

**EVALUATION OF THE PSYCHOSOCIAL COMPONENT OF THE
PROJECT: LKATR 301**

**BUILDING PSYCHOSOCIAL WELLBEING AMONG INDIVIDUALS,
COMMUNITIES LIVING IN TSUNAMI AFFECTED AREAS, WITH
IMPROVED RESPONSIVENESS FOR THE PREVENTION AND
MANAGEMENT OF GBV**

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Executive Summary

In the wake of the tsunami that hit Sri Lanka on 26 December, 2004, killing at least 38,000 people, and displacing up to a million more, UNFPA decided to broaden its traditional emphasis on reproductive health to address the psychosocial needs of tsunami-affected persons of the country. After initially considering the development of specific psychosocial programs, UNFPA opted instead to pursue primarily a capacity building approach, with the aim of improving the capacity of the Ministry of Health (MOH), and in particular, the Directorate of Mental Health, to promote psychosocial wellbeing in all districts of the country. Funding was also allocated to the Family Health Bureau (FHB) within the MOH to expand the reach of its Adolescent Life Skills Programme to tsunami-affected areas it had not yet been able to service. Funding was also provided to the Psychosocial Forum within the Consortium of Humanitarian Agencies (CHA) for strategic planning and the publication of guidelines for doing good psychosocial work. Finally, significant funding was allocated to a new research project within the Social Policy Analysis and Research Centre (SPARC) at the University of Colombo. That project focused primarily on the development of culturally appropriate, empirically sound tools for assessing psychosocial wellbeing in Sri Lanka, based on a locally derived model of psychosocial wellbeing as defined by Sri Lankans themselves. In addition to these explicitly *psychosocial* projects, a set of *gender-focused* projects was also funded as part of the overall UNFPA psychosocial funding effort. Although the focus of this evaluation on the so-called psychosocial elements of the funding effort, we discuss in some detail below how this distinction between *psychosocial* activities and *gender-focused* activities had limited meaning in the field, and should be discarded in future UNFPA planning.

The evaluation addressed the following:

- The effectiveness, efficiency, relevance and sustainability of the different components of the psychosocial project
- Ways that the activities of the project have contributed towards improving the psychosocial wellbeing of the Tsunami affected communities

- Linkages between the psychosocial component and the gender component of the project
- The appropriateness of UNFPA continuing its broadened focus on psychosocial interventions and activities

The evaluation was based on a review of all relevant documents, site visits to several communities in different districts, and interviews with UNFPA staff, with the Directorate of Mental Health and her UNFPA psychosocial consultant, with Deputy Provincial Directors of Health Services and medical officers in various districts, with the staff of PADHI at the University of Colombo, with the staff of the Adolescent Life Skills Programme at the FHB, with the coordinator of the Psychosocial Forum at the Consortium of Humanitarian Agencies, and with staff at the Ministry for Disaster Management.

Key findings include the following:

- Funding for the Adolescent Life Skills Programme has been well worthwhile. The programme is well conceived and executed, and UNFPA has significantly expanded its reach. Outcome evaluation is a critical next step for this programme.
- Funding for the PADHI project has also been worthwhile. Good progress has been made towards all project aims. A conceptually sound model of psychosocial wellbeing has been developed, a methodology for helping organizations assess the psychosocial relevance of their objectives and the fidelity of their programme implementation has been developed and is being field tested, a resource centre is being created, and project findings are being incorporated into various parts of the university curriculum. However, considerable work remains to be done to complete the rapid assessment tool within the funding period, and we recommend the hiring of a consultant to facilitate this process in a timely fashion.
- Funding to support strategic planning and publication activities of the Psychosocial Forum has been well justified. The PF is an important organization,

bringing together representatives of numerous NGOs, INGOs, and government agencies to improve the quality of psychosocial services and enhance their coordination. All activities funded by UNFPA have been completed or are near completion: an expert consultant was hired to facilitate the strategic planning workshop, a report of that workshop has been translated and published, and guidelines for effective psychosocial programming have been written and are in the translation phase.

- The rationale for UNFPA’s decision to focus resources on strengthening the psychosocial capacity of the DMH, as a means of improving the psychosocial wellbeing of individuals, families, and communities throughout the country, remains somewhat puzzling to us. Although the DMH has a national reach, it is guided quite firmly by strongly psychiatric/medical-model orientation, aimed at curing mental illness rather than promoting positive mental health and psychosocial wellbeing. It has clearly been an uphill battle to alter or expand this orientation, in our view, it has not been a particularly successful battle despite the notable efforts of Dr. Hiranti, Dr. Gnaissara, and UNFPA staff. Although most of the planned project activities have been implemented, the approach has had very limited impact at community level
 - Our interviews with MOHs and DPDHs suggested that the limited exposure to psychosocial ideas, concepts, and strategies offered during the planning meetings has had minimal effect on activities at the ground level. Most medical staff remain firmly rooted in a curative, disease model of mental health and have little understanding of, or interest in, prevention and wellness promotion strategies and concepts. We found considerable confusion regarding the meaning of “psychosocial” among the DPDH’s and MOHs with whom we spoke, and observed that the term was frequently used to refer to activities aimed at destigmatizing mental illness, raising awareness regarding mental illness, and providing respite to caregivers of mentally ill persons. This is not the model of *psychosocial* that underlies the UNFPA

approach to psychosocial wellbeing—an approach that emphasizes the promotion of wellbeing and the prevention of mental health and psychosocial problems. Community centres as specified by the National Mental Health Policy have been developed in Kuliyaipitiya and the Kalutara districts. The centre we visited in Kalutara consisted of one very small, sparsely furnished room in a medical setting, and offered a few services focused primarily on the detection of individuals in need of mental health treatment.

