ASIAN DEVELOPMENT BANK

TAR: SRI 38129

TECHNICAL ASSISTANCE
(Financed by the Poverty Reduction Cooperation Fund)

TO THE

DEMOCRATIC SOCIALIST REPUBLIC OF SRI LANKA

FOR THE

PSYCHOSOCIAL HEALTH IN CONFLICT-AFFECTED AREAS PROJECT

November 2004

CURRENCY EQUIVALENTS
(as of 22 November 2004)

Currency Unit	–	Sri Lanka rupee/s (SLRe/SLRs)
SLRe1.00	=	$0.0096
$1.00	=	SLRs104.55

ABBREVIATIONS

ADB	–	Asian Development Bank
GTZ	–	*Deutsche Gesellschaft für Technische Zusammenarbeit* (German Agency for Technical Cooperation)
TA	–	technical assistance
NGO	–	nongovernment organization
PTSD	–	post-traumatic stress disorder
UNICEF	–	United Nations Children's Fund

TECHNICAL ASSISTANCE CLASSIFICATION

Targeting Classification	–	Targeted intervention
Sector	–	Health, nutrition, and social protection
Subsector	–	Social protection
Theme	–	Inclusive social development
Subtheme	–	Human development

NOTES

(i) The fiscal year (FY) of the Government ends on 30 June.
(ii) In this report, "$" refers to US dollars.

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I. INTRODUCTION

1. The Poverty Reduction Cooperation Fund (PRCF) peer review meeting on 28 June 2004 endorsed a project proposal to reduce poverty caused by and linked to psychosocial health problems associated with the conflict in Sri Lanka.[1] Sri Lanka is emerging from two decades of civil conflict. It has acutely debilitated the population and economy. The Country Strategy and Program (CSP) of the Asian Development Bank (ADB) (2004–2008)[2] and its update (CSPU, 2005–2006)[3] strongly support the Government's efforts to reconstruct and develop Sri Lanka. The CSP and CSPU target pro-poor economic growth, with emphasis on backward and conflict-affected regions or on those facing particular hardships. The technical assistance (TA) will support the Government's program to increase conflict survivors' access to social services. In particular, mental health disorders are prevalent and chronic among the conflict survivors. Given the scale of the problem, the Government has requested ADB to help build the capacity to address the mental health of conflict-affected people.

2. The TA Fact-Finding Mission visited Sri Lanka—including Batticaloa, one of the conflict-affected areas—from 16 to 20 August 2004, to discuss with the Government and stakeholders (i) external funding coordination, (ii) TA scope, (iii) implementation arrangements, (iv) cost estimates, (v) financing plan, and (vi) outline terms of reference for experts.

II. ISSUES

3. Mental health disorders are common in developing and developed countries, and are considered one of the top 10 causes of disability. According to the *World Health Report 2001*,[4] mental health problems account for 12% of the global burden of disease. Health problems are disabling, costly, and often push families into poverty.

4. War and conflict are often linked with post-traumatic stress disorders (PTSDs) and other psychosocial diseases, and conflict-affected persons often require long-term treatment. A growing body of research shows that these problems are prevalent and chronic. Mental health problems caused by the trauma of war and conflict linger and must be solved if the victim is to return to good health. Failure to address psychosocial disorders in populations that have experienced mass violence and trauma caused by conflict can (i) leave the society vulnerable to a return to violence, and (ii) inhibit efforts to rebuild social capital and social and economic development.

5. After 20 years of conflict and repeated efforts to resolve it and achieve lasting peace, a breakthrough was achieved in February 2002. The Government of Sri Lanka and the Liberation Tigers of Tamil Eelam signed a cease-fire agreement, which, despite increasing violations, is still officially supported by both sides. In April however, the change in Government brought the peace process to a standstill.

6. During the conflict, more than 60,000 people were killed and over 1 million displaced. When the cease-fire agreement was signed, many of the displaced lived in one of the 349 Government and external agency-financed welfare centers, although about half of the displaced have now returned to their places of origin. Returnees and those who remain in the welfare centers face difficult living conditions.

