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Integrated Maternal/Child Health and Psycho-social Programme for the Eastern Province of Sri Lanka 2002 – 2004

External Evaluation
19 – 30 April 2004
Final Report

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Acronyms

CBO	Community Based Organisations
CD	Central Dispensary
CHV	Community Health Volunteer
DoH	Department of Health (Batticaloa or Ampara)
DPDHS	Deputy Provincial Director of Health Services
DS	Divisional Secretariat - Division
FHM	Family Health Midwife (Ampara)
GHC	Gramodaya Health Centres
GoSL	Government of Sri Lanka
HH	Households
KAP	Knowledge Attitudes and Practice
Karuna	War name of V. Muralitharan, former commander LTTE Eastern front
KPC	Knowledge Attitudes and Coverage
LTTE	Liberation Tigers of Tamil Elam
Maha	Main agricultural season
MoH	Ministry of Health
MOH	Medical Officer of Health
MOHMCH	Medical Officer for maternal and Child Health
NCPA	National Child Protection Authority
NDTF	National Development Fund Trust
NEIAD	North Eastern Agricultural Project
PCIA	Peace and Conflict Impact Assessment
PHC	Primary Health Care
PHI	Public Health Inspector
Prabhakaran	Velupillai Prabhakaran, Chief commander LTTE
RDHS	Regional Director of Health Services
SDC	Swiss Development Corporation
SLA	Sri Lankan Armed Forces
(S) PHM	(Senior) Public Health Midwife
TBA	Traditional Birth Attendant
Yala	Small agricultural season from April - August

Executive Summary

PROJECT NAME:

Integrated Maternal/Child Health and Psycho-social Programme for the Eastern Province of Sri Lanka 2002-2004

DONORS	SDC, UNICEF, WFP, Solidarity Chain
REPORT TITLE	External Evaluation – Final report
SUBJECT NUMBER	
GEOGRAPHIC REGION	Sri Lanka – Eastern Province – Batticaloa and Ampara Districts
SECTOR	Mother and Child Health (MCH) - Community Health – Psychoso-cial care for children in war situations
CROSS-SECTIONAL THEMES	Children – Social Development
DATE	19 – 30 April 2004
COLLATION	53 pages plus annexes
EVALUATION TYPE	External Evaluation - Programme
STATUS	Regular evaluation at end of phase I
AUTHORS	Reto Zehnder – Echanges Equipement – 1148 Mauraz Swizerland Brenda Jenkins, Public Health Nurse
TYPE OF PROJECT	Bilateral
EXECUTING AGENCY	Terre des hommes -1052 Le Mont-sur-Lausanne Switzerland, repre-sented in Sri Lanka by its delegation office in Batticaloa
TYPE OF COOPERATION	Humanitarian Aid (HA)

SUBJECT DESCRIPTION:

The programme includes 3 different components:

- **A community health component** addressing Mother and Child Health (MCH) implemented in 50 villages in three different project areas: LTTE and GoSL controlled areas of Batticaloa district and Ampara district.
- **A WatSan component** Construction of open wells and latrines are a part of the MCH component, but due to its specificity (subcontracted to local partners) it has been treated separately in this report
- **A Psychosocial component** addressing the needs of pre-school and school aged children in LTTE and GoSL controlled areas of Batticaloa district.

The MCH component works with both communities, Singhalese (Ampara) and Tamil (Batticaloa), while the psychosocial component works only with Tamil and some Muslim communities in Batticaloa district.

COMMUNITY HEALTH

The MCH component works in 5o villages, along 4 main intervention axes considered to be the most effective ones to improve the health status of pregnant women, lactating mothers, newborn babies and children up to 2 years:

- **Antenatal Care** *: 4 antenatal care visits, tetanus toxoid immunization, iron and folic acid, identification of high risk pregnancies and nutrition education.*
- **Safe Delivery** - *attended by a skilled trained assistant and appropriate care immediately after delivery.*
- **Exclusive breastfeeding and appropriate weaning** – Exclusive breastfeeding up to 6 months, continuous breastfeeding up to 24 month combined with appropriate complementary feeding
- **Appropriate management and care of the sick child** - Children who become ill can be cared for correctly at home and are referred to a medical clinic if necessary.

CONSTRUCTION OF WELLS AND LATRINES

300 latrines and 60 wells have been completed in the 50 project villages, a new contract with Sewalanka forsees the construction of 200 more latrines and 30 more wells.

THE PSYCHOSOCIAL COMPONENT

The psycho-social component is based on three type of interventions: 15 preschools with 529 children , the recreational (play) centres and 2 schools for the integration of handicapped children (79 children). The programme is implemented by 3 different implementing partners:
- Batticaloa Befrienders: 3 preschools, 10 recreational centres, 1 handicapped school;
- Koinonia: 12 preschools, 18 recreational centres
- ECIPCWO: one handicapped centre in Kattankudy

EVALUATION METHODOLOGY:

The external evaluation was part of the regular PCM procedures of Tdh, whereby a programme should undergo an external evaluation once in a 3 years phase.

The scope of the evaluation included all programme components as well as the institutional relationship between Tdh and its implementing partners. The programme components were evaluated using standard DAC criteria.

The quantitative data were mainly collected through the rich project documentation and additional information from local Departments of Health and Planning.

The qualitative data has been obtained by conducting open interviews with project staff, senior staff DoH, leaders of local NGOs, beneficiaries of WatSan projects and Swiss representatives in Sri Lanka.

Numerous group interviews were conducted with mother's groups, Community Health Volunteers, midwifes, preschool teachers, Play group animators, children and parents. Direct observation during field visits rounded up the information collected during the interviews. Only the preschools have not been visited during operation, due to school vacation.

MAJOR FINDINGS / MAJOR RECOMMENDATIONS:

- The MCH component remains for the time being highly relevant in the LTTE controlled areas, but require adaptation in Ampara. With the arrival of a new delegate this process is underway.
- To take into consideration the psychosocial well being as an entire part of adolescent health is highly relevant in the socio cultural (and not a post-war) context of Sri Lanka, where adolescent suicides are common.
- Out of the psychosocial component of the programme, the recreational activities are best able to respond to this need if they can be maintained and improved without being used and assimilated to the formal schooling system.
- The same applies to the preschools; if they are to become an advanced primary school with formal teaching and make the children comply from their earliest age to competition and performance, then they have lost their relevance.
- The MCH component of the programme has gone beyond simple transmission of health messages and produced effective changes in practice and empowerment of women.
- There is a danger to repeat health messages an unnecessary number of times and "produce" indicators, which are already achieved at the beginning of the intervention.
- Static planning and low flexibility to adapt the programme to the changing situation and to the increased knowledge gained by the well done baseline studies have reduced the effectiveness of the programme.
- The large resources of the programme should allow a larger coverage of the area, taking into account whole health zones (admin, divisions), but this again would need more flexibility by shifting villages as soon as the CHV/mothers groups assisted by DoH can take over.
- Collaboration with DoH exists but can be improved by joint planning and integration of Tdh's contribution to the district health plans.
- The WatSan component is inefficient. Part of the wells are of poor technical standards and are not offering "safe drinking water".
- Participation is still understood in the restricted interpretation of women assisting at meetings and families providing unskilled labour for the construction of wells and latrines. Transparency and participation in the design and the implementing of the programme is absent (eg. latrines).
- The announced "autonomisation" of the implementing partners in Batticaloa has not taken place; they are dependent on Tdh. Over funding, absence of a request to comply to strict

principles in terms of quality control, monitoring, training and cost effective management are some of the causes.

- The programme has a tendency to substitute themselves to missing, or weak capacities of their partners.
- Absence of clear commitment to efficiency and sustainability leads to weaknesses in terms of cost effectiveness and absence of a global or even a local (village) exit strategies. There is no vision for the future of Community Health Volunteers /Tdh Health Workers.

LESSONS LEARNT / NEXT STEPS FOR IMPLEMENTATION

- Starting from an emergency type of intervention, where large areas were under guerrilla control and undergo the process of normalisation, with the re-establishment of public health services is very demanding of a project team. It needs a high flexibility from implementing partners and funding agencies and a constant adaptation of strategies and project planning.
- The ideal strategy based on a community approach with CHV, community ownership and support to Dept of Health is a slow process. The need to provide rapidly health services to pregnant mothers and children led to distortions (e.g. paid CHVs, or substitution of DoH services) which will be difficult to correct.
- For the next phase priority will have to be given to make the MCH programme sustainable and replicable on a large scale. A model has still to be developed, where real community participation and ownership completes public health services supported by the programme.
- The Water and sanitation component needs specific knowledge and technical experience, which is not present within Tdh. Either, competent partners, can be found or Tdh should withdraw from this component.
- The psychosocial component is highly relevant and should be maintained. The question remains how to resist, without being un-participatory, to the pressure of parents and teachers who want to use play groups and preschools as preparation/complement to the unconvincing public school system. A discussion on the importance of psychosocial well-being and positive aspects of "learning by playing" has to be opened with parents and teachers.
- Tdh has to include in its project strategy clear criteria of cost effectiveness. The MCH component has to become much more cost effective by covering a larger area, becoming a real replicable model and by reducing the high overhead (delegation) costs.
- The present repartition of roles and responsibilities for psychosocial programme is not satisfactory. It is in fact the delegation office, which covers most of the monitoring and the introduction of new ideas. The implanting partners who have benefited over many years from capacity building, and equipments are still not in a position to implement the preschools and play activities. For the new phase, Tdh will have to renegotiate is relationship with Kononia and Batticaloa Befrienders.

Introduction

Type of the Evaluation

Concept of external evaluation and evaluation team

The mandate given by Tdh Lausanne was for an external evaluation. SDC desk officer in Bern had some reservation regarding the independance of the evaluation team. The team leader was early in 2001 on a Tdh identification mission in the Eastern provinces, and subsequently monitored the planning workshop held late 2001 in Negombo (Sri Lanka).

Following the ID mission, the MCH specialist undertook a Participatory Needs Assessments mission. But even if both team members had previous contacts with the project, none of them ever considered himselves as being part of Tdh[1].

The fact that both of the team members knew the complex situation in the Eastern Provinces of Sri Lanka, especially in the troubled situation following the split off, of the Eastern commander of the LTTE was an enormous advantage. Previous contacts with local NGOs and senior staff of ministry of health still in function facilitated the communication and created a relationship of trust.

Terms of Reference

Objective of the evaluation

Contractually, Tdh is obliged to undertake an external evaluation toward the end of the project cycle, i.e. at some time in 2004. Furthermore, Tdh has a stake in undertaking such an exercise so as to assess the validity of the objective, as well as to evaluate the pertinence of its action in reaching the objective. (cit. Tdh)

Scope of the evaluation

Programme structure

- *Role and function of Tdh Delegation's Project Office in Batticloa*
- *Role and function of Tdh's implementing partners*

Programme activities

- The project's activities in the light of government policies with regard to
- Maternal and child health
- The project's activities in the light of technical assistance, training and capacity building provided by Tdh
- Comparisons with similar programmes in the region/nation

Specific objectives

Assess the effectiveness, efficiency, impact and sustainability of the project supported by Tdh, focusing on:

- *Pertinence/relevance of in the respective project areas*

[1] Among the team leader's others contracts with Tdh: directing the team of external consultant leading the PCM module of Tdh's Human and Institutional Development Project financed by SDC and an average of 3-4 evaluations or training workshops /per year.

- *Continuum of services and follow-through activities*
- *Degree of project integration within the community*
- *Impact of project activities on beneficiaries*
- *Perception of services received by the beneficiaries*
- *Approach, methodology and quality of services*
- *Strengths, weaknesses, opportunities and threats (SWOT)*
- *Human resources management and development*
- *PCM (e.g. planning, monitoring and evaluation tools and systems)*
- *Quality of reporting*
- *Expression of vision for coherent project/programme evolution*
- *Assess the capacity of Tdh and its partners with regard to networking, policy dialogue and advocacy.*

EVALUATION PROCESS AND METHODOLOGY

Data collection

The quantitative data were mainly collected through the rich project documentation (activity reports, budgets, baseline surveys) conducted by the team. Useful information has also been collected from ministry of health (Health Development Plans for both Districts) and ministry of Planning (statistical yearbook for both district).

The more qualitative data has been obtained by conducting open interviews with individuals[2] (project staff, Senior staff DoH, leaders of local NGOs, mothers, beneficiaries of WatSan projects and Swiss representatives in Sri Lanka. Numerous group interviews were conducted with mother's groups, Community Health Volunteers, midwifes, preschool teachers, Play group animators, children, parents, etc. Finally direct observation during visits of antenatal clinics, well baby clinics, dispensaries, maternities, play activities, wells, latrines, etc. rounded up the information collected during the interviews. Only the preschools have not been visited during operation, due to school vacation.

Analysis of data

Data collected have been discussed among team members and shared during less formal meetings with the delegate and the head of Asia department of Tdh.

Quite same time was spent on the complex budgetary analysis, without having reached a full and transparent picture.

[2] A full list of persons met is found in annex III

Limitations

The evaluation team had to face a number of constraints and limitations:

- After the troubled election campaign (aggressions of candidates) in Batticaloa, and just one week before the start of the evaluation Batticaloa district was stricken again when local LTTE leader Karuna openly challenged the leadership of Mr Prabhakaran. Karuna's rebellion led to the invasion of the eastern Province by special commando forces of the central command and the desertion of Karuna. All LTTE cadres remaining were evacuated to Vanny for consultation and the LTTE controlled areas were nearly emptied of all its leaders: the evaluation had no contact with LTTE leadership.
- Time did not allow visits outside project areas, in order to compare and assess how much of the positive changes intervened are due to the project intervention and how much can be attributed to the better general context.
- School vacation did not allow visits to preschools
- The absence of a local resource person was felt by the team leader as a limitating factor.
- During preparation we noted the absence of return communication from SDC to contribute to the TOR and express their expectations towards the evaluation.

Feedback of evaluation results

A roundtable was held in Batticaloa on the 29 April. In presence of the full Tdh team, directors of DoH of both districts, Deputy Director of Education from Batticaloa, directors and senior staff of implementing partners (Koinonia, Sewalanka and Baticaloa Befrienders) the evaluation results were presented and discussed.

In Colombo evaluation results were shared with SE the Ambassador of Switzerland and the acting country director of AH-SDC.

Report and use of evaluation results

Key findings and recommendations are summarized in the present report. In order to keep a readable volume, but given the fact that the programme spreads over 3 different intervention areas and 2 quite different type of interventions, the team had to make a number of concessions:

- Skip most of the project description and stick to main data in the situation analysis, referring the reader to the strategic plan and annual reports 2002 and 2003 made by Tdh.
- Keep a short wording in its findings with a limited argumentation. This step maybe perceived by readers of a different culture as impolite and rough, we apologize in advance.
- Keep most of the more operational recommendations made by Brenda Jenkins in a separate report annexed to the present report. With regard to recommendations we tried whenever possible to formulate a number of options, leaving the Tdh team to search for appropriate solutions according to their context.

As announced during the initial and the final round-up session we would like to stress once more that this report expresses an external view, to be taken as a contribution to the forthcoming planning process. A number of findings in this report are not new to Tdh, they had been identified by the new incoming delegate since the beginning of 2004.

Part I
Situation Analysis and global Relevance

National context

Sri Lanka is among the emerging countries of Asia, with a per capita income of > 800 USD. Recent trends show a rather stagnant growth rate of approx <4%.
The 2 years long lasting ceasefire increased security and allowed access and development work in LTTE controlled areas.
With very low expenditures on health and fairly good health indicators, Sri Lanka is a positive example of a low cost, free health system.

Basic indicators

Basic health and economic indicators rank Sri Lanka among the emerging countries of Asia. Significant progress has been made over the last 40 years. National indicators are not very relevant to the situation in war-affected areas. Out of the intervention area only Ampara District comes probably close to national averages.

UNICEF fact sheet mentioned following basic indicators:

Indicator	**2002**
Population	19 mio
GNI per capita USD	840
GDP/capita annual growth rate	3.4%
Annual inflation rate 1990 – 2002	9%
HDI Ranking	89 out of 179 countries
Govt. expenditures on health, % of GDP	1.6%
Net primary school enrolment	97
Access to safe drinking water	70%

Political (in)stability

The People's Alliance government was elected in 1995 on a peace ticket, but made little real progress. During President Kumaratunga's re-election campaign in 1999, she insisted that peace in Sri Lanka would come – either through the defeat of the LTTE on the battlefield, or through her efforts to give Tamil majority areas more autonomy. This 'devolution package' faced fierce opposition from the major opposition party, the ultra nationalist Sinhala Buddhists.

The government suffered growing instability. In October 2001, President Kumaratunga dissolved parliament to avert a no-confidence motion when her government lost its parliamentary majority and members of the coalition defected to the opposition.

In the December 2001 elections, the opposition United National Party (UNP), who formed an alliance with the Muslim Congress, swept to victory, with the expected support of Tamil parties. In his election campaign, the new prime minister, Ramil Wickramasinghe, pledged to find a peaceful political settlement to the ethnic conflict. A ceasefire in early 2002 and a political agreement in December 2002 raised hopes for lasting peace. The government and re-

bels have agreed to share power, giving the minority Tamils autonomy in the north and east as they dropped their demands for a separate state.

Final results of the recent anticipated elections (April 2004) showed Mrs Kumaratunga's United People's Freedom Alliance had 105 seats compared to 82 for Prime Minister Ranil Wickramasinghe's party. During the last period the president accused former Prime Minister of making many concessions to the LTTE.

There were serious concerns about the willingness and credibility of the new majority to push forward the peace process. External and internal[3] pressure will nevertheless make it difficult for the actual government not to go ahead with the peace talks. After her victory the president called back the Norwegians to monitor new peace talks with the LTTE, and nominated a former under-secretary general of the UN as head of a special task force. Observers think that negotiations may not produce a rapid breakthrough with sustainable results. The status quo (ceasefire) is probably the most likely scenario over the next few years.

A new dimension appeared to become increasingly important for the implementation of projects in the LTTE controlled areas. Recent internal faction fighting within the LTTE led to destabilisation and to a power vacuum in the LTTE areas in the East.

Health policies and strategies

National health policies and strategies

Sri Lanka has recorded impressive achievements in health, nutrition, and family planning with relatively low levels of public expenditure on health.[4] A number of specialized publications take Sri Lanka as one of the positive examples of a country with low health expenditures (120 USD/per capita, 1.6% GDP) and fairly good health indicators (see below).

A new national health policy has been formulated that seeks to consolidate past achievements, and address new health challenges, such as the increasing prevalence of non communicable diseases, HIV/AIDS, substance abuse and the high incidence of suicides, among youth[5]

Although a countrywide good network of health facilities has been developed, relatively underserved geographical areas and population groups still exist.

