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
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COLLATION	53 pages plus annexes
EVALUATION TYPE	External Evaluation - Programme
STATUS	Regular evaluation at end of phase I
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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.