REVIEW OF THE FUNCTIONING AND IMPACT OF MOTHER SUPPORT GROUPS

in the Northern and Eastern Provinces of Sri Lanka

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Nutrition coordination unit
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REVIEW OF THE FUNCTIONING AND IMPACT OF MOTHER SUPPORT GROUPS

IN THE NORTHERN AND EASTERN PROVINCES OF SRI LANKA

CONSULTANTS WITH A CONSCIENCE

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EXECUTIVE SUMMARY

A review of the functioning and impact of Mother Support Groups (MSGs) has been commissioned by UNICEF Country Office, Sri Lanka.

UNICEF, as part of the support under its Maternal and Child Health and Nutrition Sector, has included the facilitation of MSGs through the Health Sector in the Northern and Eastern Provinces, over the past few years. The review covers MSGs in 5 Medical Officers of Health Divisions (MOH) each in Trincomalee and Batticaloa Districts of the East and 1 MOH each in Vavuniya and Mullaitivu. Setting up MSGs was one of the components of a range of activities supported under health and nutrition in these districts. Resources were provided through an EU partnership. Activities related to setting up, strengthening and supervising these MSGs were implemented at field level by 2 NGOs – 3CD in Trincomalee and SEDO in Batticaloa.

The objectives of the review were to assess if the MSGs have achieved the key objective for which they were set up. The key objective includes assisting the MOH offices through their Public Health Midwives to increase growth monitoring coverage of children under 5 years of age, increase the number of detections of pregnancy before 8 weeks and to reduce rates of anaemia among pregnant mothers. The process objectives were to enhance communication between the service providers, in this case the public health network and the target community and to impart nutrition and health messages. The secondary objective was to examine various parameters of management and functioning and the tertiary objective was to assess the external communications of the groups.

21% of the total number of MSGs facilitated with UNICEF assistance were assessed and were equal to 57 MSGs out of 269 which were supposed to be functioning. The review was conducted in the month of November 2014 and included a team of 3 consultants together with translators. The approach was qualitative assessments through mainly Focus Group Discussions (FGDs). 39 Focus Group discussions were conducted with MSGs, 2 with MOH Office teams and 1 KII with the UNICEF Program Officer in Batticaloa. Community feedback on the work of the MSGs were received from 94 persons in villages covered by the MSGs. Secondary data to verify the key objective is yet to be received.

The main findings are categorised as profile of MSG members, achievement of objectives, management aspects of the MSGs and key recommendations;

- The data base of MSG members in the East was available and therefore were able to analyse. The average age of members was 27.7 years with the youngest being 15 years and the oldest 56 years. 1/3 have either not passed or sat for their O'L examination. 76% were not engaging in any form of

paid employment. 81% were married. in Batticaloa 51% of MSG members' husbands were daily wage labourers while in Trincomalee it was 26%. 22% in Trincomalee were farmers, while there were only 10% husbands who were farming in Batticaloa. In Batticaloa 19.4% of the husbands were migrant workers. So the lowest forms of employment of husbands was in Batticaloa – nearly 70% being migrant workers and labourers. 44% of members and their families were Samurdhi beneficiaries.

- In the East, there seemed to be an increase of approximately 1/3 over base coverage (between the time MSGs were initiated and June 2014) in growth monitoring, while in the North it was difficult to estimate a figure. In both the North and East there seemed to be an increase in numbers of pregnancy detected before 8 weeks. The response was positive in 93% of FGDs in the East and in 66% of FGDs in the North. Confirmation of the improvement in growth monitoring, early detection of pregnancy and rates of anaemia need to be confirmed with MOH data. The consultants have not received this information from the respective OH offices.

- 64% of MSGs stated that they spent 14 hours per month on activities, while in the North 91% spent 11 hours or less on activities of their MSG. MSG members generally spent an 18 hour day and had little time to spare on these activities.

- Only about 1/4th of the community members interviewed knew that there was an MSG in their village.

- The public health network and the community had been brought closer together because of the communication of the MSG. The main messages carried by the MSG was about dates of clinics and weighing posts as well as about the conduct of special events.

- Messages imparted on nutrition and health were very broad. Food preparation demonstrations were done by the MSG, mainly where the WV HEARTH program was implemented.

- Training had been mainly provided to office bearers of MSGs and was not uniform and at depth. Therefore MSG members were often not aware "why" certain messages were given or certain activities performed by the PHM. This was verified by the scores of the self evaluation questionnaire that was answered by the MSGs, where the overall score was 65%.

- The mandate of the MSG was very much of a service provision approach and not about problem analysis and participatory development, which enabled empowerment. While there was commitment on the part of the members to serve the community and improve nutrition, certain aspects such as record keeping, maintaining lists of target beneficiaries and rates of malnutrition together with notes on improvement or deterioration of the nutrition status and follow up action required need strengthening. Decision making on what to do was often "PHM driven". Also MSGs were winding down their activities as partners facilitating these MSGs had completed their partnership agreement with UNICEF. This should be addressed immediately.

- There were grave socio economic problems in the villages which were part of the review. These were the lack of livelihood opportunities and low income, rampant domestic violence, large numbers of female headed and female maintained households, high levels of migration of men and also both parents in many cases, child abuse and increasing numbers of teenage pregnancies.

These issues limit the improvement of malnutrition and health and also the participation of women in these kinds of activities especially without rewards and remuneration.