National health policy recognizes community participation as an important component of the health development process, as evidenced by the participation of about 15,000 young volunteer health workers who assist in PHC activities. Community financing of health activities by philanthropists and voluntary groups in the community is not an unusual practice. However, community participation in the planning process leaves much room for improvement. A negative feature appears to be the gradual erosion of the value system of mutual self-help, which is a part of the national culture.

The government is well aware that to achieve the goals of the national health policy, individual or household health behaviour must change. Promoting such change through health education is therefore a major part of all the components.

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[3] We strongly resented a general and strong refusal, by all classes of the Sri Lankan society, to go back to war.

[4] The US spends 4 times the proportion of its GDP and as much as 37 times more per person, for a relatively modest improvement in its health indicators: Life expectancy at birth 73-77 yrs ; Child mortality <5 : 16 – 8 5‰ ; life lost to poor health 11.5 – 9.5.

[5] WHO country health profile

Health indicators

GLOBALLY SATISFIYING HEALTH INDICATORS		
Life expectancy		73 years
Infant mortality rate (< 5 year)	(133 in 1960)	16‰
Infant mortality rate per 1,000 live births (2001)		12.2
Infant mortality rate (< 1 year)	(83 in 1960)	17‰
Skilled attendant at delivery		97
Antenatal care coverage		98
Contraceptive prevalence		71
Tetanus Toxoid immunization of pregnant woman		> 90%
Vaccination coverage 1 year old children		98%
Children Exclusively Breastfed < 6 month		54%
Children still breastfeed 20-23 month		62%
Maternal Mortality ratio (adjusted 2000(		92
Pop. Using improved drinking water		77%
Pop. Using adequate sanitation facilities		94%
AND SOME GLARING NEGATIVES		
Children <5 have under-weight (W/H)		29.4%
Children < 5 suffer from stunting (low height for age)		13.5%
Pregnant and lactating mothers suffer from Anaemia		< 11g/dl
Low birth weight of < 2500 grams (maternal under-nutrition).		>15%

Health of schoolchildren[6]

A study done between harvests, immediately after the failure of crops because of drought, showed that schoolchildren in Moneragala district seem to be less stunted but more wasted, which suggests that they experience acute but seasonal under-nutrition. Two other observations were noteworthy:

- First, boys were significantly more likely to be undernourished than girls
- Second, more than 80% of children were classified as anaemic but apparently did not have iron deficiency anaemia according to their blood picture. Parasitic infections such as hookworm and *Plasmodium* spp. may contribute to anaemia, but the prevalence of both was low, which suggests that anaemia is mostly the result of dietary deficiency.

The study suggest that effort to provide nutritional supplements to school children during periods of poor food intake may benefit children and help to prevent acute undernutrition.

[6] Health and nutritional status of school children in two rural communities in Sri Lanka, S.D. Fernando, in Tropical Medicine and International Health, Vol 5 No 6 , June 2000

CHILD RIGHTS

Despite a two-year-old ceasefire, there are still many children suffering the effects of 20 years of conflict. It is estimated that 50,000 children in the affected region are out of school; around, 140,000 have been displaced, landmines have killed 20. Independent from war, sexual abuse is in increase and child labour is still present. Alarming is the high rate of suicide among adolescents

Child abuse

Child abuse, including sexual abuse, is a regular occurrence in Sri Lanka, as in many other countries in the world. In addition, perpetrators often avoid detection. This is due to a number of factors, amongst them the denial of abuse amongst traditional society, some childcare professionals, police and medical professionals.

Furthermore, inadequate skills in working with child victims can prevent a child from feeling safe enough to disclose crucial information. While sexual abuse increases[7] there seems to be a net drop in abuse of child domestic workers.

Far from trying to quantify the phenomena, some indicators may help to grasp the extent and frequency of child abuse. Child abuse cases (276) reported to the NCPA during 2001 swelled up to 366 in 2002. Sexual abuse touches both male and female children. While male children are most likely to be abused by foreign homosexuals in the coastal areas[8] (see ILO study), girls are more often abused by locals (friends and family members).

Demobilised child soldiers

By the end of last year UNICEF had recoded 1301 under aged soldiers within the LTTE troops[9]. Since the beginning of 2004 LTTE started to release some of these child soldiers. First, at a very slow rate (107 children in the first three months of the year), these figure had jumped by another 454 by early April. Since the LTTE forces on April 9 defeated a breakaway group under their former eastern commander, an unknown number of child soldiers surrendered to the main LTTE force. According to UNICEF, after the families of children demanded their return 209 were released to their homes; a reported 800 others from Karuna's disbanded force returned home on their own and thousands more child soldiers are believed to remain with LTTE forces in the north of the country.

Foreign assistance

The Tokyo Conference on Reconstruction and Development of Sri Lanka was held on June 2003 in Tokyo with the participation of Ministers and representatives from 51 countries and 22 international organizations. The Conference noted the importance of urgent humanitarian assistance as well as medium to long-term assistance to rebuild the conflict-affected areas in the North and East, and to assist in the development of the entire country. The Conference emphasized the importance of taking full account of the delicate ethnic and geographical bal-

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[7] Prof. Harendra de Silva, Chairman, NCPA, told the 'Sunday Observer[7']', that child abuse cases had increased by ten fold since 1995

[8] Nevertheless, the paediatrician at Ampara hospital reported more cases of abuse involving boys than girls, although there are few tourists in Ampara.

[9] Grey figure is likely to be much higher. Only 1/4 of the children recently released and registered with UNICEF were on their original database.

ance in providing assistance. The participating donor countries and international organizations have demonstrated their willingness to extend assistance to a cumulative estimated amount, in excess of US$ 4.5 billion[10] over the four-year period from 2003 to 2006. The Conference commends both parties for their commitment to a lasting and negotiated peace based on a federal structure within a united Sri Lanka. Art. 18 of the final communiqué closely linked the assistance to substantial and parallel progress in the peace process towards fulfilment of the objectives agreed upon by the parties in Oslo.[11] If no substantial progress is made in the peace process then foreign aid is most likely to drop over the next few years.

REGIONAL CONTEXT: MULTIPLE PROFILES IN PROJECT AREA

Batticaloa and Ampara District fall within the North-Eastern Province of Sri Lanka, with Trincomalee as its capital.. The North-Eastern province covers all of LTTE controlled areas in the North and in the East. It is actually the only province without elected provincial MP's, but with a fully functional provincial administration. It is with the Provincial Ministry of Education that SDC has signed an agreement for their programme in the North.

The Tdh project area in the East is split of into 3 different areas, covering two districts.

Batticaloa District

More than half a million people are divided among 14 Administrative Divisions. Around 400'000 are Tamils, 139'000 Muslims, and a handful Sinhalese and Burgers.

Batticaloa district is a rich paddy producing district: the 60'000+ acres of irrigated land and another 82'000 acres of rainfed land produced over 140'000 MT of paddy in 2001/02. Other main crops are cashew nuts, coconut, manioc and varieties of peas. A rich assortment of vegetables are grown, part of them in 80'000 (9'500 acres) of home gardens. Cow and buffaloe milk is common (2.8 million litres in 2002). Sea fishing and lagoon fishing is another important economic sector for Batticaloa district.

During the war Batticaloa had the lowest per capita income of USD 221.50. Between 1981 – 90, Batticaloa had for several years a negative growth rate (-1.9%). No recent and accurate figures are available, but there has been an economic recovery over the last few years.

Agricultural production is sufficient to cover nutritional needs of the population. In the uncleared areas 2 major programmes, one financed by Japan and the other one by the World Bank, are underway to rehabilitate water tanks and irrigation schemes.

The 100 km long Batticaloa lagoon divides the district in two areas: the highly populated eastern seaboard under government control and the western paddy land under LTTE control.

LTTE controlled areas- Batticaloa district

Areas under LTTE control are the D.S Divisions of: Mamunai West, Manmunai South-West, Porativu Pattu, Koralai Pattu West, the Western portion of Koralai Pattu and Eravur Pattu.[12]

The total population under LTTE control is estimated at 125'000, out of a population of approx. 545'000 for the entire district.

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10 Japan: 1 billion US $, Norway: 90 million US $, USA: 54 million US $, EU: 250 million €

11 Follows a list of ten points all parties in Sri Lanka will have to comply, before aid is delivered

12 see map in annex

Compared to our last visit in 2001 the situation in the then "uncleared" areas has drastically changed. Borders between GoSL and LTTE are open, traffic flows freely and security has improved. Agricultural inputs, such as fertilizers[13] can again be delivered to the paddy farmers. Lagoon fishing, an important income source, takes place at night and was not allowed during wartime.

Rehabilitation work on schools, medical facilities and roads are underway. Ministry of Health has a number of rehabilitations planned over the next 3 years. While DoH services are being re-established, ICRC and MSF closed down their mobile clinics.

One of the main problems is staffing of government services (health, education, etc) in the LTTE controlled areas. There is very few qualified staff living in these areas. Staff and their families from areas under GoSL control are not ready to go and settle down in the LTTE areas. The number and the qualification of LTTE staff to be integrated in "official" services is yet unknown.

Another problem remains the territorial administration and how this is shared between GoSL line ministries representatives in Batticaloa and the de facto administration. LTTE, not being in a position to raise official taxes, is funding its administration by an unofficial and untransparent system of taxes and tolls.

During our visit there was very little military presence in the LTTE controlled areas. Part of the former tigers had fled with Karuna. The troops loyal to Prabhakaran were called back to Vanni for consultation.

Further development of this key area for the Tdh project depends on the normalisation within the LTTE, the peace talks with GoSL and economic (agricultural) recovery. It is purely speculative to make any prognostics at this point. The project will have to monitor the situation closely and adapt its strategy accordingly.

. GoSL controlled Tamil &/Muslim costal areas- Batticaloa district

Government troops are controlling the coastal areas of Batticaloa district, where the majority of the population lives. The main tension in these areas exists between the Muslim and the Tamil communities. In the early 90 heavy clashes between Tamils and Muslims, supported by government troops, led to massive destruction and causalities amongst both communities.

These areas have a decent medical supply. Tdh's partner Koinonia and Batticaloa Befrienders are running preschools and play activities in the area.

DoH statistical data on PHC in Batticaloa District

In Batticaloa district, basic health indicators are globally much below the national figures. It is even more striking when it comes to population figures: households are bigger (5.2 – 4.7) an estimated population doubling time of 37 years compared to 64 years for Sri Lanka, total fertility rate per woman (2.6 – 1.9)

Major problems common to conflict affected areas (mostly those under LTTE control and GoSL control) that suffered interethnic (Muslim-Tamil) violence are:

[13] Fertilizers, batteries, specific medical supplies were not allowed to enter uncontrolled areas before the ceasefire.

- Absence of latrines, only 20% of the HH have latrines (high incidence of bowel diseases and worm infections).
- High incidence of malaria and seasonal J.E. (Japanese Encephalitis).
- Malnutrition: Low birth weight (25%), stunting of children < 5 and Anaemia of pregnant woman.
- High incidence of pesticides poisoning (1060 cases/year admitted in Batticaloa Hospitals) and burns (suicidal attempts)
- High incidence of alcohol related problems (illicit liquor)
- Home deliveries. 70 % in the LTTE areas[14], compared to 45% in Batticaloa District and 2% in Sri Lanka
- Insufficient indoor care facilities (out of 15 facilities operating in a pre-war situation, 9 are destroyed and not operating) Whole divisions have no permanent medical facilities.
- Poor availability of Family Planning Services (higher fertility rate, high teenage pregnancies - 11.8% compared to 8.6% in Sri Lanka: 35.4 % births over Para 3+. Woman of child bearing age using modern contraceptive methods - 29% in Batticaloa, compared to 49.5% in Sri Lanka)
- Absence of Domiciliary Health Services in large parts of the LTTE controlled areas

Ampara district

Ampara District has a population of close to 600'000, divided in 20 D.S. Divisions. Tdh is present in two divisions with the MCH component; Uhana (52'000) and Mahaoya (18'000). This district is mostly populated by Singhalese (39.3%), Muslims (41.6%) and a Tamil minority of 18.7%.

Shortage of land is getting problematic in Ampara. The irrigation scheme is one of the oldest in Sri Lanka. Third generations living on the plots attributed 30 years ago to their families can no longer split up the land. Young families will have to find other income sources, or migrate to urban centres.

Medical services, and health indicators in Ampara come close to national averages.

The Tdh Baseline survey Batticaloa district

Prior to programme start, but after the planning and budgeting phase, Tdh conducted a baseline survey in each of the project areas. The methodology used was one derived from the KPC 2000+ toolkit. The questionnaire, the sampling methodology, the training of the field staff and the testing of the questionnaire were done according to well-recognised standards.

[14] Figures before the ceasefire, confirmed by the baseline study of Tdh (52% in uncleared and 62% grey areas)

Main results of the baseline survey can be summarized as follows:

Indicator	**Percent of positive answers**		
	Batticaloa	Uhana	Mahaoyo
1. Maternal Health Card possession	64	91	92
2. Tetanus Toxoid Coverage (≥ 2 injections)[15]	54	59	47
3. Antenatal Care Coverage (≥4 visits)	63	79	79
4. Iron Supplementation Coverage	87	97	92
5. Adequate intake of iron during pregnancy	6	87	50
6. Delivery by Skilled Health Personnel	54	87	93
7. Clean Cord Care (for home deliveries)	90		
8. Immediate Breastfeeding	51	97	86
9. Placement at birth (with the mother)	45	37	86
10. Postpartum Check by Health Professional	56	90	89
11. Excl. Breastfeeding for children 0-6 months	35	64	79 (4 month)
12.Continued Breastfeeding up to 24 months	55	100	96
13. Maternal knowledge of childhood danger signs	36	60 ≥ 3signs	55 ≥ 3signs
14. Feeding Practice During Illness	45	29 < liquid 50 < food	62 < liquid
15. Maternal Interpretation of Child Growth Chart	50	99 have a card	73
16. Childhood Vitamin A Supplementation	36	46	
17. Malaria Prevention through bed net use	18	58	66
18. Access to Safe Drinking Water	95		
19. Hand Washing Practices	72		

THE PSYCHO-SOCIAL COMPONENT IN BATTICALOA DISTRICT (LTTE AND GOSL CONTROLLED AREAS)

Preschools are the main element of the Ministries of Education preschool education. Although they are part of their strategy that, "*Every child should enrol for2 years in a preschool*" there are no preschools run by Ministry of Education. All preschools are run by private, church, non-governmental organizations or municipal councils. There are several hundred preschools in Batticaloa District[16].

[15] There could be discrepancies in the TT figures. Given that the ANC coverage is higher, then one would have anticipated this to be reflected in the TT coverage. It could be that women were already adequately immunised during previous pregnancies and that this factor was not taken into full account.

[16] Only in Batticaloa Town education zone (1 zone out of 3) there are 197 preschools.

Part II
Mother & Child Health Component

SHORT DESCRIPTION

Target groups

The target groups comprise women and children from Tamil (Batticaloa) and Singhalese communities (Ampara). The focus is on pregnant women, lactating mothers and infants/children up to the age of 3 years. At the onset of the MCH programme the target group for children was up to the age of 24 months. This changed during 2003 in line with UNICEF policy.

Intervention area and coverage

30 villages in Batticaloa district (Eravur Pattu and Manmunai S-W divisions) and since 2003 another 20 villages in Ampara district (Uhana and Mahaoya divisions)[17]

Division	No of families		Target families	Of which:		
	Division	Project villages		Pregnant women	Lactating babys <3m	Children 7 – 36 m
Manmunai S-W (Paddipalai)	5818	6411	1695	234	232	1461
Erravur Pattu (Badulla Rd)	16760	3288	1137	173	149	964
Uhana	13824	1477	345	63	57	251
Mahaoya	4608	2729	709	107	91	513
	41'010	**13'905**	**3'886**	**577**	**529**	**3'189**

Objective

Improved health status among pregnant women, lactating mothers, newborn babies and children up to 2 years, by providing access and services according to the minimum package as defined by UNICEF/WHO.

[17] seemap annexe II

Expected results

- **Antenatal Care** - *Health and well being of all pregnant mothers and unborn children through 5 minimum interventions. These are: 4 antenatal care visits, tetanus toxoid immunization, iron and folic acid, identification of high risk pregnancies and nutrition education.*
- **Safe Delivery** - *Pregnant women of target area deliver their baby by a skilled trained assistant and the newborn baby and mother get appropriate care immediately after delivery.*
- **Exclusive breastfeeding and appropriate weaning** - *Children are protected from infectious diseases and are well nourished up to 24 month.*
- **Appropriate management and care of the sick child** - *Children who become ill can be cared for correctly in the home and are referred to a medical clinic before complications arise.*

As a consequence of uniform logframe planning, the two districts of Ampara and Batticaloa have the same common themes of MCH[18], while the baseline data and the available health services are quite different.

The main difference is that the Ampara Programme, has no TBA training component.

The strategies used in the implementation of the MCH programmes in Batticaloa and Ampara are as follows: -

- Training and support (payment) of Community Health Volunteers
- Formation of women's groups in the villages
- Health Education at various occasions (clinics, home visits, plays, etc.)
- Assistance to DOH to run their Antenatal and Well Baby Clinics

[18]Antenatal Care, Safe Delivery, Exclusive Breast-feeding & Appropriate weaning and Appropriate Management and Care of the Sick Child

FINDINGS MCH PROGRAMME

Relevance of the MCH programme

The MCH component is especially relevant in the LTTE controlled areas, compared to Ampara where generally MCH uptake of services is higher.
To maintain relevance attention has to be given to:
- avoiding repetition of topics
- respect the boundaries of DoH policies and support DoH services without substituting them.

The overall intervention of Tdh in Eastern Sri Lanka is relevant. MCH awareness of woman, especially in the LTTE areas, was very low. The education component brought the woman to access MCH services and facilities as they became available. Access and service provision went hand in hand. In a society that is heavily gender imbalanced the education of women assists in their empowerment and is an achievement in itself. Personal behaviours and attitudes could be changed, which proves again the relevance of the intervention. The messages were realistic.

The overall design followed UNICEF and WHO guidelines and is globally inline with the SL DoH guidelines and policies. Whether all international guidelines are applicable in a given context remains questionable (eg boiling water, excl. breastfeeding up to 6 month, etc.) Up until now the government policy has been exclusive breastfeeding until 4 months of age.

MCH IN BATTICALOA DISTRICT

The MCH programme was of high relevance when it started in the LTTE controlled areas, at a time where medical services were very poor. If it wants to maintain its degree of relevance, the programme requires permanent adaptation to changing situations. The main risk is to loose its relevance by delivering MCH services, which should be delivered by the DoH. While in 2001 health services were totally broken down in the then uncleared areas, by now services are existing but still need support. From an "emergency" service providing approach the programme will have to move to a support programme to DoH.

There were good reasons to start in a relatively small area (number of villages) and invest time and resources on baseline studies and capitalization. As the pilot phase is now over the programme requires expansion to cover whole DoH zones (corresponding to approx. one administrative division).

