender Development Index</td>
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<tr>
<td>GEM</td>
<td>Gender Empowerment Measurement</td>
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<tr>
<td>GO</td>
<td>Government Organization</td>
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<tr>
<td>HEB</td>
<td>Health Education Bureau</td>
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<tr>
<td>HEDMaTC</td>
<td>Health Emergency and Disaster Management Training Centre</td>
</tr>
<tr>
<td>HEO</td>
<td>Health Education Officer</td>
</tr>
<tr>
<td>HDI</td>
<td>Human Development Index</td>
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<tr>
<td>HRC</td>
<td>Human Rights Commission</td>
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<tr>
<td>ICCPR</td>
<td>International Covenant on Civil and Political Rights</td>
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<td>ICPD</td>
<td>International Conference on Population and Development</td>
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<tr>
<td>IDP</td>
<td>Internally Displaced Persons</td>
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<tr>
<td>INGO</td>
<td>International Non-Governmental Organization</td>
</tr>
<tr>
<td>IP</td>
<td>Implementing Partner</td>
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<tr>
<td>IUD</td>
<td>Intrauterine Contraceptive Device</td>
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<tr>
<td>LBGT</td>
<td>Lesbian, Bi-sexual, Gay and Transgender</td>
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<tr>
<td>MCDWA</td>
<td>Ministry of Child Development and Women’s Affairs</td>
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<td>MDG</td>
<td>Millennium Development Goal</td>
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<tr>
<td>M&amp;E</td>
<td>Monitoring and Evaluation</td>
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<tr>
<td>MIS</td>
<td>Management Information System</td>
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<tr>
<td>MLT</td>
<td>Medical Laboratory Technician</td>
</tr>
<tr>
<td>MO (MCH)</td>
<td>Medical Officer (Maternal and Child Health)</td>
</tr>
<tr>
<td>MO (STD)</td>
<td>Medical Officer (Sexually Transmitted Diseases)</td>
</tr>
<tr>
<td>MOH</td>
<td>Medical Officer of Health</td>
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EXECUTIVE SUMMARY

Introduction

This report presents the results of the Sri Lanka UNFPA Country Programme Evaluation (CPE) conducted by a three-member team during February and March 2011. The current Country Programme Action Plan (CPAP) is a five-year framework defining cooperation between the Government of Sri Lanka and UNFPA covering the period 2008 to 2012. This is the seventh country programme cycle (CP7) and the principal emphasis of CP7 is on Reproductive Health, with fewer resources targeting gender and Population and Development (P&D) components. In addition to the national level support to these three thematic areas (RH, Gender and P&D), five districts namely, Anuradhapura, Batticaloa, Kalmunai - a RDHS Division of the Ampara District), Nuwara Eliya, and Vavuniya, were chosen for focused UNFPA interventions based on maternal mortality and other RH related indicators.

Evaluation purpose

Assessing the factors that hindered and facilitated the achievement of program goals, the purpose of the evaluation is to draw on lessons learned for the next CP cycle (CP8) and as a formative evaluation – to improve the remaining years of the current cycle. The primary stakeholders in this evaluation are the UNFPA country office, and the relevant government and non-governmental implementing partners.

Evaluation objectives and interventions

Objectives of this evaluation are to: assess the extent to which CP7 achieved its outputs and contributed to its intended outcomes and impacts; assess the extent to which CP7 helped to enhance government commitment to the ICPD programme of action, Millennium Development Goals (MDGs) and other national priorities; and to provide lessons learned and recommendations that can be applied to the next country programme strategies as well as to the current programme cycle.

The programme is expected to be results oriented with emphasis on national capacity building, especially in the delivery of high quality, equitable, inclusive and sustainable services. The interventions under the RH components are directed at enhancing capacity of the national health system to improve the quality of and demand for comprehensive RH services, increasing availability of and access to high quality RH services in conflict affected and underserved districts, increasing efforts to prevent sexually transmitted infections and HIV/AIDS among women and young people and increasing coverage and utilization of youth friendly RH services. Under the gender component the activities are designed to strengthen capacities of the government, non-governmental organizations (NGOs) and community organizations to prevent and respond to gender-based violence and to strengthen national capacity and institutional mechanisms for increased state accountability to fulfill and protect the rights of women and girls. Interventions in P&D are directed at increasing availability and utilization of population data disaggregated by sex and age mainly via support for the 2011 census, for the development of new data bases, and for capacity building among relevant IPs in planning and analytical skills.

Evaluation methodology

To achieve the above broad evaluation objectives, a set of key evaluation questions were developed. To answer these questions, the evaluation focused on the country programme design and management issues and the strategies used to achieve the outcomes under the three programme components (RH, Gender and P&D), by employing the five DAC criteria, namely, relevance, effectiveness, efficiency, sustainability and impact wherever their application was feasible. The evaluation did not undertake a cost-benefit assessment.
of the interventions to measure efficiency. Data to support the evaluation assessment came from national, provincial and district level stakeholders as well as from UNFPA country office staff, and consisted of both secondary and primary sources. Evaluation findings are based on a mix of quantitative and qualitative evidence bringing out viewpoints of the stakeholders by triangulating multiple sources of data such as face-to-face interviews with individuals, phone interviews, direct observations, focus group discussions, questionnaires, documents, and websites. Due to the lack of baseline data and the contribution of many other organizations in the same programme area, counterfactual analysis was a challenge. A one-shot design was used to assess the outcome of the intervention.

Main conclusions

This is the seventh country programme cycle and the overall program design is to a large extent in line with the government development needs, UNFPA mandate, ICPD programme goals, MDGs and stakeholders' needs. This CP also has benefitted from the well established health system with a work programme that aligns well with the requests from the government. The link between UNFPA and the existing health system at all levels to which these inputs have been added, was a key facilitating factor that has enabled these activities, as well as the components of the RH programme implemented by the Ministry of Health, to be carried out. This is less evident in the gender and P&D components as the negotiations and stakeholder participation in planning has not been fully participatory, a shortcoming that appears due to comparatively weak governing structures within the implemeningation partners (IPs), relative to that found in the health sector.

Overall, UNFPA interventions under CP7 are appreciated by the IPs and according to the findings, interventions have contributed positively to the country programme. The national execution modality is a good strategy as it builds not only ownership but also local capacity to manage grants and projects. However, there are areas where improvements could be made to achieve better results. Specifically, better outcomes could be achieved by attending to a few basic management issues such as delays in funding processes, thorough improved consultative processes during annual work plan preparation (as is being done with the Ministry of Health) and through well planned capacity building activities that are, in turn, based on solid needs assessment. The government's plans to improve the collection, processing and analysis of the 2011 population census are supported by UNFPA and are highly appreciated by the government. The same appreciation is received from the Ministry of Health as the RH programme is geared towards strengthening the health sector structures and service delivery at all levels. The capacity development work with the MCDW has contributed to bring forth more technical understanding on CEDAW, UN SCR 1325 and other resolutions and mechanisms which are necessary to realize the international commitment on women’s rights by the Sri Lanka government. There was strong collaboration and partnership between the DCS and UNFPA due to the activity that was backed by a strong and long history of government policy. It is envisaged that, with UNFPA support, gender-specific statistics in this and other areas will be greatly improved upon successful development and availability of “engendered population census data,” the most important source of national and sub-national level data. Gender mainstreaming is apparent in the country programme and specifically in the areas of reproductive health and gender-based violence. The scaling up of women centres has taken place without consolidating the experiences and without a finalized protocol for the centres. Sustainability of women centres is an issue that needs consultation and planning with IPs. A rights discourse is not clearly visible in the centre discussions and in capacity development programmes. Finally, the recent collaboration with the Human Rights Commission under the gender component has enabled the incorporation of UN SCR 1325 in the curriculum of HRC gender unit which is responsible for the capacity enhancement of the government agencies on human rights and women’s rights.
Recommendations

Current gaps that exist on the government side with regard to AWP clearance time and fund transfers need to be discussed and solutions agreed upon with relevant government authorities to increase efficiency and effectiveness of programme implementation which, in turn, would produce better results from the planned interventions.

Effective partnerships need to be sought with the National Planning Department which has principal responsibility for integrating multifaceted development issues in national planning. Under the partnership with Ministry of Child Development and Women’s Affairs (MCDWA), the National Plan of Action on Women can be the key document that needs support from UNFPA. A special focus on section UN SCR 1325 in the national plan of action on women is needed to ensure commitment to this section and place needed attention on the comments of the CEDAW committee in 2011. UNFPA has introduced a new civil society led and holistic approach to GBV prevention, intervention and advocacy through women centres. This is a model that can be replicated by other agencies and by the government as a strategy to combat GBV. However, consolidation of learning of this model of combating GBV through a community led approach is needed before sharing it with other relevant agencies.

UNFPA should be seen operating at an upstream level, using its comparative advantage notably in supporting the accessibility and availability of quality data for evidence-based planning in the three programmatic areas (RH, Gender and P&D). UNFPA partners with key stakeholders, such as MOH, WHO, UNAIDS, Ministry of Finance and Planning, Ministry of Social Services, MCDWA, NGOs and CSOs has the mandate to support countries in using population data for policies and programmes to reduce poverty and to ensure safe motherhood and that every young person is free of HIV, and every girl and woman is treated with dignity and respect. Although support was provided by placing short-term local consultants and training input to enhance capacity of staff in relevant ministries and departments to support implementation of development interventions and preparation of development plans, there should be much more support in terms of technical input and sustainable capacity building, upon careful capacity gap assessments, in relevant development/implementing partners to ensure that ICPD programme goals, MDG goals, a human rights-based approach, and gender concerns are implemented, integrated and reflected in planning documents. As such, UNFPA should be more involved in policy dialogue and strategic level to influence institutional changes, particularly in the accessibility and the use of quality data for decision making. A monitoring system needs to be established to do periodic assessments to see if the process is on the right path to achieve expected results. For example, facilitating development of a “model” to enhance the use of data from Reproductive Health Management Information System (RHMIS), could enhance the quality of services through evidence-based decision making.

Expansion of UNFPA’s focused interventions to other districts or any scaling up of activities in the five districts should be a decision made after consultative process with the National Planning Department together with relevant ministries, mainly health. UNFPA engages successfully in a number of downstream activities in RH and Gender. Currently, support to P&D is somewhat limited to national level and programme support in P&D should be revisited to assess the needs at district level. UNFPA should make use of its comparative advantage working in the areas of P&D, RH and Gender, operating with clearly defined strategy or policy framework to balance the upstream and downstream activities.

Strengthening the monitoring and evaluation capability of CSOs in population, gender and RH should be an explicit part of UNFPA’s strategic plan for capacity building of CSOs. For capacity building activities, there is a need to develop a strategic approach and expand partnerships with training and research institutions to ensure effectiveness, efficiency and sustainability.
The current CP lacks evaluability assessments, and it would be helpful to establish baseline values and targets with a monitoring system that includes clearer indicators. Although it may not be required by UNFPA, M&E guidelines to conduct evaluability assessment during planning stage, including IPs in evaluability assessments would be helpful in setting up and agreeing on baseline values and targets. This would also help in developing an integrated and comprehensive M&E plan, as planning an intervention and designing an M&E strategy are inseparable activities.

Preparation of the Country Population Assessment (CPA) report should be given priority in the remaining period of the current cycle to provide a basis for planning for CP8. Given the multiple development initiatives in the country, documentation of the current situation is a felt need for planning purposes. The CPA report (2006/2007) which provides a good basis for planning in all three programmatic areas is outdated and the need for a current assessment is urgently felt. Several recommendations offered in that CPA are still applicable and worth revisiting until the new CPA is prepared. This executive summary presents only a selected set of recommendations that are considered as priorities for follow up and action.

In concluding, the country office has planned to prepare a dissemination plan to utilize the evaluation findings and recommendations. This is highly commended as this step is not always performed at the end of an evaluation exercise. The evaluation team supports the dissemination plan and recommends that country office ensures that results will be used, translated into program policy language, disseminated to relevant stakeholders and decision makers, and used for ongoing programme refinement.
1.0 INTRODUCTION

Sri Lanka, a lower middle-income country, with a per capita gross national income of USD 1,990 has a population of around 20 million¹. Scoring favorably on population indicators with a life expectancy at birth of 73 years, infant mortality rate of 15 per thousand live births and maternal mortality ratio of 39.3 per hundred thousand live births, the population of Sri Lanka is expected to stabilize at 24 million in 2030.

Since 1983, Sri Lanka experienced a civil conflict which resulted in the loss of over 60,000 lives and the displacement of a large number of people. While the entire country has been affected by this conflict, the northern and eastern provinces have been the most directly affected. Until the government of Sri Lanka declaration of victory over the LTTE, insecurity displaced more than 280,000 people, according to the United Nations Office for the Coordination of Humanitarian Affairs.

The current Country Programme Action Plan (CPAP) is a five-year framework defining cooperation between the Government of Sri Lanka and UNFPA covering the period 2008 to 2012. It is based on the development challenges identified in the UN Common Country Assessment, the Country Population Assessment and the development parameters identified in the United Nations Development Assistance Framework (UNDAF), and in conformity with the National Population and Reproductive Health Policy (1998), the National Women’s Charter (1993) and the National Development Framework – Mahinda Chinthanaya (2006-2016). The CPAP prepared in close consultation with the Government and other national stakeholders defines the broad outline of the goals that the Government and UNFPA subscribe to and the strategies for implementation within agreed financial parameters. It responds to the ICPD Programme of Action, MDGs and CEDAW. The seventh country programme (CP7) is aimed to reflect UNFPA’s new strategic direction that supports Sri Lanka and its civil societies to implement the ICPD Programme of Action based on the principle of national ownership. In doing so it seeks to help achieve the MDGs with a focus on visible and measurable results at the community level. It expects to build on UNFPA’s comparative advantage, taking into consideration the planned interventions by other UN and development partners and thus advances the UN reform goals.

UNFPA supports countries in using population data for policies and programmes to reduce poverty and to ensure that every pregnancy is wanted, every birth is safe, every young person is free of HIV/AIDS, and every girl and woman is treated with dignity and respect “because everyone counts”. UNFPA is the only UN body which provides a comprehensive package of services on, for and about reproductive health and broader population dynamics. This is a critical part of its mandate and distinguishes it from other agencies working on various aspects of health, gender relations and populations issues.

1.1 Background

CP7 is said to be guided by the principles of the new strategic direction that includes human rights, gender mainstreaming, culturally sensitive approaches, focus on marginalised and excluded people, populations affected by humanitarian and emergency situations and young people. The overall programme is expected to contribute to the stated outcomes in the three programmatic focus areas, namely, reproductive health, gender, and population and development. The programme is expected to be results oriented with the emphasis on national capacity building especially in the delivery of high quality, equitable, inclusive and sustainable services.

¹ Statistical Data Sheet, Sri Lanka, 2009. Department of Census and Statistics
These projects are mostly funded through UNFPA regular resources and implementation has two modalities, which are UNFPA execution and national execution. The 7th country programme (2008-2012) has a total budget of USD 18 million for the five year cycle. This includes USD 9 million from regular resources and USD 9 million through co-financing modalities and/or other, including regular, resources. However, the actual resource allocations have changed over time, based on the resource availability and programmatic needs. The UNFPA resource allocation system has classified Sri Lanka as a group C country. Group C countries have made significant progress by meeting all eight of the thresholds.

Table 1: UNFAP Resource Allocation for CP7 (USD, in million)

<table>
<thead>
<tr>
<th>Thematic area</th>
<th>Regular resources*</th>
<th>Other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reproductive health</td>
<td>5.75</td>
<td>4.25</td>
<td>10.00</td>
</tr>
<tr>
<td>Gender</td>
<td>2.00</td>
<td>4.75</td>
<td>6.75</td>
</tr>
<tr>
<td>Population and development</td>
<td>0.50</td>
<td>-</td>
<td>0.50</td>
</tr>
<tr>
<td>Programme coordination and assistance</td>
<td>0.75</td>
<td>-</td>
<td>0.75</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>9.00</strong></td>
<td><strong>9.00</strong></td>
<td><strong>18.00</strong></td>
</tr>
</tbody>
</table>

Source: UNFPA records

The country program has national level interventions, and in addition, has focused interventions in five selected districts that have been targeted to receive assistance by UNFPA with the intention that additional districts with poor social indicators are to be considered for inclusion in the subsequent years, subject to the availability of funding. According to the CPAP, district level interventions under Reproductive Health (RH), Gender and Population and Development (P&D) components will focus in these five areas, enabling a convergence of coherent interventions in all three sectors in the 7th Country Programme (CP7). The five districts are as follows:

Vavuniya – Northern Province; Batticaloa – Eastern Province; Kalmunai (the RDHS Division of the Ampara District) – Eastern Province; Anuradhapura – North Central Province; Nuwara Eliya – Central Province.

Selection of the districts

Based on maternal mortality and other RH related indicators, UNFPA and the Government had selected five districts for CP support.

Three of the abovementioned five districts are conflict-affected districts. The RH indicators in these districts are much poorer than the national averages especially in terms of MMR, and CPR. Anuradhapura was contiguous to the conflict affected districts and was subject to sporadic security operations which made these areas very vulnerable. Home deliveries and teenage pregnancies are relatively high in these districts with Batticaloa recording 5% home deliveries which is the highest in the country. Nuwara Eliya has the largest percentage of plantation population in the country where 30 per cent of the population lives below the poverty line. The health system, though present in the plantation sector, has gaps in human resources and health reporting and may not be up to the expected standards. Anuradhapura has a high concentration of most at risk population for HIV (sex workers and military transit point). Being a large district there are intra district variations in health indicators and service delivery and under reporting from under-served pockets. The district also reports a high incidence of teenage pregnancies. Vavuniya, in addition to being a district which hosts a large numbers of IDPs from time to time, also functions as a critical referral centre for high risk pregnant mothers. It is centrally located as a hub for service delivery and thus is a critical gateway to the other areas in this province.

The interventions to address the needs in RH (including ARSH), gender and P&D in these districts were strategized in consultation with the provincial and district authorities and civil society organizations.
district specific plans were prepared for each district within the strategic framework of the Health Master Plan before initiation of work.

The focus at district level interventions was expected to safeguard women’s health and secure the right to bodily integrity and protection. Under this theme the principal interventions planned were: a) meeting unmet needs for contraception to reduce abortion and reproductive morbidities and save women’s lives; b) strengthen maternal health services; c) strengthening services for prevention, early detection and management of reproductive organ malignancies; d) prevention and management of GBV and e) addressing sexual and reproductive health of adolescents and youth. The PD component was to a large extent, limited to national level interventions, except some capacity development activities of provincial level officers on integration of population aspects into planning process. Detailed district plans for UNFPA support had been developed for each district in consultation with the provincial, district and local stakeholders.

In addition to the five districts, Matara District (Southern Province) received support for women centers after tsunami.

Figure 1: District Map of Sri Lanka
CP7 has specific programmes and strategies to address the aforementioned areas and are implemented by government and non-government institutions, such as the Ministry of Health, Ministry of Finance and Planning (Department of Census and Statistics, National Planning Department), Ministry of Child Development and Women’s Affairs (MCDWA), Ministry of Social Services, CSOs, and NGO networks among others.

1.2 Evaluation purpose and objectives

Evaluation purpose

UNFPA programme management guidelines advise that the end-of-programme evaluation be conducted during year four of the CP so that lessons learned from the current CP and recommendations from the evaluation can be incorporated into the new programme cycle. Furthermore, as per UNFPA policy and procedures, the upcoming new CPD needs to be backed by the evaluation of preceding CP. Therefore, the purpose of this evaluation is to assess the achievements of the 7th country programme, the factors that facilitate or hinder achievement, and to compile lessons learned in respect of each of the programme stages to inform development of the next country programme cycle (8th country programme). As such this evaluation is crucial in preparing the next country programming cycle.

While it is critical to have this CP7 evaluation at this stage, through this exercise the Country Office will reflect on and document major lessons learned from the implementation of the current CP (i.e. CP7), gather recommendations for improvements, and use the results of the evaluation for the development of CP8. Since there is more than one and a half years left in the programme cycle, this exercise is also treated as a formative evaluation whereby lessons learned are expected to feed into the rest of the CP7.

Evaluation objectives

As expressed in the TOR, main objectives of the CP7 evaluation are to:

a) Assess the extent to which the seventh country programme has achieved its outputs and contributed to its intended outcomes and impacts in light of the Objectively Verifiable Indicators (OVI) stated in the approved country programme.

b) Assess the extent to which the seventh country programme contributed to enhance government commitment to the ICPD programme of action, Millennium Development Goals and other national priorities.

c) Provide lessons learned and recommendations that can be applied to the next country programme strategies.

1.2.1 Evaluation scope and questions

The evaluation covered the outcomes and outputs under each programme component as specified in the Terms of Reference (TOR - see Appendix 1 for details) and attempted to look at all aspects as highlighted in the TOR and key evaluation questions included the following:

Overall programme design and management: How is the country program designed and managed in terms of outcomes and outputs as specified in the CP7? Is the programme design appropriate for a UNFPA category
“C” country? Did CP7 achieve its outputs and contribute to the intended outcomes and impacts? What are the lessons learned? And what are the facilitating and hindering factors in the achievement of CP results? Based on the CPAP, each programme had its own specific key questions for evaluation.

Key questions under the Reproductive Health component include:

- Are the proposed activities aimed at improving the quality of comprehensive RH services effectively implemented? What is their likely contribution?
- Was the availability and access to high-quality, gender-sensitive reproductive health services adequately supported in conflict-affected and underserved districts?
- Has the capacity of government, private and civil society organizations to provide high-quality reproductive health services been enhanced?
- How effective were the activities included in the programme to prevent sexually transmitted infections and HIV/AIDS among targeted group of persons?
- Have the activities supported and increased the coverage and utilization of youth-friendly reproductive health services?

Key questions under the Gender component include:

- What institutional mechanisms are in place to empower communities to protect rights of women?
- What institutional mechanisms are developed to ensure the effective implementation of the national action plan on the Domestic Violence Act?
- How effective was the GBV forum as a mechanism to promote multi-sectoral intervention to GBV prevention? As a coordinating body what was the approach taken by the forum and how cost effective was this intervention? Was there demonstrated ownership by members?
- How appropriate are the women centres to the local context as a protection mechanism/safe space? How many are functional and utilized by women and girls on ground? How effective are the centres as a multi-faceted service provider?
- How effective are the knowledge building strategies on GBV? Who is involved in the process? How is efficiency ensured?
- How effective and efficient was the support extended to national mechanisms to promote participation and protection of women as stipulated in UN SCR 1325?
- How effective and sustainable were the different interventions with MCDWA and HRC as oversight mechanisms?
- What mechanisms are in place to ensure the women participation in peace processes are in line with 1325?

Key questions under the Population and Development component include:

- Has the use of disaggregated data in formulation of MDG based policies, sector plans and programmes increased at national and sub-national levels?

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2 Category C countries are those that have made significant progress by meeting all eight of the thresholds (births with skilled attendants 60% or higher; contraceptive prevalence rate (modern methods only) 25% or higher; adult HIV prevalence 5% or lower; adolescent fertility rate 65 per 1,000 women aged 15-19 or lower; UFMR 60 per 100,000 live births or lower; literacy rate among 15-24 year old females 80% or higher and proportion of population aged 10-24 years old 33% or lower) for ICPD goal indicators and receive approximately 6-7% of programme resources (source UNFPA, 2008).
• Is institutional capacity to integrate population and programmes into national and sub-national development planning and budgeting enhanced?

The strategies used to achieve the above three programme component outcomes were assessed by employing DAC criteria, namely, relevance, effectiveness, efficiency, and sustainability wherever their application was feasible. Due to the limited time and the lack of appropriate data and control groups, impact assessment was not attempted in this study. The likelihood of impact is assessed when it was feasible. The evaluation did not undertake any cost-benefit assessment of the interventions to measure efficiency. The TOR specifies about 25 evaluation questions under these criteria. While it was not possible to answer all 25 questions, the team made an attempt to respond to them as far as possible.

1.3 Evaluation methodology

After reviewing the TOR, the team prepared an evaluation design matrix (sample attached - Appendix 2) which served as a tool for planning the evaluation. Based on the programme's logic and purpose of the evaluation, the team selected an evaluation design which served as the overall strategy for systematic data gathering and analysis. Proposed data collection methods in the matrix were linked to each evaluation question. In selecting a suitable method to evaluate the program design and management issues, practical concerns such as what information is already available, how much time is available and what data collection and analysis procedures are feasible within the available time frame were taken into consideration.

Data collection took place mainly at three levels, national, provincial, and district and the data came from both secondary and primary sources. Stakeholders were identified at national and sub-national levels in consultation with relevant stakeholders and UNFPA. The key informants of this evaluation are listed in Appendix 3.

The findings are based on a mix of quantitative and qualitative evidence bringing out details from the viewpoint of the stakeholders by using multiple sources of data. The study attempted to triangulate data sources, data types, data collection methods and investigators. As such, the evidence in this study includes data collected from direct observations, interviews, focus group discussions, questionnaires and secondary sources. Several different approaches were used so that the weaknesses of one approach are offset by the strengths of another, enhancing the validity of the data.

According to the evaluation criteria set forth, the evaluation questions were mainly descriptive and normative and thus did not require an evaluation design (experimental or non-experimental) per se. However, assessing the impact requires an evaluation design and with lack of baseline data and the contribution of many other organizations in the same programme area, counterfactual analysis is a challenge and measuring UNFPA attribution is difficult. As such, there was no attempt made to compare with a control group before and after the interventions. It was possible to measure the contribution and in some instances where there had been no efforts by any others; results could be linked to the interventions of UNFPA. In such situations, impact linked to UNFPA interventions has been clearly identified. A one-shot design was used to assess the outcome of the intervention.

Gender as a cross cutting theme was given prominence in the design of evaluation. In the formation of evaluation questions in all programme components and in selecting stakeholders, gender equality was given due attention. While analyzing information, gender equity and equality was a criterion for analysis.

The information for the evaluation was obtained from desk (document) reviews, archival data, presentations by each of the NPOs, in-depth interviews with NPOs, key informant interviews (key informants identified
from the desk reviews as well as discussions with NPOs and IPs, observation, telephone interviews, IEC materials, field visits, focus group discussions, and informal group discussions.

The team had to follow slightly different strategies to collect information from the three programmatic focus areas, as the programme components’ interventions had different stakeholders at different levels. As such the field visits also had to be planned accordingly. All five districts were visited for assessing the RH component and three districts were visited for evaluating the gender component. Information on population and development was collected mainly at the national level. Wherever it was possible, all three members of the team were present at meetings and discussions.

The evaluation addressed DAC criteria: relevance, effectiveness, efficiency, and sustainability. As mentioned earlier, impact assessment was not done. The country programme cycle has nearly two years of implementation to be completed. As such, some sections of the programme are still at a formative stage – and assessment of likely impact and their sustainability in most cases would be subjective.

Performance indicators (only a few were available) as set by UNFPA in accordance with the UNDAF indicators were taken into consideration as benchmarks for evaluation. However, due to the indicators being long term targets and the evaluation is done only after little more than two years of programme implementation, the team of evaluators developed a set of indicators, wherever feasible, in consultation with the NPOs. In RH, there were indicators identified in the sub outputs of each output and these were assessed as far as possible. In addition, the evaluator developed some process indicators which were assessed.

1.3.1 Ethical considerations

Key stakeholders were given the opportunity to provide their feedback and suggestions to be included in the evaluation recommendations through debriefing at different levels. Due to the cancellation of the meeting that was scheduled to discuss the evaluation design and the inception report, the stakeholders did not have an opportunity to provide their comments and suggestions to the design issues and data collection methods and tools. The evaluation draft report was circulated for their review and comments on the findings and their interpretations. Several presentations were done for the UNFPA staff, Evaluation Management Committee (EMC)\(^3\), as well as other key representatives of the IPs to provide an opportunity for their feedback.

During the evaluation planning stage, the country office Evaluation Manager has had several meetings with the EMC and frequent discussions with prospective key informants regarding the upcoming evaluation. The evaluation team, upon reviewing the country programme documents and the TOR, submitted a list of key informants to be interviewed and the Evaluation Manager set up the meetings, with the informants’ consent (verbal as well as via email) to participate in the interviews. Necessary input to the evaluation had been already arranged as agreed and the interview respondents had been informed of the evaluation purpose, rights and obligations of participating in the evaluation. As such, a formal consent form was not introduced before the interview procedure. The team obtained verbal consent to provide information and observed privacy and confidentiality considerations. Some interviews were tape recorded with the approval of the informant. Direct note taking was done at all other times. Interviews and meetings with the stakeholders were held at convenient times without interrupting their work schedules and the comments and feedback

\(^3\)EMC membership - Director ERD Min of Finance and Planning, Dir. Dept of Foreign Aid and Budget monitoring (DFABM, Representation from MOH, Representation from Ministry of Child Development and Women’s Affairs (MCDWA), M&E Advisor UNDP, UNFPA Representative and UNFPA Evaluation Manager.
received at the interviews were treated confidentially. Where case confidentiality was maintained by the project personnel (such as in GBV), the team honored the principles of the decisions made and elicited only the information that was released by the centers. Unless the individual beneficiaries of these services volunteered to give detailed information, the team did not request sensitive information. This did not hamper the information required for answering the evaluation questions.

1.3.2 Challenges and limitations to evaluation

All the logistical arrangements were planned well and there were no major challenges in carrying out the evaluation exercise.

The initial plan was to visit the Women Centers in all five districts; however the weather was a hindrance and two planned districts, Ampara and Batticaloa, could not be visited due to heavy flood situation. The Women Centres in these districts were occupied by the people as a shelter and the ethical considerations prevented the team from visiting the locations for gathering information on GBV and other related questions on gender component. The center managers were interviewed over the phone once the situation got better. Other than that this situation, of the country was conducive for an objective and participatory evaluation. A few challenges were experienced as follow.

CP7 support to Sri Lanka was mainly towards strengthening of the existing systems and there are several donors working in the same geographic regions. Contamination was an issue and in the absence of ex-ante reviews and evaluability assessments, it was difficult to measure achievements/change, with specificity, as a result of UNFPA interventions. Limited availability of baseline data and targets in some of the programme components posed a challenge to the evaluation. The available targets and indicators were set for the five years and this evaluation is done after less than three years.

The program included capacity building of government and civil society on gender, rights-based approaches, social equity perspective in achieving poverty reduction strategies and MDGs, cultural sensitivity, and so forth. However, there were no specific/relevant indicators to measure these, posing challenges to measure relevant outcomes. Qualitative indicators to measure processes (process indicators) were lacking. The indicators to measure capacity development and empowerment of communities of women, men and youth were not developed during the programme development stage and it caused a difficulty in the evaluation. In addition, the process indicators were not developed and the team found it difficult to assess the rich processes of change that were evident as a result of CP7.

Staff turnover was also an issue as lack of continuity led to lack of institutional memory and incomplete information, specifically in the P&D sector, both UNFPA as well as the implementing partners’ part.

Time constraints to extend the number of days in the field to cover more participants and especially the non-beneficiaries, limited any comparison of service users with non-users.

Time was too short to measure capacity development (for example to do a document analysis before and after, or in-depth interviews of representative number of trainees/participants).

A few of the training programmes had clear tasks to be accomplished after the completion of the activity, but a few other training programmes that were conducted as part of capacity development programmes did not have baseline values or a needs assessment. Therefore, it was difficult to assess the progress or the contribution made to the department as a result of the capacity development and awareness raising programmes. Documentation of the follow up of the capacity development was weak and the team could not
track the changes as an outcome of the capacity development programs. The lack of institutional memory due to high turnover of staff made it even more difficult to obtain information.

Lack of comparable financial data (due to changes in the coding system every year) posed limitations for expenditure calculation on programme interventions. Over the years, codes given to expenditure specific to programme components have changed and now there is a new coding system that is issued by UN HQ for global use. With these changes in allocated codes, monitoring of expenditure under a specific activity in any given time was a challenge. While this is an area that needs support and clarity from UN HQ, similar difficulties were documented in the previous country programme (CP6) evaluation report\(^4\) as well.

The 7\(^{th}\) programme cycle is for five years starting from 2008 and in reality the interventions have been on the ground for a period of two and half years or less given the past situation in the country. As such, some interventions are too premature to assess for their impact.

1.3.3 Evaluation team

The three member team comprised technical persons\(^5\) on reproductive health, gender and population studies. The sections on RH, Gender and P&D were prepared by each of the respective technical persons and the team leader, who is also the contributor to the P&D section, was responsible for the rest of the report. The entire report benefitted by the comments and feedback received from the country office staff and the team members, stakeholders, and UNFPA Asia Pacific Regional Office.

1.3.4 Structure of the report

With a brief background to the evaluation, its scope, objectives and evaluation methodology, the report provides the context within which the country programme operates. With a general discussion on the programme design, programme management and partnership assessment that are common to the overall country programme, the report discusses the findings under each programme component, namely Reproductive Health, Gender, and Population and Development. The strategies employed to achieve the results (as given in the TOR and the CPAP) are assessed using DAC criteria – relevance, effectiveness, efficiency, sustainability and impact.

Since the three programme components have specific characteristics, each component will discuss separately, the facilitating and hindering factors in achieving results, and program design issues and management issues that are relevant to that particular component. Although this may sound repetitive, it was unavoidable given the nature of the interventions under each programme component (RH, Gender, and P&D). As such, it was decided to have the aforementioned issues discussed under each individual programme component while general issues relevant to the overall programme design (2.1) and management and partnerships (2.2) were discussed in the beginning under the evaluation findings of the country programme.

While conclusions and recommendations that are specific to each programme component are discussed under each programme, overall conclusions and recommendations that are common to CP7 are discussed separately. Although the recommendations have to be limited to 15, it was difficult to limit the number and as such the recommendations that are considered priority are marked with an asterisk.


\(^5\) Composition of the team: Reproductive health team member with MBBS, PhD, gender person with MA in women studies, and population & development person with a PhD in Rural Sociology and Demography.
2.0 EVALUATION FINDINGS

In the seventh country programme cycle, the following outcomes are expected under the three key programme components.

Reproductive Health: improved and equitable access to utilization of high-quality reproductive health information and services for women, men and young people, particularly those living in conflict-affected areas and on plantations.

Gender: strengthened institutional mechanisms and empower communities to protect the rights of women.

P&D: Enhanced utilization of population data and strengthened capacity to track progress in implementing national poverty reduction strategies and in achieving the Millennium Development Goals, using a gender and social equity perspective.

Several strategic interventions are employed to achieve these outcomes.

The following section discusses the programme design and the management issues in general. While these are common to the overall CP7, each separate programme component will also provide a brief on program design and management that is specific to the individual programme under the relevant section.

The evaluation of the program design and program management is based on the contextual analyses of the CP7 document, CP Action Plan (CPAP), Standard Progress Reports, Annual Work Plans, interviews and discussions held during the evaluation.

2.1 Program design

Sri Lanka has become a signatory to the Millennium Declaration by signing it with 190 other countries in year 2000. By including the MDGs into the Government's ten year development plan “Mahinda Chinthana: Vision for a new Sri Lanka” which extends from 2006 to 2016, the Sri Lankan Government has given high priority to MDGs and has specified the Government’s commitment towards the achievement of them for all people in the country. This commitment needs the support of all the development partners and all the citizens whose contribution is essential in the attainment of these goals.

The following two charts (Fig.2 and 3), as conceptualized by the country office, give a schematic presentation of CP7 and its relationship between the proposed outcomes, and the associated outputs; and the country programme alignment with UNDAF and the national development framework. In the country programme, the outcome and output statements were designed to follow clear program logic in a way that achievement of the planned outputs lead to proposed outcomes, by employing the selected strategies to implement the interventions.

Viewed from a results-based management perspective, the program design has some strengths: some outputs are sufficiently specific, are measurable by the available information, and clearly related to the proposed outcome. If implemented well, the design addresses key development areas that the country needs. However, there are some inconsistencies between CPD, CPAP and AWP indicators in terms of the formulation and classification of outcomes, outputs, targets and indicators. Some of the indicators are too general and data is incomplete. Also, some important indicators are missing or limited, for example, those for assessing the extent to which services, policies and programs are rights-based, gender-sensitive, and
culturally-sensitive. Qualitative indicators to measure processes are not included in the design. An evaluability assessment at the time of programme design stage would have been helpful.

Despite the ICPD framework on integration of RH, PD and Gender Equality, the linkages between the RH, Gender and PD components appeared weak especially in the implementation on the ground. Although in the design of the programme, linkages seem logical and integrated the implementation of the programme components seem to be happening without much cross-fertilization. One good example is that the existence of Mithuru Piyasa and its services were not known to the beneficiaries or the service providers of Women Development Centres in Matara. Somewhat similar services are offered in these places, but implementation responsibilities are under two different programmatic areas and the implementation on the ground is happening in isolation to a great extent. A similar situation has prevailed in the past as this was brought up in the previous country programme evaluation (CPE 6) as well. The report stated “Programme components have been implemented basically as vertical projects with little synergy or lessons sharing among them. Many CO staff says there has not been much synergy among the programme components. (CPE 6, page 54 under II.E.3 implementation: synergy and learning lessons).