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[1] The TA first appeared in *ADB Business Opportunities* (Internet edition) on 5 July 2004.
[2] ADB. 2003. *Country Strategy and Program (2004–2008): Sri Lanka*. Manila.
[3] ADB. 2004. *Country Strategy and Program Update (2005–2006): Sri Lanka*. Manila.
[4] World Health Organization (WHO). 2002. *World Health Report 2001*. Geneva.

7. All these circumstances, among other problems, have led to a sharp increase in psychosocial disorders in the country. An entire range of mental disorders and their symptoms were found. Most notably, suicide and drug abuse have become more prevalent. The following figures illustrate the situation:

(i) Suicide is an alarming problem. The country ranks seventh in world suicide statistics. The suicide rate among male Sri Lankans is over 40.0 per 100,000 (India 12.2, Philippines 2.5).[5]
(ii) Over 70,000 patients are admitted annually to state hospitals for poisoning, which, in most cases, are attempted suicides. Twelve percent die.
(iii) Studies focusing on the conflict-affected areas reveal that 27.6% of the population suffers from severe PTSDs.
(iv) The rate of severe psychiatric diseases has risen by 14% between 1980 and 2000.
(v) The chronically ill, together with those severely traumatized by war, represent about 3–5% of the population of the northeast. They urgently need services but facilities were either damaged in the conflict or are overcrowded.
(vi) Recent studies[6] show that 10% of the population is in urgent need of counseling. About 60% of the population in the north and east (the war-affected zones) needs psychosocial support services.

8. Displacement, violence, urbanization, migration, social and economic pressures, and trauma have exacerbated psychological distress, leading to a loss of social cohesion and social capital. Evidence is strong that poverty and psychosocial health are linked in many ways. People traumatized by war are usually those who lose their homes and their livelihood. Many families lose their breadwinner, and children lose their parents.

9. Activities to cope with PTSDs and other mental disorders are important. This project meets an urgent demand in developing member countries, and ADB support is crucial. Community psychosocial health programs have been proven to be effective in treating mental health problems in poor populations.

10. Among the hundreds of nongovernment organizations (NGOs) in Sri Lanka, 24 are working in psychosocial services for children affected by the conflict and operate counseling centers using community based approach. The main players are the United Nations Children's Fund (UNICEF) and German Agency for Technical Cooperation (GTZ), both working with traumatized children on a large scale, covering primary and secondary schools in the whole northeast of the country. Privately funded NGOs like Sahanaya have significantly helped improve services, and Government agencies hold activities in most provinces. Among the NGO and Government programs are mass media initiatives and school-based educational efforts. Several are directed specifically at the police, armed forces members, and prison officials. However, NGOs face serious financial and capacity constraints and need assistance to improve their service delivery. Many activities, especially of UNICEF and GTZ, focus on children, and services for adults are few.

III. THE TECHNICAL ASSISTANCE

A. Purpose and Output

11. The Project's overall goal is to reduce poverty caused by and linked to psychosocial health problems associated with the conflict. The Project's purpose is to pilot-test the provision of services to people affected by psychosocial health problems.

[5] WHO. 2003. *WHO Suicide Rates*. Available: http://www.who.int/mental_health/prevention/suicide/suiciderates/en/
[6] Simms, Chris. 2002. *Psychosocial Distress in Sri Lanka—A Needs Assessment Using Livelihood Approach*. Colombo.

12. The TA will focus on psychosocial health problems in the context of poverty. Many of the mentally ill are displaced, unemployed, victims of violence, or have lost their families. The main TA output will be to develop and pilot-test an approach to help mentally ill people, their families, and communities by providing services like counseling, awareness creation, medical service, training of staff, and institutional development. Service delivery will rely wherever possible on NGOs. The principles of the TA are (i) community-based participatory approach, (ii) working with people with psychosocial health problems as "agents" for change, instead of "victims," (iii) effective services for both adults and children, (iv) public-private partnership, and (v) service delivery that includes establishing links with economic opportunities.

