**EVALUATION
REPORT**

CHILDREN AND THE 2004 INDIAN OCEAN TSUNAMI

AN EVALUATION OF UNICEF'S RESPONSE IN THE MALDIVES (2005 - 2008)

CHILD PROTECTION

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CONTENTS

ACRONYMS

AGO	Attorney General's Office
ARC	American Red Cross
CBO	Community Based Organization
CCC	Core Commitments for Children in Emergencies
CE	Community Educators
CP	Child Protection
CFSC	Child and Family Service Centers
CRC	Convention on the Rights of the Child
CSC	Community Services Center
DAC	Development Co-Operation Directorate (DCD-DAC) of the Organization for Economic Co-Operation and Development (OECD)
DGFPS	Department of Gender and Family Protection Services (formerly Ministry of Gender & Family, MGF, changed in 2009)
DRC	Drug Rehabilitation Center
FCPU	Family and Child Protection Unit
FCSC	Family and Child Services Center
FPU	Family Protection Unit
FHS	Faculty of Health Sciences
GOM	Government of the Maldives
GO	Governmental Organization
IDP	Internally Displaced Person
IFRC	International Federation of Red Cross and Red Crescent Societies
IGMF	Indira Gandhi Memorial Hospital
IO	International Organization
MCHE	Maldives College of Higher Education
MDG	Millennium Development Goals
MDP	Maldivian Democratic Party
MGF	Ministry of Gender and Family
MGFDSS	Ministry of Gender, Family Development and Social Security
MGFSS	Ministry for Gender and Family and Social Security
MHF	Ministry of Health and Family (2009)
MOE	Ministry of Education
MOH	Ministry of Health
MPND	Ministry of Planning and National Development
MPS	Maldives Police Service
NGO	Non-Governmental Organization
NNCB	National Narcotics Control Board
PEF	Protective Environment Framework
SSW	Social Service Worker
UN	United Nations
UNCT	United Nations Country Team
UNDP	United Nations Development Program
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
URC	Unit for the Rights of the Child
WDC	Women's Development Committee
WHO	World Health Organization

EXECUTIVE SUMMARY

CHILD PROTECTION PROGRAM OVERVIEW

The most significant early protection response to the tsunami addressed psychological distress amongst disaster affected communities. A self-organized group called the "Social Support and Counseling Services" lobbied to be included as a formal sector of the National Disaster Management Center (NDMC) and also helped to establish a multi-sectoral coordination working group. "Emotional support brigades" comprised of national volunteers worked in Malé and several of the affected outer islands to promote psychosocial support activities. Additionally, they also established a temporary hot line to handle distress calls.

The United Nations Children's Fund (UNICEF) promoted a "second wave" of psychosocial support, extending training and support programs for community volunteers and teachers at atoll capital and island levels. International non-governmental organizations (NGOs), such as the American Red Cross, continued and strengthened these efforts thereafter. The tsunami disaster also led to the creation of new community-based organizations that engaged in projects in the atolls as well as new Male-based NGOs.

The recovery response promoted government restructuring. In 2006, the Ministry for Gender and Family (MGF) was reorganized in an effort to meet its objectives of promoting and facilitating the welfare of women, children and family rights in the Maldives. This involved establishing different units under the Ministry to deal with various facets of promoting women's, children's, and family rights, including the Family and Child Protection Authority (replacing the URC), Family and Child Protection Services and Family and Community Development. The Maldives Police Service's special unit to deal with child and family related concerns—the Family and Child Protection Unit (FCPU) based in Malé--started training officers to deal with child abuse.

The early development response focused on revitalizing the government's plans to decentralize child protection services. 21 Child and Family Service Centers (CFSC) were established at the atoll capital level—with the intention of eventually placing social service providers in the outer islands as well. Different levels of government supported social work training programs were established to support the Ministry's decentralization program.

In 2007, the MGF, in collaboration with the Attorney General's Office (AGO—and now Prosecutor General's Office), began the process of reviewing legislation to bring it into conformity with the principles of the Convention on the Rights of the Child (CRC). The AGO's work included incorporating provisions of international human rights law into domestic legislation. With the national elections in 2008, the Maldives entered a period of political transition.

EVALUATION METHODOLOGY

The purpose of the evaluation is to determine the outcome-impact of the inter-agency child protection response to the tsunami in the Maldives and draw lessons and recommendations that will be useful for strengthening on-going development programming and policies to improve the well-being and rights of children and women.

Within this context, the evaluation seeks to achieve three inter-related objectives:
- Provide an outcome-impact analysis of the child protection program (2005-2008) in the Maldives
- Examine DAC[1] evaluation criteria as applied to the child protection sector
- Provide evidence-based conclusions, lessons learned and recommendations

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[1] DAC refers to the Development Co-Operation Directorate (DCD-DAC) of the Organization for Economic Co-Operation and Development (OECD).

The evaluation focused on two of the child protection program's work strands: psychosocial support and NGO and civil society development. It also examined the extent to which child protection results were achieved in each phase (early—recovery--early development) and, today, are likely to be sustained.

The evaluation employed a sequential mixed methods approach that combines comprehensive coverage with in-depth and holistic analysis of program results. Phased sampling was employed for this evaluation. Initially, primary data collection sites outside of Malé were randomly selected. Islands within the atolls were then selected through convenience sampling. Sampling of community members and key informants was based on considerations of who could provide valuable information and who would be representative of the population as a whole. Criteria were also applied to some participants, such as children who were required to be between the ages of 13 and 17 years.

Outer island research took place in Raa, Kaafu and Laamu. Focus groups and key informant interviews were initiated in each of the atoll capital and outer island groups. In total, 213 people (87 men and 126 women) participated, including those in Male.

MAIN FINDINGS

Psychosocial Program

Early response to psychosocial concerns was significant. The American Red Cross (ARC) program alone reached over 66,000 people on 76 tsunami-affected islands in 7 different atolls.

The evaluation sought to determine the outcomes of these psychosocial programs by asking parents to rank their communities' ability to support children's psychosocial well-being immediately after the tsunami and now (as of January 2009), using a 5-point Likert scale. Community ranking results are different for atoll capital versus outer islands. Community members from atoll capitals perceived almost "normal capacity" immediately after the tsunami, with slight improvements to date. Community members on outer islands, in contrast, perceived that their capacity to care and protect their children immediately after the tsunami was significantly "diminished" with little to no improvement to date.

Atoll capitals fared better post-tsunami due to basic resources (i.e., hospitals, schools etc.) that have at least been maintained, if not slightly improved. For the outer islands, however, the situation both post-tsunami and currently is much less hopeful. The psychosocial program may have provided relief to disaster victims immediately after the tsunami; however it did not strengthen community capacity to support children long-term.

Decentralized Social Services

Tsunami funding enabled the government and UNICEF to revitalize pre-existing plans for the decentralization of social services. The establishment of 21 social service centers (FCSC) and new social work trainings are the most significant outcome achievements in the child protection sector.

FCSCs, however, face key challenges. They are primarily staffed by young adults (average age 23.5 years) with limited training (37% had 3-month Social Service Worker certificates from the Center for Continuing Education; 63% received one year diplomas or advanced certificates) and limited experience (ranging from one month to two years). Their work remains largely center-based and focuses on: case management; workshops about the center's role in the community; counseling; and participation in community events.   Community mobilization, linkages with CBOs, and advocacy and prevention programs are not evident.

The evaluation assessed the level of awareness of the FCSC in the atoll capital and outer communities. Almost all island participants throughout the atolls were aware that the center existed, but they were

largely unaware of the center's purpose or services. The absence of a community engagement strategy and civil society involvement limits FCSC effectiveness.

Civil Society Development

UNICEF worked with Journey, a national NGO whose members are recovering drug addicts, to put the issue of drug abuse and child rights on the Maldives' national agenda. These efforts led to growing dialogues between Government, NGOs and civil society on how to tackle this serious and growing threat to the nation's youth. Innovative programs—such as Wake-up!—were piloted. Moreover, the new coalition government has pledged increased attention to drug abuse prevention and addiction treatment.

Other NGOs and their programs have sustained as well. The evaluation assessed the extent to which NGOs that emerged after the tsunami addressed child protection and well-being concerns and continue to do so today (January 2009). According to recent reports that examined civil society actors within the capital (Raajje Foundation, 2009), 14 of 32 Malé-based NGOs identify their focus as child- and/or drug-related, including 4 that focus primarily on drug issues. Of these 14 child focused NGOs, 4 (29%) have suspended operations. Additionally, of the one-half of these child focused NGOs (7 out of 14) that formed after the tsunami, 4 (57%) are not presently active.

The number of active NGOs in the outer islands also has decreased. Countrywide, over 700 organizations have sought registration with the government through 2008. However, only a handful of organizations are active, primarily due to a lack of internal capacity and financial support for the civil society sector in general (Raajje Foundation, 2009). Additionally, the Raajje Foundation (2009) assessment sighted a lack of coordination, cooperation and pooling of resources within the sector as problematic.

Legislative Framework

The Government has committed to the principles and values of the Convention on the Rights of the Child (CRC) and fulfilled its reporting obligations on the CRC by submitting periodic reports. Efforts to integrate the CRC into domestic law have been strengthened, even while enforcement is lagging behind. Child rights advocates suggest that Law 9/91 (the Law on the Protection of the Rights of the Children) is insufficient to safeguard children's rights, and also that key amended legislation remains in draft form.

LESSONS LEARNED AND CONCLUSIONS

Prior to the tsunami, UNICEF had a limited protection program (administratively subsumed in the education sector) that promoted occasional studies on child protection concerns and small pilot projects to stimulate child protection activities in a handful of islands. Many of the tsunami related opportunities were missed due to the lack of agency capacity across the board.

UNICEF Maldives played a supportive role within the United Nations (UN) family as the UN Population Fund (UNFPA) led protection and psychosocial responses. The unique risks faced by children in response to this disaster were joined—and in some cases, subsumed—under concerns related to women and the elderly (Patel, 2006; UNFPA Maldives, 2006b).

A flaw in almost all protection programs was the lack of a systematic process for consultation with local communities. The extent of local island buy-in and ownership of projects is one of the most important determinants of the long-term viability and sustainability of social welfare and child protection programs. Hence, it is important to ensure the necessary human resources, with country-specific social sector expertise and community development and gender specialization, review and support analysis and programming planning. Social sector expertise is also necessary for strengthening the qualitative aspects of monitoring and evaluation on how to address women's and children's rights in a culturally sensitive manner.

If UNICEF's Child Protection Program is to become a central component of country efforts in the future, more consistent human resources will be required—particularly social sector, gender and socio-legal expertise. Better access to local knowledge and a better understanding of community development processes also would improve the program's focus, integration and sustainability. The current approach of relying solely on short-term consultants for assessment and research purposes is not optimal, and may be one reason for the fragmented and over-ambitious nature of previous programs.

RECOMMENDATIONS

Government of the Maldives and its Partners

Implement a comprehensive prevention, care and treatment program for drug addiction: The greatest threat faced by Maldivian children and youth—drug addiction--must be addressed on an urgent and comprehensive basis. Responses should involve all stakeholders from government and civil society, and be grounded in the recognition that this issue constitutes a major public health and child protection problem. Prevention efforts should be integrated within activities that children and youth participate in and within broader school and livelihood programs. Treatment and care policies and programs should also recognize that children and youth with addiction issues are distinct and different from the broader adult population who abuse drugs, and that greater opportunity for intervention exists with them.

Promote an island-wide child security and well-being community mobilization campaign: A nationwide initiative to engage atoll communities in creating protective environments for their children is needed. A series of well designed and facilitated parent and community leader strategy sessions on each island, addressing the overarching theme of how to create a healthy environment for children, would be the central focus of this mobilization strategy. The series would focus on security and well-being themes, such as "raising healthy children", "making our island safe for our children", and "preparing our children for success in school", as well as other priority concerns identified by parents. The series also would provide opportunities to address more difficult concerns (such as domestic violence, rape, bullying, and other serious abuse and exploitation problems) in ways that may be less confrontational and stigmatizing than previous efforts. The campaign needs to be pragmatic and solution-oriented, with clear understandings about the availability and limitations of government support for follow-up. Matching community support (participation and financial) would be required as well.

Reorient the role of staff in the social service centers towards facilitation of community prevention, awareness and mobilization: The placement of service providers in atoll capitols has created an opportunity to expand the role and effectiveness of these frontline workers. An important next step towards achieving consistent results would be to reorient the social service providers' activities towards community prevention, awareness and mobilization. In addition to providing remedial services, the service providers would play key roles in the community mobilization campaign, and support and supervise NGO work on children's activity programs (see below). It is important to note that given the lack of service providers per island, those present must be willing (and mandated) to address a range of community concerns. Specialization—or a narrow focus—is not feasible at this point in time. An important aspect of this reorientation will be re-training away from a service delivery model and towards community development and mobilization methodologies. In the short-term, this could be accomplished through in-service training. However, in the long-term it should be built into future social work training and degree programs.

Establish minimum child security and well-being standards and ensure that the community mobilization campaign addresses them: Through an interactive process with communities, the government should establish a mandated set of minimum child security and well-being standards for all outer islands. These should be achievable rather than idealistic standards. The following set of child and parent priorities were identified through this evaluation, and each requires monitoring of progress:
- Sports and playground space: established, equipped and maintained by community and safe
- Activities programs: 3-4 organized activities are offered on a weekly basis
- Safe school standards: zero tolerance for physical abuse, emotional abuse and bullying

- Awareness and surveillance programs: initiatives on key concerns, such as drug addiction in schools; roles and requirements for island authorities, religious leaders, parents and others are established and maintained on a regular basis.

Consolidate support for at least one "child well-being" NGO per island to implement activity programs: After the tsunami, there was a mushrooming of many NGO fragmented efforts to care and protect children. It is time to refocus civil society support for children, especially on outer islands. One step in that direction is to provide ongoing and sustained support for at least one community designated NGO, which would emerge from the mobilization exercises discussed above. The NGO, with government budgetary support and high quality community mobilization training, would be responsible for implementing the island activity programs, supervising standards established for sports and playground space, and contributing to safe school and awareness and surveillance programs. Communities should be expected to support—and contribute to— their islands' "child well-being" NGO as well.

Further develop the monitoring and evaluation system: While the government has substantially invested in efforts to better understand the situation facing children in the Maldives through research, the ability to monitor and report requires further progress. Efforts to develop a joint database that would house case-related statistics from multiple stakeholders must be prioritized, and delays in commencing the project must be reduced. Information should be shared and publicly accessible. Programs already in place need to be evaluated for effectiveness on an annual basis. Technical capacity in order to establish and run the system is necessary, and requires government investment.

UNICEF-Maldives and Partners

Continue to enhance existing government partnerships: Political changes in the past year present new opportunities to work with the government on setting child protection priorities. These opportunities must be capitalized upon in order to achieve the goals set forth in the 2008-2010 UNICEF Country Program. UNICEF Maldives must be the key government partner to implement the government recommendations noted immediately above. UNICEF Maldives should continue to enhance its existing partnerships with multiple government agencies and build new partnerships as needed. Each sector's program should provide both strategic direction and technical support for sustainable developments in a way that ensures government responsibility and accountability over emerging social protection systems.

Support NGO development and capacity building: The burgeoning civil society within the Maldives requires additional support and UNICEF should continue to assume a leadership role in engaging government, NGO and private sector partnerships. Sustainable and ongoing partnerships, such as that with Journey, should be encouraged to exist and continue. The Child Protection Program, in particular, should support NGO capacity building and technical knowledge as part of the government's mobilization strategy.

Build child protection capacity: None of the above will be possible unless UNICEF Maldives' Child Protection Program upgrades its competence—especially in social sector, gender and socio-legal expertise. Ensuring community development perspectives and better access to local knowledge is required as well.

UNICEF and Partners – Global

Enhance child protection emergency response regionally: UNICEF's emergency response capacity was over-stretched by the multiple countries affected by the tsunami. It would therefore be important to identify a cadre of child protection professionals in the South Asia region with proven experience in emergency response to offer surge capacity in the event of future emergencies. Sri Lanka and India would seem to be appropriate locations to begin to build this roster—and UNICEF's protection unit in Colombo would be one source to consult.

Develop a medium-term plan for capacity building and technical support: UNICEF could usefully develop a medium-term technical support plan to enhance UNICEF Maldives' capacities to promote

community development and address critical child protection concerns. Technical exchange linkages with Sri Lanka and India, as well as with Southeast Asian countries, such as Indonesia, would be fruitful avenues to pursue. UNICEF staff in the Maldives would greatly benefit from methods training in order to employ (or properly supervise) "real time" assessments capable of determining both the extent of a problem (prevalence) and local perceptions of child security and well-being.

1. INTRODUCTION

1.1 Country Context

The Republic of the Maldives is an archipelago of approximately 1,190 coral islands situated in the Indian Ocean, approximately 250 nautical miles off the southwest coast of Sri Lanka. At the last census, in 2006, the population of the nation was nearly 300 000. At this time, over one-third of the population was living in the capital Malé, almost half were under the age of 14, and the median age was 17.9 years (Government of the Republic of the Maldives, 2007). While nearly 35% of the country's population resides in Malé, the rest of the population is scattered over approximately 198 islands, many with fewer than 200 residents. This dispersal of the remaining population not only means communication and transportation difficulties, but also increased cost of social sector interventions (estimated to be 4 to 5 times higher per capita than the average for the region; UNICEF Maldives, 2008a).