Overall, CPAP is designed with a broad framework and the number of outcomes that are to be included in the CPAP is limited, as per guidelines on CPAP preparation, compelling CO to keep to a few broad outcomes and outputs. These have higher level indicators which are not easy to measure and monitor on a periodic basis. For periodic monitoring purposes, the interventions that are contributing to the outputs (and in turn outcomes) need to be “unpacked” and measurable indicators have to be set up with targets and timelines. While CPAP does not allow this kind of in-depth indicator setting, for internal working purposes, a detailed monitoring plan needs to exist to ensure effective monitoring and evaluation of the interventions. Although to a certain extent this takes place at the time of AWP preparation, complete information on baselines, benchmarks and performance indicators were not available partly due to the reason that CPAP format does not have a window to include detailed indicators for periodic monitoring.

In general, UNFPA monitoring tool (ATLAS) focuses more on tracking financial expenditure rather than completion of programme activities/interventions and as such indicators are not available to make formative assessments of programme results, especially for the government IPs. In the absence of a detailed programme monitoring plan in the system, as a solution, each PO has developed an individual review plan to monitor the programme via dialogue with IPs, field visits and review of progress reports and documents. As such, the individual programmes had an in-built monitoring mechanism, specifically in the RH component, where main emphasis is on programme performance. The focus of a monitoring tool on financial expenditure tracking established within the UNFPA system leads to measuring progress/results using fiscal expenditure and implementation rate interpreted in dollar terms, limiting the measure of actual programme performance against the expected/planned outcomes or outputs. If a system is developed in line with the requirement of COAR preparation, it could have been made more useful. The standard on-line monitoring system that is in place does not provide adequate information as the basis for an evaluation. Non-government IPs had a system established to report their progress quarterly. Governments IPs are submitting annual progress reports per the UNFPA guidelines which discuss both the performance progress as well as financial progress.
Figure 2: Overall schematic representation of the seventh country programme

UNFPA 7th Country Programme (2008-2012)

Outcome 1: Reproductive Health
Improved and equitable access to and utilization of high-quality reproductive health information and services for women, men and young people, particularly those living in conflict-affected regions and on plantations

Outcome 2: Gender
To strengthen institutional mechanisms and empower communities to protect the rights of women

Outcome 3: P & D
Enhanced utilization of population data and strengthened capacity to track progress in implementing national poverty reduction strategies and in achieving the Millennium Development Goals, using a gender and social equity perspective

Output 1: Enhanced capacity of the national health system to improve the quality of and access to high-quality reproductive health services in conflict-affected and underserved districts

Output 2: Increased availability of and access to high-quality reproductive health services in conflict-affected regions and on plantations

Output 3: Increased efforts to prevent sexually transmitted infections and HIV/AIDS among women and young people

Output 4: Increased coverage and utilization of youth-friendly reproductive health services

Output 1: Strengthened capacities of the Government, NGOs and community organizations to prevent and respond to GBV

Output 2: Strengthened national capacity and institutional mechanisms for increased government accountability to fulfill and protect the rights of women and girls

Output 1: Increased availability and utilization of population data disaggregated by sex and age

Source: UNFPA Country Office, Sri Lanka
Figure 3: Alignment of CP7 with UNDAF and Mahinda Chintana (Vision for a new Sri Lanka) goals and MDGs

Source: UNFPA CO
UNFPA strategic direction focuses on supporting national ownership, national leadership and capacity development as well as advocacy and multi-sectoral partnership development. The strategic direction also guides UNFPA with regard to results-based management, UN reform, knowledge sharing, and resource mobilization. However, the design does not clearly specify monitoring these.

Other design issues

Sri Lanka as a Category “C” country: The TOR requests to see if the programme design is appropriate for a UNFPA category “C” country. UNFPA resource allocation system classifies programme countries into three categories, “A”, “B” and “C” based on a set of eight indicators and Sri Lanka is said to have made progress in meeting all eight of the thresholds.

Although national performance of Sri Lanka is well on the path of achieving MDGs, according to the Department of Census and Statistics, there were sharp variances at regional level with wide discrepancies in poverty between districts, between cities and in small pockets even within the same city. Several disaster situations (such as conflict, tsunami, floods) which led to loss of lives and displacement of large number of people, further dampened the development of the country and had a negative impact on the social and economic well being of the affected populations.

Even with the progress made in achieving several social indicators such as MMR, IMR, and with universal access to health services, quality of services has been a major challenge in Sri Lanka. As indicated in the CPAP, even the well established system of providing family planning services seem to have some limited service provision as evident by the percentage (12-18%) of unmet need for FP. CPAP states “One third of all pregnancies end in abortion, which is one of the leading causes of maternal deaths. Most women who seek abortions are married women over the age of 35, indicating the existence of gaps in the quality and availability of family planning (FP) services.” The report also goes on to say that access to reproductive services to be limited, especially in the northern and eastern provinces. Home deliveries and teenage pregnancies are relatively high in these districts with Batticaloa recording 5% home deliveries which is the highest in the country. Nuwara Eliya has the largest percentage of plantation population in the country where 30 per cent of the population lives below the poverty line. The health system, though present in the plantation sector, has gaps in human resources and health reporting may not be up to the expected standards. Anuradhapura has a high concentration of most at risk population for HIV (sex workers and military transit point). Being a large district there are intra district variations in health indicators and service delivery and under reporting from under-served pockets.

With regards to the HIV/AIDS, although Sri Lanka is not a high prevalent country the risk factors that can trigger the epidemic are high. Also, the gap between onset of puberty and age at marriage is high which has resulted in increase in pre-marital sexual relations. UNFPA has identified the areas where assistance is needed and the relevant interventions (with the implementing partners).

As such, even though Sri Lanka is in category “C”, the programme design is suitable for the country’s situation for the reasons elaborated. The design has to address the problems faced by selected pockets and populations and CP7 has specific programmes and strategies to address the aforementioned areas and are implemented by government and non-government institutions, such as the Ministry of Health, Ministry of

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6 Births with skilled attendants 60% or higher; CPR (modern methods only) 25% or higher; adult HIV prevalence 5% or lower; Adolescent fertility rate 65 or lower per 1000 women aged 15-19; UFMR 60 per 1000 live births or higher; MMR100 per 100,000 live births or lower; literacy rate among 15-24 yr old females 80% or higher; proportion of population aged 10-24 years 33% or lower.

7 Family Health Bureau, Ministry of Health figures 2011 indicate unmet need for FP around 8-9% for 2008-2009. 12-18% CPAP states may have been in selected Ares in 2007 when plans were drawn.
Finance and Planning (Department of Census and Statistics, National Planning Department), Ministry of Child Development and Women’s Affairs (MCDWA), Ministry of Social Services, CSOs, and NGO networks among others.

The current CP addresses these isolated pockets with wide differences in social indicators by targeting the areas taking the district based approach. This is further elaborated under the relevance section of RH output 1. The new census data and the data from detailed household survey planned by the Ministry of Economic Development would be able to provide latest situation to back the evidence of the said discrepancies and the next CP should be able to make decisions on design issues and resource allocation that are suitable for category “C.” The mix of strategies that are applied in the current programme design serves the current needs of Sri Lanka where the conditions are not homogenous across the country.

Gender mainstreaming

A clear effort was made to ensure that gender is mainstreamed throughout programming, specifically in RH. In RH, specific gender issues were given prominence, such as GBV and health sector responses to it, HIV/AIDS and gender equality in intervention and treatment. In addition specific attention is paid to ensure reproductive health services to women in marginalized sectors. This was done effectively as the systems are established well within the health ministry and the delivery of services was relatively easy. The P&D component incorporated the need for strengthened gender analysis, gender-disaggregated data, gender-sensitive coordination, monitoring and evaluation mechanisms. Although these are not yet fully realized, at least the conceptualization had taken place at the planning level. Once completed, the census, as a national data base, will be providing data suitable for gender analyses. Even if the data is available, much more work has to be done to translate these concepts into action if disaggregated data is to be used for meaningful gender-based planning, budgeting and policy making. However, institutionally, within UNFPA, a mechanism to ensure gender mainstreaming in the programme components is not established and this needs to be linked to the annual planning process and monitoring mechanism of UNFPA to confirm systemic and institutionalized gender mainstreaming.

2.2 Programme management and partnerships

The success of the UNFPA country programme depends on the national partners as the implementation lies with them. At the apex level UNFPA is guided by the Department of External Resources with regard to policies and financial procedures and operations of UNFPA support to the country. MOH assumes the coordination role and key implementation role and key responsibility for the RH component, MCDWA for the gender component and NPD and the Department of Census and Statistics jointly for the P&D component.

The partnership with government agencies and ministries is successful and needs to continue as it ensures equitable distribution of benefits to wider section of the population and it also enables the influence of policies at sectoral level. UNFPA has successfully influenced the Family Health Policy of the health sector and has made contribution to the introduction of initiatives to redress of GBV through the health sector. The partnership with civil society has been fruitful in many ways. UNFPA has introduced an institutional mechanism to the combating of GBV through the women centres and civil society organizations have taken leadership in taking these initiatives forward. The involvement of communities in the prevention and intervention of GBV is promoted through these women centres and this is a positive impact of the UNFPA partnership with civil society organizations. The HIV prevention activities carried out with organizations working with youth is another area in which positive stakeholder partnership is discerned.
The current CPAP does not identify the Ministry of Social Services as an implementing partner, but UNFPA has supported (according to the AWPS and as evident in the key informant interview) the ministry in building its capacity for planning in the areas of ageing. The ministry has a key role in current emerging population issues that are within UNFPA’s mandate. With the diverse and changing needs of families due to the demographic changes, there is a need to ensure that economic and social policies are responsive to these changes. A Family Policy for Sri Lanka is being prepared by the Ministry of Social Services and there are areas where UNFPA can be engaged strategically as the policy cuts across many of the areas that are included in the current CP7 and may provide directions when planning CP8.

The RH component provides the largest support to the CP7 compared to the Gender and P&D. While the latter two components are comparatively small in terms of financial resources, some of the interventions on gender and youth are part of RH. In terms of human resource allocation, equal weight is given to reproductive health, gender, youth and HIV, and population and development and each has one programme officer. The distribution of volume of work and the responsibilities among the NPOs may not be balanced, as indicated by some NPOs. The programme benefits by an external advisor for RH on GBV, and also other local technical expertise as and when needed. The capacity of human resources at CO may need to be re-considered if UNFPA further expands its support at the national and district level. While it is not sustainable to allocate CO staff at district level, UNFPA could factor in the deficiencies in HR aspects when expanding or rolling out activities at district level. Due to the small size of the country and easy access to remote areas, it is not feasible to establish district base branch offices. Support to capacity building at district level may be included in the next country programme with clear exit strategies while closing the gaps that exist in the government administrative system. The following indicates the situation in the country with regard to the public administration system and any support to strengthening the country capacity in a sustainable manner would be seen by the government as a positive contribution from UNFPA.

“Mahinda Chintana: Vision for a New Sri Lanka - A Ten Year Horizon Development Framework, 2006-2016” identifies some inadequacies in the Public Administration System. As per the document, they are as follows:

- Weak public policy management
- Reluctance to engage in horizontal consultation in decision making
- Poor client orientation in the delivery of public services
- Mismatch of emergent task demands with the available knowledge and competence of human resources
- Absence of system-wide accountability and transparency in the conduct of government business
- Outdated system and procedures unsuited to modern day demand for the effective flow of public business
- Inefficient management of resources and low levels of productivity

Although the above mentioned inadequacies may not be the case in IPs that UNFPA partner with, UNFPA should factor these in when planning the AWPs in order to set realistic targets. Since capacity development of IPs is part of the CP, addressing these inadequacies should take some priority for sustainability and ownership of the Country Programme by IPs. Recognizing the fact that change is a long process, engaging the private sector, academic institutions, and selected NGOs to work with the government institutions in the implementation might be an effective and efficient way to achieve the expected CP outcomes and outputs.

In the UNFPA CP, commitment and support of the implementing partners contributed positively in achieving anticipated results. However considerable delays in the disbursements of funds from the Treasury to the government implementing partners impacted negatively in timely completion of programme operation.
Procurement aspects were managed on time by most institutions, but the operations were delayed or not done at all due to funding delays (may be delays in approval in the government mechanism). The issue of delay in receiving funding from the Treasury was mentioned by almost all IPs as a problem in achieving planned results within the timeline. Implementing partners at sub-national level were especially affected by this delay.

In late 2008, there had been delays in recruitment of programme staff resulting from delayed clearance and signing of the CPAP by the government. Some programme staff could only join in mid 2009 which negatively affected the CO ability to ensure implementation of the planned programme.

Currently, as indicated by all three POs during individual face-to-face interviews, as well as group meetings, UNFPA programme staff are overloaded with programme responsibilities and day-to-day activities. An external consultant’s assistance is sought to carry out some of the programmes such as GBV. The lack of routine mechanism of sharing of progress reports, to exchange experience and work accomplishments of POs limits the linkages between/cross-fertilization of the RH, Gender and P&D components. If there is a monthly forum to exchange experience of each programme component activities, it would help strengthening the programme interventions. The lack of synergy in the individual programme components was commented on in the previous country programme evaluation as well. This lack of synergy was also seen on the ground and the interventions could be more effective if there was more awareness of other IPs on UNFPA funded activities in the same locations or districts.

The following chart represents the current human resource structure.
Figure 4: Human resource structure for management of CP 7

Source: UNFPA country office
Based on the existing partnership mechanisms at the various levels, UNFPA has continued to partner with key stakeholders, such as MOH, WHO, UNAID, Ministry of Finance and Planning, Ministry of Social Services, Ministry of Child Development and Women’s Affairs, NGOs, and CSO. Each programme component under the country programme has national implementing partners working directly with the programme officers responsible for that component.

Partnerships in RH programme have supported implementation of quality programme activities. It should be depicted as a good practice since these partnerships enhance the efficiency, effectiveness and ensures national ownership which in fact is in line with Paris declaration and helps activities become economical because these do not depend on international expertise. The close partnership with other agencies such as WHO and UNICEF ensures complimentarity and avoids duplication of the support.

The AWP government clearance process experienced some delays which affects the activity implementation schedules. Assessment of the AWP preparation and approval process needs to be considered for effective and efficient programme implementation. The preparation of AWPs could be more consultative in P&D and gender components, similar to the process followed by RH sector where full participation of all concerned parties were requested by the senior authorities in reviewing and prioritizing the work plans. The decision to cover AWP for a two year period seems to be a step in the right direction which can improve the efficiency and effectiveness of the country programme by avoiding delays in the approval process. This also enhances commitment of the IPs as well as NPOs for smooth continuity of the planned interventions.

The UNFPA strategic direction focuses on supporting national ownership, national leadership and capacity development as well as advocacy and multi-sectoral partnership development.

The financial resources to implement the annual work plans were distributed using two different modalities: UNFPA execution and national execution. UNFPA execution means that UNFPA directly spends certain budget lines in the work plan. National execution means that national implementing partner spends UNFPA resources through its accounts to implement project activities. The UNFPA execution modality makes the funds transfer efficient, thus allowing the programme interventions on time without delays, achieving a higher implementation rate. On the other hand, the national execution modality is a good strategy as it builds not only ownership but also local capacity to manage grants and projects. In the RH component, the effectiveness of the national execution is very evident as most of the agreed objectives were delivered and the implementation was efficient as the health system was well functioning and the Health Ministry officials were taking the lead in the implementation both at national and district levels. Both types of cash transfers, in combination, works well and a long-term strategy is to be thought for overall sustainability and ownership.

While the above discussion was on the overall programme design and management issues, the following section presents the evaluation findings under the three programme components separately, namely Reproductive Health, Gender and Population and Development. First, the program design issues and programme management and partnership issues that are specific to the programme component will be discussed, and then the strategies for achieving results/outputs will be assessed using DAC five criteria.

2.3 Reproductive health

2.3.1 Context

One of the main features of the health policy of Sri Lanka has been the gradual expansion of health services to the population of Sri Lanka. Provision of services for reproductive health has been a key component of these programmes. A Presidential Task Force associated with health policy formulation in 1992 considered policy measures that needed to be taken regarding services for special groups, which included many
components of RH. It addressed some of the issues related to quality of service delivery like client/patient
rights, respect for their dignity, ensuring easy accessibility of services of desirable quality free of cost and
counseling services for adolescent females in preparation for motherhood.

Following the ICPD meeting in 1994, a Population and RH policy was formulated for Sri Lanka in 1998. The
policy identified several goals which addressed crucial and emerging RH issues like fertility decline, unplanned
pregnancies, safe motherhood, responsible adolescent and youth behaviour, reproductive tract infections
and gender equity.

2.3.2 Programme design (Reproductive Health)

According to the CPAP, the expected outcome of the RH component has improved with equitable access to
and utilization of high quality RH information and services for women, men and young people, particularly
those living in conflict affected and marginalized rural areas and on the plantations. The four outputs
included in this component are linked to the expected outcome and are to be achieved by inputs through the
state health sector supported by the NGO sector where relevant.

Six (6) outcome indicators have been identified as follows:

- Contraceptive prevalence rate for modern methods
- Unmet need for family planning
- Percentage increase in national budget allocated to contraceptives
- Gender based violence recognized as a public health priority in the health policy
- Condom usage rate
- Proportion of young people aged 10 – 24 years using RH services.

The outcome indicators, though all are linked to RH services, are influenced by varied inputs that are
implemented through the state sector, other donors and other sectors. For this reason, it is not practically
feasible to assess the impact of the CPAP of UNFPA in influencing these indicators. The main inputs under
UNFPA support were to strengthen the already existing health system to deliver better quality services and
improve coverage. The contributions made through UNFPA support are to be assessed in relation to the
relevant indicators that reflect these interventions, under each sub output and it is evident that these have
contributed to strengthening the health system and in improving quality even though it is not possible to
attribute changes solely to UNFPA CP.

The national health system in Sri Lanka has a programme aimed at provision of RH services with
responsibilities for implementation based on the provincial health system. UNFPA along with the relevant
stakeholders have identified interventions that are likely to improve the effectiveness and the efficacy of the
national programme. Interventions are aimed at building the capacity of the health system to improve the
quality of comprehensive RH services with special focus on selected areas. These included selected districts,
which for a variety of reasons required additional supportive measures.

Even though Sri Lanka is identified as a low prevalence country in respect of HIV/AIDS, there are risk factors
that could lead to an epidemic situation. Hence, it was considered necessary to direct interventions focusing
on high risk groups and to develop new approaches to minimize spread of HIV/AIDS. Adolescent and youth
form a special group for whom the targeted programmes through the existing health system are limited.
Focusing on the interventions in supporting provision of services for this group from UNFPA is likely to
contribute to the needs of this important sub group of the population.
In keeping with the above, the outputs included under the RH component are as follows:

Output 1: Enhanced capacity of the national health system to improve quality and demand for comprehensive RH services
Output 2: Increased availability and access to high quality RH services in conflict affected and underserved districts
Output 3: Increased efforts to prevent sexually transmitted infections and HIV/AIDS among women and young people
Output 4: Increased coverage and utilization of youth friendly RH services

2.3.3 Programme management and partnership (Reproductive Health)

In keeping with the procedures to be followed in developing the CPAP of UNFPA, the documents have been prepared in consultation with the stakeholders, approved by the key implementing partners obtaining formal approval at national level.

The 7th country programme focuses on provision of financial, technical and policy support for the four outputs indicated above, each of which was to be achieved through a series of strategies. Implementation of a major component of the activities to achieve the above outputs are linked to the existing national health care system, hence the main implementing partner is the Ministry of Health at the national level. In relation to output 2, the Provincial Directorates of Health and the district level health staff are the main partners in the programme management.

In the implementation of the RH component, the NGO sector was involved in partnership with the relevant national programme in implementing some activities in relation to output 3 and some inputs related to output 4.

Partnerships have been established with the World Health Organization, UNAIDS and other organizations to ensure that the activities identified in CPAP are supplemented and not duplicated by those implemented by others. This was especially important in implementing the programmes at the district level. Several links have been established to facilitate/assist in different activities. These links include those with the Health Emergency and Disaster Management Training Centre (HEDMaTC) at the University of Peradeniya, Department of Community Medicine, University of Colombo, Sri Lanka Medical Association and professional bodies such as College of Forensic Pathologists and Sri Lanka College of Obstetricians and Gynaecologists (SLCOG).

A two pronged approach was adopted in addressing the outputs under this component.

1. Support for interventions for policy, advocacy and strengthening of health systems for quality improvement of RH services.
2. District-level interventions focusing on five districts, Anuradhapura, Batticaloa, Kalmunai, Nuwara Eliya and Vavuniya.

In the sections to follow, each of the four outputs in the RH component is presented separately, to ensure clarity.
2.3.4 Output one

Enhanced capacity of the national health system to improve quality and demand for comprehensive RH services.

Relevance

In Sri Lanka, the state health sector is the main provider of comprehensive RH services through field based and institutional services, the Family Health Bureau (FHB) being the decentralized unit within the Ministry of Health mainly responsible for this programme. Supporting the existing health care system for provision of RH services contributes to the national programme and the beneficiaries of the national RH programme. This is in accordance with UNFPA’s Strategic Plan Development Results Framework.

Even though the health related indicators are considered satisfactory especially in comparison to other countries of the region\(^8\), available information indicates that there are inter district variations\(^3\) and there is a possibility that there are ‘pockets’ within districts that need special attention. The need for quality maintenance and improvement is of relevance in improving the outcomes that have already been achieved in the area of RH. Such quality improvement has to be undertaken at all levels of the health care delivery system, national, provincial, district and divisional levels. In order to enhance the capacity of the service providers to improve the quality of services, inputs are required in relation to development of infrastructure facilities including availability of equipment, basic and inservice training of relevant categories of staff and focused advocacy where relevant.

Data from Demographic and Health Survey (DHS) 2006/07 indicates that there is a marginal increase in the Age Specific Fertility Rates (ASFR) in all age groups, compared to the data from DHS 2000, except for the age group 15-19 years. \(^9\) Thus, there is a need to improve access for family planning services through expanding the choice of FP methods and at the same time, ensuring that RH commodities are available as required. Enhancing commodity security through UNFPA interventions is likely to facilitate availability of services at all levels.

Country population assessment (2007) highlights the need for implementation of effective Behaviour Change Communication (BCC) activities as a key area aimed at promoting RH services, especially in areas where relatively ‘new’ inputs are to be introduced.

Gender based violence (GBV) is a hidden problem which has to be addressed through varied inputs, in both health and social sectors. Support from UNFPA is focused on two aspects, one focusing on capacity development of health personnel at all levels in strengthening the national capacities to integrate RH and gender in disaster management and response and the other, to facilitate the development of centres for counseling, treatment and management of GBV at selected health care institutions. These interventions are linked to the comparative advantage of UNFPA in promoting RH and addressing sexual and gender violence, including those in emergencies and conflict situations.

The occurrence of emergency situations is a likely phenomenon with Sri Lanka having had to face many large scale emergencies during the recent years. Being prepared to attend to the health needs (especially RH needs) in such situations has to be considered a necessity in a health system. Training of district level

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personnel and incorporating RH and gender components into the national disaster preparedness plan will make a positive contribution to provide RH services in such emergencies.

The interventions planned under the CPAP, include conducting research for policy advocacy and programme planning in the key areas relevant to RH where the findings will contribute towards development of policies and programmes based on evidence. Details of these interventions are given under strategy number seven.

Though varied in focus, all above strategies would make a positive contribution to develop capacity of the national health system to improve quality and demand for comprehensive RH services.

**Effectiveness**

This output was to be achieved through seven strategies. In keeping with the strategies, the work plans for the years 2008 – 2010 have included several sub outputs and activities. The effectiveness of each of the strategies was considered in relation to the sub outputs and the activities given in the work plans under each strategy. During the evaluation, it was observed that some of the interventions were on going and some were completed only during the latter part of 2010, thus posing a limitation in obtaining quantitative information related to the effectiveness. However, efforts were made to make an assessment, as far as possible.

As each strategy has a different focus and related activities, they are presented separately even though there is some degree of overlap.

**Strategy 1: Establish a Quality Assurance (QA) system at national, provincial and district levels for RH**

This strategy was to be achieved through several activities, grouped under two sub outputs in the work plan.

1.1. Strengthen national capacities for basic training of key categories of RH staff through skills based training

This is a key intervention undertaken to improve quality of services. Based on an assessment of the workload of the Public Health Midwives (PHMs) and following a policy dialogue on the relevance of the tasks of PHMs, UNFPA supported the review and update of curricula of basic training of PHMs. This work is ongoing. The curriculum revision was undertaken through a series of consultative meetings with stakeholders. Assistance provided by UNFPA has supported all stages of the curriculum revision undertaken so far.

Documents indicating the status of curriculum review were available for perusal and they indicated that the ‘new’ concepts in RH have been incorporated into the revised curriculum. The needs of trainers have been identified and training programmes have been initiated as an on-going Continuous Professional Development programme for trainers. However, a formal system through which to implement an on-going professional development programme is yet to be developed.

WHO guidelines and protocols have been used as the basis for the curriculum update. It was seen that the support from the two sources, supplemented each other to facilitate the expected outcomes.

This intervention is likely to contribute towards improvement of quality of RH services through improved training of PHMs, key field level health personnel responsible for RH services. In order to assess its

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10 UNFPA focus under this programme is limited only to curriculum revision of the PHMs.
effectiveness, several more steps are required, commencing from implementation of the revised curriculum. Thus, it is necessary to develop a system for monitoring the implementation of the revised curriculum and assess the effectiveness, on RH services.

1.2. A functional quality assurance system for maternal health, family planning and WWC programmes established based on evidence based protocols, guidelines and standards in FP, Pregnancy, Childbirth, Postpartum and Newborn Care (PCPNC), WWC, GBV and Adolescent Sexual and Reproductive Health (ASRH).

UNFPA support to implement this strategy include: adapting international guidelines and protocols for pregnancy, childbirth, postpartum and newborn care and post abortion care. Preparation of a training guide to be used for training of trainers of health personnel at district level and conducting a needs assessment on Emergency Obstetric and Neonatal Care in partnership with UNICEF and WHO and in collaboration with the SLCOG.

Conducting a workshop to reach consensus between quality secretariats, FHB, Colleges etc., on criteria and setting up of standards for a quality assessment programme, is scheduled for the year 2011.

The present system of monitoring the provision of RH services includes the periodic reviews mostly, based on the information collected through the reproductive health management information system (RHMIS), collected from the MOH level upwards. In some instances, information available from supervisory field visits and those collected on special “topics”, are also discussed at these reviews. However, a majority of these assessments are mainly based on quantitative information and does not have indications of quality.

At the time of the evaluation, process to develop a functional quality assurance system has been initiated. Development of indicators for quality assessment needs to focus on data which can be obtained in a practical and feasible manner. Implementing an effective system for monitoring the RH programme has to be considered as an important activity contributing to improving quality of services.

The above two interventions are likely to contribute towards improvement of quality of RH services in the long term. However, as individual activities, their focus differs. The multiple inputs required to improve quality have to be considered in total in order for the quality improvement to be effective.

**Strategy 2: Expansion of choice of family planning methods**

This strategy included two components, expanding FP/sub fertility services and improving coverage of WWC services which are integral parts of the comprehensive RH services provided through the state health sector.

2.1.1. **Family planning services**

Training programmes for service providers in FP have been implemented as given in the work plan.

Regular review meetings at district level are held bi-annually with MO (MCH), RSPHNO and laboratory staff to monitor implementation of RH activities. Table 3 provides information on total number of FP clinics in the country and the number of sterilizations carried out at the central level institution, the FHB for the period 2007 – 2010. This table shows an increase in the number of FP clinics as well as in the number of female sterilizations done at the FHB, with a decline in the number of male sterilizations.
Table 3: Selected Information of FP services at national level, 2007 – 2010

<table>
<thead>
<tr>
<th>FP service</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of functioning FP clinics</td>
<td>1,832</td>
<td>1,860</td>
<td>1,890</td>
</tr>
<tr>
<td>(four methods)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of female sterilizations done</td>
<td>3,300</td>
<td>3,683</td>
<td>3,743</td>
</tr>
<tr>
<td>at FHB</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of male sterilizations carried</td>
<td>27</td>
<td>26</td>
<td>15</td>
</tr>
<tr>
<td>out at FHB</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: Family Health Bureau, 2011

Availability of implants have contributed to improve the choice of family planning methods. UNFPA has been providing Implanon for three years since 2007. This support has been continued, with the provision of 15,000 sets of Janelle (implant) in 2010, leading to continuation of availability of implants. Table 4 provides information on the pattern of use of contraceptives and the unmet need for FP, at the national level, for the years 2006 – 2009 based on the information available at the FHB, through the RHMIS. Data for 2010 was not available at the time of the evaluation and there is no data available on the discontinuation rates.

Table 4: Information of contraceptive use (national level) 2006 – 2009

<table>
<thead>
<tr>
<th></th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eligible couples</td>
<td>15.8</td>
<td>15.2</td>
<td>15.9</td>
<td>16.0</td>
</tr>
<tr>
<td>Users of modern methods</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>of contraception as %</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>of total eligible</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OC</td>
<td>6.9</td>
<td>7.3</td>
<td>7.4</td>
<td>7.5</td>
</tr>
<tr>
<td>DMPA</td>
<td>17.5</td>
<td>17.7</td>
<td>17.4</td>
<td>17.7</td>
</tr>
<tr>
<td>IUD</td>
<td>6.8</td>
<td>7.4</td>
<td>7.9</td>
<td>8.5</td>
</tr>
<tr>
<td>Implants</td>
<td>-</td>
<td>-</td>
<td>0.5</td>
<td>0.7</td>
</tr>
<tr>
<td>Condom</td>
<td>4.2</td>
<td>4.8</td>
<td>5.2</td>
<td>5.6</td>
</tr>
<tr>
<td>Female sterilizations</td>
<td>13.8</td>
<td>14.0</td>
<td>13.8</td>
<td>13.8</td>
</tr>
<tr>
<td>Male sterilizations</td>
<td>0.5</td>
<td>0.4</td>
<td>0.4</td>
<td>0.3</td>
</tr>
<tr>
<td>Total current users</td>
<td>49.9</td>
<td>51.8</td>
<td>52.7</td>
<td>54.2</td>
</tr>
<tr>
<td>Unmet need</td>
<td>n/a</td>
<td>9.6</td>
<td>8.8</td>
<td>8.4</td>
</tr>
</tbody>
</table>

Source: Family Health Bureau, Ministry of Health, 2011.

Periodic quality checks of the contraceptives which are procured with GOSL funds commenced in 2010, in collaboration with the National Drug Quality Assessment Laboratory (NDQAL). According to the information available from the National Programme Officer, Family Planning (NPO, FP) at the Family Health Bureau, Ministry of Health, there have been no major issues related to the quality of contraceptives reported, until the time of the evaluation. Promoting such an activity by UNFPA has contributed to improved quality of family planning services.

Training of service providers, preparation of a manual for primary health care on sub fertility, user guide for Implanon, guidelines for service providers on IUD and oral contraceptives and a set of flash cards for family planning have been developed. Perusal of these documents indicated that the included relevant content areas were user friendly and according to available information from FHB, these have been distributed to all relevant health staff.
The effectiveness of the continuing professional development programmes for Medical Officers in family planning through a series of articles in the Ceylon Medical Journal could not be assessed at the time of the evaluation. Such an assessment would require a special study. Producing an advocacy booklet on the national FP programme is to be done in 2011.

Provision of equipment for IUD services in underserved areas in the North and East is to be done in 2011 and the implementation of the enhancement of the sterilization programme at FHB, was delayed due to unforeseen circumstances in which the services of the consultant was not available for some time.

2.1.2. Sub-fertility services

These services were focused as an intervention in this CP through supporting the development of investigation facilities for sub fertility in state sector hospitals. Such facilities in the state sector institutions were limited in comparison to those in the private sector. UNFPA supported the training of 80 Medical Laboratory Technologists (MLTs) attached to the hospitals in the state sector in techniques of seminal fluid preparation.

There has been some delay in establishing selected services for sub fertility at FHB due to the unexpected circumstances in which the services of an Obstetrician & Gynecologist were not available for a short period. The impact on the FP programmes due to this delay could not be assessed, as these events occurred only a few months prior to the evaluation.

Establishing a database on service provision for sub fertility at the RH laboratory at FHB was carried out in December 2010, with support from UNFPA, providing required infrastructure facilities. At the time of the evaluation, the database was being established.

2.1.3. Other interventions

Involvement of the Sri Lanka Army to provide information to its cadres on RH, has not been possible due to problems related to fund transfers. Efforts need to be made to overcome administrative issues to involve special groups (such as armed forces), through a focused advocacy programme.

A ‘Help Desk’ to provide information to service providers is being established at FHB. As this is a relatively new venture, it will be useful to make an assessment of the usefulness of the ‘help desk’ to the service providers.

2.2. Improve coverage of WWC services

A pilot study on alternative methods of cervical cancer screening was to be undertaken by FHB. The evaluator was informed that it has been decided not to conduct this study as the method that may be developed will be not as robust as that used at present; hence there are ethical issues in applying the findings at the national level.

Inadequate numbers of trained cytoscreeners was a main handicap in conducting WWCs. At present, cytoscreening is carried out in approximately 40 laboratories in the country. In order to improve cytology screening, 25 full time cytoscreeners were recruited and trained. Such training programmes are to be continued. This group has been appointed to selected hospitals. Consultant Obstetricians and Gynaecologists were provided ‘Updates’. These are to be continued for all relevant categories of senior medical personnel.
Advocacy meetings to establish WWC services have been undertaken in underserved districts UNFPA support is likely to make a positive contribution in improving the coverage of these services.

The expected outcome of these interventions is the improvement in the coverage of screening using PAP smears. Available data indicate that over the period 2007 to 2010, the percentage of PAP smears screened in laboratories has shown an increase indicating the improvements in the availability of facilities including the services of cytoscreeners.

A summary of the activities related to WWCs are given in Table 5a and 5b.

### Table 5a: Information of WWCs – 2010

<table>
<thead>
<tr>
<th></th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of pap smears sent for screening</td>
<td>83,480</td>
<td>94,156</td>
<td>108,255</td>
<td>111,250</td>
</tr>
<tr>
<td>Number of pap smears screened in labs</td>
<td>48,266</td>
<td>60,355</td>
<td>108,255</td>
<td>111,250</td>
</tr>
<tr>
<td>Percent pap smears screened in labs</td>
<td>57.8</td>
<td>64.0</td>
<td>67.8</td>
<td>82.4</td>
</tr>
</tbody>
</table>

Source: Family Health Bureau, Ministry of Health, 2011

### Table 5b: Training programmes related to WWCS - 2009/2010

<table>
<thead>
<tr>
<th>Training</th>
<th>For whom</th>
<th>Time</th>
<th>Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colposcopy workshop</td>
<td>VOGg</td>
<td>-</td>
<td>40</td>
</tr>
<tr>
<td>Training</td>
<td>MOOH</td>
<td>2 days</td>
<td>60</td>
</tr>
<tr>
<td>Training</td>
<td>PHNSs</td>
<td>2 days</td>
<td>126</td>
</tr>
<tr>
<td>Training</td>
<td>RMoo</td>
<td>1 day</td>
<td>85</td>
</tr>
<tr>
<td>Cytoscreening training</td>
<td>MLTt</td>
<td>3 weeks</td>
<td>36</td>
</tr>
<tr>
<td>Review meeting</td>
<td>MOO/MCH</td>
<td>1 day</td>
<td>7</td>
</tr>
<tr>
<td>Annual review meeting</td>
<td>cytoscreeners</td>
<td>-</td>
<td>40</td>
</tr>
<tr>
<td>Advocacy meetings</td>
<td>Various districts</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

Source: Family Health Bureau, Ministry of Health, 2011.

The number of WWCs conducted during the year 2010 by district is given in Table 6, by the number of MOH areas and by population of the district. It is seen that WWCs are conducted in all districts, the numbers varying widely with more than one WWC per MOH area in many of them. However, it is seen that in the north and east, the number of WWCs within the district is less than the number of MOH areas with Mannar and Mullaitivu, having no WWCs at all. This observation may be linked with the conflict/unsettled situation that existed in these districts until recently.

### Table 6: Number of WWCS conducted by district, 2010

<table>
<thead>
<tr>
<th>District</th>
<th>Number of MOHS</th>
<th>Number of WWCs</th>
<th>Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ampara</td>
<td>7</td>
<td>7</td>
<td>301,193</td>
</tr>
<tr>
<td>Anuradhapura</td>
<td>19</td>
<td>21</td>
<td>932,080</td>
</tr>
<tr>
<td>Badulla</td>
<td>15</td>
<td>15</td>
<td>893,417</td>
</tr>
<tr>
<td>Batticaloa</td>
<td>11</td>
<td>12</td>
<td>582,662</td>
</tr>
<tr>
<td>Colombo</td>
<td>12</td>
<td>45</td>
<td>1,724,982</td>
</tr>
<tr>
<td>Colombo M.C</td>
<td>13</td>
<td>10</td>
<td>686,873</td>
</tr>
</tbody>
</table>
Strategy 3: Operationalize a sustainable national quality RH commodity security (RHCS) plan

UNFPA supported the development of a national quality RH commodity security plan by providing an opportunity for the officer in charge to be trained overseas, in 2009. The training focused on the use of a computerized inventory system CHANNEL and at present this system is being used at FHB. However, due to problems related to the “security” of the use of the software, this system has not been extended to other areas. Selected Medical Officers were trained in the use of CHANNEL, with support from UNFPA. However, the relevant officials at FHB have indicated that this system needs to be reviewed and improved. If it is not feasible, another model where there are no ‘security risks’ may have to be introduced. UNFPA also supported the improvement of data handling facilities at the Medical Supplies Division, at the Ministry of Health to facilitate the functioning of the RH commodity security plan.