B. Methodology and Key Activities

13. The TA methodology follows a phased approach, with a preparatory study and a project implementation phase, an evaluation, and identification of up-scaling potentials. The TA will thus have four components:

14. **Component 1: Background, Baseline, and Design Study**. Under this component, the background of psychosocial health problems in the context of poverty in Sri Lanka will be analyzed and possible activities developed. An outline of the feasibility study is in Appendix 2. The activities will include the following:

(i) Develop a methodological framework.
(ii) Assess studies and activities on psychological health problems and poverty, and the situation of the target group, especially the context and reasons for psychosocial health problems, emphasizing the link between psychosocial health problems and poverty.
(iii) Consult with target groups (e.g., focus group discussions).
(iv) Assess the services available to the mentally ill.
(v) Analyze how psychosocial health is being handled in the community.
(vi) Identify the victims and the effects of their illness on families and communities (i.e., the “Target Groups”).
(vii) Prepare a strategy on how to help the target groups, using existing structures, communities, and networks.
(viii) Analyze the needs for capacity building, community development, and financing.
(ix) Identify ADB’s comparative advantage in this area.

15. At the end of component 1, the benefits and costs of the proposed pilot project will be assessed. A detailed work plan and costing for component 2 will be prepared. The terms of reference for NGOs and a set of criteria for choosing NGOs and other agencies will also be prepared. The work plan, costing, terms of reference for NGOs and selection criteria will be approved by ADB.

16. **Component 2: Pilot Programs**. Based on the program of activities recommended in component 1, different types of programs and services to help the Target Groups will be implemented under component 2, which may include elements such as training of professionals, institutional development, and payment of lump sum to finance service delivery. The project team will cooperate with NGOs. The services will be delivered to the victims, their families, and communities, and may comprise counseling, awareness raising in the community and among professionals, medical support, job creation, and improving institutions that deliver the support. Ways to (i) strengthen the local governments’ impact on Target Groups, and (ii) achieve sustainability of the pilot-tested services will also be explored. Component 2 will seek to provide services to Target Groups that do not currently have access to such services and to improve services to Target Groups that do have access to some form of such services.

17. **Component 3: Evaluation**. Components 1 and 2 will be documented, assessed, and evaluated in a report. Lessons learned will be identified to determine the potential for scaling-up the TA to a larger Project. If the Pilot Program under component 2 improves services and key indicators such as the poverty ratio and psychosocial health (especially suicide rates), ADB may consider a larger investment or sector project.

18. **Component 4: Advocacy and Partnership Development**. Toward the end of the Project, the report reflecting the findings of component 3 will be shared with the key stakeholders in a national workshop, and follow-up actions, including co-financing in ensuing loan projects, will be considered.

19. TA consultants will thoroughly analyze the outputs of Components 1–3 and the views of stakeholders, discuss the findings with stakeholders, and recommend ways to improve the basic conditions for psychosocial services. The consulting services will carry out a baseline and feasibility study, including a project design for the pilot phase (component 2). Following are some key issues to be reviewed by the consultants: (i) psychosocial health prevalence, (ii) available services, (iii) existing gaps, (iv) services to be provided under component 2, (v) selection criteria for NGOs, (vi) mechanisms for community involvement, and (vii) community involvement and public-private partnerships (public service and NGOs). The specialists will develop a way to improve community services, especially on how to develop and strengthen their delivery. The specialists will assess the possibilities of further cooperation with other development partners, especially UNICEF and GTZ.

C. Cost and Financing

20. The TA is estimated to cost $500,000 equivalent, of which ADB will finance $400,000, covering the entire foreign exchange cost of $73,000 and $327,000 equivalent of the local currency cost. The TA will be financed on a grant basis by the Poverty Reduction Cooperation Fund, funded by the Government of the United Kingdom, to be administered by ADB. ADB will finance the pilot services, consulting services, production of reports, workshops, and administration support services. The Government contribution of $100,000, equivalent in kind, will cover office accommodation, counterpart staff, and transport (Appendix 3).

