

Evaluation of access to high quality sexual and  
reproductive health services and information in the  
Maldives

5<sup>th</sup> Country Programme 2011-2015

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*EVALUATION REPORT*

*December 2014*

Prepared for: UNFPA Maldives

Prepared by: Shaffa Hameed

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## Acronyms

ASRH	Adolescent Sexual and Reproductive Health
AWP	Annual Work Plan
BBS	Biological Behavioural Survey
BCC	Behaviour Change Communication
CBO(s)	Community-based Organisation(s)
CCA	Common Country Assessment
CO	Country Office
CP3	Third Country Programme
CP4	Fourth Country Programme
CP5	Fifth Country Programme
CPAP	Country Programme Action Plan
CPD	Country Programme Document
CPE	Country Programme Evaluation
CSO(s)	Civil Society Organisation(s)
DaO	Delivering as One
DHS	Demographic and Health Survey
DRR	Disaster Risk Reduction
DV	Domestic Violence
ERG	Evaluation Reference Group
ESCAP	Economic and Social Commission for Asia and the Pacific
FGM	Female Genital Mutilation
FPA	Family Protection Authority
GBV	Gender-based Violence
GOM	Government of Maldives
HDI	Human Development Index
HMP	Health Master Plan
HPA	Health Protection Agency
ICPD	International Conference on Population and Development
IGMH	Indira Gandhi Memorial Hospital
IP(s)	Implementing Partner(s)
ISDR	International Strategy for Disaster Reduction
LDC(s)	Least Developed Country (s)
MARP	Most at Risk Population
MDG(s)	Millennium Development Goal(s)
MIC	Middle Income Country (status)
MOE	Ministry of Education
MOH	Ministry of Health
MoHRYS	Ministry of Human Resources, Youth and Sports
MTR	Mid-term Review
MYS	Ministry of Youth and Sports
NGO(s)	Non-governmental Organisation(s)
NIE	National Institute of Education
NRA(s)	Non-resident Agency (s)
OHCHR	Office of the High Commission for Human Rights
RH	Reproductive Health

RR	Reproductive Rights
SHE	Society for Health Education
SP	Strategic Plan
SPR	Standard Progress Report
SRH	Sexual and Reproductive Health
TOR	Terms of Reference
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNCT	United Nations Country Team
UNDAF	United Nations Development Assistance Framework
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organisation
UNFPA	United Nations Population Fund
UNICEF	United Nations Children’s Fund
UNODC	United Nations Office on Drugs and Crime
UNOPS	United Nations Office for Project Services
UNRC	United Nations Resident Coordinator
UNRCO	United Nations Resident Coordinator’s Office
UN Women	United Nations Entity for Gender Equality and Women’s Empowerment
WHO	World Health Organisation
YHC	Youth Health Café

## Executive Summary

This independent study commissioned by UNFPA Maldives seeks to evaluate access to high quality sexual and reproductive health services and information as a component of the Maldives United Nations Development Assistance Framework (UNDAF) 2011-2015, with a view to informing the next programme cycle. This evaluation drew upon and therefore evaluated agency performance for the first 3 years of CP5 2011-2015 and UNDAF 2011-2015- i.e., 2011, 2012, and 2013. This study utilised primary data collected using key informant interviews as well as secondary data collated via document review to answer evaluation questions formulated under the 4 evaluation criteria- relevance, effectiveness, efficiency, and sustainability.

In terms of *relevance*, the findings indicate that the needs of the target population were taken into account in the programme inception stages. However, given the lack of data in subsequent years to indicate whether or not the needs have evolved made it difficult to confirm that UNFPA assistance towards the needs of the final beneficiaries *remains* relevant. The study also finds that UNFPA priorities and government priorities are generally well aligned even though it does not appear to have translated into government commitment in terms of financial and human resource allocation. UNFPA has also responded well to two major shifts in context- the major overhaul to the health sector and the country’s graduation to a Middle Income Country (MIC)- by providing assistance to the Health Ministry as well as conducting Mid-year Review of the UNDAF Action Plan in mid-2012, and realignment of the Maldives CPD to the UNFPA Revised Strategic Plan.

The *effectiveness* assessment examined the progress and achievements for 3 outputs relevant to the study: *RH Output 1: Strengthened capacity of Ministry of Health and Family, sub-national level governments and civil society organisations to plan and deliver high-quality and equitable RH services and information, including responses to emerging issues in Maldives; RH Output 2: Improved access of young people of SRH services and information in Male' and on selected islands; Gender Output 3: A strengthened national response, including by the health sector, to violence against women and girls, taking into account linkages to protection and legal services.* The effectiveness assessment according to the output indicators shows that neither of the two RH outputs (2 of 4 targets met for RH Output 1; 1 of 3 targets met for RH Output 2) or the relevant Gender output (1 of 4 targets met) have been achieved yet. However, the study indicates that the indicators did not capture the vast volume of activities that were implemented. Notable examples of these include achievements in the cervical cancer screening programme, establishment of the Domestic Violence Act, and advocacy for integration of Life Skills education into the school curriculum. It was also noted that evidence-based policy advocacy was often difficult given the lack of high-quality data- this absence was found to expose emerging issues to political manipulation, and issues without moral links were prioritised over pertinent issues that may be culturally sensitive.

With regard to *efficiency* of resource allocation, UNFPA demonstrated flexibility in redeployment of funds (from strategies that are no longer relevant) to facilitate implementation of pertinent interventions. In terms of human resources, the study found that human resource allocation for the evaluation period did not match the priorities and the level of support required by implementing partners to maintain momentum in implementation and ensure a comprehensive approach. Partnerships between UNFPA and implementing partners were also found to be mismatched in terms of role and decision-making ability- this has resulted in power imbalances and unrealistic and unmet expectations. Partnerships with other UN agencies were found to be lacking in coordination, negatively affecting implementation as a result of duplication and overutilisation of common implementing partners.

The sustainability assessment highlighted the difficulties in focusing on sustainable activities in a country context that has been in flux as the Maldives. The loss of technical capacity as a result of redundancy packages introduced mid-cycle necessitated assistance to re-build the capacity UNFPA had assisted with in previous years. Moreover, changes in the health sector infrastructure required assistance to acclimatise remaining health personnel with new procedures. And lastly, the changes in government- of which there were three, during this programme cycle- introduced (and reintroduced) new priorities and new policy-level decision-makers, which demanded repetitive efforts by UNFPA to build partnerships and advocate policy attention.

The report concludes by providing 11 evidence-based conclusions build on the assessments under the evaluation criteria and are linked to 7 recommendations that provide contextualised suggestions for the upcoming Country Programme.

## 1 Introduction

This independent evaluation is commissioned by UNFPA Maldives to evaluate access to high quality sexual and reproductive health services and information as a component of the Maldives United Nations Development Assistance Framework (UNDAF) 2011-2015, with a view to informing the next programme cycle.

### 1.1 Purpose and objectives of the evaluation

This evaluation precedes the Common Country Assessment and is driven by the need to develop a better Country Programme Document (CPD) in the next programme cycle. Complementary to the overall UNDAF evaluation, the UNFPA commissioned this study to have a specific look at the sexual and reproductive health (SRH) aspect of its work and agency performance using the following criteria:

- *Relevance* of UNFPA's contribution to SRH in the face of the changing national priorities and contexts
- *Effectiveness* of Country Programme Document (CPD) and its proposed strategies in terms of progress towards the stated results (subsequently recommend strategies to improve impact for the next CPD/UNDAF in the context of UNFPA's Strategic Plan 2014-2017 based on lesson learnt from the first 3 years of implementation of the CPD/UNDAF
- *Efficiency* of key partnerships in the pursuit of results, including interlocutors within partners (with a view to explore possibilities of partnerships for the next UNDAF/CPD in the context of UNFPA Strategic Plan 2014-2017)
- Extent to which UNFPA's intervention have contributed to *sustainable* institutional change that increase the capacity to deliver in terms of improved access to high quality sexual and reproductive health (SRH) services.

The specific objectives of this sub-evaluation as listed in the Terms of Reference<sup>1</sup> are:

- Based on the UNDAF Mid Term Review (MTR) and other recent publications:
  - Assess the progress towards achievement of results stated in the CPD expressed through the indicator framework
  - Assess the progress towards national development goal in the area of improved access to high quality sexual and reproductive health service

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<sup>1</sup> See Annex 1 for Terms of Reference



- Describe and assess the impact of the changing institutional, political and cultural context on the possibility of delivering results in this area
- Review effectiveness of strategies and partnerships of the UNFPA CPD; compare the strategies to the strategic direction outlined in UNFPA Strategic Plan 2014-17 and make suggestions for the next UNDAF/CPD
- Assess the extent to which the results framework in the CPD, and the programming practices expressed through the implementation strategies and AWP was conducive to effective country programme delivery.

## 1.2 Scope of the evaluation

At its onset, this evaluation exercise was envisaged to be a component of the main UNDAF Evaluation that was being conducted concurrently, commissioned by the UN Resident Coordinator's Office. Thus, joint meetings with the UN RCO, UNFPA, and the consultants were held during the inception phase to contextualise this study with the main UNDAF Evaluation. While agreements were made regarding joint utilization of stakeholder meetings and data sharing, this evaluation was delineated from the UNDAF Evaluation in terms of depth and focus of information required. This evaluation is designed to stand alone as a sub-evaluation of UNFPA assistance for the Reproductive Health and Rights component of Fifth Country Programme 2011-2015 (CP5).

With regard to time frame, this evaluation drew upon and therefore evaluated agency performance for the first 3 years of CP5 2011-2015 and UNDAF 2011-2015- i.e., 2011, 2012, and 2013. Although this evaluation is taking place late 2014, the monitoring and evaluation data necessary may not be complete or up-to-date and hence the evaluator's decision was to exclude the year 2014 from this study.

## 2 Methodology

This chapter is organised into 3 sections, beginning with a description of the process including evaluation criteria and questions guiding this evaluation. This is followed by an overview of data collection methods and analytical strategies. The final section offers a reflection on the limitations and challenges of this evaluation.

### 2.1 Evaluation criteria and evaluation questions

The evaluation process was structured into three phases: inception phase, data collection, and analysis and reporting phase. Culminating with the inception report, the inception phase (1-14 August 2014) provided valuable insight and perspectives regarding approach and scope of the evaluation. Preliminary meetings with stakeholders were useful in revealing broad overview of UNFPA partnerships and identifying lines of enquiry for in-depth interview. Similarly, the initial document screening for data availability assisted in identifying key issues for in-depth document review.

Data collection was undertaken intermittently during 1-21 September 2014, with few interviews being conducted later in the month due to scheduling difficulties. Data analysis was conducted concurrently and proved useful in identifying emerging themes and allowed verification between reports and narratives. The reporting phase involved submission of the first draft for internal review followed by minor updates to incorporate feedback from UNFPA CO. An important component of this phase is the validation workshop where findings were shared with stakeholders- the long period for the validation phase (i.e. October 2014) is attributed to workshop scheduling difficulties to include all participating organisations and individuals.

Developed and informed by the UNEG guidelines<sup>i</sup> as well as the UNFPA CP Evaluation Handbook,<sup>ii</sup> this evaluation of the RH Component of the Fifth Country Programme (CP5) is assessed against four evaluation criteria:

**Relevance:** the extent to which the objectives of a development intervention are adapted to national needs (e.g. needs of the population, in particular vulnerable groups) and are aligned with government priorities as well as policies and strategies of UNFPA

**Effectiveness:** the extent to which the objectives of the intervention have been reached

**Efficiency:** how resources/inputs (funds, expertise, time, etc.) are converted into results

**Sustainability:** The continuation of benefits from a development intervention after its termination.

Guided by these criteria, this study will seek to answer the following evaluation questions:

**Evaluation Question 1:** To what extent is the UNFPA support in the Maldives in the field of SRH:

- (a) adapted to the needs of the population;
- (b) aligned with the priorities set by relevant national policy frameworks as well as the UNFPA strategic plan and
- (c) responsive to changes occurred in the national development context during its period of implementation?

**Evaluation Question 2:** To what extent:

- (a) did UNFPA supported interventions contribute (or are likely to contribute) to sustainably improve access to high-quality SRH services and information, particularly in underserved areas, with a focus on young people and vulnerable groups?
- (b) are population data taken into account to inform such activities?

**Evaluation Question 3:** To what extent:

- (a) has UNFPA made good use of its human, financial and technical resources in pursuing the achievement of outcomes defined in the country programme?
- (b) did the intervention mechanism of working in partnership foster or hinder the achievement of the programme outputs?

**Evaluation Question 4:** To what extent has UNFPA been able to support its partners and the beneficiaries in developing capacities and establishing mechanisms to ensure ownership and the durability of effects?

## 2.2 Data collection methods and analysis

Based on the evaluator's understanding of ToR guidelines, a mixed methods approach was taken to utilise quantitative data to assess progress and achievements alongside qualitative data to yield more nuanced insight into factors that affect progress or lack thereof. An evaluation matrix<sup>2</sup> was compiled based on preliminary stakeholder meetings and initial document screening, which in turn informed the selection of data collection methods. This study utilised primary data collected using key informant interviews as well as secondary data collated via document review.

*Document review*<sup>3</sup> provided the starting platform to gaining familiarity with the key stakeholders, emerging evaluation issues, and data gaps. In addition to informing the inception phase, further in-depth review was undertaken to assess the progress of the SRH programme towards stated results as well as examining the extent of strategic alignment between various strategies.

Quantitative data compiled (from documentation such as prior reports and indicator databases) to assess progress towards achievement of results stated in the CPD were analysed on two levels: descriptive analysis to describe activities

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<sup>2</sup> See Annex 2 for evaluation matrix

<sup>3</sup> See Annex 3 for list of documents consulted

and results achieved and comparative analysis to assess impact of activities and progress against baseline data.

*Key informant interviews:*<sup>4</sup> Primary data was generated from 20 semi-structured in-depth interviews with key informants from relevant partner agencies, guided by an interview guide.<sup>5</sup> Respondent selection was undertaken in consultation with UNFPA in order to identify individuals most relevant and involved in UNFPA-assisted activities. Interviews were grouped in cases where there was more than one relevant person in the same organization. Some organisations chose to include additional personnel; most likely to avoid data gaps- however, care was taken to avoid more than three respondents and to match in seniority to allow for candid responses. Invitations to participate as well as logistical arrangements were made by UNFPA though all interviews were conducted in person by the evaluator with no UNFPA presence. Prior to the interview, all respondents were informed of the purpose of the interview and confidentiality assured.

Additionally, a *field visit* was attempted at the Reproductive Health Centre at IGMH, the government hospital in Male', to check whether the trainings and procedural changes from the newly instated guidelines on youth-friendly and GBV-sensitive services were apparent at the service level. However, the staff were unable to provide any information unless cleared by hospital management- since this formal route would reveal a more polished insight than would a random visit, this has not been pursued as yet. One piece of information that was gleaned from that conversation was that they no longer implemented the Adolescent Health Unit (and that they were aware of a youth-friendly service being developed in Kulhudhuffushi), that the Family Protection Unit handled the GBV cases, and that a separate service handled the cervical cancer screening. This indicates a less than comprehensive service at the RH Centre at IGMH, a service suggested by both interview data and document as the leading service on reproductive health issues.

Qualitative analytical methods including thematic and content analysis were applied to the interview data in order to gain a nuanced understanding of agency performance, efficiency of current partnerships, and relevance of UNFPA's contribution in the context of changing national priorities.