To guarantee its future relevance the programme will need to develop a sustainable and adaptable model for community based MCH services; a model which can and will be taken over by DoH and the local communities.

MCH in Ampara district

The relevance of the MCH programme in Ampara is more problematic then in the LTTE controlled areas. In fact basic MCH services and practices in Ampara are of quite good standards. This was already suspected during the first mission[19] of Brenda Jenkins, and later it was confirmed by the baseline studies. The main reason to work in Ampara district was to be present in all three ethnic communities. The presence in Ampara helped Tdh to remain present in the

[19] It is worth noting that during the Ampara mission there was a complete lack of DOH statistical data available.

LTTE controlled areas as one of the only foreign NGOs during all the troubled years. Ethnical equity is acceptable as justification, and respects fully the "no harm criteria" of PCIA.

Nevertheless the programme should be redesigned for the specific Ampara context. Giving respect to predefined indicators and results played against an optimisation of the programme intervention.

Impact of the MCH programme

Globally, due to multiple factors, significant progress in terms of MCH practice and services has been made. The part of Tdh's programme is difficult to determine.
Specific impacts observed in the Tdh project areas:
- women's empowerment due to increased knowledge
- increased confidence and motivation of the CHV
- better recognition of the CHV by their community
- improved ante-natal and well baby clinics

To measure impact would need a deeper analysis, especially to include some fieldwork in areas not covered by the intervention of Tdh. There is no doubt that significant progress has been made in terms of MCH coverage and services, part of this due to the presence of trained and motivated CHV and the follow up by Tdh project staff.

RECENT IMPROVEMENTS ACKNOWLEDGED BY DOH:

- Woman are accessing the clinics (antenatal clinics and well baby clinics), due to better services in the clinics, the presence of qualified staff, improved transport and security and definitely due to the mobilisation by the CHV in the project areas.
- Uptake in hospital deliveries, less use of TBAs.
- Better immediate post-natal care, by PHM and CHV home visits.
- Ongoing improvements in the hospitals.

How far the three first improvements are due to the intervention of the programme, and how much is due to peace and better public services is difficult to determine.

Regarding the future, there is room for improvement in a number of areas where the combined intervention of Tdh and DoH has still not yet produced a significant impact.

MAIN WEAKNESSES REMAINING – ROOM FOR IMPROVEMENTS

- Care of the sick child: Management of temperature (to avoid infantile convulsions), recognizing when the child needs assistance, additional fluids during sickness, adequate nutrition, knowledge of common diseases and safe medication.
- Better understanding of basic health problems:
  Why are we doing it? (An understanding of better practices and not obedience to norms) and –
  What can be done on the family/community level?
- In the LTTE controlled areas and some remote areas of Ampara, access to qualitative and close primary health care remains weak.

- Lack of medical personal,[20] and buildings and equipment not yet been rehabilitated

If a number of changes in terms of health practices and health services are not evolving rapidly, this is partly due to the fact that in a period of reconstruction and normalisation health is low on the agenda. There are no direct and immediate threats on health, and main concerns are focused on agricultural recovery, education, transport, infrastructure, etc.

Effectiveness and coverage

The MCH programme will most likely achieve its objective and results as defined in the agreed logframe.

Globally the initial situation has been proven to be much better than the assumption made during the planning phase. Available financial resources allowed the project to punctually support the DoH (transport and rehabilitation of clinics).

Even after an extension to 50 villages the coverage remains thin.

Planned results achieved in the project areas:

We reproduce only a brief extract of some recently measured results. Precise results will be produced by the final baseline survey. Tdh has to assure that final surveys are done according to protocols and sampling methodologies used during the initial survey. Nevertheless we can expect that significant results have been achieved in the villages covered by the MCH programme. Sometimes the indicators fixed in 2002 have been achieved far ahead of schedule.

SOME SIGNIFICANT INDICATORS

- attendance to ANC	***Target***	***Baseline***	***Achieved***
- Batticaloa	90%	63 %	≈ 94%
- Ampara		88/ 79%	≈100 % / nd
- hospital delivery			
- Batticaloa	nd	54 %	≈ 70%
- Ampara		87 / 93%	≈100 %
- exclusive breastfeeding			
- Batticaloa	75%	35 %(6m)	≈ 83%
- Ampara		64 / nd%	≈ 81 %
continued breastfeeding			
- Batticaloa	90%	50 %	nd
- Ampara		100 %	nd
- care of the sick child			
- Batticaloa	90%	26 %	≈ 49 %
- Ampara		40/ 50%	nd

There are a number of remarks regarding this purely quantitative analysis of pre-fixed indicators:

- Indicators have been fixed prior to the baseline surveys. Some indicators (especially in Ampara) had been reached already before the programme started.

[20] Difficulties for health personnel to live in the LTTE areas, sometimes shortage of midwifes even if 50% of health staff are PHM, absence of Doctors (DOH), CHVs under the authority of the DOH are not regularly assisting the clinics and are not motivated to work in the communities, lack of transport facilities for health workers

- Indicators are measuring changes in knowledge, sometimes in practice, but they do not measure how these results have been achieved. The pressure on the team to achieve the planned indicators leads to unhealthy distortion of the project's model of action (paid CHVs, free allocations to beneficiaries, direct intervention by Tdh midwifes and nurses)
- A lot of improvement is due to improved general conditions since the ceasefire.

If the above-mentioned, plus many others results have been achieved, this is due to a great extent to Tdh's good training and monitoring capacity. A motivated and well-trained Tdh team has achieved the training of over 50 CHVs and 14 traditional birth attendants who receive regular upgrading and monitoring visits.

Results achieved outside the original planning

The programme realised a number of unplanned and foreseen results. Unfortunately these strategic changes were never reflected in the project planning. At least after the original base-line survey, and certainly after the "opening" of the LTTE controlled areas the planning document, including the logframe should have been adapted and changes communicated to all partners.

The most significant new project axis introduced was the logistic and material support to the Ministry of Health. In order to overcome transport difficulties Tdh loaned the Department of Health in Batticaloa one 4 WD vehicle[21] and three motorcycles to carry out Antenatal and Well-Baby Clinics and follow-up visits in areas under LTTE control. During field trips the Tdh vehicles also offer transportation to DoH midwifes. Another unplanned support was the reconstruction of two clinics and repair work and equipment of some other clinics. There is no doubt that this support is welcomed by the DoH, but in order to become more effective and efficient this type of support should be given in the framework of the respective Health Plan for Ampara and Batticaloa, regardless of whether the health structure to be rehabilitated is located in a "Tdh village" or in some neighbouring village. The reconstruction of clinics, which are used 2 days a month, is questionable. DoH is rather thinking of multifunctional buildings which could be used for preschools, Village Development Committees, etc.

This kind of material support has been possible due to over budgeting and the fact that health education is basically a cheap intervention. Large unspent financial resources have been allocated to action in margin of the agreed strategic plan.

In Ampara, the team took the initiative to promote agricultural activities such as home gardening (with an interesting use of empty fertilizer bags) plantation and consumption of wing beans, etc. They also started autonomous, child run, weekly clubs in the villages.

Coverage

The coverage remains at village level and given the important resources at the disposal of the project one could expect the programme to cover a whole medical division, which closely follow the boundaries of the administrative divisions.

[21] Unfortunately this vehicle had an accident and was totally destroyed

	No of GNDivisions	No of villages
Reached		
Eravur Pattu	**39**	**12**
Manmunai S-W	**24**	**18**
Uhana	**58 (64 villages)**	**10**
Mahaoya	**17 (73 villages)**	**10**
Total	**138 GN Divisions**	**50**

The concentration during the first pilot year on 14 villages was certainly justified, but by now the programme should have reached its "vitesse de croisière" and expanded according to available resources.

Participation and ownership

Real participation, involvement and ownership by communities remain difficult, partly due to the unclear power situation in the LTTE controlled areas and partly due to the absence of a real project policy/approach in this regard.

The women's groups are an interesting starting point to develop a sustainable strategy, especially in the case that Tdh does not succeed in finding a viable solution for the CHVs.

Relationships with DoH are regular, but Tdh's investments in Health structures (clinics) are not always optimised regarding the Health planning. This even if DoH has been consulted and has agreed to the investments.

THE WOMEN'S GROUP

The women's group and the CHVs are the basic intervention modus of the project. These regular gatherings and the educational training they receive are obviously highly appreciated by the women (pregnant women and mothers, as in the target group). There was clear evidence during the talks with women to show that natural leaders are emerging. A key point of the women's groups is that they are pivotal to the improvement in mother and child health.

There is an overall awareness that ownership was not truly theirs, but with Tdh. As long as women feel that ownership is '*because they receive benefits'* from the programme, or that they '*could not manage without the CHV'*, then this can continue to create dependency, as opposed to self-sufficiency.

THE COMMUNITY HEALTH VOLUNTEERS

Their perception is clearly belonging to Tdh, this is even materialised in Ampara, by uniforms, Tdh insignia and Swiss flags! The fact that they are paid, supervised and trained by Tdh, makes them responsive to Tdh and not to their community, or to their beneficiaries (women groups)

There is no doubt that the CHVs issue from the community and that these communities appreciate their work. In this respect the continued training/support that has been provided to them from programme staff has no doubt contributed towards their willingness to take on additional duties and earn additional consideration and recognition from their communities.

THE COMMUNITIES

There is, for the time being, little to no community involvement or ownership regarding the MCH programme. Unfortunately, due to recent political turmoil, the evaluation team was not in a position to discuss this issue with village authorities. But visibly village development

committees and village authority, both under LTTE control, are not (or not yet) full partners of the programme.

DEPARTMENT OF HEALTH

Collaborative and regular contacts with both DoH exists. The collaboration exits on the operational level with the midwives, the decentralised doctors in the divisional hospitals and with the DPDHS. Nevertheless, the collaboration remains on the level of regular information and direct support to the MCH and well-baby clinics in the project villages.

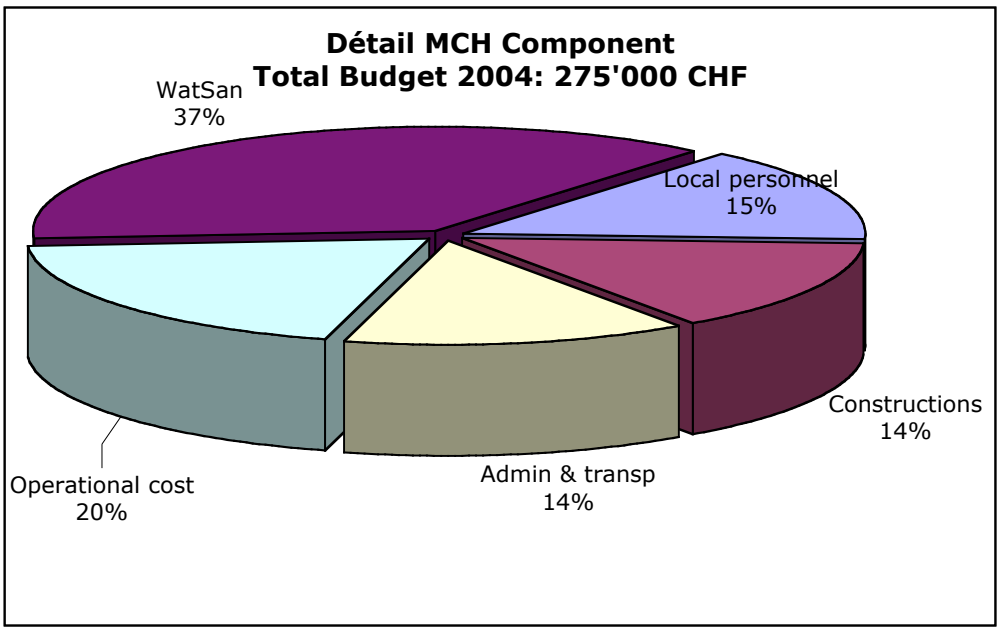
Efficiency

Health education being a relatively cheap intervention, there has to be a large coverage to justify expensive administrative and support costs.

Compared to national health expenditures the part allocated to MCH and health education is large (needs further analysis).

(Over)budgeting being done before planning there was a pressure to spend the excessive resources by launching new and not necessarily planned activities (constructions, etc.)

The MCH component including Water and Sanitation[22] accounts for half of the programme costs, without the drilling of wells and the latrine construction the part of MCH falls down to 1/3 of the overall costs



If we remove the 103'234 CHF for the WatSan component (well and latrines in the Mahaoya Division) and divide the remaining 171'973 by the 50 villages in which Tdh is operating we reach a cost per village of 4'440 CHF/village/year. For the villages in the Mahaoya Division we will have to add another 10'000 CHF for the WatSan component.

The MCH component (without WatSan) is the only component that is run directly by Tdh. A large part (at least 50% of 140'000 CHF) of the delegation (called Technical support by Tdh)

[22] WatSan falls within MCH for the programme structure and the budget

has to be added to MCH. The overall cost of the MCH component can then be estimated at 242'000 CHF.

We have to remember that education is only part of MCH and that MCH is only a part of primary health care (PHC) and again that PHC is by far not the most expensive part of a national Health system. In this regard and compared to national expenditures on health[23] the above project cost are high.

In regard to the overall project budget of approx. 600'000 CHF, this represents 40% of the total project costs[24]. Given the fact that the programme is mainly a MCH programme these are minimum values, which should be respected.

SOME REMARKS REGARDING THESE FIGURES:

- Operational expenditure includes most of the costs that can be directly attributed to the costs in the villages (costs of the CHV, direct aid to beneficiaries, etc.).
- In regard to the limited percentage represented by the operational costs, one may asked why not multiply the intervention area. By doubling the intervention area we would hardly touch the other costs (maybe some additional transport costs), but earn a lot in term of efficiency.
- The 70'000 CHF part of the technical support (delegation costs)[25] are too expensive. This is stated in the knowledge that project staff working on MCH in the delegation office are separately accounted for (40'809 CHF): the same applies for transport, admin and external consultancies (38'214 CHF).

Budgeting has been done before exact project costs were known. Once the budget allocated and the real costs of health education were known, it was evident that the programme would massively under spend on MCH. Rather than reduce an agreed budget, the programme increased expenditure on construction (reconstructions of clinics not foreseen in the planning) and general expenditures. These changes were duly reported and de facto accepted by SDC and Tdh HQ, but they are key elements that weakened the efficiency of the programme**.**

[23] 120USD/head

[24] 57% if we include the WatSan component.

[25] Delegation cost are more administrative costs then technical support. Technical support in this case would need a PH specialist capable to bring some added value to DoH and develop sustainable policies.

Sustainability

Sustainability is another problematic criteria in regard to the MCH intervention.

CHVs are considered as Tdh employees, community ownership that would give them a viable long-term existence, is not yet achieved, nor really addressed.

If the CHVs are difficult to sustain the women's groups may offer a sustainable solution, with or without CHVs and allow Tdh to move out of existing target villages by the end of 2004.

For the time being sustainability and exit strategy is neither the concern of Tdh at HQ, or at delegation level. The subject has not been brought forward with the team and the CHVs who consider themselves as Tdh employees. There is no exit strategy, not on the global level, not even at the village level. The first 14 villages are now in their 3rd year and one would think that basic health knowledge and practices are acquired. If the programme succeeds and attains the planned level of **KAP**, then what is the reason to stay in the same villages for years?

Women groups interviewed felt that they are still very much dependant on the programme's CHVs. Beside these signs of dependency, there were also women who now felt well empowered and declared themselves ready to teach other women. It was felt that women in Ampara were less subjected than there counterparts. Also, the women in the LTTE areas had endured long-term conflict, which would equally affect abilities – lack of education etc. The women who felt more confident and well-empowered were those in the Ampara villages.

True sustainability lies not just in the acquisition of knowledge, but in the gradual enhancement of their capabilities, plus confidence in themselves to continue good health practices.

Approaches (model of action)

Health education

Health education has been a core component of the MCH activities and is indeed one of the strengths of the programme. It was clear from discussions with the women's groups that these sessions were welcomed and that they had learnt important MCH health messages. MCH health education has involved a specific number and type of subjects to be repeated at very frequent intervals (depending on the length of input to a village). Whilst a re-enforcement of messages has its place, the benefits of the same messages need to be balanced against the negative aspect of repetition.

Likewise, whilst it is important for women to have health messages on the importance of ANC attendance, it is equally relevant that they eventually take their own initiative to attend for care, rather than have the CHV follow up and remind them.

The village entertainment that is created by Tdh's cultural programmer is an interesting tool to promote health messages. It could be improved by increased participation from villagers, and it could be worthwhile showing the husbands also as hard-working men, with their own problems and how this affects family relationships - and not only as drunkards!

Health education is still a very much one-way model. There is the teacher (CHV, Tdh midwife & nurse) and the mother who is supposed to be "taught". The trend today is more towards health communication whereby knowledge flows also from the mothers to the "teachers" and solutions are developed in participatory way.

Integration – Connectedness

The MCH component is in permanent contact with the DoH, especially on the level of the PHM and the MOH in their respective medical divisions. The DoH still has very limited resources (financial and human), which they have to invest with parsimony on priorities identified by them. Gradually the Tdh health team appears to have taken on more activities over time, which has led to a form of PHM substitution.

Few contacts exist with other NGO's, but this is not a lack of interest by Tdh to network, rather an absence of other actors in this field. Only very recently World Vision has started to be active in PHC within areas under LTTE control.

Strength and weaknesses

- ♥ MCH, focus on health education and support to DoH for service provision is still relevant, especially in the LTTE controlled area.
- ♥ Health messages have been well accepted and led to positive changes in practice.
- ♥ Access and use of ANC and WBC are improved.
- ♥ Quality of pre/post natal services are good.
- ♥ Growth monitoring and vaccination coverage of children are general and have good quality.
- ♥ Women have been empowered through education.
- ♥ Mothers group are a promising structure for increased sustainability (peer learning).
- ♥ A good baseline study provided valuable data.
- ♥ Project has moved according to plan and is most likely to achieve its planned results.
- ♥ CHVs are trained, motivated and recognized in their community.
- ♥ Continued support to DoH (transport, equipment, reconstruction)
- ♥ Some interesting initiatives, such as using cultural events produced by the children of playgroups for health education.

- ⊖ Operations have been adapted to changing situations but not the initial plan and indicators.
- ⊖ The specificity of Ampara, would have needed a specific programme adapted to their situation.
- ⊖ The transition from "emergency" to "rehabilitation" is under way but long term sustainability is not yet addressed.
- ⊖ Absence of exit strategy from "older" villages.
- ⊖ Even with 50 villages, coverage remains sparsely compared to resources invested.
- ⊖ Sometimes unnecessary repetition of health messages already well known.
- ⊖ Globally the MCH component is not very cost effective, especially due to the high "overhead" costs.
- ⊖ Real participation of beneficiaries and communities remains poor.
- ⊖ Classic one-way health education instead of three-way, interactive health communication.
- ⊖ Support to DoH could be better integrated into departmental health plan.