D. Implementation Arrangements

21. The Project will last 36 months, from January 2005 to December 2007. Component 1 will last 4 months, and the remaining components 32 months. The Executing Agency will be the Ministry of Women Empowerment and Social Welfare. The implementing agency will be an NGO. The steering committee, which will advise and oversee the Project, will be constituted by members from Government agencies, stakeholders, and development partners (UNICEF and GTZ).

22. The Government will appoint a project director and designate counterpart staff to work with the consultants. A project office for the consulting team will be established after TA signing. The office will have utilities, furniture, and local telephone services.

23. Component 1 will use the services of an international psychosocial health expert (2 person-months) and a domestic community development and social participation specialist (4 person-months). All consultants will be recruited individually, in accordance with the *Guidelines on the Use of Consultants by the ADB and Its Borrowers* and other arrangements satisfactory to ADB for the engagement of domestic consultants. Outline terms of reference are in Appendix 4.

24. Components 2, 3, and 4 will be implemented through an NGO. It will be selected by ADB—taking into account proposals made by the Government—in a competitive bidding according to criteria developed in component 1 and in accordance with ADB's *Guidelines on the Use of Consultants by the ADB and Its Borrowers* and other arrangements satisfactory to ADB for the engagement of domestic consultants. Pilot districts under component 2 will be Trincomalee (Eastern Province) and Monaragala (Uva Province).

25. The consulting services will be carried out over 4 months, from December 2004 to March 2005. The consulting team will submit an inception report within 2 weeks from the start of the TA, the draft final report in the first week of the fourth month, and the final report within 4 months from the start of the TA. The TA will include field visits, stakeholder mapping and participatory planning to facilitate consensus building among a wide range of stakeholders such as development partners, NGOs, health staff, and political and administrative leaders at various levels. The consultants will organize at least one workshop in Colombo and one workshop in each district to solicit views and discuss options and activities with stakeholders. The consultants will prepare a self-standing project concept, which will be implemented in component 2. The consultants will develop criteria to select the implementing NGOs and prepare the bidding process.

IV. THE PRESIDENT'S DECISION

26. The President acting under the authority delegated by the Board, has approved ADB administering technical assistance not exceeding the equivalent of $400,000 to the Government of Sri Lanka to be financed on a grant basis by the Poverty Reduction Cooperation Fund for the Psychosocial Health in Conflict-Affected Areas Project, and hereby reports this action to the Board.

TECHNICAL ASSISTANCE FRAMEWORK

Design Summary	Performance Indicators/ Targets	Monitoring Mechanisms	Assumptions and Risks
Goal Reduce poverty caused by and linked to psychosocial health problems associated with the conflict	Poverty among target population reduced from 37% (head count poverty ratio) to 15%; suicide rates in the pilot areas reduced from 40 per 100,000 to 10 per 100,000	Poverty statistics; suicide statistics	
Purpose Pilot-test provision of services to people affected by psychosocial health problems	Services established and tested for possible scaling up.	Project reports	**Assumption** • The tests are effective. The Government is willing to use the project experiences for scaling up services.
Outputs Component 1: Background and baseline study Component 2: Pilot programs Component 3: Documentation and identification of lessons learned Component 4: Advocacy and partnership development	Strategies, design, and terms of reference of the pilots prepared by the end of month 4 Pilot programs show potential to deliver services to the target group by the end of month 36 Pilot programs show the feasibility of service delivery to a defined number of people by month 36 The project experiences are discussed with stakeholders Scale-up potential and follow-up actions are visible by month 36	Report Project reports, external evaluation Project reports, external evaluation Project reports, workshop results	**Assumptions:** • A sufficient number of qualified NGOs are available and willing to work with the project. • Target groups can be identified and are willing to work with the project. • The services help the people return to normalcy. **Risk:** • Financial resources for scale-up may be limited. The Government may not be committed to the program.
Activities Develop a methodological framework Identify and contact target groups and NGOs in the target areas Elaborate a project design	A framework is developed NGOs and target groups are identified Problems and needs are assessed by month 5 The design is developed by month 5	Report Report Project reports	**Assumption:** • Data is available. **Risks:** • Access to data may be difficult. • Targeting may be difficult. High-quality consultants and NGOs are needed. • The piloted services are effective.