### 2.3 Challenges and Limitations

One limitation of this evaluation exercise is the reliance on one method of data collection each, for quantitative and qualitative data. In order to counter this as much as possible, care was taken to triangulate the data using different sources and conflicting figures and narratives (in reports or in interviews) were crosschecked and verified. Additionally, the validation workshop held during the reporting phase was an important step in verifying the data gathered. The workshop included an exercise inviting written feedback under Chatham House Rule<sup>iii</sup> where participants are able to express their views anonymously and

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<sup>4</sup> See Annex 4 for list of persons consulted

<sup>5</sup> See Annex 5 for interview guide

without being attributed to their organization. The worksheet<sup>6</sup>, included in Appendix 5, included a summary of activities undertaken under each strategy, evaluator's comments and questions for discussion, and participants were invited to list strategy-specific challenges they encountered. Although the turnout was low, the workshop provided a lot of data and perspective. In addition to the seminar, the validation phase included circulating an electronic copy of the draft report to the stakeholders, allowing opportunity for language-based (e.g., to rule out misrepresentation in phrasing), and more institutional feedback.

A recurrent challenge faced throughout the study was the unavailability of most relevant interview respondents. Most frequently this was due to busy schedules and in instances where interviews could not be scheduled even after extending data collection periods, the next most relevant individuals were interviewed. Similarly, swift changes in key personnel in key organisations lead to much loss in institutional memory as well as insight into challenges in various stages of the activities. This was countered by efforts to locate these key individuals and interview them as ex-staff.

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<sup>6</sup> See Annex 6 for validation seminar worksheet

### 3 Country context

This chapter provides an overview of the country context in which this evaluation is set, including major shifts that affect the focus of this evaluation, sexual and reproductive health (SRH).

#### 3.2 Maldives

The Maldives is an island nation comprising 1192 coral islands, out of which 188 are inhabited by approximately 330,000 people.<sup>iv</sup> The geographical dispersion of the population challenges equitable service provision, including health services. As a result of the high concentration of health services, schools, and employment opportunities in the capital city Male', it is inhabited by 35% of the total population, making it one of the most densely populated cities in the world.<sup>v</sup> The population structure of the Maldives is similar to that of developing countries where a large proportion belonged to the younger age groups- the Statistical Yearbook 2013 reported that 22% of the total population is aged between 15-24 years.

The political climate in the Maldives has been extremely volatile in past decade, including a lot of civil unrest in opposition to the numerous government changes. The 2008 Presidential Elections led to a change in government that had been in power for the preceding 30 years. In February 2012, extreme unrest resulted in a transfer of power to a transitional government that lasted until Presidential Elections the following year. The elected government of 2013 remains in power and the political situation appears to be relatively stable at the time of this evaluation.

In addition to the political instability and worsening fiscal crisis, the country's graduation from a Least Developed Country (LDC) to a Middle Income Country (MIC) was identified in the MTR as contributing to changes in the programming environment.<sup>vi</sup> Despite this, the Maldives is South Asia's only 'MDG+' country, having achieved significant progress 5 out of the 8 MDGs ahead of 2015 (namely, MDG1, 2, 4, 5, and 6). However, emerging evidence suggests that Maldives may be regressing in some areas, including reproductive health.

Lastly, and despite limited supporting documentation, it is worth noting that there have been increasing reports of growing influence of Islamic fundamentalism in the Maldives.<sup>vii</sup> A stark change from the relatively moderate practice of Islam in previous years, extremist factions have been increasingly visible and vocal, including street protests calling for full enactment of the Sharia (Islamic Law) instead of Sharia-based state law, which the country had thus far maintained.<sup>viii</sup>

#### 3.3 UN and UNFPA response

Signed in 2010, the United Nations Development Assistance Framework (UNDAF) 2011-2015 is undergoing its final evaluation, following a Mid-Term Review (MTR) in 2013. The Government of Maldives and UNCT made the decision to volunteer as a 'Delivering as One self-starter' country, effectively

replacing the Country Programme Action Plans (CPAPs) with the UNDAF Action Plan 2011-2015.

Currently, UNFPA is among the 4 out of the 16 active UN agencies that have residence presence in the Maldives, though with a non-resident country director based in Sri Lanka. Active since the 1980s, UNFPA is in its fifth cycle of assistance from 2011 to 2015 with three programme components: reproductive health and rights; population and development; and gender equality.<sup>ix</sup> As will be discussed in the following chapters, UNFPA assistance in this cycle operated under three different governments following the changes mentioned above, and this has had severe repercussions to implementation of UNFPA-assisted interventions.

### 3.4 Health

The 5<sup>th</sup> UNFPA Country Programme 2011-2015, the UNDAF 2011-2015 and the UNDAF Action Plan were formulated in partnership with the democratically elected government of 2008 that had overseen major changes to the health sector. This included the Decentralisation Act 2010 which mandated newly-formed City and Island Councils to provide basic healthcare services, as well as the 2009 privatization process that saw seven health corporations take ownership of assets related to health services.<sup>x</sup>

However, the unforeseen transfer of power in February 2012 saw these changes reversed, bringing more major changes including financing health services and health insurance, shifting the programming environment further. Moreover, the introduction of voluntary redundancy packages in the face of limited technical capacity led to further deterioration of manpower, having a more direct effect on UN-supported capacity building efforts.<sup>xi</sup>

In light of these changes in government, the need to assess the impact on UNDAF 2011-2015 led to the Mid-year Review of the UNDAF Action Plan in mid-2012, and realignment of the Maldives CPD to the UNFPA Revised Strategic Plan. (This is further discussed in 4.1.3 Response to changing priorities and contexts)

### 3.5 Sexual and Reproductive Health in the Maldives

According to the Maldives ICPD Review in 2012, the Maldives has come a long way since the Cairo Convention, including fully achieving ICPD goals and Millennium Development Goals (MDGs) regarding infant, early childhood, and maternal mortality rates (MMR).<sup>xii</sup> Antenatal and neonatal care services have been made available throughout the country, and government and NGOs alike have made notable efforts to strengthen the reach of reproductive health services in the atolls.<sup>18</sup>

However, similar to the MMR that saw a slight increase in 2010,<sup>12</sup> significant improvements in SRH appear to be accompanied with caveats. Despite contraceptives being available in all islands, the contraceptive prevalence rate remains low at 27% for modern methods.<sup>xiii</sup> Moreover, the most common method of contraception appears to be female sterilization (10.1% of all methods) whereas the most uncommon (0.5%) method was male sterilization, thus indicating severe gender imbalances. The availability of emergency

contraceptive pills marked a milestone, though they are available only to married couples, despite persistent reports of unsafe abortions among unmarried people.<sup>13</sup>

Although great strides have been made regarding raising awareness of HIV and STIs, there is a continued reluctance to provide contraceptive services to unmarried youth. The reluctance is often attributed to religious boundaries as premarital sexual activity is prohibited in Islam. However, in-depth study has shown that this may be distinguished to two factors- one, the misidentification of socio-cultural pressures as religious, which renders sexual health taboo; two, the susceptibility of policy makers to socio-cultural influences leading to fragmented institution support- combine to limit sexual health for youth in the Maldives.<sup>xiv</sup>



## 4 Findings and Analysis

The findings of the evaluation are presented below, organised according to the 4 overarching evaluation questions corresponding to the evaluation criteria of relevance, effectiveness, efficiency and sustainability.

### 4.1 Relevance

**Evaluation Question 1:** To what extent is the UNFPA support in the Maldives in the field of SRH:

- (a) adapted to the needs of the population;
- (b) aligned with the priorities set by relevant national policy frameworks as well as the UNFPA strategic plan and
- (c) responsive to changes occurred in the national development context during its period of implementation?

#### 4.1.1 Relevance to needs of the population

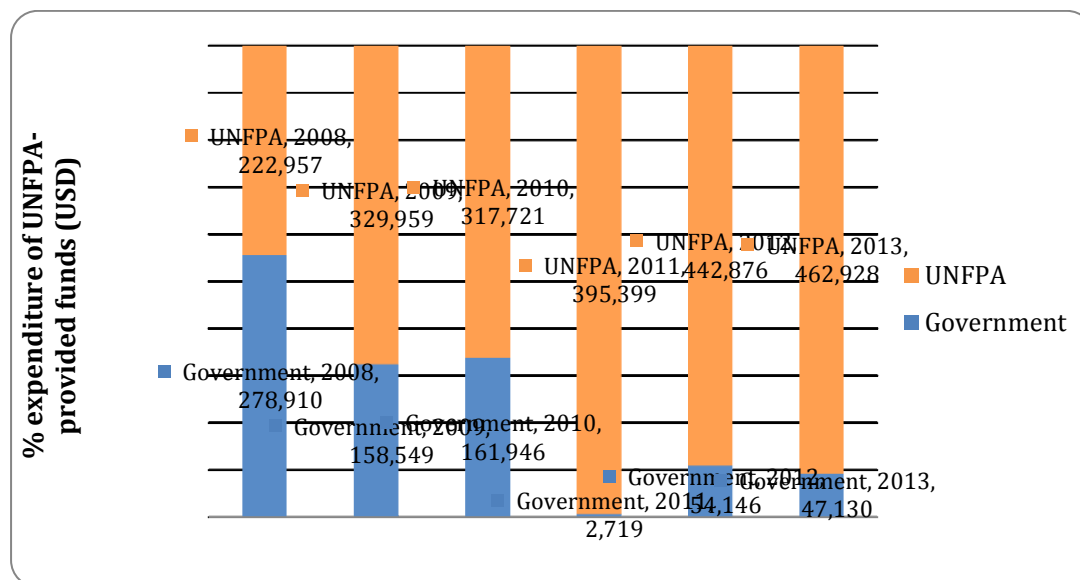
*Evaluation Question 1a* demands a distinction between beneficiaries at different levels, given how the needs of final beneficiaries may not necessarily be reflected in government priorities.<sup>2</sup> Final beneficiaries, in this case, are women, men and adolescents with particular emphasis on poor and vulnerable groups, at national and sub-national levels. Thus EQ1a refers to the extent to which final beneficiaries' needs are reflected in UNFPA assistance.

Assumptions contained therein is that the needs of these groups have been identified, were well taken into account at the time of programme planning, and is responsive to changes during implementation from 2011 onwards. The sources of information and baseline data identified in the UNDAF 2011-2015 and the CPD5 2011-2015 are the Maldives Demographic and Health Survey (DHS) 2009 and the Behavioral and Biological Survey (BBS) 2008, indicating that the needs of the target population were taken into account in the programme inception stages. Although it may be argued that fundamental issues, such as unmet need for family planning, will remain a challenge throughout the Country Programme, the CP Evaluation guidelines<sup>2</sup> emphasise the need to check the *continuous* correspondence between programme objectives and evolving needs. In the case of this evaluation, there has not been any data (or any explicit references to data) to indicate whether or not the needs have evolved making it difficult to confirm that UNFPA assistance towards the needs of the final beneficiaries *remains* relevant.

#### 4.1.2 Alignment with national priorities

*Evaluation Question 1b* refers to the alignment of UNFPA priorities to Government priorities. UNFPA priorities on SRH issues as stated in the CPD 2011-2015<sup>9</sup> appear to be generally well-aligned with the National Reproductive Health Strategy 2014-2018<sup>xv</sup> in that they both aim to provide SRH information and equitable services to men, women, and young people. This is a stark difference to the Health Master Plan 2006 – 2015 that ignored the curative aspects of SRH needs among youth and instead focused only on providing information.<sup>xvi</sup>

However, interview data suggests that while such an alignment is common on paper, it does not necessarily translate into action in terms of financial and human resource allocation. The figure below shows that it is not a matter of inability to commit financial resources; government implementation (i.e., expenditure of funds provided by UNFPA) is extremely low, especially in comparison to the previous country programme.



**Figure 1: Comparison of UNFPA and Government implementation rates for CP4 (2008-2010) and CP5 (2011-2013)**

#### 4.1.3 Responsive to changing priorities and contexts

*Evaluation Question 1c* emphasises the evolving nature of developmental contexts and national priorities and the ability of the UNFPA to respond to those. As noted in Chapter 3 Country Context, two notable shifts in context have had an effect on UNDAF achievements and UNFPA Country Programme implementation, particularly in the reproductive health and rights component.

Firstly, the Decentralisation Act 2010 introduced by the 2008 Government as well as the privatization process of 2009 brought about a major overhaul to the health sector. The UNFPA response to these involved providing assistance in CP5 under a dedicated strategy (Strategy 2: Policy development in reproductive health to support the role of the Ministry of Health and Family with regard to decentralization, privatization and emergency preparedness in the health sector). However, following the unforeseen change in government in February 2012, these policies on decentralisation and privatisation were reversed and further changes including financing health services and health insurance were implemented.<sup>10</sup> UNFPA assistance by then was in the face of diminishing technical capacity as a result of the newly introduced redundancy packages.<sup>11</sup>

UNFPA response included the Mid-year Review of the UNDAF Action Plan in mid-2012, and realignment of the Maldives CPD to the UNFPA Revised Strategic Plan. These included “strengthening of the health system by identifying gaps, orienting

and training health workers, allocating limited resources more efficiently, and monitoring needs and outcomes can contribute to mitigate tensions caused by inadequate and unequal services. Improvements to the targeting system to better identify vulnerable and marginalised groups, including women and expatriate migrant workers, can help adjust priorities and service provision” (p.5)<sup>11</sup>

Secondly, the country’s graduation from a Least Developed Country (LDC) to a Middle Income Country (MIC) required UNFPA to again adapt as it led to further changes in the programming environment.<sup>6</sup> Though expected to transition to upstream policy advocacy activities from service-level downstream work, the UNFPA continues to focus on a combination of upstream and downstream activities. This appears to not only suit the Maldivian context where many of the systems expected of an MIC are absent, but appreciated by IPs that continue to rely heavily on UNFPA assistance in the absence of adequate government funding for SRH.

## 4.2 Effectiveness

**Evaluation Question 2:** To what extent:

- (a) did UNFPA supported interventions contribute (or are likely to contribute) to sustainably improve access to high-quality SRH services and information, particularly in underserved areas, with a focus on young people and vulnerable groups?
- (b) are population data taken into account to inform such activities?

*Evaluation Question 2a* aims to assess the degree of achievement of the outputs as well as if and how this has contributed (or is likely to contribute) to the achievement of outcomes as set in the CPD. The first part of this section presents this analysis, including a review of the breadth and depth of outputs including contextual factors that may have affected this impact. Secondly, as requested in the ToR, this evaluation includes a comparison of UNDAF/CPD strategies to the strategic direction outlined in the UNFPA Strategic Plan 2014-2017 with a view to recommend strategies for the next UNDAF/CPD.

Activities for the Reproductive Health and Rights component for CP5 were directed towards achieving the outcome “Improved access to quality sexual and reproductive health services and information for women, men and adolescents, including poor and vulnerable groups, at both national and local governance levels” (p.6)<sup>9</sup> guided by two outputs:

*RH Output 1: Strengthened capacity of Ministry of Health and Family, sub-national level governments and civil society organisations to plan and deliver high-quality and equitable RH services and information, including responses to emerging issues in Maldives*

*RH Output 2: Improved access of young people of SRH services and information in Male’ and on selected islands*

Additionally, one output from the Gender Equality component of the CP5 is also considered to be a part of UNFPA assistance on SRH.