Over the past 30 years, the Maldives has become increasingly prosperous with an annual growth rate of over 9% (Patel, 2006), and a nominal per capita income of $2,806 in 2007 - the highest in South Asia (UNICEF Maldives, 2008a). Yet, there remain significant disparities among citizens of the country. According to the Government's Vulnerability and Poverty Assessment, conducted in 2004, the divide between rich and poor falls along geographic lines and regional inequalities between the capital, Malé, and the atolls are rising (MPND, 2005). In addition, there are significant differences in services and infrastructure available in Malé versus in the atolls (Patel, 2006).

Legislatively, the Maldives began to lay the foundation for fulfilling children's rights in 1991 with the introduction of Law 9/91--the law on the "Protection of the Rights of Children"--to ratify the Convention on the Rights of the Child (CRC). Child rights efforts continued in 2000 when a new Family Law increased the minimum age for marriage to 18 years (MGF, 2006a). In 2002, the Government also ratified the two optional protocols to the CRC. As of 2006, efforts continued through proposed legislation in Parliament, with several new child-related polices under development (namely the Disability Act, Evidence Act, and Education Act). These policy-related efforts have continued through the present with the development of additional acts, including the Children's Act and Juvenile Justice Act.

Table 1: Key Pre-Tsunami Child Protection Milestones

An overview of key pre-tsunami milestones in Child Protection for the Maldives:

1990   **The Maldives signs the Convention on the Rights of the Child (CRC)**
1991   **CRC ratified**
          Year of the Maldivian Child
          National Conference on Children
          Law 9/91 "Protection of the Rights of Children" enacted
          National Plan of Action drafted
1992   **National Council formed** to provide direction/guidance in monitoring and implementing CRC
          Unit for the Rights of Children (URC) established under the Home Ministry
1997   **Juvenile Court established**
          Family and Child Protection Unit (FCPU) of (now) Maldives' Police Service is formed
          Efforts to mainstream child protection through training island/atoll leaders begin
2000   **Family law enacted**
2001   **Website of URC launched**
          Consultative process to develop a National Plan of Action for the Maldivian Child 2001-2010
          Pilot project to decentralize Child Protection services begins in Addu Atoll
2002   **Maldives ratifies the two optional protocols to CRC**

Source: MGF (2006b) Gender & Development Indicators

Since the tsunami, the Maldives' economy has been recovering and is back on track to graduate from a Least Developed Country (LDC) to a Middle Income Country (MIC) in the near future (UNICEF Maldives, 2008b). The country is also on the path towards achieving the Millennium Development Goals (MDG), with success recorded already at the national (aggregate) level (UNICEF Maldives, 2008b). Despite increases in economic growth and human development, there has not been a corresponding increase in social development indicators, including gender equity (Patel, 2006). Rapid growth and urbanization have been accompanied by the challenges of tackling drug abuse, reducing unemployment and creating a safe and secure environment for children and young people.

Rapid economic and social changes, however, have affected children and women in major ways, such as urbanization and over-crowding of the capital. Major challenges include the erosion of traditional family arrangements and structures; increases in juvenile delinquency and drug misuse among children and youth; lack of easy access to good quality education and health care; and, rising unemployment (UNICEF Maldives, 2008a).

Drug abuse has emerged as a major threat. Records of arrests related to drug abuse suggest there are between 2,000 and 3,000 "severe addicts" nationwide (NNCB, 2004). In 2004, the government stated that 50.4% of the total number of reported drug abuse cases involved individuals less than 24 years of age (MOH, 2006). The United Nations Children's Fund (UNICEF) believes that heroin use has reached 30% among youth less than 24 years of age (UNICEF Maldives, 2008b). In the capital city, Malé, where 77% of the country's addicts live, approximately 10% of the youth population is using drugs (UNICEF Maldives, 5 December 2007). Recent statistics issued by the Maldives Polices Service (MPS) were documented on their website in 2007 and 2008 reveal that drug offences are the most common cause of arrest for those under 18 years of age (www.police.gov.mv).

The Maldives is undergoing rapid political change as well. In 2008, the adoption of a new constitution was followed by the nation's first multiparty presidential elections. A coalition led by the Maldivian Democratic Party (MDP) won, and a new president was sworn into office in November 2008. This election has brought with it a period of significant transition within the country as a whole, and has dramatically altered the political landscape. Increased attention to social sector development is evident within the coalition's platform: to reduce the cost of living, close doors to drugs, provide affordable healthcare, connect the country through an integrated transport system, and establish an equitable system of housing (UNICEF Maldives, 2008a).

1.2 Tsunami Context

The Indian Ocean tsunami on 26 December 2004 caused significant destruction, including loss of life, displacement, loss of livelihoods, and damage to infrastructure throughout the Maldives. Significant economic losses were also recorded due to interruptions in tourism, which accounts for 33% of the country's gross domestic product (GDP) (Patel, 2006). Overall, economic losses cost an estimated US $470 million and environmental losses were estimated to be at least US $9.8 million (UNICEF-Maldives, 2005). The disaster caused 82 deaths, 57 of whom were children, and 26 people were listed as missing (NDMC, 2005).

All inhabited islands were affected by the tsunami, which displaced 29,577 people (UNFPA, 2006). The islands of Kandholhudoo in Raa Atoll and Kohufushi in Meemu Atoll were the most seriously affected, having suffered displacements of over 1,000 people. Raa Kandholhudoo was totally evacuated. Th.Villifushi and Madifushi, L.Mundoo, Dh. Maaemboodhoo, and Ga. Villingili recorded 500-1,000 displaced people, and 38 other islands recorded displacement of over 50 people (Patel, 2006). Annex 1 includes a table showing the number of deceased and missing persons by atoll.

According to the National Disaster Management Center (NDMC), there were no separated, unaccompanied or orphaned children by the tsunami. There was, however, widespread fear, anxiety and depression among tsunami affected populations. Families who lost their homes and/or were displaced from their own islands also had to contend with congested camp living conditions with minimal amenities

and no privacy. Tensions and, at times, open hostility arose between host and internally displaced person (IDP) communities, thereby adding to the stresses and deprivation engendered by the displacement itself.

The loss of livelihoods and competition for relief-oriented employment jobs added to these IDP-host community tensions as well as to distress among family members. While there were no reported incidences of child sexual abuse or trafficking, there were concerns that incidences of domestic abuse and neglect were rising due to crowded situations in temporary shelters and the added demands on parents. Children's daily routines, peer interactions and overall sense of normalcy were swept away as over one-third of the Maldives' schools and playgrounds were damaged or destroyed completely by the tsunami.

2. CHILD PROTECTION RESPONSE TO THE TSUNAMI

2.1 Child Protection Sector Overview

The most significant early protection response to the tsunami aimed to address psychological distress amongst disaster affected communities. A self-organized group called the "Social Support and Counseling Services" lobbied to be included as a formal sector of the NDMC and also helped to establish a multi-sectoral coordination working group. With the help of this group, "emotional support brigades" comprised of national volunteers worked in Malé and several of the affected outer islands to promote psychosocial support activities. A temporary hot line by this same group was established to handle distress calls. UNICEF promoted a "second wave" of psychosocial support, extending training and support programs for community volunteers and teachers at atoll, capital and island levels—efforts that international non-governmental organizations (NGOs), such as the American Red Cross (ARC), continued and strengthened thereafter.

Early response psychosocial programming was oriented around two main areas: training and the the provision of direct interventions. Training targeted both local community volunteers working with the Ministry for Gender and Family and Social Security (MGFSS) (Patel, 2006) in affected islands, and teachers in schools throughout the country who were to provide psychosocial support to their students (World Bank et al. 2005). The American Red Cross provided training and materials to community volunteers and teachers, while the United Nations Population Fund (UNFPA) and UNICEF provided logistical and technical support to these projects. In addition, the Ministry of Health, the World Health Organization (WHO) and UNFPA partnered to increase the capacity of island health workers to deal with psychosocial issues (World Bank et al. 2005). Throughout 2005, the Unit for the Rights of Children (URC) at the Ministry of Gender and Family (MGF), the Juvenile Court at the Ministry of Justice, the Attorney General's Office (AGO), Maldives Police Service (MPS) and the Care Society (an NGO) were UNICEF's main partners.

The tsunami response stimulated an increase in national NGOs. Before the tsunami, there was a handful of Malé-based NGOs but usually one NGO per atoll. The tsunami disaster led to the creation of new NGOs that engaged in advocacy and, to a lesser extent, service provision in Malé.

The recovery response included considerable government restructuring. As of 2005, the Maldives' child protection system consisted of the Juvenile Court, in which protection proceedings take place; the Family and Child Protection Unit of the police (FCPU); the Unit for the Rights of the Child (URC), which works both in child welfare and juvenile delinquency and was then part of the Ministry for Gender and Family[2]; and the National Council for the Protection of the Rights of Children, which is responsible for monitoring and lobbying for the inclusion of children's rights in government policies.

In 2006, MGF was reorganized in an effort to meet its objectives of promoting and facilitating the welfare of women, children and family rights in the Maldives. This involved establishing different units under the Ministry to deal with various facets of promoting women's, children's, and family rights, including the Family and Child Protection Authority (replacing the URC), Family and Child Protection Services and Family and Community Development. The Maldives Police Service's special unit to deal with child and family related concerns—the Family and Child Protection Unit (FCPU) based in Malé--started training officers to deal with child abuse.

Earlier development response focused on revitalizing the government's plans to decentralize child protection services. Eventually, 21 Child and Family Service Centers (CFSC) were established at the atoll capital level, with the intention of eventually placing social service providers in the outer islands as well. Different levels of government-supported social work training programs were established to support the Ministry's decentralization program. These included a one-year university diploma course in Sri

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[2] The Ministry for Gender and Family became the Department of Gender and Family Protection Services, under the Ministry for Health and Family, at the end of 2008.

Lanka, and a social work training program offered at the Faculty of Health Sciences within the Maldives College of Higher Education. The latter Malé-based course currently offers an advanced certificate with the intention of evolving into a graduate degree program with support from the University of Newcastle/Australia.

In 2007, the MGF in close collaboration with the Attorney General's Office (AGO) - now Prosecutor General's Office - began the process of reviewing legislation to bring it into conformity with the principles of the CRC. AGO's work included incorporating provisions of international human rights law into domestic legislation. With the national elections in 2008, the Maldives entered a period of political transition.

2.2 UNICEF Programme

In the aftermath of the tsunami, UNFPA was appointed lead United Nations (UN) coordinator for the protection sector, and within this context, UNICEF's early response to address child protection was largely financial and technical. UNICEF commissioned an International Federation of Red Cross and Red Crescent Societies (IFRC) team to conduct a rapid assessment of the psychosocial condition of affected populations. The results of the assessment, which indicated widespread trauma in varying degrees, led to the training of volunteers to provide psychosocial support.

Two months after the tsunami, a more comprehensive post-tsunami psychosocial needs assessment exercise was initiated by UNICEF, with partners including: the Unit for the Rights of the Child (URC) in the Ministry of Gender, Family Development and Social Security (MGFDSS), the Faculty of Health Sciences of the Maldives College of Higher Education, the Narcotics Board and the Society of Health Education. A consultant led the exercise along with the UNICEF Maldives Child Protection Officer. The assessment focused on identifying medium and long-term psychosocial needs of children and their caregivers, and on determining other children's vulnerabilities. A workshop conducted in parallel with the assessment focused on four target groups, namely, children, parents, teachers and health care workers.

UNICEF financially supported the MGF's implementation of a Psychosocial First Aid course to deal with the emergency situation. This involved the training of 300 teachers and provided them with basic skills in understanding the nature of trauma among children and in assisting them, through creative arts and expressive therapies, in the immediate aftermath of the disaster (Michaelson, 2005; UNICEF Maldives, 2005). UNICEF also supported the Psychosocial Support and Counseling Unit at the NDMC to conduct various activities in the four relief camps in Malé and other tsunami affected islands. In doing so, approximately 21,000 children were reached (UNICEF Maldives, 2005) with materials such as toys, clay, paints, crayons, and paper (Michaelson, 2005).

UNICEF's recovery response supported the MGF to decentralize social services and to address gaps in the "protective environment" for children. UNICEF Child Protection (CP) also worked with UNFPA to provide training and technical support to the Family Protection Unit (FPU) at Indira Gandhi Memorial Hospital (IGMH) in Malé. The FPU became a point-of-contact for children coming into the health system with abuse issues or mental health/trauma related to the tsunami (UNICEF Maldives, 2005). UNICEF continued to support the Government's drafting of the first periodic report (combined first and second report) to the Committee on the Rights of the Child. It also facilitated trainings on family conferencing by the Juvenile Court and workshops on the "rule of law" by the AGO (UNICEF Maldives, 2005).

UNICEF's early development response refocused its child protection program in an effort to consolidate its support for a more comprehensive child protection system for the Maldives. The three focus areas included: Child Protection Services; Justice for Children; and the HIV/Drug Prevention Project. During this time, UNICEF supported the drafting of the Juvenile Justice Act and the National Strategic Plan for HIV/AIDS. In 2008, UNICEF and (then) MGF began a national study on "Understanding the Situation of the Children in Maldives" to gather quantitative and qualitative data on violence against children.

3   EVALUATION APPROACH / METHODOLOGY

3.1 Objectives and Approach

The purpose of the evaluation is to determine the outcome-impact of the inter-agency child protection response to the tsunami in the Maldives and draw lessons and recommendations that will be useful for strengthening on-going development programming and policies to improve the well-being and rights of children and women. Within this context, the evaluation seeks to achieve three inter-related objectives:

- Provide an outcome-impact analysis of the child protection program (2005-2008) in the Maldives
- Examine DAC[3] evaluation criteria as applied to the child protection sector
- Provide evidence-based conclusions, lessons learned and recommendations

With these objectives in mind, the research team:

- Looked for evidence of incremental and observable changes in the areas of child welfare and rights policies, social services delivery systems, and drug prevention and care services.
- Attempted to answer the question of "what difference" the various interventions have made to improvements of child rights and to securing a protective environment for children.
- Worked backwards to determine the factors that best explain the results that were realized, and those that have fallen short.

The evaluation focused on two of the child protection program's work strands, specifically psychosocial support and NGO and civil society development. It also examined the extent to which child protection results were achieved in each phase and, today, are likely to be sustained.

Development of social protection systems—the central goal of recovery and early development post-tsunami child protection efforts—takes many years to achieve. While new systems are established in some of the tsunami affected islands, the results of these efforts have yet to impact child care and protection trends at the atoll or national levels. The evaluation therefore focused on program outcomes (rather than impacts): changes in the behavior, relationships, activities, or actions of people, groups and organizations with whom a program directly works. The focus on program outcomes was deemed appropriate at this point in time since much of the government and UNICEF's work in the child protection arena focused on capacity building and sustainability, which outcome evaluations are better able to track than impact evaluations.

3.2 Outcome Methodologies

In the area of protection in emergencies, there is insufficient clarity as to the effectiveness of different approaches in working with children, and a key objective of this and other child protection evaluations is to learn what works best. A major evaluation design component is to compare different interventions with one another, or where a similar program does not exist. One of the key comparisons in the Maldives is between "new" (Family and Child Services Centers) and non-existent social service delivery models.

A second key comparison is between areas covered and not covered by the UNICEF-supported substance abuse program: is there evidence to suggest that this is an effective model to prevent substance abuse and rehabilitate drug addicted youth? The evaluation also employed a "retrospective baseline" approach to examine community perspectives on psychosocial well-being immediately after the tsunami, as compared to 2008.

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[3] DAC refers to the Development Co-Operation Directorate (DCD-DAC) of the Organization for Economic Co-Operation and Development (OECD).

The evaluation employed a sequential mixed methods approach in an effort to combine more comprehensive coverage with an in-depth and holistic analysis of program results and a holistic understanding of the context within which each work strand was implemented. During the evaluation's inception phase, this mixed methods approach was selected for four main reasons: strengthening validity through triangulation; using the results of one method to help develop the instrument of the other; extending the comprehensiveness of findings; and, generating new insights. The composition of the national research team was determined accordingly.

Phased sampling was employed for this evaluation. Initially, primary data collection sites outside of Malé (i.e., the three atolls) were randomly selected. Islands within the atolls were then selected through convenience sampling: the atoll capital was selected as this is where the Family and Child Services Centers (FCSCs) are located, and then a nearby "outer" island that was convenient to reach given transportation and time limitations. Sampling of community members and key informants was based on considerations of who could provide valuable information and who would be representative of the population as a whole. Criteria were also applied to some participants, such as children who were required to be between the ages of 13 and 17 years of age.

Field visits were limited to 9 days: 4 days in Raa atoll, 2 days in Kaafu, and 3 days in Laamu. Focus groups and key informant interviews were initiated in each of the atoll capital and outer island groups.
In total, 213 people (87 men and 126 women) participated:

- 133 community members: 60 children (aged 13-17 years), and 73 parents
- 26 staff of Community Based Organizations/NGOs/International Organizations
- 54 Government staff (including 25 staff at FCSCs).