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Design Summary	Performance Indicators/ Targets	Monitoring Mechanisms	Assumptions and Risks
Implement pilot services Evaluate the pilot results and identify lessons learned Discuss lessons learned and options for scale-up	Pilot projects are successfully implemented by month 36 The pilot projects are evaluated by an independent evaluator by month 36 A workshop is held with the Government and stakeholders Possible follow-up actions and scale-up are discussed and agreed on with Government and stakeholders by month 36	Project reports Documentation and evaluation report Workshop results Agreements with Government	**Assumption:** • The Government is committed to the Project.
Inputs Consulting services, workshops, focus group discussion, field visits	A total of $430,000 for 2 person-months' international and 4 person-months' local consulting services At least two participatory workshops	Consultant reports	

NGO = nongovernment organization.

TENTATIVE OUTLINE OF THE FEASIBILITY STUDY (COMPONENT 1)

I. Baseline Study on Psychosocial Health in the Target Districts

A. Existing Psychosocial Problems in the Target Districts
1. Evaluation of Existing Studies
2. Results of Focus Group Discussions

B. Available Services for the Target Groups
1. Public Services
2. Private and Nongovernment Organization (NGO) Services

C. The Asian Development Bank's Comparative Advantage in the Area

II. Design of Pilot Studies

A. Services to be Provided
1. Target Groups
2. Communities

B. Implementation Arrangements-Organization and Administration of Service Delivery

C. Costs of Proposed Pilot Studies

Appendixes

I. Terms of Reference for the NGOs
II. Selection Criteria for NGOs
III. List of Potential NGOs
IV. Criteria for Measuring the Success of the Pilot Studies
V. Statistical Annex

COST ESTIMATES AND FINANCING PLAN
($'000)

Item	Foreign Exchange	Local Currency	Total Cost
A. Poverty Reduction Cooperation Fund Financing[a]			
1. Consultants			
a. Remuneration and Per Diem			
i. International Consultants	48.0	0.0	48.0
ii. Domestic Consultants	0.0	16.0	16.0
b. International and Local Travel	5. 0	3.0	8.0
c. Reports and Communications	0.0	1.0	1.0
2. Pilot	0.0	270.0	270.0
3. Training, Seminars, and Conferences			
a. Facilitator	0.0	5.0	5.0
b. Conference	0.0	10.0	10.0
4. Surveys	20. 0	0.0	20.0
5. Miscellaneous Administration and Support Costs	0.0	2.0	2.0
6. Contingencies	0.0	20.0	20.0
Subtotal (A)	**73.0**	**327.0**	**400.0**
B. Government Financing			
1. Office Accommodation and Transport	0.0	30.0	30.0
2. Remuneration and Per Diem of Counterpart Staff	0.0	60.0	60.0
3. Others	0.0	10.0	10.0
Subtotal (B)	**0.0**	**100. 0**	**100.0**
Total	**73 .0**	**427. 0**	**500.0**

[a] Administered by the Asian Development Bank.
Source: Asian Development Bank estimates.

OUTLINE TERMS OF REFERENCE FOR CONSULTANTS

1. The consulting services will carry out a baseline and feasibility study, including a project design for the pilot phase (component 2). The following are some key issues to be reviewed by the consultants: (i) psychosocial health prevalence; (ii) available services; (iii) existing gaps; (iv) services to be provided under component 2; (v) selection criteria for nongovernment organizations (NGOs); (vi) mechanisms for community involvement; and (vii) social participation, including public-private partnerships to bolster internal efficiency. All consultants will be recruited individually in accordance with *Guidelines on the Use of Consultants* of the Asian Development Bank (ADB), and other arrangements satisfactory to ADB for the engagement of domestic consultants.