Globally the intervention is fully justified (with question marks in Ampara). The planned results will be achieved: the weakness lies more in the way these results have been achieved.

Part II Water and sanitation

Introduction

The WatSan part of the MCH component has encountered a number of difficulties and short-falls this situation was known by Tdh, who frequently reported upon. Part of these difficulties lies in the weakness of the local implementing partners to whom Tdh subcontracted the constructions of wells and latrines.

Specific relevance of each component

Organised and adapted disposal of human waste is essential in the area (risk of pollution to the high water table).
Subsidized latrines for low-income families are only one possible solution.
Providing SAFE drinking water, which does not necessarily mean construction of wells, is also relevant.

Latrines

Latrines are quite common and widely used in Sri Lanka. First urinating pits and toilets, dated as early as 200 BC, with a 3 chamber filtration system can been seen a Anuradhapura museum.

A PRA conducted in the 10 villages of Uhana division in Ampara showed that out of 1'557 households 403 had concrete, 732 traditional latrines. Only 422 had no facilities within their compound. No data exists for the LTTE controlled areas of Batticaloa, but observation showed quite a high number of toilet facilities attached to houses. Beside the privately constructed toilets there are, as usual, numerous NGO sponsored toilets.

Rural families with some monetary income, and after having built a concrete house invest most likely in permanent toilet facilities. Toilets used by adults, but smaller children will not use them.

Sewa Lanka's PNA conducted in 10 villages indicated latrines as 1st priority in 7 villages and wells in two others, there was no opportunity for evaluation team to cross-check these results[26].

Poorer households and household with little capacity manpower, such as female-headed households will hardly invest in toilets, as long as they live in a precarious mud house. For such households the provision of latrines can be justified.

Wells

Access to water and specifically to **safe** drinking water varies a lot according to the project area. In most areas, and specifically those under irrigation (Uhana Division and large parts of Batticaloa project areas) access to water is not a major problem. Due to high ground water level and use of chemicals in the irrigated paddy fields most of this water is either muddy or

[26] It is noted that the initial MCH Needs Assessment (2001) also revealed a public need for latrines- especially in Ampara.

polluted. Safe drinking water, because we can hardly expect people to treat[27] all their water, remains therefore a relevant project intervention.

The question for both human waste disposal, and even more for providing safe drinking water is to know whether such programmes lies within the competence area of Tdh. Already during the planning phase in 2001 some concerns were raised regarding the technical capacity and knowledge of Tdh to handle WatSan projects. Today our findings confirm that WatSan projects should be handled by either specialised agencies[28] capable to develop and apply new performing and cost effective technologies - and not repeat old worn out and ineffective and inefficient technologies.

Effectiveness Planned objective – degree of achievement

Over 300 latrines have been constructed; most of them are used and are of qualitatively good standards.
60 wells have been constructed; out of them the 30 in Batticaloa district are of very poor quality.
Interference from LTTE hampered beneficiary selection and contracting in Batticaloa.
According to Tdh ordered water analysis, the quality in all the wells is highly unsatisfactory

Expected results – achieved results

Result: *The population in the target area has access to clean drinking water and adequate sanitation*

Indicators: *2003: 78 wells, 200 water-seal latrines; 2004: 100 wells and 50 repaired; all wells maintained; health education complete*

The project will meet its quantities indicators. Over 300 latrines (102[29] in Batticaloa & 200 in Ampara) and 60 wells have been completed by end of 2003. A new contract with Sewa Lanka foresees to build 200 more latrines, and 30 more wells in Mahaoya Division of Ampara. In Batticaloa district the WatSan component was terminated by end of 2003.

Due to the implementing capacity of the local partner and the interferences from LTTE authorities, effectiveness differs a lot among the 3 project areas.

AMPARA:

Sewa Lanka is one of Sri Lanka's NGOs, with a long experience in WatSan. In Ampara they have been implementing agency for major international partners, among them HELVETAS. Under the leadership of Asano Usui, a Japanese VSO, they built up their own project team to implement the Tdh WatSan project. Tdh could leave the project implementation in good hands without an intensive monitoring.

[27] Boiling water is advertised by most projects, but to our understanding may not be very realistic, except for babies and small or sick children. Also, boiling does not eliminate chemical pollution.

[28] Even if Sewalanka is considered one of them they still would need a technical input from outside

[29] 33 more toilets are nearly completed

All the wells visited are of good design and good technical standards. Users group[30] exists and they have collected a small contribution (± 50 RS) for maintaining the well. The surroundings are kept clean, the covers of well being replaced after use, etc.

At the initiative tof the Tdh delegate, water has been tested regarding its bacteriological cleanliness. Chemical pollution, such as fluorine content has been analysed[31]. But what is unacceptable is very high bacteriological pollution. All wells in Ampara have up to 10 times more faecal pollution than the admitted norms. The difficulty to produce safe drinking water by open wells is widely known in the area (e.g. Helvetas in Ampara). New solutions will have to be searched for.

BATTICALOA

Koinonia, the implementing partner for Batticaloa district, faced much more difficulties to implement the project than Sewa Lanka. Part of it was due to interference by LTTE authorities in the areas under their control. Beneficiaries, martyr's families, contractors and prices have sometimes been imposed by LTTE. Nevertheless, the main weakness lies certainly in the lack of experience and management capacity of Koinonia and missing technical monitoring by Tdh.[32]

The results[33] are highly unsatisfactory wells. The wells visited all had technical problems, as follows:

- *splits, one well is sinking down on one side.*
- *brownish water not suitable for drinking, probably due to bad quality of bricks,*
- *vanishing water level,*
- *external contamination, due to the absence of cover,*
- *muddy and dirty environment around the well, absence of apron, presence of livestock, absence of maintenance, etc.*

Beside the technical problems there is also a problem of localisation and missing coordination among agencies. In Rugam the functioning Tdh[34], OXFAM, ICRC and private wells are within 500m, while people declare to have moved back to Rugam[35] from their existing home because of the lack of water in the border areas.

The latrines are globally satisfactory. The ones visited were of good technical quality. A recent Tdh monitoring showed that out of 135 latrines 102 were completed, out of 95 of good quality, the remaining ones estimated as not satisfactory

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[30] We use the term of users group rather than water committee, knowing that it is mostly an informal grouping of the 10-15 families who share the use of a well.

[31] The proximity to irrigated paddy fields (sometimes less than 20 m) and the high water table of the wells contribute to the risk of pollution by excess fertilizer and pesticides.

[32] Wells constructed for OXFAM by Koinonia are of better standards, probaly due to OXFAM's experience in WatSan and a better contracting from their side (design – technical control, etc.)

[33] Physically the evaluation team checked 6 wells in the Badulla Rd.

[34] The last one constructed

[35] Where they have been displaced during war times

Global

Physical outputs have been achieved, the health education component is analysed within the MCH component of the project. There has been no specific health education by the implementing partners, this being done by the Tdh CHV's.

Regarding the impact on the long-term goal, as defined by Sewa Lanka's Logframe to "*Reduce water borne diseases such as cholera, dysentery and diarrhoea,"* it is difficult to measure given the coverage and the existence of multiple intervention in this area. Nevertheless, the over 500 latrines will make a contribution to the sanitary environment in the project villages. The contribution of the wells is somewhat less significant, due to the existence of many other wells and water quality, which most of the time will still need further treatment (filtration, boiling, chlorination, etc.) in order to be declared "safe drinking water".

"*Formation and strengthening 10 village CBOs*", is another objective highly overstressed. If local CBO's will emerge in a near future due to Tdh's intervention these will be the actual women's groups (of MCH component). We would not qualify the fact that 10 families contribute together the cleanliness of their common well a CBO.

Efficiency – cost analysis

Latrines: Globally high costs due to more expensive type of achitecture, especially in Batticaloa (Koinonia), weak contracting and absence of cost effective technologies.
An increase of at least 3 times compared to Helvetas.
Wells:Good quality in Ampara compared to low quality delivered by Koinonia (Batticaloa).

AMPARA

The total budget for 2004 is 5'812'870 Rs (77'500 CHF)[36].

• *200 toilets 18'350 Rs (244.- CHF) each*	*3'760'000*	
• *30 wells 52'589 Rs (700.- CHF) each*	*1'577'670*	
• *Transport of building material*	*20'000*	
Total construction costs	*5'357'670*	
Total admin, supervision, training, staff include. Transport	*455'200*	*8.5%*

The increase from 2003 to 2004 has been justified by increased cost of construction material[37], increased transport cost in Mahaoya Division and expected deeper water level.

Helvetas in the same project area, implementing toilets with local partners, has unit costs of 3'500 – max 5'000 Rs/toilet. Tdh costs are 300% higher. This is due to Helveta's more rational architecture. It's latrine model has a more cost-effective design (absence of door frame, less paint, etc.) and uses modern cheap but highly resistant techniques such as fibrocement roof. Helvetas, due to the multiplication of implementing partners, could negotiate cheaper prices.

BATTICALOA

Toilets have been budgeted at 16'000 Rs/toilet, effective expenditures were 13'500 Rs. The wells were budgeted at 25'000 Rs, effective expenditures was 26'630/well. This figure does not include 264'000 RS administrative costs and 55'000 RS supervisor's salary costs.

[36] Exchange rate 75

[37] A bag of cement = 380 Rs – 450 Rs, iron bar 60 – 185 Rs etc.

The cost of the toilets and especially the cost of wells (given the poor quality) are too high.

Our main concern with Koinonia are the very high global overheads to be added to all their programmes to cover poor project management and nearly total absence of field monitoring, capacity building and training within its staff.

Participation

Expected free labour force was provided, but real beneficiary participation and empowerment remains poor.
Essential accountability to the affected population/beneficiaries (prior to the donors) was totally absent.

There is a misunderstanding in both project areas of real participation. Participation is viewed strictly in terms of labour and sand, etc provided by the beneficiaries. Beneficiaries have not been consulted, nor informed on the project design. They do not know the cost of their toilets, nor are they in position to explain why they have been chosen as beneficiaries. Technical and financial options have not been discussed with them. It is easy to imagine that some beneficiaries would have come up with cheaper designs, plus higher participation in order to add a front wall or a water tank to their toilet.

Accountability to the beneficiaries is today an essential part of any intervention[38]

Strength and weaknesses

- ♥ Good acceptance and utilisation of the toilets by the beneficiaries.
- ♥ Well integrated in the global development (housing) trends observed in the villages
- ♥ Beneficiaries participation (free labour) was easily acquired
- ♥ Number of wells and latrines constructed in time

- ⊖ Wells do **not** provide safe drinking water
- ⊖ Project not adapted to technical capacities and experience of implementing agencies
- ⊖ Overall high costs
- ⊖ No alternative options using more effective and cheaper techniques has been developed
- ⊖ Lack of real participation and transparency/accountability to the beneficiaries
- ⊖ Unacceptable technical quality of numerous wells in Batticaloa

Globally the project has achieved its indicators (no. of wells and latrines) but in no way its objective (result WatSan), which was the provision of clean (safe) drinking water.

[38] See SPHERE, Red Cross, ALNAP, etc. standards

Lessons learnt

- Tdh should be extremely careful if they want to implement WatSan project, accept its own limitations and hand out contracts to experienced and capable partners.
- The general principle of Tdh to work with local partners where their added value is visible is not applicable to WatSan projects, where there is no added value by Tdh.
- Negotiate with the implementing partners their overhead cost, which should remain within acceptable limits, 10-15%, in normal cases.
- Introduce proper monitoring by project partner or external technician if internal resources are insignificant.
- Improve coordination with other actors in the field of WatSan and specifically with the local water department.
- Adapt planning to identified needs and interventions outside, rather then a stiff linear planning of 3 wells/village.

Part IV Psycho-social component

Preliminary remarks

The main focus of the evaluation was on the MCH and WatSan component.

Short description

The psycho-social component is based on three type of interventions:

- 15 preschools with 529 children
- The recreational (play) centres
- 2 schools for the integration of handicapped children (79 children)

And implemented by 3 different implementing partners:

- Batticaloa Befrienders: 3 preschools, 10 recreational centres, 1 handicapped school
- Koinonia: 12 preschools, 18 recreational centres
- ECIPCWO: one handicapped centre in Kattankudy

Objective

Children up to 14 years old will be better prepared to become active citizens of their communities, while integrated into the community and the educational system with psychosocial support.

Staff Training

Stafff training has been sporadic according to opportunities. The most important was a 6-month training provided by the War Trauma and Psychosocial Support Programme (WTPSP) for Batticaloa Befrienders. In addition both partners have benefited from the MDF workshops.

Major Findings

Still weak data

We still know very little to what degree children have been affected by the past war situation. It is to Tdh's credit to have engaged in a study[39] that is testing methods for the evaluation of psychosocial programme impact by the Refugee Study Centre, University of Oxford.

The psychosocial well being of Sri Lankan children is certainly not only dependent on their exposure to war situation. Cultural and family conditions have a predominant part in the high suicide rate of adolescent

The continued concern about the high suicide rate among youngsters, especially young girls, is still missing a proper analysis and a preventive policy. For sure the suicide rate is not linked to the war situation, but it is a widespread phenomena in Sri Lanka. Certainly the social and family pressure on the child is very high, especially the expectation that the child succeeds in school.

[39] Financed by USAID

Specific relevance of each component

Pre-School

Sri Lanka has, from our understanding, a very formal education system. Beside school education there is no alternative way. Schools from grade 1 to grade 9 go along a predefined national curriculum, which has to be strictly followed; national exams have to be passed at a given age, etc. One of the most stressing is the "Scholarship Examination" at the end of grade IV (approx 11 years), the outcome of which decides whether you will get free GoSL scholarship up to the end of your schooling. One can easily understand the pressure poorer families will have to put on their children if they want them to succeed in school. Parents and teachers still believe strongly in this very formal educational system, whereby strict discipline and punishment[40] is the common rule.

Pre-schools are highly fashionable in Sri Lanka and there are hardly any ONG or CBO who do not run some pre-schools. There are 169 preschools in the Batticaloa education zone[41]

What is the point for Tdh to sponsor 15 out of this number? The preschool programme comes from a time where there were visibly less preschools than now.

An implication by Tdh for the preschool can only be justified (pertinent) if it is to add value and create better and more innovative preschools. This requires a Tdh capacity to prove and to disseminate techniques which show that learning by play is possible and that schooling is not necessary a traumatising experience for a child.

Until now there are little signs that this happens in the Tdh sponsored preschools:

- The major improvement/innovation made over the last years is the syllabus (guidebook) introduced recently, and which is normally compulsory for all the preschools. It has been developed and introduced by UNICEF and the Ministry of Education.
- Under pressure from parents and teachers the preschools, including Tdh sponsored ones, have come back to more formal education.
- The argument that children who go to preschools succeed in the primary schools is not really relevant knowing that almost all children go to preschools

SCHOOL FEEDING

The nutritional status of the children does not justify a nutrition programme. Several arguments speak against a full meal provided by Tdh in the preschools:

- It does not respond to any standard of a nutrition programme and in no way addresses any form of malnutrition.
- It does not replace a family meal, as mothers will have to cook a midday meal for the remaining children coming back from school.
- The Deputy Director of the Ministry of Education in charge of the preschools does not recommend it.
- It keeps the children after 11:30 am which is the time limit fixed by MoE to release small children from school.

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[40] The law allows physical punishment of boys, and the school laws of children of both sexes

[41] Batticaloa District comprises 3 education zones (

- It is expensive and mobilises human resources that would be much better invested in an improved care and "encadrement" of the children.
- A consistent and nutritional "snack" during the morning seems more preferable than a midday meal.

Recreational activities

Recreational activities, plays, meeting friends, decompress after a heavy school day, or from oppressing family situation, therefore who would refuse this to children and adolescents?

Especially in the Sri Lankan context, and not particularly due to the war, these types of activities are essential for the well being and the harmonious development of the child. If it prevents some cases of adolescent suicide, or suicide trials by burning themselves or swallowing pesticides,[42] then relevance is out of question.

Tdh, had already identified this very issue and started the play activities well ahead the actual programme. Whilst I found the recreational activities (former Play Activities) at a first analysis in 2001 not absolutely relevant, I am, after a deeper insight into Sri Lankan childhood, convinced of the relevance of this type of activity. However, the relevance of the approach chosen is questioned.

FEEDING DURING PLAY ACTIVITIES

See remarks for the preschool.

The argument that children will not come to the recreational activities if they don't get food is a "killing" argument for the quality and/or the relevance of the recreational activities.

Effectiveness

Preschools

Result

Children are enrolled into governmental schools. Improved nutritional status of the beneficiaries of the preschools.

Indicator

By the end 2004 95% of Tdh pre-school children are admitted into government primary schools and 90% of the children meet the WHO standard for weight for age

Assessment

Most of the children entering primary schools come out of preschools; 600 boys out of 644 who entered primary school in and close to Batticaloa town, but only 250 girls out of 242.[43].

The project cannot claim improvement on the health status of the children, with the type and frequency of meal distributed.

We are very sceptic on both indicators, as there is an absence of proper baseline findings. Subjectively we might have to admit that both indicators might have already been reached before the start of the programme and are close to normal conditions in preschools

[42] The two most common forms of suicide attempts reported by Batticaloa Hospital (and MSF in 2001)

[43] These "town" ratio falls down to 50-60% in remote rural divisions

An indicator measuring the quality and tempo of a learning process based on active learning techniques and play compared to rigid learning "by heart" would have been interesting.

Globally we cannot confirm that Tdh preschools have brought an added value to the preschool system in Sri Lanka. The Ministry of Education mentioned that there is only one NGO (not Koinonia nor Befrienders) who is doing regular training and upgrading of their preschool teachers.

The preschool teachers are under high pressure from parents and primary school teachers to limit the use of the UNICEF guidebook, based on learning by playing, and return to more formal education and discipline. How the preschools, funded by Tdh and run by Koinonia and Befrienders, will resist to this tendency by convincing and educating parents and teachers on the positive aspect of the UNICEF/MoE curriculum has to be closely monitored.

If health and well being (physical health) of the children is the objective of the project, then results should not be measured in term of success in education, knowing that the tremendous pressure put on the children to succeed in school is one of causes leading to adolescent suicide. There may well be a moment when the project will have to choose between schooling at any price,[44] or the well being of the child.

Play activities,

Result

The play activities will allow more children to develop their talents and competence, which will help them to contribute to a more harmonious society

Indicator

By end 2004 children's talents are exhibited through public performance, at least once a year; Indicators to measure traumas are established; 5-10% of the play activities are mixed, at least 30% of the respective minority group, Tamil or Muslim; 1 year after leaving the play activity at the age of 14 years, up to 50% of the children are actively engaged in some form of community work.