Eleven atolls and the capital Malé were included:

Table 2: Evaluation Sample by Geographic Location

Region	# participants
Malé (capital)	**36**
Outer Atolls	**177**
Dhaalu	1
Faafu	1
Gaafu Dhaalu	1
Haa Alifu	1
Kaafu (including Maafushi, Thulusdhoo & Vilingili)	49
Laamu (including Fonadhoo & Gan)	57
Meemu	1
Noonu	2
Raa (including Dhuvaafaru & Un'goofaru)	61
Seenu	2
Vaavu	1
Total # Participants	**213**

* Field visits were conducted to these atolls.

3.3 Sector-specific Questions and Issues

The evaluation was informed by the DAC Criteria for Evaluating Development Assistance: Relevance, Effectiveness, Efficiency, Impact, and Sustainability (OECD, 1991). Specific questions were crafted to examine these criteria in the context of the Child Protection Program and post-tsunami contexts. These questions were examined within two main child protection work strands: psychosocial support, and NGO and civil society development. Outcome and sustainability questions were also used to examine broader child protection systems development. The list of adapted DAC criteria questions are found in Annex 2.

3.4 Cross-cutting Issues

Advocacy, Policy and Coordination analysis focused on the timeliness and appropriateness of early response advocacy and subsequent policy developments; relationships between provincial and national policy initiatives; the extent to which policy developments have contributed to the evolution of a child protection system; and, the effectiveness of coordination and inter-agency partnerships.

Reaching the most vulnerable analysis examined outreach efforts in the psychosocial support work strand to reach children in marginalized tsunami-affected camps and communities.

Gender analysis focused on the extent to which a gender perspective was mainstreamed across the two work strands. It also focused on broader programmatic efforts to address gender equity and power dynamics.

Early response, recovery and early development linkages are examined within each of the two works strands, as well as across the broader child protection program. The focus is on timeliness and appropriateness of interactions between a focus on vulnerable groups and support to protective systems development.

Child Protection Systems Capacity Development: The evaluation team utilized UNICEF's Protective Environment Framework (PEF) to determine the extent to which current child protection systems in the Maldives provided a protective environment for children. The PEF was assessed through a participatory assessment exercise that included key stakeholders from government and affected communities, and provided a format in which they evaluated the eight key components of this framework.

3.5 Cost Expenditure Analysis

Preliminary research into budgetary issues resulted in the conclusion that a cost-effectiveness evaluation would not be possible. The decision to not pursue this aspect of the evaluation was further augmented by the ethical argument that it is not possible (or desirable) to attach a monetary value to—or compare the costs of—a protected versus non-protected child.

Instead, the evaluation sought to determine trends in governmental support for child protection, focusing on government budget allocations for "social services," from which child protection is funded. Information regarding government budgetary allocations was obtained through publicly available data issued by the Ministry of Finance and Treasury. Similar information on budgetary expenditures for other components of the child protection agenda was unfortunately not publicly available.

Additionally, information is not disaggregated, thus information on specific ministerial budgets was not available. When available, UNICEF budgetary data were obtained from internal Annual Reports. To the extent that trend analysis was possible, governmental budgets were reviewed for the years 2000 through 2008. UNICEF budgets were reviewed for the years 2005 through 2008. These findings are included in Sections 4.6 and 4.7.

3.6 Data Sources and Research Team

Secondary data were obtained from a number of reports issued by the government; UN agencies: WHO, UNFPA, UNICEF and the United Nations Development Program (UNDP); International Organizations (IOs) such as the IFRC and American Red Cross; and in-country NGOs, including the Raajje Foundation. Sources consisted of annual reports, donor reports, research findings, situation reports, needs assessments, post-tsunami recovery evaluations, and government statistics. The Ministry of Health and Family (MHF), the key government partner on child protection concerns (including drug abuse), was the main source of statistical data. Individual Family and Child Services Centers (FCSC), also part of the Ministry, were requested to provide statistical information regarding the number of cases seen since opening and the number and type of awareness and outreach initiatives performed. This data was important to ensure a comparative component in the evaluation. Additionally, case-related statistical information was accessed from the Family and Child Protection Unit (FCPU) of the Maldives Police Service.

Primary data was collected through informant interviews and focus group discussions (FGD) with community members (including parents and children) in three atolls and through key informant interviews with stakeholders in both Malé and the three atolls: Kaafu (Thulusdhoo and Maafushi), Raa (Un'goofaru and Dhuvaafaru) and Laamu (Fonadhoo and Gan). In total, 12 focus group discussions were held with children, parents and recovering drug users, and 42 key informant interviews with governmental, non-governmental, and community based organizations (CBOs) dealing with child- or drug-related issues.

Quantitative and qualitative indicators were employed to guide data collection and analysis. Quantitative indicators included:

- % of key emergency tasks undertaken using UNICEF Core Commitments for Children in Emergencies (CCC)
- % of key protection activities undertaken but not addressed in CCCs
- % of island communities reporting relevance criteria
- # affected people reached
- # of trained psychosocial volunteers and/or school counselors
- # of cases: provision of social assistance and outreach initiatives to outer islands between new and old models
- % communities reporting better/same/worse psychosocial well-being
- % budget change over time (2004-2008)

Qualitative indicators included:

- Community perceptions regarding their respective island's psychosocial well-being, NGO activities, and necessary improvements.
- Government officials and NGO staff perceptions of the same.

Each indicator was assessed through both primary and secondary data collection. For the primary data, participatory methods were used to involve affected communities, children and other stakeholders as evaluation participants. Gender awareness methods were employed to ensure that the voices of both women and men contributed to the evaluation. Participants' confidentiality was ensured through the process of obtaining verbal informed consent.

Given the limited amount of baseline information available, comparative methods were employed to ensure that some measure of difference between communities could be obtained, and descriptive statistics generated using Microsoft Excel. Qualitative data underwent initial preliminary analysis through debriefings by the national research team over two days, and were coded thematically.

The evaluation was conducted by a team of independent evaluators with knowledge of child protection issues, including: a global consultant, a country team leader and two national research assistants. The

evaluation framework was developed in August 2008, but field work was delayed until the end of December—and was completed 2.5 months later in mid-March 2009.

3.7 Limitations

There are several constraints that limit the validity and adequacy of this evaluation's conclusions. First, an "end of project' evaluation design cannot control for economic, political, or other events that occurred during the life of a program and it is not possible to determine if and how they may have affected outcomes. Second, explanation of constructs are affected by the inter-agency nature of the Child Protection Program and the corresponding lack of a precise overall program theory, missing variables and unclear implementation steps. Third, while many participating agencies initiated single agency project assessments per relevant work strands, an overall aggregate baseline was never developed. Hence, the evaluation team relied on secondary data, participant recall and other retrospective techniques to recreate pre-intervention conditions. Finally, the small sample sizes for some of the groups interviewed limited statistical analysis and constrained the possibility of making program outcome comparisons.

In addition, there were significant operational constraints:

- Time constraints: the initial evaluation was planned to occur over 6 months. However, due to in-country delays, the time available was compressed to 2.5 months.
- Transportation & logistical challenges: the evaluation team was only able to visit 3 outer atolls during the one month period of primary data collection.
- Data availability: many secondary data sources were not available or accessible to the evaluation team and, in many cases, other research scheduled for completion was not yet finalized.
- Contextual challenges: the Maldives is undergoing a period of political transition; staffing and responsibilities are changing throughout key ministries, including the new Ministry for Health and Family.

4. EVALUATION FINDINGS

4.1 Overview: Outcome Analysis

The American Red Cross (ARC) initiated a large psychosocial program, reaching an estimated 66,136 people on 76 tsunami-affected islands in 7 different atolls. The program also trained 1,145 community facilitators and 173 government ministry personnel. Through the program, a total of 212 teachers from across seven atolls also received training to identify stress in children, provide psychological first aid and conduct resilience activities (IFRC, 2008, p. 5). By the end of 2005, another 70 volunteer counselors, 321 teachers, and 6 master-trainers in 21 atolls were trained in psychosocial support and intervention techniques. Through the coordinated psychosocial response, 22,500 people were provided with social support and counseling services (World Bank et al., 2005; WHO, 2006).

Focus group discussions held in three atolls (six islands) revealed a high level of appreciation for the psychosocial activities and trainings provided to both children and parents. 96% of parents and 89% of children who received activities/trainings stated they were relevant. Non-traditional psychosocial programs, such as livelihoods programs, were mentioned by parents as being useful because of the relationship between economic needs and psychosocial problems.

Despite broad endorsement of the usefulness of these programs, concerns also were raised. During relief and early recovery phases, psychosocial emergency responses mirrored the centralized approach by government—they were top-down and dominated by a Malé perspective (Patel, 2006). Community members felt this approach largely ignored the realities and perspectives of the local communities, as well as their pre-existing capacities and structures.

The evaluation also looked at whether the psychosocial program has led to identifiable changes. To do so, parents on the six islands were asked to rank their communities' ability to support children's psychosocial well-being at two points in time: immediately after the tsunami and currently (January 2009).   An average across all parent focus groups determined that since the tsunami, parents believe there has not been any improvement in their communities' ability to support children's psychosocial well-being.

However, when parent rankings are disaggregated by island status (i.e., atoll capital versus outer island), the results are strikingly different. Parents from atoll capitals perceived limited incapacities immediately post-tsunami, with slight improvements by 2009; that is, atoll capitals appear to have fared better post-tsunami due to existing resources (i.e., playgrounds, activities, schools, etc.) that have at least been maintained, if not slightly improved. For the outer islands, the situation both post-tsunami and currently is much less hopeful. Parents on outer islands perceived significantly diminished capacity immediately post-tsunami and no improvement as of January 2009.

The evaluation examined the effectiveness of the new FCSC service delivery model using the "old" model of service delivery as a point of comparison. The former model of child protection service delivery was centralized in Malé. In the atolls, service delivery was entirely voluntary. The "new model" for child protection services involves a continuation of the central services offered by the Department of Gender and Family Services (DGFPS) and FCPU/MPS in Malé. Additionally, it now includes a new dedicated Family Protection Unit (FPU) at the Indira Gandhi Memorial Hospital (IGMH), and the decentralization of the child protection system to the atoll capitals through the installment of Family and Child Services Centers (FCSC).

The FPU provides support to women affected by violence and children suspected of being abused who come to the hospital. In the eleven months from August 2005 to June 2006, a total of 49 cases of child abuse were recorded by the unit (UN Maldives, 2007), representing 46% of the total cases brought forward to the FPU. The unit aims to improve the responsiveness of the health sector towards cases of abuse. However, it has limited coverage outside of the capital (UN Maldives, 2007).

Since the establishment of FCSCs in 21 atolls, there has been increased reporting of child protection concerns and an overall increase in public awareness about child abuse, according to key informants at the centers. 73% of staff at the 11 FCSCs that participated in the evaluation noted increased awareness about the work of the center and the issue of child abuse since the center opened. Additionally, 55% stated that formal reporting had increased. Statistical information provided for the evaluation by the Department of Gender and Family Services (DGFPS) under the Ministry of Health and Family (MHF) in Malé appears to support these assertions. The FCSCs recorded a total of 750 cases and 235 prevention activities in the atolls as of the end of October 2008.

The new model of formal decentralized services faces significant challenges. FCSCs are primarily staffed by young adults (average age 23.5 years) with limited training (37% had 3-month Social Service Worker(SSW) certificates from the Center for Continuing Education); 63% received one year diplomas or advanced certificates and had experience ranging from one month to two years.

In looking at civil society development, the evaluation sought to determine the extent to which NGO/CBOs are focusing on child protection and welfare concerns. According to recent reports that assess civil society within the capital Malé (Raajje Foundation, 2009), 14 of a total 32 Malé-based NGOs identified their focus as child- and/or drug-related, including four that focused primarily on drug issues. Of these fourteen NGOs/CBOs, four have suspended operations in order to re-set their direction for the coming years, representing 29% of the total number of child- and/or drug-related NGOs in the capital. Additionally, one-half of these NGOs/CBOs (7 out of 14) formed after the tsunami; and, in 2009, four of these "tsunami created" NGO/CBOs are not active. UNICEF findings from 2006 on NGOs within 14 atolls outside of Malé suggest that 14% were registered post-tsunami. Of those for whom details were available (n=40), 45% were no longer active. In both the capital and the outer islands, the number of active NGOs has steadily decreased over the past two years (2007-2009).

The normative drug addiction treatment system in the Maldives consists of three main options for government-sponsored treatment and rehabilitation: Himmafushi's Drug Rehabilitation Center (DRC), a residential treatment program; the Community Services Center/Greenge (CSC) in Malé, (former) NNCB's aftercare center; and Addu Atolhu Rehabilitation Center. In addition, the (former) National Narcotics Control Board (NNCB), in partnership with the United Nations Office of Drugs and Crime (UNODC), is sponsoring a methadone treatment program (MMT) in Malé. NGOs also offer support to people with substance abuse issues—both active addicts and those in recovery. Journey, an NGO run by and for recovering addicts (and supported by UNICEF since 2006) provides a drop-in center in Malé and 12-step programs in both Malé and Addu.

There is a lack of empirical data and evaluation of any drug treatment, rehabilitation or supportive programs offered in the country, and there are no official statistics maintained on relapse rates. However, key government informants perceived the rate of relapse to be decreasing, from an estimated 50% in 2005 to 40% currently. This estimated 10% decrease was attributed to increased awareness and willingness among drug users to access assistance offered by the CSC and NGOs such as Journey.

4.2 Overview: Specific Child Protection Sector Questions

This section provides an overview of findings on specific child protection sector questions pertaining to relevance, effectiveness and efficiency. These questions are also explored in subsequent findings on the psychosocial support, and civil society and NGO development work strands.

Relevance

UNICEF's Core Commitments to Children in Emergencies were used to guide UNICEF Maldives' early response. Directives on rapid assessment, psychosocial support and separated children (which helped determine this was not a significant problem) were most relevant. UNICEF's transition from a service delivery approach to an institutional and capacity building approach during the recovery phase was

appropriate given the increased capacity needs in the aftermath of the disaster, and the funds that the organization commanded.

At the same time, much of UNICEF's work in this sector was undertaken by international consultants. UNICEF found it difficult to obtain either temporary or long-term technical national assistance because of an insufficient pool of local expertise. Assessment exercises were affected accordingly, appearing at times to be disconnected from island culture and realities. The post-tsunami psychosocial needs assessment chronicled post traumatic stress symptomology at the expense of investigation of family and community supports (see IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings, 2007). Their assessment lacked sufficient guidance on how to engage extended families or island level committees in social welfare and community care roles. The absence of a relevant focus and analysis on social and community strengths may, in part, be responsible for the shortcomings of the psychosocial program's outcomes.

Effectiveness

One of the more effective post-tsunami achievements has been the acceleration of the social service delivery model. Thirty social workers graduated from the SSW course in 2008, and have begun working in the 21 FCSCs in the Atolls and in the DGFPS/MHF in Malé. Center and Ministry personnel have also undergone training for a newly developed procedure manual governing their work. The Procedure Manual on Delivery of Services, also developed with UNICEF, pulls together information on the statutory requirements of national legislation and international conventions to provide practical guidance on social work best practices and tools. While significant challenges remain, the process of decentralization is slowly achieving some of its intended objectives.

At the same time, the effectiveness of UNICEF's overall protection program was diminished by the lack of realistic planning and in-house sector expertise. UNICEF Maldives' Annual Reports state that one-third of planned activities in 2006, and a similar proportion in 2007, remained incomplete due to over-ambitious planning by the program, difficulties in multi-sectoral cooperation, and bottlenecks and lack of absorption capacity in government. A lack of inter- and intra-sectoral coordination, including the lack of capacity in government agencies to coordinate various stakeholders, and high staff turnover have resulted in instability within UNICEF's work on drug abuse/prevention (UNICEF Maldives, 2007). The lack of social sector expertise—especially as it relates to social sector and community development specialization and access to local knowledge—also limited the effectiveness of child protection programming.

Efficiency

The extent of local community buy-in and ownership of projects is arguably the single, largest determinant of the long-term viability and sustainability of programs. In the Maldivian context, a distinction may be made with regard to national level partnerships and related island governments, on the one hand, and civil society and community needs and priorities, on the other hand. With this distinction in mind, there appears to have been an imbalance in national level human and financial investments compared to civil society and social sector investments. The absence of NGOs or competent academic institutions that could be commissioned to conduct rapid, social sector assessments in the Maldives also was a drawback to efficient program planning. At the time, there was not a regional roster of consultants/organizations that could be tapped for early deployment of experts to conduct rapid, social protection needs assessments.

4.3 Psychosocial Support

Within the psychosocial work strand, the evaluation examined community perceptions of the relevance and effectiveness of work in this sub-sector and its contribution to community capacity to support children's psychosocial well-being. It also provides findings on the government's post-tsunami decentralized social service approach.