- The psychosocial manual to be created as part of this project has yet to be completed; consequently, trainings using that manual have yet to be conducted. *More critically, however, we believe that an adequate infrastructure at the district and regional levels has not been created in which trainings using the manual are likely to have a lasting impact.* Despite considerable effort and resources expended by the DMHS, we do not see a significant interest within the Ministry of Health, beyond the office of the Director, in psychosocial approaches.

- We do believe there is merit in supporting a broadening of the DMH's focus to include psychosocial activities, in particular activities focused on the prevention of mental health problems and the promotion of psychosocial wellbeing. However, this is likely to be long-term, gradual process. To the extent that UNFPA wishes to see more immediate impacts on the psychosocial wellbeing of Sri Lankans, we suggest that it may be most fruitful for UNFPA to continue to partner with institutions and organizations that are already committed to psychosocial work, and whose capacity for psychosocial activities could be strengthened with UNFPA support. At the national level, examples include the FHB and the Ministry of Social Services, both of which have considerable reach throughout the country. At the NGO level, we recommend continued support for organizations such as WIN and Sarvodaya, which have strong records of providing psychosocial services in various parts of the country. We also recommend support to the Psychosocial

Forum (PF) at the Consortium of Humanitarian Agencies. The PF does not have enforcement capabilities; however, it is well positioned to promote high standards of conduct among participating organizations, and to foster greater communication and coordination among organizations and agencies engaged in psychosocial activities.

In sum, we find that UNFPA's effort to address psychosocial wellbeing has yielded mixed results. We strongly support the continued inclusion of psychosocial priorities in future UNFPA funding cycles and program planning; however, we suggest (1) doing away with the distinction between gender-focused and psychosocial-focused activities, and emphasizing instead the support of psychosocial approaches to addressing the wellbeing of Sri Lankan families generally, and the gender-specific needs of girls and women in particular; and (2) focusing future funding efforts on expanding the reach and capacity of organizations and institutions already engaged in and committed to psychosocial concepts and intervention approaches.

Introduction

The traditional mission of UNFPA has been to improve the reproductive health of women in Sri Lanka. The decision to fund projects that are broadly psychosocial in nature and not directly related to reproductive health represents something of a departure for UNFPA. The plan to develop an explicitly psychosocial set of projects funded by UNFPA was developed in the wake of the devastating Tsunami that hit the island on 26 December, 2004, killing at least 38,000 people, and displacing up to a million others. In response to the anticipated and perceived needs of the survivors, a great many national and international non-governmental organizations (NGOs and INGOs) provided a diverse array of psychosocial and mental health interventions. According to numerous observations and reports, services were often duplicated, and in some instances interventions were not helpful—and may even have caused harm—to project recipients. UNFPA staff originally hoped to fund psychosocial services on the ground that would be of high quality, and that would avoid the duplication and questionable effectiveness of some existing psychosocial interventions. However, a decision was made to shift away from becoming yet another actor in the crowded psychosocial field, providing additional services in a field where a lack of services was not the problem (rather, coordination and quality control of existing interventions were the critical needs). Instead, UNFPA adopted a multi-component, two pronged approach to enhancing the psychosocial wellbeing of Sri Lankans, both within and outside of Tsunami-affected areas. One approach would focus on gender-specific concerns, the other would focus on improving the capacity of national, regional, district, and community-level structures to respond to psychosocial needs in culturally appropriate and effective ways.

Although the focus of this evaluation is on those UNFPA-funded activities that fall within the “psychosocial” part of the project, we also refer briefly to aspects of the “gender” component. As we make clear below in the “Conclusions and

Recommendations” section, we wish to call into question the utility of distinguishing between “gender”-focused interventions and “psychosocial”-focused interventions. In the course of conducting this evaluation, it became evident that effective psychosocial interventions are inherently sensitive to and inclusive of gender concerns; conversely, effective gender-focused interventions are inherently psychosocial in nature, addressing a range of needs and concerns common to program recipients (clients, participants, etc.). For example, women experiencing gender-based violence do not merely need violence-cessation or shelter-based interventions; they often need social support, economic assistance such as livelihood support programs, counselling, childcare assistance, and other empowerment-focused programs. The two “women’s centres” we visited in Matara (run by Women in Need, or WIN) and Kirinda (run by Sarvodaya) were in fact fundamentally psychosocial service providers, who offered a variety of psychosocial projects to women, children, adolescents and men. Although both centres included a focus on gender-based violence and offered some services specifically for women, both framed their approaches as psychosocial rather than in terms of gender, and the range of programs offered in both centres covered the gamut of psychosocial interventions (a variety of classes, social support groups, community gatherings, drop-in centres, livelihood projects, etc.). In both settings, it was clear that a broad, inclusive psychosocial approach was the most effective way to address gender specific issues, including the reduction and prevention of GBV in the communities served. In short, addressing the needs of women and children is inherently a psychosocial endeavour; likewise, addressing psychosocial needs effectively must be a process in which gendered concerns are central to all program development and implementation processes (though we recognize the problematic reality that gender is too often overlooked in psychosocial programmes)..