Assessment

The indicators are not really measuring the result. It is difficult to estimate how the children through the play activities have developed their talents and competence. The sport and the cultural animators of Tdh have developed sport activities and dramas, which are played in villages to raise awareness on health messages. There are regular sport events organised between different groups of play activities.

There is only one play activity where Muslim and Tamil children are mixed, because all the other areas are populated by just one ethnic group. There is no systematic follow up of children who left the recreational activities.

Through USAID funding Tdh, together with the Refugee Centre of the University of Oxford, tested a number of tools to monitor the impact of recreational centres on traumas.

We are concerned on the trend to organize tuitions classes during play activities. There is a constant tendency to fall back on traditional educational models

[44] Knowing that schools lead in more than 50% of the cases to drop-out and unemployment. In the schools checked in 2001 not one child passed the examination. A survey indicated that out of 8'613 children in grade 5 only 6'000 where eligible to sit the playgroups exam and only 617 passed the exam.(most of them in Batticaloa town)

Globally the recreational centres we visited were very crowded with few animators present; most of the children being left on their own to play. Two animators for up to 100 children is quite common. Some of the recreational centres on the Badulla Road, visited by surprise, were not functioning.

The objective of mixing was totally unrealistic. The only playgroup located in a mixed (Tamil/Muslim) quarter of Batticaloa has always been like this and remained the only one. It is unrealistic to move Muslim children to Tamil area, or vice versa.

Children of playgroups becoming active citizens is also above the capacity of the project. It has never been monitored, or proven, that this is due to playgroups. Concerns on these two indicators have already been formulated during the planning phase.

Handicapped Children

The evaluation team has not assessed this part of the programme as the schools were closed (vacation). At a meeting with parents of handicapped children, they expressed their satisfaction about the programme.

Networking:

Result

The establishment of an active network among CBO's, NGOs and the government that leads to improved complementary services in the area of trauma counselling, special healthcare and nutrition

Comments

Tdh is part of the INGO forum in Batticaloa, but globally there is very little networking and coordination going on among INGOs and NGOs. Typical examples can be found by proliferation of wells in the same area, the latrine programme, the non-integration of savings and credit schemes with agricultural development and health. A positive example is Sewalanka in Ampara who are considering taking over the Tdh CHVs in the 10 villages in Uhana and use them for their credit and savings groups.

Efficiency

Costs per intervention

Effective costs are difficult to calculate, because on top of the contract with the partner, there are at least 3 salaries (Cultural- & Play animator, Vigie, plus part of the salary of Mr. Kamal and part of transport costs).

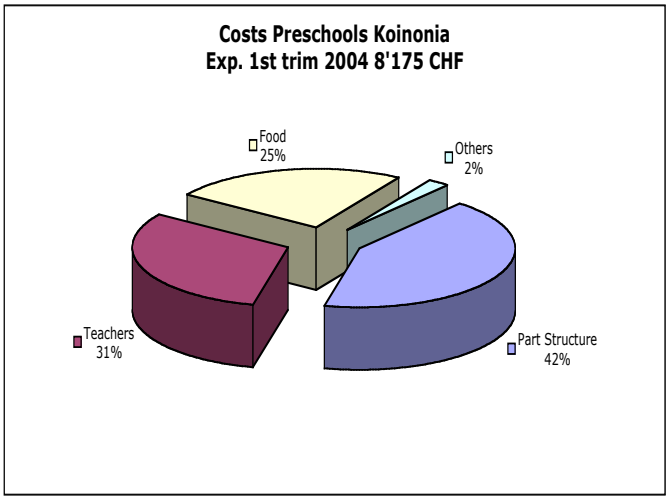
The preschool teachers salary are rather below the level recommended by the Ministry of Education. The buildings and the equipment (plays, sport equipment, etc.) are at a bare minimum level. The monitoring, the training, the organisation of cultural and sports events are not done by the partners and the schools and the recreational centres are expensive. Again we have to look at the large costs of food (not really relevant in the given situation), and the administrative costs of the partners.

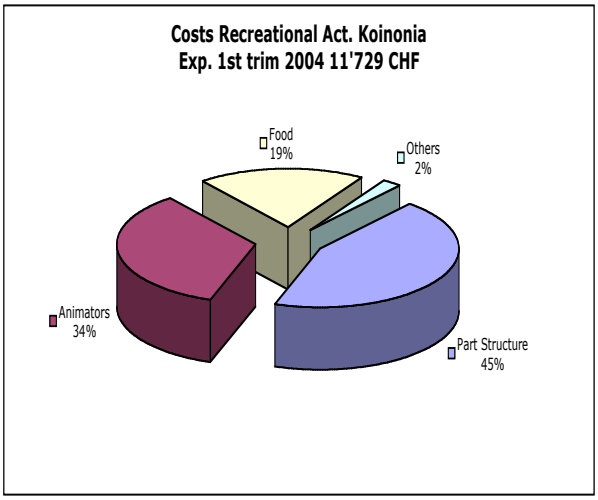
Basically the partners have never learnt that money is an issue; their demands have been accepted without too much questioning during the years where the programme was well funded.

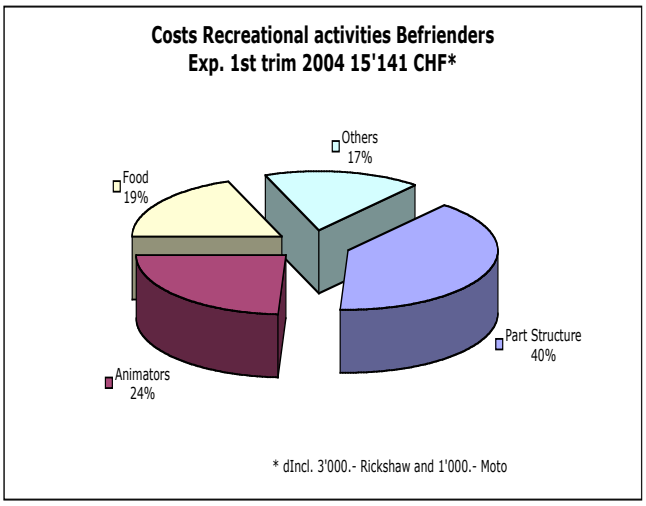
COST ANALYSIS

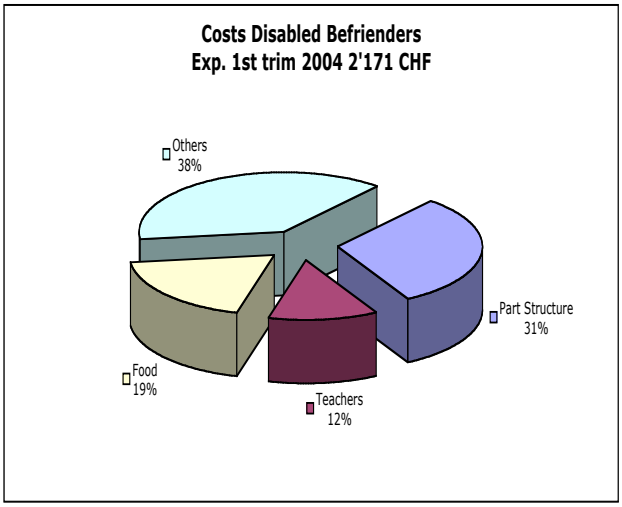
We tried our best to analyse type of costs per activity and organisation The accounting system of Tdh does not allow analytical bookkeeping and the cost of several partners are accumulated in the same accounts. This summer Tdh will install their accounting software "Saga" which will resolve part of this problem.

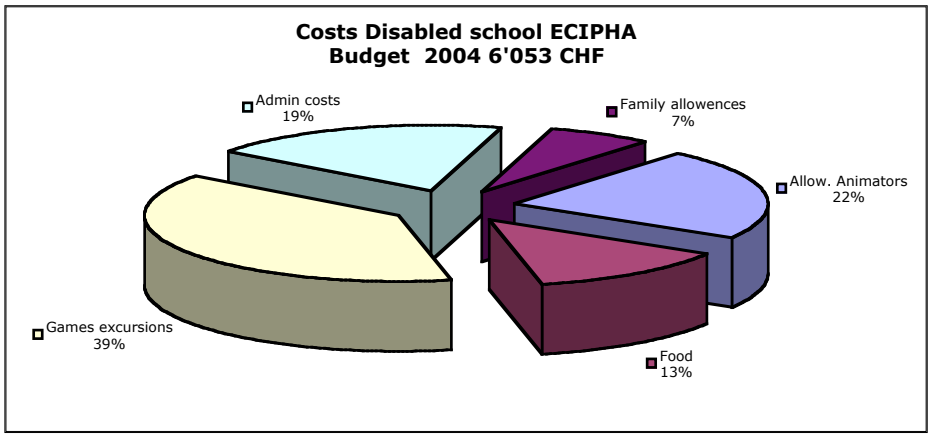
Nevertheless graphs reflect the reality. In these graphs costs of Tdh staff working exclusively for preschools and play activities are NOT included.











Sustainability

Result

By 2004, autonomy and sustainability of the projects are improved

Indicator

By the end of 2002 the implementing partners and CBOs formulate and agree on a strategy leading to sustainability and autonomy; By the end of 2004 the community is financing 25%-50% of the sub-project. That is done under the conditions that the community claims ownership of the sub-project and they are in charge of administering and running the project.

Assessment

This result has not been achieved but Tdh has taken up the point.

In 2002, after the cease fire and partial normalisation, it was an ideal moment to formulate with Koinonia and Befrienders the planned strategy, However, this was not done. All the "messages" sent to the partners went the opposite direction. The local partners continue to be heavily dependent and supported by Tdh as in 2004.

Koinonia has received each year an increased budget, even if they had a large under spending the year before.

Koinonia Psycho-social	Year	Budget in RS	Expenses	Under-spent
	2002	4'119'000	3'522'179	569'821
	2003	4'867'000	4'059'423	807'577
	2004	5'788'200		
Kononia WatSan	2002	1'925'000	949'978	977'022
	2003	2'959'000	2'149'215	809'785

In 2003 Tdh increased the total budget for Koinonia from 80'000 CHF in 2002 to over 100'000 CHF, despite under spending of 21'000 CHF (25%) in 2002.

The picture is similar with the Batticaloa Befrienders; budgets are constantly increasing, with Tdh funding transports (threewheelers) and offering a computer. Both organisations have massively increased their administrative staff, without assuming a minimum of monitoring and training.

Above all, it is Tdh staff following up the preschools and recreational centres[45]. It is also Tdh staff organizing sport and cultural activities. Besides a monthly meeting of 1-2 hours, which is used to pay the teachers/animators and collect their reports, Kononia is not bringing in any added value to the activities under their full responsibility. Batticaloa Befrienders has tighter monitoring, together with longer and more interesting staff meetings, but it is still the Tdh cultural and sport animators who intervene heavily in the playgroups.

By engaging the former "independent" BATT team[46] and using them to monitor and to intervene in activities under the full responsibility of local NGOs, these NGOs become more de-

[45] You hardly find any annotations by Koinonia field staff in the log book of the centers/schools.

[4646] Mr Kamal, Vigy and

pendent and less responsible. In the presence of the weak field management of the implementing partners the heavy follow–up by Tdh staff in the centres leads to a type of co-management. Who is actually running the psychosocial programme? The permanent involvement by Tdh staff is well accepted (desired) by the implementing partners, but act against autonomy and independence and is globally unsatisfactory.

Part V
Delegation office and PCM

Programme Management

Project structure

The MCH component is run directly by Tdh, with local partners for the Water component (Koinonia in Batticaloa and Sewa Lanka in Ampara). The DoH is also a partner in terms of service provision. The Psychosocial component is run by Batticaloa Befrienders and Koinonia.

Project cycle management

Institutional constraints on the planning process

Constraints from Tdh Lausanne and funding agencies predetermine the planning process. In the case of Sri Lanka this is at the origin of a number of weaknesses. In fact after the identification mission (early 2001), Tdh had to get the budget approved by their board in September. Once the budget approved followed the planning workshop, again on assumptions made by the Tdh psychosocial team and rough data collected during the identification mission. Followed the approval of the project and its budget by SDC. After acceptance of the programme Tdh could start preparation in order to set up a delegation office in Batticaloa and prepare the baseline surveys. The real baseline datas were available only in the middle of 2002, even 2003 for Ampara.

The needs assessment in Ampara had pointed out that further exploration was needed, as it was clear at the time that women were accessing MCH – what they lacked was better awareness in respect of health education. However, that could not be a singular factor for such a large investment. The drive to work with Singhalese communities seemed to take precedence.

Excellent data collection and documentation

The programme in Eastern Sri Lanka is a model in terms of data collection. A serious baseline was designed, against what precise measure can be made. The team have been formed in survey techniques and the protocols responded to good standards. This knowledge can, and will have to be used, to undertake a final survey at the end of the project cycle.

Tdh will have to decide to undertake the final survey early enough, so that data can be fed into the planning of the new phase. On the other hand a late (end of the year 2004) survey will give a more precise indication on what has been achieved in 3 years.

Flexibility and adaptability in planning

The major weaknesses in the PCM of the programme was an incapacity to adapt the planning and action to a fast changing situation in the area. A first adaptation was necessary after the baseline surveys, especially for the Ampara part of the programme. A second adaptation was

necessary after the ceasefire[47], especially for the MCH component in the LTTE controlled areas, and probably as well for the psychosocial component of the programme.

Instead of these adaptations the programme management kept to the predefined indicators, many of them had lost in the meantime their validity. These, in spite the recommendations during the planning process to consider the indicators and partly also the results as temporary, knowing that real indicators could only be elaborated through the increased knowledge and experience gained by implementing the project.

Monitoring

MONITORING

For the MCH component there was a constant monitoring going on, with some highlights such as the intermediate survey made in 2002. The baseline data facilitated the constant data collection and the monitoring process. The baseline survey contained quite a number of interesting data, regarding practices of pregnant women and mother of young children. Additional data on why they are acting like this and on possible solutions and local resources could have been more systematically collected.

Realising that qualitative monitoring of the psychosocial component, especially the recreational activities was, and is a difficult issue Tdh joined together with The Refugee Studies Centre of the University of Oxford (a leading research institute in this field) to undertake a research on possible tools to evaluate impact of their intervention.

Reporting

The monthly reports and the semi-annual report have provided a good basis for ongoing monitoring of the project. The evaluation carried out by Brenda Jenkins in December 2002 has helped to point weaknesses in the MCH component and how these could be addressed in 2003. This has lead to a change in monitoring practices and staff are now involved in 'process recording' which will help to back-up quantitative data from monitoring of the baseline survey results.

The financial reporting is absolutely transparent, explanations are given on the fluctuations in budget line items (sometimes several hundred percents). These reports did not generate a reaction from SDC in Berne. Does this mean that there was an agreement on the new programme components that have been added (construction of infrastructures, a new approach toward DoH, an increased WatSan programme, etc.) ?

If these strategic changes were clearly accepted, then why was no adaptation of the programme documentation and Logframe was ask for?

[47] to some extent planning was changed in Batticaloa, as they had to adapt to the lack of the mobile INGO clinics and the 're-entry' of the government sector. Linkage did become stronger with the DoH in order to support them, but as we know it has turned out that Tdh has taken on more and more of what we consider to be DoH responsibility.

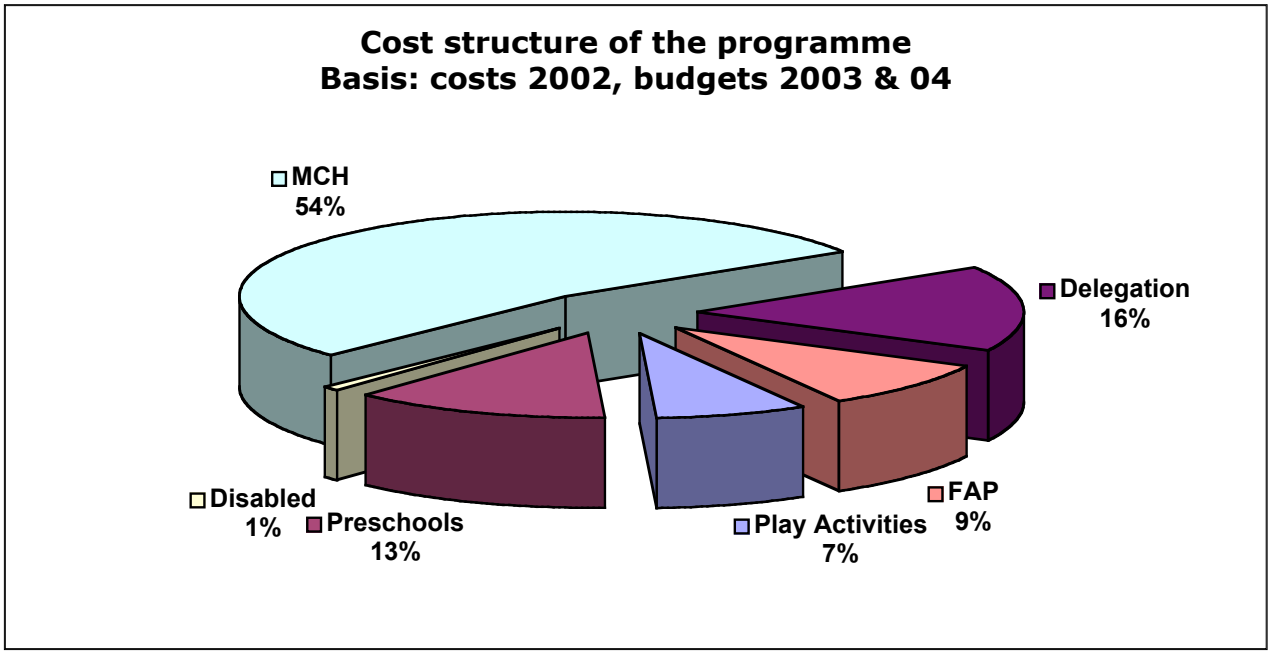
Finances

Efficiency

Efficiency is a weak point of the project, partly due to the absence of a clear institutional commitment to this criterion.

Cost structure

The different programme components account the following percentage of the overall cost:



Budgeting and accounting

Through the above analysis of efficiency for the different programme component we have already sufficiently drawn the attention of the reader on the problem of budgeting.

Over budgetisation and the way subcontracting with local partners was done made the programme not very cost effective compared to its output and compared to other interventions in the area. This is regrettable, especially knowing that the local team of Tdh have done a great job and achieved the results they have been asked for. Knowing also that the needs in the field of PHC are still enormous in the area and that the local DoH struggles with extremely reduced budgets to achieve globally good results.

Right from the beginning there was a misinterpretation of the real cost of health education but the main causes which led to this situation are probably more institutional behaviours, such as not giving the necessary weight to criteria - such as efficiency.

In order to keep admin costs low in terms of percentage, and justify an expatriate delegate, the INGO's (not only Tdh) need consistent budgets. This applies also to overheads of HQ's. The interest to increase the institutions project volume takes priority over adapted and cheap field techniques with small budgets.