Early Response

The establishment of the National Disaster Management Center (NDMC) the day after the tsunami, as well as its provision of psychosocial services within the first week through the "Social Support and Counseling Services (SSCS)" group (World Bank et al., 2005), helped to prioritize psychosocial needs in the Maldives. Within the United Nations, UNFPA took a lead coordination role on psychosocial activities (IFRC, 10 January 2005) and child protection (personal communication, 2009) working closely with the NDMC, IFRC and other international actors. UNFPA supported national authorities and liaised with local NGOs in the provision of psychological first aid during the early days following the disaster. "Community Educators" (CE) were trained and began working in five, severely affected atolls to provide ongoing assessment and psychosocial support for the first six months (UNFPA, 2006, p. 33).[4]

Recovery

The International Federation of the Red Cross and Red Crescent Societies was a significant actor in the sector throughout the early response and recovery phases. Overall, the Federation initiated a Psychosocial First Aid course to deal with the immediate emergency situation. This involved training volunteer counselors, health workers and other relevant individuals in basic skills to understand the nature of trauma and assist traumatized people in the immediate aftermath of the disaster. Another training program was targeted at teachers and provided training in understanding children's responses to trauma, the use of creative and expressive arts for children, and the identification of children who may need further assistance.

Specific National Societies, such as the American Red Cross (ARC), undertook large-scale projects/programs of a psychosocial nature. Ten days after the tsunami, a two-member American Red Cross (ARC) team specializing in psychosocial support reached the Maldives to provide support to psychosocial efforts (IFRC, 10 January 2005). From its inception in November 2005 through its completion in June 2008 and with a total budget of USD $2.7 million (personal communication, 2009), ARC's psychosocial support program (PSP) reached the vast majority of affected island communities and displaced groups through its implementation on 76 separate islands in 7 different atolls. The PSP reached a total of 66,136 people throughout the country, including the provision of training for 1,145 community facilitators and 173 government ministry personnel (73 as crisis intervention technicians and 100 as crisis intervention specialists).

Through the program, a total of 212 teachers from across seven atolls also received training to identify stress in children, provide psychological first aid, and conduct resilience activities (IFRC, 2008, p. 5). Within the first year after the tsunami, 70 volunteer counselors, 321 teachers, and 6 master-trainers in 21 atolls were trained in psychosocial support and intervention techniques. Through the coordinated psychosocial response, 22,500 people were provided with social support and counseling services (World Bank et al., 2005; WHO, 2006).

Save the Children contributed to the overall efforts of the child protection sector by providing assistance to assess urgent and psychosocial needs throughout communities in the affected atolls during the recovery phase.

Early Development

The early development program supported the government's plan to decentralize social services. By 2008, 30 social workers graduated from the SSW course, and started working in the 21 FCSCs in the atolls and in the DGFPS/MHF in Malé (UNICEF Maldives, 2008a). Center and Ministry personnel have also undergone training for a newly-developed procedure manual governing their work. The Procedure Manual on Delivery of Services, also developed with UNICEF, pulls together information on the statutory requirements of national legislation and international conventions to provide practical guidance on social

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[4] www.unfpa.org/emergencies/pacific/docs/unfpa-tsunami-yr-end-rpt.pdf

work best practices and tools. UNICEF also continued to support expansions and amendments to national legislation governing children and their rights.

Community Perceptions of Relevance and Effectiveness of Psychosocial Response

Given the logistical challenges of delivering programs and services in an island country, early psychosocial responses to the most affected island communities required considerable time to coordinate. Still, about half of the island groups interviewed for this evaluation reported timely responses, while the other half emphasized delays.

Focus group discussions held in three atolls (six islands) with children (n=57) and parents (n=69) revealed a high level of appreciation for the activities and trainings provided to both children and parents. Namely, 96% of parents and 89% of children participating in focus groups who received activities/trainings stated they were relevant. Non-traditional psychosocial programs, such as livelihoods programs, were mentioned by parents as being useful because of the relationship between economic needs in the community and psychosocial problems within destitute families.

Table 3: Overview of Psychosocial Activities

Psychosocial Activities	Organization	No. of Islands
Disaster preparedness	ARC/IFRC/Care	6
Psychosocial workshops for parents	ARC	6
Other events for children	Care/IFRC	3
Livelihoods programs	Care	3
Psychosocial training programs	Care/ARC	3
Sports activities for children	ARC/French Red Cross/other	3
Psychosocial workshops for students	ARC	2
Violence against women (VAW) awareness	Care	2
Children's art show	Japan International Development Aid (JICA)	1
Children's camp	Unknown	1
Counseling for children	MGF	1
School-based programs	School	1

Activities recalled by focus group participants may be broadly grouped into seven categories: events, trainings/workshops, provision of material goods, recreation and art programs, counseling, school-based programs, and other types of activities (i.e. water/sanitation programs). The majority (86%) of psychosocial trainings and workshops targeted parents or other adult community members. Participants described attendees at these sessions as overwhelmingly women.

Figure 1: Activity Typology

Type of Activity

- Event — 14%
- Training/Workshop — 49%
- Material Goods — 3%
- Recreation/Art Program — 12%
- "Counseling" — 10%
- School Program — 5%
- Other — 7%
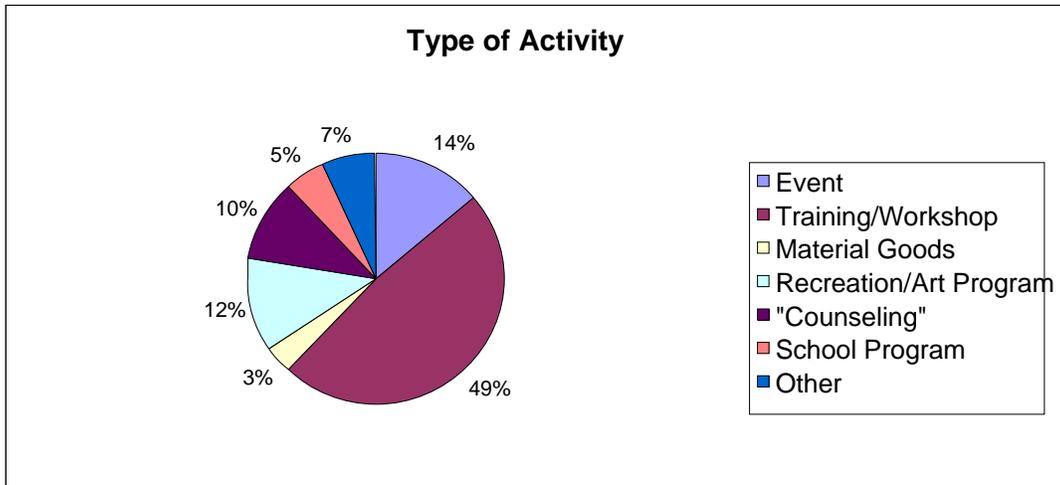
Focus group discussions also identified several community perspective concerns. First, there was a tendency amongst international agencies toward "over-assessment" of community needs at the expense of delivery of services. Second, was the belief that the psychosocial responses mirrored the centralized approach by government—they were top-down and dominated by a Malé (and predominantly male) perspective (Patel, 2006). Community members felt this approach ignored the realities and perspectives of the local communities, as well as their pre-existing capacities and structures. Third, the majority of focus group participants described activities in this sub-sector as "ad-hoc or "one-time events." They also noted that most of the activities in this sub-sector have been discontinued. Finally, focus group participants believed that efforts to address tensions between host and IDP communities were insufficient and ineffective.

Psychosocial Well-Being

The evaluation explored adult and children's perceptions of "change" in the communities' ability to support children's psychosocial well-being immediately after the tsunami, as compared to now (January 2009). Separate child and parent focus groups were asked to identify what "psychosocial well-being" meant to them and how it was best achieved. Based on these criteria, participants were then asked to rank their community's ability to support psychosocial well-being from the two points in time noted above.

For children, the primary ingredients of psychosocial well-being included: happiness and good feelings, good relationships, and positive environments. Children also identified five key psychosocial well-being supports: parents/family support; friends; activities (including sports and cultural events); a peaceful and clean environment; and a good education as necessary for their happiness. For parents, the priorities were much the same, and emphasized positive family environments, safe spaces and regular activities for their children as the priority supports necessary for psycho-social well-being.

Table 4: Top 5 Parent-Identified Mechanisms/Supports Necessary for Child Well-Being by Number of Endorsements

Criteria	Combined		
	Atolls Endorsing	# Participants	Top 5 Ranked
Programs for children & youth	Raa (R), Kaafu (K), Laamu (L)	61	1
Good Parenting	R/K/L	51	2
Park/playground facilities	R/K/L	47	3
Good education/school (quality)	R/K	34	4
"Peaceful" community	R/K	26	5
Drug prevention		19	
Medical facilities		19	
Material needs (food/water)		15	
Protective environment		15	
Religion (Islam)/teachings		15	
Good friends/peer group		11	
Life skills		9	
Youth Center		9	

Source: Focus Group Discussions with parents; N=69

Parents were asked to rank their communities' ability to support children's psychosocial well-being immediately after the tsunami and now (as of January 2009), using a 5-point Likert Scale. 5, an average across all parent focus groups, determined that communities had "diminished capacity" post-tsunami to support children's psychosocial well-being (ranking = 2.83). Since the tsunami, however, parent participants felt there has not been any improvement in their communities' abilities to support children's psychosocial well-being (ranking = 2.83).

The results are strikingly different, however, when community rankings are disaggregated by island status (i.e., atoll capital versus outer island). Community members from atoll capitals perceived almost "normal capacity" post-tsunami, with slight improvements reported currently. It would seem that atoll capitals have fared better post-tsunami due to basic resources (i.e., hospitals, schools etc.) that have at least been maintained, if not currently slightly improved. For the outer islands, however, the situation both post-tsunami and recently is much less hopeful. Community members perceived that capacity post-tsunami was diminished, with very little improvement to-date.

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[5] 1-5 Likert Scale: 1. no capacity; 2. seriously diminished capacity; 3. diminished capacity; 4. almost normal capacity; 5. normal capacity

Figure 2: Community Ranking by Island Status: Immediately After the Tsunami and Currently
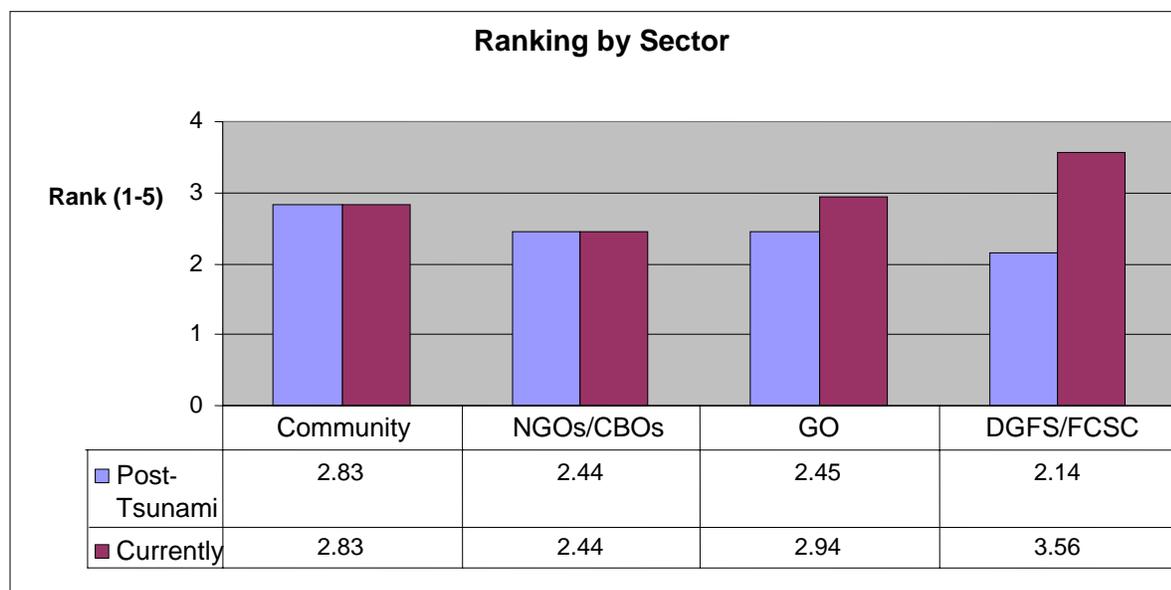
Ranking by Island Status

	Post-Tsunami	Current
◆ **Atoll Capital**	4	4.5
■ **Outer Island**	1.66	2
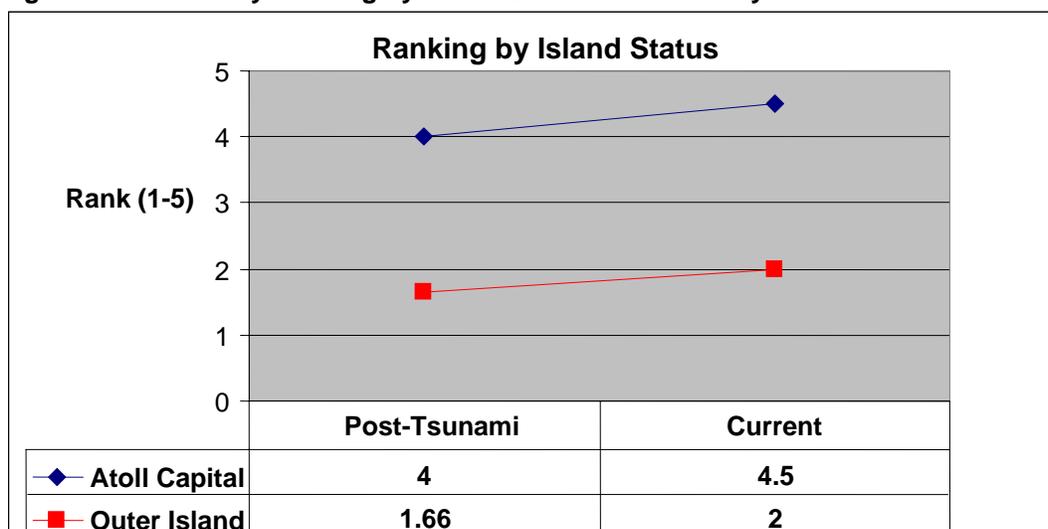
The same ranking exercise was initiated with key informants in government agencies, including FCSC staff and staff of NGOs/CBOs. It provides an interesting point of comparison with parents' perceptions of community capacity to support children's well-being. Government agencies (GO) perceive greater improvements in capacity among communities than do NGOs/CBOs or the community members themselves. Comparative findings indicate a gap in service-provider and parent perceptions of collective capacities to promote child security and well-being, especially in the outer islands.

Figure 3: Average Ranking Compared Across Sectors

Ranking by Sector

	Community	NGOs/CBOs	GO	DGFS/FCSC
■ Post-Tsunami	2.83	2.44	2.45	2.14
■ Currently	2.83	2.44	2.94	3.56

FCSC Model

The evaluation explored the effectiveness of the new FCSC service delivery model using the "old" model of service delivery as the comparative baseline. The former model of child protection service delivery was centralized in Malé. In the atolls, service delivery was entirely voluntary. In 1999, the MGF initiated a short workshop for volunteer child protection workers from all the atolls on international conventions, domestic legislation, prevention, and counseling and investigation skills. Volunteers were provided basic

information on how to assist with child abuse cases and conduct awareness raising activities. After the trainings, volunteers returned to their respective islands, and very few engaged in social sector activities (MGF, 2007).

Baseline

Under the old model, case records were not maintained; however, statistical information was recorded at MGF in Malé. A significant proportion of cases from 2000-2005 (23%) were coded by the URC as "behavior problems" or "miscellaneous". There was a lack of clarity and overlap between the case codes (i.e., between psychological problems and mental health issues; family problems and behavior problems; etc.).

Table 5: Child Protection-Related Cases Reported to URC, 2000-2005

	2000	2001	2002	2003	2004	2005
Total No. of Cases	**580**	**433**	**396**	**310**	**349**	**274**
Behavior problems	*4*	*22*	*64*	*34*	*46*	*41*
Child abuse (physical)	*15*	*15*	*29*	*12*	*12*	*13*
Child abuse (psychological)	*1*	*-*	*1*	*3*	*2*	*4*
Child abuse (sexual)	***61***	***37***	***41***	***19***	***39***	***35***
Children in conflict with law	*76*	*62*	*133*	*135*	*69*	*48*
Miscellaneous	*97*	*77*	*87*	*23*	*20*	*18*

Source: MGF (2006a) "Combined report to Committee on the Rights of the Child". Malé: Ministry of Gender and Family.

The Family and Child Protection Unit (FCPU)/Maldives Police Service (MPS) also kept statistics on child sexual abuse cases reported to the unit.

Table 6: Child Sexual Abuse Cases Reported to the MSP, 2001-2005:

Year	2001	2002	2003	2004	2005
No. of Cases	68	98	75	62	89
Referred to Attorney General's Office	62	83	46	21	26

Sources: personal communication, FCPU, 11 February 2009; UN Maldives, 2007

MGF-URC and FCPU-MSP statistics are significantly different. This is most evident in their respective data on reported child sexual abuse cases.