A primary question asked by UNFPA of this evaluation is whether the UNFPA should continue to expand its focus by including funding for psychosocial projects in the next funding cycle. Therefore, in addition to evaluation the specific components of the psychosocial part of this UNFPA project, we will also make specific recommendations regarding the relevance of psychosocial projects to UNFPA’s mission and offer

suggestions for ways in which UNFPA can support effective psychosocial programming within its primary focus on reproductive health.

Objectives of the evaluation

The overall objective of the evaluation was to review the goals and strategies of the psychosocial component of the project LKATR 301 and to assess their effectiveness in contributing to the achievement of the goals of the UNFPA country programme.

The evaluation addressed the following:

- The effectiveness, efficiency, relevance and sustainability of the different components of the psychosocial project
- Ways that the activities of the project have contributed towards improving the psychosocial wellbeing of the Tsunami affected communities
- Linkages between the psychosocial component and the gender component of the project
- The appropriateness of UNFPA continuing its broadened focus on psychosocial interventions and activities

Methodology

The evaluation team used the following methods:

- **Documentation analysis:** Review of the project documents & reports, plus selected output in the form of manuals and IEC material produced.
- **Interviews, meetings and telephone conversations** with UNFPA staff, and partner organisations; Director Mental Health and her staff, the PADHI team of the University of Colombo, District Health staff and representatives of partner organisations such as WIN and Sarvodaya (A list of persons met is given in Annex I)
- **Visits** to women's centres at Matara (WIN) and Kirinda (Sarvodaya) Community centre at Kalutara
- Discussion of draft report at presentation to UNFPA and partners

Psychosocial Assessment of Development and Humanitarian Interventions (PADHI)

Background

One component of the UNFPA psychosocial funding effort has been to support a research-based project at the University of Colombo, through the Social Policy Analysis and Research Centre (SPARC). The project is entitled *Psychosocial Assessment of Development and Humanitarian Interventions (PADHI)*, and represents one of several projects housed within SPARC. The proposal for PADHI was developed in the wake of the Tsunami, and was based on the recognition that despite a plethora of Tsunami-focused psychosocial interventions, as well development and humanitarian intervention programs ostensibly guided a psychosocial framework, no clear understanding had yet been developed for what psychosocial wellbeing actually means in the socio-cultural context of Sri Lanka. Moreover, and perhaps most importantly, there was at the time no available tool that could easily be used by NGO/INGO and governmental actors to assess the impact of development and humanitarian interventions on psychosocial wellbeing.

In its original proposal, PADHI outlined three primary objectives:

- 1) To develop and empirically test a conceptual framework for understanding psychosocial wellbeing among Sri Lankans;
- 2) To develop and pilot test a methodology and related tools for assessing the impact of development and humanitarian interventions on psychosocial wellbeing in Sri Lanka; this includes (1) a rapid assessment tool, and (2) a methodology for helping organizations assess various aspects of their planning and implementation processes using a psychosocial framework;
- 3) To incorporate knowledge attained through the above processes into university curricula, with the aim of integrating newly developed understandings of psychosocial wellbeing and its assessment into the learning experience of university students

4) To develop a resource centre

The PADHI team is comprised of a senior program coordinator, an academic resource person, four program officers each with specific project-related responsibilities, a finance and administration Coordinator, and a publications coordinator. A visiting research intern from Colombia University in the United States was also working on the project for a period of three months. The project is under the direction of Professor Ramani Jayatillake in the Sociology Department at Colombo University, and is jointly co-directed by Professor Gameela Samarasinghe, a psychology professor at the University of Colombo.

Relevance

The PADHI project is clearly relevant to the overall aim of improving the psychosocial wellbeing of Sri Lankans. A reliance on conceptual frameworks developed in other socio-cultural settings, or the use of narrowly defined mental health instruments that only assess symptoms of psychiatric distress, cannot adequately assess the diverse elements that comprise psychosocial wellbeing in Sri Lanka. The proposed methodology of conducting rapid ethnography and then drawing concrete indicators from that ethnographic data for the development of a contextually grounded assessment tool is an established and well-regarded approach and should be adequate to enable the PADHI team achieve its aims.

Efficiency

The resources allocated to the project seem to be sufficient. In fact, one challenge the PADHI team has encountered has been utilizing existing resources. Team members reported some difficulty working through the University of Colombo bureaucracy in order to acquire basic resources such as furniture and related supplies. There was some frustration that this made progress slower than anticipated.

Effectiveness

There are numerous strands to the PADHI project. Considerable time and effort has gone into the development of a framework that describes psychosocial wellbeing among Sri Lankans, with the aim of using that framework to development the assessment tool and

the methodology for assessing objectives and implementation. An extensive literature review was conducted in order to develop the conceptual framework, and a multi-level, ecological model was subsequently developed. The team then conducted a series of focus groups in Ampara and Habantota, including participants of both genders, representing diverse ages and ethnic groups. In addition, key informant interviews were conducted. One aim of the focus groups and key informant interviews was to assess the validity of the framework. At this point, a wealth of qualitative data has been collected and is currently being analyzed. In addition, four workshops were conducted to develop, critique, and revise the methodology for examining organizational objectives and program implementation.