Networking

The INGO/IO group in Batticaloa has a coordination role for both development and emergency INGOs with the Government Agents, the LTTE and the local NGO body INNAYAM. The Terre des hommes (Tdh) Delegate has worked closely with this group and represents the INGOs at the Triple R Framework meetings.

The evaluation has not assessed the coordination work and the role of Tdh played in these forums. By taking over the senior nurse from the former MSF programme, Tdh captured the experiences made by MSF's mobile clinics. The same link exists with DoH by hiering a retired senior DoH midwive.

Globally networking remains poor in Batticaloa, every organisation seems to manage their own programme, without sharing resources or interventions among different partners according to their geographical location or specific competences (e.g.WatSan, Savings and Credit schemes, Agricultural Extension work, etc).

Tdh pointed out that due to concerns of 'duplication' by INGO's, voiced extensively by the LTTE and the Government, it has been difficult to encourage other NGOs to carry out programmes in the target villages.

MODEL OF ACTION / TRANSVERSAL CRITERIA'S

Participation and empowerment of beneficiaries and communities

As mentioned before, the MCH has strongly impacted on the empowerment of women participating in the mothers group. The willingness to go ahead and the results achieved until now opens the road for increased participation and ownership.

Partly due to the unclear power structure in the LTTE controlled areas there is little involvement[48] by the local Village Development Committees or local administration. In Ampara, where this should be possible, no specific efforts had been developed in this direction.

Empowerment of local implementing partners

Despite the effort made over the last years[49] Koinonia and The Batticaloa Befrienders are both still totally depend on Tdh. This lies partly in their own institutional structure, both partners are a "one man show".

They are interested to built up a real associative structure, with members and governing board, diversify their partners and leave the Tdh umbrella.

On the other hand Tdh has given the necessary support, but never a clear message about their exit strategy from these two partners. The feeling that by supporting small local NGOs the added value of Tdh is more visible may be right if these NGOs are competent, combative and willing to gain independence. None of these arguments fully applies in Batticaloa.

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[48] A young LTTE "health" agent, with whom Tdh was collaborating, disappeared during the latest events

[49] Koinonia and Befrienders has benefited since mid 90ties of the support of Tdh and the Batticaloa Training team

If investments in term of capacity building and empowerment of local partners have to be maintained, Tdh should closely evaluate which partner is capable to fructify such an investment. We are sceptic regarding the actual implementing partners of Tdh in Batticaloa.

Gender

The MCH programme is making a great contribution to increased equity and responsibility of women. This remains for the time being confined to Mother and Child Health and Education. Empowerment made in these areas may filter down to other areas.

On the other hand Tdh is aware of the missing involvement of men in the field of education, health and care for their families. The right approach to change practice in this field has not yet been found. It is definitely not by playing and enforcing an image of the alcoholic violent father[50] that the situation may change

In terms of programme staff there is a real will to promote learning and staff promotion among Tdh's mostly female staff. This is definitively not the case within the two partner organisations in Batticaloa.

We can also mention the promotion of the very rare women employment in the rural area by employing 50 female health "volunteers".[51]

Peace building

The disabled component of the Tdh programme is in some document sold as "Inter ethnic understanding". There is also mention of a result stemming from the promotion of mixed children's groups and the promotion of active engagement in the public life of adolescents when they leave the recreational activities.

It is probably above the programmes capacity to intervene actively in peace building. The political context is far too complex and fast moving to promote such activities. They also lay outside Tdh's intervention fields.

It is sufficient for this project to apply "No harm criteria" as defined in a number of documents (PCIA[52] and others). As far as our observations in the field have gone, there is no evidence that the local team does not spontaneously apply such criteria.

[50] It was noted that both the children club presentation and the cultural event by a Play Activity Group stressed out those negatives examples.

[51] Would they be "volunteers" if they were men, or would they be "workers"?

[5252] Tdh being member of the KOFF Sri Lanka can easily provide these criteria to the team

Part VI - Recommendations –Options to Consider

1. The MCH programme

1.1. Make the MCH component a replicable, large scale, adapted, model.

- *The targeted areas should no longer be at village level but at the level of Health division (close to administrative divisions). Ideally to cover the whole LTTE controlled area within the next phase. This would mean stepping out of actual project villages by leaving behind a viable model for continued (community based and DoH assisted) MCH education and services.*
- *It is considered necessary that women's groups should become autonomous in time, with the ability to venture into other activities, as well as promoting health. Such a strategy based on women/mothers (groups) as "partners in health & development" could be interesting and challenging to develop and test over the next phase.*
- *Health education is a relatively cheap intervention, programme support structures have to be accordingly adapted, intervention areas chosen large enough, and the overall budget adapted.*

1.2. Get this CHV model to become viable or drop it.

- *Develop a sustainable model for the CHVs not only for the 50 Tdh (CHVs) but for all CHVs in a future target area. The CHV will most likely need some kind of incentive to perform effective work. These incentives have to come from resources within the community and not from external donor.*
- *Discuss with the CHVs and the community what kind of extended role they could play in the community and whether these services could procure them some revenue. It should be a specific offer responding to a demand clearly expressed by the community and not a standardised product decided by the programme.*
- *Well trained Community Health (& development) Workers (and not volunteers) could be moved from one village to another to start, train and assist women's group over a one year period.*

1.4. Whatever strategic options are taken the MCH should become a part of PHC and integrated in the national/regional Health policy.

- *DoH should be associated right from the planning phase of the new phase.*
- *Investments such as rebuilding clinic,s or health centres, have to be done according to the medium investment plan worked out by the respective DoH, even if the health structure is not directly located in a "Tdh" village.*
- *If Tdh wants to develop a replicable, adapted model for MCH and/or PHC they should provide a technical 'expert' on PHC management, with the focus on periphery MOH centres. Such action obviously requires discussion with the DOH, in order to see if this suggestion would fulfil a real need for them.*

1.5. Education should go out of beaten tracks and develop and test new, innovative techniques based on Health communication and 3 way learning.

- *There is a need to avoid a kind of rote learning. It is not just an acquisition of knowledge - it needs to be followed, wherever possible, by appropriate and independent action from the women beneficiaries.*
- *Promote activities that enhance women to take a lead in health education once they have had sufficient input. For instance they could take turns in leading a group session on a subject.*
- *MCH issues could be based on live situations, whereby problem solving rests with the women themselves, with input only as necessary from the CH. The use of positive role models could be used from the community as examples of how changed attitude and behaviour is productive.*
- *During the health education through dramas played in the villages, consideration has to be given to the participation of people from the villages. Expose the Tdh cultural programmer to interactive theatre techniques as the ones derived from the pedagogy of the oppressed and developed by Augusto Boal*[53]
- *Health education could go beyond the basic messages and include new themes as asked by the women, or defined according to improved situation monitoring (e.g. drug compliance, self medication, family planning, juvenile suicide, etc.)*
- *Globally the health education has to become more dynamic and innovative. More health communication, than one-way teaching. Models of tree way learning (learning in, lateral learning and learning out) could also be interesting to study.*

2. The water and sanitation component

2. 1 Safe human waste disposal is essential, but latrines may not be the only option

- *There is an agreement that the quality of ground water is in danger and that safe human waste disposal is essential.*
- *Human waste disposal in fragile environments is a technical problem, which needs more capacities than Tdh and its partners can put at their disposal.*
- *It is only after having assessed alternative system that the option of "latrines" can be taken.*

2. 2 Stop building latrines in someone's garden, but do it differently

- *Health, a proper compound, safety, etc. are of sufficient concerns for the people to invest in latrines.*
- *This is a starting point to mobilise them to build latrines, only then can it be decided what type off assistance (technical, material, financial) they would need to realise THEIR latrine*[54].
- *"This latrine has been built by Koinonia, sponsored by Tdh, funded by UNICEF" in big blue letters should disappear from private compounds and be replaced by "this*

[53] Used with success with peasants and street children by the Tdh programme in Burundi

[54] This is exactly the action desired by the MoH in Kaluwanchikudi during one of the meetings held in Batticaloa District. He was in fact critical of the latrine building that had taken place.

latrine has been built by my father XY" in the memory of the family.

2. 3 Even latrine building needs real "technical support"

- *Tdh, its implementing partners and the contracted entrepreneurs have to acquire the necessary technical knowledge in term of design, material and techniques before they should go on building latrines.*
- *By improved design (no more door frames, limited roughcasting, etc.) new techniques (fibrocement reduces by 1/3 the use of cement for the roof, etc.) Helvetas can built toilets for 3'500 – 5'000 RS in Ampara. Tdh is 300-400% more expensive !*

2. 4 Increase participation, accountability and transparency towards beneficiaries

- *Increased participation is not more free work delivered by the beneficiaries, but discuss with them the design, the cost, the technical options, the contracting and the organisation of the building site.*
- *Full transparency on costs, beneficiary selection and contracting is essential. Accountability is a first line towards the beneficiaries and not only a donor's request.*

2. 5 Provide SAFE drinking water and not just water

- *Water as such is not a problem, there is plenty in the area; the problem is safe drinking water. The wells constructed until now are unable to provide safe drinking water and a new solution for the provision of water has to be found.*
- *Wells may not be the best solution, or they will have to be properly located and built in a way that does not let the polluted "surface" water reach into the well.*
- *If safe drinking water cannot be provided than treatment has to be studied. Boiling is not the most feasible solution. Helvetas is testing on large- scale family units of water disinfection by solar exposure, a method already accepted by the MoH.*

2. 6 If Tdh continues WatSan project, contracting with local NGOs has to be reviewed

- *Actual contracting is much to expensive for the quality delivered by the NGOs (especially Koinonia).*
- *Beside admin cost not exceeding 10 – 15% (max.20% according the way it is calculated) the NGO has to assure quality control, monitoring and maintenance. A two or three yeas guarantee for a well seems a minimum.*
- *Finished works have to be handed over with a protocol in presence of a technician and the owner (family, community,) all imperfections noted and corrected by the NGO on their own expenses or less value applied to the payment.*
- *If local NGOs are not willing to accept "normal" condition of contracting, Tdh could contract directly private contractors through an open tender.*

3. The psycho social programme

3. 1 Even under pressure from parents and teachers, Tdh has to watch not to fall back to formal education in the preschools

- *The only reason to continue to support preschools is to defend a open, interactive education model, if it is to run ordinary preschools there is no need of an specialised, expensive INGO.*
- *Exposing children two years earlier to stress, competition, performance and discipline is definitively not Tdh's role. It is important to prove, and than convince parents and primary school teachers that learning by playing is possible and effective.*

3.2 Recreational activities should to be preserved/separated from tuition.

- *Whatsoever frequency and duration, it is important to offer some recreational activities to the children and pre-adolescents; this space should not be eaten up by tuition classes and preparation for scholarship examinations.*

3.2 Review the implementation of the programme through local NGOs

- *If the programme is run by a local NGO, the organisation should be in a position to guarantee a high quality, innovative model of teaching and recreational activities, which contribute to a balanced well being of children and adolescent.*
- *Training their staff, developing cultural and sportive activities, introducing proper monitoring tools (eg the ones proposed by the University of Oxford) falls within their responsibilities.*
- *Tdh should refrain from doing this within the centres of their partners with their own staff.*

4. Programme management and model of intervention

4. 1 Efficiency – The overall programme has to become more efficient.

- *Cost analysis, compared to national level, to the type of intervention and the coverage, have to become an inbuilt policy at all levels, from institutional policies down to the field.*
- *Specific indicators (or other monitoring tools) measuring efficiency have to be part of the project strategy.*
- *Cost recovery and beneficiary participation are options not to be neglected. Real cost analysis should be the driving force for budgeting. Elaborate tight budgets which may motivate the team to search for cost effective solutions.*
- *Cost effective solutions for PHC are widely documented in the literature, the team should have time to study alternative solutions. The new health and nutrition strategy developed by Tdh should addresses these issues.*
- *Negotiation with implementing partners and sub-contractors has to be more tight.*

4.2 Sustainability – A new phase should focus on a strategy aiming for sustainability and a viable exit strategy from existing villages.

- *As for efficiency the new strategic plan will have to contain clearly defined indicators measuring how viable (sustainable) the new programme strategy is.*
- *The programme has to search for a sustainable model for the CHV, or drop the idea of building sustainability on the CHVs and assess an option building on the women's groups.*

4.3 Exit from existing implementing partners

- *Time has come to initiate an open and transparent negotiation of how long, to which extent and under what conditions Tdh is ready to support the actual partners.*
- *If future or increased investment in capacity building is considered, a previous analysis on how effective this can influence a local partner is to be done. Some partners, due to absence of democratic structures and limited capacity to change are not suitable for increased investment.*

4.4 A more flexible and adaptable and participatory planning can greatly strengthen the programme and increase transparency towards donors and partners

- *The situation in the Eastern Province remains highly uncertain and changing. The programme has to be flexible enough to adapt itself to the changing environment.*
- *Reviewing annually the relevancy (validity) of the planned results and especially of the indicators designed to follow up on these results is necessary.*
- *Changes in strategy, new major interventions have to be not only communicated to HQ and SDC but integrated in the planning documents.*
- *DoH should be implicated right from the beginning in the planning of the new three-year phase of the MCH programme. Department of Education regarding the preschools.*
- *If possible respect the logic of PCM.*
  - First assess results and lessons learnt from previous intervention (final KPC survey, team's and HQ's view on present evaluation results, etc)
  - Second strategic planning session (where we want to go, what goal we want to achieve over the next three years), large consultation.
  - Tertio: Operational planning and budgeting
  If this sequence is not possible due to institutional constraints then try to negotiate a first draft version of a programme proposal and budget - to be reviewed after completion of the process

Final remarks & Acknowledgements

The evaluation was interesting and challenging. The task confronting the evaluators entailed coverage of what were basically three components of health – in the broadest sense of the word. The time allowed was, therefore, a comparatively short period and involved at all times very close co-ordination between the two evaluators and the Tdh delegate and teams.

Acknowledgment has already been expressed that not everything could be reviewed. It is to be hoped that the findings are constructive and helpful, both now and for planning the shape of future programme intervention. An old saying, but nevertheless true, is that the greatest understanding and knowledge comes from what appears to be negative learning/experiences, and not just the positive things that happen in life!

Our sincere appreciation is given to those who assisted us in the unravelling of programmes in Batticaloa and Ampara, namely, Marie-Jeanne Hautbois, Tdh delegate in Batticaloa and all her team, together with Ranjith, programme manger in Amprara and his team. Undoubtedly everyone met has contributed towards this report and its findings, but a special mention and appreciation is extended towards all the community members – women, men and children – who gave their time and allowed us to enter their lives again for a short span of time.