Figure 4: Comparison of Child Sexual Abuse Cases Reported Under the "Old" Model of Child Protection Service Delivery, 2001-2005
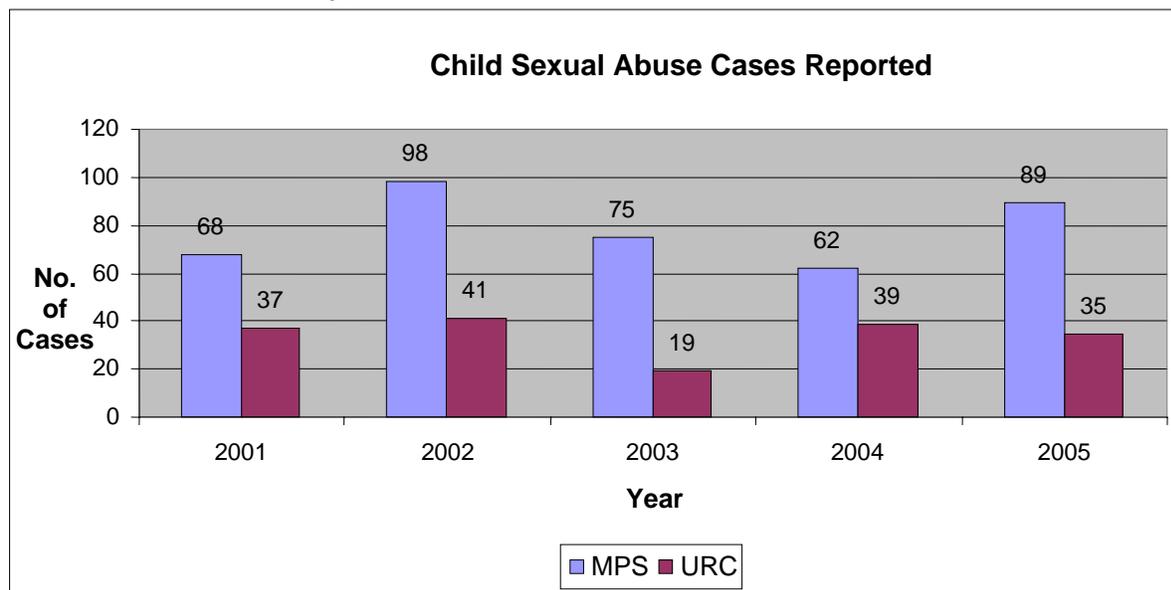
FCSC Approach

The "new model" for child protection services involves a continuation of the central services offered by the Department of Gender and Family Services (DGFPS) and FCPU/MPS in Malé. However, it also includes the establishment of a dedicated Family Protection Unit (FPU) at the Indira Gandhi Memorial Hospital (IGMH) in mid-2005, and the decentralization of the CP system to the atoll capitals through the installment of Family and Child Services Centers (FCSC), beginning in 2006.

The FPU provides support to women affected by violence and children suspected of being abused who present in the hospital. In the eleven months from August 2005 to June 2006, a total of 49 cases of child abuse were recorded by the unit (UN Maldives, 2007) representing 46% of the total cases brought forward to the FPU. The unit aims to improve the responsiveness of the health sector towards cases of abuse; however, it has limited coverage outside of the capital (UN Maldives, 2007).

Since the establishment of FCSCs and the presence of trained and paid social services workers in 21 atolls, there has been increased reporting of child protection concerns and an overall increase in public awareness about child abuse, according to key informants at the centers. Seventy-three percent of staff at the 11 FCSCs who participated in the evaluation noted increased awareness about the work of the center and the issue of child abuse since the center opened; 55% stated that formal reporting had increased.

Statistical information provided by the Department of Gender and Family Services (DGFPS) under the Ministry of Health and Family (MHF) in Malé appears to support these assertions. As seen below, the FCSCs recorded a total of 750 cases and 235 prevention activities[6] in the atolls as of the end of October 2008.

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[6] The statistics provided by MHF are not able to be disaggregated into type of case reported or prevention activity conducted.

Table 7: Child Protection Cases and Prevention Activities Reported Under the "New" FCSC Model of Child Protection Service Delivery by Atoll, 2006-2008

Atoll	Date FCSC Opened	# Cases Reported (since opening)	# Prevention Activities (since opening)
HA	8-May-08	13	1
HD	30-Aug-07	62	9
SH	8-May-08	10	3
N	30-Aug-07	40	39
R	30-Aug-07	38	17
B	8-May-08	19	3
LH	31-Aug-07	23	2
K	28-Aug-08	2	5
AA	28-Aug-08	0	5
AD	28-Aug-08	3	2
V	28-Aug-08	2	0
M	30-Aug-07	22	14
F	28-Sep-08	4	1
DH	31-Aug-07	22	8
TH	30-Aug-07	30	16
L	30-Aug-07	39	21
GA	8-May-07	38	8
GD	30-Aug-07	77	55
GN	30-Aug-07	114	23
S	2006	192	3
TOTAL:		**750**	**235**

Statistics from FCPU/MPS also demonstrate an increase in the number of child sexual abuse cases reported nationally since the decentralization of social protection services to the atolls commenced. Reported cases nearly doubled from 2006 to 2008.

Table 8: Child Sexual Abuse Cases Reported to the Maldives Police Service, 2006-2008

Year	2006	2007	2008
# Cases	99	153	180

Findings from a recent UNICEF-sponsored study suggest that formal reporting is not yet a norm within the society. Instead, the majority of children turn to friends or family members for emotional support in cases of physical or sexual abuse, with under 10% opting to inform DGFS/FCSC, schools or the police (UNICEF Maldives & MHF 2009). For community members who were aware of or suspected child abuse by a caregiver, 43% did not share with anyone, 37% discussed with friends or neighbors, and only 18% formally reported their suspicion. These findings are consistent with this evaluation's findings: children do not report physical or sexual abuse to the police, government ministries, or to their school.

The new model of formal decentralized services is not without other challenges. FCSCs are primarily staffed by young adults (average age 23.5 years) with limited training (37% had 3-month Social Service Worker certificates from the Center for Continuing Education; 63% received one year diplomas or advanced certificates) and experience (ranging from one month to two years).

Table 9: FCSC Activities as Reported by Interviewees

Activity	# FCSCs
Case management[7]	11
Workshops about the center	11
Counseling	6
Event participation	5
Advocacy	2
Sector meetings	2
Outreach	1
Referrals	1

According to FCSC staff (n=25), their work involves case management, workshops about the center's role in the community, counseling, and participation in community events. Community mobilization, linkages with CBOs, and advocacy and prevention programs were not evident.

The main FCSC challenges may be summarized as follows:

Human/financial resource constraints: All 25 FCSC staff described human and financial resource constraints as their great challenge. Across the 11 FCSCs included in this evaluation, the average number of staff was 5, including 2 case workers and one team leader who also performed case work in addition to his management duties. Many FCSCs lacked administrative staff. The majority of FCSC staff also noted the lack of training and experience as factors that limit their effectiveness and contribute to 'burn-out', and team leaders felt ill-equipped to supervise their staff or assist with these problems. Three of the FCSCs did not have the financial resources to conduct activities, including funding to travel within the atoll.

Lack of support: Participants noted a lack of support both internally for their work, and externally for the center as a challenge. Internally, many FCSC staff described the lack of supervision and support from the DGFS in Malé as missing, especially since its merger into the MHF. Externally, many described their community's reluctance to disclose child abuse formally and the stigma that is associated with accessing center services. More broadly, other stakeholders were also perceived by some FCSCs as not supporting the presence or work of the center (including courts, police, schools, health centers and atoll/island administration).

Community focus group discussions also assessed the level of awareness of the FCSC in the atoll capital and outer communities. Almost all participants were aware of the presence of the center, but largely unaware of their work or the services offered.

4.4 Civil Society Development

To assess civil society development, the evaluation team looked at changes that have occurred in the development of NGOs, including the extent to which new NGOs address child protection and well-being concerns; the extent to which links between civil society and government service providers have been established at national, atoll capital, and island levels; and civil society and government efforts to address drug treatment and rehabilitation.

Early Response

A Presidential Decree led to the formation of a taskforce at the National Disaster Management Center (NDMC) the day after the tsunami. A self-organized group called "Social Support and Counseling

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[7] Case management includes assessment, action planning, intervention (referrals/removals), and case reporting; it employs a systems approach. (MGF, Procedure Manual, 2008)

Services" integrated themselves into the NDMC, helping to establish a multi-sectoral coordination group and providing psychosocial support services to affected people. These included a walk-in counseling service in Malé, a telephone counseling service (the Tsunami Helpline), and a mobile counseling service where counselors visited relief centers and individual homes to provide crisis intervention, counseling and support (World Bank et al. 2005).

Recovery

A return to development-focused work began in 2006, with the UNICEF Child Protection program nearly doubling its implementing partners that year, including partnerships with government entities and NGOs.

Figure 5: UNICEF Child Protection Implementing Partners
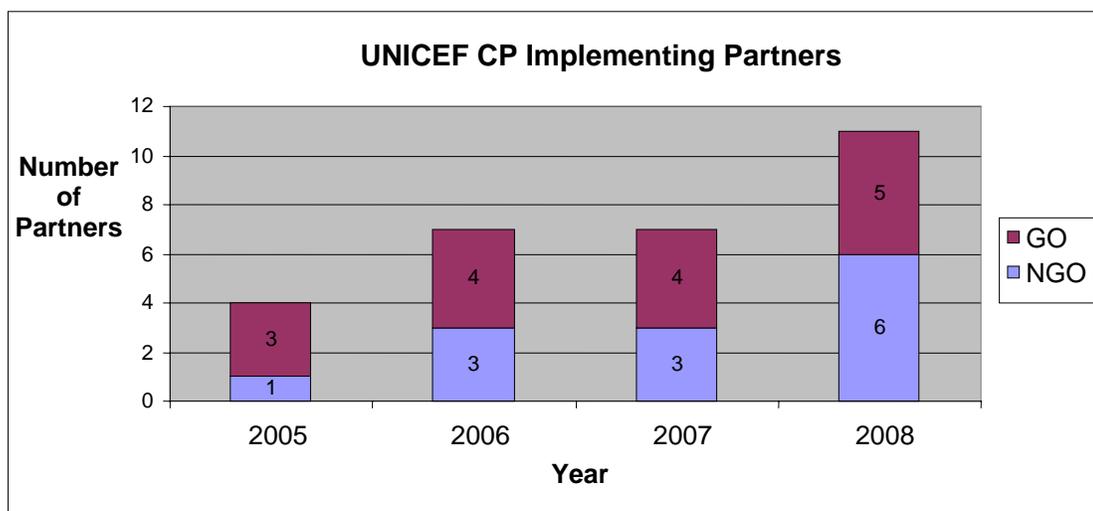
The Child Protection Program also undertook efforts to institutionalize and coordinate services more broadly, including efforts to tackle drug abuse among children and youth. UNICEF supported an ethnographic study in 2006 on substance misuse that was led by young people recovering from addiction. The report, "Voices from the Shadow," has since been used as part of the "Wake Up!" campaign discussed below (Journey & NNCB, 2007).
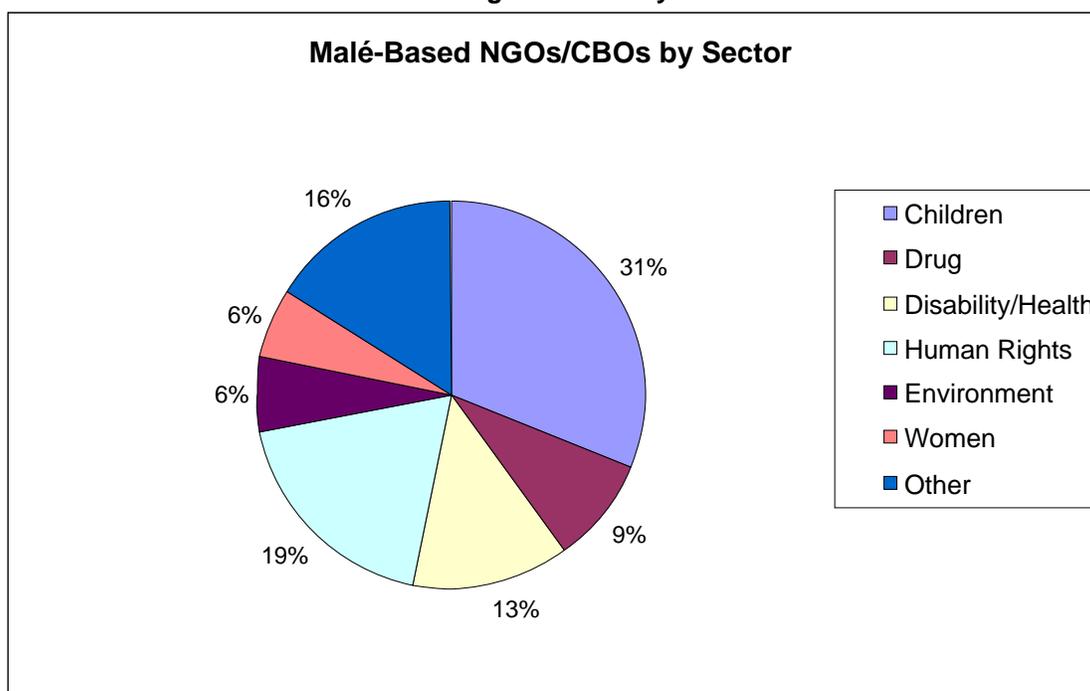
Early Development

In 2006-2008 UNICEF increased capacity building, awareness raising and outreach efforts to address the drug abuse issue. These efforts are among the first of their kind for UNICEF in the Maldives. UNICEF facilitated and financially supported a unique partnership between Journey (a local NGO), the NNCB (government), Television Maldives (Media) and Dhiraagu (a national telecommunications agency) to undertake a broad-based awareness campaign, "Wake Up!" (UNICEF Maldives, 2007).

Civil Society Capacity Development

The evaluation specifically sought to assess the extent to which new NGOs addressed child protection and well-being concerns and continue to do so today (January 2009). According to recent reports that assess civil society within the capital Malé (Raajje Foundation, 2009), 14 of a total 32 Malé-based NGOs identified their focus as child- and/or drug-related, including 4 who focused primarily on drug issues. Of these 14, four have suspended operations in order to re-set their direction for the coming years. This represents 29% of the total number of child- and/or drug-related NGOs in the capital. Additionally, of the one-half of NGOs/CBOs (7 out of 14) that formed after the tsunami, four (57% of the 7) are not presently active.

Figure 6: Malé-Based Non-Governmental Organizations by Sector

Malé-Based NGOs/CBOs by Sector

Legend
☐ Children
☐ Drug
☐ Disability/Health
☐ Human Rights
■ Environment
☐ Women
☐ Other

31% Children
9% Drug
13% Disability/Health
19% Human Rights
6% Environment
6% Women
16% Other

Information gathered by UNICEF Maldives in 2006 (based on government data and field visits) regarding NGOs within 14 atolls outside of Malé, demonstrated that 14% were registered post-tsunami. Of those for whom details were available (n=40), 45% were no longer active. Unfortunately, in both the capital and the outer islands, the number of active NGOs has steadily decreased over the past two years. Countrywide, over 700 organizations have sought registration with the government through 2008. However, few are active, primarily due to a lack of internal capacity and financial support for the civil society sector in general (Raajje Foundation, 2009). Additionally, the Raajje Foundation (2009) assessment sighted a lack of coordination, cooperation and pooling of resources within the sector as problematic.

Civil Society and Government Linkages

Further, the evaluation explored linkages between government service providers and civil society actors at the national, atoll capital, and island levels. Key informant interviews accessed via 15 CBOs and NGOs in both the atolls and capital, described decreased NGO-GO activities in the past year. One NGO in an outer island approximated a 50% decrease in their activities in partnership with government over the past year. In part, this may be due to the political transition; however, key informants in the atolls also shared that high turnover of government staff, including within the Ministry of Health (MOH), Ministry of Education (MOE), and island offices, had played a role.

Child protection-related NGOs/CBOs that participated in the evaluation also described their relationships to government agencies as largely ad-hoc partnerships for specific projects or events. Of those interviewed, 60% of NGOs/CBOs had partnered with MPS and/or MOE to deliver awareness raising activities or participate in an event. Overall, key informants highlighted the lack of coordination between government and civil society as a detriment to the work necessary to ensure child protection.

Overall, it appears that the 'building back better' strategy did not adequately focus on the development of civil society as a key long-term child protection actor. NGOs/CBOS that relied on tsunami-related funding have ether fallen into disarray or stopped their program altogether. (Raajje Foundation, 2009).

Civil Society Involvement in Drug Abuse Treatment and Rehabilitation Services

The normative treatment system in the Maldives consists of three main options[8] for government-sponsored treatment and rehabilitation: Himmafushi's Drug Rehabilitation Center (DRC), a residential treatment program; the Community Services Center/Greenge (CSC) in Malé, (former) NNCB's aftercare center; and Addu Atolhu Rehabilitation Center (RC). In addition, the (former) NNCB, in partnership with the United Nations Office on Drugs and Crime (UNODC), is sponsoring a methadone treatment program (MMT) in Malé.

Officially opened in 1997 and run by the (former) NNCB, the DRC has since assisted an estimated total of 2,400 clients (personal communication, 10 February 2009) through residential treatment that employs a therapeutic community (TC) model. The TC model focuses on community outreach and self-help. UNICEF and United Nations Office for Project Services (UNOPS) in 2007 undertook the renovation of the CSC to help provide aftercare and vocational opportunities for young recovering drug users. Key informants in this evaluation noted the current numbers of clients using each facility as shown in Table 10.