With a view of improving the stock maintenance and record keeping at the Regional Medical Supplies Divisions, an intervention was undertaken aimed at capacity development of the store keepers. These aim at minimizing depletion of stocks and ensuring proper storage of contraceptives. The visit to the stores at FHB showed the well organized way in which the stocks are maintained and the implementation of an effective record keeping system.

Although included in consecutive AWPs of UNFPA, the new Action plan for RHCS is not yet established and the evaluator was informed by the NPO (RH) that such a plan is being developed. Thus, it is not possible to
make an assessment of the effectiveness of RHCS plan at the country level at present. The contributions made by UNFPA in ensuring commodity security over the past several years may have contributed to the observation made by the NPO (RH) that there have been no stock outs of contraceptives for over the past 12 years. It must be noted that all contraceptive supplies other than the implants have been purchased by the Government of Sri Lanka during the past years.

**Strategy 4: Build national capacity for effective behavioural change communication for RH**

Health Education Bureau is the unit in the Ministry of Health responsible for undertaking interventions related to BCC. UNFPA, CPAP identifies that support be provided to build the national capacity for effective behavioural change communication for RH which included the formulation of a BCC strategy for RH, which is to be carried out in 2011.

As planned, UNFPA has provided support for development of relevant materials on several aspects related to FP and FP methods during the period 2008-2010. However, the development of a documentary film for the general public, a poster and a sticker on GBV, is to be done in 2011.

Mobilization of the media for BCC in RH has been focused on by UNFPA by conducting awareness among media through media seminars on GBV and a visit by media personnel to Mithuru Piyasa at Matara Hospital, to show ‘best practices’. Sixty media personnel participated in the field visit. Perusal of available documents and discussions with the Director, HEB indicated that the response of the media has been positive.\(^ {11}\)

It was observed that HEB has developed a system to follow up on activities undertaken by the journalists, following these inputs. The publication of articles related to GBV and other areas of RH on a periodic basis was observed indicating the interest created by the media targeted activities undertaken by HEB with UNFPA support. There was no document available indicating the number of articles/programmes related to RH published/conducted in all media and it was not feasible to obtain such information. Number of articles had been published in national newspapers on RH issues, within the preceding 2-3 months. It would be necessary to conduct a separate study to obtain quantitative data on such activities.

A ‘Media Award’ was given to the best publication on RH issues for the year 2010 supported by UNFPA.

One issue of ‘Sepatha’ (a periodic publication by HEB) on RH issues has been published in Sinhala and the Tamil version was being done at the time of the evaluation. This publication has been distributed to all health units and the relevant field health personnel and included several articles on common RH issues written in simple language, useful for the field health personnel in their day to day activities. However, it was not possible to assess the use of these documents by the field health personnel, during the evaluation. A number of radio programmes on RH issues have been conducted and it was not possible to assess the contribution made by these programmes in improving awareness on RH issues.

**Strategy 5: Mainstream gender and RH in the health sector emergency preparedness and response**

According to the CPAP, UNFPA support is focused on strengthening the national capacities to integrate RH and gender in disaster management and response. Interventions were aimed at capacity development of a pool of national level trainers and upgrading skills of service providers in the state sector and in the NGO sector to manage RH services including prevention of GBV during emergencies.

\(^ {11}\) S.Amunugama, personal communication, 2011.
Upgrading the knowledge of health and related personnel is being undertaken by the Health Emergency and Disaster Management Training Centre (HEDMaTC), University of Peradeniya. There are two programmes conducted by the Centre, one of which focuses on integrating sexual and reproductive health (SRH) in crisis, into emergency preparedness and response programmes. These programmes are ongoing and at the time of the evaluation 125 personnel mainly from the state health services have been trained.

For each programme, a pre-post evaluation was done and the available documents indicated that the programmes have contributed to improvement of knowledge related to the content areas. A follow up meeting of some trained personnel was carried out recently and informal discussions were held to assess their capacities. The report on this ‘review’ was not available at the time of the evaluation. Hence, there is no evidence available as to whether there were opportunities for the trainees to use the knowledge.

In addition to the above, UNFPA supports relevant districts in responding to emergency situations, by procurement and stockpiling of sanitary packs, delivery packs and emergency RH kits. A ‘Technical Guide on RH for Auxiliary Health Workers’ has been prepared and is awaiting distribution to the field based health workers, linked with a training programme.

Coordinator, disaster preparedness and response division, Ministry of Health, informed that a draft document on a ‘Strategic Plan for health sector disaster/ emergency preparedness’ has been drawn up and is under review by a Steering Committee. Both reproductive health and gender issues are included in this strategic plan. UNFPA has served as a member of the steering committee. Follow up on the status of this plan and its implementation is an important aspect to be considered to make these inputs useful, in the long term.

**Strategy 6: Strengthen health sector to respond to gender based violence**

Integration of the GBV management and prevention into the health sector was one of the interventions that are expected to assist in mainstreaming gender within the health sector.

Following the tsunami and based on the experience from a pilot project conducted in Anuradahapura, a centre was established for counseling, treatment and management of GBV at Matara Hospital ‘Mithuru Piyasa’. UNFPA supported the follow up on this activity by linking up with FHB, Ministry of Health and the provincial and district health staff, in expanding such services to several other hospitals, Nuwara Eliya, Dickoya, Tambuttegama, Kalmunai, Batticaloa and Valachchinai. The staff of these centres have been trained. Support has been provided by UNFPA to develop the infrastructure facilities at these venues. Some of these centres have been in existence only for a short time and in others; the activities have not yet started.

A key input, that of developing a computer based MIS from the hospital GBV centres has commenced. Development and implementation of such a system will have a useful impact on the possibility of having an effective monitoring system. Hence, at the time of the evaluation, availability of data on use was limited.

The only data available was from ‘Mithuru Piyasa’ which is the established GBV centre at Matara BH. The data indicates the total number of visits for the years 2008, 2009, 2010 and 2001 up to May, as 147, 509, 885 and 713 respectively. The number of ‘new cases’ at the centre for the years 2009, 2010 and 2011 (up to end May) were 356,610 and 332 respectively. The number of persons visited shows an upward trend indicating the increase awareness and acceptability of the services provided by Mithuru Piyasa. No additional information was available.
In addition, awareness programmes for district level health staff (teams comprising MO (MCH), some MOHs, PHNS, PHI and HEO) have been done using a module developed with support from UNFPA. This intervention is to be extended to the field level health personnel.

Once the GBV centres are fully established at the district level, it may be necessary to study the role of the field health personnel in identification and referral of those requiring assistance at these centres and the role that they could play in their follow up. However, it is necessary to be sensitive to ethical issues that may arise in co-opting filed health staff for follow up on those subjected to GBV.

Additional inputs in terms of support to develop protocols on clinical management of rape and adapting the WHO guideline on “Guideline on clinical management of rape survivors” were being attended to at the time of the evaluation. According to the UNFPA Consultant on GBV, the development of 1) facilitator manual for training of health staff in GBV 2) handbook on GBV for health personnel and 3) protocol for establishment and management of GBV care centres are being done and are in draft form.

**Strategy 7: Support operations research and studies for improved management of RH services and to provide evidence based advocacy for policy**

The CPAP identified several operational research studies, the findings of which were to be utilized in improved management of RH services and to provide evidence based advocacy for policy.

The study on unintended pregnancies included a qualitative component to examine factors that constitute the unmet need and how couples/women deal with unintended pregnancies, provider perspectives and a hospital based study on induced abortion. This study has been completed and a report is available. Dissemination of the findings is yet to be done.

A study on Human Papilloma Virus and cervical cancer screening was carried out by the Epidemiology Unit of the Ministry of Health. The findings have been disseminated and the evaluators were informed that the findings have been used in making policy decisions, related to introduction of the vaccine at country level.

Bongaarts analysis of DHS data to determine the contribution of induced abortion on the current fertility rates was carried out by a local consultant along with the Department of Census and Statistics. The report is available and is to be disseminated.

A study on teenage pregnancies is being carried out by the University of Colombo in collaboration with the Family Health Bureau, Ministry of Health. The study was carried out in the three districts: Colombo, Anuradhapura and Batticaloa using both quantitative and qualitative approaches.

An in-depth analysis of the maternal deaths due to suicide, homicide and violence during the past two years is to be carried out during 2011/12, to determine the contribution of socio cultural determinants including gender stereotyping and GBV on the health of pregnant women.

As described above, the planned operational research activities have been completed and one other is ongoing, as per schedule. Action has been taken to utilize the results of one study by policy makers. Action to follow up on the findings of the other studies is being taken, in collaboration with the relevant national level stakeholders.
**Efficiency**

Of the total allocation for the project for the years 2009 and 2010, a substantially high proportion has been allocated for RH outputs (38.6% in 2009 and 51% in 2010). Of these amounts, the highest allocations were for the inputs into the underserved districts 63.9% and 60.2% for the years 2009 and 2010 respectively. The percentage allocation of funds for the HIV and youth components were 4.4% and 2.2 % for HIV and youth programmes in 2009 and 5.6% and 3.9 % to the programmes in 2010.

**Table 7a: Financial allocation for main component of the UNFPA project (in USD)**

<table>
<thead>
<tr>
<th>Year</th>
<th>Budget allocation (USD)</th>
<th>% allocation of the budget to components of the UNFPA programme</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>4,649,019</td>
<td>38.6</td>
</tr>
<tr>
<td>2010</td>
<td>4,167,689</td>
<td>51.0</td>
</tr>
<tr>
<td>For RH, HIV and youth</td>
<td>1,796,569</td>
<td>48.0</td>
</tr>
<tr>
<td>2009</td>
<td>2,124,863</td>
<td>51.0</td>
</tr>
<tr>
<td>2010</td>
<td>2,124,863</td>
<td>63.9</td>
</tr>
<tr>
<td>Gender programme</td>
<td>487,672</td>
<td>10.5</td>
</tr>
<tr>
<td>2009</td>
<td>541,576</td>
<td>13.0</td>
</tr>
<tr>
<td>2010</td>
<td>541,576</td>
<td>13.0</td>
</tr>
<tr>
<td>Population &amp; development</td>
<td>134,672</td>
<td>2.9</td>
</tr>
<tr>
<td>2009</td>
<td>50,748</td>
<td>1.2</td>
</tr>
<tr>
<td>2010</td>
<td>50,748</td>
<td>1.2</td>
</tr>
<tr>
<td>Others</td>
<td>2,230,106</td>
<td>48.0</td>
</tr>
<tr>
<td>2009</td>
<td>1,450,502</td>
<td>34.8</td>
</tr>
</tbody>
</table>

Source: UNFPA, country office.

**Table 7b: Distribution of finances for RH (national and district levels) HIV and youth programmes**

<table>
<thead>
<tr>
<th>Year</th>
<th>Budget allocation (USD)</th>
<th>% Distribution of budget by programme</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>1,796,569</td>
<td>2,128,862</td>
</tr>
<tr>
<td>2010</td>
<td>2,128,862</td>
<td>30.2</td>
</tr>
<tr>
<td>RH – Ministry of Health</td>
<td>530,462</td>
<td>641,261</td>
</tr>
<tr>
<td>2009</td>
<td>641,261</td>
<td>29.5</td>
</tr>
<tr>
<td>2010</td>
<td>641,261</td>
<td>30.2</td>
</tr>
<tr>
<td>RH – District level programme</td>
<td>1,148,758</td>
<td>1,281,968</td>
</tr>
<tr>
<td>2009</td>
<td>1,281,968</td>
<td>63.9</td>
</tr>
<tr>
<td>2010</td>
<td>1,281,968</td>
<td>60.3</td>
</tr>
<tr>
<td>HIV programme</td>
<td>78,537</td>
<td>118,821</td>
</tr>
<tr>
<td>2009</td>
<td>118,821</td>
<td>4.4</td>
</tr>
<tr>
<td>2010</td>
<td>118,821</td>
<td>5.6</td>
</tr>
<tr>
<td>‘Youth’ programmes</td>
<td>38,810</td>
<td>82,812</td>
</tr>
<tr>
<td>2009</td>
<td>82,812</td>
<td>2.2</td>
</tr>
<tr>
<td>2010</td>
<td>82,812</td>
<td>3.9</td>
</tr>
</tbody>
</table>

Source: UNFPA, country office

The seven strategies included in the CPAP to achieve output 1 were to be carried out by several implementing agencies, focusing on a range of activities. Hence it is possible only to make an overall assessment of the efficiency relevant to output 1. Almost all activities were to be implemented through the different existing mechanisms for delivery of health services which is a very effective way. As mentioned earlier, the partnerships developed were with well established organizations/institutions that lent their support to implement the activities as relevant to them.

Many of the activities aimed at capacity building of different categories of health personnel providing RH services. However, it was not possible to assess the efficiency of the training programmes as contributing to the quality of work as no data was available to make such an assessment. The other main inputs were related to provision of equipment, most of which had been done in 2010. During this evaluation, it was not feasible to obtain any information on the utilization of this equipment.
It was not possible to carry out a cost effectiveness analysis, based on resources used and the costs and quantities of these resources. However, delays in the availability of financial resources were highlighted by many programme implementers.

As all activities under this output were to be carried out by the Ministry of Health, the human resources involved were those who undertake service provision, as their normal duties. However, it is necessary to consider the possibility that giving the responsibility of undertaking activities implemented by several donors including UN agencies to the same categories of staff may lead to problems related to the ability of such personnel to perform the varied tasks adequately as mentioned by a senior official at the Ministry of Health.

**Sustainability**

A major component of the RH programme of the UNFPA is focused on strengthening of the existing national health system in the country, with limited interventions into the NGO sector. The national ownership of the interventions could be considered as an important factor that contributes to the sustainability. The continuation of the interventions initiated under the CPAP is likely to be an integral part of the RH services that continues to be provided through the national health system.

At the time of the evaluation, it was observed that for each of the two thematic areas, Gender and P&D, there was a separate NPO available, which was not the situation with RH. Instead, two NPOs and one Humanitarian Coordinator are responsible for components within the RH programme. As the outputs 1 – 4 are closely linked and with a separate officer being responsible for a sub division within output 2, there seems to be fragmentation of the implementation of the interventions under the RH programme. It is also necessary to consider the workload for each staff member. The RH programme needs to be implemented in a cohesive manner to ensure sustainability of the programme, as this is a major component under the CPAP, both in terms of financial resources and interventions.

Many of the inputs have focused on capacity building and supporting services through supply of equipment and other infrastructure facilities and are linked to the functions of the respective implementing agencies. The maintenance of equipment in the state sector institutions is handled through an organized system (via biomedical engineering divisions linked to respective PDHS/RDHS offices). Hence, the sustainability of the use of this equipment is likely to be continued over a reasonable period, making a positive contribution to the sustainability of many of the activities of the programme.

Supply of contraceptives (implants) has to be made sustainable by the government taking over the supply in a phased manner as was envisaged in the CPAP. Action needs to be initiated from now itself, so that a smooth takeover is ensured, as it happened in respect of other contraceptives provided through the national programme.

**Impact**

The impact has to be assessed in relation to the extent to which the strategies included in the CPAP has enhanced capacity of the national health system to improve quality and demand for comprehensive RH services. Due to the multiple inputs through the state sector, different development partners and other sources that are ongoing, it is not possible to assess an impact of the contribution made by CPAP per se, in enhancing capacity of the health sector.

However, there are several inputs which are likely to have a medium/long term impact on the quality assurance of the health system and these are discussed briefly in the sections to follow.
Review and revision of curricula of PHMs, linked with development of a continuing education programme of trainers and appropriate follow up is likely to have a medium/long term impact of the quality of the inputs to the RH programme through improved knowledge and skills of the field level health staff.

Support provided, contributed to the expansion of choice of family planning methods through provision of implants along with training activities, at the national and district level. However, an effective monitoring programme needs to be in place to ensure a sustainable impact on FP services. Linked to this same outcome is the implementation of an effective national quality RH commodity security plan and ensuring continuity of such a plan. According to available information there have been no ‘stock outs’ of contraceptive commodities in recent years.

Impact of the behavioural change communication for RH undertaken so far under the CPAP needs to be assessed and the inputs from such an assessment should be considered in developing the BCC strategy during the year 2011. It is envisaged that a BCC strategy is to be developed during the year 2011. It is necessary for the next CPAP to take into consideration the contents of the BCC strategy so developed and consider providing support to implement selected activities.

Without any baseline information or any valid information at the time of the evaluation, it is not possible to make any quantitative estimate of the impact. However, activities related to establishment of GBV centres in several hospitals, training of district health staff has developed the capacity of the health system to respond to GBV. Mainstreaming gender and RH in the health sector emergency preparedness and response linked with appropriate training is a key input that has been facilitated by this CPAP.

Several operational research activities have been undertaken, some of which have been completed. Dissemination of the research results are linked with the research and it was noted that the result of one study that was conducted has been used in making policy decisions related to HPV immunization.

The output one which includes the seven strategies presented above focuses on widening access to comprehensive RH services with emphasis on improving the quality of services and in promoting capacity building to support strengthening of the health system. These aspects are important in applying human rights standards related to RH programmes.

2.3.5 Output two

Increased availability and access to high quality RH services in conflict affected and underserved districts

The CPAP adopted a two pronged strategy of catering to the humanitarian needs of the communities and capacity building of the district health system to strengthen the delivery of quality of RH services. The rationale for the choice of these five districts is given in Part IV of the CPAP.

In the CPAP 2008 – 2012, the districts identified as ‘underserved’ were: Anuradhapura, Nuwara Eliya, Batticaloa, Kalmunai RDHS area in Ampara district, and Vavuniya. The selection of districts has been based on criteria relevant to family planning indicators. Key RH indicators for the five districts are given in table 8.
Table 8: RH indicators in the five districts

<table>
<thead>
<tr>
<th>Indicator at district level</th>
<th>Anuradhapura</th>
<th>Batticaloa</th>
<th>Kalmunai</th>
<th>Nuwara Eliya</th>
<th>Vavuniya</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total fertility rate (2006/07)</td>
<td>2.3</td>
<td>2.8</td>
<td>2.9</td>
<td>2.6</td>
<td>N/A</td>
</tr>
<tr>
<td>Maternal mortality rate (2006)</td>
<td>29.7</td>
<td>77.4</td>
<td>85.0</td>
<td>80.7</td>
<td>39.3</td>
</tr>
<tr>
<td>Contraceptive prevalence rate (2006/07) all methods</td>
<td>74.0</td>
<td>34.5</td>
<td>69.5</td>
<td>69.5</td>
<td>N/A</td>
</tr>
<tr>
<td>Contraceptive prevalence rate (2006/07) modern methods</td>
<td>62.6</td>
<td>34.0</td>
<td>49.9</td>
<td>63.2</td>
<td>N/A</td>
</tr>
<tr>
<td>Unmet need for FP 2006/07 spacing</td>
<td>2.4</td>
<td>10.6</td>
<td>11.7</td>
<td>5.2</td>
<td>N/A</td>
</tr>
<tr>
<td>Unmet need for FP 2006/07 limiting</td>
<td>1.9</td>
<td>12.2</td>
<td>3.7</td>
<td>4.0</td>
<td>N/A</td>
</tr>
<tr>
<td>Deliveries attended by skilled attendant (2006/07)</td>
<td>98.1</td>
<td>98.4</td>
<td>96.8</td>
<td>95.8</td>
<td>N/A</td>
</tr>
</tbody>
</table>


Relevance

Even though at the national level, many of the RH related indicators are satisfactory, it is well documented that there are important differences observed at sub national levels, maternal mortality rate, contraceptive prevalence rate, percentage of teenage pregnancies being among them. Three of the districts included in this CPAP were either conflict affected or were bordering such districts. There are many reasons as to why RH related indicators are poor in these areas compared to other districts. Improving the health services in underserved districts is a priority for the Sri Lankan government and all districts included in the CPAP were of the view that such inputs were useful for the target population. There are several other donors who provide inputs into the health sector, not necessarily for the RH services. Among them are WHO, UNICEF and the World Bank. Available information from the districts indicate that WHO support is mainly in the form of technical inputs, in keeping with their normative function with UNICEF focusing mainly on children with special emphasis on nutritional problems. World Bank inputs have facilitated development of infrastructure physical facilities, with UNFPA supporting limited refurbishment facilities, provision of equipment, training and technical assistance. Thus, UNFPA assistance complements the assistance provided by other major donors. However, it was not possible to assess inputs from other sources, during this evaluation.

Capacity building of the district health system to strengthen the delivery of quality of RH services was the main focus of the interventions at the district level. The interventions required differed between areas, hence the relevance of developing appropriate programmes/activities suited for the district.

District based component has been included in the CPAP to cater to the humanitarian needs of the affected communities and to improve the capacity of the district health system to provide RH services. Selection of the districts have been done on the basis of available data related to RH services and the development of a

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plan to identify the inputs required at the district level was done in consultation with the provincial and
district health staff. One of the districts included is in the central province, one other, in the North Central
Province and other two in the Eastern Province.

The interventions focused on providing equipment and other infrastructure facilities to expand the
availability of RH services and capacity development of relevant personnel as relevant to each district. Even
though the focus of interventions was similar in all districts, there were wide variations in the actual
implementation at district level. The resource allocations were also different. Developing a summary table
indicating the inputs to different districts was not feasible.

All strategies focus on areas that are aimed at improving the quality, availability and accessibility of RH
services, with the different inputs supporting the contributions by different activities, depending on the
needs of each district.

**Effectiveness**

The expected outcome of the inputs at the district level has been identified as: improving capacities of the
health system, NGOs and communities to increase the coverage and quality of family planning, reproductive
cancer screening, maternal health services, RH information and services to youth and to effectively respond
to GBV.

Table 9: Selected information of contraceptive use (5 target districts) 2008 – 2009

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Anuradhapura</th>
<th>Batticaloa</th>
<th>Kalmunai</th>
<th>Nuwara Eliya</th>
<th>Vavuniya</th>
</tr>
</thead>
<tbody>
<tr>
<td>OC</td>
<td>18.0 18.0</td>
<td>14.8 14.1</td>
<td>15.0 15.6</td>
<td>14.3 15.2</td>
<td>12.8 14.1</td>
</tr>
<tr>
<td>Female sterilizations</td>
<td>15.1 14.0</td>
<td>8.9 9.1</td>
<td>8.1 10.4</td>
<td>36.1 35.4</td>
<td>13.9 13.4</td>
</tr>
<tr>
<td>Male sterilizations</td>
<td>0.3 0.2</td>
<td>0.3 0.1</td>
<td>0.7 0.0</td>
<td>0.3 0.2</td>
<td>0.1 0.1</td>
</tr>
<tr>
<td>Total current users</td>
<td>59.2 60.0</td>
<td>36.0 39.9</td>
<td>31.0 35.4</td>
<td>66.5 67.1</td>
<td>38.6 40.4</td>
</tr>
</tbody>
</table>

Source: Family Health Bureau, Ministry of Health

Effectiveness of the planned programme under CPAP is presented in brief, for each district separately.
Information on contraceptive practice in the five districts in the years 2008 and 2009 are given in Table 9. The
inter-district variations are marked with Anuradhapura and Nuwara Eliya districts showing the percentage of
current contraceptive users to be 60% or more with that in Vavuniya, Kalmunai and Batticaloa being in the
range of 30% – 40%.

In general, district level staff has been actively involved in conducting all activities with satisfactory links
between the institutional services and field based services. Maintenance of equipment has been carried out
through the Biomedical Engineering unit at the RDHS offices.
Anuradhapura

Anuradhapura is one of the two districts in the North Central province with a population of approximately 900,000 spread out over an area of 6,664 sq.km, with a population density of 119 per sq.km. There are 19 MOH areas, 284 PHM areas and 176 field clinic centres. The population distribution indicates that the majority of the population lives in rural areas.

Six strategies were to be implemented to achieve the above and the effectiveness of the activities included under these strategies is described briefly.

Strengthening CEmONC facilities at Teaching Hospital, Anuradhapura, Base Hospital (BH), Tambuttegama and BH, Padaviya has been carried out by UNFPA through provision of equipment and training of labour room staff. Non availability of Obstetricians at the two BHs has limited the use of the facilities.

Improvement of basic maternity care services were assisted with UNFPA funds, with provision of equipment for labour rooms, antenatal wards in peripheral institutions and by providing transport facilities to enable emergency transfer of mothers. Equipment required for improving the services provided at the field level antenatal clinics were provided through UNFPA funding. UNFPA assistance was used to improve the availability of test kits for testing for urine for albumin, sugar and hemoglobin levels.

Capacity development was supported through providing an ‘update’ on skills related to intra partum and early postpartum care, to approximately 500 nursing staff and midwives. Many of the interventions have been carried out during the year 2010.

All the above inputs are aimed at improving maternal care and reducing maternal morbidity and mortality. There is no available data to make any assessment of the effectiveness of the interventions during this period and also it is necessary to consider that the period during which changes are expected to occur is relatively short.

The other main focus of the inputs to the Anuradhapura district was those targeted at improvement of neonatal care services, by upgrading the facilities at the PBU at TH and the Special Baby Care Units at BH Tambuttegama and DH, Kekirawa. However, non availability of a Pediatrician at DH, Kekirawa has limited their use. Staff in the peripheral institutions was trained in life saving management of the newborn, which aims at improving neonatal care. There is no information available regarding the neonatal mortality and morbidity in these hospitals to make an assessment of the effectiveness of such training.

Additional interventions to improve the capacity of the health system to increase the coverage and quality of the RH programme included: improvement of transport facilities for field health staff and facilitating educational programmes undertaken by the MOHs through provision of multimedia projectors and other facilities. Support for the activities of WWCs has been facilitated by the provision of a microscope to the TH, Anuradhapura, though no data is available related to the use of this facility per se.

RDHS and both MO (MCH) have been trained at HEDMaT on SRH in emergencies. Sub-district level training to train MOHs, PHNSs and SPHMs (a total of 50) has commenced.

Training relevant to GBV was undertaken for all staff at BH, Tambuttegama (approximately 350). Initial work in setting up of a GBV centre at Tambuttegama hospital has been done and the activities of the centre are due to commence shortly. Several programmes aimed at increasing community awareness have been carried
out. It is not possible to assess the effectiveness of the UNFPA contribution in services related to GBV as such services are yet to be commenced.

A wide range of inputs aimed at improving maternal and neonatal health have been included at the district level, most of which have been carried out in 2010. Assessment of the effectiveness of these inputs was not feasible at the time of the evaluation.

Even though physical facilities, provision of other support facilities and capacity development of staff have been done with UNFPA assistance, non availability or trained skilled medical personnel (at consultant level) is seen to have interfered with the provision of services, as at the time of evaluation.

**Batticaloa**

Batticaloa district is one of the three districts in the Eastern province of Sri Lanka, where a conflict situation prevailed for several years. The district has one Teaching Hospital, three Basic Hospitals, four District Hospitals, five Rural Hospitals, 6 Central Dispensaries & Maternity Homes and 13 Central Dispensaries. The number of MOH areas in the district total to 14.

With assistance from UNFPA, the CEmONC facilities at the Teaching Hospital Batticaloa, the Base Hospitals at Valachchinai and Kalavanchikudi have been improved through provision of required equipment and supplies. The available facilities for newborn care at BH Valachchinai were also improved with the provision of equipment. Skill based training for labour room staff has been undertaken at the TH, Batticaloa. Procurement of essential test kits for improvement of screening facilities at field level ANCs was done. However, sustaining the availability of these kits in the future is an important issue.

Trained health volunteers worked as a link between the state health system and the community, especially in the resettled areas. Training of trainers in updates of FP and WWC programmes has been done. Health staff has been trained in addressing RH needs and gender issues in emergency situations. The district focal point for disaster management has been trained in the MISP on RH during emergencies.

There is no programme aimed at adolescents and youth in this district and this was identified as a need that has to be addressed. Upgrading facilities at the STI clinic has been done in consultation with NSACP. At present HIV testing is done at TH, Batticaloa.

Establishment of a GBV centre at the TH Batticaloa has been done some time ago, by the Consultant Psychiatrist at the time. The already implemented activities were reoriented to be in line with the national plan following advocacy meetings with health authorities and hospital staff has commenced.

Available data from the RDHS office at Batticaloa indicate several improvements in RH indicators, even though all of them are not directly linked to the UNFPA interventions. Some indicators are: the reduction of teenage pregnancies, from 12.6 in 2008 to 11.2 in 2010, increase in users of modern methods of contraception from 36.9% in 2008 to 39.6% in 2010, increase in the number of WWCs from 13 in 2008 to 59 in 2010 and IUD facilities being available, 17 clinics and 10 MOHs having been trained in insertion of ‘Jadelle’.

The Regional Training Centre (RTC) where basic training of PHMS and PHIs take place is under the purview of the RDHS, Batticaloa and at the time of the visit, both training programmes were on going. The facilities available for these trainees were minimal (compared to other RTCs). Improving the infrastructure facilities, IT facilities, library facilities and other support would make an important contribution, to make the training of
these categories of staff more effective. Additional provision of appropriately trained human resources having competency to train PHMs under the new curriculum is an urgent need.

Kalmunai

Kalmunai Regional Director of Health Services (RDHS) division has been included as one of the target areas under the UNFPA, CPAP 07.

The CEMONC facilities at Ashraff Memorial Hospital, BH Kalmunai North and BH Akkraipattu were strengthened by providing equipment for operating theatres, labour rooms and for neonatal units. A list of equipment was available for perusal. A 12 day skill based training programme for labour room staff was done at the memorial hospital and BH.

The facilities at ANCs have been strengthened by supplying basic equipment required and by provision of test kits. However, the sustainability of such supplies is an issue. Updates on FP and WWC have been done. The clinic schedules have been revised to allow more time for field visits by the PHMs.

So far, the MO (MCH) has not been trained on the MISP for RH in emergencies, but has been requested to attend the training scheduled for March 2011.

Upgrading facilities at the STI clinic has been done in consultation with NSACP with provision of equipment including dark ground microscope and a binocular microscope. PAP smears are taken in 25 clinics conducted in 10 MOH areas. However, there are no facilities for smear examinations; hence they have to be sent out for reporting. The MO (MCH) is a recent appointee and has not received training related to GBV. However, there is a resource pool for GBV training at the district levels and two ToT programmes have been conducted on prevention and management of GBV using the training module prepared by UNFPA. Four programmes have been conducted for divisional level staff.

There are 4 GBV centres within the district, with GBV centres at BH Kalmunai North and Akkaraipattu being in place for about three years and those at AMH and BH Samanthurai being functioning for about 1 year. As there is no information system it was not possible to obtain information on the use of these centres. It was noted that these centres are linked with the mental health services.

Some of the components of the district level interventions through UNFPA were provided in 2010. This posed a major limitation to assess the effectiveness of the UNFPA programme at the district level, except for the assessment of the conduct of the planned activities, which has been presented in this section.

Nuwara Eliya

Eight strategies were to be implemented to achieve the above and the effectiveness of the activities included under these strategies are described briefly.

Establishing additional outreach facilities for antenatal care was planned and was carried out at Lindula and Walapane hospitals by making available mobile scanners and through visits by Consultant Obstetricians. UNFPA supported the services at field based clinics through the availability of test kits. With nearly half the institutional deliveries taking place in base and divisional hospitals in the district, improving the infrastructure facilities and equipment at Dickoya and Rikillagashada Base Hospitals have been undertaken. (There was no Consultant Obstetrician at the Rikillagaskada hospital, hence optimal use of the support provided could not
be achieved so far). Investigation facilities have been improved at the GH Nuwara Eliya. Training of labour room staff is another activity facilitated through UNFPA.

All above inputs are focused towards improving quality of maternal care aimed at improvements in maternal morbidity and mortality. In a majority of instances, the inputs have been in place for a few months only. According to limited quantitative evidence available at the RDHS level, the percentage of mothers receiving antenatal care has not shown much change between 2009 and 2010 (approximately 88%) and the percentage of home deliveries has reduced from 1.28% in 2008 to 0.89% in 2010. Number of maternal deaths also has remained the same between 2009 and 2010, at 26. The evaluator is of the view that the inputs have been implemented only for a relatively short period of time to show any quantifiable improvements in these indicators.

Development of booklets on RH, gender and FP to educate couples at pre conception level is being undertaken. The availability of the Tamil version is very relevant to this district. Male participation has been promoted through many approaches. However, no data was available on the extent of male participation.

Establishing outreach FP clinics in three out of the five new MOH areas have been done and available information from the relevant health staff indicates that provision of such services has led to easier access of the RH services to the target population. This is very likely considering the geographical distribution of the population within the district. Increasing the number of methods of FP available by introducing Jadelle is being planned (5,000 units have been made available). MO (MCH) has been trained in insertion of Jadelle and training of MOHs will follow.

Improving commodity security by using an operating system is to commence with the MO (MCH) having being trained in the software “CHANEL”. However, implementation of this system depends on the decision to be made by the FHB.

Regarding the WWC services, there were two main interventions, conducting a consultative meeting to review the WWC programmes and to introduce a register for referrals, in addition to which strengthening of investigation facilities and pap smear reading facilities were done at the BH, Nuwara Eliya.

The district focal point, MO (MCH) has been trained on MISP on RH in emergencies at the HEDMaT. There is no ongoing programme for youth on RH. Action has been taken to train Health Volunteers during the period 2008 – 2010. An improved transport facility for health staff is available through the provision of a double cab.

Training of staff for prevention of GBV was undertaken 2 months ago. Two GBV centres based on the Matara model has been set up very recently in Nuwara Eliya general hospital and Dickoya base hospital. Technical assistance in training of health personnel and infrastructure facilities were made available through UNFPA. The GBV centres were to commence their functioning early; hence it was not possible to make any assessment of their effectiveness.

Vavuniya

Vavuniya district is situated in the Northern Province, with an estimated population as at end December 2009 of 224,210 and a population density of 114 per sq.km. A majority of the population are resident in rural areas. The district included 4 MOH areas which include 41 PHM areas and 15 PHI areas. The district has 1 District General Hospital, 1 Base Hospital at Cheddikulum, 8 divisional hospitals and 1 primary medical care unit.
With assistance from UNFPA, the CEMONC facilities DGH, Vavuniya has been improved through provision of required equipment.

Outreach clinics are conducted with participation of VOGs, due to the heavy workload of the VOGs, as nearly 90% of all mothers within the district and several from the adjoining districts of Mannar, Mullaitivu and Kilinichchi come to this institution for delivery. However, mobile clinic facilities have been facilitated by UNFPA, and the MOHs and staff provide services using this facility. At the time of the evaluation, this facility was also used for provision of services to the resettled populations.

Quality of ANC at the peripheral clinics has been improved, as per the assessments made by the health staff, with provision of support facilities e.g. screens, beds. However, there was no way of verifying these statements.

Protocols have been developed for timely referral and the documents were available. Staff of GH has been trained in ‘safe motherhood’. However, skill based training in CEmOC for staff of GH has not been done as yet. In 2009 and 2010, several training programmes have been done in relation to FP, WWC and GBV.

A total of 20 rural health assistants have been supported and they assist the PHMs in their work. It is envisaged that more PHMs will be available within 1-2 months, so that their services may not be needed in the future.

It was noted that WWCs are not conducted within the district except in the MOH area of Vavuniya South (1 clinic/month) even though a cytoscreener and facilities for examination of PAP smears are available at the GH, Vavuniya. A total of 10 medical officers (2 MO’s from the hospitals and 8 MOHs) have been trained in insertion of Jadelle. This method of FP is being carried out in GH, Vavuniya and MOH area, Vavuniya South. Insertion of IUCDs is limited and is carried out only in the MOH, Vavuniya South and in the GH.

Two MOHs have been trained on MISP on RH in emergencies and 3 other district level officers are due to attend the programmes scheduled for March 2011.

From September 2010, RDHS Vavuniya is responsible for the delivery of RH services to those remaining in the Welfare Centres (numbering approximately 19,000). The services are provided through 2 PHMs, 1 PHNS and 4 Health Volunteers with the MOH of the area providing clinical services.

In the aftermath of the circumstances faced by the “displaced” population, there is a need for counseling services, to those still in the welfare centres as well as for those who are resettled. Nine persons have been identified to be trained as counselors.

In Vavuniya, data on the health service provided through the RDHS are available for 2009 with limitations in such availability for 2010, at the time of the evaluation.

Efficiency

As shown in tables 8 and 9, there were wide variations between districts in terms of indicators of RH. Under the CPAP, required interventions at district level were identified and specific interventions were provided to influence RH services. Focusing on districts enabled identification of interventions relevant to the district and assisted in ‘micro planning’ implying more appropriate use of support provided. Resources were directly sent to the province/district, thus minimizing issues related to delays in fund transfers at different levels, thus improving the efficiency.
The interventions did not overlap with other interventions funded by other sources within the district and were closely linked with the national level programmes aimed at providing RH services. Most programme strategies are still relevant as far as these districts are concerned with some modifications made in relation to their future needs.

Focusing on selected districts in supporting availability and access to high quality RH services in conflict affected and underserved districts has been a concern expressed by several stakeholders. The views expressed, identified both the positive and the negative aspects of such an approach. In terms of attempting to focus on district based needs, it is a positive step. However, the selection of districts has to be criteria based and be done in a transparent manner and need to ensure that there is no duplication with the inputs from other funding organizations.