*Gender Output 3: A strengthened national response, including by the health sector, to violence against women and girls, taking into account linkages to protection and legal services*

#### 4.2.1 RH Output 1

This output refers to UNFPA assistance aimed towards strengthening the capacity of the health system including governmental and civil partners in providing RH services and information at national and regional levels. It appears to be a continuation of work towards outputs from CP4 RH Output 1 “*Enhanced capacity of the national health system to deliver high-quality, integrated and comprehensive reproductive health services.*”<sup>xvii</sup> The strategies guiding RH Output 1 are:

Strategy 1: Developing a knowledge base on emerging SRH issues, such as declining contraceptive use and increasing adolescent pregnancy, through research and surveys

Strategy 2: Policy development in reproductive health to support the role of the Ministry of Health and Family with regard to decentralization, privatization and emergency preparedness in the health sector

Strategy 3: Strengthening the capacity of civil society organizations to provide sexual and reproductive health information and services, including for migrant populations

Strategy 4: Strengthening the capacity for reproductive health commodity security, including the expanded use of the Logistics Management Information System (LMIS)

Strategy 5: Strengthen the capacity to develop and implement an evidence-based behaviour change communication strategy to revitalize family planning efforts

With the Ministry of Health (MOH) as the main Implementing Partner (IP), implementation was often compromised by several challenges caused by drastic changes to health system, MOH priorities, and MOH personnel.

Strategy 2 regarding supporting MOH to implement decentralisation and privatisation of health services is one component that was adjusted mid-cycle due to the change in government in 2012. Adjusting to a decentralised health system was a major overhaul in terms of public health programming, staff, and public trust issues, and the assistance of UNFPA and WHO was gratefully noted by health sector personnel. The new government of 2012 no longer supported the decentralisation and privatisation policy and the subsequent re-centralisation caused major upset within the health system and the assistance environment.<sup>10</sup> Moreover, the redundancy packages offered attracted much of the technical personnel from the healthy system, further deteriorating the IPs ability to implement the planned activities.<sup>11</sup> One of the major constraints faced

by UNFPA in 2012 was the fact that there was just one technical staff at MOH tasked with overseeing the national reproductive health program as well as other programs with other donor agencies.<sup>xviii</sup>

One main activity that is noted as a success by both the UNFPA and IPs is the cervical cancer screening programme tenuously linked to Strategy 1: *Developing a knowledge base on emerging SRH issues, such as declining contraceptive use and increasing adolescent pregnancy, through research and surveys*. Although its links to this overarching strategy is unclear in that there is no explicit reference to data that led to cervical cancer being identified as a prominent and emerging SRH issue prevailing over others, the subsequent stages were by the book- a situational analysis was conducted, advocacy completed and government support confirmed by 2012 and guidelines developed, personnel trained and service piloted in 2013.<sup>xix</sup>

The cancer-screening programme overtook two other activities under Strategy 1, both of which were commenced earlier and seem to have much stronger links to this Strategy on developing a knowledge base on emerging SRH issues. The first was a study entitled *Reproductive Health Knowledge and Behaviour Among Unmarried Young Women in Maldives*, which had been compiled prior to 2011 and was awaiting approval and release. The report was finalised in 2011, sent to Ministries in 2012, officially released in 2013<sup>19</sup>- extremely slow progress, especially compared to the Screening Programme. Similarly, the Functional Analysis of health systems saw little progress despite being an activity that could yield ample data on the roles, functions and workloads of RH personnel.<sup>xx</sup> Although data collection was completed prior to 2011, the activity stalled at data cleaning phase after the Ministry of Health was restructured and the Decision Support Unit dissolved in 2012.<sup>20</sup> UNFPA's efforts to revive it by repeatedly facilitating consultancies were unsuccessful as the IP added further demands to the deliverables and the data and consultant became inaccessible.<sup>7</sup>

The establishment of the Logistics Management Information System (LMIS) (Strategy 4) is appears to be near completion but it has its roots in CP4, the evaluation for which noted that it had been functional by 2010.<sup>17</sup> According to interview data, LMIS soon encountered technical issues that have not been resolved because the source code could not be retrieved as it remained under the ownership of the consultant, and not the Ministry of Health. This reasoning is nearly as trivial as the Functional Analysis stalling because the consultant lost the data and report - the susceptibility of key, costly, and potentially sustainable activities to such avoidable and trivial obstacles, mostly to do with ownership, warrants attention in programme planning stages.

Strategies 3 and 5 are discussed in section 4.2.3 RH Outcome achievements given how they are linked much more directly to the output indicators.

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<sup>7</sup> Narrative from documents and interviews report the consultant claiming the data, analyses and reports were lost in a lightning incident.

#### 4.2.2 RH Output 2

RH Output 2 reflects a prioritization of young people and the need to provide them with SRH services and information. It is a continuation of work from CP4 RH Output 3 *Improved access to reproductive health information and services for young people*.<sup>17</sup> The strategies to achieve this output are<sup>9</sup>:

Strategy 6: Develop a health strategy for youth that includes access to RH services and information, with the participation of young people

Strategy 7: Strengthen the capacity of the youth centres in Male' and on selected islands to provide life-skills education, counselling and youth-friendly sexual and reproductive health information, including on HIV/AIDS, violence against women and girls, and other gender issues

Strategy 8: Strengthen the capacity of the health sector to provide youth-friendly health and RH services in Male' and on selected islands, including through school health settings

The main implementing partner for this output was the Ministry of Human Resources, Youth and Sports who underwent a mandate change following the transfer of power in February 2012, consequently named the Ministry of Youth and Sports. A major detrimental factor affecting this partnership was reported to be the high turnover rate of key technical staff spearheading the interventions, burdening less familiar staff that remained.<sup>xxi</sup> Despite the loss of institutional memory, interview data shows that longstanding conflicts between UNFPA and this IP (incurred during the joint venture Youth Health Café) negatively affect this partnership. Signing of the Annual Work Plan was delayed in 2011<sup>21</sup> as well as in 2012 (due to unspecified challenges), which affected implementation.<sup>xxii</sup>

Although the development of the Youth Health Strategy (YHS) under Strategy 6 had been completed during CP4, it remained in the commenting phase throughout 2011.<sup>21</sup> It was revived in high-level policy discussions in 2012 as a result of strong advocacy efforts by UNFPA,<sup>22</sup> and stalled just short of endorsement in 2013 due to political instability and lack of government ownership.<sup>xxiii</sup> The UNFPA attributes the stagnation of the Youth Health Strategy in 2013 to lack of commitment and absence of a champion at MHRYS<sup>23</sup>- it is also worth noting that the UNFPA themselves lost the Program Officer for Youth/HIV AIDS in 2012 and chose to divide the youth portfolio to remaining programme staff.<sup>22</sup> Thus it appears that the pressure required to advocate the YHS was not maintained from either UNFPA or MHRYS.

Strategy 7 to strengthen the capacity of youth centers to provide SRH information and services included developing Standards for Youth-Friendly Health Services and to link this with national standards and guidelines for minimum service packages (for ASRH services) at various levels of healthcare facilities. These, along with a background paper on current health service provision and utilisation by young people, were completed by early 2013 but remained at endorsement phase throughout 2013. Regarding strengthening youth centers, document review shows a lot of support being directed to the existing Youth Health Café in Male'<sup>xxiv,25</sup> with which UNFPA has had a longstanding ineffectual partnership from previous Country Programmes

including UNFPA phasing out their support in CP4. The challenges that made this partnership ineffectual include operational difficulties such as the YHC property being vulnerable to vandalism- as there is no evidence these challenges will not reoccur, it seems inefficient to resume UNFPA assistance to this activity.

Upon examining Strategy 7 at the activity-level, it appears that unlike Strategy 6, Strategy 7 included a mixture of activities that do not seem to be linked or aligned towards one strategy, i.e. to strengthen the capacity of youth centers. Apart from reviving support to the YHC, several activities involved supporting IPs in one-off instances (such as Youth Day) and training workshops.<sup>25</sup> These activities with low sustainability are somewhat balanced by integration of ASRH component into the NGO Democracy House Leadership programme and supporting the NGO SHE efforts for information and service provision.<sup>25</sup> However, it has to be highlighted that both of these are CSOs, the support for whom has been prioritized under Strategy 3. Though some blurring and overlap between Strategies is expected in practice, this instance shows that support to CSOs was duplicated and that this was at the expense (in terms of time, funds, and attention) of support to strengthen youth centers.

Strategy 8 pursuing provision of youth friendly SRH services reportedly encountered active and passive resistance in 2013.<sup>23</sup> An alternative route to achieving the output was devised in collaboration with the IP for this strategy, the Centre for Community Health and Disease Control to develop national guidelines for youth friendly services and service delivery packages for each level of health service delivery.<sup>21</sup> Under a lead role by the CCHDC (by then called the Health Protection Agency) the guideline was finalized and ready for political endorsement by 2013.<sup>23</sup>

The broad phrasing of Strategy 8 subsumes (and hides) the majority (if not all) of key activities undertaken in the education sector with regard to SRH. In contrast to the high staff turnover in Health and Gender IPs, key personnel at Education have mostly remained the same. Possibly as a result, the main challenge remains the same- lack of consensus on how to deliver SRH information in schools in the Maldivian context, beginning with disagreement on calling SRH 'Life Skills Education'. Although the latter is no doubt more palatable in this society, assessing effectiveness of life skills education is often misleading because the typical indicator used involves counting the number of workshops and trainings, both of which are unsustainable downstream activities that may be conducted at a large volume without adequate monitoring of their results and impact.

One activity is the integration of life skills education into the school curriculum- the approach to incorporate life skills into the curriculum is the most recent from trials and errors by UNFPA to address the gap in sexuality education in the country since previous country programmes.<sup>17</sup> Although concept paper and resource material development were implemented on track in 2011, this activity stalled in 2012<sup>22</sup> (reportedly during the political instability), and again in 2013 due to difficulties with hiring an international consultant to integrate LSE into curriculum.<sup>xxv</sup> Eventually a consultant was sourced to examine the extent of comprehensive sexuality education content in the new curriculum- the results

highlighted several gaps in Life Skills sessions where SRH-specific lessons were possible and pertinent.<sup>xxvi</sup>

Similarly, the second main activity in the education sector- integrating Life Skills Education training into training modules at the Maldives National University- has the potential to have a sustainable and broad impact in that it trained trainee teachers to deliver Life Skills Education. Following several meetings, UNFPA was assured that Life Skill Education modules had been adapted to their needs and integrated- this remains to be verified and the extent of integrating SRH components checked.

### 4.2.3 Gender Output 3

Despite being under the Gender Equality component, Gender Output 3 is included in this evaluation because gender-based and sexual violence is considered a part of sexual and reproductive health. The strategies to achieve Gender Output 3 *a strengthened national response, including by the health sector, to violence against women and girls, taking into account linkages to protection and legal services* are

Strategy 9: Operationalising the national action plan on violence against women and girls

Strategy 10: Establishing a comprehensive mechanism to ensure systematic protection, aftercare and reintegration services for female victims of violence

Strategy 11: Building the capacity of the health sector to respond to gender-based violence by strengthening training, screening, and data management and developing national guidelines and standard operating procedures on clinical management of rape

A recurring challenge with this component involved the ever-changing composition of implementing partners, of which were sometimes many. The main IP for this output in 2011 was Department of Gender and Family Protection Services.<sup>xxvii</sup> By the time the Gender AWP in 2012 was signed, it was with the Ministry of Gender, Family and Human Rights and the G3 Output required collaboration with other partners, particularly with the newly-formed Family Protection Authority (FPA)- as a result, activities for this output was at one point overseen by 3 project directors.<sup>xxviii</sup> In 2013, activities under this output had to be distributed among many AWPS signed with different IPs and thus implementation required a lot of coordination- this had to be undertaken by UNFPA because the capacity was absent in the FPA, the agency mandated to oversee the implementation of the DV Act.<sup>xxix</sup>

The main activity under Strategy 9 was the establishment and rollout of the Domestic Violence Act. The DV Bill had been drafted in 2010 but required much lobbying before it was sent to the Majlis in 2011, and enacted in 2012. Narrative in reports suggests this strategy was very time-consuming (most of 2012)<sup>xxx</sup> as it required constant advocacy and coordination between the numerous IPs. This, in turn, is attributed to limited human and financial resources at the FPA, thus requiring UNFPA assistance in terms of funds and multisectoral coordination.



Interview data shows that the additional work of advocating the DV Act in the face of unreceptive attitudes among the implementing partners in law enforcement and the judiciary contributed to the lengthy duration of implementing the DV Act.

Sensitizing and trainings on implementing the DV Act was undertaken mostly under Strategy 10 on establishing comprehensive mechanism to ensure systematic protection, aftercare and reintegration services for female victims of violence. Although much of the work on this strategy was dependent on the DV Act (there were existing guidelines and SOPs for shelter, but they lacked the policy support)<sup>28</sup> and thus did not gain momentum until 2012, beginning with multisectoral training and sensitization for IPs.<sup>28</sup> At end of 2013, there does not appear to be a functional mechanism to ensure systematic protection or services for victims of violence, and the UNFPA reports continued advocacy for the newly-formed FPA to prioritise establishing referral mechanisms and less on service provision.

Strategy 11 on building the capacity of the health sector to respond to GBV serving to bridge the gap between GBV and public health saw little progress until 2013.<sup>20</sup> This included the activity on developing SOPs on the clinical management of rape, the implementation for which had been planned every year (2011, 2012, and 2013).<sup>29</sup> From 2013 onwards, activities proceeded swiftly- not only were the guidelines and national action plan (on health sector response to GBV) developed and endorsed but health personnel were trained to implement them.<sup>29</sup> Additional activities such as high-level discussions to strengthen the Family Protection Unit (under the Maldives Police Service management) and to integrate domestic violence into the child protection database were also implemented<sup>29</sup> and if maintained, have the potential for a broad and sustainable impact.

#### **4.2.4 Overall achievement of SRH interventions**

The table below outlines indicators for each output and their status at the end of the evaluation period (2011-2013).<sup>8</sup>

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<sup>8</sup> A more detailed table of output indicators noting annual achievements (to indicate pace of progress) is given in Annex 7

**Table 1: Output indicators and status**

<b>RH1 Output Indicators</b>	<b>Status</b>
1) Strategic National Action Plan on Disaster Risk Reduction and Climate Change incorporates reproductive health and gender issues. Baseline: none; 2015 Target: issues incorporated into strategic national action plan	Not likely to be achieved
2) Number of subnational governments with NGOs and CSOs providing information and services on reproductive health and rights. Baseline: 0; 2015 Target: 6	Partially achieved
3) Computer-based logistics management information system is in place at national and subnational levels. Baseline: no system in place; 2015 Target: system in place	Not achieved yet
4) Behaviour change communication strategy for family planning developed and implemented. Baseline: no strategy; 2015 Target: strategy developed and implemented	Achieved
<b>RH2 Output Indicators</b>	<b>Status</b>
5) Health strategy for youth is approved and implemented. Baseline: no strategy approved; Target: strategy approved and implemented	Partially achieved and on track
6) Number of youth centers in Male and selected islands offering life skills education. BL: 1; Target 5	Not achieved yet
7) Number of health facilities in Male and selected islands providing youth-friendly health services. 2010 BL: 1; 2015 Target: 5	Not achieved yet
<b>G3 Output Indicators</b>	<b>Status</b>
8) Number of women and girls affected by violence accessing health and protection service. 2009 BL: 183; Target 275	Achieved
9) Number of shelters operational and used by female victims of violence 2010 BL: 0; Target 2	Partly achieved
10) Gender-based violence incorporated in the training curriculum for relevant categories of health care providers. BL None; Target: Yes	Partially achieved and on track
11) Existence of guidelines and standard operating procedures on clinical management of rape. Baseline: none; Target: established.	Partially achieved and on track

One of the most striking features of this table is that the vast volume of activities discussed in the preceding section is not captured by the corresponding output indicators. For example, achievements in the cervical cancer screening programme and establishment of the DV Act are not reflected in any output indicators. This indicates a weakness in formulating indicators, an aspect that was found to be weak even in the CP4 Evaluation.<sup>17</sup> It also indicates a weakness in mid-year planning and implementing results-oriented interventions- in other words, a tendency to introduce interventions that are not aligned with the country programme outputs and indicators. As the preceding sections have shown, implementation often tends to be slow and time-consuming, and the interview data indicates that much of this time is spent in advocating for government attention and coordination among implementing partners. This would show (and has been shown as) a lack of progress and stagnation in SPRs, and might be prompting previously unplanned activities that do not necessarily contribute to output indicators.