Significant steps remain to be done. Most importantly, the rapid assessment tool has not yet been developed. Indicators for relevant domains of psychosocial wellbeing will need to be drawn from the extensive qualitative data that have been gathered, and a measure will need to be created using those indicators. That instrument will then need to be readied for field testing (review by expert panel, translation and back-translation, review for ease of understanding), then pilot tested and validated in the field. During our meeting with PADHI staff, there was some concern raised by team members about the reductionist nature of selecting indicators, thereby losing the richness of the qualitative data. Team members also suggested that it might be better to specify key domains for organizations to assess, without including specific indicators that might overly constrain the assessment process. *In our view, however, it is essential that a rapid assessment tool include specific indicators of psychosocial wellbeing in key domains, to facilitate its use by agency staff who have neither the time nor expertise to engage in instrument development in order to significantly adapt the measure for their particular context. Such an approach would also limit comparability of results across projects and sites.* On the other hand, we recognize that it may be useful to create a flexible tool, so that different organizations can select the domains they wish to assess; however, the identification of relevant indicators is essential to the development of any rapid assessment tool and should not be left to target organizations to complete.

The development of a methodology for helping organizations develop psychosocial objectives and assess the quality and fidelity of their program implementation appears to be proceeding on schedule, and is currently being field tested via a consultation with CARE, an INGO. We had a field visit scheduled in Kirinda with the PADHI staff who were doing the field testing of the methodology with CARE; however, due to an unspecified delay, the staff did not show up at our scheduled meeting and we returned to Colombo without having had the opportunity to interview the staff members. As we did not have this meeting, and were not presented with specific information about the methodology during our meeting with the staff of PADHI at Colombo University, we have limited information at this point about the process or utility of this methodology other than to note the considerable thought and effort that has gone into its development.

Research from the PADHI project has already begun to inform the curriculum offered to students interested in psychosocial wellbeing, development, and humanitarian assistance. A module based on the PADHI project has been incorporated into a course for students earning a post graduate diploma in Counselling and Psychosocial Work (PGDCP). Reading groups have been developed for undergraduates. Other efforts to incorporate PADHI findings into existing courses are continuing, including in the Post Graduate Diploma in Development Studies (PGDDS) and Post Graduate Diploma in Conflict and Peace Studies (PGDPS). The unit also has held workshops for practitioners.

A resource centre has been developed as planned; however, the PADHI team reported that space limitations have limited the size of the centre and its capacity to expand beyond its current size.

Sustainability

As noted earlier, findings from the PADHI project have already begun to inform the learning experience of students in several undergraduate and diploma programs; in this way, the project has begun to ensure a degree of sustainable impact. On the other hand, PADHI staff also noted that they have at times been treated as outsiders to the university, because none of the staff (except the two faculty supervisors/project co-directors) are

full-time faculty at the University of Colombo. This has apparently resulted in numerous delays and a less than hospitable welcome by some university administration staff. It is therefore unclear to what extent the university represents a viable longer-term home for PADHI. On the other hand, PADHI does fit well within the overall focus and framework of SPARC, so perhaps these difficulties can be managed with a bit of diplomatic assistance from SPARC faculty members.

The PADHI project has considerable potential to create highly useful assessment methodologies that can assist local, national, and international organizations doing psychosocial work in Sri Lanka (regardless of whether such work is defined explicitly as psychosocial or is framed as *implicitly* psychosocial within the context of development-focused interventions). Our primary concern has to do with the rate of progress at which the development of the rapid assessment tool is proceeding. In our view, the rapid assessment tool is the PADHI output mostly likely to be of interest to organizations engaged in psychosocial or development work in Sri Lanka. Program evaluation, an impact assessment in particular, has become a major priority of funders; consequently, the rapid assessment tool is likely to be of considerable interest in the development of locally relevant and meaningful evaluation plans. The use of a combined qualitative-quantitative approach to instrument development can often be employed within a fairly brief time period; however, because of the considerable time spent on the literature review, development of the model of psychosocial wellbeing, development of the objectives and implementation assessment methodology, and the gathering, coding, and analysis of focus group and interview data, we are somewhat concerned that the team may not be on schedule to complete the development and field testing of the assessment tool within the specified project time period.

- At this point, we would encourage the team to move forward with the selection of key domains and relevant indicators for the assessment tool. Once the tool has been developed, field testing should begin as soon as possible.
- We also recommend the identification and hiring of an external consultant with expertise in psychosocial measure development, who can help the team transition into the quantitative phase of developing the rapid assessment tool. The team is

strongly qualitative in its experience and expertise, and may benefit from the assistance of a consultant with a quantitative background and experience in instrument development.

Assistance to the Directorate of Mental Health for the establishment of a psychosocial programme

Background

The Ministry of Health was selected as one of two executing agencies of the psychosocial component of the project (the other being the University of Colombo). A major part of the project was to be implemented through the Directorate of Mental Health, while the wellbeing of adolescents affected by the tsunami was to be addressed by the Family Health Bureau.

The Directorate of Mental Health is relatively new within the Ministry of Health and is under the Deputy Director General Medical Services. It has very limited resources—physical, financial as well as manpower—and lacks a clearly defined and adequately established structure through which to reach the community.