**Sustainability**

Implementation of programmes through the provincial/district level gives a sense of ownership to the district level health staff in implementing activities and the flexibility afforded to make decisions relevant to the district facilitates their involvement. However, where financial support is required to continue an activity or implement an activity, the ability of the province/district to continue implementation, may be less, compared to the situation where an activity is implemented at the central level.

The partnerships established with the provincial/district level authorities and UNFPA seem to work well as far as implementation of CPAP is concerned.

Availability of facilities for maintenance of equipment provided under the project facilitates such continuation. However, where procurements and additional finances are required, sustainability may be an important issue.

**Impact**

In general, there is an improvement in many of the facilities providing RH services and in RH related indicators even though it is not possible to attribute these changes to CPAP. Capacity development has been undertaken in several ways and the impact of these inputs could not be assessed as information on follow up on the use of such capacity was not available. Strengthening of institutions through provision of equipment has occurred as a direct intervention through CPAP. However, the extent of the use of such equipment could not be assessed due to many limitations. Available data on current use of contraception is limited and does not enable to make any assessment of the impact of the inputs through this CPAP.

**2.3.6 Reproductive health interventions in conflict affected areas**

A special situation arose in mid 2009, due to the large influx of displaced persons from the conflict areas (approximately 300,000) to specific districts within a short period of time, when the need for provision of RH services became a high priority. The response from UNFPA in this crisis situation with the focus on improving the RH services through provision of facilities, provide for training of volunteers, etc., to the displaced persons contributed to the efforts made by the Sri Lankan government and other agencies.

The activities described under this section were not included under the CPAP, but were implemented in response to the needs that arose in relation to the humanitarian crisis situation that occurred in the year 2009. Hence, only the effectiveness will be presented in this report.
UNFPA CPAP, in keeping with the UNDAF 2006-2010 recognized the need for interventions to improve socioeconomic conditions and services for conflict affected communities particularly IDPs. The second output of the UNFPA CPAP aims to increase availability of and access to high quality RH services in conflict affected and underserved districts, and addresses the RH needs in selected districts.

Though not included in the CPAP prepared in 2008, the need for RH services became very acute in 2009 following the end of the conflict situation which resulted in a large influx of displaced persons mainly to Vavuniya and to some extent, to Mannar. In this context, there was a need to respond to this humanitarian crisis and a need to support the Ministry of Health to coordinate RH related activities, and UNFPA shared this responsibility along with other agencies. At present, resettlement process is on going and the need for RH services continues, though in a different context.

Effectiveness

Involvement of UNFPA in humanitarian work commenced during the post tsunami period when a Humanitarian Coordinator was appointed based in the country office to coordinate the activities supported by the UNFPA.

In this situation, the provision of health services was being coordinated by the ‘Health Cluster in Emergencies’, with WHO and the Ministry of Health as the Co-Chairpersons. UNFPA, UNICEF, health officials of the Northern Province, representatives of INGOs and NGOs working in the area, served as members of this group. The group met regularly once in two weeks, to review the situation and to plan and monitor the interventions, so as to minimize any overlap or duplication. At the same time, a similar group was formed in Vavuniya including members or representatives of these same organizations, to regularly review and implement the interventions at the field level. FPA and a staff member of the health team working with UNFPA in Vavuniya represented UNFPA as members of this group. This group met once a week. Members of the ‘Health Cluster’ still meet on a regular basis, about once a month.

The main areas of service provision supported by UNFPA during the crisis situation in late 2008 and 2009 were: maintenance of a buffer stock of RH commodities, provision of clinic services first through the mobile clinic facilities and later by establishing five ‘static’ clinic centres in the ‘welfare centres’, provision of hygiene packs, maternity kits, provision of emergency RH surgical kits and deployment of health volunteers to enhance the RH services in these areas.

UNFPA’s humanitarian response aimed to ensure uninterrupted RH services to IDPs, returnees and host communities and the services were focused towards this output. The Ministry of Health staff provided the technical services with FPASL contributing to the activities by providing logistic support, which included making available the facilities for mobile clinics and making purchases that were required urgently.

Information on services provided through mobile and static RH clinics are given in table 10. Detailed information related to distribution of hygiene packs, maternity kits, emergency RH surgical kits etc., are given in table 10.
One of the key inputs undertaken by UNFPA was the prompt identification and relocation of the PHMs who were among the displaced population (approximately 50) and get them involved in provision of services. Recruitment of 5 Public Health Nursing Sisters was undertaken to supervise the work of the PHMs. In addition, UNFPA has provided essential equipment to the facilities established in the centres.

Contributions were made through improvements in communication facilities among the health staff and in developing a system for optimal utilization of available facilities for RH (example: provision of beds to Ayurveda Hospital at Peripeymadu Vavuniya to provide facilities for postnatal mothers and the newborn).

Several bilateral and multilateral agencies provided funds to the Common Health Action Plan.

Presently, the population is being resettled and the physical facilities for provision of services are being rebuilt. UNFPA country programme supports the provision of RH services by providing equipment to some hospitals and also supporting implementation of mobile clinic services by providing a vehicle suitable for this purpose.

Activities undertaken in the emergency situation and the current status were reviewed and a draft report was available. While identifying the need for more focused/targeted programmes in the future, the achievements of a number of activities have been highlighted in this report. Collaboration with the Family Planning Association of Sri Lanka has being considered as a positive feature. This report raises queries regarding the sustainability of the activities implemented by UNFPA. The uncertainties related to funding flows have been highlighted as having an influence on the efficiency and effectiveness.

The focus of output 2 is mainly on supporting activities in selected districts to meet the RH rights of the population as described above. Creating an environment that promotes RH inputs in these districts is one of the expectations from these inputs. Very special groups whose rights for RH services have been considered as a priority were those of displaced populations, where inputs related to the humanitarian assistance were provided and is being continued to an extent.

### 2.3.7 Output three

Increased efforts to prevent sexually transmitted infections and HIV/AIDS among women and young people.
Relevance

Considering the global division of labour in relation to the activities aimed at HIV/AIDS prevention, UNFPA has been identified to be the lead agency for reduction of sexual transmission of HIV, empowering men who have sex with men, sex workers, transgender people to protect themselves from HIV infection and to fully access anti retro viral therapy and to meet the needs of women and girls and stop sexual and gender based violence.

In keeping with the above and the emphasis placed on HIV prevention in Mahinda Chinthanaya and the Health Sector Master plan, the activities under the 7th country programme focused on two areas, namely, developing capacities of National Sexually Transmitted Diseases and AIDS control Programme (NSACP) and Community Strength Development Foundation (CSDF) in HIV prevention in the area of sex work and establishing a country partnership forum for groups working in HIV prevention activities among vulnerable women and girls (Daffodil group).

HIV prevention activities have to use a multi pronged approach if they are to be effective and the development of capacities of NSACP and the NGO sector, fostering linkages between the state and NGO sector are key inputs that have a positive impact. According to UNGASS report, only a limited number of community based organizations (CBOs) work with female sex workers. Hence developing their capacities and forming a network is likely to enhance their contribution to prevention of HIV transmission through sex workers.

The other main focus of the CPAP was to create an enabling environment by conducting advocacy among relevant groups. Key groups among those who need to be included in the advocacy programmes were the personnel involved in law enforcement at different levels and included, police, judiciary and trainers of these categories of persons. The aim of these advocacy programmes was to reduce the arbitrary arrest of sex workers (particularly street based) and the creation of an enabling environment for HIV prevention activities.

Effectiveness

The current status of the activities planned to achieve this output are summarized below, to indicate the extent to which the planned outcomes have been achieved.

The key inputs identified in the work plans based on the CPAP were: development of capacities of NSACP, development of a forum of NGOs working with sex workers and linking them with the national programme in HIV prevention in the area of sex work and provision of technical assistance to draw a road map for UNFPA support in HIV prevention.

Technical assistance was provided from APRO in January 2009. The roadmap suggested a series of interventions, a majority of which have been completed by the time the evaluation was undertaken.

The establishment of a network of NGOs for “HIV prevention in sex work” (Daffodil group) was undertaken successfully in early 2009. Seven NGOs in eight districts are members of this network with the Community Strength Development Foundation (CDSF) as the lead organization (list of partner organizations is given in table 11). During the meeting with the members of the network, it was noted that they form a cohesive group, and work in their own areas. They have regular review meetings once a month at which they share their experiences. These organizations work through a limited number of field staff who carries out activities aimed at: identifying those involved in sex work and promotes use of condoms among them, increase clinic
referrals and supporting those identified by enabling them to use the facilities of a drop-in centre and also to link them with possible alternative options for income generation.

CSDF is linked with the national level health sector programme, NSACP and serves as a member on six of their seven sub committees. They have also taken an active part in the mapping exercise undertaken by NSACP, funded by UNAIDS/World Bank, to make an assessment of the size and location of sex workers. This community lead estimation was reported nationally in the 2008-2009 Sri Lanka report to UNGASS.

The main objectives of CSDF and their partner organizations were: to increase the knowledge on HIV/AIDS and STI including RH among sex workers, to promote condom use correctly and consistently among sex workers and to increase the clinic referrals. Available data for the period March 2009 to December 2010 show that a total of 4,498 sex workers were provided with relevant services with the highest number (3,448) being in the districts of Colombo and Gampaha (Table 11).

The activities undertaken by the NGOs that formed the network are limited to those described in para 3 under effectiveness. There was no explanation available as to the low rate of distribution of condoms except for the fact that the activities in some of the network partners have commenced within a short time period prior to the evaluation.

Table 11: Information on services provided by members of the network – March 2009 to September 2010

<table>
<thead>
<tr>
<th>Organization</th>
<th>sex workers provided with services</th>
<th>Registered sex workers</th>
<th>Street based hot spots</th>
<th>Hotspots of SW brothel, lodge, night clubs</th>
<th>Clinic referrals</th>
<th>Condoms distributed</th>
</tr>
</thead>
<tbody>
<tr>
<td>CSDF (Colombo &amp; Gampaha)</td>
<td>3,015</td>
<td>955</td>
<td>245</td>
<td>104</td>
<td>158</td>
<td>321,783</td>
</tr>
<tr>
<td>RGP Anuradhapura</td>
<td>107</td>
<td>107</td>
<td>12</td>
<td>2</td>
<td>38</td>
<td>10,928</td>
</tr>
<tr>
<td>ECDIC- Ratnapura</td>
<td>92</td>
<td>52</td>
<td>82</td>
<td>0</td>
<td>22</td>
<td>22,619</td>
</tr>
<tr>
<td>WGSP Kurunegala</td>
<td>63</td>
<td>63</td>
<td>15</td>
<td>0</td>
<td>6</td>
<td>240</td>
</tr>
<tr>
<td>LSS Kandy</td>
<td>35</td>
<td>35</td>
<td>10</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>CEF Puttalam</td>
<td>10</td>
<td>10</td>
<td>3</td>
<td>0</td>
<td>1</td>
<td>277</td>
</tr>
<tr>
<td>HNRDF Galle</td>
<td>54</td>
<td>54</td>
<td>15</td>
<td>0</td>
<td>0</td>
<td>450</td>
</tr>
<tr>
<td>SLHDF Polonnaruwa</td>
<td>36</td>
<td>36</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>3,422</td>
<td>1,312</td>
<td>386</td>
<td>106</td>
<td>225</td>
<td>356,297</td>
</tr>
</tbody>
</table>

Source: CSDF records

Outreach activities by CSDF and the network members have been facilitated by making available advocacy materials, developed in collaboration with NSACP and providing them with training on their use and other communication strategies.

Establishment of drop-in centres is another activity facilitated and at present there is a total of 8 drop-in centres available in 8 districts.

Support for CSDF in terms of training in specified areas, provision of equipment has been undertaken. Constraining factors are mainly related to the need for additional staff, facilities for drop in centres and other facilities such as transport. At present, there is a good rapport between CSDF and NSACP and between all
members of the network. In most of the districts, the linkages established between the state health sectors were satisfactory even though in some instances, there were issues related to availability of such support. The extent to which these factors influenced the results could not be estimated at this stage.

The activities are being continued and are likely to contribute to the expected outcomes of the programme.

Capacity development of CSDF staff has been a major input that has been achieved through the activities, which has a long term impact. However, it must be noted that CSDF received additional support for their capacity development through other sources. Development of a reporting system and a system for monitoring and evaluation of the network organizations has commenced and perusal of available documents indicate that a satisfactory standard has been achieved in these areas.

The main activity to be implemented through NSACP was to promote an enabling environment, through advocacy among different groups of law enforcement officers. Initially, these programmes focused on the police officers and programmes were conducted in the police stations in which they work. However, this programme had to face many problems specially related to logistics, feasibility etc. During an internal review undertaken in 2010, it was recommended that this programme be revised to focus on training of trainers and to incorporate basic knowledge on HIV prevention in the training of all categories of police personnel.

Two training programmes have been conducted for senior level police personnel identified by the authorities (ASP and above- 42 and 53 in each group). A module has been developed and the training was skill based and participatory. This module was available for perusal and was found to be comprehensive and well designed. Each of the trainees were provided with a CD giving the material that can be used when they undertake training (a copy of the CD was available for perusal).

An assessment in the level of knowledge among the participants who underwent this training has shown an increase in their knowledge in the areas of ‘non transmission’ and on prevention and 94% of the participants said that this programme did not disrupt their day to day duties. NSACP plans to conduct about 10 such programmes this year. In 2011, assistance will be provided to develop inputs into the basic curricula of the police personnel.

Efficiency

Implementation of programmes through CSDF and the partner organizations were seen to be influenced by limitations in the human resources available. The activities undertaken by the members of the ‘daffodil group’ contributed to the expected outcomes of NSACP. The positive influence of the programme strategy of strengthening the capacity of CSDF has been shown by their ability to write up a proposal for funding through GFATM and receive support as one of the sub recipient under the next round of funding (no documents were available as confirmation).

The linkages between the national programme and the lead NGO and the partner organizations were seen to be working well, indicating that the strategy adopted in establishing such links supplements actions taken by the two sectors. However, this is a subjective assessment by the evaluator.

Sustainability

Upgrading of facilities and provision of equipment for CSDF has assisted in sustaining the activities envisaged while support for development of educational material and other similar inputs included in this programme
could have a long term influence on the contributions that NSACP and the relevant NGOs could make to the prevention of spread of HIV.

CSDF capacity building has improved the capability of sustaining the programme. However, non availability of donors will be a major factor that will influence sustainability of the activities of the ‘daffodil group’.

**Impact**

Potential impact of this intervention on the AIDS prevention strategies are to be achieved through a number of different inputs supported through national programmes, unilateral and multilateral organizations and the NGO sector.

Capacity development of the national programme, NGO sector and activities geared towards other relevant sectors such as law enforcement authorities are likely to have an impact by influencing attitudinal changes among the relevant groups. However, sustainability of the programmes needs to be ensured, for such outcomes to be a reality.

One of the key activities under output 3 is aimed at working with a most at risk population, female sex workers, to whom support is provided to prevent them from STDs and HIV infection. Promoting selected community based organizations to be linked with the formal health system contributes to strengthening their capacity to provide the services.

**2.3.8 Output four**

**Increased coverage and utilization of youth friendly Reproductive Health services**

**Relevance**

Youth comprise a group that has special needs in the area of sexual and reproductive health (SRH). The needs relate to their level of knowledge, attitudes and beliefs, behaviours and risks. The strategies included in this component are in keeping with the UNFPA’s four key elements for UNFP supported adolescent and youth programmes, namely supporting policy development to address young people’s issues, providing comprehensive SRH education, promoting a core package of SRH services and ensuring young people’s leadership and participation.

Ministry of Health has initiated a process of developing a Youth Health Policy (document titled ‘National Policy and Strategic Plan for Young Persons’) and has also commenced on providing youth friendly services implemented through 26 centres based in government hospitals (selected TH,BH,DH and one PU), with plans to extend the services to 50 hospitals. However, the Ministry, after implementing this programme on a pilot basis, changed their strategy to provide such services through the clinics set up in the offices of Medical Officer of Health. At the time of the evaluation, this process had commenced. The strategies planned by UNFPA included support for finalising policy and strategies, supporting selected YFS services aimed at promoting a core package of SRH services and introducing a peer education programme.

**Effectiveness**

Providing support to finalise the draft document ‘National Policy and Strategic Plan for Young Persons’ available at the time of the evaluation, was a key activity to be undertaken. The procedure for selection of a local consultant to finalise this document has been initiated.
Providing support to the activities of the Youth Friendly Service (YFS) at Aluthgama, a community based centre in the field area of the National Institute of Health Sciences (NIHS) is being continued along with the services provided by the YFS of SLAVSC in Kandy. A review undertaken in November 2010 showed that the utilization of services for medical services, counselling or condoms were annually 2-3% of the total number of persons who visited the centres at both Aluthgama and in Kandy (table 12), which indicated a low rate of utilization of services, for the purposes for which such services were set up. This same review suggested that this support be discontinued. This decision seems to be linked to the low rate of use of the facilities.

Table 12: Number of clients for RH related clinic and counselling services

<table>
<thead>
<tr>
<th>Provider and service</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>Total</th>
<th>% of total visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>SLAVSC</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RH related clinic &amp; counselling</td>
<td>n/a</td>
<td>n/a</td>
<td>150</td>
<td>112</td>
<td>132</td>
<td>394</td>
<td>1.1</td>
</tr>
<tr>
<td>All clinic &amp; counseling</td>
<td>85</td>
<td>14</td>
<td>169</td>
<td>168</td>
<td>420</td>
<td>856</td>
<td>2.4</td>
</tr>
<tr>
<td>NIHAS, Aluthgama centre</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
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<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td></td>
</tr>
<tr>
<td>All clinic &amp; counseling</td>
<td>40</td>
<td>41</td>
<td>219</td>
<td>38</td>
<td>403</td>
<td>741</td>
<td>1.14</td>
</tr>
<tr>
<td>For all activities services</td>
<td>6,522</td>
<td>15,511</td>
<td>13,814</td>
<td>16,542</td>
<td>14,095</td>
<td>66,484</td>
<td></td>
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</tbody>
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Source: Adolescent Sexual and Reproductive Health Programme, Assessment & Road Map, UNFPA, Sri Lanka, November 2010.

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Source: Adolescent Sexual & Reproductive Health Programme, Assessment and Road Map, UNFPA, Sri Lanka, November 2010.

During the year 2010, Sarvodaya Shanthi Sena Sansadhaya undertook several activities related to adolescent sexual and reproductive health, with UNFPA assistance in the districts of Anuradhapura and Vavuniya. All eight activities given in the work plan have been conducted.

It was noted that the training programmes have been implemented through a group identified by UNFPA. It is necessary to use appropriate guidelines in choosing the trainers especially when such training focuses on areas such as SRH and is linked with village level implementation. This observation is made as there were concerns expressed which highlighted the need to pay attention to the selection of trainers.
**Efficiency**

The programme activities of supporting YFS in two settings, one in an NGO setting and another in the state sector did not duplicate any of the activities undertaken by the state sector YFS programme. However, available data showed major limitations in the use of such services. Sharing of the experiences would be a useful input in planning future programmes.

In 2010, an approach to empower youth through a peer education programme was started in collaboration with the youth wing of Sarvodaya the Shanthi Sena Sansadhaya. It is not possible to make any assessment of the activities undertaken as the programmes have been in existence for a relatively short period of time. However, the experience gained in implementing this programme in two districts is likely to enhance the efficiency of any future programmes.

**Sustainability**

The main counterpart organizations responsible for this output were: the Ministry of Health and two NGOs, SLAVSC and Shanthi Sena Sansadhaya. Development of a draft document ‘National Policy and Strategic Plan for Young Persons’ was an activity undertaken by the Ministry of Health and is an integral part of the activities of the Directorate of Youth, Elderly and Disabled. Assistance from the UNFPA has contributed in supporting these activities while the Ministry of Health has ownership to continue with the activities that are planned for the welfare of the youth.

The partnership established between Shanthi Seva Sansadhaya, the youth wing of a well established national level NGO (Sarvodaya), could strengthen the youth educational activities undertaken with a focus on selected districts, provided that the programmes are implemented in an effective and acceptable manner and are reviewed periodically. It is necessary to focus attention on developing ‘trainers’ within the organization itself, to facilitate sustainability.

**Impact**

The support to be provided to finalize the draft document on ‘National Policy and Strategic Plan for Young Persons’ is likely to have a long term impact. That work has to be linked with the development of a plan to implement the activities along with a plan for monitoring the implementation needs.

Available information through the evaluation indicates that the impact of these inputs in supporting YFS centres was relatively low.

Peer education programme on ASRH has been initiated by UNFPA and is likely to make a useful contribution even though it is not possible to make any concrete observations as the activities have commenced only during the past year.

Rights of youth as a group are recognized and several activities have been included under this output. An important feature is the involvement of youth and youth organizations in many of the activities included in this programme.

**2.3.9 Facilitating factors (RH)**

The most important facilitating factor is the link between UNFPA and the existing health system to which these inputs have been added on. Active involvement of the Ministry of Health through the Family Health
Bureau, HEB, NSACP and at the provincial and district levels at all stages is a positive factor that has enabled the activities to be carried out along with the components of the RH programme implemented through the health system. It also enhances the capability of the health system through many inputs, mainly provision of supplies and equipment and by capacity building.

In some instances, the CPAP has highlighted and initiated activities that would be beneficial in the medium and long term, hence attention has been drawn to the relevant units in the Ministry to commence such work (e.g. revision of curricula for PHMs). Identification of appropriate inputs by UNFPA that enhances the capabilities of the national/district health system is of special importance. Collaboration with other agencies that support RH activities with a view to avoiding duplications and enhancing supplementation is also an important facilitating factor. Other linkages such as those established with selected NGOs (e.g. CSDF, Sarvodaya youth wing), SLMA, universities, professional bodies etc., for specific activities could be considered as a facilitating factor as the choice of such partners have taken into consideration the appropriateness and the competencies of these partners in carrying out the specified activities.

Availability of a roadmap for the ASRH programme highlighting the activities to be considered is another step in favour of improving these services. The reviewer was made to understand that steps have been taken to enhance ‘youth participation’ in UNFPA programming for youth for which purpose a youth mobiliser has been included as a team member. This can be considered as a step in the right direction.

2.3.10 Hindering factors (RH)

Even though the activity plans have been drawn up on a biannual basis, the financial transfers have to be done on an annual basis. Due to the delays in the transfer of funds, in some instances, it has not been possible to carry out all the planned programmes before the end of the year, at which time all unused sums of money will have to be refunded. There seems to be a possibility of a “rolling plan” for activities. However, no such possibility exists for finances. This implies that the funds are ‘not available’ for the planned activities as the allocation for the following year will be reduced by the amount of money that was unutilized.

A review of this system to facilitate use of funds has to be considered taking into consideration, the existing system of disbursement of funds at the level of UNFPA as well as the Ministry of Health. The evaluators were informed of the procedure for disbursement during the discussions at the high levels of the Ministry of Health, and there is a need for all implementing partners to take note of these procedures.

In order for all activities to progress satisfactorily, several aspects need to be addressed. One of the main constraints faced by the implementers are those related to availability of human resources which is the responsibility of the Ministry of Health. Any intervention in this sphere is beyond UNFPA’s mandate.

At the level of programme management, it was noted that the responsibilities of implementing different sections of the work plan aimed at achieving four outputs included under RH, needs to be reviewed taking into consideration the technical competencies required by the responsible officers and the contributions made by each of the outputs to the expected outcome of the RH component as a whole.

2.3.11 Conclusions (RH)

1. UNFPA has supported the implementation of several activities that focused on strengthening quality and coverage of RH services. These include: revision of curricula of PHMs, providing support for activities promoting the development of a functional system of quality assurance, capacity building of categories...
of personnel involved in providing RH services, assistance to develop a RHCS. These inputs, singly or in combination contribute towards quality and coverage of RH services.

2. Including RH and Gender issues in the draft plan on ‘disaster preparedness and response’ along with training of district level personnel on SRH in crisis situations and strengthening health sector response to GBV through establishment of centres for counseling and management of those affected by GBV, contribute towards gender mainstreaming in health related activities.

3. At district level, improvement of facilities for provision of maternal and neonatal care has been done through a range of interventions at institutional and at field level, most of which has been completed in 2010. Capacity building of staff at all levels has been carried out. However, there were major limitations to the assessment of effectiveness of such inputs due to paucity of data.

4. UNFPA played an important role during the humanitarian crisis situation that arose in 2009 through several measures to enhance accessibility of RH services. Provision of mobile clinic facilities continues such support to the resettled population.

5. The linkages established between state sector NSACP and the NGO CSDF seem to make a positive contribution in conducting preventive work among female sex workers. The work undertaken by NSACP aimed at sensitization and improving knowledge of the law enforcement officers is being continued.

6. Approaches used in ensuring increased coverage and utilization of youth friendly RH services included advocacy at the level of policy makers and programme planners to focus on finalizing the youth health policy and to develop a strategic plan along with a plan for implementation and monitoring. The review undertaken has provided useful insights to the future of the programme.

2.3.12 Recommendations (RH)

Recommendation 1 (During CP7)

To be facilitated by UNFPA during the years 2011 – 2012, the balance period of the current CPAP.

Several key activities were identified during the evaluation and to prioritize the activities that have been included in the work plan for the years 2011- 2012.

Support is provided to follow up the National BCC Strategy and the strategic plan to be developed during the period 2011 -2012, for its implementation, while ensuring quality. Developing a resource pool for BCC at district level along with the establishment of a committee at district level, in collaboration with the FHB, HEB to enhance the ability to develop, implement and monitor district level BCC activities should be considered in the inputs at district level. Support for development of effective models to be used in communication relevant to RH inputs needs to be considered in view of its importance.

The recommendations given below are for consideration by UNFPA in collaboration with the relevant stakeholders, at the time of development of the next CPAP.

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13 action to initiate a QA system for RH services, develop a BCC strategy, initiate a formal system of CPD programme for trainers of RH service providers, development of an information system for GBV, and finalize youth health policy.
Recommendation 2*

UNFPA to facilitate the establishment of a continuing professional development programme for trainers of RH service personnel linked to a plan for monitoring the implementation of the curriculum as well as the training programme. This activity should follow the curriculum review process. UNFPA needs to support the development of educational technology expertise at the Ministry of Health, (national level), at the ET &R Unit.

It is recommended that technical support be provided to develop and implement a system of quality assurance of all relevant training programmes for RH personnel, in collaboration with the different stakeholders. Such a programme needs to consider the application and usefulness of the training in field situations and should provide inputs to make the programmes more effective.

Incorporating basic concepts of SRH in crisis situations into existing training programmes of medical undergraduates and postgraduates needs to be facilitated.

Recommendation 3*

Facilitate the development of a “model” to enhance the use of data from RHMIS especially at the lower levels of the health care system in evidence based decision making, once the revision of the RHMIS is completed. Such a model will enhance the quality of services through evidence based decision making.

Recommendation 4*

Provision of support for selected districts has to be considered in relation to the activities proposed at the district level that are keeping in line with the national programme. As a short term, it is necessary to consider sustaining the support provided to the five districts, to enhance consolidation of inputs already provided.

In a future programme, linked with ‘district based support’, UNFPA needs to focus on improving RH services especially in the ‘pockets’ where outcomes show a need for improvement. A mapping exercise may be used to identify service availability and other socio demographic factors influencing such observations.

Recommendation 5*

Extend the support provided by UNFPA in improving the availability of services of GBV centres to more of the middle and higher level health care institutions. This should be linked with an effective information system which should be used as a monitoring and planning tool.

Facilitate the use of field health personnel in the identification, referral and follow up of GBV, specially among women in the reproductive age (the responsibility of the field health staff of a health unit has been identified as being focused on women in the reproductive age), without causing an additional workload to the work of the PHM and taking into consideration the ethical issues.

Recommendation 6*

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14 As there are varied types of capacity building activities, such a plan should be developed in stages and in a manner that will allow flexibility to be adopted for different programmes.
Two aspects that need UNFPA attention in relation to provision of services for the youth are: to support development and implementation of a monitoring mechanism for the implementation of the strategies identified in the youth health policy. Once developed, to carry out a review of the effectiveness of the peer education programmes funded by UNFPA with a view to improvement of the effectiveness of such an activity, before expanding this programme to other districts.

Recommendation 7

UNFPA support to strengthen the links with NSACP and CSDF has to be continued with regular monitoring to enable optimal use of the GO/NGO linkages in implementing activities focusing on involvement of community level groups in promoting an enabling environment. CSDF network is strong but needs inputs in technical and managerial aspects and assistance in strengthening the ability to develop linkages with other relevant organizations. It can be an effective mechanism for combating HIV and GBV and empowering the sex workers to take control of their issues.

Recommendation 8

Collaborative efforts to be made by UNFPA and the stakeholders to identify subject areas in which an evidence base will promote appropriate decision making for policies related to improvement of RH services. This recommendation focuses on getting research activities carried out by appropriate organizations/institutions through UNFPA, to support policy.

2.4 Gender

2.4.1 Context

The Gender component of the UNFPA 7th county programme is in line with the government vision on “Diriya Kantha” as outlined in the development framework of Mahinda Chinthanaya 2005. The key focus area of prevention of violence against women (VAW) under “Diriya Kantha” has received a prominent place in UNFPA gender output one. The specific attention to tsunami and conflict affected women as mentioned in Mahinda Chinthanaya is ensured through the selection of the districts of Matara, Ampara, Batticaloa, Vavuniya, Anuradhapura and Jaffna with a specific focus on the women in the affected communities.

The National Plan of Action on Women and the National Action Plan on the Implementation of Prevention of Domestic Violence Act of 2005 are the two key documents that have received the attention and technical support under UNFPA Gender outputs one and two. This is one specific way that UNFPA has ensured action towards the national goals on gender equality and women’s rights in Sri Lanka.

The Gender component of UNFPA 7th country programme is guided by MDG, CEDAW and UNSCR 1325 which are international treaties signed and agreed by Sri Lanka government. MDG goal 3 has been revisited and higher targets are set in Sri Lanka and gender is mainstreamed in all other MDG goals.

UNFPA 7th programme is in line with the International Conference on Population & Development agenda and UNFPA mandate. The two outputs under the gender component are directly contributing to the UNDAF outcome 4 –“Women are further empowered to contribute to and benefit equitably and equally in political, economic and social life.”
Status of women in Sri Lanka

In Sri Lanka the status of women is comparatively better than their counterparts in the South Asia region based on the Gender Development Index (GDI). According to the Human Development Index (HDI) in 2005 Sri Lanka had the rank of 99 out of 177 countries and the GDI rank was 88 with a value of 0.735 which was better than the average of all developing countries. However Gender Empowerment Measurement (GEM) rank of 63 was below average of all developed countries and lower than many South Asian countries. This is due to lower rate of women in parliament and in decision making. Only 5.8% women members of parliament and 5.8% women in the cabinet are recorded in 2007. In 2006 the Gender Gap Index was 13 with a score of 0.720. The sub indexes were: economic participation and opportunity rank 84, Educational attainment rank 52, Health and survival rank 1, political empowerment rank 7. (Global Gender Gap report 2006 and the rate is inequality 0.00 and equality 1.50).

The maternal mortality rate decreased from 62 to 100,000 live births in 1976 to 39.3 in 2006. Life expectancy rate was more for females (76 in 2001 compared to 72 for men). Fertility rate has increased from 1.9 in 2001 to 2.4 in 2006. Institutional birth delivery as at 2005 was 99.5%. However, 30.3% pregnant and 31.6% non-pregnant women were suffering from anaemia in 2006 (Global Gender Gap report 2006).

Even though the status of HDI, GDI is high the incidence of gender based violence is disturbing in Sri Lanka. The legal framework is strong and in place to combat GBV and Sri Lanka has signed all the key mechanisms on human rights – UDHR, CRC, CEDAW, Convention on Torture and other Cruel, Inhuman or Degrading Treatment or Punishment 1984, DEVAW, ICCPR. The national machinery is in place with Ministry of Women’s Affairs established in 1983, Women’s Charter adopted in 1993, National Committee on Women established in 1993, National Plan of Action drafted in 1996 based on Beijing platform for action on women. With all these laws, policies and mechanisms in place, the country suffers from a high incidence of GBV. Due to lack of systematic data on GBV the incidence cannot be quantified but studies which have explored the prevalence of domestic violence in Sri Lanka found figures ranging from 27% (Perera 1990), 32% (Samarasinghe 1991) to as high as 60% (Deraniyagala 1992). (WHO information sheet on GBV in Sri Lanka).

Female headed households have been on the increase since the start of the conflict and by 2006/7 the island wide percentage was 23.4%. Further to this the percentage of women and girls in the Internally Displaced Population is mentioned anecdotally as very high and demanded attention of policy makers and donors. It was not possible to get specific sex disaggregated data on these groups as in the districts the data is categorized only as families and individuals and not under sex and age.

2.4.2 Programme design (Gender)

UNFPA has decided to make gender as a specific programme component and has made a clear strategic decision to work on the prevention, intervention and policy advocacy on the GBV issues. UNFPA has taken on board the MCDWA as a key partner in strategizing towards the redress of GBV. UNFPA has also taken a conscious decision to work on the issues of women’s rights and gender with specific attention to war and disaster affected women. This attention is justifiable considering the prolonged conflict situation and the worst ever disaster that affected the women in many ways. In the crisis situations the psycho-social networks developed over the years by the women got destroyed and the lives of these women in displacement are impacted by this destruction. Furthermore, the reproductive health issues of women and girls and GBV did not receive due attention during conflict, and post conflict periods as well as in post disaster situations. In such a context, UNFPA has stepped in to develop the concept of women centres and the development of a community based response to address GBV and strengthen the psycho-social network around these centres which are frequented by women.
Issues of gender based violence were a priority in the programme. GBV was focused as a women’s rights issue that needs a multi-sectoral and institutional approach to its redress. The state accountability to redress GBV is the main focus of the output one. In addition to the state accountability, mobilization of communities to respond to the issues of GBV is planned through the establishment of women centres. Facilitation of the Forum against GBV as an advocacy platform was to ensure collective voice and action towards policy reform. A knowledge base was created on GBV through research. Awareness raising and capacity development was planned at different levels.

UN SCR 1325 as an international instrument to enhance participation of women in decision making and in peace processes was given specific space in the programme design. The promotion of state accountability to the implementation of articles of UN SCR 1325 was the focus of output two. At the time of programme design, the issues of war affected women and girls were a priority that needed redress. This situation has changed since 2008 with the conflict coming to an end and peace being established in the country. Even though the attention to UN SCR 1325 is still valid, the government agencies have changed their priorities and promoting women in peace building does not receive sufficient attention.

The following outcomes and outputs were drafted under the gender component

The expected outcome of the gender component is to strengthen institutional mechanisms and empower the community to protect the rights of women and girls. This outcome specifically contributes to the UNDAF outcomes on gender and governance. Whilst gender cuts across all outcomes and outputs of the country program, it also has two specific outputs, one of which focuses on GBV and the other on rights of women and girls more broadly.

The outcome indicators are as follows:

- Resources mobilized to implement the national domestic violence programme of action.
- Percentage increase in reporting on GBV
- Percentage increase in national budget for implementing the national programme of action for women
- Number of women participating in the peace process at the national level.

There are limitations in the outcome indicators as they do not capture the results of the range of activities and input by UNFPA. For example the outcome indicators do not capture the mobilization of communities and civil society organizations around the issues of GBV and women’s rights. Lack of baseline data on the gender component was another limitation in assessing the outcomes.

Output 1

Strengthened capacities of the Government, non-governmental organizations (NGOs) and community organizations to prevent and respond to gender-based violence.

Strategies:

- Support advocacy for the implementation of the Action Plan on the Implementation of the Domestic Violence Act
- Facilitate multi-sectoral interventions and mechanisms to provide an effective response to combating gender based violence by strengthening and sustaining the GBV Forum
• Enhance the capacities of selected NGOs to manage and scale up women centres in selected districts that cater to the specific needs of women and girls
• Strengthening of community action and responsibility for prevention of GBV
• Knowledge building and technical assistance

The strategies towards output one, covers a few programme areas – knowledge building through research, strengthening institutional mechanisms, capacity development, facilitation of community responses and organization towards intervention and prevention and advocacy on issues of GBV.

The output indicators set for the output one are as follows:

• Number of initiatives implemented under the national domestic violence programme of action
• Number of women and girls accessing support services through women’s centres
• Number of awareness campaigns organized for and by men and boys
• National and sub-national mechanisms in place to monitor and reduce GBV

It is evident that there are limitations in these indicators. They do not capture the processes facilitated by UNFPA and the qualitative results of such processes, especially the empowerment of the communities and institutions. The indicators are too quantitative in nature.

Output 2

Strengthen national capacity and institutional mechanisms for increased state accountability to fulfill and protect the rights of women and girls

• Capacity building on UN SCR1325 at district and national level for both protection and participation of women and girls
• Support to relevant independent commissions and inter-ministerial mechanisms to play an oversight role to protect the rights of women and girls and monitor implementation of relevant plans and conventions
• Facilitating the participation of women at all levels in the peace building process in line with UN Security Council Resolution 1325

The output indicators are:

• Number of initiatives supported to facilitate the implementation of the national programme of action for women
• National and sub-national mechanisms in place to monitor implementation of the Convention on the Elimination of All Forms of Discrimination against Women
• Number of NGOs and community-based organizations engaged in advancing gender goals

Here again the output indicators do not capture all three key areas covered under UNSCR 1325 – participation in peace processes and decision making, provision of special needs of women and girls, and protection and security of women.