Table 10: Clients per Facility as Reported by Key Informants

Facility	Clients
DRC Himmafushi	132 (118 males and 14 females)
CSC Malé	130-150 recovering addicts (80-100 parents)
Addu RC	68 (24 in-house, 44 from community)
MMT	31 (28 male and 3 females)

Civil society NGOs also offer support to people with substance abuse issues—both active addicts and those in recovery—through a number of innovative programs. Journey, an NGO run by and for recovering addicts and supported by UNICEF since 2006, provides a drop-in center in Malé and 12-step programs in both Malé and Addu. In 2008, UNICEF enhanced their support of Journey through the provision of continuous on-the-job coaching and training in organizational and financial management; offering quarterly strategic planning and organizational development sessions; monthly in-house training sessions on various aspects of management for all staff; and facilitating the hiring of a manager/supervisor, and a Field Coordinator based in Addu (UNICEF Maldives, 2008a).

The Society for Women Against Drugs (SWAD) offers counseling for families (including parents), a self-help group for female recovering addicts, vocational trainings, and mentorship programs for recovering addicts. A small rehabilitation center run by VYDS (an NGO) in Velidhoo was closed in 2008 due to decreased support and staffing. However, the organization still offers a counseling service.

There is no empirical data or independent evaluation results of any drug treatment, rehabilitation or supportive programs offered in the country. There are also no official statistics maintained on relapse rates. However, key government informants perceived the rate of relapse to be decreasing, from an estimated 50% in 2005 to 40% currently. This estimated 10% decrease was attributed to increased awareness and willingness amongst drug users to access assistance offered by the CSC and NGOs, such as Journey.

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[8] Some facilities have recently discontinued operations. The first-ever Drug Rehabilitation Centre for Children was opened in 2007; this facility has since been closed because, according to the government, the numbers of children with drug-abuse issues were fewer than expected (MGF, 2007, p.20). According to key informants, those under the age of 18 years requiring institutional treatment and rehabilitation are now placed in the DRC with adults.

Despite this perceived reduction in the relapse rate, the same participants believed that treatment and rehabilitation options for children and youth are limited and that there are also insufficient facilities and programs to assist them in reintegrating back into communities. While the CSC was initially conceived as a "Halfway House"—a residential facility within the community that could facilitate transitions—this function has not materialized.

In sum, there are small yet promising activities being undertaken by NGOs like Journey. Nationally, however, the Maldives lacks a systemic and comprehensive response to the immediate threat of drug abuse and addiction. Cooperation from schools and the MOE would seem important—and is currently missing—for broad-based prevention programs to be successful. Within child protection, there appears to be a reluctance to acknowledge drug abuse as a protection issue. Many government service providers suggested that drug abuse fell outside of their social services mandate.

4.5 Cross-cutting Issues

Advocacy and programmatic attention to psychosocial issues, coupled with ample funding, provided the government with an opportunity to expedite pre-existing plans to decentralize social services to the atolls. The chart below shows the rapid acceleration of FCSCs during the recovery and early development phases of the tsunami response. Of the ten FCSCs that opened in 2007, six were in atolls significantly impacted by the tsunami (NDMC, 2005).

Figure 7: FCSC Openings by Year
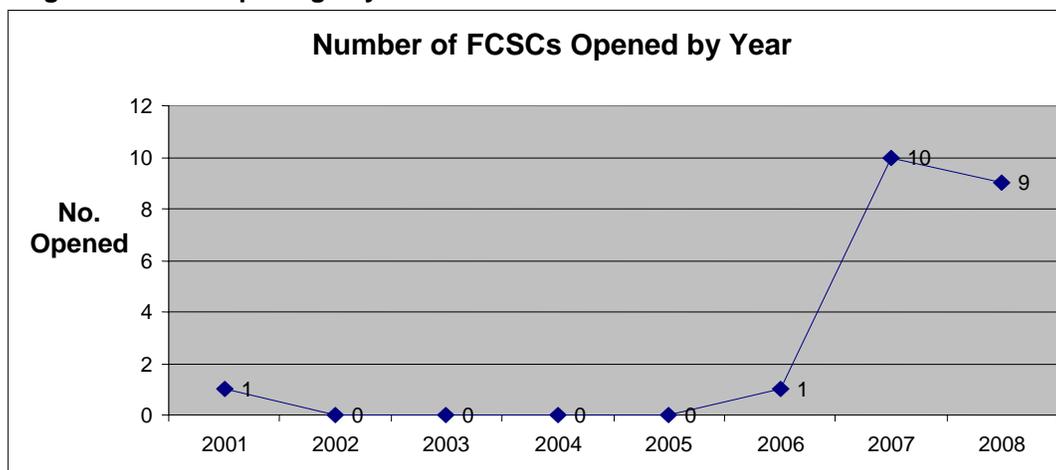
Considerable policy action also occurred in the aftermath of the tsunami, including:

- drafting the periodic reports to the Committee on the Rights of the Child that commenced in 2005 with UNICEF support;
- creation of a multi-sectoral working group at MGF to address gaps in the "protective environment" for children in 2006; and
- embarking on a process of amending or creating legislation concerning children, including drafting of the Juvenile Justice Act, a National Strategic Plan for HIV/AIDS, and the Children's Act, and to initiate a national campaign on drug prevention and recovery in 2007 (UNICEF Maldives, 2005, 2006a, 2007).

An advocacy campaign was also launched to combat substance abuse and addiction. This nationwide campaign—"Wake Up!—was launched at the end of 2007 through the initiative of Maldivian youth with the support of the NNCB, Journey, and UNICEF. The campaign emphasized the importance of community support and acceptance in breaking the stigma of drug abuse and promoting recovery among

addicts, and implored parents and teachers to discuss drug use and its consequences openly with children and youth. "Wake Up!" messages were distributed (initially in English) through billboards, posters, brochures, TV, and radio spots. A special campaign website (www.wakeup.mv) was also created to provide further information.

The campaign reached over 2,000 people (youth, parents, recovering addicts) with drug prevention messages (UNICEF Maldives, 2008a) and trained 20 young peer educators (UNICEF Maldives, 2007). In January 2009, evaluation participants were asked to rate the effectiveness of "Wake-Up!" public awareness efforts. The average rating across civilian and government service providers was "ineffective". Reasons provided included culturally "inappropriate" materials; English-only messages (translation took place in 2008); and distribution to the atolls without local planning or buy-in. In January 2009, the "Wake-up!" campaign was being rethought.

Additional civil society actors are engaged in drug abuse public awareness activities, including to outer atolls. SWAD and Paradigm (limited activity) planned a joint prevention program, and VYDS offered awareness programs targeting parents, religious leaders, and youth through schools in N. Velidhoo. Vilingili Youth and Sport Association (Vienca) and Fanas included prevention and public awareness within their organizational activities. Most of these drug prevention activities were ad-hoc and not sustainable. NGO staff and evaluation participants highlighted the following obstacles to a more comprehensive and sustainable drug abuse prevention program:

- Funding issues
- Human resource constraints – lack of qualified staff, no training/mentorship
- Low financial compensation for those working in the sector (both GO & NGO)
- Stigma and labeling by the broader community and lack of awareness
- Political/structural challenges – limited political will, merging of departments
- Limited communication and coordination in sector
- Insufficient aftercare/referral services
- Legislative challenges – criminalization of the "addict"

Reaching the Most Vulnerable

The early response psychosocial program reached all of the tsunami-affected islands in 7 different atoll clusters. Its scope was expansive and inclusive while also targeting adults and children who exhibited high levels of stress reactions. Mediation programs evolved to respond to tensions that emerged between host and displaced person populations, and livelihood programs appeared to be equitably distributed across tsunami-affected islands. UNICEF and its NGO partner, Journey, also embarked on an assistance program for drug addicts. The program's staff were former drug addicts themselves.

Gender

The Child Protection Program addressed gender-specific vulnerabilities amongst children. It appears, however, that the program lacked social, cultural and gender analyses necessary to address gender disparities and inequalities. Program targeting and coherence was affected accordingly.

While the Maldives did not have a well developed social welfare system, it did have an extended family system, island level Women's Development Committees (WDC) and other mechanisms that perform basic social welfare and community care roles. Engaging in gender and social analysis to identify social and community strengths (as well as weaknesses) would have been useful from a sustainability perspective.

Emergency, Recovery and Development Linkages

UNICEF Maldives was confronted for the first time with the challenge of responding to a major emergency situation in a country with little experience of disaster management. According to an internal UNICEF

emergency review document, the absence of an overall emergency officer or an experienced emergency focal point in the staffing structure of the Maldives Country Office prevented UNICEF from organizing and mounting a rapid assessment exercise and from making urgent actions and decisions following onset of the crisis (UNICEF 2005). UNICEF's early protection response also lacked sufficient support due to the small size of the office, inexperienced staff in emergencies, and the absence of local (and operational) NGOs.

UNICEF's recovery and early development transitions from a service delivery approach to an institutional and capacity development approach was highly appropriate given the increased capacity needs in the aftermath of the disaster, and the funds that the organization commanded. It also maintained positive relationships with key government ministries, which engendered key initiatives, such as the decentralization of social services and related training programs. At the same time, engagement with local communities and beneficiaries in planning and decision making, as well as monitoring and reporting was weak, and community development expertise was absent.

Child Protection Systems Capacity Development

The evaluation sought to appraise the current overall capacity of the protective environment for children in the Maldives. It created indicators for each of the eight components of UNICEF's Protective Environment Framework (PEF), and engaged community members and government service providers in a participatory exercise to use these indicators to evaluate the current (January 2009) status of each component.

The table below outlines these PEF key components, along with their appraisal based on the evaluation's findings. Commentary is provided to support participant appraisals.

Table 11: PEF Component Appraisals and Related Commentary

Framework Element	Key Indicators	Appraisal (strong/high; moderate; weak/low)	Commentary
Open Discussion & Engagement with Child Protection Issues	Safe Reporting	**Moderate**	• Increasing recognition of the situation facing children in the Maldives and awareness of child abuse issues at the community level. • Collaborative research and recent government/UNICEF analyses at the national level; evaluation of pilot FCSC in Addu and FPU at IMGH. • Civil society and government (FCSCs & Police) activities to raise awareness of child protection issues through workshops and presentations. • Increases in case reporting in past years, though hampered by small/close island communities, which is a risk to confidentiality and safe reporting options. • Parents shared that their children would most likely report to them first, and not to the police, Ministry, or school. • Media coverage of "sensational" cases, but no consistent reporting on trends and issues.
	Analysis of Threats	**Moderate**	
	Open to Sensitive Issues	**Weak**	
	Media Coverage	**Moderate**	
Children's Life Skills, Knowledge & Participation	Child-friendly School Environment	**Moderate**	• Programs for children highlighted as one support mechanism/activity necessary for well-being. • The children's focus groups highlighted parents' and their own skills. • Limited activities for children post-tsunami and currently outside of the school environment. • Recent research found high rates of bullying and teacher-perpetrated violence at schools throughout the country. • One NGO nationally (Care Society) is active with children who have disabilities; significant challenge in the outer atolls for families with children who have disabilities. • Institutionalized children in two shelter homes received little support post-tsunami and are largely ignored by mainstream services; only recently were children at the ETCC permitted to attend the community school. • No systematic inclusion of children's voices in broader decision making.
	School Enrollment	**Strong**	
	Vulnerable Access	**Moderate**	
	Participation Promoted	**Weak**	

The Capacity to Protect Among Those Around Children	Emotional Support	**Moderate**	• Schools are ill-equipped to respond to child protection concerns, including drug abuse.
	Strain on Caretakers	**Moderate**	• Teachers are not trained. They are not responding to bullying and violence in the school. Most of the schools interviewed did not have a school counselor on staff.
	Teacher Support	**Weak**	
	Religious Support	**Weak**	• Administration was unsure of the process/procedure to undertake should a child protection concern be raised.
			• Lack of support for parents/families with children who have disability (physical or mental), especially outside of Malé.
			• Limited attention to involve religious leadership in efforts to deal with child/drug abuse.
			• Sector-wide challenges with inter-agency cooperation were noted.
Services & Programs	Knowledge, Training & Practice	**Moderate**	• Decentralization of services 2006-2008 has established FCSCs in 20 of 26 administrative atolls; each in the atoll capital. Limited extension of FCSC services to islands outside of the atoll capital.
	Coverage	**Moderate**	
	Linkages and Referral	**Weak**	
			• MPS has a dedicated unit responsible for investigating and monitoring child protection issues, the Family and Child Protection Unit (FCPU), based in Malé; Indira Gandhi Memorial Hospital (IGMH) in Malé has a Family Protection Unit (FPU) to respond to child abuse and domestic violence.
			• Lack of coordinated linkages across government agencies, lack of information sharing, and lack of involvement of civil society actors.
			• Interagency referrals lack follow-up.
Monitoring & Reporting	Government capacity	**Moderate**	• Government recognition regarding shortcomings, including lack of human resource base.
	Civil society/NGO	**Weak**	
	Coordination	**Weak**	• Narrow and nascent systems in place to monitor and follow-up on specific cases.
			• Systems are in silos; communication across the sector lacking; case information is duplicated; no follow-up.
			• Information is not publicly accessible; reported/available statistics are not disaggregated by type of abuse experienced, geographic location, age of child etc.
			• Efforts are underway to establish a joint database which will house all case-related information and will be accessible by GOs.
			• Many NGOs are marginalized in the sector; lack of NGO/GO cooperation and information sharing.

Governmental Commitment to Fulfilling Protection Rights	Convention Commitments	**Strong**	• Government has signed and ratified: Convention on the Rights of the Child & Optional Protocols to CRC, Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment & Optional Protocol,
	CRC Implementation	**Moderate**	• International Covenant on Civil and Political Rights (ICCPR), and CEDAW.
			• Issues remain to integrate commitments into domestic policy; legislative reforms to implement CRC (Juvenile Justice Act and Children's Act) have been drafted but are delayed.
			• Near universal primary school attendance and birth registration throughout the country.
			• Government budgets towards social services overall have increased; unclear reporting on how much funding directed to children.
			• The President's Manifesto clearly indicates drug abuse as a priority, and many current government officials have issued statements in support of children's rights.
Protective Legislation & Enforcement	Norms & Legal Definitions	**Moderate**	• A number of different current legislative instruments that intersect with child protection issues; issues both with the legislation and with its compliance and implementation.
	Child Friendly System Capacity	**Weak**	
	Detention (Juvenile)	**Weak**	• Except during custody matters, no opportunity for the child's right to express his/her opinion during proceedings.
	Evidence	**Moderate**	• No child friendly pathway within the judicial system, significant potential for re-victimization.
			• Significant delays (up to 5 years) and inconsistent outcomes in judicial processes; disconnection between violations and consequences.
			• Detention is largely house arrest, but there are no separate facilities for children detained due to drug abuse or other criminal offence.
			• Cases of physical abuse or neglect noted as especially difficult to move forward.
			• Burden of proof is on the "victim" including, medical records and other "hard evidence"; some courts will not accept DNA as evidence despite it being available.
			• Law enforcement has begun a comprehensive training program (with UNICEF support) for investigating officers; enforcement notes legislative framework governing their work as being ineffective and non-operational.

Attitudes, Traditions, Customs, Behavior & Practices	Protective features	**Moderate**	• Tradition of protective response from the community, especially for girl children. These protective responses (including history of early marriage) have been overwhelmed by current social issues (drug addiction, gangs, media exposure). • Taboo nature of child abuse issues within the Maldives, as elsewhere. • Abuse is not shared openly in the community; stigma and shame would result for the family. • Some reluctance to recognize child abuse as something that occurs internally within the family, rather its seen as a risk from "outsiders" or "foreigners"–continued progress is needed though attention to these issues increased. • Some cultural gap present in communities between the traditional definition of a child and the international definition (e.g., eligibility for marriage, work, family responsibilities).

4.6 UNICEF'S Contribution

The UN Country Team (UNCT) quickly established a Disaster Task Force led by the UN Resident Coordinator. UNFPA was assigned the leadership role for protection and UNICEF engaged in child protection early response activities within these operational structures. UNICEF worked in coordination with government bodies, including the Psychosocial Support Unit of the National Disaster Management Center, the Unit for the Rights of the Child of the Ministry of Gender, Family Development and Social Security (MGFDSS), and the National Narcotics Control Board (NNCB). UNICEF also worked with the newly-created government IDP Unit to ensure its policies reflected core principles for the protection of children in unstable situations. There were only a few NGOs in the islands and the capital city of Malé. UNICEF's NGO partners were the Faculty of Health Sciences (FHS) of the Maldives College of Higher Education (MCHE), Society of Health Education, and the Boy Scouts of Maldives. The International Federation of the Red Cross also conducted a rapid assessment.

UNICEF Maldives' early response program supported the training of volunteer counselors from the private sector in visiting islands and by interacting with families to enable them to support children's psychological stresses. They called the intervention "psychological first aid". The trainings were conducted in collaboration with UNFPA, the International Federation of Red Cross and Red Crescent Societies and the Ministry of Gender, Family Development and Social Security (MGFDSS). They were trained to organize Emotional Support Brigades composed of about 10 to 20 volunteers from the community who were given two to three hours of training on the "Five Steps in Psychological First Aid". These included assessing the needs of the people, listening, being empathetic, accepting their feelings, maintaining eye-to-eye contact with persons with serious problems and referring them to where help can be gained.