Among the four indicators of RH Output 1, one appears to be near completion, and one fully achieved. The achieved Indicator 4 on implementing the Behaviour Change Communication (BCC) strategy (Strategy 5) was developed and verified by stakeholders by 2011, and is being currently implemented. However, it is worth noting that the 4<sup>th</sup> CPE reports that BCC was given priority in the CP3 2003-2007 before being further pursued in the CP4 2008-2010. Despite this late achievement, this output is likely to have a broad impact given how activities implemented include dissemination of print material, 3 TV programs, and 2 radio programs by 2011 (including some activities under the 7 Billion campaigns),<sup>xxxii</sup> as well as a drama series promoting the ICPD agenda by 2013.<sup>30</sup> The breadth and depth of this output is yet to be investigated, depending on the availability of data on the materials' dissemination and viewers' feedback. Nonetheless, achievements regarding the BCC Strategy cannot be wholly attributed to this programme cycle, and reflects the pace of implementation that should be taken into consideration for the next Country Programme.

The indicator near completion is regarding mobilisation of NGOs and CBOs to provide SRH information and services to youth. Although partnerships with NGOs were attempted during CP4 as an outreach effort, only one partnership was established with an NGO with little experience in RH and RR issues.<sup>17</sup> Thus the process of identifying CSOs for partnership via thorough selection process was begun in 2011,<sup>31</sup> 4 NGOs trained and mobilized (all 4 to provide SRH information in Male' and islands, 1 also providing services in Male') by 2012.<sup>18</sup> However, SPR 2013 indicates that the number of active CSOs dropped to 3 in 2013, leaving 1 providing services and 2 providing information.<sup>19</sup> Interview data indicates that this slight regression is a result of UNFPA's inability to actively prod and guide all the civil partners into action, as is reportedly required. From an evaluators perspective of the broader picture, this regression of one well-paced indicator coincided with the timeframe UNFPA pursued the cervical cancer screening programme indicating that a human resource issue is possible. Although it may have been too ambitious to target service provision by CSOs, this intervention is a good example of a CP5-bound output with broad impact (as it reached underserved island communities) contributing to the RH outcome.

In contrast to RH Output 1, all 3 indicators for RH Output 2 were clearly defined allowing easy monitoring, and explicitly linked to each of the 3 strategies enabling easy alignment of activities towards output achievement. The Youth

Health Strategy indicator appears to be achieved, though it cannot be counted as a planned success of CP5 given how it was developed prior to 2011.<sup>17</sup> The target for the indicator on number of health facilities in Male' and selected islands providing youth-friendly health services may be unambiguously assessed as incomplete. This is because the development of national standards for youth friendly services, no matter how pertinent, is but one of many steps towards establishing that service provision.

Regarding the Gender Output 3 indicators, the activities on establishing and advocating the DV Act are not captured in the current indicators- instead two of the indicators count the number of cases and shelters.<sup>27</sup> A revision was suggested in SPR 2012 to reflect establishment of mechanisms at protection, service provision and aftercare stages<sup>28</sup>- this would have been a very positive revision but the suggested revisions do not appear to have taken effect. Nonetheless, current indicators of counting the number of GBV cases presented at health services show the target has been achieved. The second indicator is partly achieved because shelters, though established, were not confirmed to be operational at the time of the evaluation.<sup>30</sup> Indicators 10 and 11 on instating guidelines and training modules on GBV are both at approval stage and are expected to be completed by 2015.

Overall, the effectiveness assessment indicates that neither of the two RH outputs (2 of 4 targets met for RH Output 1; 1 of 3 targets met for RH Output 2) or the relevant Gender output (1 of 4 targets met) have been completed and that as a result, the desired outcome for the RH thematic area for CP5 has not been achieved yet.

#### **4.2.5 Alignment with UNFPA Strategic Plan 2014-17**

The main purpose of this evaluation is to inform upcoming strategies such as the next UNDAF and CPD by comparing the effectiveness of current strategies to the strategic direction of the UNFPA Strategic Plan 2014-17. Upon comparison of SRH-relevant strategies, there appears to be intra-agency congruence within UNFPA in that the CPD 2011-2015, UNDAF 2011-2015, and the SRH 5 Year Implementation Plan are well aligned, and are within the bounds and priorities set out in the Strategic Plan 2014-2017.

#### **4.2.6 Evidence-based advocacy**

Evaluation Question 2b is assessed against the presence of strengthened national policies and international development agendas through integrated evidence-based advocacy and policy dialogue. As discussed in EQ1a, present relevance of UNFPA activities to the needs of the population is difficult to ascertain in the absence of grassroots data in identifying and monitoring these needs. Oftentimes, emerging issues are based on anecdotal reports that do not provide adequate clout for UNFPA to advocate further investigation or policy attention.

Examples of issues that did not get any traction include reports of FGM and abortion. Conversely, cervical cancer is an issue that was advocated successfully and gained governmental support, beginning with situational analysis to ascertain its prevalence. However, advocates do recognize that this success may be partly attributed to the cervical cancer screening activity having its roots in

government’s political manifesto and not having cultural sensitivities like FGM and abortion. Yet again contradictorily, advocacy for the Domestic Violence Act was expected to be an arduous process but instead was swiftly approved. Based on these, it may be helpful to recognize that the absence of high-quality data exposes emerging issues to political manipulation, and that this is especially true for SRH issues that are considered to be culturally sensitive.

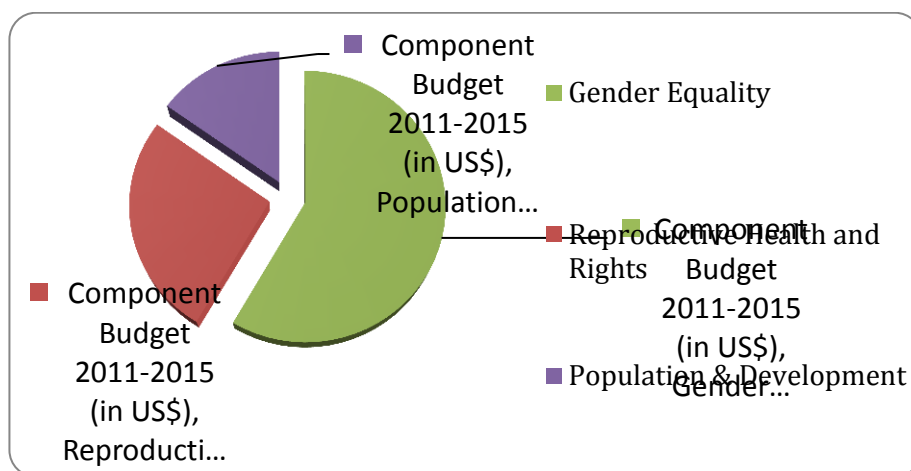
### 4.3 Efficiency

**Evaluation Question 3:** To what extent:

- (a) has UNFPA made good use of its human, financial and technical resources in pursuing the achievement of outcomes defined in the country programme?
- (b) did the intervention mechanism of working in partnership foster or hinder the achievement of the programme outputs?

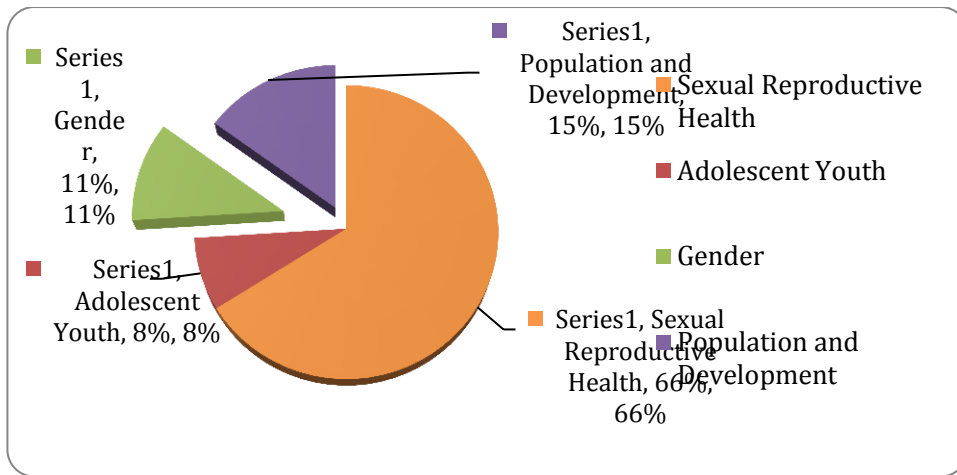
#### 4.3.1 Financial resources

The efficiency assessment is about whether or not UNFPA made good use of its financial resources to pursue the SRH outcomes of CP5- *“improved access to high-quality sexual and reproductive health services and information for women, men and adolescents, including poor and vulnerable groups, at national and subnational levels.”* The figure below depicts the share of the total CP5 budget allocated to SRH interventions. The Gender Equality component working towards the outcome *“the institutional capacity of government bodies and the community is strengthened to address gender issues for the full realization of the rights of women and girls”* had more funds allocated than the other components combined, with little justification in CPD5 regarding this distribution.<sup>9</sup>



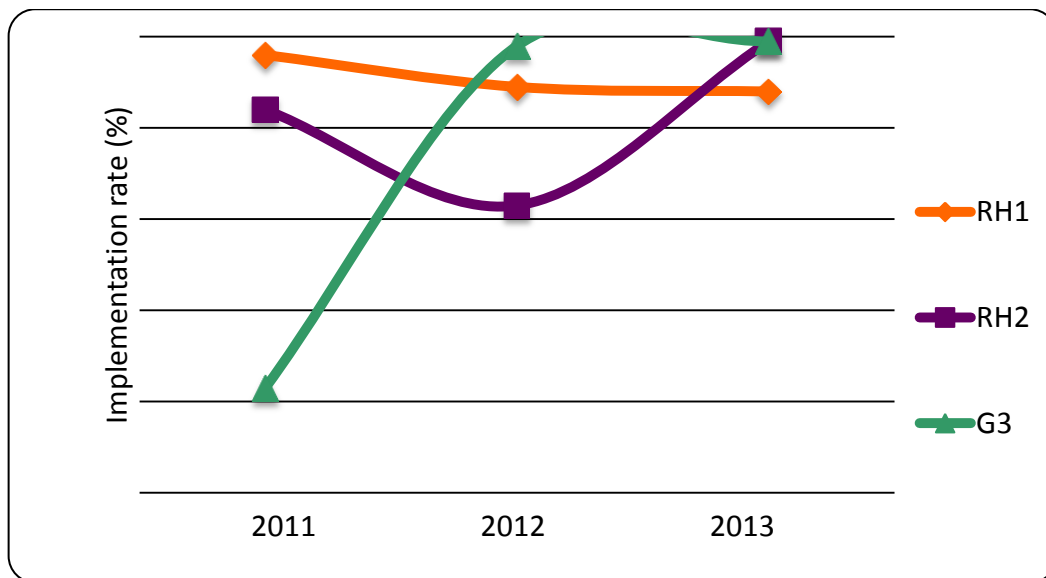
**Figure 2: Budget allocation by component in CPD5 2011-2015 (in US\$ millions)**

The realignment of priorities in light of the new Strategic Plan of the UNFPA brought about the following changes to resource distribution.



**Figure 3: Budget distribution by component following realignment to UNFPA Strategic Plan 2014-2017 for 2014-2015 (%)**

As at the end of 2013, USD789, 629 had been spent on SRH interventions. The implementation rate for each of the outputs relevant to this evaluation for the years 2011, 2012, and 2013 are shown below.



**Figure 4: Implementation rate by year and output (%)**

As the figure shows, implementation rate is generally very high, except for Gender Output 3 in 2011. As the Standard Progress Report for G3 indicated, little else was done for that work apart from lobbying for progress on the Domestic Violence Bill.<sup>27</sup> It is worth noting that implementation rate is calculated as the proportion of funds spent out of the final revised budget for the output that year. It appears that the final budget, revised at a quarterly review, used in the calculation is often significantly different to the initially allocated amount—meaning that implementation rates may not be as pleasantly high as shown in the above figure if they were calculated based on initially allocated budget. Moreover, major revisions to budget after commencing the output interventions could be indicating funds being redeployed to ad-hoc activities or to other planned activities within the year, or to the same activity postponed to following

years- all of these possibilities indicate weakness in programme planning and budget allocation during CP5 development.

#### 4.3.2 Human resources

The UNFPA CO currently employs 4 support staff and 3 professional staff. The senior-most 2 professional staff wear several 'hats' - the International Programme Coordinator oversees the Population and Development programmatic component of CP5, and the Assistant Representative oversees the Gender component. A Program Officer was employed to oversee the Reproductive Health and Rights portfolio, though this position was vacated during this evaluation.

Until 2011, a Program Officer for Youth/HIV AIDS had been employed to pursue youth-related interventions (mainly RH Output 2) but after her resignation in early 2012,<sup>22</sup> the position was abolished since the position was linked to a specific pocket of funding that became depleted. The youth portfolio was then divided by sector- youth health interventions was assigned to the RH Officer, and education-based interventions to the Gender Officer. It was noted in the Standard Progress Report for the following year (2013) that youth initiatives were implemented sector-wise (i.e., health and education separately) and was no longer a comprehensive response.<sup>23</sup> Corroborated by interview data, it appears that the lack of dedicated personnel for Youth interventions detracted from the focus and pressure needed to progress in this output. This is evidenced by the drop in implementation rate in 2012 for RH2 (see Figure 4 above) and stagnation of YHS in the advocacy and endorsement stages in 2013.<sup>23</sup>

On the other hand, an argument could be made against the necessity of a dedicated youth officer because human resource constraints hindrances are usually found in IPs- if they do not invest in the dedicated personnel, progress in activities would still be slowed down. However, both interview and documentary evidence suggests that UNFPA remains the driving force in SRH interventions- thus, instead of slowing to match implementing partners' pace, it would increase efficiency of UNFPA output to employ priority-specific (in this case, Youth-specific) technical staff to maintain pressure on IPs.

Other issues that need to be addressed in order to improve the efficiency of human resources in the UNFPA CO include the need for prompt decision-making (which may be impaired by the Country Director being non-resident) to minimise the deliberation period regarding IP requests. Interview data also indicates that more transparency and involvement of staff in planning phases to encourage ideas and approaches will improve cohesion within the team and consistency in dealing with IPs.

#### 4.3.3 Partnerships

*Evaluation Question 3b* refers to the efficiency of partnerships between UNFPA and implementing bodies in the pursuit of results targeted in the RH component outcome and outputs. This assessment primarily draws on qualitative key informant interview data gathered from a list of stakeholders compiled in consultation with UNFPA. Though the interviews proved insightful

and frank, not all information was verifiable. What is presented here is an analysis of data triangulated with multiple data points organised into issues that have affected partnerships.

Narratives from implementing partners indicate that there are three main hindrances to their partnership with UNFPA.

UNFPA is perceived to approach from a position of power- in terms of technical expertise and resource allocation. This aspect seems to be rooted in a mismatch between counterparts- UNFPA has few but primarily technical staff that are paired with implementation level counterparts who do not have the power to influence decisions as required by UNFPA.