2.4.3 Programme management and partnership (Gender)

The strategies that were selected under the gender component required partnership with diverse development actors and agencies at different levels. The evaluation confirms that UNFPA has made good
decisions with regard to the selection of strategic partners representing GO, NGOs and community groups under output one. The partner selection is in line with the three pronged approach to GBV – intervention, prevention and advocacy at different levels. UNFPA has made conscious efforts to collaborate with the national machinery on women to ensure the implementation of the policies and laws relevant to the prevention of GBV. The choice of MCDWA and Womens’ Bureau shows UNFPA commitment to work with the Government agencies to redress the issues of GBV in Sri Lanka.

UNFPA has entered into partnership with three key national NGOs, namely Women Development Centre (WDC), Women in Need (WIN) and Muslim Women’s Research and Action Forum (MWRAF). These organizations have long years of experience and achievement in the redress of GBV in Sri Lanka and have a wide network around them which represent the government offices, NGOs and communities. These organizations have the structure to reach the grassroots and have the capacity to mobilize women, men, youth, children around the issues of GBV. Their organizational vision and strategies are compatible with the UNFPA mandate and approach.

In addition to these three organizations, UNFPA has entered into agreements with Ministry of Health as a key partner in the prevention of GBV. This is a unique partnership in the integration of GBV prevention, intervention and advocacy in the health sector. For the first time in Sri Lanka, systematic GBV redress mechanisms are introduced to the health sector and the capacity development process is initiated at all levels. A positive impact of such strategies was discerned during the evaluation. This strategy involved the agencies such as Family Health Bureau (FHB), RDHS and MOH offices. In addition to these key partners from GO and NGO sectors, UNFPA has also involved HRC as an independent body to speak and act against GBV and promote rights of women. A capacity development process is in place with HRC staff at all levels to enhance understanding on gender and women’s rights with a specific focus on GBV.

Further to the above agencies, UNFPA has also collaborated with CSDF, an organization working on the rights of sex workers. This is a bold and commendable step towards the promotion of rights of groups who are usually stigmatized and marginalized in Sri Lanka. The partnership with CENWOR, WERC, and Damrivi was to build knowledge through research and the partnership has achieved its goals.

However, the strategic partnership with MCDWA under output two had difficulties and the programme implementation was not efficient. The state technical capacity and commitment towards the implementation of UN SCR 1325 was not strong and thereby UNFPA partnership with MCDWE and NCW did not bear fruit. The fact that MCDWA did not consider UN SCR 1325 as a document that needs their fullest attention due to the conflict coming to an end and peace being established in the country, made implementation of the strategies under output two rather difficult. The officials of MCDWA lacked the understanding on UN SCR 1325 and UNFPA had to take necessary steps to bring clarity on the articles of UN SCR 1325 through capacity building programmes conducted with these officials. The continued high turnover of the decision making staff at the MCDWA was another reason for the lack of efficiency and effectiveness of the implementation of programmes. The issue was beyond UNFPA reach and it had negative impact on the gender programme. However, UNFPA NPO on gender made considerable effort in minimizing the damage and made timely alterations to the programme to sustain the effectiveness. Placement of UNFPA supported staff within the MCDWA was one such strategy implemented to help the technical capacity of the MCDWA.

2.4.4 Output one

Strengthened capacities of the Government, non-governmental organizations and community organizations to prevent and respond to gender-based violence.
**Relevance**

GBV forum has addressed a number of technical issues in the prevention, intervention and advocacy towards GBV through coordination of agencies on the issues of GBV, preventing duplication of programmes in the same locations, bringing in collective voices in policy advocacy and lobbying. It has brought forward agencies working on the issue together with a clear focus on policy reform. In brief the forum has provided a space for different actors working on the issues of GBV to share, express, plan and act towards change and transformation.

Women centres are a felt need in the country. Many stories and interviews with stakeholders during evaluation attested to its relevance. A safe space for affected women and collective community response to GBV has become a national need.

GBV is an issue that has not received sufficient attention in the government sector. The services provided for the prevention and interventions of GBV are limited. The counselling and legal service is not provided free of charge by the local government agencies and all affected women do not have access to the limited services provided by NGOs. The policies and laws are in place to combat GBV but the implementation is weak.

Capacity development on GBV and PDV Act of 2005 is a felt need. Many law enforcement officials lack an understanding of the PDV Act. Awareness raising on GBV was carried out by many organizations but engaging men in the prevention was rather limited. Therefore, UNFPA efforts in awareness raising and promoting the engagement of men in the prevention of GBV through GBV forum and women centres seem to be a useful strategy.

**Effectiveness**

A. Support Advocacy for the implementation of the Action Plan on the Implementation of the Domestic Violence Act

UNFPA Sri Lanka technically supported the National Committee on Women (NCW) in the development of the Plan of Action supporting the Prevention of Domestic Violence Act that came into operation on 3 October 2005. A number of capacity development programmes were conducted on issues of GBV and PDVA with UNFPA support to ensure technical capacity of MCDWA and other law enforcement institutions to combat GBV and implement PDVA. After a survey done on capacity development needs of Women Development Officers (WDOs) attached to MCDWA, 25 WDOs and 11 counselors of the MCDWA were trained on the PDV Act and its provisions. WDOs and police officers in charge of the police women desks were trained on GBV data collection at divisional secretariat level.

A workshop was conducted with 35 script writers on GBV and PDV Act to ensure proper reporting and media coverage of GBV issues. This was done in partnership with MCDWA and the Media Ministry. UNFPA technical input was given to design the programme and PDV Act steering committee members were also part of the panel. In 2010 another workshop on domestic violence and PDV Act was held with 35 media personnel – script writers, editors, poets and reporters was done in collaboration with Women’s Bureau. After the programme a follow up was done by the Women’s Bureau and a change was discerned in the editorial columns and headline of the newspapers. A follow up programme is planned with the same media personnel to ensure the learning is put to practice.
Nearly 12,000 persons are trained on the GBV issues with a specific focus on PDV Act through 15 women center capacity building processes. UNFPA became a part of PDVA steering committee on invitation of MCDWA and technical input was ensured to the committee processes by UNFPA.

In partnership with the University of Colombo, an awareness raising programme was conducted on PDV Act and GBV with the participation of popular artists and singers at the university premises. The event was attended by 2,000 male and female students. A poster on VAW was done by Women’s Bureau with technical assistance from UNFPA staff. This was displayed in key places like police stations, hospitals, bus halts and railway stations.

However, apart from the awareness raising and capacity building of different actors, other planned activities with the MCDWA could not be carried out due to institutional issues and high turnover of the MCDWA staff. The 2008, 2009 and 2010 progress reports of the MCDWA show minimal achievements and results. There was general unclarity on the roles and responsibilities of the MCDWA, Women’s Bureau and NCW. Such unclarity among the three units of the MCDWA had a negative consequence on the UNFPA programme and the intended objectives on the implementation of the PDV Act and the National Plan of Action on Women were constrained. The steering committee on the effective implementation of the PDV Act was established with UNFPA support in the latter part of 2007. This committee did not meet regularly as anticipated and MCDWA capacity to monitor its progress was lower than expected. This slowed down the plan to support the regularizing and operationalizing of the committee. The 2011 work plan with UNFPA calls for MCDWA to organize multi-sectoral advocacy meetings to measure the progress of implementation of the Plan of Action on Domestic Violence Act No. 34 of 2005.

It is to be noted that at the national and sub-national level the mechanisms to monitor GBV is led by the civil society groups in an informal manner. The media monitoring and case monitoring is done by UNFPA gender partners at sub-national level along with the other CSOs. The Sri Lanka Police has a mechanism to keep data on the reported cases in all police stations and the data can be accessed through the Department of Police. The government hospitals also keep a data base on the reported cases at the hospital. However, the unreported cases are missing in these statistics. The information on GBV both at national level and sub-national level is very hard to access by the public. Most of the data bases are not regularly updated and the systems need proper maintenance and human capacity building on the development and updating of data. In summary the GBV monitoring is weak and needs a lot of institutionalizing and systemizing.

The technical capacity and understanding on women’s rights and gender within the MCDWA was not sufficient to carry out activities which needed specific expertise. For example standardizing the training materials on GBV prevention did not take place as there was no one in the Ministry who could lead this process. The task was then handed over to NCW members but the coordination of the tasks was weak and the output was not achieved.

Even though a NPPP officer was placed within the Ministry with UNFPA assistance the expected results were not achieved as the person concerned could not get integrated in the culture of MCDWE. More consultation and discussions are taking place between UNFPA and MCDWA on the human resource needs to realize planned activities. The agreement to support three programme officers and a senior advisor on gender and women’s rights is a constructive move in the right direction.

B. Facilitate multi-sectoral interventions and mechanisms to provide an effective response to combating gender based violence by strengthening and sustaining the Forum against GBV
The forum against GBV was started in 2005 as a response to GBV in the aftermath of tsunami disaster and it has grown in many ways since then. The membership expanded and the activities got systematized through terms of reference. UNFPA chairs the forum meetings and contributes financially and technically to the implementation of the Forum strategic plans.

Since 2008, the forum against GBV planned three advocacy events and the members contributed financially and technically in the implementation of same. The 2010 advocacy event organized by the forum against GBV with the transport sector was a very good example of how multi-sectoral and multi-faceted approach to GBV prevention can be successful. In 2010 the focus was on “stop sexual harassment in public transport” and this advocacy event was planned in detail with all 20 members who proactively participated in the joint campaign. In 2010 seven membership organizations contributed LKR 2,350,506 in addition to the UNFPA contribution of LKR 2,585,506 for the advocacy event. The 2010 campaign included research into the issue, branding of buses, and sensitization of drivers and conductors on GBV with the support of private bus owners, advocacy with public transport board, police and the commuters, and a media campaign involving print media with a newspaper supplement in three languages, FM radio clips and a sticker campaign. All these activities contributed to a successful campaign against GBV in the transport sector.

Twenty five INGOs and NGOs took the responsibility of raising awareness on GBV with commuters, officials of transport sector and police. UNFPA also facilitated media events and produced different IEC materials in consultation with forum members. The CD produced with popular songs with a GBV focus is disseminated among the private bus drivers in different routes. The multi-faceted approach to one specific issue with coordinated activities around it has made a lot of impact on the transport sector. The forum has investigated into policy reform on over crowded bus services and prevention of sexual harassment in buses.

Conceptually, the need to involve men in combating GBV was a message promoted by the forum and which received attention since 2009 sixteen days activism. This message is being captured by media and organizations at different levels.

As for the identified gaps, the medium of instruction of the forum was a concern for a few members and the suggestion was to promote the use of local language whenever possible or provide simultaneous translation facilities. A number of suggestions to broaden the activities and open the discussions to controversial issues such LGBT was proposed. The forum needs to incorporate these findings in the next strategizing process. Lack of enthusiasm and participation of the government agencies in the forum is also a concern that the forum needs to address.

More than 90% of forum members confirmed their willingness to continue being part of the forum against GBV and get involved in the advocacy campaigns. All members expressed a sense of belonging and responsibility towards the Forum advocacy events. Their perception was that coming together as a Forum and continuing it for four years was a great achievement in itself. The rights based approach to forum plans was also mentioned as an achievement.

The core forum membership is thirty in number and the regional and district level membership is through the existing GBV networks at the district levels. All forum members are happy with the role of UNFPA as the chair of the forum and the UNFPA facilitation role is appreciated. In 2008 and 2009 there were lapses in facilitation at different intervals due to delays in recruiting a forum facilitator.

However the forum can still grow into a strong policy advocacy mechanism supported by in-depth research and energized by the voices and action of different stakeholders at all levels. It can be a good pressure group towards policy reform and programme implementation. The forum is used as a sharing and learning platform.
and 80% of forum members suggested that space should be provided for agencies to present their success stories and models in combating GBV. UNFPA can capitalize the space and share its best practices on GBV prevention such as women centre community approach and Mithurupiyasa.

C. Enhance the capacities of selected NGOs to manage and scale up women centres in selected districts that cater to the specific needs of women and girls

A number of capacity strengthening programmes were conducted to capacitate the NGO staff in managing the women centres. Initially a workshop on GBV was conducted to enhance in-depth knowledge on the causes and effects of GBV and all the three partner NGO staff attended this workshop. Another workshop was conducted with the women centre managers to facilitate their understanding and skills on managing the centres. At the beginning of the annual planning cycle a participatory planning process is conducted with the centre managers and the other relevant staff. However, more focussed training and discussion with mobilizers, counsellors and lawyers is needed for the purpose of updating knowledge and facilitating learning among the centres and the partner NGOs.

D. Strengthening of community action and responsibility for prevention of GBV

Women centres were initially started in 2005 as a response to the incidence of gender based violence in the aftermath of tsunami disaster and were conceptualized as safe and accessible spaces for physically and psychologically affected women. The primary focus was the safe space for women to recover and access information on the services available for their physical and mental well-being. Over the years the centres grew in number and in the delivery of services to women.

Out of the fifteen women centres a selected sample of eight women centres were visited as part of field visits and the team had consultations with different stakeholders on ground. The selection of women centres was done in consultation with the UNFPA staff, and the relevant NGOs. The selection criteria were based on the NGO representation, district representation and the clientele that the centre is serving. The selected sample included the plantation sector; tsunami affected communities, IDP settlements, and covered districts in the South, East, Central, North Central and North. Efforts were made to meet a cross section of women centre staff, government agency officials, the clientele and the communities around the centre. Focus group meetings and individual interviews were conducted to collect information and the data was supplemented with observations made during the visits.

Women centres were initiated as a response to GBV in a crisis situation in the post tsunami context. The Matara centre has effectively addressed many challenges of working in a crisis situation on a difficult issue like GBV. The experience of WIN, the first UNFPA partner NGO to start women centres, in working in crisis situations and long years of dealing with GBV issues and running crisis centres were helpful in managing the programmes and meeting challenges. The same applies to WDC, which as an organization that has been working in North and East both during conflict and tsunami disasters. Their experience and expertise in working in crisis situations and on women's rights issues helped UNFPA programme on GBV to be effective in crisis situations just as in development settings.

Since 2007, the women centres grew in number and expanded to 5 districts over the years. Prior to such expansion a mapping exercise was done on the GBV interventions in the districts of Nuwara Eliya, Vavuniya, and Batticaloa by an external consultant in 2008. At present there are 15 women centres spread over 6 districts and managed by three well-experienced NGOs who have their regional and district structures in place.
Out of the eight centres visited only four were running effectively and efficiently. One centre in Mihintale was relocated due to long distance from rural clientele. Another centre in Madawachchiya had internal staff issues and had to be replaced. A new management is in place now. The centre in Nochchiyagama receives a lot of attention and support from the government officials but the community mobilization has not happened to the desired extent and the mobilized women groups were limited in number. The women present, did not demonstrate good understanding on gender or GBV, irrespective of them having received training on gender. The Hope Estate centre does not show signs of effectiveness and systems are not in place.

All centres are maintaining a registry of the people who visit the centres and the analysis show a wide range of ages from 1 year to 72 years of different population groups of women, men, youth and children.

The women centres are frequented by women as the main focus group and all centres show statistics of an increase of women, men and children who come to obtain the services (table 13).

The initial concept of safe spaces has evolved to more focused service provision, mobilization and skill development through the centres.

Table 13: Number of people accesses the women centers

<table>
<thead>
<tr>
<th>District</th>
<th>Kovilkulam WWC</th>
<th>Sithambarampura WWC</th>
<th>Batticaloa District</th>
<th>Nuwara Eliya District</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vavuniya District</td>
<td>699</td>
<td>268</td>
<td>1380</td>
<td>2090</td>
</tr>
<tr>
<td></td>
<td>363</td>
<td>50</td>
<td>1318</td>
<td>2160</td>
</tr>
<tr>
<td></td>
<td>210</td>
<td>40</td>
<td>1268</td>
<td>1976</td>
</tr>
<tr>
<td></td>
<td>268</td>
<td>1380</td>
<td>971</td>
<td>1236</td>
</tr>
<tr>
<td></td>
<td>50</td>
<td>784</td>
<td>515</td>
<td>669</td>
</tr>
<tr>
<td></td>
<td>106</td>
<td>461</td>
<td>415</td>
<td>456</td>
</tr>
<tr>
<td></td>
<td>123</td>
<td>211</td>
<td>332</td>
<td>332</td>
</tr>
<tr>
<td></td>
<td>229</td>
<td>460</td>
<td>252</td>
<td>252</td>
</tr>
</tbody>
</table>

Note: The clients who received Individual counseling services have not added to the above numbers
Source: Women centre records

The key services that women access in all centres are legal aid and counselling with a specific GBV prevention and family focus. The part time lawyers and counsellors are supported with UNFPA funds and every centre has at least one part time practicing lawyer and qualified counsellor. In the event that these women have no access to such free legal aid and counselling services in the districts, their access to such services has increased over the years. However the demand for these legal and counselling services will be increased with time and the centres might need a fulltime counsellor and lawyer.

Table 14a: Number of people accessing services – April to December 2009 (pilot project period)

<table>
<thead>
<tr>
<th>Legal Counseling</th>
<th>Family Counseling</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women Men Total</td>
<td>Women Men Total</td>
</tr>
<tr>
<td>Vavuniya District</td>
<td></td>
</tr>
<tr>
<td>Kovilkulam WWC</td>
<td>75 31 106</td>
</tr>
<tr>
<td></td>
<td>22 123 145</td>
</tr>
</tbody>
</table>
85% of women met during field visits appreciated the services provided by the centres. It was revealed that many rural women who were disserted or separated were unable to file maintenance cases due to lack of knowledge or lack of access to legal service. They have suffered silently without being able to get any maintenance for years from their spouses. This has resulted in a number of hardships to the women and their children. In a situation like this they welcomed the services of the centres.

In Matara magistrate court and district court the highest number of maintenance cases was filed by WIN with UNFPA support. Having a qualified and committed practising lawyer in the centres has undoubtedly helped the women who need legal aid.

More maintenance cases are filed by lawyers in all centres than cases under PDV Act. It was mentioned that the women do not like to access the provisions of the Act due to fear and lack of security. In the event that there are no crisis shelters for the affected women to stay in, women are compelled to go back to the perpetrator. There is a fear in obtaining protection orders against their spouses as women fear more violence against them once the interim period is over. The complexity of the understanding of the PDV act by lawyers and judges and the difficulty in implementation of the act in the absence of permanent shelters or family counselling has prevented women accessing the provisions of this act. This was the same in all district centres managed by all three NGOs. This led to a situation where cases of domestic violence were settled outside court more frequently. The centres can provide space for such settlements involving the counsellor, adults and key persons from the village as done in the past.

Table 15: Legal action taken for the 2009 and 2010 (Filed cases, and referrals to legal aid)
Table 5 * Legal assistance for obtain legal documents, land issues, kidnaps, labor....

All centres were striving to keep an income generating project on going. It was mentioned that such projects are an attraction to women from poor families to come to the centre and earn an income. In Polhena centre and in Rikillagaskada a thriving income generating project was observed and women were active and engaging. In Rikillagaskada the women have organized themselves to be traders and they run a Sunday fair near the centre where public access is good. It was making profit and one woman had bought a three wheeler with such profit. In Polhena, women earn around Rs. 2,000 – 3,000 per month through coconut fibre carpet making. They feel happy as this is extra income to them. The reason for such project promotion is seen as an intervention to GBV through economic empowerment of women. Many women made it clear that such an income made them feel proud and strong in negotiation at home. In the Hope centre in Hanguranketha, the women are involved in soap making and the estate management has made arrangements for them to sell the soap they make to the families in the estate.

Further to the key services mentioned above, the centres also provide space for women to come together and exchange ideas and chat. During the field visits the team observed a clean and friendly environment with basic facilities in place. The water service and toilet facilities were observed to be good. But a few centres need to improve this facility. The women access the library and most of the main newspapers were in place for the women and men to read. A newspaper stand and a small library with an average number of books were available in all centres.

A qualified counsellor with experience of befriending, listening, counselling, screening and doing referrals is rare in these districts, but the centres are all blessed with such service. The confidentiality maintained in all centres was high. The professional approach to counselling by the implementing agency is seen in the women centres. All these counsellors are visiting the centres at least one day a week and they are on call if there is an urgent case reported. These counsellors are attached to the main district office of the NGO and keep the continuous link with referral services and networks. There is rich interaction between the lawyers and counsellors and they keep each other informed of the processes and incidents and maintain confidentiality all the time.

The most significant aspect of the centre is the community mobilization that has taken place around it. All NGOs met during field visits, mentioned that the mobilization of women and formation of groups around the centres was a slow process and it took nearly one year to get the women organized. The only exception to
this is in Rikillagaskada where the WDC Hanguranketha network was already in place. All centres had around 7-10 groups of women organized in groups of five or eight. Each group has a leader and they meet once a week in the centre. The meetings are facilitated by group leaders and the social workers in the centre are present at these meetings. These meetings are spaces for women to bring their issues of concern and discuss the next steps. The redress strategies and referrals to counsellor and lawyers is also decided at these meetings. The specific GBV issues discussed were domestic violence, rape, incest issues and sexual harassment in work place and community. Specific issues of teenage pregnancies and extra–marital affairs are also discussed at these forums. Extra–marital affairs and desertion is said to be on the increase over the last few years. Not much attention was given to the issues of abortion and sexuality. Women centers have conducted community awareness programmes targeting men and boys from 2009 onwards. Such groups varies from community leaders, unemployed youth, police and military, small and medium entrepreneurs, sports men and boys, and threewheel drivers/bus drivers/conductors covering a cross section of the society around the women centres.

Table 16a: Type of problems (2009)

<table>
<thead>
<tr>
<th>Type of problem</th>
<th>Vavuniya</th>
<th>Batticoloa</th>
<th>Nuwara Eliya</th>
<th>Anuradhapura</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domestic violence</td>
<td>88</td>
<td>34</td>
<td>79</td>
<td>66</td>
</tr>
<tr>
<td>Family issues (financial, jobs, assistance)</td>
<td>61</td>
<td>31</td>
<td>51</td>
<td>28</td>
</tr>
<tr>
<td>Child abuse</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Land issues</td>
<td>22</td>
<td>8</td>
<td>14</td>
<td>3</td>
</tr>
<tr>
<td>Physiological problems</td>
<td>6</td>
<td>8</td>
<td>8</td>
<td>3</td>
</tr>
<tr>
<td>Legal documents (Birth certificates, ID, Married Certificate)</td>
<td>42</td>
<td>12</td>
<td>25</td>
<td>28</td>
</tr>
<tr>
<td>Other issues (kidnapings, illegal business, labor...)</td>
<td>8</td>
<td>10</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td>229</td>
<td>106</td>
<td>184</td>
<td>130</td>
</tr>
</tbody>
</table>

Table 16b: Type of problems for the project period of 2010

<table>
<thead>
<tr>
<th>Type of problem</th>
<th>Vavuniya</th>
<th>Batticoloa</th>
<th>Nuwara Eliya</th>
<th>Anuradhapura</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domestic Violence</td>
<td>208</td>
<td>68</td>
<td>167</td>
<td>85</td>
</tr>
<tr>
<td>Family issues (financial, jobs, assistance)</td>
<td>154</td>
<td>59</td>
<td>78</td>
<td>38</td>
</tr>
<tr>
<td>Child abused</td>
<td>8</td>
<td>1</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Land issues</td>
<td>46</td>
<td>14</td>
<td>22</td>
<td>15</td>
</tr>
<tr>
<td>Physiological problems</td>
<td>3</td>
<td>4</td>
<td>12</td>
<td>3</td>
</tr>
<tr>
<td>Legal documents (birth certificates, ID, marriage certificate)</td>
<td>67</td>
<td>28</td>
<td>90</td>
<td>110</td>
</tr>
<tr>
<td>Other issues (kidnapings, illegal business, labor...)</td>
<td>34</td>
<td>24</td>
<td>7</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>520</td>
<td>198</td>
<td>381</td>
<td>258</td>
</tr>
</tbody>
</table>

Source: Women centre records

The women groups were organized and their capacity is built through training. These group leaders are formed into a watch group to be vigilant on the GBV issues in the coverage areas. The watch group meet once a month on a regular basis and if needed they also meet in the centre on a case basis. The watch groups have access to the centre managers, the counsellors and lawyers via a hotline.
Youth groups and children groups are also formed around the centre. The youth groups are mobilized and are actively involved in bringing different issues of GBV to the attention of the centre staff. In one of the Matara centres this group was able to close a video shop which was involved in showing phonographic material to school children.

The adult men are also organized around the centres and their mobilization is through different religious and cultural events such as a thovil\textsuperscript{15} and kavi maduwa\textsuperscript{16}. Groups of three wheel drivers were engaged in prevention of GBV in Malimbada and Mihintale centres. The communities mobilized around the centres were receiving training and capacity building on GBV to help them to identify cases and to prevent them.

More attention is given to risk groups and benefits were seen in the districts. e.g. using three wheel drivers to prevent the incidents of violence against young girls through various interventions.

One concern discerned during evaluation was the lack of attention to power inequality in gender relations within the family and community. The accepted way of thinking within the family, community and the perceptions of a few health sector field officers who met during the field visits, were that existing relationships in the family should not be disturbed when implementing gender programmes with the community members. Issues of sexuality and bodily integrity were not discussed much in the centres, especially among women groups. But among the youth, such discussions were taking place and they showed the need for more guidance to understand and address these issues. They felt that this information and understanding is important to keep the family in harmony. Guidelines for the centre management and mobilization of communities are disseminated among the centres. But there was unclarity on the concepts of watch group, protection committees, and task forces with local agency representation. More discussion on the formulation of these committees are needed. Formalizing a centre protocol has not happened.

The women centres started income generation programmes and skill development of women to attract them to the centre. The focus then started shifting from prevention and intervention to GBV towards income generation, as many women were poor and welcomed the idea of income generation. However, the centre has to maintain its focus on GBV issues and create space for community mobilization and vigilance of issues of GBV. However, these centres can attract other agencies working on income generating projects to support the women members who show interest in skill-development and self employment.

Reporting on implementation of centre activities lacked a format/design to capture the qualitative aspect of the achievements. Data analysis and documentation of stories in the centres need to be more systematic and fed into a data base. A number of women centre staff interviewed during evaluation requested UNFPA technical support in this regard.

E. Knowledge building and technical assistance

Research was done on the link between gender, GBV and different religions to add to the volume of knowledge on gender. In 2010, research was commissioned by UNFPA in partnership with WERC on Hinduism and the patriarchal world view in Sri Lanka. The research findings show the discriminatory practices against

\textsuperscript{15} Thovil is an event which is traditionally held to bring solace to people affected with different sicknesses and makes an appeal to Gods to take care of the sick person. Dance as a form of art that is used during this event to call the Gods and devils to the same platform and to punish the devil for entering the soul of the sick person.

\textsuperscript{16} Kavi Maduwa is a social event in which poetry is used to elaborate on a selected topic and bring in different perspectives on it in the form of an argument. There is a lot of humour and fun in the kavi maduwa, while communicating key messages through that.
women produced by Bhraminical Hinduism. This research covers the different practices of Hinduism in Jaffna, Batticaloa and the plantation sector.

UNFPA partnership with Faith Based Organizations involved Damrivi Foundation, an organization working with Buddhist priests to prevent GBV. This is in line with the highlights of the ICPD-International Conference on Population and Development to involve FBO to combat GBV. Damrivi Foundation conducted a programme at Tissamaharama in 2009 and it was titled “VAW - a Buddhist Perspective”. This advocacy meeting involved 78 monks, 40 nuns and 30 lay people. The book “Violence against Women – a Buddhist Perspective” authored by Dr Lakshman Senanayake was presented at this meeting. During this event an appeal was made to Buddhist monks to be more vigilant to the incidents of violence and to intervene in preventing GBV through sermons and religious preaching. A plan to establish an inter-faith network on VAW was discussed at this meeting.

MWRAF, an organization working on rights of Muslim women, is engaged in the final phase of a research on Gender and Islamism as commissioned by UNFPA. It is expected to finalize the research and use it to enhance knowledge of the “Inter-religious Federation of Ampara District” a network of religious leaders working in Ampara. There are leaders of all religions represented in this federation and a number of dialogues on issues of GBV and domestic violence, ethnic harmony are being facilitated by MWRAF. A research on Gender and Christianity is planned for 2011 as part of the UNFPA gender output on knowledge building on the intersections of GBV.

UNFPA strategy on how to use the information generated on the intersection of gender, GBV and religion is not clear yet. UNFPA needs to investigate on how these comprehensive researches and knowledge built can be used to further the discourses on gender and to plan advocacy with interfaith organizations and networks.

Efficiency

In Sri Lanka many organizations are working on GBV issues but the interventions are mostly uncoordinated and done in isolation. These programmes have resulted in inefficient use of resources. There is a lot of duplication of programmes in the same locations. Most activities did not have the strength to advocate for policy change as they were isolated events. In such a situation the forum against GBV has made a conscious effort to coordinate different agency activities on a selected GBV issue and focus the energies on policy advocacy and lobby with the relevant government institution. The forum strategy on combating sexual harassment in the transport sector is one such efficient programme.

The funding for Forum against GBV campaigns and events is a collective effort. UNFPA provides the forum facilitator and physical spaces for the forum meetings. UNFPA technical support on gender and women’s rights is ensured through the participation of National Programme Officer on Gender at the Forum. Many members appreciated this technical input from UNFPA. However, a lot of time of the NPO on Gender is spent on Forum work and this needs to be revisited to maximise the use of NPO’s time on policy advocacy with the national machinery on women.

The three NGOs selected to implement the women centre programme are very experienced and have long years of experience in networking with different agencies and actors in addressing issues of GBV. Their technical capacity is very high and they have well trained and committed staff. They have a referral mechanism worked out with the government agencies, police, courts, prisons, health sector and other key agencies. UNFPA has made a good selection of the three key NGOs who have undertaken to establish and run the women centres. The planned activities are implemented by each of the centres taking into consideration the local context. Slight changes were made in the activities but the key outputs are all met on time. The
centres are running effectively apart from a few which had to be re-opened or re-located due to issues of location.

Mobilizing communities of women, men, children, and youth paved way to a holistic approach to the GBV prevention and intervention. It made GBV prevention everybody’s responsibility. In order to mobilize these groups the centre had at least one activity to attract each group. Like play areas for children, music classes and music instrument to the youth, bon fires and sports events for men, religious and IGP for women and library for all categories. Mobilizing communities to take the responsibility of vigilance on GBV and to intervene when necessary is a cost effective and locally led approach to combat GBV.

The protection committees are a higher committee with the representation of key persons from the village, Grama Niladari, PHI, mid-wife, Samurdhi Officer, civil committees, teachers, principals, priests, CDO, WDO, adult promotion officer, psycho-social officer and women leaders. This group meets bi-annually and takes strategic decision on GBV prevention. This network is very important for the women centres when referrals are made and cases are handled effectively. This committee is a useful link to access government services.

The capacity development of frontline workers is an effective method to involve different categories of government and NGO staff to focus on issues of GBV and plan the redress strategies. This programme can be replicated in other districts.

**Sustainability**

The Forum against GBV has sustained its efforts for the last four years after its revival in 2007. The membership values the forum and a lot more demand it coming from different agencies and districts to join the forum. This is a good sign of its sustainability as a forum. The sustainability of the Forum against GBV is ensured by its active membership and strategic planning process. However, more fundraising activities can be facilitated and also involvement of commercial sector can be useful. All core members take responsibility of the advocacy events and show ownership of the processes. The loose network in the Forum makes it possible for free expression and flexibility. The Forum will continue to act as an advocacy platform even if UNFPA support is withdrawn.

Sustainability of the women centres is yet to be decided. The women centres take a long time to establish and owned by the communities which is the ultimate goal. Right now the centres are involved in the mobilization of the communities and building a network of government service providers and other actors around it. This is a slow process. Running a centre is also expensive. Many stakeholders said that they need another 3-5 years of funding to maintain this model and put the mechanisms firmly in place. All three NGOs are planning income generating projects as a way to sustain these centres and help women. But UNFPA needs to help these NGOs to think beyond IGP and explore other strategies to continue the services. The community network and the protection committees linked to the centre will continue to operate even after UNFPA assistance is withdrawn. However, more time and capacity building is needed for these networks to strengthen their ties and work independently. The legal and counselling services provided by these centres are professional in nature and if the NGOs involved have to continue the services it will be hard on their organization. The demand for these services is increasing and community expectations are growing. The NGOs will find it difficult to handle this situation unless a plan is worked out soon.

**Impact**

As observed in Malimbada, and Nuwara Eliya Hope estate, the UNFPA assisted women centre is the only NGO response to GBV in these areas. The mobilization around this issue is very high and the communities and
estate management are taking responsibility to work on prevention and intervention of this issue. The three wheel drivers group who are actively working as a watch group in Malimbada is one example of this mobilization. The women centres are respected by the police and Grama Niladri, (local government representative at sub national level). They frequent the centres and bring the cases of GBV to the attention of the centre staff. The centre managers have access to police and can solve certain related issues by giving a phone call to the police officers. There is a strong network built around the issue of GBV in these locations and this has created a momentum. Above all the activities carried out, awareness raised on the issue is very significant.

The collective advocacy work of the Forum against GBV and the link with policy formulation bodies of the transport sector is a positive impact of UNFPA supported programmes. The forum has carved out a path to bring changes in laws and policy work through campaigning and lobbying with different stakeholders.

2.4.5 Output two

Strengthen national capacity and institutional mechanisms for increased state accountability to fulfill and protect the rights of women and girls

Relevance

Sri Lanka is a country which was impacted by a long drawn conflict. Rights of women and girls were violated in many parts of the country due to the violence that was an integral part of the conflict. Women and girls faced issues of insecurity and lack of protection. UN SCR 1325 and 1820 are relevant resolutions in times of conflict and in post conflict situations. Therefore UNFPA’s decision to strategize towards the realization of the articles in UN SCR 1325 was timely and relevant. However, the conflict situation changed from war to peace over the last two years. The relevance of the UN SCR 1325 as an international framework for action is reduced due to this transition. Instead of developing specific national plans on the UN SCR 1325, the government has now decided to include the articles of UN SCR 1325 in the revised national plan of action on women. In addition, a need for in-depth understanding on UN SCR 1325 and skill on developing strategies in relation to it is discerned by the MCDWA and UNFPA has made arrangements to train MCDWA staff and other relevant government officials on the UN SCR 1325. The in-depth understanding of UN SCR 1325 within the national machinery on women and among CSOs is limited and the awareness raising conducted during the period of evaluation can be concluded as relevant and timely.

Effectiveness

Strategies:

A. Capacity building on UN SCR1325 at district and national level for both protection and participation of women and girls

B. Support to relevant independent commissions and inter-ministerial mechanisms to play an oversight role to protect the rights of women and girls and monitor implementation of relevant Plans and Conventions

C. Facilitating the participation of women at all levels in the peace building process in line with UN Security Council Resolution 1325

The strategies under output two are all linked and focused on the implementation of the international conventions, especially UN SCR 1325 and relevant national plans on women. However, limited achievement is discerned under output two of the gender component. The limited achievement is due to a few factors. UN
SCR 1325 is not seen as an important resolution that needs a national plan by the government and the resolution is taken on the face value and interpreted differently in the post-conflict situation. The elements of participation of women in peace processes and decision making, protection and security, attention to specific needs of women and girls are relevant articles in UN SCR 1325 that are important in the post conflict situation. The stakeholders lacked this understanding on the relevance and UNFPA has planned capacity development programmes to address this situation. In addition, there is no specific government agency that is taking lead on the implementation of UN SCR 1325 in Sri Lanka.

In view of this, UNFPA has selected Human Rights Commission (HRC) as a possible partner in the implementation of UN SCR 1325 and securing women’s rights. A needs assessment of HRC was done involving all the regional and district offices of HRC. Interviews were held with 38 HRC staff and 14 outside agencies as part of the assessment. This activity has generated interest and enthusiasm on gender within HRC.

A mapping exercise was done on UN SCR 1325, 1820, 1888, 1889 provisions, national plans and interventions on these conventions with the assistance of CENWOR. A follow up is designed based on the findings. A human rights lecturer from Colombo University was supported to attend 10th anniversary of UN SCR 1325 and as a result of this participation and capacity building, information on UN SCR 1325 is integrated in the faculty of law curriculum.

Capacity building of 10 women centre managers and Human Rights Commission officers in the districts on UN SCR 1325 was carried out. In addition, three training workshops were conducted with 40 frontline workers on UN SCR 1325 in partnership with NGOs in Kurunegala district.

An advocacy meeting with 58 gender advocates on 26 indicators of UN SCR 1325 was organized by UNFPA as a part of a wider capacity building and awareness raising on UN SCR 1325. UNFPA has also provided technical assistance to CEDAW CSO forum processes and reported on GBV and health sector in UNCT CEDAW report.

Most of the activities completed since 2008 are directed towards awareness raising and capacity building on the UN SCR 1325. No concrete action was initiated to lobby with the government to implement the provisions in the resolution. In general the rights discourse is slowed down in Sri Lanka. The conflict situation has changed and peace prevails in the country. Therefore the relevance of UN SCR 1325 is reduced and government does not seem to agree on the need for a national plan on the resolution. UNFPA has to review this output two and develop different strategies to reach the goal of securing the rights of women and girls.