The project envisaged the achievement of the following through the Directorate of Mental Health Services (DMHS):

- a) build capacity of primary health care personnel at District and Divisional levels to address the psycho social needs of individuals and communities they serve;
- b) strengthen the national coordination role of the Directorate of Mental Health;
- c) facilitate effective incorporation of psychosocial components in mental health policy formulation;

Relevance

In the wake of the tsunami the UNFPA identified the need for providing psychosocial support to those affected by it and recognised that the problem had to be addressed at the individual, community, district and national policy making levels. As such it chose to

address the need to build technical and operational capacity within the DMHS. This approach, however, had a very limited impact on putting in place services necessary for *“the speedy normalisation of life in tsunami-affected areas, with a view to promoting greater resilience and reducing distress”*. This was partly because the implementation of activities commenced rather late in mid-2006, and also because of the limited capacity of the DMHS to undertake the types of activity needed to achieve the above. We recognise the importance of incorporating promotive and preventive aspects of mental health and wellbeing to the services provided by the MOH; however, such an approach is unlikely to bring about changes at community level in the short term.

Efficiency

Only a small portion (25 %) of the allocated funds have been utilised by this component. Funds that had to be released for district activities have not been sent to the districts due to difficulties and delays at the Ministry of Health. Some of the funds have been re-programmed for the supply of vehicles for district mental health activities.

Effectiveness

One of the activities of the project was to *“contribute to the development of the psychosocial components in the National Mental Health Policies, Plans and Legislation”*. The consultative process for developing the National Mental Health Policy took place during the year 2005 before the commencement of the project; however, it appears that the UNFPA inputs were able to influence the thinking of the DMHS to include a psychosocial component in to the policy; unfortunately, that component is very modest and is dwarfed by the nearly exclusive emphasis on clinic and hospital-based curative approaches. The sections of the policy that refer to psychosocial elements are very brief and limited, and look at *psychosocial* mainly from the perspective of the psychiatric/medical model (e.g., awareness campaigns to educate the public about mental health and reduce the stigma of mental illness). In the face of the massive opposition by the powerful Psychiatry lobby towards prevention and wellness promotion concepts and strategies, there is little doubt that the UNFPA did strengthen the hand of the DMHS in regard to creating a space for the inclusion of psychosocial concepts and activities.

However, as noted, the mental health policy is almost entirely focused on curative approaches, with minimal consideration of the sort of psychosocial emphasis that the UNFPA funding was aimed at fostering. Funding from the project has been utilised to print the policy and circulate it to the districts and MOH offices.

Technical support and human resources in the form of a Consultant and Medical Officers as well as logistical support in the form of computers and furniture have been supplied to the Directorate of Mental Health Services. A monitoring and evaluation framework has been developed with the assistance of the UNFPA. District coordinating committees have been established in all the tsunami affected districts and the DMHS is in the process of developing a TOR for the committees. The evaluators found that the level of interest and frequency of meetings of the committees varied among the districts. The national plan also called for the identification of a mental health focal point per district; this has been done in some districts. Vehicles have been purchased by the UNFPA to facilitate the work of the mental health focal point at District level. The distribution of vehicles has been delayed, awaiting an appointment from the Minister for ceremonial hand over.

A series of meetings have been conducted with the district and national level authorities to plan for provision of psychosocial services. Each district had produced plans to implement the mental health policy and a section on psychosocial activities was a prescribed component of the plan. However, most of the “psychosocial” activities planned were based on the narrow medical definition of *psychosocial* (e.g., prevention of suicide through early recognition / detection / treatment of depression). In the districts affected by the conflict where psychosocial programmes had been in place from before the project (Trincomalee and Kalmunai), the plans included psychosocial activities more along a wellbeing-promotive and distress-preventive model, and some of the planned activities had been implemented. Discussion with district officials in Hambantota and Kalutara revealed that district planning has been carried out in consultation with the district psychiatrists. This influence is reflected in the plans. In the immediate aftermath of the tsunami, a WHO funded “psychosocial” project had been implemented in the affected areas. This took the form of early detection of persons with distress in the

community and referral for treatment. This model also may have influenced the thinking at district level.

Very little of the psychosocial components of district plans have been implemented. In fact, during our meeting with medical staff in Hambantota, we were struck by the seeming unfamiliarity of the DPDHS and the medical officers with the psychosocial approach guiding the UNFPA funding for the DMH; this was despite their participation in several planning meetings during which psychosocial activities were identified and included in their overall mental health plans.

The national mental health plan includes the setting up of community centres in each MOH area. These have been set up in Kuliyaipitiya and Kalutara districts. We visited the centre at Kalutara. The centre serves as a referral centre for individuals showing signs of psychiatric morbidity, and for people deemed to be in need of counselling. The centre is in the charge of a Medical Officer who also acts as the focal point for mental health. On a different note, we do note the encouraging activities of a centre in Kalmunai developed prior to the UNFPA grant, which provides a wide range of psychosocial services.

The project planned to provide training in psychosocial work for all public health personnel at community level, Medical Officers of Health and any personnel from other sectors invited by the DPDHS, or the District Coordinating Committee. A manual for use during the trainings is in the final stages of development; since the manual is not complete, the trainings have not yet taken place. This project also included review of pre-service training syllabi of some of the above-mentioned categories of service providers. This review has not been conducted yet.

Because the manual has not gone into print yet, we consider it important to have a panel of experts including those who have field experience in psychosocial work, to review the document, followed by piloting it in a district or division before being introduced to the whole country. The piloting may be used to test out methodologies for the training process itself. Currently, it is planned that the DMH will train trainers at district level

who in turn would train the field workers. Since psychosocial work is rather new to the MOH personnel it is essential to ensure that the training reaches the field health workers without distortion. The identification of a national core group of experts who would help the districts to train and implement preventive and promotive activities may be a worthwhile strategy to explore. While we recognise that preventive and promotive aspects of mental health may best be delivered through the DMH, we firmly believe that it is important that all health promotion activities (be it mental health, MCH, prevention of infections or NCDs), should have a “psychosocial approach” and that the training is an opportunity to address this issue.