Mauraz, 12th May 2004

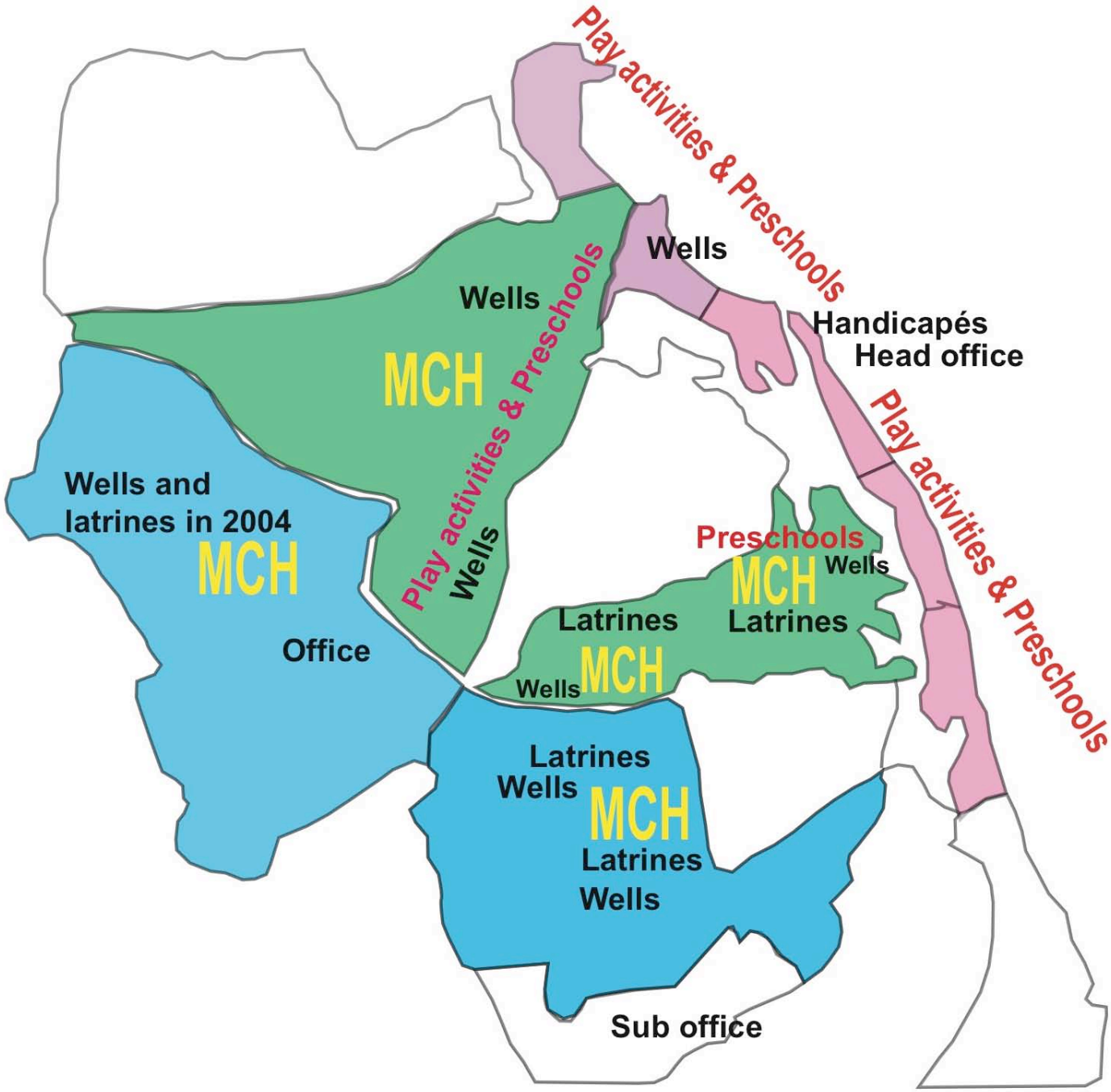
Brenda Jenkins. 28th May 2004

Annexes

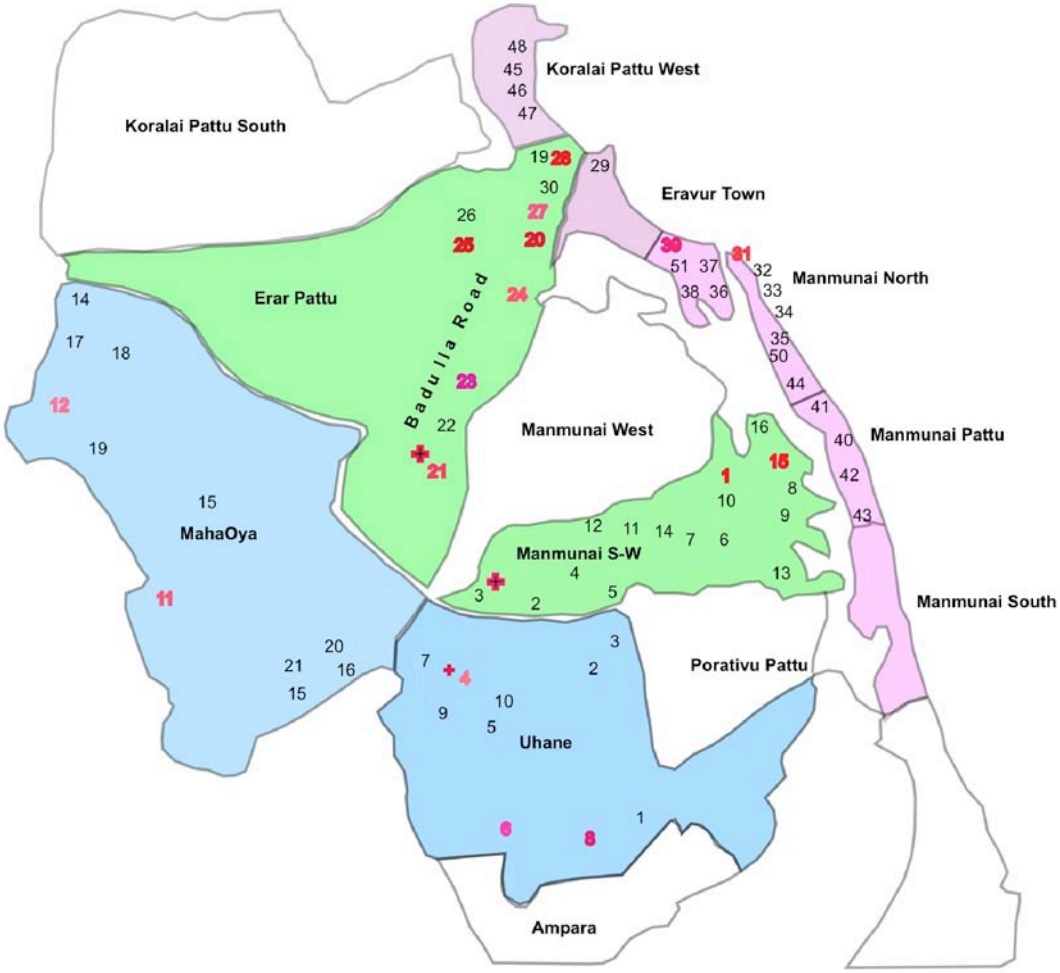
I.	**Maps**
II.	**Peoples met**
III.	**MCH: Full report**
IV.	**Research on Methods for the Evaluation of Psychosocial Programme**
V.	**Terms of reference**

ANNEX I MAPS

Localisation of the different programme components



PROJECT VILLAGES



Annexe II

Peoples met

Dr. Williams	DPDHS	MoHDoH Batticaloa district
Mr & Mrs Dr Ganeshan	Paediatrician and Psychiatrist	MoHDoH Batticaloa district
Mr. Anton	Director	KOINONIA
Mr. Chandra		KOINONIA
Dr. I.S. Jayasinghe	DPDHS	MoHDoH Ampara district
Dr. Mrs Abeyanayake	Paediatrician	MoHDoH Ampara district
Mr A.A.P. Deepal	District Director	Sewalanka Foundation Ampara
Mrs. Asano Usui	Chief Child Welfare Unit	Sewalanka Foundation Ampara
Mrs R. Srinivasan	Director Early Childhood Dev.	Ministry of Education Batticaloa
Mr T.G. Dissanaya	Legal Officer	Sarvo
Mr. A.A. Bawa	Director	Planning Dept Ampara
Mr. Nersarajan	Programme Officer	USAID Ampara
Mr. Ranasinghe	Representative	Agromat Foundation Ampara
Mrs. Paramanandan	SPHM	MoHDoH Illupadichchenai
Mr. Arul	Director	Batticaloa Befrienders
Dr. Krishanthe	In charge of Talesimia	MoHDoH Ampara
Dr. Atapattu	MOHDOH	Bokkabadde
Dr M. Jafeea	MOHDOH	
Dr. Navalojattan	MOHDOH	Chenkaladdi
Mr Darran	VSO Volunteer	Occupational therapist
Dr Krtishnakumar	MOHDOH	Kaluwanchikudi
Mrs Latitha	SPHM	Kaluwanchikudi
Mrs Sreenivasan	Assistant Director of Education	Batticaloa
S.E. M Regazzoni	Ambassador of Switzerland	Colombo
Martin Stürzinger	Representative PA IVAdviser for Peacebuilding	Swiss Embassy Colombo
Andreas Wiederkehr	Outgoing Countzry Director	HELVETAS Colombo
Silvaine	Incoming Country Director	HELVETAS Colombo
Rudolf Fankhauser	Acting Deputy country director	AH- SDC Jaffna & Colombo office
Mrs Andrea James	UNICEF Representative Batticaloa	

ANNEXE III

FULL MCH REPORT

Additional Report on the visits to Batticaloa and Ampara MCH Programmes – 19th to 29th April 2004.

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BACKGROUND

Maternal & Child Health Programmes have been established in 53 villages within the districts of Batticaloa and Ampara. In Batticaloa the programme started in 14 villages during 2002, with expansion to the current 33 villages in 2003: the majority of these areas are under the total control of the LTTE.

The movement towards conflict resolution has enabled an improvement for government health staff to reach health facilities and provide MCH for people living in previously defined 'uncleared' areas. Likewise, women are now able to access local health clinics and hospitals, whereas before they had to gain MCH and PHC care from ICRC and MSF clinics: both of these mobile services were withdrawn in '02 and '03 respectively. The number of hospital deliveries has now increased: the '04 March Report indicates that approximately 70% of births take place in hospital, compared to 54% noted in the baseline survey.

The Special Care Baby Unit in Batticaloa Hospital receives assistance from a Dutch paediatric nurse, working under the auspices of 'Voluntary Services Overseas'. The aim is to upgrade nursing care practices, skill and knowledge over a period of two years. The maternity unit is for renovation through UNICEF funding. When meeting UNICEF representative, Andrea James, *questions were raised about the care of women during their time of labour and hospital delivery. Reportedly there are potential plans through UNICEF and the 'Family Bureau' in Colombo to train staff on nutrition, care of the mother at delivery and the role of fathers.*

In Ampara the programme commenced in 2003 within Uhana Division, followed by the Mayaora Division in 2004: both cover 10 villages. The communities in Mayaora are more widespread than in Uhana, with a divisional hospital that provides poor and inadequate maternity facilities. During this second visit there was no obvious improvement since the original Tdh health needs assessment[55] was undertaken in 2001. Nevertheless, the rate of women delivering in the hospital is over 90% – as indicated by the 2004 Mayaora baseline survey. It is planned

[55] Participatory Needs Assessment in Ampara District: October 2001: Brenda Jenkins

that UNICEF will fund renovation of the labour unit and maternity ward. Additionally, the central government has embarked on a new two-storey structure for cases other than maternity, although the District MOH/MCH reports that progress is slow.

TARGET GROUPS

The target groups comprise women and children from Tamil (Batticaloa) and Singhalese communities (Ampara). The focus is on pregnant women, lactating mothers and infants/children up to the age of 3 years. At the onset of the MCH programme the target group for children was up to the age of 24 months. This changed during 2003 in line with UNICEF policy.

The educational status of the women is generally low (early primary level) and this is particularly noticeable in the Batticaloa target areas. However, for women beneficiaries in the Ampara District the education attained is more variable and ranges from nil up to '0' level standard. Besides household responsibilities and childcare women also work on cultivation, fishing activities and in some instances small shops, depending on opportunity.

COMMON STRATEGIES

The two districts of Ampara and Batticaloa have the same common themes of MCH, apart from the Ampara Programme, which has not had a TBA training component. The thrust of activities and training are focused towards: -

- Antenatal Care
- Safe Delivery
- Exclusive Breast-feeding & appropriate weaning
- Appropriate Management and Care of the Sick Child

The strategies used in the implementation of the MCH programmes in Batticaloa and Ampara are as follows: -

- *Community Health Volunteers*
- *Formation of women's groups*
- *Health Education*
- *Assistance to MOH Antenatal and Well Baby Clinics*

Community Health Volunteers

Selection of both married and unmarried women come from the local target villages, thus ensuring that CHVs are both familiar and acceptable to the beneficiaries. It is noted that some women had previously worked in the government sector as unpaid CHVs. The total number of CHVs in Batticaloa and Ampara are 33 and 20 respectively. All 20 CHVs were met in the Ampara regions and 10 selected CHVs in Batticaloa.

Following the selection of suitable trainers the same approach towards training topics for the CHVs was taken in both Districts, with initial input on community development and baseline survey techniques, followed by the undertaking of a household level survey.[56] Subsequent training was for a period of two 5-day sessions in Batticaloa and for 5 days in Ampara District. Continuous support and monitoring is provided through regular meetings with their health supervisors/trainers: additional training has been given for the Batticaloa teams. It is considered that: -

The length of initial training could be longer for the Ampara CHVs in order to give them a more comprehensive grounding in MCH.

The 30 CHVs met from Batticaloa and Ampara Districts appeared motivated to fulfil their community roles for a variety of reasons, but in respect of the Uhana volunteers the support from Tdh was stressed as a lone factor. Significantly it was difficult to ascertain what the CHVs had learnt from their target beneficiaries. Like any form of adult education it is not just a one-way process of giving information, but also involves learning from people about their own informal/formal knowledge and life experiences.

A key pivotal focus of the programme is to raise awareness about MCH through health education from the CHVs, thereby promoting access to government health services. Additionally, home visiting comprises an important element of their work in order to reach target women and children on an individual basis. The period post-natally is covered by the CHVs, according to need. (In Batticaloa the TBA will visit within 24 hours of a home birth and in cases of a hospital delivery, when the mother returns from hospital).

Their role in assisting the government health staff has developed and is becoming increasingly valued and seen as necessary by the PHMs. This was particularly observed in Batticaloa, where the CHVs appear to have taken on key roles of providing linkages between community and PHMs. This leads one to consider the following: -

- In order to assist the community and DOH the CHVs role could be extended into other aspects of PHC activities, thus potentially developing community involvement.

[56] Tdh Household Level Survey based on - Household Baseline Survey Draft Generic Tool' and the 2000+ Field Guide, August 2001. Developed by Donna Espeut. The Child Survival Technical Support Project.

- In turn this raises issues of whether government CHVs could be possibly retrained and similarly motivated to work for their community. This poses questions about payment versus non-payment and the longer-term sustainability of CHVs.

It was keenly recognized that communities appreciated the CHVs work. In this respect the continued training/support that has been provided to them from programme staff has no doubt contributed towards their willingness to take on additional duties. The importance of monitoring and supportive mentoring cannot be regarded as merely essential tools, but also as mechanisms of maintaining motivated health workers who are valued for what they do.

Women's Groups

A key thrust of the MCH programmes has been the formation of women's groups through the CHVs: they are derived from the target groups. It is important to note that groups have been formed during different phases in both districts, therefore comments and impressions received from them were equally variable.

There was clear evidence during the talks with women to show that natural leaders are emerging. The strength of some women was more obvious with those met in Ampara – even amongst those in newly formed groups. However, the groups met in Ampara were small, whilst some of the meetings in Batticaloa were much larger, to an extent that the opportunity and/or desire for the women to speak might have been decreased. In such cases the group meetings were a mixture of those receiving pre-school activities, MCH or simply that more women were invited from the village as a whole.

A key point of the women's groups is that they are pivotal to the improvement in mother and child health. This is where true sustainability lies. Not just in the acquisition of knowledge, but in the gradually enhancement of their capabilities, plus confidence in themselves to continue good health practices. It is considered necessary that women's groups should become autonomous in time, with the ability to venture into other activities, as well as promoting health.

The above aspect was explored with the mothers and it was revealed that women saw possibilities for the future. They looked ahead to some saving schemes, not only those that required monetary savings, but other investments such as the group saving of rice: five women from the group in Warapitiya in Ampara suggested that they each save a Kg of rice and in due course they would receive 5Kgs. Small income generating activities, such as keeping chickens and running a small farm together were also mentioned. (The linkage between health and income

was definitely apparent). Others from Pollebadde felt the bond growing between them was gaining strength and expressed a desire to work together now and in the future.

Wherever possible the discussions with women aimed to seek a sense of ownership from them in respect of the MCH interventions. Admittedly this was not possible with all the groups met, as they were relatively new, but there was an overall awareness that ownership was not truly theirs, but with Tdh. It is considered important that: -

A programme perspective that includes the participation of women/mothers as 'partners in health' AND development is necessary. As long as women feel that ownership is* 'because they receive benefits' *from the programme, or that they* 'could not manage without the CHV', *then this can continue to create dependency, as opposed to self-sufficiency.

The women's groups met in Uhana and Mayaora showed an apparent less reliance on benefits. This could be due to many factors, but consideration is given to the shorter period of intervention within these target villages and that the harsh impact of long-term conflict had affected the populous in Batticaloa to a greater extent.

Another possible reason is that the position of females within the Singhalese communities is 'stronger'. This was noted in respect of the prioritizing of feeding preferences, as both male and females are treated as equals[57]*. These same aspects may be reflected in other areas of the women's lives. For instance, in the village of Waripitiya, husbands were reported to care for their wives post-natally, whereas one usually assumes this to be a female carer's role in the context of Asian countries.*

Health Education

The giving of health education has been a core component of the MCH activities and is indeed one of the strengths of the programme. It was clear from discussions with the women's groups that these sessions were welcomed and that they had learnt important MCH health messages. Clarification was gained from the CHVs in Batticaloa that changes had actually been observed in conjunction with what the women were saying.

MCH health education has involved a specific number and type of subjects to be repeated at very frequent intervals (depending on the length of input to a village). Whilst a re-enforcement of messages has its place, the benefits of the same messages needs to be balanced against the negative aspect of repetition.

[57] Participatory Needs Assessment in Ampara: Brenda Jenkins: Dated November 2001

There is a need to avoid a kind of rote learning. It is not just an acquisition of knowledge - it needs to be followed, wherever possible, by appropriate and independent action from the women beneficiaries.

Likewise, whilst it is important for women to have health messages on the importance of ANC attendance, it is equally relevant that they eventually take their own initiative to attend for care, rather than have the CHV follow up and remind them.

Health Education is also undertaken by the Cultural Programmer who along with Batticaloa Befrienders, their animators and MCH CHVs produce entertainment with a focus on getting health messages across, either via role playing, music and dance. On average each village will have one 'show' a year, which is well attended.

< ***Consideration to be given to the participation of people from the villages in future productions.***

< ***It could be worthwhile showing the husbands also as hard-working men, with their own problems and how this affects family relationships - not only as drunkards!***

It became obvious that health education topics were also an entry into a learning environment that had been missed as a child, thus giving women an added incentive to attend health sessions. For instance, a mother from the village of Abeypura welcomed an opportunity to gain any knowledge, as her schooling was completed at the age of 7 years. In contrast were the women from Pollebadde village (Mayaora), who were educated up to '0' level standard and viewed health education as an opportunity for further development.

< ***Whatever the reason, health education can become a route towards empowerment of women.***

The women from Abeypura, who had received programme input for one year, were confident in their ability to pass on health messages to other women in their community. There was a reported demand for a dissemination of knowledge, as other women who are not in the target category wanted to join the established groups. This fact also emerged from some women met in Batticaloa.

However, true participation (which also necessitates people's involvement in decision-making processes) was not seen as very high during health education sessions. The reasons underlying this are probably variable, but from a practical stance could be attributed to a lack of truly participatory facilitation skills on the part of the CHVs. Additionally, there could be a need to get the message across, without recognizing the importance of variability and innovation, which is essential to participatory teaching and learning. The assessment of 2002[58]

[58] Review of the First Phase 2002 in Batticaloa District: Brenda Jenkins, January 2003.

had recommended ways forward. Additional suggestions are given below: -

- Promote activities that enhance women to take a lead in health education once they have had sufficient input. For instance they could take turns in leading a group session on a subject: also encourage them to activity spread the messages within their villages.
- MCH issues could be based on live situations, whereby problem solving rests with the women themselves, with input only as necessary from the CHV.
- The use of positive role models could be used from the community as examples of how changed attitude and behaviour is productive.
- The model being used in Eygpt and discussed in the Katmundu Regional Workshop could be helpful to reflect upon.

During a session with the CHVs it was identified that women have little knowledge on the importance of medicine compliance. Drugs prescribed are not taken either sufficiently, or for the required number of days. Only one of the ten CHVs interviewed had awareness of this fact. The BATTICALOA MOH for MCH and the RDHS from Ampara also viewed the problem of non-compliance with medication as a problem.

It is suggested that the issue of drug compliance be introduced into the health education component which tackles care of the sick child.

A meeting with a VSO volunteer[59], who works as an Occupational Therapist, raised the issue of mental health disabilities in children[60]. Concern was expressed on: -

a) Problems at time of delivery, with resultant brain damage (forceps delivery are said to be common).

b) Epileptic fits that could lead to mental impairment.

During research into mental health disabilities he stated that parents invariably reported a history of fits in infancy. It is subjective, but the link needs to be made into the occurrence of infantile fever and subsequent management by the family.

The importance of women knowing the appropriate care of a child with a high fever is paramount.

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[59] A study (Funded by Save The Children) by the VSO volunteer is available to Tdh upon request.

[60] Dr. and Mrs. Ganesh (psychiatrist and paediatrician at Batticaloa Hospital) had also raised concerns about the link between problems at time of a women's delivery and subsequent mental impairment.

Other health education topics identified from beneficiaries were a need to be better informed about family planning. Although family planning methods are available from the government health sector the women are generally ill informed on the main methods available. The Batticaloa Health Development Plan of 2002 shows that the total fertility rate is 2.6% compared to the national rate of 1.9%. The Tdh midwife and nurse are giving individual education on family planning, plus assisting women with transportation to hospital for IUD insertion. However, the CHVs state that they have not yet had training on the topic.

- Family Planning CHV training and follow up is needed. Such action was recommended in the December 2002 assessment.
- In order to link more effectively into the psychosocial programmes the topic of child development and parenting would be appropriate. Steps in this direction could potentially raise parent's awareness on the importance of play in their children's early years.

If this knowledge is lacking, or insufficient, amongst the preschool teachers then training is also suggested for them.