**Efficiency**

A lot of planned activities under the partnership with MCDWA did not happen due to lapses on the part of the Ministry. Working with the MCDWA on policy issues is time consuming and demands a lot of time and energy of the NPO on Gender. This partnership needs to be strengthened and regularized by involving all the units of MCDWA. The policy and legal expertise of the NPO on gender is to be capitalized for this purpose. Building capacity of the staff of MCDWA is necessary for effective implementation of the UNFPA plan and to ensure sustainability. Placing programme officers within the MCDWA is a good idea but MCDWA has to take up the responsibility of integrating such capacity to the ministry structure.

In view of the above mentioned difficulties in working with MCDWA, UNFPA has expanded the partnership with different government agencies and commissions under the gender output two and the partnership with HRC has proved to be efficient and fruitful. HRC education unit is already engaged in capacity building of different government agencies on gender and UN SCR 1325 which is a quick response to the UNFPA work.
with the commission. HRC is actively involved in the preparation of a training manual to build capacity of HRC staff on GBV and UN SCR 1325.

**Sustainability**

The sustainability of the inter-ministerial monitoring mechanisms set up in MCDWA with UNFPA support is questionable. Such committees need good coordination and follow up. Within MCDWA no unit is set up to do this coordination. UNFPA needs to negotiate such space and commitment with MCDWA. Utilization of UNFPA technical input and financial input by MCDWA is weak. A number of planned activities did not take place. More time has to be spent on MCDWA in the annual planning process and ensure involvement of all the different units. Technical assistance to MCDWA will be sustainable if counterpart staff is identified within MCDWA. So far the placement of technical persons in MCDWA did not lead to the integration of technical expertise to MCDWA as there was no Ministry staff being identified to work alongside the technical person. The high turnover of the officials of MCDWA is another issue that makes the programme ineffective and less sustainable. The capacity that was built did not sustain within the organization.

**Impact**

UN SCR 1325 is being discussed at different fora and agencies and UNFPA capacity building has shown results. HRC has taken UN SCR 1325 on board as a relevant policy framework and has started building the awareness and skills of commission staff at different levels on the articles of the resolution.

### 2.4.6 Facilitating factors (Gender)

Men and boys have shown interest in becoming partners in the prevention of GBV and community responses are very encouraging. More space is to be created for this interaction. Special groups like three wheel drivers are mobilized and have proactively contributed to prevent GBV. The police have joined in the process of GBV prevention and have become very supportive to the women centres. Health sector field staff is increasingly joining the campaigns and awareness programmes of women centres.

At the focus group meeting with members of the forum against GBV, evidences were gathered on how the collaboration among UN, INGOs and NGOs have worked towards lobby and advocacy for policy reform on GBV issues.

Religious leaders have shown interest in the ongoing GBV campaigns and interfaith committees have agreed to work towards the prevention of the issue. The discussions with MWRAF staff on their activities with religious leaders’ forum in Ampara district confirmed the active engagement of the faith based organizations/groups on the prevention of GBV.

The national machinery is appreciative of UNFPA technical capacity on gender and women’s rights. The MCDWA has opened its doors to UNFPA technical input and invites UNFPA to its monitoring committees and policy platforms. A good rapport is built between UNFPA and MCDWA.

The CSOs have accepted UNFPA women centre approach to redress GBV and they have faith in this approach. A number of interviews held during the field visits with the community groups and CBOs in Matara, Anuradhapura and Vavuniya districts confirmed their acceptance and involvement in the women centre programme.
2.4.7 Hindering factors (Gender)

Focused attention is given to service delivery and a general lack of commitment to right based approach among the stakeholders is observed during the evaluation. This has hindered UNFPA approach to rights based programming and implementation. Welfare oriented thinking to gender is prevailing among the development actors and among the government agencies. Most of the programmes conducted by MCDWA are focused on skill development, family oriented nutrition programmes, income generation, and saving and credit programmes. Issues of reproductive health, abortion, teenage pregnancies, early marriages of girls, desertion by the partners, and HIV/AIDS have not received the due attention of many government and non-government organizations. This has obstructed the women’s rights approach of UNFPA. Not much attention is given to power analysis in gender relations and this has impacted on discourses on gender and GBV.

Focus is on reproductive health rights and not much attention is given to sexual rights in the programme design and delivery by UNFPA strategic partners. Many agencies do not want to disturb the status quo and transform power relations.

Attention to income generation in the women centres has diluted attention to GBV prevention. Many women visit the centre with the expectation of developing their skills and earning an income. IGP is a good initiative to attract women to the centres but the focus on GBV is to be maintained and improved. Demand for legal services at the women centres can increase with time but the supply of this service can have problems due to the part time service of the lawyers.

Quantitative reporting formats may not capture the qualitative aspect of GBV prevention and intervention activities.

2.4.8 Conclusions (Gender)

UNFPA has introduced a new civil society led holistic approach to GBV prevention, intervention and advocacy through women centres. This is a model that can be replicated by other agencies and by the government as a strategy to combat GBV. UNFPA can document this model/approach and share it with a wider audience. The scaling up of women centres has taken place without consolidating the experiences and without a finalized protocol for the centres. The existing guidelines have gaps and these need to be reviewed and discussed with the women centre staff and stakeholders before finalizing. Conceptual clarity on different terms was lacking in the stakeholders working with women centres and an in-depth understanding/ dialogue on these concepts is needed. Rights discourse is missing in the centre discussions and in capacity development.

Sustainability of women centres is an issue. UNFPA will not be able to sustain all centres for a long time as the expense is high. The objective of community taking responsibility and ownership to prevent and intervene in GBV is yet to be fully realized. The government responsibility in the service provision to affected women and communities is yet to be ensured and the NGOs who are running the women centres need support and strategies to sustain the momentum generated through the women centres.

Capacity building on gender and prevention of GBV, UN SCR 1325 are done by many agencies and trainers. No uniform curricular is agreed upon with the executing agencies/NGOs. Capacity development on UN SCR 1325 has happened with organizations and front line workers but no follow up is done. A broader capacity building plan is not drawn for each year and this has resulted in isolated capacity development events without much impact. Standardization of resource persons, materials and curriculum has not taken place.
Placement of technical assistance within MCDWE needs careful consideration and joint planning between UNFPA and MCDWA. Technical skills need to be institutionalized and sustained through a counterpart placement. A senior advisor on gender and women’s rights is required to guide the MCDWA and the advisor has to have strong educational background on gender and seniority to advocate policy reform with high officials. The experience and capacity of national programme officer on gender is to be capitalized for policy advocacy work with Ministries and to develop strategies to ensure output two.

UN SCR 1325 as a resolution that needs immediate attention of the government and the urgency of a national plan on UN SCR 1325 has lost the momentum. The provisions of UN SCR 1325 are incorporated in the National Plan of Action on women. National Plan of action is recently revised and the responsibilities of different government agencies and NGOs are agreed upon. However, UN SCR is still relevant in the post conflict situation and working on UN SCR 1325 needs to involve different stakeholders in addition to the MCDWA. HRC as a possible partner to implement and advocate for UN SCR 1325 is a good selection. More discussion and building conceptual clarity on UN SCR 1325 is needed within the government agencies. The state sector technical capacity on UN SCR 1325 is to be developed and innovative action is needed in this regard. Learning from other post conflict countries can be shared with the interested agencies to enable innovation in planning initiatives.

Sexual rights of women can be a focus area for UNFPA to develop programmes under RH and gender components. The right to bodily integrity needs to be given specific attention and space in programming in the 8th CP and needs to be based on a gender-power analysis. Securing sexual rights of young girls needs specific programme directions and allocations.

2.4.9 Recommendations (Gender)

The recommendations given below are for consideration by UNFPA in collaboration with the relevant stakeholders, at the time of development of the next CPAP.

Recommendation 1*

Consolidate the learning of the women centres and develop a protocol that include – guidelines for selection of location, setting up a centre, mobilizing communities, setting up committees and groups, stipulate roles and responsibilities of centre staff, clarity on the concepts and rights based approaches, and directions for monitoring and reporting. Facilitate a process to develop strategies for sustainability of the centres, including exit strategies, and ensure the participation of all stakeholders in the process – women centre staff, NGO staff, local government officials and police, key persons in the district/location and other agency representatives.

Recommendation 2*

National Plan of Action on Women can be the key document that needs support from UNFPA under the partnership with MCDWA. Specific focus on the section on UN SCR 1325 in the national plan of action on women is needed to ensure commitment to UN SCR 1325 and place significant stress on comments of CEDAW committee in 2011. UNFPA needs to strategically continue the work they do with the MCDWA on UN SCR 1325 and step up the advocacy on formulation of a national plan on UN SCR 1325. The work done with HRC to draw up a capacity building plan to enhance HRC staff capacity to deal with women’s rights violations and manage cases on GBV has to be furthered and linked to the UN SCR 1325 national plan formulation and implementation.
Recommendation 3*

Sexual rights of women and girls need to be explicitly addressed in the 8th country programme of UNFPA. The RH and gender components can integrate sexual rights in the programme outputs and ensure due attention to these rights of women and girls with a specific focus on youth as a target group.

Recommendation 4

Once all the researches are ready a national symposium on gender, religion and interfaith advocacy on GBV can be organized with the aim of dissemination of knowledge and developing future strategies.

2.5 Population and Development

2.5.1 Context

Sri Lanka is now entering the final phase of demographic transition and a scenario of low fertility and low mortality. Currently the population growth rate in the country is estimated to be 1.1 per cent with a Total Fertility Rate (TFR) of 1.9 and a life expectancy at birth of around 73 years. Given the current fertility and mortality indicators in the country the population is expected to stabilize around 24 million in the year 2030. The country will witness a doubling of its aged population (over 60 years) to 22 per cent of the total population by 2030. Sri Lanka has experienced an increasing trend in the ageing of its population since 1950s. The share of the elderly population increased from 5.4 per cent in 1946 to 10 per cent in 2001. These demographic trends indicate that the proportion of the younger population below 15 years of age is decreasing. However, in absolute terms the young population (10-24 years) is increasing and currently constitutes about 27 per cent of the total population. The following figures (5a-to 5d) from 1990 to 2020 shows the change in age structure demonstrating that Sri Lanka has begun the conversion of its age pyramid from being broad base to being barrel shaped by 2020 (source: Department of Census and Statistics website).

Figure 5: Population pyramid
(5a-1990, 5b-2000, 5c-2010 and 5d-2020)

Whilst this is a result of declining fertility and increasing life expectancy, the issue of ageing requires urgent attention to ensure improved quality of life of the aged especially to address poverty among the elderly, exclusion from development processes and health insecurity with special reference to the increasing prevalence of non communicable diseases. Feminization of ageing is of particular concern as the life expectancy for women is at least six years more than that for men and the higher incidence of poverty among widowed ageing women. Ageing, internal and international migration, changes in marriage and family structure are some important population issues that confront the country today. The table (table 17) below
shows the population projections indicating the increase in population of 60 years and above. The “young old,” those who are 60-70 years of age, would require to be actively engaged in some economic or social activities the government programmes are now focusing on opportunities to keep this group occupied.

Table 17: Projected elderly population, age 60+

<table>
<thead>
<tr>
<th>Year</th>
<th>Elderly Population in Thousands</th>
<th>Elderly as Percent of Total Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001</td>
<td>1,907</td>
<td>10.0</td>
</tr>
<tr>
<td>2011</td>
<td>2,742</td>
<td>13.1</td>
</tr>
<tr>
<td>2021</td>
<td>3,980</td>
<td>17.8</td>
</tr>
<tr>
<td>2031</td>
<td>5,062</td>
<td>21.9</td>
</tr>
</tbody>
</table>

Source: UNFPA, Population Association of Sri Lanka

Trends and patterns of population by age, sex, and place of residence determine the demand for and supply of goods services, hence must constitute an important basis for planning and resource allocation decisions. Systematic consideration of these, however, is limited by shortages of manpower and skills in the utilization of data.

UNFPA situation with regard to Population & Development

UNFPA’s interventions under this country programme contribute to the UNDAF outcome “Economic Growth and Social Services are Pro Poor, equitable, inclusive, and sustainable.” Within this broad framework, UNFPA and the implementing partners have identified the provision of support to increase the availability and utilization of population data disaggregated by age and sex as a way to achieve the following outcome: “enhanced utilization of population data & strengthened capacity to track progress in implementing national poverty reduction strategies and in achieving MDGs, using a gender and social equity perspective.” The indicator “national development and sectoral plans take into account population and gender dimensions” is selected as the measure of this outcome.

As a result of the planned interventions, the CPAP states the expected output as “increased availability and utilization of population data disaggregated by sex and age,” and the areas of support were identified as capacity building aimed at increasing knowledge and enhancing skills to improves the utilization of population data and trends for development planning processes; institutional capacity building for gender analysis, planning and budgeting; and strengthened institutional capacities to monitor progress towards poverty reduction goals and MDGs.

The key strategies and related activities identified for implementation to achieve the above, as per CPAP are to:

- Improve the collection, processing and analysis of 2011 population census,
- Incorporate population and gender concerns in national, sectoral, and sub-national level planning and build capacity for monitoring the National MDG Plus Goals,
- Strengthen health sector planning to incorporate population trends and patterns,
- Support policy research on critical population, reproductive health and gender issues and high level evidence based advocacy, and to
- Conduct a gender-based violence survey in selected districts, including the five focus districts for UNFPA programme implementation.
According to the CPAP, during the initial four programme cycles (CP1-CP4) UNFPA’s support to DCS had contributed to the development of its capacity to organize and conduct censuses and surveys and to analyze results. As reported in COAR, there had been a limited input on P&D and phasing out of population and development support to Sri Lanka during the past two programme cycles (CP5 and CP6).

It is with this background that CP7 cycle is implemented in an era when Sri Lanka is in need of strong Population and Development component for the country’s development planning. As explained later in the report under programme management and partnerships, UNFPA should recognize P&D as an important area when planning the next programme cycle to gain the maximum for the country during this “demographic window.”

The following section presents evaluation findings and conclusions regarding UNFPA support provided to achieve expected outcomes and outputs in the P&D component. Accordingly, this assessment is focused on the interventions and strategic approaches to achieve the planned results.

To reiterate, the expected outcome as stated in the CPAP is: enhanced utilization of population data and strengthened capacity to track progress in implementing national poverty reduction strategies and in achieving MDGs, using a gender and social equity perspective and its indicator is that national development and sectoral plans take into account population and gender dimensions. The output is to increase availability and utilization of population data disaggregated by sex and age.

Indicators to measure these outputs are specified as:

- Number of national and sectoral strategies and plans incorporating sex and age-disaggregated data and analysis
- Number of national and sub-national plans using gender sensitive indicators for monitoring and evaluation
- National database on population and gender established
- Number of advocacy events informed by analysis of data disaggregated by sex

In the absence of detailed and complete background information on P&D, it was not possible to gather information on baseline or targets. With regard to the third item, there is no national database on population and gender and as such the baseline for that is “none existence of such database.” Plans are on the way to accomplish this in 2011 and 2012.

The key IPs were identified as being CSD, NPD, and the Ministry of Social Services, as well as potential key partners including the University of Colombo, IHP, IPS, and CENWOR. Interviews were held with these partners and the information in the following sections came mainly from the content analysis of the key informant interviews, document review (list attached), observation, structured survey questionnaires, telephone interviews, and staff interviews, and web searches. Similar to the RH and Gender components, the evaluation addressed the issues of relevance, effectiveness, efficiency, impact and sustainability. As mentioned earlier, the program is not yet complete and two more years of implementation have yet to be completed. It is premature to assess the impact of those activities that are still in their formative stages.

While the programme cycle took a late start due to the late approval of AWPs, much of the work was accomplished during 2009, and 2010. Key inputs were for capacity building for census preparation and support to NPD for integrating population and gender dimensions in the national planning process. Input in the P&D sector planned for the coming months during 2011 and 2012 are:
- Advisory missions through international consultants, data processing, software, analysis, estimation and modeling
- Trainings: gender analysis, population projections, migration, population dynamics
- Dissemination and publicity: GIS, Census Info, data users, and publicity.
- Strategy for in-depth analysis, and in-depth analysis of selected themes, potential data users training, and dissemination.

2.5.2 Programme design (Population and Development)

As stated above, P&D component has one broad outcome and one output measured by several output indicators. Keeping in line with the expected outcome, there is a logical sequence to the outputs planned. The indicators identified are measurable and the key strategies identified are appropriate and feasible. Although not all planned activities in the AWP reflected the approaches and the strategies set forth in the CPAP, in general, the programme design was backed by logical linkages between interventions and expected outputs leading to the overall outcome. One weakness was the lack of baseline values for many of the indicators and targets which limited the periodic monitoring for progress. The design does not show how stakeholders will be engaged in reviewing the progress monitoring. There is no systematic review process and as such some aspects are only brought to light long after the implementation or during an evaluation such as this one (CPE7). Had there been a monitoring mechanism embedded in the design, some of the shortcomings that this evaluation identified would have been uncovered much earlier.

The P&D programme has included some support for critical areas such as policy and planning, knowledge management for advocacy, policy analysis, support for research and training, and strengthening data availability and quality. While these areas are linked to other programmatic areas, there were not many interlinkages as depicted in the framework (figure 3). There was limited synergy between the three programme components and P&D could and should provide a stronger foundation for the overall CP.

There was no record of ex-ante reviews at the design stage of any proposed activities and as such, the evaluability of some interventions had not been assessed before implementation. This was a common observation in all programme components and not specific to P&D only.

However, the design of most of the P&D programme interventions are based on discussions with stakeholders and previous recommendations made by technical missions and are logically linked to the planned output. Overall, the programme inputs are aligned well in achieving the expected results.

Exit strategies, specifically in institutional capacity building where UNFPA supported placement of consultants/project officers were not well thought out and were not explicit in the design. It would be useful if implementing partners had plans in place when UNFPA resources pull out. It should be clear to both parties how the enhanced capacity will be sustained and what steps will be taken to ensure its long-term sustainability. Having an exit strategy per se does not guarantee sustainability; however, monitoring such a strategy could help future direction for IP’s ownership. In the absence of a thoughtful process for ownership the sustainability of UNFPA supported interventions could be at a stake once funding and other support cease.

2.5.3 Programme management and partnerships (Population and Development)

UNFPA had identified key partners as the Department of National Planning, the Department of Census and Statistics, and the Ministry of Social Services. A few of the potential partners are the University of Colombo,
IHP, IPS and CENWOR. The Ministry of Indigenous Medicine should also be included as a potential partner for the reasons described below. The Department of National Planning is the apex body for incorporating population dynamics and their impacts on needs and services into the country’s development planning. However, up until the engagement in the preparation of the National Development Framework (Mahinda Chinthanaya), UNFPA’s support to the Department of National Planning has been minimal. Furthermore, the Department’s capacity to integrate population dynamics in national and sub-national planning has also been weak.

According to the CPAP, UNFPA had planned to strengthen the health sector by placing a population specialist at the Department of Planning of the MOH for one year; however, the AWPs do not reflect this activity in the plan. With the abolition of the Population Division located at the MOH, incorporating of population issues in health sector planning has become weak and as the country is experiencing a rapid demographic change, strong partnership in population and development with the MOH is crucial and timely.

A life cycle approach to planning for services and facilities could be a major contributor to health service planning. Adequate population data and population projections are available and can be used for planning for different needs of specific age groups. UNFPA plans to support work on population projections in the remaining programme cycle. As the elderly population keeps growing, their preferences for health care needs have to be taken into consideration. In Sri Lanka, some elders, especially in rural areas, prefer indigenous medicine as opposed to western medicine. The Ministry of Indigenous Medicine could be a potential implementing partner as the needs of the age structure changes and demand for ayurvedic and indigenous medicine becomes greater with the growing population of the elderly.

With regard to the P&D component, the lack of both a tracking tool to monitor the results as well as M&E capacity and awareness within the implementing agencies pose a challenge in results-based management of the CP. There is no monitoring system established to measure results and no organization assessments performed to gauge the capacity of IPs in monitoring results. CP7 provided some support with skill development and by placement of project officers to analyse population and gender related data for planning and monitoring at macro level. UNFPA supported the Department of National Planning with technical expertise for the staff of Human Resource Planning section to initiate a programme, including the training of staff, to strengthen the Department’s capacity to integrate population and gender concerns, and to develop a work-programme for the years 2009-2012. However, there was no feedback nor reporting system established to assess if expected roles/tasks have been fulfilled and results achieved as intended or not.

The information in this section may not be complete and accurate. Getting access to data in P&D was limited and other POs had no institutional memory on P&D related activities and to some degree it reduced the access to information needed for this assessment. Since most P&D issues are at the policy level, lack of information sharing could affect all other programmatic areas. The lack of a formal platform/an institutional mechanism for formal exchange of information does limit opportunities to share experience to work as a team. Interventions in P&D can have a positive influence on all other programmatic areas and as such they (gender and RH) should be well integrated into P&D. P&D should be seen as the foundation, as it covers all aspects of human development. As ICPD clearly documents “…the world agreed that population is not about numbers, but about people, implicit in this idea that every person counts. …empowerment of women is not simply an end in itself, but also a step towards eradicating poverty and stabilizing population growth. Reproductive health and rights are cornerstones of women’s empowerment.” Managing P&D programme should get more attention and more strategic partnerships should be built in the coming years to have a strong base for supporting national level population policies. Specifically, the National Population and Reproductive Health Policy (2000-2010) might have to be revisited.
UNFPA has a comparative advantage over the other development partners in establishing strong partnerships with government institutions and broader development community to support policy dialogue, advocacy and advisory services in P&D. Currently, this seems weak perhaps due to the limited input in P&D during the last two programme cycles. In CP7, key output expected and the strategic interventions are as follows.

### 2.5.4 Output one

While the expected output is “increased availability and utilization of population data disaggregated by sex and age,” the strategic interventions focused on supporting this output are: (a) the 2011 census; (b) a national survey on gender-based violence; (c) capacity-building aimed at increasing knowledge and enhancing skills to improve the utilization of population data and trends for development planning processes; (d) institutional capacity-building for gender analysis, planning and budgeting; and (e) strengthened institutional capacities to monitor progress towards poverty reduction goals and the Millennium Development Goals, using a gender and social equity perspective.

The following discussion under the DAC criteria will assess the strategies that are employed to achieve the intended output and in turn the outcome in the P&D component.

**Relevance**

The second MDG country report (2009/2010) brings out the regional imbalances due to inequalities, especially in the districts such as Nuwara Eliya, Badulla, Ratnapura, and conflict affected areas. The report also indicates the government’s interest in linking MDG key performance indicators with ministries’ budgetary process. The emphasis given to the MDG indicators in the planning process shows the need and the importance of having reliable, valid disaggregated data for evidence based planning and budgeting.

As such, UNFPA’s role in continuous support for capacity building in the area of disaggregated data and its utilization is invaluable. Much needed data are produced mainly by the Department of Census and Statistics and UNFPA support in the P&D component makes an important contribution towards capacity building of CSD staff who are implementing national surveys such as Demographic and Health Survey, Household Income and Expenditure Survey, and the special MDG Indicator Survey etc. The data base provides the opportunity to analyse the issues related to MDG by province, district, sector, age group and sex. UNFPA support in capacity building is relevant.

UNFPA’s support in terms of disaggregation and utilization of data for policy and planning is highly relevant to the National Development Strategy (Mahinda Chinthana), the MDG-based comprehensive national development strategies and other sectoral policies and programs. In the realm of population policy, improvements in population data gathering and analysis and in the dissemination of data and relevant research are considered the principal mechanisms for policy implementation. The MDG-based comprehensive national development strategy emphasized the implementation of human-rights based and family centred comprehensive state policies to support vulnerable groups of the population including youth, elderly and the disabled, as well as a recognition and reflection of demographic changes in social policies, programs and development plans.

Capacity building of institutions has been a strategy of UNFPA to improve the utilization of population data and trends for development planning processes. This is relevant as the government is now more inclined to use evidence based data for results-based planning, as MDG progress report indicates, and as such there is a felt need for the use of valid and reliable data for establishment of baseline and monitoring purposes.
UNFPA input to staff training is one of several strategies/aspects in institutional capacity development efforts. This strategy per se is relevant, and if implemented and followed up well, could be effective and efficient. With good participant selection and proper placement after the training, capacity building of staff can be a sustainable approach with positive impacts. While the strategy is relevant, we cannot be conclusive in findings if the trainees are in positions that match the skills and knowledge gained as a result of the training. More follow up work needs to be done under this component. Current evidence is weak due both to the paucity of participants that were accessible for interviews and the low response rate for the questionnaire (Appendix 5).

UNFPA has provided technical assistance in policy dialogue, advocacy and advisory services to its implementing partners and this approach is relevant as these are very much within the mandate of UNFPA. National and local capacity building and institutional development projects/programmes as well as appropriate sector specific interventions including gender mainstreaming initiatives have been a part of the P&D component. All these are relevant to the national development as well as UNFPA’s roles and responsibilities toward the Government of Sri Lanka.

**Effectiveness**

There are three main implementing partners supported by UNFPA - DCS, the National Planning Department, and the Ministry of Social Services. Support for the Ministry of Social Services was minimal compared to the other two.

UNFPA’s support to the DCS is to improve the collection, processing and analysis of 2011 census.

Support to census in engendering: technical assistance by way of consultancy was provided and a large workshop was attended by key staff from the Department of Census, line ministries, as well as from research institutions dealing with gender and data. The primary focus was to provide advice on how the census questionnaire and manual should capture economic activities of women in the informal sector and on training for the enumerators to enter the data. The census questionnaire reflects formal and non-formal economic activities undertaken by women and inclusion of this specific question is an effort due to UNFPA’s support to the census preparation. The output of the gendered census could produce data that are useful for gender analysis to capture social dimensions and incorporate gender perspectives in all analyses and planning (examples include education, household income, nutritional status, and diseases).

UNFPA had identified, jointly with the DCS, capacity gaps and tailored technical assistance and trainings on specific areas and had provided services (TA and training) to address these capacity gaps. Although it was planned this way, not all training had been effective. Related to preparation of the census, ten staff members attended workshops and training overseas, while ten received training at the University of Peradeniya. One staff member from the DCS was trained specifically on engendering the census at a workshop in Bangkok and two members received training in population and development, linkages and challenges especially in relation to household composition and gender, for two weeks in India. Furthermore, about 45 participants from various levels participated in a workshop to discuss engendering the census. The CO also sponsored DCS senior officials to participate in UN Statistical Commission Conference in New York, and ESCAP Statistical Commission meetings which were regarded as very useful and relevant by the participants. The census questionnaire was piloted and enumerators also had extensive training on data collection to capture the information needed in the survey. In addition to these, several training workshops took place in Colombo and at the provincial level for CSD staff and provincial administrative staff.
With regard to national capacity development, UNFPA’s contribution has been vital in the upcoming census programme, and its efforts have been much appreciated by the Government. Furthermore, the CO coordinated a number of technical missions of international experts to support the pre-enumeration phase of the census. Technical assistance provided included data editing and imputation, identification of a suitable method of enumeration (de jure); and capacity building in gendering the census. UNFPA inputs have also included various trainings in CensusInfo Package, dissemination techniques including web-based user friendly interactive tabulations (REDATM), engendering the census, population and development, linkages and challenges especially in relation to household composition and gender, census communication, post enumeration procedures, and GIS. While some of the training on these topics was done overseas, some were at local universities.

According to the feedback, technical expertise provided through international consultants had been regarded as useful and timely by the DCS authorities. The integration of a capacity building element is seen as successful in facilitating transfer of knowledge and building of capacity of relevant DCS professionals’ competencies in census and other statistical undertakings.

The benefits of these trainings will be realized fully only when they are applied and the effectiveness will be seen in the quality of data as well as the kind of analyses and tabulations that the census will produce. It is likely that all the focused training on the census will produce positive results. So far the census preparation has benefitted from UNFPA inputs, according to key informants’ feedback.

If the current status of data and their tabulations are a reflection of previous awareness programmes, training and technical assistance to departments on gender and record keeping, cannot be said to be fully satisfactory. Despite training in and awareness building on the need for disaggregated data, major documents do not yet present sex-disaggregated data and tabulations did not reflect gender-based analyses in most cases (eg. MDG progress reports, Annual Health Bulletin, MOH). Age disaggregated data are more commonly available. This is not due to any lack of data, as most of the raw data include sex and age variables by geographic locations and are available to prepare gender, age and location specific statistics. Analytical capabilities exist in the departments as evident by the demographic and health survey reports where sex and age disaggregated data are available.

Gender dimensions of the MDGs in Sri Lanka-2007, a publication sponsored by UNDP states: “The two major national institutions responsible for the collection, analysis and dissemination of data on an island wide scale are the Department of Census and Statistics and the Central Bank of Sri Lanka. Line ministries also collect data relating to their own mandates with varying degrees of efficiency as seen in the annual censuses or reports. Research institutions publish data from generally micro level studies that are qualitative and complement national data. A seemingly intractable problem experienced in studies is the lack of easy access to comprehensive sex disaggregated data at national or sub national levels. It transpired that data is usually collected by sex but that financial constraints limit the analysis and publication of all this data. Hence there is an absence of adequate published sex disaggregated data at sub national level as well as gaps in poverty data as the household is the unit of analysis.”

Census 2011 is making attempts to incorporate variables that will enable tabulations by sex for gender based planning. It is worthwhile to follow this up and to be engaged in capacity development on this front. One observation made regarding access to census data was the cumbersome process that data users have to go through to obtain data. There was specific reference to accessibility of census data and the process may be difficult due to the existing laws - Statistics Ordinance which does not allow divulging individual information. Therefore, restrictions may apply when releasing census data. However, there should be a way to provide
data for academic and research institutions when requested. New data collection is expensive and optimum use should be made with available data.

The DCS could partner with academic institutions or any other data requesting institutions when preparing reports using census data if restrictions apply when releasing census data.

Based on document review and the interviews with DCS staff, UNFPA has provided valuable and timely input to census preparation and UNFPA has a work plan to follow up and assist with data analyses and further training. UNFPA has prepared 24 months AWP ahead of time to ensure timely and continuous support for the pre-enumeration, enumeration and post-enumeration phases of the census.

**Support to the National Planning Department**

Coordination with Department of National Planning: The Department of National Planning within the Ministry of Finance and Planning is responsible for guiding the preparation of national development plans and advising the Department of National Budget and External Resources on resource allocation. UNFPA supported NPD to incorporate population and gender concerns in national sectoral and sub-national level planning and to build capacity for monitoring the National MDG plus Goals.

Given the greater focus on population issues in national development planning, trends and patterns of population by age, sex, and place of residence determine the demand for and supply of goods and services. This has called for attention for the planners to base population issues in planning and resource allocation decisions. However, limited capacity is available for systematic incorporation of the implications of population dynamics in planning at national, sectoral and sub-national levels. Absence of a separate unit or cell within the Ministry of Planning resulted in marginalization of population issues and their integration in national and sectoral planning, and resource allocation decisions.

The current country programme revived UNFPA’s support to population and development and established a partnership with the Department of National Planning of the Ministry of Finance and Planning which is the apex body responsible for national development planning.

UNFPA supported the Department of National Planning (as per 2009 AWP) with a short-term consultant to review and edit national and sectoral policy and planning documents prepared by the department on population and development issues. With the aim of addressing gender issues in the development planning process, Department of National Planning has identified the need to strengthen its (the department’s) capacity for systematic incorporation of the implications of population dynamics in planning at national, sectoral and sub-national levels and in resource allocation decisions. Two Project Officers, funded by UNFPA were placed within Department of National Planning to assist the Social Protection Division of Department of National Planning to incorporate gender concerns in the national development planning process and budgeting.

It was also noted that several resource persons funded by UNFPA, enhanced the quality of the work of the unit. Although the number of workshops was reported and engagement of the three officers was on record, there was no progress report of outputs filed in UNFPA reporting system. According to a key informant, these are stemming from a long term HR issue, about which, the team had no detailed information due to confidentiality and privacy. As such, some of the shortcomings in the P&D component may have been due to the gap that existed in the CO without a person in-charge of the P&D section.
Several provincial level workshops on population planning were scheduled by Department of National Planning, but only one provincial workshop had taken place (in Anuradhapura). According to one of the resource persons who contributed to the training, this had been a very effective programme which should have been conducted in other provinces as well.

Discussions with the Department of National Planning staff and a project officer who was formally funded by UNFPA, revealed that the input of the short-term consultant was effective and contributed to the production of “Mahinda Chintahnaya Way Forward” Chapter 8 which incorporated the population emerging issues (as the chart in appendix 6 shows) in development planning.

Support to the Ministry of Social Services

UNFPA also extended its support to the Ministry of Social Services and Social Welfare to address policy and advocacy issues on ageing. However, UNFPA’s support to the ministry has been on a small scale under this CP, with some input in the capacity building via training of key ministry staff. Although this ministry is not an IP, given the demographic changes in the country, it might be useful to engage them in policy dialogue for enhancing the quality of life, especially for the elderly.

Recently, the ministry had prepared a Family Policy for Sri Lanka and is currently being reviewed by relevant ministries for their comments. Upon receiving the comments and suggestions, a national forum will be convened to discuss the policy prior to submitting it for cabinet approval.

Other areas

According to the CPAP, support for establishment of a national database on population and gender was planned, but this is not yet accomplished. This will be done in the remaining period of the CP7.

Another area that needs attention is vital statistics.

The Registrar General’s Department, which was formed in 1864, is entrusted with collection and compilation of vital statistics (births, marriages and deaths). Sri Lanka has one of the best civil registration systems in South Asia and its coverage is quite good. Civil registration activities were decentralized to the divisional secretariat level in the early 1990s. Data related to the cause of death is an important area for improvement in view of the rapid epidemiological transition and projected increase in the number of deaths accompanying the ageing population. Several key informants mentioned the need to build up the technical competence of the registrars to improve the quality of data, especially the data related to cause of death. This would be an area where UNFPA can have an input which will make an impact in the services, especially for the elderly. There is a gap in the knowledge, awareness and understanding of the use and application of data by the data collectors and data analysts. This in turn affects the data users as the quality may be sub-optimal. There is a need to fill this gap to improve the quality of data for policy planning and decision making.

Efficiency

The major challenges in the implementation of the CP were: Delays in the disbursements of funds from the Treasury to the government implementing partners under the national execution modality. This resulted in the delayed implementation of activities by some of the implementing partners especially the partners at the sub-national level.
There were delays in recruitment of UNFPA programme staff resulting from delayed clearance and signing of the CPAP in late 2008 and further delay resulting in having to manage recruitment of several programme posts simultaneously with limited HR capacity. Key programme staff could only join mid 2009 which negatively affected the CO ability to ensure implementation of the programme.

Delays in the AWP government clearance process also affected the timely implementation of the programme. The timeline and procedures for preparation and approval of AWPs may have to be reconsidered if the country programme is to be managed and implemented efficiently.

While some of the specifically targeted training provided to the Department of Census & Statistics was quite useful in carrying out the census preparation and analytical work, not all inputs on capacity development seem to have produced the expected returns. Not all trainees were given an opportunity to share their experience in the workplace, nor were they placed in positions where they could apply the skills gained. There is a dissatisfaction among some who returned after a useful (according to their self-reporting) training programme.

The cost of training was not calculated, but whether capacity building equals “training” and if that is the most efficient way of capacity building is questionable – unless there is a mechanism to follow up closely the sharing and application of the knowledge and skills gained.

Given the lack of disaggregated financial data by main outputs, it was not possible to properly evaluate efficiency in accordance with DAC criteria. Data collection, analysis and surveys are important for policy and planning and require more resources. UNFPA should work more on advocacy for increasing national commitment for resource sharing.

Absence of a separate unit or cell within the Ministry of Finance and Planning resulted in marginalization of population issues and their integration in national and sectoral planning, and resource allocation decisions.

Sustainability

Sustainability is questionable with regard to inputs in capacity development, unless there is a system of training of trainers, or a (dissemination/transfer of knowledge) cascading mechanism developed within the organizations. With institutionalized mechanisms to ensure that capacity gaps are filled, the efforts to increased capabilities can be made sustainable. Opportunities to apply what is learned should be available to further enhance the knowledge and skills gained. Although capacity development has been the major intervention within P&D, poor or lack of conceptualization of exit strategies, the sustainability of expected outcomes cannot be ensured.

Placing a counterpart in IPs for population and development may not be a sustainable solution unless an exit strategy is drawn up with senior officials who are in-charge from the beginning of the placement and to provide an allocation for a year or two with a clear TOR and with clear commitment that this position will be absorbed into the regular cadre. However, as an initial input this might be necessary as the P&D component needs attention to make the maximum during this “demographic window.” Sri Lanka needs more attention in population planning and such expertise seems lacking in most of the government departments.

Impact

The country office made notable efforts to engender the 2011 census through provision of technical assistance and short-term training for DCS experts. The support attempted inter-alia to address under-
estimation of women’s participation in economic activity and their contributions to the national economy. It is envisaged that gender statistics, in this and other areas could be improved with the successful engendering of population census data, the most important source of national and sub-national level data. This is likely to have a positive impact on gender responsive budgeting and planning. The detailed data on regional and the lowest level administrative divisions would also be available for sub-national planning which could have a greater impact on social policies and service delivery. However, the actual impact has to be seen a few years later.

Increased institutional capacity of Demographic Department, built through the previous UNFPA CPs (not part of current CP, but was done several years ago), has an important impact on improved policy designing on population and development and an increased number of nationally representative quality surveys and analysis. Most of the leading offers in DSC are graduates from this department.