Another planned activity was the development of IEC materials for individuals and communities on how to protect and promote their own wellbeing. A poster on prevention of suicide had been produced and distributed. A booklet on life skills directed at the general public as well as field health workers has been developed. Currently the illustrations for the booklet are being prepared; consequently, the booklet is yet not ready for print. How the booklet will be distributed and utilised is not very clear but on perusal of the contents it appears to be useful as supplementary reading material for the activity book on life skills used by the FHB in their school health programme.

Sustainability

It is difficult to comment on the sustainability of the project. The activities do not appear to be a coherent whole addressing the problems and needs identified in the project document. The orientation and sensitivity to the need for community-level psychosocial interventions and programmes that we observed at the level of the DMHS was generally not reflected in the district level personnel.

The capacity of the DMHS to complete the training manual and to conduct district level trainings once the UNFPA project funding expires is questionable, due to funding limitations facing the Director. Of greater concern, however, is the nearly complete lack of a viable interest in and commitment to developing and carrying out psychosocial activities of a promotive or preventive nature at the district level. The manual itself

emphasizes and includes a range of highly relevant and useful topics and related activities; however, the manual and associated trainings will be of limited value without an infrastructure (e.g., community centres and well trained staff) and district-level commitment to implementing the ideas and activities contained in the manual and developed during the planned trainings. On the other hand, it is possible that the trainings could be structured so as to provide opportunities for advocacy for psychosocial approaches, and to increase interest in and a greater commitment to the provision of psychosocial activities at the district level. This together with advocacy at all levels, national, district and community levels may be necessary to bring about the changes in attitudes and practices envisaged by the DMH.

Although a major part of the activities listed in the project document has been accomplished, in our view the project on the whole has contributed little to the stated overall aim of “*supporting people to get through their grieving process whilst meeting their basic and other practical needs has been considered the most appropriate approach in the given context*” and “*to ensure a speedy normalisation of life in the tsunami-affected areas and protection from possible harm or exploitation whilst efforts for normalisation are underway*”. In fact, we found little evidence that UNFPA funding to the DMHS has yet had any clear impact on the psychosocial wellbeing of people living in tsunami-affected areas. Nor did we find evidence to suggest that the MOH is better positioned as a result of UNFPA funding to respond effectively to the psychosocial needs likely to arise in the event of another natural disaster such as the tsunami of 2004.

Psychosocial health of adolescents affected by the tsunami

The psychosocial component of the project supported the Family Health Bureau (FHB) to address the wellbeing of adolescents and young people affected by the tsunami. This was planned to be achieved through the existing programme of school health and the life skills development programme. The Family Health Bureau (FHB), a well established unit within the Ministry of Health coming under the Deputy Director General of Public Health Services, has a long established partnership with UNFPA. The unit is responsible for the

planning, organisation and delivery of maternal and child health (MCH) and family health services and has several divisions headed by consultant community physicians, School Health being one such sub-unit. The organisation has direct access to and a degree of control over field health personnel. The FHB has been working in collaboration with the Ministry of Education (MOE) on adolescent health issues over a long period of time.

The Life Skills Programme of the FHB, a collaborative programme with UNICEF, has been in place since 2001. The objective of the programme is to reduce risk behaviours among adolescents, with special emphasis on prevention of teenage pregnancies, HIV/AIDS, tobacco, alcohol and drug use. An activity based manual in Sinhala and Tamil addressing the ten core life competencies has been developed and is available. In addition the FHB and the Ministry of Education (MOE) have collaborated in producing two booklets on adolescence which are used as supplementary reading material in grades 6-11. These are available in both Sinhala and Tamil languages.

The implementation of the programme is through the building of a regional resource pool consisting of selected Medical Officers of Health (MOHs) and Medical Officer Maternal and Child Health (MOMCH) at district level. This core group of trainers in turn train the PHIs, in-service advisors (ISA) of the MOE, selected teachers and peer groups. The MOH and PHI, in addition to the teachers conduct life skills programmes for children as part of the school medical service.

This programme had been implemented countrywide except in the Colombo and Kalutara districts. The FHB therefore chose to use UNFPA funding to introduce the programme in these two districts (also affected by the tsunami) including schools within the Colombo Municipality and the area served by the National Institute of Health Sciences field practice area. Approximately 1017 schools were reached through the programme. Training of trainers as well as the training of In Service Advisors (ISAs), teachers and Public Health Inspectors (PHIs) have been completed and the programme is being implemented in schools in these two districts.

Relevance

The programme is well planned and appropriate teaching learning methods are used in imparting knowledge as well as to achieve the desired behaviour change. The manuals and supplementary reading material is attractively produced. Although some loss of quality could be expected in the transfer of skills through training of trainers to implementers, the availability of expertise at district and MOH levels facilitate and support school based activities.

Efficiency

The funds were used to fill an identified gap in the existing programme and supplements a service in place. All allocated funds have been utilised.