Assistance to MOH Antenatal and Well Baby Clinics

There is a stated shortage of PHMs, particularly in Batticaloa District with an overall shortfall of 13 staff in this target area[61]. A lack of doctors attending ANCs is reportedly another difficulty being encountered by the midwives.

The assistance given to both the ANC Clinics and WBCs from the Tdh programme is significant. It was evident that increased support is being welcomed by the PHMs. It was also stressed by the Tdh team that the provision of additional services assisted the clinics to function more effectively, thus attracting women to attend. In turn this also aids the performance target indicators, set at the very early stages of the programme.

The health team appears to have gradually taken on more activities over time. However, and in spite of the pertinence of Tdh support, it is viewed that PHMs should carry out the tasks of taking blood pressures, blood samples and other activities that are deemed as their role within antenatal clinics.

Given that an increase in DOH community staffing is not foreseeable within the near future then a way forward to assist in this field could be to: -

[61] There has been no midwifery training for 2 years. It is planned that training will commence, but at the best outcome it could be another 2 years before qualified PHMs emerge into community work.

- Extend the role of CHVs, in order to release PHMs for more skilled activities. The CHVs could take on the weighing of the infants/children – either in the clinic or in the villages. If such action is taken then -
- The CHVs would require training on correct weighing, plotting of growth charts and an appropriate recognition of

when, why and whom to refer to when there are cases of concern.

- Provide additional baby weighing scales – if necessary.
- Provide stethoscopes for the midwives who do not possess them. Currently the midwives in the Badella Road area do not have this equipment, therefore although trained to do so are practically unable to carry out this essential ANC activity. Blood pressure machines are also needed for the Uhana area[62].
- Haemoglobin (Hb) meters to be used by the PHMs. Minimal training for PHMs would be required from the Tdh midwife, plus the possible purchase of additional Hb meters.
- In the absence of the MOH the Tdh health midwife is reportedly assisting PHMs when they are uncertain about the height of the fundus (uterus). IF there is a need for additional training, or upgrading, on this essential antenatal examination it is suggested that a practical step would be for the midwife, assisted by the SPHM, to give formal training input to ALL community midwives.
- Follow-up monitoring to take place over a defined period of time to assure that ALL PHMs are confident and able to check fundal height & foetal heart sounds efficiently and safely – in the knowledge that referral onto secondary care takes place in case of problems detected.
- On a broader aspect consideration to be given to the employment of an ex-patriate technical 'expert' on PHC management, with the focus on periphery MOH centres. Such action obviously requires discussion with the DOH, in order to see if this suggestion would fulfil a real need for them – or not.

Other issues

1: Infant Birth Weights

During a meeting with a CHV it was revealed that infant birth weights are now rising amongst the target group. This was also confirmed by the Tdh nurse/nutritionist and has been

[62] District Health Plan. Ampara District: 2003-2012

observed since late 2003. As yet this important fact has not been made known in reports, although it is a relevant indicator of a pregnant woman's nutritional status. Are birth weights rising only in the Tdh targeted areas as a result of MCH interventions, or are they rising generally and as a result of other reasons also? It is suggested that this issue be followed up within Tdh and with the MOH/MCH. For sure this information needs to be incorporated within the programme reporting mechanism.

2: <u>Teenage Pregnancies: STDs: Sexual Abuse:</u>

Concerns were raised from Dr.Jayasingha in Ampara on the above mentioned issues. On follow-up it was revealed that Sarvodaya (a local NGO) are already active in working towards the protection of abused children, with legal advice and support available. However, the issue of teenage pregnancies is highlighted again within the Batticaloa Health Development Plan of 2002 where the percentage of pregnancies in adolescent females is 11.8% compared to a national average of 8.67%.

Furthermore, during discussions with women's groups the issue of young marriages and inter-related marriages was also raised. The youngest female met was only 12 when she became pregnant by a close teenage relative. She now has two children, aged 13/12 and 4/12 – the elder child was checked for the reaching of developmental milestones, but was clearly delayed in achieving them. Medical records showed a history of fits at 12 days of age.

Points 2 & 3 are raised as pointers towards other health concerns within communities.

3: <u>Documentation</u>

It was not apparent during the evaluation whether documentation of change is process-oriented. Clearly there is a thrust towards programme indicators, but it was less apparent on the HOW and WHY of attitude and behaviour change, together with obstacles confronted and overcome, or not. Reference was made to the importance of process documentation during the assessment in December 2002. The subject is re-iterated again, simply because it is considered to be so important, if not more than the pure evidence of numerical success.

For example – the number of women attending ANCs has risen to above anticipated target figures, likewise the number of infants and children attending WBCs is rising, particularly amongst those children from 18/12 to <3years. Does that indicate that women/mothers are making effort to attend these clinics because of individual informed choices, or is it a combination of raised awareness and careful follow-up by CHVs to ensure that they attend?

In conclusion, this shorter report has intended to provide further insight into the findings of the joint evaluation undertaken. Concentration has been given to the key strategies used in the MCH programme, along with additional information gained from people met during the course of 12 days in Batticaloa and Ampara. Additional suggestions have been included, as appropriate, to points already raised in the main report.

Brenda Jenkins

Dated: 3rd May 2004

ANNEXE IV

Not directly included in our terms of reference falls the USAID funded research mentioned below.

RESEARCH ON METHODS FOR THE EVALUATION OF PSYCHOSOCIAL PROGRAMME IMPACT IN EASTERN SRI LANKA

OBJECTIVES

Increase accountability and effectiveness in psychosocial interventions with children.
Enable agencies to demonstrate the impact and outcome of interventions and empower them in their relationship with donors.
Enhance the profile of psychosocial programming through the introduction of effective Monitoring & Evaluation and reporting mechanisms.
Feed findings into an international network of academics & practitioners involved in development of Monitoring and Evaluation practice for psychosocial interventions with children.

AIMS

Develop tools, methods and principles for evaluation of psychosocial interventions with war-affected and displaced children. These tools, methods and principles should be:

- *Child participatory.*
- *Usable by local practitioners*
- *Valid across cultures and contexts*

Pilot tools and methods, and clarify principles through working within a psychosocial project in a conflict-affected area of eastern Sri Lanka.

ASSESSMENT

The evaluation of the above research was not within our terms of reference. Reading the report, interviewing play activity animators and children who have participated in the research allows us some remarks concerning the research:

- An absolutely positive and welcomed initiative by Tdh[63] to undertake the research and mandate a competent and recognized institution to implement it.
- The tools tested are globally interesting tools, not too difficult to implement by fairly well trained and competent project staff.
- There are nevertheless not free from being biased.
- The major criticism can be addressed to the way the research was implemented on the ground. (once more it is not what is done, but the way things are done). This reduced greatly the relevance and the final result of the exercise.

Among these criticisms:[64] reservation is given due to the time allowed us for a rapid survey.

- If the idea was to leave some monitoring tools behind, this is not the case. Local staff has not got the necessary understanding and training. The training they received was to assist the research team, but without the explanation of what they were doing. Relating to the question on what you have learnt they could not answer, or answered

[63] The research was funded by USAID and had no incidence on the Tdh programme budget.

[64] To be taken with all the necessary reserves, our time and mandate did not allow a proper analysis

"*we have to make drawings with children*" - *we have to tell them not to go to the pond*" - "*we have to work in small groups*" - "*we have to play* ".

- Senior staff (Tdh's training team, who could have benefited from the exercise were excluded. The reason is not quite clear. One explanation they received was that they may bias the results, but there are obvious cases of biases (interpretation by the expatriate team members).
- Koinonia, the implementing agency, was visibly not more concerned, for as they told us they were glad to open (and get the addendum to the budget) new play activities for the sake of the research.
- A total lack of transparency and probably of real participation from the children. Children interviewed, to whom we read some of the results of the research, (interpretation of their drawings) were highly astonished on what was done with their "participation".
- Globally the feeling prevails on the ground that the team and children have been used to produce a research of the benefit of British scholars, but not to help Kononia to improve the recreational activities.

Annexe V

TERMS OF REFERENCE FOR THE EXTERNAL EVALUATION OF THE MATERNAL/CHILD HEALTH AND PSYCHOSOCIAL PROJECT FOR THE CONFLICT AFFECTED COMMUNITIES OF THE EASTERN PROVINCE OF SRI LANKA 2002 – 2004

1. Background

Tdh has been working in Sri Lanka since 1978. Most of the projects are now run by local partners. In the Eastern Province of the country, Tdh continues to support a psychosocial programme together with two local organizations, Koinonia and Batticaloa Befrienders.The collaboration, in the form of pre schools and therapeutic play activities, started in 1993 and is aiming at helping children from conflict-affected families

Meanwhile, in August 2000, the Tdh delegate in Sri Lanka warned the home office in Switzerland of the growing need for basic health assistance in the Eastern Province where Tdh has had an educational accompaniment programme in the war zones of Sri Lanka. In November, the military conflict sharply escalated in the Wanni and Jaffna zones with concomitant ripple effects in the east. The Batticaloa – Ampara region saw what appeared to be a massive increase in health and nutritional needs among the population, and in particular those in the 6 IDP camps[65] and in the Uncleared Areas. In part, these needs reflected an overall worsening of socio-economic conditions; but a notable decrease in International NGO health and other humanitarian activities played an equally important role. These important decreases in INGO activities were due to both a re-deployment toward the north, and to poor donor response to major appeals and consequent downsizing of various INGO programmes.

2. Factors which weighed in favor of our choice of projects in 2002

There were several strong arguments militating in favor of our choices.

a.) The glaring needs of the populations in the concerned sectors in both mother and child health and psychosocial care[66];

b.) Tdh's past projects had benefited from the high esteem of all Stakeholders, major and minor :

- the communities, organised as Community-Based Organisations (CBO's), had cooperated among themselves and with Tdh and its partners[67] in creating gender-sensitive psychosocial programmes;
- both warring factions had permitted Tdh reasonable access to the affected populations;

c.) In the previous phase (up to 2001), Tdh counterpart personnel had been identified and had benefited from an intensive cycle of institution-building measures. As a result, they were credible local NGO's in the area of community training and organisation. The key elements of the project cycle – planning, monitoring and evaluation – had been learned;

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[65] 3 in Batticaloa, 3 in Ampara Districts

[66] See : Brenda Jenkins, "PNA Reports for Batticaloa and Ampara September-October 2001," Tdh.

[67] Primarily Koinonia and Batticaloa Befrienders

d.) An in-depth knowledge of the physical and socio-political geography of the project area was an indispensable factor in the present programme's- as well as in the future programme's – success. A strengthening of the INGO network would complement the fine work already carried out with the local NGO's and CBO's.

e.) Approval by SDC/HA of this 3-year project, with the stipulation that the overall project would be externally evaluated toward the end of the cycle.

3 Specific problems which were to be addressed

The project would, complementary to governmental health services and NGOs present in the curative health sector, cover 4 essential MCH interventions.

- Safe delivery for pregnant mothers and minimum care of the newborn baby
- Exclusive breastfeeding for 4 months (encouraged to 6 months), Complementary feeding practices and child nutrition
- Adequate care and management of the sick child
- Provision of safe drinking water

The expected objective of these interventions was to be be a considerably improved health status among pregnant women, lactating mothers, newborn babies and children up to 2 years. Infant mortality and morbidity among the target population would be reduced.

4 Local resources, potentials and stakeholders

Unlike other projects in the Asia zone, Tdh was a major factor in the implementation of the project. This was due to the weak state of local ngo's, Koinonia and Batticaloa Befrienders, in the Tamil area around Batticaloa. Measures have been taken to reinforce their institutional development.

In Singhalese Ampara, Sewa Lanka has been the prominent implementing agent in the water and sanitation field. It is a mature and well-structured organization.

The Ministry of Health (MOH), finally, is the long term carrier for health services. Its role is and will remain essential in the search for a sustainable health care system.

5 Justification of the evaluation

Contractually, Tdh is obliged to undertake an external evaluation toward the end of the project cycle, i.e. at some time in 2004.

Furthermore, Tdh has a stake in undertaking such an exercise so as to assess the validity of the objective, as well as to evaluate the pertinence of its action in reaching the objective.

6. AIM AND SCOPE OF THE PRESENT EVALUATION

7. 6.1 Aim of the evaluation

	The aim of the evaluation is to assess the measure of success in reaching the proj objectives :
Objective	Improved health status among pregnant women, lactating mothers, newborn babies a to **3** years, by providing access and services according to the minimum package as de UNICEF/WHO.
	And in achieving the specific results referred to in the logical framework analys

	Results (Health component)
I	**Antenatal Care** Health and well being of all pregnant mothers and unborn children through 5 minim interventions. These are: 4 antenatal care visits, tetanus toxoid immunization, iron an identification of high risk pregnancies and nutrition education.
II	**Safe Delivery** Pregnant women of target area deliver their baby by a skilled trained assistant and th baby and mother get appropriate care immediately after delivery.
III	**Exlusive breasfeeding and appropriate weaning** Children are protected from infectious diseases and are wellnourished up to 24 montl
IV	**Appropriate management and care of the sick child** Children who become ill can be cared for correctly in the home and are referred to a before complications arise
VI	**Water** The population in target area has access to clean drinking water at community-manag village level.

Children and Families Community Based Rehabilitation Project	
	Goal (development objective) by 2004
To contribute to the establishment of a more harmonious society primarily in the Batticaloa District with a participatory approach	
	Objective by 2004
Objec-tive	Children up to 14 years old will be better prepared to become active citizens of their communities, while integrated into the community and the educational system with pscyhosocial support.
	Results (Psychosocial component)
I	**Pre -schools:** - More children are enrolled into governmental schools. - Im-proved nutritional status of the beneficiaries of the pre-school
II	**Play activities:** **-** The play activities will allow more children to develop their talents and competence, which will help them to contribute to a more harmonious society
III	**Integration of disabled children:** - The number of children who are socially integrated, through activities and family counselling is improved
IV	**Networking: -** The establishment of an active network among CBO's, NGOs and the government that leads to improved complementary services in the area of trauma counselling, special healthcare and nutrition
V	**Sustainability: -** By 2004, autonomy and sustainability of the projects is improved

6.2 Scope of the evaluation

The scope of the present evaluation should cover the following:

6.2.1 Programme structure

- Role and function of Tdh Delegation's Project Office in Batticloa
- Role and function of Tdh's implementing partners

6.2.2 Programme activities

- The project's activities in the light of government policies with regard to Maternal and child health
- The project's activities in the light of technical assistance, training and capacity building provided by Tdh
- Comparisons with similar programmes in the region/nation

6.3 Specific objectives

Assess the effectiveness, efficiency, impact and sustainability of the project supported by Tdh, focusing on:

- Pertinence/relevance of in the respective project areas
- Continuum of services and follow-through activities
- Degree of project integration within the community
- Impact of project activities on beneficiaries
- Perception of services received by the beneficiaries
- Approach, methodology and quality of services
- Strengths, weaknesses, opportunities and threats (SWOT)
- Human resources management and development
- PCM (e.g. planning, monitoring and evaluation tools and systems)
- Quality of reporting
- Expression of vision for coherent project/programme evolution
- Assess the capacity of Tdh and its partners with regard to networking, policy dialogue and advocacy.

7. METHODOLOGY

In principle, the team of evaluators will be free to elaborate their own methodological tools. However, the evaluation should comprise:

a review of the most recent Government/LTTE decisions and/or regulations with regard to CEDC, in particular street children

- a review of the relevant project and sectoral documents
- collaboration with SDC's representative office in Jaffna/Colombo.

More precisely different field visit should take place:

1. In Batticaloa :

- Meetings with the staff, according to their different activities : MCH, water & sanitation, pre-schools, play activities
- Meeting with the health department in the two counties of Chenkaladi and Kalavanchikudy
- Meeting with the community health volunteers in the two counties of Chenkaladi and Kalavanchikudy
- Meeting with Koinonia
- Meeting with Batticaloa Befrienders
- Meeting with one administrative officer from the government and one from the LTTE
- Visit of the district hospital (the delegate's suggestion would be to meet with the doctors residentially to save time)
- ***Meet with midwives and other ancillary government health staff working on MCH in target areas. (Considered to be very important to meet with)***
- Visit of an ANC clinic and discussion with the women – ***suitable for observation but not necessarily focus group discussion***
- Visit of a WBC clinic and discussion with the mothers – ***suitable for observation but not focus group discussion – too busy and noisy.***
- Visit of some families (see also with the clinics) ***Visits to communities to meet with women in their own environment - to enable group discussion and an interactive form of participatory engagement to freely take place.***
- Visit of some (one) pre-schools and discussion with the teachers and the children
- Visit of a recreational centre and discussion with the animators and the children

2. In Ampara :

- Meeting with the team
- Meeting with the health department in the two counties of Uhana and Maha Oya (a discussion with the medical staff at the clinics is also possible. We could get the MOH as well)
- Meeting with the health volunteers from the two counties of Uhana and Maha Oya
- Meeting with Sewa Lanka
- One meeting with the community and/or with one women's group (cf. clinic)
- Meeting with one administrative officer (the person in charge of administration)
- Visit of the district hospital (time permitting)
- Visit of the polyclinic in Bokkebadde
- Visit of an ANC clinic and discussion with the women - Visit of a WBC clinic and discussion with the mothers .
- Visit of some families (grouping those last four points might be possible) –

This visiting schedule may have to be prioritised, given the limited time available, by the team members and the delegate.

8. FEEDBACK, REPORTING, INFORMATION SHARING

A feedback roundtable will be organized after the evaluation. The evaluators are requested to present their findings and first conclusions, in order for the partner organisations to hear, discuss and share their opinions.

The lead consultant will then elaborate and write the evaluation report, which should comprise the main findings, conclusions and recommendations.

The recommendations should provide an important lead in finalising the next cycle of this project for the period 2005-7.

9. HUMAN RESOURCES

A team of three persons will conduct the present external evaluation:

- a seasoned team leader with a deep knowledge of Tdh projects, including MCH work; he will be responsible for the report writing
- a public health expert with a thorough knowledge of Tdh MCH work in Asia;

A qualified interpreter/assistant to the team leader with relevant humanitarian experience will also be recruited.

10. TIME FRAME

Ideally, the present external evaluation should be conducted within a period of two weeks, ideally 18 to 30 April 2004 . These two weeks do not include the more detailed preparation of the methodological tools for the evaluation; they are earmarked solely for fieldwork. The Tdh Delegations will provide logistical assistance for the organisation of the fieldwork. The one-day feedback roundtable will be organised at the end of this period; the lead consultant will elaborate and submit the draft report two weeks after the roundtable.

11. BUDGET

(The budget will be elaborated separately.)

Le Mont sur Lausanne, International Women's Day 2004/Michael Sidman

ANNEXE VI

DEBRIEFING IN SRI LANKA: POWERPOINT PRESENTATION

see separate Acrobat file: SLDebriefing.pdf