Similarly, UNFPA supported the establishment of the Population Association of Sri Lanka (PASL) a few years back (not during this CP cycle), and now it is functioning well, giving a forum for academics and non-academics to present papers and discuss research on P&D. The membership has grown and the Association is now able to sustain the organization without external funds. While both these activities are not supported in the current CP with the exception of ad hoc support for advocacy events such as World Population Day, these are examples of impact created by UNFPA’s support in previous years. The popular publication “Ageing Population in Sri Lanka - Issues and Future Prospects” is a joint production by UNFPA and PASL in 2004. This publication is widely used and it has been translated to Sinhala and Tamil (Tamil translation is an activity during this programme cycle).

### 2.5.5 Facilitating factors (Population and Development)

According to the feedback from the past trainees/participants, training input was of high quality as UNFPA was able to engage qualified resource persons as well as good institutions where overseas training was concerned.

Commitment of the implementing partners, based on observation during interviews was found to be commendable. Similarly, in the Country Office, professional contributions of the programme staff and the strong partnerships with implementing agencies that they capitalize upon were distinct assets to the country programme.

Support in terms of technical expertise from the Regional Office, and other TA missions had been a tremendous input to P&D component.

At the national level, the national execution modality, as explained earlier, has contributed to achieving the intended results, and having national ownership which increases sustainability as the administrative procedures are adopted to suit both UNFPA and the government structure.

### 2.5.6 Hindering factors (Population and Development)

Human resource issue: For a period of time there was no technical staff to deal with P&D within implementing partners (NPD and MOH). Although the population division was established within the Ministry of Plan Implementation to integrate population variables in development planning, it was later moved to the

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18 Formerly Demographic Research and Training Institute (DTRU)
Ministry of Health, and now moved to FHB to facilitate the implementation of the national reproductive health programme including family planning. As such, the absence of a separate unit or cell within the Ministry of Planning resulted in marginalization of population issues and their integration in national and sectoral planning, and resource allocation decisions.

Lack of technical expertise to spearhead the P&D programme in the Country Office (there was a gap for a few months and this hampered the progress of P&D activities). Currently this gap is filled.

As explained elsewhere in the report there are some limitations with regard to indicators. Accessibility of baseline data for monitoring purposes was limited.

According to the country office key informant feedback, conducting evaluability assessments are not an M&E guideline requirement. However, had there been evaluability assessments and ex-ante evaluations at the planning/proposal stage of the interventions; it would have made the task of monitoring of progress much easier.

2.5.8 Conclusions (Population and Development)

Notable contributions are made to improve the 2011 Census. If implemented and followed up well, this input could contribute to achieving the output under the PD component – “increased availability and utilization of population data disaggregated by age and sex.”

Capacity development has been a major input in P&D, and seen as a positive contribution by the IPs. However, the follow up of these capacity development activities have been minimal and in the absence of a capacity needs assessment, it is difficult see the outcomes as a result of capacity development efforts. Review of some CD activities revealed that mechanisms are/were not in place for assessing the outcome of the interventions.

Review of major planning documents did not reflect the use of gender analysis as expected in the P&D component, but the need for such analyses was accepted by most IPs and lack of human resource issue was explained as the reason. Tabulations did not use sex disaggregated data in many instances although raw data on males and females are available. Discussions with relevant staff (analysts) show that gender based analyses could be done with a few hands-on training. Those who prepare reports may have been following the same templates that were used in previous years and without any directive from the supervisors the analysts will not be taking the initiative to producing different tables. As discussed above, under effectiveness, it is also observed that allocation of resources to be a limiting factor stated in the Gender Dimensions of the Millennium Development Goals in Sri Lanka 2007 “It transpired that data is usually collected by sex but that financial constraints limit the analysis and publication of all this data. Hence there is an absence of adequate published sex disaggregated data at sub national level as well as gaps in poverty data as the household is the unit of analysis.”

Feasible and still valid recommendations are available in the past review documents for follow up and implementation (examples, CPA, APRO mission report, Messay mission report, etc). Only some are followed up and there is room for including these in the remaining period of the programme cycle or include them in the CP8.

There is a tremendous potential in the P&D sector to implement activities with low cost and high visibility by engaging institutions such as the Demography Department at Colombo University, IHP, IPS and other relevant agencies to support policy and advocacy initiatives on P&D. While UNFPA has not had much interaction with
these institutions in the recent past, the discussions with a few of the key persons from these institutions revealed their wish to collaborate with UNFPA in the area population studies.

With the gap that the P&D component experienced as explained above, there is a task ahead to catch up with the country’s P&D situation and needs if UNFPA is to re-engage in high visibility interventions. This might be difficult without some outside assistance, by way of a short-term consultancy – preferably a local consultant who is familiar with the recent developments in P&D, existing policies, established working committees, ongoing surveys and purposes and current academic studies related to population. While this will be a short-term support to the P&D component, getting the CPA report out during CP7 would be an urgent task that will provide a sound basis for CP8 preparation.

Overall, the focus and emphasis on advocacy and lobbying for population policy could and should be made stronger than the current engagement given UNFPA’s mandate in population and development.

2.5.9 Recommendations (Population and Development)

Recommendation 1 and 2 are to be considered within the current programme cycle (CP7). Both recommendations are related to preparation of an effective Country Population Assessment, although they are undertwo recommendations.

Recommendation 1 (within CP7)

Country Population Assessment (CPA) to be planned as a priority activity in the 2011 AWP. This is a key publication by UNFPA and high quality reports have been produced before. UNFPA should identify technically qualified contributors/authors to undertake the responsibility of the chapters. Some of the recommendations in the previous CPA are still valid and should be revisited and followed up. According to a recent mission report, the TOR for CPA is already being prepared and this should be followed up closely. A new CPA will provide the situational analysis for a sound strategic planning, stakeholder mapping and prioritizing of activities. CPE7 and several review reports and mission reports could be an input to CPA preparation. Census preliminary data should be available for preparation of the CPA.

Suggested interventions to facilitate the above recommendation would be: to continue dialogue with institutions such as the Demography Department, University of Colombo, Institute for Health Policy for feasible ideas for collaboration. To facilitate preparation of CPA, UNFPA could advocate for facilitating a coordination mechanism for population, gender, and RH programmes. This could play a key role in sustaining integration of population, gender and RH factors into development of policy and planning.

Recommendation 2 (within CP7)

The current country programme would benefit from a short-term local consultant (in the absence of a CPA) with expertise in demography and population studies to provide a detailed overview of the P&D status, data availability, data needs and gaps, existing research, policies and programmes and partners who are currently contributing in population and development. Identifying joint programmes would have tremendous benefits. The outcome of the consultancy would be helpful when planning for CP8 and for the rest of CP7 as well.

The recommendations (3-5) given below are for consideration by UNFPA in collaboration with the relevant stakeholders, at the time of development of the next CPAP.
Recommendation 3*

Capacity of DCS and NPD should be further developed to undertake the policy-oriented analyses needed for addressing important current and evolving issues, including demographic transition concerns such as ageing and the feminisation of ageing, youth issues and needs of women and families resulting from internal and international migration.

It might be useful for UNFPA to do an organizational capacity needs assessment (jointly with the IP – .ie. DCS and NPD) to identify the capacity gaps so that UNFPA could support fill these gaps.

Recommendation 4*

UNFPA could support a manual on how to incorporate population, gender, RH and poverty aspects into development planning and policies. Currently, there are no training materials on this and UNFPA jointly with NPD could plan for it.

Recommendation 5*

With regard to presentation of evidence, the lack of sex-disaggregated data is still a challenge. It is evident that despite the data being available, tabulations are seldom presented for males and females separately making it difficult to do gender analyses. This holds even for the important current national documents. UNFPA should focus its capacity building efforts to improve the use of sex and age disaggregated data in the planning process. Especially since quality of data and gender issues are at the heart of UNFPA mandate, this would be an area that needs strengthening. Attention to data quality has to be emphasized with training at different levels focusing on coordination between data collectors, analysts, and data users to ensure quality checks.
3.0 OVERALL EVALUATION LESSONS LEARNED, CONCLUSIONS AND RECOMMENDATIONS

3.1 Lessons learned (All three sections combined)

Obtaining consensus from stakeholders and carrying out periodic reviews is necessary and is being done. There may be a need to review the work plans as implementation may not be possible due to reasons beyond the control of the implementers. For example, non availability of required human resources or due to changing needs of the RH programme.

UNFPA has designed an integrated model to address the GBV issues at the local level through the women centres. It is an effective mechanism to involve the communities, NGOs, and government agencies in the prevention and intervention of GBV. The model cuts across all population groups and has promoted awareness on the issue. It has organized these groups into committees and consortiums around the issues of GBV. The networks are strong and independent. The model has catered to specific needs of women, men and youth. The involvement of a cross section of the society along with service providers and decision makers is a strong way to combat the issues of GBV.

GBV is an issue that is complex and need multi faceted interventions and resources. It is also an issue where many actors do not want to get involved due to the complexity and high expenditure. Another reason is the notion that GBV is an issue which happens mostly in the private sphere and no one should interfere with it. However UNFPA has taken a conscious decision to work on GBV and has boldly facilitated mechanisms to redress it.

Forum against GBV has emerged as a platform for advocacy on GBV and has taken a multi sectoral approach to its work. It has become a space where knowledge and skills are shared and collective visioning is facilitated to combat GBV. It is a successful network of different actors with expertise, resources and commitment to work on the issue of GBV. Such a collective effort has a lot of potentiality to advocate for changes in policies.

Partnership with the national machinery requires time, patience and energy. It also needs collective strategizing and capacity development. Such partnership will enable change in perspective, approach and demand commitment to the realization of women’s rights by all parties involved.

Issues of sustainability and impact have to be taken into consideration at the design stage of the projects and programme. Depending on the nature of the interventions the results may take longer time than the programme cycle period to show an impact and to assess its sustainability. Proxy indicators can be developed to assess the likelihood of the impact and the sustainability.

It is advisable for UNFPA to be engaged in upstream advocacy policy area or identify interventions which can make difference in the long-run. For example, then Demographic Training and Research Unit (DTRU), now the Department of Demography in the Faculty of Arts, University of Colombo, was originally established under the sponsorship of UNFPA in 1973 and became a fully fledged department in 1997. The Department with a highly qualified team of academics and professionals undertake research and consultancy services to public, private & NGO sector organizations. Currently five with PhDs, three with Masters Degrees serve as faculty with over 1000 students taking demography as a subject. A special degree in Demography will be offered starting this year which will produce a resource base in the area of population and development.
Preparation of work plans covering two years (instead of annual plans - AWPs) should be promoted as it gives continuity and commitment to the program and could offer more effective and efficient outputs of the planned interventions. A two year work plan is already in place for P&D. Exploring the feasibility of linking the two year work plan to a two year financial plan or modifying the accounting system appropriately so that some leverage is given to the implementers to keep up with the delays that occur during transfer of funds is another aspect to be considered. However, at the same time, UNFPA needs to ensure the IPS that funding commitments cannot be guaranteed for two years – it can only be tentative plans depending on resource availability.

From a cross-county experience, it pays to provide programme management training to a team established under all implementing partners to ensure transparent and accountable implementation of the work plan.

Record keeping and data collecting: if documentation is maintained systematically (keeping progress reports, monitoring reports, activity implementation report and completion reports), the lack of continuity due to staff turnover could have been less problematic. There should be a system for any PO to follow up on interventions, especially since some are cross-cutting.

Apparently, there are surveys implemented at the provincial level (apart from the census) to collect detailed data on households. There is plenty of data in the country, but most of the time it is fragmented and not in a form that can be readily used for the planned purposes. Without a body and a management system to coordinate these efforts, the quality of data can be questionable. Currently, without a responsible unit or a system, it seems a difficult task to monitor and maintain a log of number of activities with regard to the number of data sources/data collecting efforts in the country. Given the number of initiatives related to P&D by different government and non-government institutions, without a coordinating mechanism it is a challenge to be aware of the current status.

UNFPA three focus areas (RH, Gender, P&D) are closely integrated and the strategies and interventions to achieve CP outcomes have to be understood by all stakeholders to avoid any possible overlap which may lead to duplication in human resource and fund allocation. It was beneficial for the evaluation team members to work closely during field visits, interviews and focus group discussions. This could be practiced in joint evaluations as well; however time factor could be an issue which may not allow all members to participate in each and every interview and meeting on all CP focus areas. Yet, this exposure was invaluable for the team when making conclusions and assessing effectiveness, efficacy etc.

Similarly, it would have been useful to the evaluation team as well as to the NPOs if the entire UNFPA programme team and other concerned staff attended when NPOs presented their programme components to the evaluation team prior to starting field visits and preparation of the interview guides. Especially since these programme components are integrated and interdependent in many aspects, this opportunity would have given a holistic view of the CP prior to the evaluation exercise. However, busy schedules and timing conflicts did not allow all NPOs and other relevant CO staff to be present at these briefings. Each NPO made their individual presentations to the team. Nevertheless, the rich briefings by the NPOs to the team were invaluable in understanding the overall programme logic as there was sufficient time for questions and clarifications.

Completing the Inception Report before meeting the team and the briefings by the NPOs has some limitations. However, there was room to revise it after meetings with them. It was useful to present a brief introduction on M&E to the evaluation team and the NPOs to bring everyone on board with the evaluation terminology, concepts, and methods.
The following section presents the overall conclusions and recommendations that are common to all three focus areas (RH, Gender and P&D).

Detailed recommendations are given under each individual section. Due to the number of interventions and strategies adopted, it was necessary to discuss conclusions and recommendations under each section separately. The following presents a set of conclusions and recommendations that are common to CPE7.

3.2 Overall conclusions

1. The program design is relevant and planning has been done well. However, there are too many activities that are beyond the capacity of the NPOs to follow up. This is even more challenging due to the weak structures and capacity in some of the relevant ministries. The Ministry of Health is exceptional with regard to this – its long history of establishment contributes positively, although HR issues remain as a challenge due to the growing demand for health services. As such, the selection of interventions has to be in line with the capacity of the IPs. Limit the activities to a few that can have a high impact. The use of academic institutions as an extended arm has not been fully explored.

   a. The effectiveness and the efficiency of the overall programme are negatively affected by the delays in (a) AWP approval and (b) delayed fund disbursements procedures as reflected by almost all implementing partners.

   b. AWP preparation and engagement of a wider audience, like the approach taken in RH is effective. The RH programme was widely discussed, participated by all levels of health ministry officials which provided an opportunity to review past progress and shortcomings, discuss and prioritize the work plans. This increases the ownership, clarity of the interventions and human resource issues, and the ability to make a commitment to implementing the agreed plan. There is transparency as well. Timing of AWP preparation, approval procedures have to be discussed and agreed upon to avoid delays in the implementation. The decision to prepare two year work plan is considered positive by almost all key informants.

2. The focus of UNFPA monitoring tool on financial expenditure tracking established within the UNFPA system may have led to measuring progress/results using fiscal expenditure and implementation rate interpreted in dollar terms, limiting the measure of actual programme performance against the expected/planned outcomes or outputs. If a system is developed in line with the requirement of COAR preparation, it could have been made more useful. The standard on-line monitoring system in place does not provide adequate information as the basis for an evaluation.

3. Capacity building should continue with technical support to quality assurance of training materials and pedagogy. A clear needs assessment by the IPs identifying capacity gaps would be useful. Clear indicators and targets should be set in advance to assess outcome of capacity building initiatives. Counterpart placement in IPs (NPD, MCDWA) to strengthen institutional capacity could be a short-term arrangement with clear exit strategies.

3.3 Overall recommendations

Recommendation 1*

AWP preparation, specifically for P&D and gender components as mentioned earlier, could take a more detailed consultative process with a clear commitment from the IPs with specific responsibilities. Although RH component followed a consultative process, feedback from a key informant responsible for planning
stated the concern over lack of presence of NGOs who are implementing partners in the process. Senior officials who are aware of the holistic view need to be present in order to make it clear to all parties on other funders/donors where the gaps are and the activities supported by them to avoid duplications in efforts and resources. UNFPA should request clear guidelines on AWP approvals and clearance procedures from the government counterparts to avoid any confusion or delays due to internal hierarchical considerations/issues. According to a CO key informant, this issue had been raised several times within UNCT, however situation has remained the same.

Recommendation 2*

With regard to funding delays, UNFPA needs to discuss this further with ERD to identify the bottle necks. According to the IPs, there had been a several month lag from the time the checks were issues by UNFPA until the funds were received from Treasury. Actual time line of the process for a few cases could be prepared to understand where the blocks are in the process of fund disbursements. Unless this is remedied the effectiveness and efficiency of the programme will continue to be affected negatively. While national execution modality is a good strategy, the delays experienced lowers the efficiency and therefore, UNFPA need to remedy the situation by negotiating with the relevant government ministry/department.

Recommendation 3*

A monitoring mechanism to be established which will also address the horizontal linkage issues. Currently, programme components have been implemented and operated as vertical projects with little synergy and this needs attention to make the CP more effective and efficient. There is a lot of rich interventions on the ground, but limited HR capacity and time constraints may have been a challenge to make effort to work in an integrated fashion in the field and when planning. At programme planning level a model could be developed to illustrate as to how each programme component is linked to achieve the overall objectives of the country programme.

a. Overall, CPAP is at a higher level and has a broader framework, and this may be a limitation that comes with the requirement specified in the guidelines of CPAP preparation. While CPAP provides the overall framework, CO should be able to expand on it further, as an internal working document allowing inclusion of detailed measurable indicators and realistic targets.

Careful attention needs to be given to the outcome indicators formulation when the program is initially designed to ensure that the indicators are specific, measurable, realistic, achievable, and tracked in a consistent systematic way. Where development of indicators involves a wide range of stakeholders, sufficient time should be allocated for necessary participatory processes.

Recommendation 4*

Strengthening the monitoring and evaluation capability of CSOs in population, gender and RH should be an explicit part of UNFPA’s strategic plan for capacity building of CSOs. UNFPA should ensure that CSOs have the ability to monitor and evaluate their interventions and report development results rather than reporting achievement of outputs and completion of activities. For capacity building activities, there is a need to develop a strategic approach and expand partnerships with training and research institutions to ensure effectiveness, efficiency, and sustainability of such programmes.
**Recommendation 5**

Data and research dissemination strategies, especially with regard to disaggregated data, need to be evaluated and improved in order to increase availability of and access to these critical resources which are important sources for national planning in all development sectors including RH, gender and P&D.

Specifically, availability and accessibility of data (census and DHS data) should be reviewed. Department of Census should be able to draw guidelines on easy access to data to those who could make a contribution to research and policy planning.

**Recommendation 6**

There should be a Coordination Committee, based on the apparent need to improve coordination and harmonization of the national programs on population, gender and RH issues at the sub-national level – specifically at provincial level. Facilitating a coordination mechanism would play a key role in sustaining integration of population, gender and RH factors into development policy and planning. This evaluation did not have sufficient information to ensure that such a committee is already in place or not.

The following section provides brief suggestions on evaluation utilization.

### 3.4 Evaluation utilization

To systematically ensure that the results of this evaluation are used to inform programming and strategic and policy decisions, UNFPA evaluation will prepare, implement, and monitor implementation of management responses.

At the time of the report preparation, the evaluation team did not have sufficient information to make an assessment of how much resources in terms of budget, staffing and time would be needed to follow up the recommendations. The recommendations marked with an asterisk are considered as priorities and the evaluation team suggests that the country office staff consider the rest of the recommendations based on the availability of resource capacity and feasibility. Three recommendations are included for consideration during the current programme cycle (CP7).

New programme documents or new strategic or policy decisions may be reviewed to assess the extent to which they used results and recommendations from UNFPA evaluations.

UNFPA CO has plans to develop a dissemination plan to inform relevant stakeholders. The Country Office could encourage the stakeholders to use the findings for ongoing programme refinement.

E-system (Department of Foreign Aid and Budget Monitoring (DFABM) will be used to share information/evaluation findings.
4.0 APPENDICES

Appendix 1: Terms of Reference

THE BACKGROUND

Sri Lanka is a lower middle-income country, with a per capita gross national income of USD 1,990\(^{19}\). It has a population of around 20\(^{20}\) million. Sri Lanka scores high on population indicators with a life expectancy at birth of 73 years, infant mortality rate of 15 per thousand live births and maternal mortality ratio of 39.3 per hundred thousand live births\(^{21}\). Sri Lanka has a population where women outnumber men. Sri Lanka has made great strides in bringing down its infant under five and maternal mortality rates.

More than two decades of conflict between the Government of Sri Lanka and the Liberation Tigers of Tamil Eelam (LTTE) separatist movement and resulting population displacement have caused a complex emergency in Sri Lanka. In the months leading up to the May 2009, government of Sri Lanka declaration of victory over the LTTE, insecurity displaced more than 280,000 people, according to the United Nations Office for the Coordination of Humanitarian Affairs.

The 7\(^{th}\) UNFPA country programme (2008-2012) is based on the findings of the 2006 common country assessment and responds to the Millennium Development Goals (MDGs), the Programme of Action of the International Conference on Population and Development (ICPD), and the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW). The programme has been developed within the framework of the United Nations Development Assistance Framework (UNDAF). It is in conformity with the national population and reproductive health policy (1998), the national women’s charter (1993) and the national development framework (2006-2016). The Country Programme Action Plan (CPAP) of the 7\(^{th}\) UNFPA country programme was signed with the government of Sri Lanka at the end of 2008.

The UNFPA programme recognizes the need to enhance the quality and scope of reproductive health services within the overall goal of poverty reduction. It seeks to address regional disparities and will focus interventions on underserved areas of the country. The programme provides support to strengthen reproductive health care in conflict-affected districts within the context of promoting equity and contributing to an environment for sustainable peace. It will also increase support to advance the rights of women, with a focus on combating gender-based violence, strengthening oversight mechanisms to protect the rights of women and girls, and facilitating the participation of women in peace-building efforts.

In addition to national level interventions, UNFPA provides focused interventions in selected districts especially for strengthened service delivery. The country programme is implemented in five districts:

- Anuradhapura – North Central Province
- Batticaloa – Eastern Province
- Kalmunai health division of the Ampara District – Eastern Province
- Nuwara Eliya – Central Province
- Vavuniya – Northern Province

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\(^{20}\) Source: Registrar General’s Department

\(^{21}\) Source: Department of Census and Statistics
The programme is guided by the overarching principles of the new strategic direction that includes human rights, gender mainstreaming, culturally sensitive approaches, focus on marginalised and excluded people, populations affected by humanitarian and emergency situations and young people. The programme contributes to outcomes in three focus areas: reproductive health, population and development and gender. The programme is results oriented and emphasizes national capacity building especially in the delivery of high quality, equitable, inclusive and sustainable services.

The 7th country programme (2008-2012) was approved by the UNFPA Executive Board with the total budget of USD 18 million for the five year cycle. This includes USD 9 million from regular resources and USD 9 million through co-financing modalities and/or other, including regular, resources. However, the actual resource allocations have changed over time based on the resource availability and programmatic needs. The UNFPA resource allocation system has classified Sri Lanka as a group C country. Group C countries have made significant progress by meeting all eight of the thresholds for ICPD goal indicators and receive approximately 6-7 percent of programme resources.

<table>
<thead>
<tr>
<th>Area</th>
<th>Regular resources*</th>
<th>Other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reproductive health</td>
<td>5.75</td>
<td>4.25</td>
<td>10.00</td>
</tr>
<tr>
<td>Gender</td>
<td>2.00</td>
<td>4.75</td>
<td>6.75</td>
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<tr>
<td>Population and development</td>
<td>0.50</td>
<td>-</td>
<td>0.50</td>
</tr>
<tr>
<td>Programme coordination and assistance</td>
<td>0.75</td>
<td>-</td>
<td>0.75</td>
</tr>
<tr>
<td>Total</td>
<td>9.00</td>
<td>9.00</td>
<td>18.00</td>
</tr>
</tbody>
</table>

*Numbers given in millions of USD

1.1 Reproductive health component

The intended outcome of the reproductive health component is improved and equitable access to utilization of high-quality reproductive health information and services for women, men and young people, particularly those living in conflict-affected areas and on plantations.

Output one seeks to enhance capacity of the national health system to improve the quality and demand for comprehensive reproductive health services. Interventions such as strengthening quality assurance systems for comprehensive reproductive health services, building the capacity of the health sector to respond to gender-based violence, developing the skills of health workers to promote effective behavioural change, assisting in mainstreaming reproductive health care and gender dimensions in disaster preparedness and emergency responses and enhancing the capacity of the health sector to plan, monitor and evaluate the reproductive health programme are being implemented in partnership with Ministry of Health.

Output two focuses on increase availability and access to high-quality reproductive health services in conflict-affected and underserved districts. The programme uses a two-pronged strategy: (a) cater to the humanitarian needs of the affected communities, and (b) build capacity of the district health system on an incremental basis to provide reproductive health services.

Under the first prong of the strategy, UNFPA supports (a) a buffer stock of reproductive health commodities; (b) mobile health services in remote areas; and (c) the deployment of skilled voluntary health workers. Under the second prong of the strategy, UNFPA supports (a) strengthening local institutional mechanisms to deliver a basic package of reproductive health services; (b) adapting and translating standards and protocols and facilitating their utilization through in-service skills development; and (c) enhancing good health behaviour. Since the demographic profile of the North and East includes a high percentage of widows, young female combatants and households headed by women, the programme provides services that cater to their specific needs. The programme also provides services for internally displaced persons and plantation communities.
Output three focuses on increase efforts to prevent sexually transmitted infections and HIV/AIDS among women and young people. This output contributes to the national HIV/AIDS strategic plan in areas where UNFPA has a comparative advantage. The strategies towards this output are: (a) develop and implement the national behaviour change communication strategy; (b) promote condom programming; and (c) expand prevention services for specific population groups, including vulnerable women, members of uniformed services and out-of-school youth.

Output four of the reproductive health outcome addresses increased coverage and utilization of youth-friendly reproductive health services. UNFPA supports (a) innovative ways of reaching young people with gender-sensitive information and counselling services; (b) an enabling policy and programme environment; (c) the mainstreaming of youth-friendly services in the health sector; (d) the participation of young people in designing, implementing and monitoring policies and programmes; and (e) strengthening the capacity of the Ministry of Health to plan, manage and coordinate youth-friendly health services.

1.2 Gender component

The intended outcome of the gender component is to strengthen institutional mechanisms and empower communities to protect the rights of women. Under this outcome, output one focuses on strengthening capacities of the government, non-governmental organizations (NGOs) and community based organizations (CBOs) to prevent and respond to gender-based violence. Further UNFPA support provides for faith-based organizations through NGOs to strengthen their advocacy with religious leaders. UNFPA has implemented several strategies and activities such as (a) enhancing the capacities of NGOs to manage and scale up women’s centres; (b) improving referral mechanisms to improve access to support services; (c) strengthening community action to prevent gender-based violence; (d) enhancing partnerships with men and boys; and (e) facilitating multispectral mechanisms, including the Gender-Based Violence Forum, to provide an effective response to gender-based violence. UNFPA will continue to play a leading role among development partners in this area.

Output two focuses on strengthening national capacity and institutional mechanisms for increased government accountability to fulfill and protect the rights of women and girls. The programme supports (a) building the capacity of the Ministry of Child Development and Women’s Affairs to advance gender goals through evidence-based interventions; (b) relevant institutions and mechanisms in overseeing, monitoring and protecting the rights of women and girls; (c) empowering individuals and communities to safeguard the rights of women and girls; and (d) facilitating the participation of women in the peace-building process.

1.3 Population and development component

The expected outcome of the population and development component is to enhance utilization of population data and strengthened capacity to track progress in implementing national poverty reduction strategies and in achieving the Millennium Development Goals, using a gender and social equity perspective.

The output of the population and development component focuses on increasing availability and utilization of population data disaggregated by sex and age. Population and development interventions are focused on supporting (a) the 2011 census; (b) a national survey on gender-based violence; (c) capacity-building aimed at increasing knowledge and enhancing skills to improve the utilization of population data and trends for development planning processes; (d) institutional capacity-building for gender analysis, planning and budgeting; and (e) strengthened institutional capacities to monitor progress towards poverty reduction goals and the Millennium Development Goals, using a gender and social equity perspective.
2.0 PURPOSE OF THE EVALUATION

The purpose of this evaluation is to conduct an end of programme cycle evaluation to assess the achievement of the 7th country programme, the factors that facilitate or hinder achievement, and to compile lessons learned in respect of each of the programme stages to inform development of the next country programme cycle (8th country programme).

Main objectives of the evaluation are to:

- Assess the extent to which the seventh country programme has achieved its outputs and contributed to its intended outcomes and impacts in light of the Objectively Verifiable Indicators (OVI) stated in the approved country programme.

- Assess the extent to which the seventh country programme contributed to enhanced government commitment to the ICPD programme of action, Millennium Development Goals (MDGs) and other national priorities.

- Provide lessons learned and recommendations that can be applied to the next country programme strategies.

The stakeholders in the evaluation include UNFPA, national counterparts/government, implementing partners and beneficiaries.

3.0 SCOPE OF THE EVALUATION

3.1 Time period

The CPE covers the period 2008 to present of the 7th UNFPA country programme cycle.

3.2 Geographical regions

The CPE will cover central level and districts of Anuradhapura, Batticaloa, Nuwara Eliya, Vavuniya and Kalmunai health division of the Amapara district.

3.3 Evaluation criteria and questions

Evaluation criteria and questions of CPE applicable to the three programmatic areas (Reproductive health, Gender, Population and Development) are as follows:

Relevance
- Is the programme consistent with the needs and priorities of its target group?
- Is the programme design in line with national needs and priorities?
- Is the programme in line with ICPD programme actions and MDGs?
- Is the overall CPAP design intuitive and logical? Does it efficiently enable desired project outputs? Do the stated needs of the beneficiaries appear to have been accurately assessed?
- How well does the CPAP integrate with objectives envisaged in UNDAF?
- Is the programme design appropriate for a UNFPA category ‘C’ country?

Effectiveness
• Have the inputs and activities led to the outputs and outcomes (or is there reason to believe the activities will do so during the remainder of the programme)?
• Have the planned geographical areas and target groups been successfully reached?
• How the district level approaches are tailored to the specific needs of the districts and what extent this district level approach is effective?
• What are the constraining and facilitating factors and the influence of context on the achievement of results?

Efficiency

• What is the quality of outputs and outcomes achieved in relation to the expenditure incurred and resources used?
• To what extent has implementing partners utilized the UNFPA funds and to what extent has the overall process including cash flow systems worked well?
• Are the resources spent as economically as possible; could a different intervention have addressed the same needs at a lower cost? Could more results have been produced with the same resources?
• To what extent has the country programme utilized the capacity and expertise of the UNFPA staff/human resources?
• Is the staffing setup of the UNFPA country office appropriate for effective and efficient implementation of the country programme?
• Whether the partners selected to implement the CPAP interventions were the 'right' ones

Impact

• Have long-term results been achieved or are likely to be met?
• To what extent does UNFPA intervention contribute to capacity development and the strengthening of institutions in Sri Lanka?
• What has happened or is likely to happen as a consequence of UNFPA efforts?

Sustainability

• Will the programme have lasting results after the programme termination? If so, what evidence supports this conclusion?
• Are involved counterparts willing and able to continue programme activities on their own after UNFPA’s involvement ends?
• Have programme activities been integrated into current practices of counterpart institutions and/or target population?
• How effective are the partnerships that UNFPA has established?
• Did programme design include strategies to ensure sustainability?

In addition to the above mentioned evaluation criteria, the evaluation will assess the extent to which the overall UNFPA’s programme has integrated gender and rights-based approaches.

The UNFPA humanitarian response project is reviewed in December of 2010 and the review findings and recommendations will be available to the evaluation team for their consideration. The purpose of this
humanitarian review is to enable donors, UNFPA and implementing partner, the Family Planning Association Sri Lanka (FPASL), to take decisions on the future orientation of the programme, to introduce, if required, corrective measures to improve the implementation of the project, to verify the need, if any, of extension of the project, and to learn lessons from experience for future planning new programmes/projects.

3.3 Evaluation ethics

The CPE is to be conducted legally, ethically, and with due regard for the welfare of those involved in evaluation, especially women, children, and members of other vulnerable and disadvantaged groups, and in accordance with the United Nations Evaluation Group ethical guidelines for evaluation, at www.unevaluation.org/ethicalguidelines.

4.0 METHODOLOGY

The evaluators will be expected to propose the methods, approaches, and evaluation design that are appropriate for the CPE in the inception report.

4.1 Data collection

In terms of data collection, the evaluation will use multiple methods that may include document review (please see annex 2 for list of proposed documents), focus group discussions and key informant interviews, in-depth interviews, field visits and questionnaires, as appropriate and as feasible. Methods may vary by project and will reflect the precise nature of the aspects under examination and the personal expertise. Apart from a preference for triangulation, the evaluators could consider existing data, published research etc. Further, it is required that the evaluators explain their proposed methods and approaches especially those related to sampling, data collection, and data analysis in both the inception report and final report. The evaluators should explain in their final report (a) how its methods suitably addressed the evaluation’s objectives and (b) the weaknesses or limitations of the methods and sampling.

4.2 Stakeholder involvement

An inclusive approach, involving a broad range of stakeholders, should be taken. The evaluation will have a process of stakeholder mapping that would identify both UNFPA’s direct partners as well as stakeholders who do not work directly with UNFPA, but play a key role in a relevant outcome or thematic area in a national context. Relevant stakeholders should be involved at the different stage of the CPE including design, data collection, data analysis, reporting especially at the recommendation formulation process, debriefing, and dissemination as appropriate. The final evaluation report should describe the efforts made to include stakeholders in these processes and the positive consequences of these efforts.

5.0 THE EVALUATION TEAM

The evaluation will be conducted by an independent evaluation team comprising a technical expert for each thematic programme area – reproductive health, gender, and population and development – and one team leader with broad evaluation expertise.

5.1 Competencies for the Team Leader

1. Development sector background
2. Excellent analytical, writing and communication skills
3. Leadership and good management skills
4. Ability to work with a multi-disciplinary team of experts
5. Excellent problem identification and solving skills
6. Language skills: written and spoken proficiency in English

5.2 Qualifications and experience of Team Leader

1. Minimum of Masters Degree in social sciences, development studies or a related field
2. Minimum of 10 year experience in conducting/managing program evaluations
3. Experience in mainstreaming and management of cross cutting themes
4. Familiarity with the UNFPA work will be an added advantage

5.3 Roles and responsibilities of the Team Leader

1. Provide the inputs for quality aspects of the overall process
2. Compile the inception report with the inputs from national consultants
3. Compile draft and final reports and deliver them on time, considering the quality aspects. The team leader will have primary responsibility for the timely completion of a high-quality evaluation that addresses all the items required in this TOR.
4. Provide leadership to the evaluation team
5. Responsible for debriefing the findings when required
6. Liaise with Evaluation Manager

5.4 Competencies for the thematic consultants

1. Excellent analytical, writing and communication skills
2. Ability to work with a multi-disciplinary team of experts
3. Excellent problem identification and solving skills
4. Language skills: written and spoken proficiency in English and Sinhala/Tamil
5. Should be able to deliver the requirements on time

5.5 Qualifications and experience of thematic consultants

1. Should be an expert on either reproductive health/gender/population and development field
2. Minimum of five years experience in conducting evaluation
3. Experience in conducting evaluations in reproductive health/gender/population and development sectors

5.6 Roles and responsibilities of the thematic consultants

1. Prepare the inception report with the UNFPA standards
2. Evaluate the each thematic section of the country programme
3. Involve in debriefing
4. Deliver quality reports on time

6.0 EVALUATION MANAGEMENT
A management structure will be established and it includes:

- An Evaluation Management Committee (EMC)
- Evaluation Manager

The EMC membership includes Director of External Resources Department of Ministry of Finance and Planning, Director of Department of Foreign Aid and Budget Monitoring (DFABM), representations from Ministry of Health (MOH) and Ministry of Child Development and Women Affairs (MCDWA), the Monitoring and Evaluation Advisor of UNDP, the UNFPA Representative, a UNFPA National Programme Officer and the UNFPA National Programme Officer for Monitoring and Evaluation. Under the overall guidance of the UNFPA Representative, the UNFPA National Programme Officer Monitoring and Evaluation will act as the Evaluation Manager.

Quality assurance of the evaluation process and products is the responsibility of the EMC. The other main oversight activities of the EMC would be: approve TOR, select and debrief evaluation team, organize technical support, approve inception report and final evaluation budget, monitor progress of evaluation activities, review and comment on drafts, approve evaluation reports, disseminate and follow-up to evaluation finding and assess performance and approve payments to evaluators.

Under the overall guidance of the UNFPA Representative, the National Programme Officer Monitoring and Evaluation will act as the Evaluation Manager. He will support the team to convene, coordinate and support the EMC meetings, lead development of the TOR and the management response, manage the evaluation budget and ensure logistical and administrative support, coordinate with UNFPA relevant units which include Asia Pacific Regional Office, facilitate access to background documents, upload evaluation TOR and final report into UNFPA docshare (UNFPA Intranet).

The EMC and the Evaluation Manager will provide oversight to an evaluation. Supported by the Evaluation Manager, the EMC will regularly meet as needed to undertake the main oversight activities such as select and debrief the evaluation team, organize technical support, approve inception report and final evaluation budget, monitor progress and quality of evaluation activities, review and comment on drafts, approve evaluation reports, disseminate and follow-up to evaluation finding.

The UNFPA Sri Lanka country office with the support of implementing partners will provide the logistical support for the overall evaluation process.