IPs perceive that they are held to unrealistic expectations in terms of navigating culturally sensitive issues in the absence of institutional support or protection

Government partners perceive that their needs are not reflected in collaborative activities with the UNFPA, and do not find them amenable to negotiations or compromise. It is worth noting that civil society organisations do not find this to be the case with their collaboration with UNFPA

From the perspective of UNFPA, there are three factors that affect their partnership with implementing partners.

UNFPA perceives that the role they are commonly required to play is that of a gap-filler in meeting funding shortages for unplanned activities.

UNFPA finds that the lack of ownership from government partners hinders the progress and sustainability of their interventions.

UNFPA finds the weaknesses of civil society result in parallel and sometimes duplicate activities with government partners

Regarding UNFPA partnership with other UN agencies, analyses of documentary and interview data from UNFPA, WHO, UNICEF, UNDP, and UN Women (agencies relevant to the SRH component) revealed two negative consequences resulting from the current state of uncoordinated partnership- overutilization and fatigue among CSOs, and duplication of work. The general consensus was that the Delivering as One approach had not been implemented during 2011-2013. Lack of coordination was highlighted by all 5 UN agencies as a prominent feature of their collaborative activities, and this was largely attributed to lack of leadership from the Resident Coordinators Office. Interview data indicates that the HIV Thematic Group and Gender Thematic Group met very infrequently, though the latter group is reported to have worked well, facilitating the only noted point of collaboration- the issue of gender-based violence (GBV).

Collaboration on GBV activities included assistance for commemorating the 16 Days of Activism against Gender Violence and the Gender Advocacy Working Group. It was noted by interviewees that the collaboration largely constituted parallel pooling of funds- this was differentiated from providing joint funding as this was reportedly extremely difficult given the differing financial systems between UN agencies. As a result, the already short-staffed CSOs mandated with implementing GBV activities receive different pots of funds from various UN



agencies and struggle to implement and disperse the funds. This highlights the first negative consequence of current collaborative efforts of UN agencies- the need to involve civil society organisations although they have been recognized as weak (limited capacity among few personnel), combined with the shortage of CSOs who are willing and active leads to overutilization and fatigue among the CSOs.

This is not dissimilar to instances where government IPs also receive various pots of funds from the different UN agencies to implement similar activities (none of which IPs would decline, given their own funding shortages)- this then leads to UN agencies vying for the IP's attention at the year's end, in order for their activities and funds to be dispersed. While overlapping mandates is not a problem in principle, the absence of coordination has led to duplication of activities- the second negative consequence of limited coordination among UN agencies. The trainings conducted to sensitise the police and the judiciary to facilitate the rolling out of the Domestic Violence Act was noted by both parties- UNFPA and UNDP- as an instance of duplication. Until UNFPA ceased their trainings following their mid-term review, both sets of training were conducted throughout the country, and sometimes in the same atoll. Similarly, the development of the RH Strategy was attempted twice by UNFPA and later redone with WHO, with both agencies reporting that collaboration from the beginning might have saved the time and funds.

The afore-mentioned negative consequences- duplication and fatigue among IPs- resulting from the lack of coordination between UN agencies cannot be attributed to UNFPA alone. In fact, in both instances of duplication, UNFPA is credited as the agency opting out or seeking collaboration. Moreover, UNFPA has successfully coordinated with UNICEF in their approach to deliver sexuality education by delineating and identifying their responsibility to be integration of Life Skills into the curriculum while UNICEF (and UNODC, now absent) worked on filling the gaps such as developing training manuals. The chapter on Recommendations discusses the opportunities for effective partnerships with other UN agencies.

#### 4.4 Sustainability

**Evaluation Question 4:** To what extent has UNFPA been able to support its partners and the beneficiaries in developing capacities and establishing mechanisms to ensure ownership and the durability of effects?

Evaluation Question 4 is regarding checking the extent to which “the benefits of the country programme likely to continue beyond the programme completion.”<sup>2</sup> Compared to the previous Country Programme, relatively fewer one-off activities were undertaken or supported by UNFPA since the 4<sup>th</sup> CPE. It is worth noting that this is in spite of continuous requests from Government IPs to bridge their funding shortages to conduct trainings and producing print materials.

Strategy 1 on developing a knowledge base on emerging SRH issues did not prioritise activities that tapped into routinely collected data in order to regularly and systematically monitor data on SRH needs and emerging issues. Strategy 2 on providing technical assistance for RH policy development at MOH was

susceptible to political context and had not identified that risk despite politically volatile times.<sup>18</sup> Strategy 3 to strengthen the capacity of CSOs to provide SRH information and services proved unsustainable, as they required technical handholding, funding assistance, and vigilance by UNFPA to keep them active. Strategy 4 on establishing LMIS has the potential to be sustainable if expanded use can be encouraged.<sup>9</sup> Strategy 5 on strengthening (who's?) capacity to maintain a BCC strategy does not appear to be sustainable as it is unclear who will take ownership of the intervention and ensure relevance of the strategy.

Regarding strategies for RH Output 2, Strategy 6 on developing a Youth Health Strategy appears to have incorporated sustainable factors such as government endorsement, however difficult it may be to reach that phase. Similarly, Strategy 8 on instating national standards for youth friendly service provision requires government endorsement and has been led by the IP.

With the sustainability assessment, however, it is worth recognizing the difficulties in focusing on sustainable activities in a country context that has been in flux as the Maldives. The loss of technical capacity as a result of the redundancy package introduced mid-cycle would have necessitated assistance to re-build the capacity UNFPA had assisted with in previous years. Moreover, changes in the health sector infrastructure would require assistance to acclimatize remaining health personnel with new procedures. And lastly, the changes in government would have introduced (and reintroduced) new priorities and new policy-level decision-makers which demand repetitive efforts by UNFPA to build partnerships and advocate policy attention.

## 5 Conclusions

The overall performance of the UNFPA with regard to their SRH interventions needs to be considered within the context of the major changes in the country context, particularly the health sector. The **relevance** of UNFPA interventions had to be continuously adjusted to align with 3 different governments (and subsequent policy directions) during the first 3 years of the programme cycle. The **effectiveness** and implementation of the interventions was heavily dependent on IP personnel, which suffered great losses as a result of redundancy processes. The **efficiency** of UNFPA resource allocation, though least affected, included diversion of funds and human resources to cover for diminishing commitment of the same from implementing partners. And lastly, the efforts to focus on **sustainable** interventions could not be prioritised amidst the changing country context.

The following strategic level conclusions were developed to allow concessions for these unavoidable challenges as much as possible, and are presented in order of priority. As instructed in the UNEG guidelines<sup>1</sup>, these conclusions go beyond answering the evaluation questions (these are discussed in Chapter 3: Findings and Analysis) and are reasoned evidence-based judgments based on those answers. The conclusions are linked to specific recommendations that provide contextualised suggestions on addressing issues raised in the corresponding conclusion.

**Conclusion 1:** UNFPA has not maintained pressure to prioritise collecting and utilizing high-quality data for policy dialogue and advocacy. This exposes emerging SRH issues to political manipulation and issues without moral links are prioritised over pertinent issues that may be culturally sensitive

- *Origin:* Evaluation Question 2b: To what extent are population data taken into account to inform such activities?
- *Evaluation criteria:* Effectiveness
- *Associated recommendation:* 1

**Conclusion 2:** UNFPA priorities were aligned with the national priorities as set in national policy documents but failed to ensure that national counterparts were able and willing to commit adequate resources in the face of competing priorities

- *Origin:* Evaluation Question 1b: To what extent is the UNFPA support in the Maldives in the field of SRH aligned with the priorities set by relevant national policy frameworks as well as the UNFPA strategic plan?
- *Evaluation criteria:* Relevance
- *Associated recommendation:* 4

**Conclusion 3:** Partnerships between UNFPA and IPs have been mismatched in terms of role and decision-making ability- this has resulted in power imbalances, unrealistic and unmet expectations

- *Origin:* Evaluation Question 3b: To what extent did the intervention mechanism of working in partnership foster or hinder the achievement of the programme outputs?
- *Evaluation criteria:* Efficiency
- *Associated recommendation:* 2

**Conclusion 4:** Lack of coordination in collaborative efforts between UNFPA and other UN agencies has negatively affected implementation as a result of overutilization and fatigue of CSOs and duplication of work

- *Origin:* Evaluation Question 3b: To what extent did the intervention mechanism of working in partnership foster or hinder the achievement of the programme outputs?
- *Evaluation criteria:* Efficiency
- *Associated recommendation:* 3

**Conclusion 5:** Incorporating sustainability factors such as exit strategies and eventual IP ownership proved to be challenging for UNFPA amidst government instability, high turnover and weak civil society

- *Origin:* Evaluation Question 4: To what extent has UNFPA been able to support its partners and the beneficiaries in developing capacities and establishing mechanisms to ensure ownership and the durability of effects?
- *Evaluation criteria:* Sustainability
- *Associated recommendation:* 4

**Conclusion 6:** There is a lack of cohesion and alignment between activities (planned and new), strategies, outputs, and indicators such that progress in these do not always contribute to achieving planned outcomes

- *Origin:* Evaluation Question 2a: To what extent did UNFPA supported interventions contribute (or are likely to contribute) to sustainably improve access to high-quality SRH services and information, particularly in underserved areas, with a focus on young people and vulnerable groups?
- *Evaluation criteria:* Effectiveness
- *Associated recommendation:* 5

**Conclusion 7:** Inadequate attention is given to developing and revising indicators to reflect changing priorities and targets, thus weakening monitoring and evaluation

- *Origin:* Evaluation Question 2a: To what extent did UNFPA supported interventions contribute (or are likely to contribute) to sustainably improve access to high-quality SRH services and information, particularly in underserved areas, with a focus on young people and vulnerable groups?
- *Evaluation criteria:* Effectiveness
- *Associated recommendation:* 5

**Conclusion 8:** There is a tendency to introduce new interventions without due attention given to how it fits into the framework of strategies and outputs, whether or not it duplicates other interventions, and the resources (time, financial, human) it will take away from existing planned interventions.

- *Origin:* Evaluation Question 2a: To what extent did UNFPA supported interventions contribute (or are likely to contribute) to sustainably improve access to high-quality SRH services and information, particularly in underserved areas, with a focus on young people and vulnerable groups?
- *Evaluation criteria:* Effectiveness
- *Associated recommendation:* 1, 5

**Conclusion 9:** UNFPA has demonstrated adeptness in exploring and undertaking alternative approaches to sensitive issues. In this regard, the persistent efforts to introduce sexuality education in schools and establish youth health services are notable

- *Origin:* Evaluation Question 2a: To what extent did UNFPA supported interventions contribute (or are likely to contribute) to sustainably improve access to high-quality SRH services and information, particularly in underserved areas, with a focus on young people and vulnerable groups?
- *Evaluation criteria:* Effectiveness
- *Associated recommendation:* 6

**Conclusion 10:** UNFPA has demonstrated flexibility in redeployment of funds (from strategies that are no longer relevant) to facilitate implementation of pertinent interventions.

- *Origin:* Evaluation Question 3a: To what extent has UNFPA made good use of its human, financial and technical resources in pursuing the achievement of outcomes defined in the country programme?
- *Evaluation criteria:* Efficiency
- *Associated recommendation:* 6

***Conclusion 11:*** UNFPA has demonstrated proficiency in facilitating policy dialogue and platforms that has led to advancement in SRH issues, such as gender-based violence and permissibility of abortion

- *Origin:* Evaluation Question 3a: To what extent has UNFPA made good use of its human, financial and technical resources in pursuing the achievement of outcomes defined in the country programme?
- *Evaluation criteria:* Efficiency
- *Associated recommendation:* 7

## 6 Recommendations

The recommendations presented below are closely linked to the conclusions and are presented in order of priority. It is worth noting that while these recommendations are devised in line with the future direction of UNFPA assistance with the Maldives classified as a Pink country, they assume the current state of institutional capacity and inclination among government and civil implementing partners.

### Recommendation 1

Prioritise and systematise data collection and cultivate a reliance on evidence for programme planning and resource allocation

- *Priority:* High
- *Target Level:* Country Office
- *Based on conclusions:* 1
- *Evaluation criteria:* Relevance, Effectiveness

The absence of high-quality data makes it difficult to ensure continued relevance of interventions and makes SRH issues susceptible to political manipulation where culturally sensitive issues are overlooked in programme planning and resource allocation. This may be countered on two levels.

Firstly, it is recommended that UNFPA maintain a stronger resolve in requiring evidence to shape their priorities and assistance to IPs. Interview data indicates that much of the work on identifying which issues to prioritise over others is informed by political agenda, individual interests, and even by how neatly it may be completed. What this leads to is a collection of activities that may have been completed without controversy and fulfilled political pledges but have little relevance to target population, do not contribute to the overarching outcomes, and most importantly, had exhausted the finite time, human, and financial resources. While it is recognised that UNFPA support does not exist in a political vacuum and often deals with polarizing issues, the presence of high-quality data will provide compelling reasons and facilitate advocacy to attend to pressing SRH issues.

However, Maldives is classified as a PINK country, and the modes of engagement for UNFPA do not include knowledge management. It is recommended that the UNFPA assist IPs to utilise the wealth of information routinely collected especially in health services and incorporate needed data questions into routinely collected data. For example, a partnership with the HIV unit may be forged to collect data on STIs at-risk population (which includes youth) data.

### Recommendation 2

Revisit selection of focal points within IPs to match priorities and counterparts, taking into consideration the level of involvement and support required by IPs

- *Priority:* High
- *Target Level:* Country Office
- *Based on conclusions:* 3
- *Evaluation criteria:* Efficiency, Effectiveness

This recommendation is based on recognizing the different demands of IPs and responding to those accordingly. The effectiveness assessment in Chapter 3 highlighted the slow progress of some interventions and interview data suggested this was often a combination of two things: one, unwillingness and stagnation among IPs' leadership and two, IP implementing capacity. The first requires UNFPA to continuously advocate and urge policy counterparts within the IP to take action, such as decision-making, endorsement, or commitment of resources. The latter challenge of limited IP capacity requires UNFPA to assist and support implementation, ranging from letter writing to arranging venues to sourcing technical expertise. UNFPA has thus far attempted to respond to these two types of demands through one technical staff assigned to the programmatic area and support staffs that assist when prompted as they divide their time across all UNFPA work. The efficiency assessment has shown that the partnership between UNFPA and IPs are negatively affected by unrealistic expectations and power imbalances because the UNFPA and IP counterparts are mismatched.

It is recommended that the UNFPA revisit selection of focal points within implementing partners. In light of future direction with Maldives as a Pink country and UNFPA assistance focusing on advocacy and policy dialogue, government counterparts would need to be engaged at policy and decision-making levels. This is under the assumption that UNFPA will have minimal engagement in capacity development or assist with service delivery (as has been the case in preceding years), in which case it is highly recommended employing short-term dedicated personnel to pursue that output. This is expected to ease power imbalances, facilitate clearer communication, and improve implementation rate with IPs that require high level of support while allowing core UNFPA personnel to continue focus on policy dialogue.

### Recommendation 3

Strengthen communication and coordination with other UN agencies to delineate areas of work and improve effectiveness and efficiency of collaborative efforts

- *Priority:* High
- *Target Level:* Country Office
- *Based on conclusions:* 4
- *Evaluation criteria:* Efficiency

The efficiency assessment of partnership between UNFPA and other UN agencies (notably WHO, UNDP, UNICEF, and UN Women) has shown that the lack of coordination in their collaborative efforts has led to overutilization of IPs (particularly CSOs) and duplication of work. The lack of coordination is often



attributed to weakness in leadership from the Resident Coordinator's Office- this is expected to improve with the recent appointment of a new Resident Coordinator. Similarly, the UNAD 2011-2015 was identified as being weak in that it was a compilation of list of activities planned by the various UN agencies and not a rigorously vetted collaborative plan by sharing work plans by the UN CT. This, too, is expected to improve with the next UNDAF for which planning has begun.