A. Psychosocial Health Specialist and Team Leader (international, 2 person-months)

2. The specialist should be a medical doctor or equivalent with at least 10 years' experience of working in developing countries, and have experience in the region and in post-conflict situations, in project design, and as team leader. The specialist's input will be divided into two missions—one at the beginning and one toward the end of the 4-month period. The specialist will:

(i) develop a methodological framework for the study;
(ii) assess the types, prevalence, and incidence of mental health problems, focusing on post-conflict problems;
(iii) assess studies and activities and the situation of the target group, especially the context and reasons for psychosocial health problems, emphasizing the link between psychosocial health problems and poverty, and assess the services available to the mentally ill;
(iv) identify the victims and the effects of the conflict on families and communities;
(v) consult with the target groups (e.g., focus group discussions);
(vi) prepare a strategy to help the target groups, using existing structures, communities, NGOs, and networks; and look into needs for capacity building, community development, and financing;
(vii) analyze how the community handles psychosocial health;
(viii) identify ADB's comparative advantage in this area;
(ix) assess available services (medical and nonmedical), their target groups, coverage, availability, quality, and expected impact;
(x) identify key stakeholders in psychosocial care and assess their potential to help the target groups;
(xi) travel to the project districts, assess the situation, and identify stakeholders;
(xii) define the target groups for a possible project;
(xiii) identify gaps in psychosocial services;
(xiv) identify services to be delivered to the target groups while maximizing the impact of the pilot project and the benefits generated through ADB funds;
(xv) assess the possibilities of cooperation with other stakeholders, especially with the United Nations Children's Fund (UNICEF) and German Agency for Technical Cooperation (GTZ);
(xvi) develop terms of references for NGOs;
(xvii) develop selection criteria for NGOs to deliver the identified services;
(xviii) prepare the selection procedure and identify NGOs that might participate;
(xix) develop methods to measure the results of the pilot project;

(xx) run a stakeholder workshop in Colombo, present the mission findings, and get stakeholders views on them;
(xxi) propose ways to make the pilot services sustainable after the end of the Project;
(xxii) assess the costs of replicating the pilot projects in other districts;
(xxiii) assist ADB in any other assignments as may be reasonably expected within the scope of work; and
(xxiv) write the project reports.

B. Community Development and Social Participation Specialist (domestic, 4 person-months)

3. The expert will be a sociologist or equivalent, with at least 5 years' experience in social, gender, and poverty analysis; participatory planning; and hands-on community development. The expert will:

(i) help the team leader assess studies and activities and the situation of the target group, especially the context and reasons for psychosocial health problems, emphasizing the link between psychosocial health problems and poverty; and assess the services available to the mentally ill;
(ii) help identify the victims and the effects of the conflict on families and communities;
(iii) help elaborate a strategy to help the target groups, using existing structures, communities, and networks, and look into needs for capacity building, community development, and financing;
(iv) analyze how communities handle psychosocial health;
(v) identify ADB's comparative advantage in this area;
(vi) conduct a social analysis emphasizing gender issues, reaching the poor, and participation of the poor;
(vii) plan and implement district and one country stakeholder workshops, and record the findings of plenary and personal interviews with stakeholders;
(viii) document the perceptions and priorities of stakeholders, including beneficiaries, through field visits, and prepare a participation strategy;
(ix) using the participatory approach, develop a strategic framework to improve social aspects of program design, in particular targeting the poor and women, and note risks in reaching beneficiaries;
(x) help the team leader identify the target groups;
(xi) develop methods to reach the Project's target groups;
(xii) help the team leader assess the possibilities of cooperation with other stakeholders, especially UNICEF and GTZ;
(xiii) assess the possibilities of social participation, including public-private partnerships, to bolster internal efficiency and guarantee sustainability;
(xiv) assist ADB in any other assignments as may be reasonably expected within the scope of work; and
(xv) contribute to the project reports.