Effectiveness

Coverage of the planned geographic area and the selected target group has been achieved. Although 50% of school children are adolescents and maximum school drop out takes place after the G.C.E. Ordinary Level examinations, the FHB recognises the need to reach out of school youth with similar programmes and are in the process of addressing the issue. The FHB also recognises the need to develop outcome and process indicators and the inclusion of the process indicators in the routine returns. This is an activity that has been planned. We encourage the FHB to move forward with their outcome evaluation in a timely fashion. Their intervention model is comprehensive and well-designed, we believe it is likely to show a positive impact. However, it is imperative that outcome data be gathered to establish the effectiveness of the intervention and to identify areas in need of strengthening.

Sustainability

Since the life skills education programme is well established and is recognised as an integral part of the secondary school curriculum by the MOE, sustainability is high. Some support to help develop tools for measurement of outcome may be helpful. The establishment of a resource centre per MOH area to supplement reproductive health information as well as life skills development among adolescents would support these

activities in schools and contribute greatly to the achievement of the overall objective of reducing risk behaviours among adolescents and youth.

Funding for the Psychosocial Forum

UNFPA provided funds for the Psychosocial Forum to carry out two specific activities: a workshop for strategic planning and the preparation of good practice guidelines for its members. Both activities have been completed and the strategic plan as well as the guidelines are being translated in to Sinhala and Tamil for publication. The PF made good use of UNFPA funding for their strategic planning and the translation and publication of their guidelines for good psychosocial practice.

Summary and Recommendations

1. It is appropriate for UNFPA to include a focus on psychosocial activities in its next funding cycle. However, we advocate for an integrated approach in which women's wellbeing is supported through projects that are psychosocial in their approach, yet which also have a strong emphasis on promoting the wellbeing of women, children, and families as a whole. Centres such as those we visited in Matara and Kirinda can be enhanced and expanded to reach a greater number of communities. The funding of such centres and their related activities is consistent with (and close to) UNFPA's primary focus on reproductive health and gender equality and equity; for while such centres are not specifically focused on reproductive health, they clearly promote the psychosocial wellbeing women and girls, as well as boys and men. By reducing violence, promoting positive parenting, reducing women's stress, increasing family income and literacy, and enhancing social support, it seems likely that holistic centres such as these will also have a substantial positive impact on reproductive health as well.
2. The decision to increase the capacity of the MOH to address psychosocial wellbeing seems a positive one to us, though we recognize that this approach expands the original mission of UNFPA. That is not inherently problematic; indeed, providing

support to the FHB to expand the reach of its adolescent Life Skills project has been a very worthwhile investment. However, the decision to focus resources (time, effort, funding) on strengthening the psychosocial capacity of the DMH remains somewhat puzzling to us. The DMH has a strongly psychiatric/medical-model orientation, aimed at curing mental illness rather than promoting positive mental health and psychosocial wellbeing. It has clearly been an uphill battle to alter or expand this orientation, and in our view, it has not been a particularly successful battle *despite the valiant efforts of Dr. Hiranti, Dr. Gnaissara, and UNFPA staff.*

- Our interviews with MOHs and DPDHs suggested that the limited exposure to psychosocial ideas, concepts, and strategies offered during the planning meetings has had minimal effect on activities at the ground level. Those medical staff who already had a strong psychosocial orientation have used the planning opportunities and limited material support to enhance their activities, primarily through better coordination with NGOs and INGOs. However, it is our impression that most medical staff remain firmly rooted in a curative, disease model of mental health and have little understanding of, or interest in, prevention and wellness promotion strategies and concepts. We found considerable confusion regarding the meaning of “psychosocial” among the DPDH’s and MOHs with whom we spoke, and observed that the term was frequently used to refer to activities aimed at de-stigmatizing mental illness, raising awareness regarding mental illness, and providing respite to caregivers of mentally ill persons. This is not the model of *psychosocial* that underlies the UNFPA approach to psychosocial wellbeing—an approach that emphasizes the promotion of wellbeing and the prevention of mental health and psychosocial problems.
- The Mental Health Policy includes only one paragraph that makes some reference to a potentially impactful psychosocial component: community centres to be developed by the MOH in each district. Unfortunately, community centres as specified by the Mental Health Policy have been

developed only in the Kuliyaipitiya and Kalutara districts, and the centre we visited in Kalutara consisted of one very small, sparsely furnished room in a medical setting, and offered a few services focused primarily on the detection of individuals in need of mental health treatment.

- The psychosocial manual to be created as part of this project has yet to be completed; consequently, no trainings using that manual have yet to be conducted. *More critically, however, we believe that an adequate infrastructure at the district and regional levels has not been created in which trainings using the manual can have a lasting impact.* Despite considerable effort and resources expended by the DMHS, we do not see a significant interest within the DMH, beyond the office of the Director, in psychosocial approaches.
3. Rather than expend further resources on trying to alter or expand the activities of the DMH, we believe it would be more fruitful to partner with institutions and organizations that are already committed to psychosocial work, and whose capacity for psychosocial activities could be strengthened with UNFPA support. At the national level, examples include the FHB in the Ministry of Health and the Ministry of Social Services, both of which have considerable reach throughout the country. At the NGO level, we recommend continued support for organizations such as WIN and Sarvodaya, which have strong records of providing psychosocial services in various parts of the country. We also recommend support to the Psychosocial Forum (PF) at the Consortium of Humanitarian Agencies. The PF does not have enforcement capabilities; however, it is well positioned to promote high standards of conduct among participating organizations, and to foster greater communication and coordination among organizations and agencies engaged in psychosocial activities (including development and other activities likely to have an impact on psychosocial wellbeing).