Based on findings from this evaluation, it is recommended that UNFPA consider the following factors regarding partnership with other UN agencies. Firstly, there is a need to recognise that the issue gender-based violence is a crowded issue with high visibility and multiple agency interests. Although overlapping mandates is not problematic in principle, the absence of coordination necessitates that UNFPA critically examine their unique perspective and comparative advantage over other UN agencies and trim their interventions accordingly. Examples of these include DV Act trainings that are also facilitated by UNDP and support of the GAWG and FPA that may be managed by UN Women. In contrast, despite the strong relationship between WHO and Health Ministry, UNFPA can bring a unique perspective to health sector response to gender-based violence and hence are encouraged to prioritise. There have been instances where UNFPA has opted out of certain interventions and they are encouraged to continue in the next Country Programme.

The second factor UNFPA is recommended to consider is that utilizing CSOs as implementing partners is common among other UN agencies and given the shortage of active CSOs, it has tended to be the same ones. This has then led to slowness in implementation and accumulation of funds that are often dispersed in unsustainable one-off activities at the end of the year. In order to counter this, it is recommended that UNFPA initiate communication with other UN agencies that support each CSO, and seek to clearly delineate responsibilities according to their strengths- for example, in cases where a CSO requires capacity-building, this may be yielded to UNDP to support. Although it is not as simplistic in reality, UNFPA is encouraged to seek communication and division of efforts with other UN agencies, even in the absence of functional Thematic Groups and UNDAF action plans.

#### Recommendation 4

Increase involvement of implementing partners at programme planning stages, including joint planning sessions with IPs to avoid duplication, facilitate coordination, and encourage ownership

- *Priority:* High
- *Target Level:* Country Office
- *Based on conclusions:* 2, 5
- *Evaluation criteria:* Relevance, Sustainability

Lack of government ownership of UNFPA assisted interventions was repeatedly identified as negatively impacting intervention success as well as partnerships, which in turn reduces the sustainability. Interview data gathered from UNFPA as

well as IPs indicate that improving ownership has been elusive, despite efforts. In order to address this, it is recommended that more effort be made to involve IPs in programme planning phases. Again, interview data indicates that this too has been done- the AWP's are developed in collaboration. However, the recommendation is that the following mechanisms be incorporated into the consultative meetings.

First, it is recommended that all stakeholders (government and civil partners) be consulted jointly to identify overlap and explore potential partnerships. This is expected to improve the tendency of some IPs to work within own niches, as is often reported and also lessen the burden of coordination on UNFPA.

Secondly, it is recommended that IPs and UNFPA approach the consultative meetings with a clear idea of their priorities that have been identified based on evidence, and that UNFPA reiterate that their mode of assistance is that of advising and policy advocacy. The priorities should then be discussed openly to identify commonalities and reasonable compromises made where needed. This is to encourage transparency among stakeholders and to clearly identify the extent of UNFPA assistance, which may affect government ownership

Thirdly, it is strongly recommended that this consultative meeting be attended by IP decision-makers who are relevant and capable of committing resources (financial and human) to pursue agreed-upon interventions. UNFPA is encouraged to evaluate their level of assistance based on pertinence and relevance of the intervention as well as the level of commitment from IP given how that would indicate the implementation rate.

#### Recommendation 5

Greater consideration given to developing cohesive framework of outputs, strategies, and activities with strong indicators for monitoring and evaluation

- *Priority:* High
- *Target Level:* Country Office
- *Based on conclusions:* 6, 7, 8
- *Evaluation criteria:* Effectiveness

The effectiveness assessment highlighted instances where the volume of various activities were not captured by the indicators, the disconnect between activities and strategies, and how they do not always contribute to the overarching output and outcomes. In addition to reiterating CP4 Evaluation recommendation of developing strong indicators that comply with the SMART principles (specific, measurable, achievable, relevant and time-bound), it is strongly recommended that during the planning stages, due consideration is given to ensure these are aligned. This is to be coupled with greater consideration given to finite resources such as time and human resources, avoiding duplication and overutilization of same IPs.

## Recommendation 6

Continued efforts to explore alternative approaches to sensitive SRH issues, while exercising the will to abandon interventions that have lacked IP support

- *Priority:* Medium
- *Target Level:* Country Office
- *Based on conclusions:* 9, 10
- *Evaluation criteria:* Relevance

UNFPA responded to the challenges of introducing sexuality education and youth SRH services with alternative approaches such as advocating these issues be mainstreamed- i.e., incorporation of life skills into school curriculum and establishing guidelines for youth-friendly services. This proficiency in navigating sensitive issues, adapting to changing contexts, and undertaking innovative approaches are commendable. In line with this, it is recommended that the UNFPA consider technology-based approaches. These may include strengthening capacity of CSOs to provide youth-friendly SRH information via web-based forums and apps, online peer-to-peer referrals to existing health and counseling services, and reviving the Behaviour Change Communication strategy to disseminate material online.

Regarding prioritization and directions for existing interventions, it is recommended that the life skills integrations strategy be pursued in light of the consultant's findings and urgently as the new curriculum is expected to be introduced next year. Interventions to provide SRH services via youth centers (including the Youth Health Café) may need to be ceased, as the IP (Ministry of Youth) does not appear to have the capacity or inclination to pursue this. In its stead, the strengthening of existing health services to enact the guidelines and standards for youth-friendly health services- initially by rigorous evaluation of a pilot at Kulhudhuffudhi- appears to be a more efficient way of establishing services. With regard to reviving partnership with the Ministry of Youth, it may help to recognize that their strength lies in a vast network of youth groups (though they may be sports-based) that may be utilized by linking them with established CSOs. The strategy to strengthen the health sector response to gender-based violence gained momentum late in the CP5 and it is recommended that this be prioritized over DV Act and gender sensitization trainings as these overlap with UNDP and FPA strategies whereas the UNFPA has the comparative advantage in assisting with the health sector response to GBV. Lastly, it is recommended that, if possible, efforts be made to revive the Functional Analysis of health systems and the Logistic Management Information System as they are expected to have sustainable applications, but restrict these efforts until the culmination of the current Country Programme.

## Recommendation 7

Increased efforts to facilitate platforms for multi-sectoral policy discussions on pertinent SRH issues with greater appreciation of the time-consuming nature of advocacy efforts

- *Priority:* Medium
- *Target Level:* Country Office
- *Based on conclusions:* 11
- *Evaluation criteria:* Relevance

Notable past achievements- including the policy dialogue on integrating gender-based violence into the health sector, and on evaluating the permissibility of abortion in cases of rape and incest- may be largely attributed to multi-sectoral coordination and deliberation. As such, it is recommended that UNFPA continue to facilitate and contribute to such policy discussions, with increased efforts to increase frequency, encourage wider participation, and organize them with a view to reaching consensus on pertinent issues. UNFPA is also encouraged to recognise the time consuming nature of multisectoral advocacy especially on sensitive issues and allow sufficient time for achievable targets in the upcoming country programme.

## Annex 1: Terms of Reference

ANNEX I

### TERMS OF REFERENCE

#### **Local Consultancy to evaluate access to high quality sexual and reproductive health services and information as a component of the Maldives 2011-2015 UNDAF**

(MDV-ToR/2014/10 Revised)

#### **1. Introduction**

The UN in Maldives is commissioning an evaluation of the (United Nations Development Assistance Framework (UNDAF) 2011 – 2015. As part of the overall UNDAF evaluation these terms of reference describe a specific focus on the UNFPA contribution to “improved access to high quality sexual and reproductive health services and information for women, men and adolescents, including poor and vulnerable groups at both national and sub-national level” within the overall UNDAF evaluation.

#### **2. Purpose and objective of the UNFPA component of the UNDAF evaluation**

As part of the overall UNDAF evaluation UNFPA wishes to have a specific look at part of its work and agency performance using the following criteria:

- *Relevance* of UNFPA’s contribution in the face of the changing national priorities and contexts.
- *Effectiveness* of Country Programme Document (CPD) and its proposed strategies in terms of progress towards the stated results. Recommend strategies to improve impact for the next CPD/UNDAF in the context of UNFPA’s Strategic Plan 2014-2017, based on the lessons from the first 3 years of implementation of the CPD/UNDAF.
- Access the *efficiency* of key partnerships in the pursuit of results, including interlocutors within partners with a view to explore possibilities of partnerships for the next UNDAF/CPD in the context of UNFPA Strategic Plan 2014-2017.
- Access the extent to which UNFPA’s intervention have contributed to *sustainable* institutional change that increase the capacity to deliver in terms of improved access to high quality sexual and reproductive health services.

#### **Specific objective of the sub evaluation**

- Based on the UNDAF Mid Term Review (MTR) and other recent publications, assess the progress towards achievement of results stated in the CPD expressed through the indicator framework, and assess the progress towards national development goal in the area of improved access to high quality sexual and reproductive health services.

- Describe and assess the impact of the changing institutional, political and cultural context on the possibility of delivering results in this area.
- Review effectiveness of strategies and partnerships of the UNFPA CPD; compare the strategies to the strategic direction outlined in UNFPA Strategic Plan 2014-17 and make suggestions for the next UNDAF/CPD.
- Assess the extent to which the results framework in the CPD, and the programming practices expressed through the implementation strategies and AWP was conducive to effective country programme delivery.

### 3. **Methodology and Approach**

Scope and Focus of the UNDAF evaluation are described in the UNDAF evaluation ToR (Annex 1).

The consultant will closely coordinate with the UNDAF evaluation, under leadership of the international consultant, including for stakeholder interviews, focus group discussion and other forms of data collection.

**Evaluate access to high quality sexual and reproductive health services and information as a component of the Maldives 2011-2015 UNDAF and write a report.** The basic table of content for the final report should include minimally an i) Executive Summary, ii) introduction and rationale iii) evaluation methodology iv) country context v) findings vi) conclusions, lessons learned and recommendations and vii) annexes.

### 4. **Evaluation process**

Design Phase: Development of methodology for the evaluation; Home based review of relevant documents provided by UNFPA. Analysis of assessment and evaluation documents with interim reporting to the UNFPA and UNRCO/ UNDAF Evaluation Management Group (EMG)

Data Collection Phase: In-country consultations, interviews, collection of other relevant documents and preparation of preliminary findings.

Reporting and Finalisation Phase: Presentation of first draft report and sharing review findings with UNFPA/UNRCO/ UNDAF EMG and Reference Group; feedback incorporated; completion of the report and presentation of Final Report review findings to the UNFPA/UNRCO/ UNDAF EMG and Reference Group.

### 5. **Expected Outputs**

- 1) Submission of the inception report
- 2) Submission of report on 'Access to high quality sexual and reproductive health services and information in Maldives' (1<sup>st</sup> draft)
- 3) Submission of report on 'Access to high quality sexual and reproductive health services and information in Maldives' (final)

1. A description of the methodological approach in UNFPA SRH evaluation inception report, including types of data and information to be reviewed and analysed including the timeframe for completing the evaluation based on this ToR.
2. Report “Improved access to high quality sexual and reproductive health services and information for women, men and adolescents, including poor and vulnerable groups”, responding to the objectives described above.
3. Presentation of preliminary findings at the stakeholder workshop
4. Draft report submitted to UNFPA for review and comments.
5. Final report Access to high quality sexual and reproductive health services and information in Maldives.

## 6. **Workplan**

The assignment will be both home and field based. The place of assignment is Male’, Maldives. The consultant will have a temporary office in UNFPA with access to relevant staff and documentation. The duration of the assignment will be seven weeks, between August and October 2014. The Evaluation will be developed, presenting the findings of the assessment, in line with the scope as detailed in these terms of reference.

Timeline for the evaluation process

	Activities and milestones	Dates (2014)
1	Provide inputs to define methodological approach and inception report based on this TOR	15 August
2	Conduct field activities	31 August
3	Submit draft report	15 September
4	Stakeholder workshop	26 October
5	Submit second draft report	30 October
6	Submit final report	15 November

Further, contractor will participate in Strategic Moment of Reflection workshop on UNFPA’s 6<sup>th</sup> Country Programme Development to be held in Male’ 4<sup>th</sup> quarter of 2014, one day as a participant in workshop.

## 7. **Composition of the Evaluation Team**

### ***a. Profile of the National Consultant*** ***General considerations***

- The selected consultant should have experience in conducting evaluations and demonstrated ability to work in a team.

- The evaluator should be independent from UN agencies and organisations that participated in the design and implementation of the UNDAF in Maldives

***Educational background:***

- An advanced university degree or equivalent in social sciences, project/programme management or other relevant disciplines, with specialised training in areas such as evaluation, social statistics

***Work experience:***

- At least 5 years of relevant experience and proven expertise in evaluations and reviews;
- Excellent report writing skills, analytical skills as well as good computer skills;
- Previous experience in gender equality, sexual and reproductive health or adolescent sexual and reproductive health.
- Experience in working with teams and team processes;
- Excellent English writing skills, proficiency in spoken English is required.
- The Consultant should be proficient in computer skills including use of internet and other office application

***Competencies***

- Experience in planning and implementing development related evaluations;
- Specialised technical knowledge, including in data collection and analytical skills, sexual reproductive health, adolescent sexual reproductive health, and gender equality;
- Excellent communication, interpersonal skills, teamwork and adept at working with people of diverse cultural and social backgrounds;
- Desirable knowledge of the UN system and UN country programming processes (CCA/UNDAF/CPD);
- An understanding of and ability to abide by the core values of the United Nations.

**8. Management and Conduct of the Evaluation**

- *UNFPA*

UNFPA will review and comment on the outputs of this assignment in addition to the arrangements described in the UNDAF Evaluation TOR in Annex 1

- *Day-to-day management*

The UNFPA will provide the day to day management and logistic support to individual contactor as part of the UNFPA support to UNDAF and UNFPA specific evaluation.

**9. Bibliography and Resources**

- UNDAF 2011-2015
- UNDAF Mid-Term Review (MTR)



- Mid-Year Review of the UNDAF 2012
- UNDAF Situation Analysis 2010
- UNFPA Country Programme Document (CPD)
- UNFPA Strategic Plan 2014-2017
- Country Office Annual Reports (COAR) 2011-2014
- Annual Work Plans (AWPs)
- Standard Progress Reports
- ICPD Beyond 2014
- 5-year Implementation Plan
- Country Programme indicator table

## **10. Specific Conditions**

### **Payment modalities and Administrative Arrangements**

The assignment is expected to be completed within five weeks. The financial proposal shall specify a total lump sum amount, and payment terms around specific and measurable deliverables (qualitative and quantitative). The financial proposal must include a breakdown of this lump sum amount (including travel, per diems, and number of anticipated working days).

Payment of fees will be based on the delivery of outputs, as follows:

- Upon satisfactory submission and acceptance of the inception report: 30%
- Upon satisfactory submission and acceptance of the first draft report: 40%
- Upon satisfactory submission and acceptance of the final evaluation report: 30%

If local travel outside Male' is required, daily subsistence allowance (DSA) will be paid for the duration of the mission at the place of the mission following UN DSA rates. Local travel (travel and DSA) costs outside Male' will be settled separately from the consultant fees.