The government's program to decentralize social services to the atolls through the establishment of FCSCs would not have had as much momentum without UNICEF's support and advocacy. The Child Protection program's technical and financial support to the Advanced Social Service Worker certificate has provided Maldivians with an opportunity to be trained locally in social service delivery that is contextually relevant.

UNICEF's Child Protection program and country director worked hard to put the issue of drug abuse and child rights on the Maldives' national agenda, and have promoted a growing dialogue between Government, NGOs and civil society. These partnerships resulted in efforts to raise the consciousness of Maldivians about the issue of drug abuse in their communities, as well as to build local capacity to respond to this problem.

Over this time, UNICEF Maldives' financial allocations to the child protection sector increased as a percentage of its overall operational budget. Since the tsunami, the percentage of UNICEF Maldives' child protection budget to the total budget has risen from about 8% in 2005 and 2006, to about 13% in 2007, to about 20% in 2008/09. Protection sector expenditures, however, did not keep pace. While about US $4 million was allocated to child protection in 2005, only about US $300,000 (7.5%) was spent (UNICEF Maldives, 2005). Subsequent UNICEF Maldives Annual Reports and reviews of program log frames indicated that one-third of planned activities in 2006, and a similar proportion in 2007, were not completed (UNICEF, 2006 and UNICEF 2007).

4.7 Sustainability

Since 2000, there has been a five-fold (55%) increase in the budget for "social services",[10] from which child protection is funded, according to Department of Treasury and Finance data. The percentage of the Maldives' total budget allocated to social services increased from 42% in 2000, to 51% in 2005, and 52% in 2006 (Government of the Republic of the Maldives, 2005).

Table 12: Government Budget Allocation
(In Million Rufiyaa (MRf); 1 United States Dollar (USD) = 12.75 MRf)

Sector	2000	2001	2002	2003	2004	2005	2006	2007	2008
Social Services	1140.5	1198.3	1532.8	1,667.6	1,746.8	1,985.3	3639.4	5093.6	5731.3

Sources: MGF (2006). Combined report to the CRC Committee; Ministry of Finance and Treasury (2008), Budget in Statistics 2008.

Disaggregation of budgetary expenditures indicates that education and health sectors combined received over half of the total social services budget allocation from 2000-2005. The Committee on the Rights of the Child noted that the Maldives' allocation of budgetary resources in favor of child welfare was insufficient (CRC, 2007).

The new coalition government's "manifesto" highlighted the growing drug abuse problem as one of five priority areas, and stressed its commitment to take action, including decriminalization of drug addicts. Other child protection and welfares are not mentioned within the stated government priorities.

The merging of departments and ministries that followed the change in government has raised concern among child protection advocates that child protection and welfare concerns will be marginalized within larger bureaucracies. The Children's Act and Juvenile Justice Act remain in draft form, awaiting further consultation with appropriate government officials and other stakeholders.

4.8 Summary of Main Findings

The scale of the emergency needs in the Maldives dwarfed the regular UNICEF Maldives Program of Cooperation. By March 2005, the number of personnel had quadrupled and tsunami funding had increased to US $31 million. UNICEF Maldives child protection response appeared to be in need of

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[9] Figures for 2005 through 2007 are sourced from UNICEF Maldives' Annual Reports for those years. As formal documentation of 2008 data was not available, the UNICEF Maldives Child Protection Unit provided the figures for 2008.

[10] Includes: Health, Education, Social Security and Welfare (added in 2003), and Community Services.

support because of its small staff, inexperience in emergency management, and the absence of strong local NGOs (UNICEF 2005).

Attention to psychosocial concerns also enabled the government and UNICEF to revitalize pre-existing plans to decentralize social services. The establishment of 21 social service centers and new social work training represent key recovery and early development achievements. Different levels of government-supported social work training programs also were established to support the Ministry's decentralization program. A strategy to engage community members in the process of establishing the new social service centers, however, was lacking, and the effectiveness of social welfare and child protection efforts have been affected accordingly. Neither the government nor UNICEF had the capacity to properly engage communities in participatory development processes.

There was an increase in the number of civil society organizations immediately after the tsunami, especially in the atolls. Many of these organizations, however, have since discontinued their operations and are re-evaluating their options and strategies. UNICEF continued to work with several civil society partners into 2007 and 2008 to develop their capacities. However, there is no comprehensive effort to develop civil society capacities nationwide.

UNICEF worked hard to put the issue of drug abuse and child rights on the Maldives national agenda. These efforts have led to important and growing dialogues between Government, NGOs and civil society on how to tackle this serious and growing threat. Innovative and promising partnerships and programs—such as Wake-up!—also have been piloted, and the new coalition government has pledged increased attention to drug abuse prevention and addiction treatment.

The government has committed to the principles and values of the Convention on the Rights of the Child (CRC) and fulfilled its reporting obligations on the CRC by submitting its periodic reports. Efforts to integrate the CRC into domestic law have been strengthened, even while enforcement is lagging somewhat behind. Child rights advocates suggest that Law 9/91 (the Law on the Protection of the Rights of the Children) is insufficient to safeguard children's rights, and also that key amended legislation remains in draft form.

5. THE WAY FORWARD: LESSONS & RECOMMENDATIONS

5.1 Lessons and Conclusions

Prior to the tsunami, UNICEF had a limited protection program (administratively subsumed in the education sector) that promoted occasional studies on child protection concerns and small pilot projects to stimulate child protection activities in a handful of islands. Many of the tsunami related opportunities were missed due to the lack of agency capacity across the board.

UNICEF Maldives played a supportive role within the United Nations (UN) family as the UN Fund Population Fund (UNFPA) led protection and psychosocial responses. The unique risks faced by children in response to this disaster were joined—and in some cases, subsumed—under concerns related to women and the elderly (Patel, 2006; UNFPA Maldives, 2006b).

Psychosocial needs assessments conducted in 2005 focused on post-traumatic stress symptomology and, to a lesser extent, how to support family members who were having problems (Michaelson, 2005; World Bank et al., 2005).   Subsequent psychosocial workshops covered a range of different topics, including what a tsunami is and how tsunamis are caused; the emotional and behavioral effects of natural disasters on infants, children, adolescents and adults; coping strategies for dealing with the effects of the tsunami; ways to support loved ones, students and/or clients affected by the disaster; identification when additional assistance and/or support is needed; and resources in the community to obtain further support and/or assistance (Michaelson, 2005).

Recent Inter-Agency Standing Committee (IASC) Guidelines on Mental Health and Psychosocial Support in Emergency Settings underscore the priority of support programs for parents, families and children as the core emergency intervention (IASC 2007).   From an IASC guideline perspective, the early psychosocial response did not sufficiently focus on building extended family and community support structures.   The dearth of psychosocial programs that were truly grounded in extended family and community structures would appear to be a principle reason outer island residents reported no improvements in their communities' ability to support their children's psychosocial well-being.

A flaw in almost all protection programs was the lack of a systematic process for consultation with local communities. The extent of local island buy-in and ownership of projects is one of the most important determinants of the long-term viability and sustainability of social welfare and child protection programs. Hence, it is important to ensure the necessary human resources, with country-specific social sector expertise and community development and gender specialization, to review and support analysis and programming planning. Social sector expertise is also necessary for strengthening the qualitative aspects of monitoring and evaluation on how to address women's and children's rights in a culturally sensitive manner.

If UNICEF's Child Protection Program is to become a central component of country efforts in the future, more consistent human resources will be required—particularly social sector, gender and socio-legal expertise.   Better access to local knowledge and a better understanding of community development processes would also improve the program's focus, integration and sustainability. The current approach of relying solely on short-term consultants for assessment and research purposes is not optimal, and may be one reason for the fragmented and over-ambitious nature of previous programs.

5.2 Recommendations

5.2.1 Government of the Maldives and its Partners

Implement a comprehensive prevention, care and treatment program for drug addiction: The greatest threat faced by Maldivian children and youth—drug addiction--must be addressed on an urgent and comprehensive basis. Responses should involve all stakeholders from government and civil society, and be grounded in the recognition that this issue constitutes a major public health and child protection problem. Prevention efforts should be integrated within activities that children and youth participate in and within broader school and livelihood programs. Treatment and care policies and programs should also recognize that children and youth with addiction issues are distinct and different from the broader adult population who abuse drugs, and that greater opportunity for intervention exists with them.

Promote an island-wide child security and well-being community mobilization campaign: A nationwide initiative to engage atoll communities in creating protective environments for their children is needed. A series of well designed and facilitated parent and community leader strategy sessions on each island, addressing the overarching theme of how to create a healthy environment for children, would be the central focus of this mobilization strategy. The series would focus on security and well-being themes, such as "raising healthy children", "making our island safe for our children", and "preparing our children for success in school", as well as other priority concerns identified by parents. The series also would provide opportunities to address more difficult concerns (such as domestic violence, rape, bullying, and other serious abuse and exploitation problems) in ways that may be less confrontational and stigmatizing than previous efforts. The campaign needs to be pragmatic and solution-oriented, with clear understandings about the availability and limitations of government support for follow-up. Matching community support (participation and financial) would be required as well.

Reorient the role of staff in the social service centers towards facilitation of community prevention, awareness and mobilization: The placement of service providers in atoll capitols has created an opportunity to expand the role and effectiveness of these frontline workers. An important next step towards achieving consistent results would be to reorient the social service providers' activities towards community prevention, awareness and mobilization. In addition to providing remedial services, the service providers would play key roles in the community mobilization campaign, and support and supervise NGO work on children's activity programs (see below). It is important to note that given the lack of service providers per island, those present must be willing (and mandated) to address a range of community concerns. Specialization—or a narrow focus—is not feasible at this point in time. An important aspect of this reorientation will be re-training away from a service delivery model and towards community development and mobilization methodologies. In the short term, this could be accomplished through in-service training. However, in the long-term it should be built into future social work training and degree programs.

Establish minimum child security and well-being standards and ensure that the community mobilization campaign addresses them: Through an interactive process with communities, the government should establish a mandated set of minimum child security and well-being standards for all outer islands. These should be achievable rather than idealistic standards. The following set of child and parent priorities were identified through this evaluation, and each requires monitoring of progress:
- Sports and playground space: established, equipped and maintained by community and safe
- Activities programs: 3-4 organized activities are offered on a weekly basis
- Safe school standards: zero tolerance for physical abuse, emotional abuse and bullying
- Awareness and surveillance programs: initiatives on key concerns, such as drug addiction in schools; roles and requirements for island authorities, religious leaders, parents and others are established and maintained on a regular basis.

Consolidate support for at least one 'child well-being' NGO per island to implement activity programs: After the tsunami, the mushrooming of many NGO fragmented efforts to care and protect children was seen. It is time to refocus civil society support for children, especially on outer islands. One

step in that direction is to provide ongoing and sustained support for at least one community designated NGO, which would emerge from the mobilization exercises discussed above. The NGO, with government budgetary support and high quality community mobilization training, would be responsible for implementing the island activity programs, supervising standards established for sports and playground space, and contributing to safe school and awareness and surveillance programs. Communities should be expected to support—and contribute—to their island's 'child well-being' NGO as well.

Further develop the monitoring and evaluation system: While the government has invested substantially in efforts to better understand the situation facing children in the Maldives through research, the ability to monitor and report requires further progress. Efforts to develop a joint database that would house case-related statistics from multiple stakeholders must be prioritized, and delays in commencing the project must be reduced. Information should be shared and publicly accessible. Programs already in place need to be evaluated for effectiveness on an annual basis. Technical capacity in order to establish and run the system is necessary and requires government investment.

5.2.2 UNICEF-Maldives and Partners

Continue to enhance existing government partnerships: Political changes in the past year present new opportunities to work with the government on setting child protection priorities. These opportunities must be capitalized upon in order to achieve the goals set forth in the 2008-2010 UNICEF Country Program. UNICEF Maldives must be the key government partner to implement the government recommendations noted immediately above. UNICEF Maldives should continue to enhance its existing partnerships with multiple government agencies and build new partnerships as needed. Each sector's program should provide both strategic direction and technical support for sustainable developments in a way that ensures government responsibility and accountability over emerging social protection systems.

Support NGO development and capacity building: The burgeoning civil society within the Maldives requires additional support and UNICEF should continue to assume a leadership role in engaging government, NGO and private sector partnerships. Sustainable and ongoing partnerships, such as that with Journey, should be encouraged to exist and continue. The Child Protection Program, in particular, should support NGO capacity building and technical knowledge as part of the government's mobilization strategy.

Build child protection capacity: None of the above will be possible unless UNICEF's Maldives Child Protection Program upgrades its competence—especially in social sector, gender and socio-legal expertise. Ensuring community development perspectives and better access to local knowledge is required as well.

5.2.3 UNICEF and Partners – Global

Enhance child protection emergency response regionally: UNICEF's emergency response capacity was over-stretched by the multiple countries affected by the tsunami. It would therefore be important to identify a cadre of child protection professionals in the South Asia region with proven experience in emergency response to offer surge capacity in the event of future emergencies. Sri Lanka and India would seem to be appropriate locations to begin to build this roster—and UNICEF's protection unit in Colombo would be one source to consult**.**

Develop a medium-term plan for capacity building and technical support: UNICEF could usefully develop a medium-term technical support plan to enhance UNICEF Maldives' capacities to promote community development and address critical child protection concerns. Technical exchange linkages with Sri Lanka and India, as well as with Southeast Asian countries, such as Indonesia, would be fruitful avenues to pursue. UNICEF staff in the Maldives would greatly benefit from methods training in order to employ (or properly supervise) "real time" assessments capable of determining both the extent of a problem (prevalence) and local perceptions of child security and well-being.

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7. ANNEXES

7.1 Annex 1: Tsunami-related Deaths/Disappearances by Atoll

ATOLL NAME	POPULATION (2004)	DEATHS	MISSING
Haa Alif	13,733	0	0
Haa Dhaal	17,141	0	1
Shaviyani	11,807	1	0
Noonu	10,044	0	0
Raa	15,331	3	0
Baa	9,344	0	0
Lhaviyani	8,158	0	0
Kaaf	8,458	3	2
Alif Alif	4,995	0	0
Alif Dhaal	7,063	1	0
Vaavu	1,580	1	0
Meemu	4,845	21	13
Faafu	3,864	0	0
Dhaalu	4,939	9	4
Thaa	8,513	16	3
Laamu	11,318	22	3
Gaaf Alif	8,187	2	0
Gaaf Dhaal	10,505	2	0
Gnaviyani	7,645	1	0
Seenu	17,980	0	0
TOTAL	**185,450**	**82**	**26**

Source: NDMC Situation Assessment 2005 (www.tsunamimaldives.mv)

7.2 Annex 2: Sector-specific Evaluation Questions

UNICEF Global Evaluation Criteria as it Pertains to Child Protection	Specific Questions and Issues to be Addressed
Relevance – The extent to which the Child Protection Program is suited to the priorities and policies, recipient and donor.	Were global core commitments to child protection in emergencies relevant to the tsunami and Maldives contexts? Were assessments and responses tailored to the tsunami disaster and island contexts?
Effectiveness- The measure of the extent to which the Child Protection Program attained its objectives.	How effective are the new social service centers?
Efficiency- The measure of the outputs-qualitative and quantitative-in relation to the inputs.	How efficient was inter-agency response to psychosocial concerns? Did UNICEF's "Rebuilding with Children" strategy result in early response to child protection system transition and developments?
Outcome- The positive and negative changes produced by a development intervention, directly or indirectly, intended or unintended.	How do members of tsunami affected communities rank the psychosocial well-being of their communities now—as compared to the immediate aftermath of the tsunami? To what extent are island based NGOs addressing child protection and well-being concerns? Is UNICEF supported drug rehabilitation programs achieving desired outcomes? Is this an effective model for service delivery – on drug abuse prevention and recovery & rehabilitation? Should it be rolled out to other locations?
Sustainability- Measuring if the benefits of an activity are likely to continue after donor funding has been withdrawn.	What is the government's policy, financial and human resource development commitments to child protection? To what extent are government service providers and civil society actors working together to address child protection concerns at the national, atoll capital and island levels?

7.3 Annex 3: KII Tool for Child Protection & Child Service Center

Child Protection Family & Child Service Center
Key informant interviews
DATA COLLECTION FORM

Date: _____

Informant(s) Name(s): _____

FCSC Location: _____

Interviewer: _____

INFORMED CONSENT:
Note to interviewer: please review the following with the informant PRIOR to commencing the interview; should the informant agree, proceed with the questions.
It is necessary that responses be kept confidential; only to be shared with the National Consultant.

Prior to beginning the interview, we will review information about the purpose of the project, the types of information we hope to obtain, and obtain your informed consent. If you would like more detail about something mentioned here, or information not included here, you should feel free to ask.