On the other hand, we agree with UNFPA and the DMHS that it is a needed and worthwhile effort to work towards a greater inclusion of prevention and wellbeing-promotion activities in the DMH. UNFPA may wish to consider its aims in this regard: if it is primarily interested in achieving greater psychosocial wellbeing within a relatively short time frame, it will need to focus its funding at least partly on supporting the efforts of NGOS, INGOS, and government institutions already engaged in psychosocial activities. If it wishes to adopt a long-term strategy, then additional funding for the DMH to support greater acceptance and adoption of a psychosocial approach would be merited.

4. The PADHI project has made substantial projects towards achieving its stated aims. With a bit of additional consultation, we believe the PADHI staff are likely to successfully produce the important rapid assessment tool described in their proposal to UNFPA; they are also on schedule to finalize their methodology for assisting organizations with evaluating the psychosocial relevance of their objectives and assessing the quality and fidelity of their program implementation. We recommend ongoing support to PADHI to ensure that it is able to complete its objectives successfully.

5. We encourage UNFPA to consider ongoing support to the Psychosocial Forum. The PF made good use of UNFPA funding for their strategic planning and the translation and publication of their guidelines for good psychosocial practice. We believe the PF can continue to play an important role in fostering higher quality psychosocial programming and coordinating the psychosocial activities of participating organizations.

6. We would encourage UNFPA to do away with the distinction made in this project between gender-focused projects and psychosocial projects. This distinction makes

little sense to us, and has little meaning in the community. As noted earlier, the two “women’s centres” we visited actually defined themselves explicitly as psychosocial centres, in which issues such as GBV were addressed through a variety of services aimed at women and men, boys and girls. Addressing gender-related concerns effectively is inherently a psychosocial process, in that specific gendered issues such as GBV and reproductive health clearly exist within a psychosocial context; addressing that context holistically by working with a range of psychosocial issues (literacy, stress management, childcare, employment skills, poverty reduction, conflict management) as well as targeting GBV and reproductive health directly seems to us the most fruitful approach. Clearly, that view is shared by the organizations whose centres we visited, whose reach in local communities was very impressive.

7. Finally, we return to a key statement in the original proposal for the UNFPA project:

In order to restore the conditions for promoting wellbeing and reducing distress, the coordination of services relevant to wellbeing is highly important but poorly functional at the time. It is important the coordinating bodies for psychosocial wellbeing are aware of, and play a informing/advocacy role in highlighting, emerging issues, informing the relevant sectors and helping services to reach people.

Although the data we have gathered do suggest that UNFPA funding has helped expand the reach of the Adolescent Life Skills Programme (through the FHB), and has fostered innovative and potentially impactful research on psychosocial wellbeing in Sri Lanka (The PADHI programme), we do not have the impression that a central concern in the original proposal has been adequately addressed: “coordinating the activities of psychosocial bodies.” The DMH has been assigned the role of coordinating psychosocial activities in each sector; however, we saw little evidence that DMH has been able, at the district or regional levels, to effectively coordinate the activities of local or international

psychosocial actors. We therefore encourage UNFPA to explore other avenues for enhancing the coordination of psychosocial actors and their respective activities. Possibilities include increased support for and collaboration with the Psychosocial Forum, as well as exploration of other well-positioned institutions with good reach into local communities and an established interest in psychosocial approaches, such as the Ministry of Social Services or the recently developed Ministry of Disaster Management.

Annexure I

Persons met by the evaluators

Ms. Lubna Baqi	Country representative UNFPA
Ms.Malathie Weerasooriya	Assistant representative UNFPA
Dr. Gameela Samarasinghe	Senior Technical Consultant-Psychosocial
Mr.Jayan Abeywickrama	Programme Coordinator-Psychosocial
Mr.Asela Kalugampitiya	Monitoring and Evaluation officer
Mrs.Rizvina De Alwis	Programme officer, Gender component
Mrs.Asha Abeyasekera-Van Dort	Team leader, PHADI project
Ms.Udeni Appuhamilage	Team member
Mrs.Mihiri Ferdinando	Team member
Ms.Krishanthi Anandawansa	Team member
Ms.Kanchana Kumarasekera	Team member
Ms.Sabrina Hermosilla	Research Associate
Dr. Hiranthi de Silva	Director, Mental Health Services, MOH
Dr.P. Gnanissara	Technical Consultant, DMHS
Dr.S.A.H. Liyanage	DPDHS, Hambantota
Dr.Miyasi Gajanayaka	Psychosocial focal point, Hambantota
Dr.Sunethra Wickramanayake	MOH, Tangalle
Ms.E.A.E.Chndrakanthi	Coordinator, WIN, Matara
Ms.K.H.Shanthilatha	Manager, women's centre, Polhena, Matara
Ms.Thanuja Thilakawardana	Manager, women's centre, Polhena, Matara
Ms.Sandamali Abeywgunawardana	Manager, women's centre, Kirinda
Ms.Chrishara Paranawithana	Coordinator of the Psychosocial forum-CHA
Maj.Gen.Gamini Hettiarachchi	Director-Disaster Management Centre of the Ministry of Disaster Management and Human Rights
Dr.Thalatha Liyanage	Acting DPDHS-NIHS, Kalutara
Dr.Hemanthi	MOMH-Community Support Centre manager at NIHS