## **11. Annexes**

- Annex 1: UNDAF evaluation ToR
- Annex 2: Timeline for the Evaluation Exercise

## Annex 2: Evaluation matrix

<p><b>Relevance EQ1:</b> To what extent is the UNFPA support in the Maldives in the field of SRH:</p> <ul style="list-style-type: none"> <li>• adapted to the needs of the population;</li> <li>• aligned with the priorities set by relevant national policy frameworks as well as the UNFPA strategic plan and</li> <li>• responsive to changes occurred in the national development context during its period of implementation?</li> </ul>			
Assumptions to be assessed	Indicators	Sources of information	Data collection methods and tools
<p>(1a) The needs of the population, in particular those of vulnerable groups, were well taken into account</p> <p>(1b) The CPD, UNDAF and UNFPA Strategic Plan are well aligned</p> <p>(1c) The UNFPA CO has responded effectively to changes in national development context, particularly changes in the health sector and graduation to MIC status.</p>	<p>Congruence between UN agency and stakeholder priorities</p> <p>Congruence between intra-agency (UNFPA) strategies</p> <p>Congruence between inter-UN agency priorities</p>	<p>- UNDAF</p> <p>- CPD</p> <p>- AWP</p> <p>- National policy/strategy documents</p> <p>- UN personnel</p> <p>- Govt. stakeholders</p>	<p>Document review</p> <p>Key informant interviews</p>
<p><b>Effectiveness EQ2:</b> To what extent</p>			

(a) did UNFPA supported interventions contribute (or are likely to contribute) to sustainably improve access to high-quality SRH services and information, particularly in underserved areas, with a focus on young people and vulnerable groups?  
 (b) are population data taken into account to inform such activities?

Assumptions to be assessed	Indicators	Sources of information	Data collection methods and tools
<p>(2a) Comprehensive, gender-sensitive, high-quality SRH services are in place and accessible in underserved areas with a focus on young people and vulnerable groups</p> <p>(2a) Improved knowledge, information and services among women, men and adolescents including poor and vulnerable groups at both national and sub-national level</p> <p>(2b) Strengthened national policies and international development agendas through integrated evidence-based analysis, advocacy and policy dialogue</p>	<p>(2a) Contraceptive prevalence rate</p> <p>Number of sub-national governments with NGOs/CBOs providing information and services on RH and rights</p> <p>Number of health facilities in Male' and selected islands providing youth-friendly health services</p> <p>% of schools offering life skills education programmes</p> <p>Existence of a youth health strategy that incorporates strategies to roll-out life skills education in both in and out of school settings</p> <p>(2b) Disaggregated data produced,</p>	<p>- UNDAF Mid Term Review</p> <p>- CPD</p> <p>- CP Indicator table</p> <p>- National policy/strategy documents</p>	<p>Document review</p>

	analysed and utilised at national and sectorial levels		
<p><b>Efficiency EQ3:</b> To what extent  (a) did the intervention mechanism of working in partnership foster or hinder the achievement of the programme outputs?  (b) has UNFPA made good use of its human, financial and technical resources in pursuing the achievement of outcomes defined in the country programme?</p>			
<b>Assumptions to be assessed</b>	<b>Indicators</b>	<b>Sources of information</b>	<b>Data collection methods and tools</b>
<p>(3a) The UNFPA CPD partnerships are efficient in fostering achievement of improved access to high-quality SRH services and information to women, men and adolescents particularly in poor and vulnerable groups at both national and sub-national level</p> <p>(3b) Beneficiaries of UNFPA support received the resources that were planned, to the level foreseen and in a timely manner</p>	<p>(3a) Evidence of active participation in working groups</p> <p>Evidence of active participation in intervention planning, implementing, and monitoring phase</p> <p>(3b) The planned resources were received to the foreseen level in AWP</p> <p>The resources were received in a timely manner</p>	<ul style="list-style-type: none"> <li>- UN personnel</li> <li>- Govt. stakeholders</li> <li>- Civil society partners</li> <li>- CPD</li> <li>- AWP</li> </ul>	<p>Key informant interviews</p> <p>Document review</p>
<p><b>Sustainability EQ4:</b> To what extent has UNFPA been able to support its partners and the beneficiaries in developing capacities and establishing mechanisms to ensure ownership and the durability of effects?</p>			

<b>Assumptions to be assessed</b>	<b>Indicators</b>	<b>Sources of information</b>	<b>Data collection methods and tools</b>
<p>UNFPA SRH-related interventions have contributed or are likely to contribute to sustainable institutional change that increase the capacity to deliver in terms of improved access to high quality sexual and reproductive health (SRH) services</p>	<p>Partners' capacities have been developed with a view to increase their ownership of the UNFPA initiated interventions (integrated health services, commodity security, outreach services, youth friendly services, life skills curriculum and tools)</p> <p>High quality service culture has been developed among the health professionals who benefited from capacity development interventions.</p>	<ul style="list-style-type: none"> <li>- UN personnel</li> <li>- Govt. stakeholders</li> <li>-Civil society partners</li> </ul>	<p>Key informant interviews</p> <p>Document review</p>

## Annex 3: List of documents consulted

1. UNDAF 2011-2015
2. UNDAF Mid Term Review (MTR)
3. Mid-year Review (mid-2012) of the UNDAF 2011-2015
  - 3a. UNDAF Mid year review - Overview of changes and links to CPD
  - 3b. Work Done at Retreat- Linkages between CPD and UNDAF AP\_UPDATED (working document)
4. UNDAF Situation Analysis 2010
5. Country Programme Evaluation 2008-2010
  - 5a. Evaluation – Management Response Tracking Form
6. UNFPA Country Programme Document (CPD) 2011-2015
  - 6a. CPD Planning Matrix M&E [Excel]
7. UNFPA Strategic Plan 2014-2017
8. Annual Work Plan 2011-2014, HPA
9. SRH Five Year implementation Plan [Excel]
  - 9a. MDV gender 5Y plan April2012 v2 [Excel]
10. Country Programme Indicator Table [Excel]
  - 10a. M&E System UNFPA Maldives (Draft) [Word]
  - 10b. M&E\_RH1\_2011 [Excel]
  - 10c. M&E\_RH2\_2011 [Excel]
  - 10d. Mid-year review 2012 CCHDC [Excel]
  - 10e. M&E Tool- Quarterly AWP Review 2013 HPA [Excel]
  - 10f. M&E\_MHRYS\_2013 [Excel]
11. Country Office Annual Reports (COAR) 2011-2014
12. Standard Progress Reports 2011-2013, RH
13. SRH grants to NGOs (MoUs and Reports)
  - 13a. LMIS Technical Assistance Mission Report

### Global Reports

14. ICPD Review Global Report 2014

### Relevant National studies

15. ICPD Beyond 2014- Maldives Operational Review 2012- Progress, Challenges and Way Forward, Department of National Planning
16. Maldives Human Development Report 2014
17. Study on the Decentralization Process in the Maldives, UNICEF 2013
18. Plan to Support Health System Decentralization in the Republic of Maldives 2012- 2015 (Draft 25/12/2011)
19. Maldives Millennium Development Goal Report 2013 (not approved by Government yet)
20. Reproductive Health Knowledge and Behaviour of Young Unmarried Women in the Maldives, UNFPA 2011
21. Health Master Plan 2006-2015
22. National Reproductive Health Strategy 2014-2018 (Draft)

23. Maldives Political Analysis- PDA Report to Dept. Of Political Affairs
24. Behaviour Change Communication Strategy
25. National Youth Strategy (Final Draft)
26. Background paper- Developing National Standards for Adolescent/Youth friendly Health Services in the Maldives (Final Draft)
27. Assessment of the Capacities of the Health System for the Introduction of Cervical Cancer Screening Program in the Maldives
28. Knowledge, Attitude and Practices of Women in Maldives Related to the Risk Factors, Prevention and Early Detection of Cervical Cancer

Other studies currently being conducted by UN Agencies

29. ToR- UNFPA study to identify gaps and discrepancies in national documents vis-à-vis ICPD commitments
30. ToR- UNFPA study on efficiency in health sector public spending
31. ToR- UNICEF Report on bottleneck analysis

## Annex 4: Lists of persons met and consulted

Mr. Rune Brandrup, International Programme Coordinator, UNFPA Maldives CO  
Ms. Shadiya Ibrahim, Assistant Representative, UNFPA Maldives CO  
Ms. Jeehan Saleem, National Programme Officer RH, UNFPA Maldives CO  
Mr. Mohamed Haneef, Admin/Finance Associate, UNFPA Maldives CO  
Ms. Aminath Nadha, Programme Associate, UNFPA Maldives CO  
Ms. Shaha Hashim, Admin/Finance Associate, UNFPA Maldives CO  
Mr. Igor Pokanevych, Medical Officer, World Health Organisation  
Ms. Shahula Ahmed, Programme Specialist, UNICEF Maldives CO  
Ms. Fathimath Zuhana, Programme Analyst, UN Women  
Ms. Shamha Naseer, IGP Project Coordinator, UNDP Maldives CO  
Mr. Nasheeth Thoha, IGP Project Coordinator, UNDP Maldives CO  
Ms. Geela Ali, Permanent Secretary, Ministry of Health  
Mr. Abdul Hameed, Senior Public Health Programme Office, Ministry of Health  
Ms. Nazeera Najeeb, Public Health Programme Coordinator, Health Protection Agency  
Dr. Mariyam Jenyfa, Senior Medical Officer, Health Protection Agency  
Dr. Nusaiba Farouk Hassan, Medical Officer, Health Protection Agency  
Mr. Mohamed Mahid Shareef, Permanent Secretary, Ministry of Youth and Sports  
Ms. Aminath Lugma, Assistant Director, Ministry of Youth and Sports  
Ms. Saudhath Afeef, Assistant Director, Ministry of Youth and Sports  
Ms. Fathimath Azza, Director General, Ministry of Education  
Ms. Hidhaya Mohamed, Ministry of Education  
Ms. Fathmath Shafeega, Permanent Secretary, Ministry of Law and Gender  
Ms. Aishath Shirani Naeem, Director, Ministry of Law and Gender  
Ms. Rishmee Amir, Senior Social Service Officer, Ministry of Law and Gender  
Ms. Aminath Leena Ali, Director, Policy Advocacy, Family Protection Authority  
Mr. Ahmed Musid, Director, Family Protection Authority  
Ms. Zeenath Shakir, Senior Social Service Officer, Family Protection Authority  
Ms. Shiyath Hashim, Chief Executive Officer, Society for Health Education  
Ms. Hamna Shareef, Project Coordinator, Society for Health Education  
Ms. Raashida Yoosuf, Co-founder and Vice Chairperson, Hope for Women  
Ms. Aneesa Ahmed, Chairperson, Hope for Women  
Mr. Ahmed Anwar, Chairperson, Gender Advocacy Working Group  
Mr. Ishaq Ashraf, Project Coordinator, Democracy House  
Mr. Ahmed Naaif, Web Coordinator, Democracy House



## Annex 5: Methodological instrument: Interview guide

### Key questions

#### Relevance

- In your opinion, how relevant are UNFPA's interventions to the Maldives? What role do they play, in your experience? (To IPs)
- Needs-based? Role of evidence?
- Was programming based on needs of population? In the case of SRH services: men, women, youth, poor and vulnerable?
- What were the national priorities? How were they found/realized? (To UNFPA)
- What are UNFPA's priorities? How were they realized? (To IPs)
- Was the programming responsive to address emerging needs and national priorities over 2011-2015?
- Has UNFPA contributed significantly? (To IPs)
- Is there appropriate balance between upstream (policy-level) and downstream (project-level) interventions?
- Is there need for downstream?
- To what extents are long-term development needs likely to be met across the practice areas? Are the goals realistic, at time of planning?
- Alignment:
  - between UNDAF and CPD and Strategic Plan 2014
  - between UNFPA goals and national goals
  - is it adequately aligned to the priorities of the government?
- Are government agencies' priorities aligned with each other?

#### Effectiveness

- Key achievements?
- What progress has been made towards the realization of high-quality SRH
  - services
  - info
- Accessible to vulnerable groups? How evident, in addition to indicators?
- How effective were strategies used?
- What are some positive and negative factors affecting implementation? Challenges?
- Any improvements to make implementation more effective and efficient?
- Policy dialogue
  - Effective?
  - Advocacy evidence-based?

#### Efficiency

- Partnerships
  - Key partners and intervention areas? (to UNFPA)
  - Value of UNFPA as a partner (to IPs)?
  - What are the challenges with your partnership?
  - How can they be made more effective?

- Do you think the resource allocation (financial and human resources) were adequate to produce significant results?

### **Sustainability**

- Do you believe that UNFPA interventions on SRH services and info are sustainable?
- National ownership: To what extent are UN supported interventions and results owned by local stakeholders (communities, mid or high level institutions)?
- Do the interventions have effective exit strategies?
- Institutional capacity: To what extent and in what way have national capacities been enhanced in government, independent institutions and civil society and NGOs?

## Annex 6: Methodological instrument: Validation seminar worksheet

Comments from **Group** or **Individual**? (Please circle one)

Sector: \_\_\_\_\_

Strategy	Activities and progress	Evaluator remarks and data gaps	Challenges, achievements, corrections
<i>RH Output 1: Strengthened capacity of Ministry of Health and Family, sub-national level governments and civil society organisations to plan and deliver high-quality and equitable RH services and information, including responses to emerging issues in Maldives</i>			
Strategy 1: Developing a knowledge base on emerging SRH issues, such as declining contraceptive use and increasing adolescent pregnancy, through research and surveys. <u>Activities included:</u>		Not linked to any output indicator, therefore cannot assess contribution to output or outcome achievement. <b>Q: Stark difference in progress speed of screening programme and Study. Why?</b>	
1.1 Study on Reproductive Health Knowledge and Behaviour Among Unmarried Young Women in Maldives	Study was completed prior to 2011, report finalised in 2011, sent to Ministries in 2012, officially released in 2013. Progress extremely slow, especially compared to the Screening Programme.	Three-year gap between data collection and release limits its use as 'emerging' issue. <b>Q: Joint decision to not undertake more research in 2013. Due to human resource limitation?</b>	
1.2 Cervical cancer screening programme	Stages completed relatively swiftly (situational analysis, advocacy government support confirmed by 2012/17 guidelines developed, personnel trained and service piloted in 2013. All activities for this strategy in 2013 devoted to Screening Programme.	Links to overarching strategy is unclear. No explicit reference to data that led to cervical cancer being identified as a prominent and emerging SRH issue prevailing over others. <b>Q: How was this identified and made a priority?</b>	
1.3 Functional Analysis of health systems	FA not finalised. Forwarded to Strategy 2 in 2012 for data cleaning and still no gains	Resources have been allocated to this since 2008. <b>Q: How has it been used since?</b>	

	were made until 2013		
1.4 National RH Committee and National Youth Steering Committee meetings on emerging SRH issues	Committee meetings reduced to 2 annually in 2012, and 6 times in 2013.	Reported to have led to deliberation on permissibility of abortion in cases of rape and incest. <b>Q: Is this accurate?</b> If that policy change can indeed be attributed to these Committee meetings, this activity appears to have broad and deep impact. If not: <b>Q: In what ways are these meetings useful?</b>	
Strategy 2: Policy development in reproductive health to support the role of the Ministry of Health and Family with regard to decentralization, privatization and emergency preparedness in the health sector.  <u>Activities mostly included:</u> *Integration into Strategic National Action Plan. * Technical and training support for decentralisation and privatisation. * Training activities *National RH Strategy 2013-2017	Strategy adjusted mid-cycle due to changes in government. Integration of RH concerns into the Strategic National Action Plan was postponed to prioritise assistance on decentralisation. After much technical and training assistance, 2012 transfer of power led to recentralisation. Redundancy packages offered attracted much of the technical personnel from the healthy system, deteriorating the IPs ability to implement the planned activities. *Validation and endorsement phase of the National RH Strategy appears to have progressed slowly. <b>Q: Why?</b>	Output indicator: Strategic National Action Plan on Disaster Risk Reduction and Climate Change incorporates reproductive health and gender issues. Baseline: none; Target: issues incorporated into strategic national action plan [NOT ACHIEVED]  *Several activities under this strategy for 2012-2013 appear to have been continuation of unachieved activities from Strategy 1 in 2011 (e.g., Functional Analysis, National RH Committee meetings). While flexibility in resource reallocation is good, little importance seems to be given to linking to overarching Strategy and using output indicators for monitoring. <b>Q: Is it necessary to update indicators?</b>	