7.0 PROPOSED WORK PLAN
<table>
<thead>
<tr>
<th>Activity</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recruit evaluation team</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Desk review</td>
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<td></td>
<td>5D</td>
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<td></td>
</tr>
<tr>
<td>Submission of the inception report</td>
<td></td>
<td></td>
<td>4D</td>
<td></td>
<td></td>
<td>21D</td>
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<tr>
<td>Data collection/field visits</td>
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<td></td>
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<tr>
<td>Submission of first draft</td>
<td></td>
<td></td>
<td></td>
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<td>7D</td>
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<td></td>
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<tr>
<td>Debriefing</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>4D</td>
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<tr>
<td>Solicit comments from key stakeholders</td>
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<tr>
<td>Submission of second draft</td>
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<td></td>
<td></td>
<td></td>
<td>3D</td>
<td></td>
<td></td>
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<tr>
<td>Submission of final report</td>
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<td></td>
<td></td>
<td></td>
<td>5D</td>
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<td></td>
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<tr>
<td>Disseminate the findings</td>
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<td></td>
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</tr>
</tbody>
</table>

Note: The required number of days for each evaluator for that particular activity is indicated in the above cages, totaling 49 days.
8.0 BUDGET

The estimated budget for the evaluation is as follows:

<table>
<thead>
<tr>
<th>Budget item</th>
<th>Amount (USD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant Fees</td>
<td>49,490</td>
</tr>
<tr>
<td>DSA (consultants, UNFPA staff)</td>
<td>6,698</td>
</tr>
<tr>
<td>Air ticket for Team Leader</td>
<td>6,147</td>
</tr>
<tr>
<td>Local transportation cost</td>
<td>4,040</td>
</tr>
<tr>
<td>Stationary, printing and dissemination costs</td>
<td>7,000</td>
</tr>
<tr>
<td>Communication</td>
<td>3,000</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>76,375</strong></td>
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</tbody>
</table>

UNFPA contracts with the evaluators will be managed on performance-based principles. Hence, payment of the evaluators’ fees will be staggered across the three milestones:

- Upon a satisfactory inception report – 30%
- Upon successful completion of field work – 20%
- Upon a satisfactory final report – the remaining 50%

9.0 DELIVERABLES

The deliverables from the evaluation team are:

**Inception report** – The evaluation team shall submit an electronic copy of the draft inception report to UNFPA Evaluation Manager after the 15 days signing the contract. The inception report provides an opportunity to UNFPA and the evaluation team to ensure that their interpretations of the TOR are mutually consistent. The manager will review and approve the report, which will serve as an agreement between UNFPA and the evaluation team about how the evaluation will be conducted. The evaluation team may be asked to make an oral presentation of the inception report to UNFPA and its stakeholders. The UNFPA Evaluation Manager will provide the written comments on the inception report to the team within 30 days (Please see the annex 3 for inception report guidelines). UNFPA’s approval of the inception report is required before any field work or interviews with stakeholders, implementing partners, or intended beneficiaries. Team Leader need to send the inception report before travelling to Sri Lanka.

**Draft report** – The final report of CPE should be prepared through three iterations of reports:

a. In the first iteration, the Evaluation Team prepares and submits (by team leader) a draft to the Evaluation Manager. The Manager will distribute the draft to partners for reviewing and this period, the Evaluation Manager will also send the draft to, and get feedback from the APRO UNFPA M&E Adviser. At the end of two weeks, the Evaluation Manager will convene a meeting of the EMC to discuss the comments and feedback on the draft and to prepare a response to the evaluators, outlining what needs to be done to improve and complete the report in time.

b. In the second iteration, the evaluation team submits the second draft that has incorporated the comments on the first draft. The Evaluation Manager shares the second draft with the APRO M&E adviser and with the Evaluation Management Committee. After sharing the second draft, the
committee is convened to prepare comments and to guide the evaluators on finalization of the report.

c. After the second and final round of reviewing of the drafts, the report may be finalized, depending on the satisfaction of the Evaluation Committee.

**Final Report** – UNFPA will provide the evaluation team with a recommended outline for the final report as per the evaluation guidelines (Annex 2). The report’s findings and results should follow logically from analysis, be credible and clearly presented together with analyses of achievements and deficiencies. All recommendations should (a) be supported by data analyses (evidence), findings and conclusions, (b) be clearly stated, and (c) specify who is recommended to do what by when. Costs, feasibility, and priorities for the recommendations should also be discussed.

The final report must contain a self-contained executive summary that provides a clear, concise presentation of the CPE main conclusions and key recommendations and reviews salient issues identified in the evaluation.

**Presentation** – This would include preliminary review findings to be shared for validation in a stakeholder consultation meeting.

### 10.0 DISSEMINATE AND USE OF EVALUATION RESULTS

Department of Foreign Aid and Budget Monitoring of Ministry of Finance and Planning has deployed a web based Evaluation Information System (EIS) to serve as a central repository of evaluation synthesis of development programmes and projects. This system will be used for the dissemination of evaluation findings. Apart from that other different channels of dissemination should be considered:

- Upload to UNFPA docshare (Intranet)
- The evaluation report to be printed and the hardcopy with a snapshot of findings and recommendations will be distributed among relevant stakeholders
- The report including key findings and recommendations will be shared electronically among the stakeholders and the report will be uploaded to the UNFPA Sri Lanka website
- Dissemination meetings will be conducted at national and district level

Management responses will be prepared for each of the recommendations using the standard UNFPA management response tool and they should be uploaded into central document repository within one month of accepting the final report of an evaluation.

Management responses will be developed collaboratively with relevant stakeholders. The Evaluation Manager and UNFPA Representative draft the management response, circulate the response together with the evaluation report to the relevant partner(s) and convenes a meeting to discuss and agree on the management response. (The required approval will be obtained from the key stakeholders and partners before finalizing). UNFPA Sri Lanka country office will prepare a management response monitoring checklist progress of implementing CPE recommendations.

### Annex 1: Documents to be consulted

The following documents will be shared as part of the desk review:

- Government Development Plan “Mahinda Chintanaya”
- United Nations Development Assistance Framework (UNDAF) including monitoring and evaluation framework
- Government health master plan
UNFPA evaluation reports should include all the following elements:

1. **Title page**

   Should contain name of project, programme or theme being evaluated; country of project/programme or theme; name of the organization to which the report is submitted; names and affiliations of the evaluators and date.

2. **Table of contents**

3. **Acknowledgements**

   Identify those who contributed to the review process.

4. **List of acronyms**

5. **Executive summary**

   A self-contained paper of 1-3 pages, summarizing essential information on the subject being evaluated, the purpose and objectives of the review, methods applied and major limitations, the most important findings, conclusions and recommendations in priority order.

6. **Introduction**

   Describe the project/programme/theme being evaluated, including the problems being addressed by the interventions. Summarize the review purpose, objectives, and key questions. Explain the rationale for selection/non-selection of review criteria. Describe the methodology employed to conduct the review. Detail
who was involved in conducting the review and what were their roles. Describe the structure of the review report.

7. Findings and conclusions

State findings based on the evidence derived from the information collected. To the extent possible measure achievement of results in quantitative and qualitative terms, and analyze the linkages between inputs, activities, outputs, outcomes and, if possible, impact. Discuss the relative contributions of stakeholders to achievement of results. Conclusions should be substantiated by the findings and be consistent with the data collected, and must relate to the review objectives and provide answers to the evaluation questions.

8. Lessons learned

Based on the review findings and drawing from the evaluator(s)’ overall experience in other contexts, if possible, provide lessons learned that may be applicable in other situations as well. Include both positive and negative lessons.

9. Recommendations

Formulate relevant, specific and realistic recommendations that are based on and linked to the evidence gathered, conclusions made and lessons learned. List proposals for action to be taken (short and long-term) by the person(s), unit or organization responsible for follow-up in priority order, including suggested timelines and cost estimates (where relevant) for implementation addressing each stage of the programme cycle.

10. Annexes

Attach Terms of Reference for the evaluation; list persons interviewed, sites visited; list documents reviewed (reports, publications); data collection instruments (e.g. copies of questionnaires, surveys, etc.); web links.

Annex 3: Inception report guidelines

- Explain the evaluation team’s understanding of what is being evaluated and why
- Describe the team’s strategy for ensuring the evaluation’s utility and applicability the needs of UNFPA and those of key stakeholders
- Describe the evaluation team’s plans to engage and involve these stakeholders in the design (e.g. questions, objectives, methods, data-collection instruments), data collection, data analysis, and development of recommendations
- Explain how the evaluation questions will be addressed with respect to all evaluation criteria indicated in the TOR and by way of proposed methods, evaluation design, sampling plans, proposed sources of data, and data collection procedures
  - Note: The evaluation team is encouraged to suggest refinements to the TOR and to propose creative or cost or time-saving approaches to the evaluation and explain their anticipated value
- Discuss (a) the limitations of the proposed methods and approaches, including sampling, with respect to the ability of the evaluation team to attribute results observed to UNFPA’s efforts, especially when there is no consideration of a valid counterfactual (b) what will be done to minimize the possible biases and effects of these limitations
- Explain the team’s procedures for ensuring quality control for all deliverables
• Explain the team’s procedure to ensure informed consent among all people to be interviewed or surveyed and confidentiality and privacy during and after discussion of sensitive issues with beneficiaries or members of the public
• Explain how the evaluation will reflect attention to and mainstreaming gender concerns and identify the member of the evaluation team who will be responsible for doing so
• Provide a proposed schedule of tasks, activities, and deliverables consistent with this TOR

Annex 4: UNFPA contacts

Ms. Lene K. Christiansen, Representative, UNFPA Sri Lanka, christiansen@unfpa.org
Mr. Tharanga Godallage, National Programme Officer Monitoring and Evaluation, UNFPA Sri Lanka, godallage@unfpa.org, Mobile - 0773 504 593
## Appendix 2: Evaluation Design Matrix

<table>
<thead>
<tr>
<th>Eval. Questions</th>
<th>Sub questions</th>
<th>Type of questions and Design</th>
<th>Indicators</th>
<th>Measures</th>
<th>Source of information</th>
<th>Data collection methods</th>
<th>Sampling plan</th>
<th>Data Analysis Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>1.1</td>
<td></td>
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<td>1.3</td>
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<td>2.</td>
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<tr>
<td>3.</td>
<td>3.1</td>
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<td>3.3</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>
Appendix 3: List of Persons Interviewed with Sites Visited

UNFPA

Ms. Lene Christiansen, UNFPA Representative
Mr. Gamini Wanasundara, Assistant Representative, UNFPA
Dr. Chandanie Galwaduge, National Programme Officer for RH
Ms. Revathie Chawla, National Programme Officer for HIV and Youth programmes
Ms. Sharmila Daluwatta, National Programme Officer for Gender
Ms. Lankani Sikurajapathy, National Programme Analyst
Mr. Tharanga Godallage, Programme Officer for Monitoring and Evaluation
Mr. Priyan Perera, Interim Operations Manager
Mr. Jayan Abeywickrama, Humanitarian Coordinator
Mr. Thushantha, Youth Mobilizer

Other UN organizations

Mr. David Bridger, UNAIDS Country Co-ordinator
Dr. Jayanath Ranatunga, Social Mobilization and Partnership Officer, UNAIDS
Dr. Anoma Jayatilleka, National Programme Officer, Maternal and Child Health, World Health Organization
Dr. Fredrick Abeyratna, UNDP

Ministry of Finance and Planning

Dr. B.M.S. Batagoda, Director General
Department of National Planning, Ministry of Finance Planning
Mr. W.A.D.S. Gunasinghe, Director Public Utility
Department of National Planning, Ministry of Finance and Planning

Ministry of Health (Central level)

Dr. Wimal Jayantha, Deputy Director General (Planning)
Dr. H.U.R. Indrasiri, Deputy Director General (Education, Training & Research (DDG - ET&R).
Dr. Umanga Sooriyarachchi, Consultant Community Physician, ET &R Unit

Dr. S.U.A. Wimlaratna, Director, Information, Planning Unit
Dr. Anil Dissanayake, Director – Youth, Elderly and Displaced ( D/YED)
Dr. Sarath Amunugama, Director – Health Education Bureau (HEB)
Dr. Uthpala Amarasinghe, Medical Officer, Health Education Bureau (HEB)

Dr. Deepthi Perera, Director (Maternal and Child Health ), Family Health Bureau
Dr. Chithramali de Silva, Deputy Director, Family Health Bureau
Dr. Loshan Munasinghe, National Programme Manager, Family Planning Programme
Dr. Nethanjali Mapitigama, National Programme Manager, Gender and Women’s Health programme
Dr. Nilmini Hemachandra, National Programme Manager , Maternal care.
Dr. Ayesha Lokubalasuriya, National Programme Manager, Adolescent and youth programme
Dr. Sujatha Samarakoon, Deputy Director, NSACP
Dr. Janaki Vidanapathirana, Consultant Community Physician, NSACP
Dr. Thilini Hettiarachchi, Medical Officer, NSACP.
Dr. Sugandhi Perera, Coordinator, Disaster Preparedness and Emergency division, Ministry of Health
Mr. R. Kandage, Director, Shanthi Sena Sandhanaya, Youth Wing of Sarvodaya
Mr. W. Kannagara, Member, Board of Directors, Shanthi Sena Sandhanaya
Mr. G. Wanasundara, former Executive Director, Family Planning Association of Sri Lanka
Prof. K.A.P. Sidhisena, professor of Demography, Department of Demography of the University of Colombo.
Dr. A.T.P.L. Abeykoon, Institute for Health Policy, Colombo
Mr. Amara Satharasinghe, Director, StatCap Project, Department of census and Statistics, Colombo.
Mr. Gunasekara, Director, Department of Census and Statistics

Site visits

Anuradhapura

Dr. Palitha Bandara, Regional Director of Health Services (RDHS) - Anuradhapura
Dr. Wijekoon, Director, Teaching Hospital, Anuradhapura.
Dr. P.C. Gallage, Medical Officer, Maternal and Child Health MO (MCH)
Regional Supervising Public Health Nursing Officer (RSPHNO), Office of the

Batticaloa

Dr. S. Sathutmugam, Regional Director of Health Services (RDHS) - Batticaloa
Dr. R. Navallogithan, Medical Officer, Maternal and Child Health MO (MCH)
Dr. D.M. Thamildasan, MO, Planning
Ms. S. Rajasekar, SPHNO
Ms. Rajani, Planning Officer
Biomedical Engineer
Visit to Regional Training Centre

Kalmunai

Dr. Haleema Naseemdeen, Medical Officer, Maternal and Child Health MO (MCH), Kalmunai**
Dr. M.M.S. Jaseslal Ilahi, former MO (MCH), presently at the OPD, AMH.
Ms. V. Uthayamukar, Acting RSPHNO
Mr. M. H. M. Ilyas, Planning and Programme Officer
Mr. M. C. M. Sathir, Data entry operator (funded by UNFPA)

Nuwara Eliya

Dr. Shanthi Samarasinghe, Provincial Director of Health Services (PDHS), Central Province
Dr. Sapumal Dhanapala, Consultant Community Physician, PDHS office, Central Province
Dr. D. Saman Kumari Subasinghe, Regional Director of Health Services (RDHS) – Nuwara Eliya
Dr. Thilina Wijetunga, Medical Officer, Maternal and Child Health MO (MCH)
Dr. Anuruddha Chandrasiri, Medical Officer (Planning)
Mr. B. V. D. Lasantha, Planning and Programming Officer
Sister in Charge, Ms. Freda, Divisional Hospital, Lindula.
Dr. Nihal Wijesooriya, Medical superintendent, Base Hospital, Dickoya.
Medical Officer of Health (MOH), Kotagala
Public Health Nursing Sister, MOH Office, Kotagala.

Vavuniya
Dr. R. Kuhadasan, Planning Officer, Acting RDHS, Vavuniya**
Dr. A. Baskaran, Medical Officer, Maternal and Child Health MO (MCH)
Ms. M. Jeyakumari, Acting RSPhNO
Visit to District General Hospital, Vavuniya, GBV Centre
Dr. S. Suthakaran, MO Mental Health
Mr. V. Thayamohan, Psychiatric Social Worker
Ms. A. Jayagowry, Counsellor
Ms. A. Vijalasyray, Counsellor
Dr. Chandrakumar, MO/STI, General Hospital, Vavuniya.

**Polhena Women Centre**

Thanuja Thilakawardana, Manager Polhena Women Centre
K H Shanthilatha, Manager Polhena Women Centre
S K Yamuna Sagarie, Manager Devinuwara Women Centre
G J Nelum Nishani, Manager Nadugala Women centre
S A Sanjeeewan Gunathilaka, Youth Coordinator Polhena Women Centre
Shalika Abeywickramasignhe, Counsellor WIN Matara
Lasanthi Sooriyaarachchi, Social worker WIN Matara
Thushini Withanage, Counsellor WIN Matara
Dhammika Jayawardana, Legal officer WIN Matara
Anoja Makawita, Coordinator WIN Head office

**Malimbada Women Centre**

Priyanka munasingha, Manager Malimbada women centre
B L Buddhika, Manager Malimbada women centre
Indunil Weerasooriya, Social worker
Sujatha Kodikara, Executive committee member
A Subasinghe, Community member
M C Chandra, Women group member
Mahitha Wickramasinghe, Women group member
R Praneeth Madushanka, Youth group member
Kasun Akalanka, Youth group member
Chanaka Deshpriya, Youth group member

**Nochchiyagama Women Centre - Anuradhapura**

Shyama Sudharshani, Family health officer
H M C D Ralapanawa, Inspector of Police
D M A P Bandara, Public Health Instructor
Damitha Tennakoon, Youth Services Officer
Nihal Abeyesinghe, Child rights program officer
K H C W Wickramarathne, Member women society
H Nimalawathie, Member women society
W G Himali Gamage, Member women society
Sumithra Jayapadma, Member women society
Namal Udayakumara, Youth Group
S A Roshan, Youth Group
W K Herath, Youth Group
Anoma Jayawardana, Project coordinator- WIN
Wathsala Ekanayaka, Women centre Manager
Champika Nanayakkara, Women centre Manager

Mihinthale Women Centre

Nayana priyantha, School Teacher
Muditha Lakshmi, Grama niladari
Anoma Jayawardana, Project coordinator – WIN
Ganga Alokabandara, Legal Officer – WIN
Shyama Wijerathna, Manager women centre
Shyamala Rajakaruna, Manager women centre

Others

Dr. Samapath Tennakoon, Director, Health Emergency & Disaster Management Training Centre (HEDMaTC), University of Peradeniya.
Dr. Lakshman Senanayake, Consultant to the UNFPA, RH Programme.

NGO

Mr. Lakshman, Executive Director, Community Strength Development Foundation CSDF, Colombo
Ms. Kanthi, CSDF.
(Visit to the CSDF Headquarters and to the Drop – in centre at Borella).

Representatives from:
Environment & Community Development Information Centre – Ratnapura
Laksetha Relief Services – Kandy
Wayamba Govi Sanwardena Padanama – Kurunegala
Human Natural Resource Development Foundation – Galle
Rajarata Gami Pahana Organization – Sanuradhapura
Sri Lanka Human Development Foundation – Polonnarowa
Praja Diriya Padanama – Puttalam
Community Strength Development Foundation CSDF, Gampaha.

*Director, National Institute of Health Sciences – could not be contacted after many attempts
**It was not possible to meet the two Regional Directors, Dr. S. Mahendran, RDHS Vavuniya and Dr. Ibra Lebbe, Regional Director of Health Services RDHS, Kalmunai as they were attending meetings in Colombo.
Appendix 4: List of documents reviewed

Documents/Bibliography

- Health Sector Master Plan, Ministry of Health
- United Nations Development Assistance Framework (UNDAF)
- 7th Country Programme document
- Annual Work plans
- Country office - Annual Reports
- Implementing partners quarterly reports
- UNFPA evaluation Guidelines (draft)
- Health sector response to Gender based violence – Case studies of the Asia Pacific region , UNFPA, 2010.
- UNAIDS Guidance Note on HIV and Sex work , UNAIDS, February 2009.
- Technical Assistance Mission Report – Alex Tran, Consultant to assess the capability of the University of Colombo to provide technical Assistance to the FHB for computerization of the contraceptive LMIS
- UNFPA – November 2010, Report on the development of a road map for adolescent sexual and reproductive health programming in Sri Lanka
- Reproductive Health Interventions in Conflict Affected Areas – Annual Report 2009.
- Health sector response to Gender based violence – Case studies of the Asia Pacific region , UNFPA, 2010.
• Technical Assistance Mission Report – Alex Tran, Consultant to assess the capability of the University of Colombo to provide technical Assistance to the FHB for computerization of the contraceptive LMIS
• Technical Assistance to UNFPA Sri Lanka by Tran Nguyen_ Tan, IWAG Training Partnership Coordinator, Humanitarian Response Branch July 2009.
• Report on Stocktaking Exercise - Batticaloa, Vavuniya and Kalmunai – UNFPA February 2009
## Appendix 5: Data collection instrument

Capacity Building of Census & Statistics Department (CSD) Staff - P & D Component Training Evaluation Survey Questionnaire - February 2011

### Capacity Building of Census & Statistics Department (CSD) Staff - P & D Component Training Evaluation Survey Questionnaire - February 2011

**Name of the participant (optional):** .................................................................

**Name of the course/ training attended with duration:** ................................................

**Using the scale on the right, please rate each statement below.**

#### 1. Relevance

<table>
<thead>
<tr>
<th>Statement</th>
<th>Not at all</th>
<th>Very much</th>
<th>Don’t Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. How relevant was the training for the work you were then performing?</td>
<td>1 2 3 4</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>b. How relevant was it for the work you are now performing (if different)</td>
<td>1 2 3 4</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>c. Was the timing relevant? (for immediate application)</td>
<td>1 2 3 4</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>d. Are you the most suitable candidate for the training you participated?</td>
<td>1 2 3 4</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>e. Was the content up to your satisfaction for the tasks/your job?</td>
<td>1 2 3 4</td>
<td>5</td>
<td></td>
</tr>
</tbody>
</table>

#### 2. Language skills (please assess yourself)

<table>
<thead>
<tr>
<th>Skill</th>
<th>Strongly Disagree</th>
<th>Strongly Agree</th>
<th>Don’t Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. I have the language skills to make maximum use of the training</td>
<td>1 2 3 4</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>b. I have a sound technical knowledge on CSD’s work</td>
<td>1 2 3 4</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>c. I have a sound technical knowledge on CSD’s work</td>
<td>1 2 3 4</td>
<td>5</td>
<td></td>
</tr>
</tbody>
</table>

#### 3. Supervision and Guidance

<table>
<thead>
<tr>
<th>Level/ Placement</th>
<th>Not at all</th>
<th>Very Much</th>
<th>Don’t Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Level of guidance you were able to extend to the census preparation</td>
<td>1 2 3 4</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>b. Level of supervision you were able to extend to the census preparation</td>
<td>1 2 3 4</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>c. Level of efforts to integrate what you learnt in the training</td>
<td>1 2 3 4</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>d. Level of supervision and guidance you received from your immediate supervisors (if applicable)</td>
<td>1 2 3 4</td>
<td>5</td>
<td></td>
</tr>
</tbody>
</table>

#### 4. Performance & Development (Question to the Supervisor of the participant, if any)

<table>
<thead>
<tr>
<th>Evaluation/ Satisfied with performance</th>
<th>Not at all</th>
<th>Very Much</th>
<th>Don’t Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Overall development of the participant through the assignment</td>
<td>1 2 3 4</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>b. Overall satisfaction with his/her performance</td>
<td>1 2 3 4</td>
<td>5</td>
<td></td>
</tr>
</tbody>
</table>

#### 5. Comments on Performance & Development:

______________________________________________________________________________

______________________________________________________________________________

Please answer the questions on the back. →
6. Please rate (scale of 1-5) the participant’s knowledge level “at the time of the training” and “Today”:

<table>
<thead>
<tr>
<th>Knowledge Level</th>
<th>At the time of the training</th>
<th>Today</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. About census question preparation</td>
<td>1 2 3 4 5</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>b. About integrating gender in the census</td>
<td>1 2 3 4 5</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>c. About integrating information on women’s informal economic activities</td>
<td>1 2 3 4 5</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>d. About scanning</td>
<td>1 2 3 4 5</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>e. Any other (specify)</td>
<td>1 2 3 4 5</td>
<td>1 2 3 4 5</td>
</tr>
</tbody>
</table>

Program Objectives:
(What is the objective of the specific training).

7. Based on the above program objectives, please rate each question/statement below using the scale on the right. (Think of the OVERALL Experience during and after the training)

<table>
<thead>
<tr>
<th>Experience</th>
<th>Very low</th>
<th>Very high</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Overall usefulness of the learning experience to the CSD</td>
<td>1 2 3 4 5</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>b. Relevance of the experience to the department</td>
<td>1 2 3 4 5</td>
<td>1 2 3 4 5</td>
</tr>
</tbody>
</table>

8. My knowledge/skills on census preparation related issues increased as a result of this training (Questions to the Supervisor (8a to 8e)).

<table>
<thead>
<tr>
<th>Experience</th>
<th>Strongly Disagree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. The performance of the participant met my expectations</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>b. I would recommend another colleague to this training</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>c. Debriefing was done after the training</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>d. My unit benefited from the participant</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>e. The exposure helped the program objectives</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
</tbody>
</table>
9. If your colleague were to go on a (similar) training on (census related) in the future, what would you recommend?
   a. ____________________________________________
   b. ____________________________________________
   c. ____________________________________________

10. What type of support would you need from your department to apply the knowledge you gained?
    __________________________________________________________________________
    __________________________________________________________________________

11. Are your recommendations included in the census? Yes/No. If not why?
    __________________________________________________________________________
    __________________________________________________________________________

12. What would you recommend to improve this program for the next cohort/group?
    __________________________________________________________________________
    __________________________________________________________________________

13. Based on the program objectives, what would be the most important indicators if you were to explain the success of the training program? ____________________________________________
    __________________________________________________________________________
    __________________________________________________________________________

14. Any other comments: ________________________________________________________
    __________________________________________________________________________
    __________________________________________________________________________

Thank you very much for completing the questionnaire.
FOR EACH SUB OUTPUT UNDER EACH OUTPUT, A REVIEW PLAN WAS DEVELOPED.

Two examples are given. All review formats were based on the work plan and followed a similar format,

REVIEW PLAN - OUTPUT R1 Sub output 1.1. and Sub Output 1.2.

R1 Sub output 1.1

To check on finances

<table>
<thead>
<tr>
<th>Task Description</th>
<th>2009 Responsibility</th>
<th>2010 Responsibility</th>
<th>Current status</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review and update RH component of the basic training curricula of key categories of RH staff</td>
<td>TA</td>
<td>UNFPA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TA – for specific areas</td>
<td>TA – for specific areas</td>
<td>UNFPA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Identify content areas of curricula – 20 consultative meetings</td>
<td>Identify content areas of curricula – 20 consultative meetings</td>
<td>DDG-ETR</td>
<td>DDG-ETR</td>
<td></td>
</tr>
<tr>
<td>Strengthen competency based training in clinical procedures by providing anatomical models</td>
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<tr>
<td>Prepare an inventory available in basic training centres and identify gaps</td>
<td>Prepare an inventory available in basic training centres and identify gaps</td>
<td>ETR</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Procure anatomical models</td>
<td>Procure anatomical models</td>
<td>UNFPA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prepare a module to be used in development of skills/ competencies on use of models</td>
<td>Prepare a module to be used in development of skills/ competencies on use of models</td>
<td>UNFPA</td>
<td>UNFPA</td>
<td></td>
</tr>
<tr>
<td>Conduct 2 training programmes for teaching staff on using anatomical models</td>
<td>Conduct 2 training programmes for teaching staff on using anatomical models</td>
<td>ETR</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Establish a CPD programme for teachers of basic/post basic training institutes</td>
<td>Establish a CPD programme for teachers of basic/post basic training institutes</td>
<td>ETR</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Identify training needs of the</td>
<td>Identify training needs of the</td>
<td>ETR</td>
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</tbody>
</table>
teaching staff of the basic training centres (NIHS, RTCs, NTS, PBS through 5 workshops

Finalize the CPD programme (including guidance) for the teachers on RH through 3 consultative workshops

Conduct 4 training programmes each – 5 days based on revised RH curricula for teachers in the basic/post basic training institutes. Field training centres to update their knowledge

Conduct 2 training programmes for the teachers in the basic/post basic training institutes to update technical knowledge on RH

Conduct functional task analysis of the key categories of RH staff

| Teaching staff of the basic training centres (NIHS, RTCs, NTS, PBS through 5 workshops) | ETR |
| Finalize the CPD programme (including guidance) for the teachers on RH through 3 consultative workshops | ETR |
| Conduct 4 training programmes each – 5 days based on revised RH curricula for teachers in the basic/post basic training institutes. Field training centres to update their knowledge | ETR |
| Conduct 2 training programmes for the teachers in the basic/post basic training institutes to update technical knowledge on RH | ETR |
| Conduct functional task analysis of the key categories of RH staff | ETR |

**OUTPUT R1 Sub output 1.2. FHB /HEB /SL Army**

To check on amount spent

<table>
<thead>
<tr>
<th>Adapt international guidelines and protocols for PCPNC, FP and post abortion care</th>
<th>2009 Responsibility</th>
<th>2010 Responsibility</th>
<th>Current status</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Consultative meeting</td>
<td>FHB</td>
<td></td>
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<tr>
<td>Plan to establish two tiered structure for training at district levels</td>
<td>Unfpa</td>
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<tr>
<td>EMOC assessment in selected areas</td>
<td>Unfpa</td>
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<tr>
<td>b. Workshops to reach consensus between Q. secretariat, FHB, Colleges on criteria and process of setting up</td>
<td>FHB</td>
<td></td>
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</tbody>
</table>

Ta details given in rev 2010
<table>
<thead>
<tr>
<th>standards</th>
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</thead>
<tbody>
<tr>
<td>c. TA establish QA</td>
<td>UNFPA</td>
<td>UNFPA</td>
<td>Postponed to 2011</td>
</tr>
<tr>
<td>d. TA</td>
<td>UNFPA</td>
<td>UNFPA</td>
<td></td>
</tr>
<tr>
<td>e. Assess quality gaps in A’pura district *****</td>
<td>UNFPA</td>
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<tr>
<td>f. Support development of relevant guidelines, translation, print, develop a VCD</td>
<td>FHB</td>
<td>FHB</td>
<td>Develop guidelines on IUCD female sterilization and translate guidelines for OCs, depot and print (2010)</td>
</tr>
<tr>
<td>g. Conduct supervisory visits to districts</td>
<td>FHB</td>
<td></td>
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<tr>
<td>h. Specifications for equipment for FP</td>
<td>FHB</td>
<td>FHB</td>
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</tr>
<tr>
<td>i. Regular review meetings with MO MCH, RSPHNO, SSO and laboratory staff at national level</td>
<td>FHB</td>
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</tbody>
</table>

1.2.2. Expand FP/sub fertility services

<table>
<thead>
<tr>
<th>Conduct training for service providers</th>
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</thead>
<tbody>
<tr>
<td>1 day training on IUCD (12) “ (8) 2010</td>
<td>FHB</td>
<td>FHB</td>
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<tr>
<td>1 day training for Implanon (12) “ (8) 2010</td>
<td>“</td>
<td>FHB</td>
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</tr>
<tr>
<td>3 day ToT on guidelines on OCP, DMPA, IUCD, Implanon and ECP (4) 1 day programmes at district level (12)</td>
<td>“</td>
<td>“</td>
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<tr>
<td>Standardize techniques of seminal fluid preparation and analysis thro’ training of technicians (4)</td>
<td>FHB</td>
<td>FHB</td>
<td></td>
</tr>
<tr>
<td>Description</td>
<td>Responsible Party</td>
<td>Notes</td>
<td></td>
</tr>
<tr>
<td>-----------------------------------------------------------------------------</td>
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<td>--------------------------------------------</td>
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<tr>
<td>Establish lab facilities for sub fertility</td>
<td>FHB</td>
<td>FHB</td>
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<tr>
<td>National Coordinating Committee (3 meetings)</td>
<td>FHB</td>
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<tr>
<td>Strengthen capacity of FHB for sterilizations (provide equipment)</td>
<td>FHB</td>
<td>UNFPA will do payment to vendor. D(MCH) will submit the original voucher, by end November</td>
<td></td>
</tr>
<tr>
<td>Strengthen IUD services by providing equipment for FP services in underserved areas</td>
<td>FHB</td>
<td>Postponed to 2011.</td>
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</tr>
<tr>
<td>Update medical practitioners in and outside government thro’ a series of CME updates in the CMJ</td>
<td>UNFPA</td>
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<tr>
<td>Update govt, MOs on contraception (College of Community Physicians)</td>
<td>UNFPA</td>
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<tr>
<td>Produce advocacy booklet on the national FP programme</td>
<td>FHB</td>
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<tr>
<td>Establish a help desk to provide information to service providers</td>
<td>FHB</td>
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<tr>
<td>Establish a database on service provision for sub fertility at the RH laboratory by procuring computers and providing internet facilities</td>
<td>FHB</td>
<td></td>
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</tr>
<tr>
<td>****Develop pre test and print IEC materials Leaflets (8 methods)</td>
<td>HEB</td>
<td>US $3615 advanced. UNFPA will pay vendors directly. HEB to submit original vouchers by end November</td>
<td></td>
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<tr>
<td>Improve coverage of WWC services</td>
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<tr>
<td>Plan for national strategy – 6 consultative meetings 6 meetings - 2010</td>
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<tr>
<td>-develop guidelines for WWC Build on existing guidelines</td>
<td>Postponed to 2011.</td>
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<tr>
<td>Pilot alternative methods off cervical cancer screening</td>
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<tr>
<td>Improve cytology screening – two training programmes 3 weeks duration for lab staff &amp; two updates for pathologists and Gynaecologists</td>
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<tr>
<td>Procure equipment for WWCs</td>
<td>FHB</td>
<td></td>
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<tr>
<td>Professional updates at national level: ToT at sub national level</td>
<td>FHB</td>
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<tr>
<td>2 updates for consultant VOGs 2 – in 2010</td>
<td>FHB</td>
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<tr>
<td>2 training programmes for lab staff 1 – in 2010</td>
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<tr>
<td>1 professional meeting with pathologists and gynaecologist</td>
<td></td>
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<tr>
<td>6 programmes for sub national level trainers 15 for sub national level- in 2010</td>
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<tr>
<td>Advocacy meetings at district level to establish WWCs in underserved areas</td>
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<tr>
<td>Mobilise NGO support for RH and engage SL Army to provide RH information to its cadres</td>
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<tr>
<td>Consultative meeting with NGO</td>
<td>UNFPA</td>
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<tr>
<td>Support SL Army to produce a</td>
<td>SL Army</td>
<td></td>
<td></td>
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<tr>
<td>training module</td>
<td>support SL Army to conduct TOT</td>
<td>NEW ACTIVITY travel costs to attend meetings</td>
<td>UNFPA</td>
</tr>
</tbody>
</table>
Appendix 6: “Future Programmes” towards a Caring Society - National Development Framework
(source: Mahinda Chintana Vision for the Future, NPD)

**Caring Society**

**Prosperous Family**

**Empowering Women**
- Establish a Women’s Entrepreneurship Development Fund
- Self employment scheme for women
- Introduce a special loan scheme at concessionary rate
- Establish a Women’s Data Bank to facilitate access to economic and professional data on women
- Create awareness to attract women to technical and vocational courses
- Introduce non-traditional and virtual courses to the technical education field
- to meet labour market demand
- Ensure that women are assured of wages equal to that of men
- Protect female migrant workers from economic and sexual exploitation
- Provide nutritional supplements to pregnant mothers

**Creating Opportunities for Children**
- Encourage private sector to provide quality preschool facilities
- Develop capacity and skills of preschool teachers
- Strengthen periodic investigation and develop standards of ECCD centres
- Conduct awareness programme for mothers
- Upgrade and establish new ECCD centres
- Strengthen Glass of Milk and Mid Day Meal programme
- Follow up with children of migrant mothers
- Build new homes with modern facilities for orphans
- Establish rehabilitation centres and provide counseling
- Give wide publicity to create awareness on child protection and regulations
- Improve the state of the certified schools and remand homes

**Sharing the Experiences of Elders**
- Incorporate ageing issue in development plans
- Promote elder committees
- Introduce universal pension scheme
- Recognize and support voluntary services
- Introduce health insurance system
- Establish recreational parks and walking tracks
- Provide assistive devices such as spectacles and hearing aids
- Strengthen community based rehabilitation
- Establish retirement villages
- Provide tax and other concessions to the private sector to run elders homes and care services
- Improve facilities to ensure easy accessibility to public places and services
- Facilitate cultural and spiritual activities
- Provide legal aid and counseling

**Mainstreaming the Differently-abled**
- Maintain special homes with all facilities for the differently-abled
- Establish welfare villages for disabled soldiers
- Promote private sector to establish modern differently-abled homes
- Encourage parents to look after differently-abled in their care
- Increase and regulate facilities for easy accessibility to public places and services
- Expand vocational training for the differently abled
- Support NGOs and other charities which run rehabilitation and skills development centres
- Establish special education centres with modern facilities for children with specific disabilities
- Provide non-formal education for the needy
- Make available assistive devices with latest technology
- Establish a special loan scheme for the differently-abled to encourage self employment