• The purpose of this research project is to understand and evaluate the achievements of the child protection sector in the Maldives.
• Participants will be asked questions about the nature of their work, how the Child Protection system in the Maldives is working/not, and provide recommendations for improvement. The interview will take about 1-1.5 hours and we will take notes.
• The data gathered in the interviews will be aggregated prior to dissemination. Specific quotes that exemplify a point may be used. However, the quote will be written so that identity of the individual providing the quote will not be in any way identifiable.
• During this interview. Please refrain from using any names, or other details that could identify vulnerable clients/beneficiaries.
• Being part of this research is voluntary. Participants who are being interviewed will not have to answer any questions that they do not want to. You are also free to stop the interview at any time. All information collected up to the point of withdrawal will be included in the research analysis.
• Being part of this interview will have no effect on your relationship with your place of employment, nor with your relationship to any supervisor, peer, or client in your organization.
• The National Consultant, Alison (Ali) Paul, and International Consultant, Neil Boothby have access to the information from the interviews. Your answers to the questions will be kept confidential and you will never be identified.

NOTE TO INTERVIEWER: Ask the informant whether they agree to be interviewed?   Y / N   (circle)

SECTION 1: About the FCSC

1. What is your role in the FCSC?

2. What kind of service(s)/activity does your FCSC offer in the atoll capital? (they may list things like advocacy, counselling, case management support, support to family/friends, referrals, public awareness raising, etc.) List all types of services/activities provided.

3. Who are the recipients of your services? Describe the demographics of the organization's clients/beneficiaries (e.g., affected children/family, women experiencing domestic violence, general public, government officials etc.)

4. a) How many staff and volunteers work with your organization (list separately)?
Staff:
Volunteers:

b) For staff, what kinds of training have they received?

5. a) On average, how many outreach activities has your FCSC conducted in the atoll capital in the past year (or since being established)?

Please describe the type of activity:

b) How many activities in the islands outside of the atoll capital in the past year (or since being established)?

Please describe the type of activity:

6. Does your group work in collaboration/partnership with other organizations, either formally/informally?
Y / N   (circle)

If so, please list the partner organization, whether it is a formal/informal partnership, the type of activities/partnership, and the length of time the partnership has been in place for.

7. What are the main challenges facing you in your work? Ask the key informant to list anything that comes to mind.

SECTION 2: Child Protection System Recommendations

1. Thinking back over the past 5 years, how would you say the child protection system has changed?

2. What mechanisms and activities are necessary to support children's emotional and social well-being? (Note to interviewer: List them exactly as stated. Then ask them to rank the 5 most important supports necessary in their opinion).

Free list: Rank Order:

_____   1. _____
_____   2. _____
_____   3. _____
_____   4. _____
_____   5. _____
_____
_____
_____
_____
_____
_____
_____

Comments: (Note to interviewer, please capture any comments made by the key informant regarding the supports either free-listed or ranked).

2. a) Based on the five top supports that were identified and ranked in order of importance, please rate the community's ability to support children's emotional and social well being immediately after the tsunami.

1. No Capacity   2. Seriously diminished capacity 3. Diminished capacity   4. Almost normal capacity 5. Normal capacity

Supports (from Q3):   Scale (1-5 as above)
1. _____   _____
2. _____   _____
3. _____   _____
4. _____   _____
5. _____   _____

b) Please clarify the reasons why/why not the capacity was available at that time?

c) Based on the five top supports that were identified and ranked in order of importance, please rate the community's ability to support children's emotional and social well being currently.

1. No Capacity   2. Seriously diminished capacity 3. Diminished capacity   4. Almost normal capacity
5. Normal capacity

Supports (from Q3):   Scale (1-5 as above)
1. _____   _____
2. _____   _____
3. _____   _____
4. _____   _____
5. _____   _____

d) Please clarify the reasons why/why not the capacity is available currently?

3. a) Relevance of Psychosocial Programmes: Which activities or programs launched in the atolls have helped to promote children's psychosocial well-being? Free list first. Rank top five second. This could include government, IO or NGO programmes/activities

Free list: Rank Order:
_____   1. _____
_____   2. _____
_____   3. _____
_____   4. _____
_____   5. _____
_____
_____
_____
_____
_____
_____

Comments:

b) Relevance of Psychosocial Programmes: What were the consequences (both positive and negative) related to these programs?
Positive consequences:

Negative consequences:

4. What is needed to ensure protection of children in the Maldives?

5. How could the child protection system be improved overall? What is needed to do this?

SECTION 3: Closing the interview

1. If we have any further questions, may we contact you further?   Y / N   (circle)

2. Is there someone else you would recommend we speak with regarding this issue? (List name, Organisation, contact details below)

3. Would you like to receive a copy of the evaluation once it is finalized?   Y / N
If yes, how is most convenient for you to receive? (List contact details)

Thank you for your time.

7.4 Annex 4: KII Tool for Child Protection NGOs

**Child Protection NGOs – Key informant interviews
DATA COLLECTION FORM**

Date: _____

Informant(s) Name(s): _____

Organisation: _____

Interviewer: _____

INFORMED CONSENT:
Note to interviewer: please review the following with the informant PRIOR to commencing the interview; should the informant agree, proceed with the questions.
It is necessary that responses be kept confidential; only to be shared with the National Consultant.

Prior to beginning the interview, we will review information about the purpose of the project, the types of information we hope to obtain, and obtain your informed consent. If you would like more detail about something mentioned here, or information not included here, you should feel free to ask.

- The purpose of this research project is to understand and evaluate the achievements of the child protection sector in the Maldives.
- Participants will be asked questions about the nature of their work, how the Child Protection system in the Maldives is working/not, and provide recommendations for improvement. The interview will take about 1-1.5 hours and we will take notes.
- The data gathered in the interviews will be aggregated prior to dissemination. Specific quotes that exemplify a point may be used. However, the quote will be written so that identity of the individual providing the quote will not be in any way identifiable.
- During this interview. Please refrain from using any names, or other details that could identify vulnerable clients/beneficiaries.
- Being part of this research is voluntary. Participants who are being interviewed will not have to answer any questions that they do not want to. You are also free to stop the interview at any time. All information collected up to the point of withdrawal will be included in the research analysis.
- Being part of this interview will have no effect on your relationship with your place of employment, nor with your relationship to any supervisor, peer, or client in your organization.
- The National Consultant, Alison (Ali) Paul, and International Consultant, Neil Boothby have access to the information from the interviews. Your answers to the questions will be kept confidential and you will never be identified.

NOTE TO INTERVIEWER: Ask the informant whether they agree to be interviewed?
 Y / N   (circle)

SECTION 1: About the group/organization

Note to interviewer: Please request a brochure about the organization/it's history; if this is not available please request the following information in addition to those questions below:
- mandate
- mission/vision of the organization
- objectives
- key work areas (broad overview)
- budget (if public information) and funders/funding

1. How do you classify your organization/group?
(e.g., Government agency, International organization, non-governmental organization/civil society group)

2. What kind of service(s)/activity does your group offer? (they may list things like advocacy, counselling, case management support, support to family/friends, referrals, public awareness raising, etc.) List all types of services/activities provided.

3. Who are the recipients of your services? Describe the demographics of the organization's clients/beneficiaries (e.g., affected children/family, women experiencing domestic violence, general public, government officials etc.)

4. a) On average, how many people do you reach per year?

b) How many staff and volunteers work with your organization (list separately)?
Staff:
Volunteers:

5. (FOR NGO/CIVIL SOCIETY ONLY)
a) How long has your group existed for? (Year)

b) How long has your group been involved in child protection issues?

6. Does your group work in collaboration/partnership with other organizations, either formally/informally?
Y / N   (circle)
If so, please list the partner organization, whether it is a formal/informal partnership, and the length of time the partnership has been in place for.

7.a) What are the main achievements made by your organization in the past 5 years (if applicable, or for as long as established)?

b) What are the main challenges facing you in your work? Ask the key informant to list anything that comes to mind.

7.5 Annex 5: KII Tool for Drug Rehabilitation

Drug Rehabilitation – Key informant interviews
DATA COLLECTION FORM

Date: _____

Informant(s) Name(s): _____

Organisation: _____

Interviewer: _____

INFORMED CONSENT:
Note to interviewer: please review the following with the informant PRIOR to commencing the interview; should the informant agree, proceed with the questions.
It is necessary that responses be kept confidential; only to be shared with the National Consultant.

Prior to beginning the interview, we will review information about the purpose of the project, the types of information we hope to obtain, and obtain your informed consent. If you would like more detail about something mentioned here, or information not included here, you should feel free to ask.

• The purpose of this research project is to understand and evaluate drug rehabilitation and prevention efforts in the Maldives, as part of child protection sector.
• Participants will be asked questions about the nature of their work, how the rehabilitation/prevention system in the Maldives is working/not, and provide recommendations for improvement. The interview will take about 1-1.5 hours and we will take notes.
• The data gathered in the interviews will be aggregated prior to dissemination. Specific quotes that exemplify a point may be used. However, the quote will be written so that identity of the individual providing the quote will not be in any way identifiable.
• During this interview. Please refrain from using any names, or other details that could identify vulnerable clients/beneficiaries.
• Being part of this research is voluntary. Participants who are being interviewed will not have to answer any questions that they do not want to. You are also free to stop the interview at any time. All information collected up to the point of withdrawal will be included in the research analysis.
• Being part of this interview will have no effect on your relationship with your place of employment, nor with your relationship to any supervisor, peer, or client in your organization.
• The National Consultant, Alison (Ali) Paul, and International Consultant, Neil Boothby have access to the information from the interviews. Your answers to the questions will be kept confidential and you will never be identified.

NOTE TO INTERVIEWER: Ask the informant whether they agree to be interviewed?   Y / N   (circle)

SECTION 1: About the group/organization

1. How do you classify your organization/group?
(e.g., Government agency, International organization, non-governmental organization/civil society group)

2. What kind of service(s)/activity does your group offer? (they may list things like advocacy, rehabilitation/reintegration support, support to family/friends, referrals, public awareness raising, etc.) List all types of services/activities provided.

3. Who are the recipients of your services? Describe the demographics of the organizations clients/beneficiaries (e.g., recovering addicts, general public, government officials etc.)

4. On average, how many people do you reach per year?

5. (FOR NGO/CIVIL SOCIETY ONLY)
a) How long has your group existed for? (Year)

b) How long has your group been involved in drug abuse prevention/support work?

6. Does your group work in collaboration/partnership with other organizations, either formally/informally?
Y / N (circle)
If so, please list the partner organization, whether it is a formal/informal partnership, and the length of time the partnership has been in place for.

7.a) What are the main achievements made by your organization in the past 5 years?

b) What are the main challenges facing you in your work? Ask the key informant to list anything that comes to mind.

SECTION 2: Prevention/Recovery Recommendations

1. What are the main supports required for the prevention of and recovery from drug addiction? (Note to interviewer: List them exactly as stated. Then ask them to rank the 5 most important supports necessary in their opinion).

Free list: Rank Order:
_____   1. _____
_____   2. _____
_____   3. _____
_____   4. _____
_____   5. _____
_____
_____

Comments: (Note to interviewer, please capture any comments made by the key informant regarding the supports either free-listed or ranked).

2. a) Based on the five top supports that were identified and ranked in order of importance, please rate the community's ability to support drug prevention/recovery activities.

1. No Capacity   2. Seriously diminished capacity 3. Diminished capacity   4. Almost normal capacity
5. Normal capacity

Supports (from Q3):   Scale (1-5 as above)
1. _____   _____
2. _____   _____
3. _____   _____
4. _____   _____
5. _____   _____

b) Please clarify the reasons why/why not the capacity is present/available?

3. a) Relevance of Drug Rehabilitation Responses: Which activities or programs launched in general have helped to promote prevention/recovery from drug abuse? Free list first. Rank top five second. This could include government, IO or NGO programmes/activities

Free list: Rank Order:
_____   1. _____
_____   2. _____
_____   3. _____
_____   4. _____
_____   5. _____
_____

Comments:

b) Relevance of Rehabilitation Programmes: What were the consequences (both positive and negative) related to these programs?
Positive consequences:

Negative consequences:

4. a) What is needed to prevent people from abusing drugs?

b) What is needed to help people recover?

5. How could the drug abuse rehabilitation/prevention system be improved overall? What is needed to do this?

SECTION 3: Closing the interview

1. If we have any further questions, may we contact you further?   Y / N   (circle)

2. Is there someone else you would recommend we speak with regarding this issue? (List name, Organisation, contact details below)

3. Would you like to receive a copy of the evaluation once it is finalized?   Y / N
If yes, how is most convenient for you to receive? (List contact details)

Thank you for your time.

7.6 Annex 6: Community / Parent – FGD Data Collection Form

Date:

Moderator:
Note taker:

Atoll/Island:

Participants: Number in Group:
Group Participants: Mothers/Fathers/Mixed (circle)
 # children:

Island Definition of Psychosocial Well-being

Question: What mechanisms and activities are necessary to support children's emotional and social well-being? (Ask participants to list whatever comes to mind; then ask them to come up with the top-5 most important mechanisms and activities to support children's well-being through group consensus. Record any comments)

Free list: Rank order:
                                                        1.
                                                        2.
                                                        3.
                                                        4.
                                                        5.
<u>Comments:</u>

Retrospective Baseline: Based on the five top ranked well-being criteria identified by community adults/parents, ask the group to rank their community's ability to support children's "psychosocial well-being" immediately after the tsunami. Develop a large visual scale that can be placed in front of the group so everyone can see and ask them to discuss and agree on 1-5 ranking.

1. No Capacity   2. Seriously diminished capacity 3. Diminished capacity   4. Almost normal capacity
5. Normal capacity

<u>Comments:</u>

Psychosocial Well-being Status Today

Ask participants to rank the community's ability to support children's psychosocial well-being today as compared to after the tsunami.

1. No Capacity   2. Seriously diminished capacity 3. Diminished capacity   4. Almost normal capacity
5. Normal capacity

<u>Comments:</u>

Relevance of Psychosocial Emergency Responses: Which activities or programs launched by external agencies after the tsunami helped to promote children's psychosocial well-being?

Comments:

Relevance of Psychosocial Emergency Responses: Were there negative unintended consequences related to external agencies psychosocial programs?

Comments:

7.7 Annex 7: Children – FGD Data Collection Form

Date:
Atoll/Island:

REVIEW Informed Consent

Participants: #
Age range

Common definition of psychosocial well-being?

What do you need for these things, your happiness/well-being?

What activities do you do and how often?

7.8 Annex 8: Drug Rehabilitation – FGD Data Collection Form

Drug Rehabilitation - FGD DATA COLLECTION FORM

Date: _____   **Participants: Parents**

Moderator: _____   **Note taker:** _____

Atoll/Island: _____   **Number of Participants in Group:_____**

Age range of participants

Group Participants: (recovering) addicts/community members (circle)

Through these focus groups, we aim to answer the following main questions: Are UNICEF supported drug rehabilitation programs producing results? Is this an effective model for service delivery – on drug abuse prevention and recovery & rehabilitation? Should it be rolled out to other locations?

1. What is the main reason(s) you are involved with rehabilitation/prevention programmes? (individually, they may list things like police involvement, family, friends, etc.)

2. How has their involvement with the rehabilitation/prevention programme impacted their life?

3. Ask the focus group to list the key supports required for the prevention of and recovery from drug addiction (they may list things like education, family, friends, sports programs, counselors, etc.) List them exactly as stated. When the groups is finished (free list) ask them to discuss and agree on the 5 most important.

Free list: Rank Order:
_____   1. _____
_____   2. _____
_____   3. _____
_____   4. _____
_____   5. _____
_____
_____
_____
_____
_____

Comments:

Write down comments exactly as stated:

FGD DATA COLLECTION FORM

Date: _____   **Participants: Parents**

Moderator: _____   **Note taker:** _____

Atoll/Island: _____   **Number of Participants in Group:_____**

4. Retrospective Baseline: Based on the five top ranked supports that were identified, ask the group to rank their community's ability to support drug prevention/recovery activities. Develop a large visual scale that can be placed in front of the group so everyone can see and ask them to discuss and agree on 1-5 ranking.

1. No Capacity   2. Seriously diminished capacity 3. Diminished capacity   4. Almost normal capacity
5. Normal capacity

FGD DATA COLLECTION FORM

Date: _____   **Participants: Parents**

Moderator: _____   **Note taker:** _____

Atoll/Island: _____   **Number of Participants in Group:_____**

5. Relevance of Drug Rehabilitation Responses: Which activities or programs launched have helped to promote prevention/recovery from drug abuse? Free list first. Rank top five second.

Free list: Rank Order:

_____   1. _____
_____   2. _____
_____   3. _____
_____   4. _____
_____   5. _____
_____
_____
_____

Comments:

(Write down what participants say <u>exactly like they say them).</u>

FGD DATA COLLECTION FORM

Date: _____ **Participants: Parents**

Moderator: _____ **Note taker:** _____

Atoll/Island: _____ **Number of Participants in Group:**_____

6. Relevance of Rehabilitation Programmes: What were the consequences (both positive and negative) related to these programs? Free list first. Rank order top five second.

Free list: Rank Order:

_____ 1. _____

_____ 2. _____

_____ 3. _____

_____ 4. _____

_____ 5. _____

_____

_____

_____

_____

_____

Comments:

(Write down what participants say <u>exactly like they say them).</u>

7. What is needed to prevent people from abusing drugs?

8. What is needed to help people recover?

9. How could the current rehabilitation system be improved? What is needed to do this?