<p>Strategy 3: Strengthening the capacity of civil society organizations to provide sexual and reproductive health information and services, including for migrant populations.</p> <p><u>Activities mostly included:</u> *Identify, establish partnerships with NGOs/CBOs and undertake capacity and needs assessment to deliver RH information and services</p>	<p>Identification begun in 2011; 4 NGOs trained and mobilized (all 4 to provide SRH information in Male' and islands, 1 also providing services in Male') by 2012. However, SPR 2013 indicates that the number of active CSOs dropped to 3 in 2013, leaving 1 providing services and 2 providing information. Needs/capacity assessments?</p>	<p>Output Indicator: Number of subnational governments with NGOs and CSOs providing information and services on reproductive health and rights. Baseline: 0; Target: 6 [NOT ACHIEVED BUT ON TRACK].</p> <p>*Well-paced strategy with broad impact (as it reached underserved communities) contributing to the RH outcome. Slight regression in 2013 (fewer active CSOs)- interview data indicates this a result of UNFPA's inability to actively prod and guide all the civil partners into action, as is reportedly required. <b>Q: Is this accurate? How much and what kind of assistance can be reasonably expected by a CSO in this situation?</b></p>	
<p>Strategy 4: Strengthening the capacity to develop and implement an evidence-based Behaviour Change Communication (BCC) strategy to revitalize family planning efforts.</p> <p><u>Activities mostly included:</u> finalising and implementing the BCC</p>	<p>The BCC Strategy was finalised in 2011. By end of 2013, various leaflets and brochures finalised and disseminated, 1 documentary finalised and various TV and radio programs broadcast, some under the 7 Billion campaign</p>	<p>Output Indicator: Behaviour change communication strategy for family planning developed and implemented. Baseline: no strategy; 2015 Target: strategy developed and implemented [ACHIEVED]</p> <p>*BCC has been carried over from CP3 and CP4, thus its achievement cannot be wholly attributed to CP. Despite this late achievement, this output is likely to have a broad impact given dissemination and broadcast- this remains to be investigated, depending on viewer data. <b>Q: Why was this delayed? How will the effects be measured?</b></p>	

<p>Strategy 5: Strengthening the capacity for reproductive health commodity security, including the expanded use of the logistics management information system.</p> <p><u>Activities mostly included:</u> Consultancy to assess the current needs and options to improve the LMIS system</p>	<p>Assessment of the LMIS completed though no indication of it being utilised</p>	<p>Output Indicator: Computer-based logistics management information system is in place at national and subnational levels. Baseline: no system in place; Target: system in place [NOT ACHIEVED].</p> <p>*The LMIS, also present in CP4, was reportedly function by end of CP4 but technical issues arose and utilisation ceased. <b>Q: Is this correct? Do the benefits of this system outweigh continued resource allocation?</b></p>	
<p><b><i>RH Output 2: Improved access of young people of SRH services and information in Male' and on selected islands</i></b></p>			
<p>Strategy 6: Developing a health strategy for youth that includes access to reproductive health services &amp; information, with the participation of young people.</p> <p><u>Activities mostly included:</u> Finalising the YHS</p>	<p>YHS had been completed during CP4, remained in the commenting phase throughout 2011, revived in high-level policy discussions in 2012, and stalled just short of endorsement in 2013</p>	<p>Output Indicator: Health strategy for youth is approved and implemented. Baseline: no strategy approved; Target: strategy approved and implemented [PARTIALLY ACHIEVED AND ON TRACK FOR 2015].</p> <p>*Extremely slow progress due to political instability and lack of government ownership. <b>Q: Is this accurate? Or are there other reasons for slow progress?</b> UNFPA attributes the stagnation in 2013 to lack of commitment and absence of a champion at MHRYS. However, the UNFPA themselves lost the Program Officer for Youth/HIV AIDS in 2012 and chose to divide the youth portfolio to remaining programme staff. Thus it appears that the pressure required to</p>	

		advocate the YHS was not maintained from either UNFPA or MHRYS. <b>Q: Is constant pressure required at endorsement stage? Why?</b>	
<p>Strategy 7: Strengthening capacity of the youth centres in Male' and on selected islands to provide life-skills education, counselling &amp; youth-friendly sexual and Reproductive Health information, including on HIV/AIDS, violence against women and girls, and other gender issues.</p> <p><u>Activities included:</u>  *Developing Guidelines and Standards for ASRH information and service provision  *Training sessions for health personnel  *Support for information provision</p>	<p>Developing the guidelines were postponed to 2012, presumably developed then (cannot find record of development process), and remained at endorsement phase throughout 2013.</p>	<p>Output Indicator: Number of youth centres in Male and selected islands offering life skills education. BL: 1; Target 5 [NOT ACHIEVED].</p> <p>*Evidence of support only to existing youth centre (YHC in Male') with which UNFPA has longstanding history of ineffectual partnership. Technical assistance was provided to the NGO SHE- also an existing, though inactive, service. <b>Q: Why weren't other youth centres engaged?</b> Several activities involved supporting information provision in one-off instances (such as Youth Day) and training workshops- downstream activities with little sustainability. Somewhat balanced by integration of ASRH into Democracy House Leadership programme. <b>Q: Can strengthening CSOs replace strengthening youth centres?</b></p>	

<p>Strategy 8: Strengthening capacity of the health sector to provide youth-friendly health &amp; reproductive health services in Male' &amp; on selected islands, including through school health settings.</p> <p><u>Activities mostly included:</u>          *Integration of Life Skills Education (LSE) into school curriculum          *Integrating LSE training into MNU training modules          *Developing resource material for school health officers</p>	<p>*Although concept paper and resource material development were implemented on track in 2011, this activity stalled in 2012, and again in 2013 due to difficulties with hiring an international consultant to integrate LSE into curriculum. *Likewise, LSE trainings at MNU was not completed despite several meetings</p>	<p>Output Indicator: Number of health facilities in Male and selected islands providing youth-friendly health services. 2010 BL: 1; 2015 Target: 5. [NOT ACHIEVED]</p> <p>*Strategy regarding service provision reportedly encountered active and passive resistance in 2013- developing the national guidelines for youth friendly services (of Strategy 7) was reportedly an alternate route to achieving this output. <b>Q: Is this accurate?</b> Activities under this strategy seem sustainable and have potential for widespread impact though current output indicators will not reflect these achievements unless revised. <b>Q: Would a separate strategy for school-based interventions help or hinder implementation?</b></p>	
<p><b><i>Gender Output 3: A strengthened national response, including by the health sector, to violence against women and girls, taking into account linkages to protection and legal services</i></b></p>			
<p>Strategy 9: Operationalizing the national action plan on violence against women and girls.</p> <p><u>Activities mostly included:</u> DV Bill/Act advocacy and rollout</p>	<p>Though drafted in 2010, the DV Bill required much lobbying before being sent to Majlis in 2011, and enacted in 2012</p>	<p>Not reflected in any output indicator. Narrative in reports suggests this strategy was very time-consuming (most of 2012) as it required constant advocacy and coordination among the numerous IPS, the latter a result of shifting mandates.</p>	



<p>Strategy 10: Establishing a comprehensive mechanism to ensure systematic protection, aftercare and reintegration services for female victims of violence.</p> <p><u>Activities mostly included:</u> Multisectoral training and sensitisation</p>	<p>Much of the work on systemetising mechanisms were dependent on the DV Act, so this activity gained momentum in 2012 beginning with multisectoral training and psychosocial support network. 2013 activities continued trainings and sensitization</p>	<p>Current indicators count the number of cases and shelters whereas the suggested revised indicators aim monitor establishment of mechanisms at protection, service provision and aftercare stages. <b>Q: Is this accurate?</b> Very positive revision, if they may be used to monitor continued use of these mechanisms, not just existence. <b>Q: What is the progress of these activities, under revised indicators?</b></p>	
<p>Strategy 11: Building the capacity of the health sector to respond to gender-based violence by strengthening training, screening, and data management and developing national guidelines and standard operating procedures on the clinical management of rape.</p> <p><u>Activities mostly included:</u> *develop SOPs *trainings for current and trainee healthcare providers</p>	<p>This strategy, including developing SOPs, which had been targeted every year, saw no progress until 2013. From then on proceeded relatively swiftly, including SOPs up to approval stage, trainings, strengthening of FPU and high-level discussions that prompted integration of DV into child protection database</p>	<p>Output Indicator: Existence of guidelines and standard operating procedures on clinical management of rape. Baseline: none; Target: established. [PARTLY ACHIEVED].</p> <p>*Progress on the G3 Output strategies appears to be sequential. <b>Q: Some activities may be necessary foundations for following activities but could more be achieved if pursued concurrently?</b></p>	

## Annex 7: Output achievements by year

***RH Output 1: Strengthened capacity of Ministry of Health and Family, sub-national level governments and civil society organisations to plan and deliver high-quality and equitable RH services and information, including responses to emerging issues in Maldives***

Output Indicators	Baseline	Target (and target year)	Achievements (SPRs 2011-2013)				Status as of Sept 2014
			2011	2012	2013	2014	
1) Strategic National Action Plan on Disaster Risk Reduction and Climate Change incorporates reproductive health and gender issues	None	Yes (by 2015)		Indicator changed <sup>9</sup>	No progress <sup>10</sup>		Incomplete

<sup>9</sup> “UNFPA proposes to change the indicator to *National RH emergency preparedness plan developed based on the Minimum Initial Services Package (MISP) Baseline: none; Target: plan developed and shared with stakeholders*” Strategic national action plan (SNAP) on disaster-risk reduction and climate change does not exist with the change of governments therefore this is an unrealistic indicator to achieve” (SPR\_RH1\_2012, p4)

<sup>10</sup> “Since the government has not progressed on this aspect, UNFPA has been unable to make an impact on this indicator” (SPR\_RH1\_2012, p4)

2) Number of sub-national governments with NGOs/community-based organizations providing information and services on reproductive health and rights	0	6 (by 2015)	2 <sup>11</sup>	4 <sup>12</sup>	3 <sup>13</sup>	5 <sup>14</sup>	Partially completed
3) Functional computer-based Logistics Management Information System in place at national level and in the provinces	No system in place	System in place (by 2015)			Assessment of the LMIS completed <sup>15</sup>		Partially completed

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<sup>11</sup> “ToR developed, call for proposals advertised on haveeru daily and UNFPA website for 7 days. 11 proposals from Local NGOs received. 3 from Male’ and 7 from islands. A panel of 3 evaluators selected within the UN, evaluated the proposals against an evaluation criteria which was shared with the NGOs with the call for proposals. The proposals were of very high standard and the proposed activities were linked with the BCC strategy. 5 NGOs scoring the highest were shortlisted and the 2 highest scoring NGOs were informed of their selection for 2011 round. 2 NGOs were assessed using a UN assessment checklist. MoUs have been signed with the 2 NGOs (Coalition for Human Rights and Society for Health Education) both based in Male’. This project will continue for 6 months from November 2011.” (SPR\_RH1\_2011, p6)

<sup>12</sup> “There are 4 NGOs and 1 CBO contributing to the output as such capacity developed for 4 NGOs to deliver information and 1 NGO to deliver information and services on reproductive health and right as a result this activity is contributing to achieve 1 CPD indicator” (SPR\_RH1\_2012, p5)

<sup>13</sup> “All government health service providers provide RH services to married couples. 1 NGO provide services and 2 more NGOs provide RH information” (SPR\_RH1\_2013, p4)

<sup>14</sup> “Partnered with 5 NGOs and developed their capacity to provide SRH information” (MDV CP5 Indicator Table- May2014, p1)

<sup>15</sup> (SPR\_RH1\_2013, p4)

4) BCC strategy for family planning developed and implemented	No strategy	Strategy developed and implemented (by 2015)	Strategy developed <sup>16</sup>	Strategy developed and implemented <sup>17</sup>	Completed
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***RH Output 2: Improved access of young people of SRH services and information in Male' and on selected islands***

Output Indicators	Baseline	Target (and target year)	Achievements (SPRs 2011-2013)				Status as of Sept 2014
			2011	2012	2013	2014	
1) Youth health strategy approved and implemented	No strategy approved	Strategy approved and implemented (by 2015)	Strategy approval phase <sup>18</sup>		Strategy developed	Strategy endorsed <sup>19</sup>	Partially completed
2) Number of youth centres in Male and selected islands offering life skills education	1	5 (by 2015)	No progress <sup>20</sup>		No progress <sup>21</sup>	No progress <sup>22</sup>	Incomplete

<sup>16</sup> "BCC strategy was developed by a local NGO Coalition for Human Rights in 2010. The strategy was validated in a workshop participated by all relevant stakeholders. BCC strategy has been finalized and submitted to UNFPA. Activities of the BCC strategy is linked with activity 3.1 and 3.2. Already some activities including print materials has been developed and disseminated as well as 3 TV and 2 radio programs on RH and RR have been supported by CCHDC and UNFPA. This includes some activities under the 7 billion campaigns. \*Materials printed include -booklet on 'Islamee Dhirulhun', Reference page (2050 stickers printed) for the protocols on management of pregnancy, childbirth and newborn; Information package (6000 copies) for pregnant mothers. This package is distributed to all pregnant mothers upon registration in a health facility" (SPR\_RH1\_2011, p6-7)

<sup>17</sup> "1 documentary finalised. 6 leaflets and brochures finalised and disseminated. 8 radio programs, 4 TV programs" (SPR\_RH1\_2013, p4)

<sup>18</sup> The youth strategy is still at commenting stage, and validation process has been postponed for next year

<sup>19</sup> The Minister has announced its endorsement at SAARC regional consultation

<sup>20</sup> Youth Health care' is offering Life skills Education. No new youth centres were engaged by the program. There is a need to train more facilitators

<sup>21</sup> Life skills education is yet to be integrated in youth centres and schools

<sup>22</sup> Currently UNFPA focus is to integrate CSE in curriculum

3) Number of health facilities in Male and selected islands providing youth-friendly health services	0	5 (by 2015)	Trainings begun. Need for guidelines identified <sup>23</sup>	Standards for youth friendly services developed	National standards approved <sup>24</sup>	Partially completed
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<sup>23</sup> Basic Youth friendly service training was included within the adolescent Health and development training program, and health providers from two atolls have been trained. Further, two NGOs, lecturers from Faculty of Health Science, and six staff from the central hospital has been trained on this. Guidelines and further training needed to reach target.

<sup>24</sup> National standards for providing youth friendly health services finalised. Service delivery packages for youth friendly health services for each level of health facility developed and finalised

## References

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- i UN Evaluation Group (2013) *Resource Pack on Joint Evaluations*
- ii Evaluation Branch, Division for Oversight Services, UNFPA (2012) *Handbook: How to design and conduct a Country Programme Evaluation at UNFPA*
- iii *Chatham House Rule*, accessed at <http://www.chathamhouse.org/about/chatham-house-rule>
- iv Department of National Planning (2013) Mid-year estimates from *Statistical Yearbook of the Maldives*
- v Ministry of Planning and National Development (2006) *Population and Housing Census of the Maldives*
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