Recommendations have been made based on the findings. Chief among these recommendations are;

- Analysing secondary data on growth monitoring coverage, early detection of pregnancy and anaemia rates and confirming the impact of the MSGs. This information needs to be circulated among MSGs, to keep their morale and stem the fragmentation of groups.
- Have a quick dialogue with all the MSGs and confirm if they would like to continue.
- Stream line training and include all members in training.
- Strengthen record keeping and management aspects of the MSG.
- Complete rapid studies of socio economic issues and facilitate multisectoral approaches to resolving these problems.
- Design evaluation scheme for members and groups.
- Based on the rapid studies proposed and other available information, commence immediately a multi sectoral approach to nutrition improvement.

CHAPTER 1

INTRODUCTION

1.1 TRENDS IN MALNUTRITION

1.1.1 Overall

Sri Lanka has seen an overall trend of improving nutritional status for the past 4 decades. The evidence of this improvement is in the DHS Surveys carried out from the 70s until the last DHS in 2007, where stunting among under 5s has seen the greatest improvement. Stunting (low height for age) has reduced by approximately 30% from the 1970s to a current prevalence of 18%.

However, Sri Lankans cannot be satisfied, as this trend has plateaued over the last decade with a stagnant low birth weight rate of 16.7 and the difficulty in reducing underweight among children below 5 years to less than 20%. The situation is made complex as wasting has not improved for many decades and is hovering between 14% to 18%.

1.1.2 Conflict disturbances impacting on nutrition status

The 30 year conflict has exacerbated the situation with the North and East of the country seeing fluctuations in nutrition status. The multi displacements due to war , eroding of good health and food related behavior, large numbers of female headed households being deprived economically have a great bearing on this situation.

Overall there has been improvement, but resilience in having low malnutrition status through a stable state of food security has not been achieved. This can be attributed to many factors gleaned from the large number of regional surveys and national level studies. Furthermore as evinced from KAP surveys, traditional, healthy food consumption practices have been eroded owing to the disturbances of living in IDP camps, depending on food aid of limited variety and fragmentation of families.

Studies show that the Eastern Province has seen improvements in nutrition status post war – in 2009, but with a turn for the worse with malnutrition increasing once again by 2011.

Prevalence of underweight among children under 5 years of age was yet 29% in the North in 2011. This was due to the waning of relief and recovery food assistance and slow gains in agriculture with a resultant status of food insecurity being between 40 to 65% across households in the 8 Districts of the North and East (Food

Security in the Northern and Eastern Provinces of Sri Lanka WFP Ministry of Economic Development and HARTI 2012).

This is confirmed by a recent community based Food Security and Dietary Assessment study carried out in the Muttur Division of Trincomalee District, where severe food insecurity in one Division – Muttur, was found to be 57% (Community Food Security and Dietary Intake Assessment completed by Viluthu under the SAFANSI Project of the WB)

1.2 EXISTING NUTRITION RELATED INTERVENTIONS AND GAPS

1.2.1 Types of interventions in general

Many nutrition programs have been implemented over the years, mainly by the government. The assistance of international agencies such as UNICEF, WFP and the WB have been mainly in support of strengthening ongoing government programs in the area of school feeding, supplementary and therapeutic food distribution in support of growth of children under 5 years as well as expectant and nursing mothers, micronutrient supplementation and fortification – mainly salt, capacity building of public health staff on IYCF and other areas of nutrition knowledge, assisting with growth monitoring and promotion by way of nutrition and health education and to a somewhat lesser extent for strengthening community mobilization through state and non state mechanisms towards strengthening existing public health interventions as well as to address the root causes of malnutrition pertaining to food insecurity.

Local NGOs, CBOs and CSOs have been operating at the local and national level all over the country focusing on food resource improvement, behavior change facilitation, communication campaigns and public health programs.

International NGOs such as World Vision have not only assisted with material inputs by way of food and equipment, but also brought in multifaceted programs such as HEARTH, which incorporates livelihood improvement and Behaviour Change Communication.

However there is a lacuna in knowing how effective some of these programs have been, especially community mobilization and empowerment. While nutrition status evaluation has been undertaken at regular intervals, progress reviews of a substantive nature have not been undertaken at the process level. At a time when the country is at the threshold of trying to achieve a "well-nourished nation" by 2016, it is worthwhile to objectively examine if community mobilization interventions are effective in helping to sustain gains in nutrition improvements by effecting substantial changes in the quality of life of the target populations. It is important to examine the Best Practices and Lessons that have been learnt for scaling up

such initiatives and if relationships have worked between government and non-governmental organizations in a sustainable manner.

1.2.2 Community mobilisation within the public health system

Health volunteers

There are two common interventions that the public health system of Sri Lanka has incorporated for health and nutrition promotion as part of improvement of Maternal and Child Health. The older one is co-opting health volunteers to help with the routine tasks at maternal and child health clinics. These tasks include maintaining cleanliness at the clinic, assisting PHMs with growth monitoring and distribution of Thriposha, assisting with duties such as handing over the requisite items for other routine functions, assisting with food demonstrations and education.

In this modality, there is really no element of empowerment and it is merely to assist with rather menial tasks.

Mother Support Groups (MSGs) and Mothers' Groups (MGs)

In more recent times, over the past 5 to 10 years a more "mobilized and empowering" approach has been to form " Mother Support Groups", where 7 to 10 mothers are either elected by the community or selected by the PHM and other leaders to look after the interest of mothers and children especially those under 5 years. While assisting with the same routine tasks as described under health volunteers, they are assigned more upper level tasks of mobilizing mothers to come to clinics, assist with compliance factors such as mothers ingesting supplements, drawing the attention of the PHM to vulnerable mothers and children and a host of other tasks. The MSG may or may not have a plan. They may also be asked to help achieve certain indicator targets. Sometimes MSGs are interchangeable and are called MGs. MSGs face a number of challenges such as high turnover, responsibilities of family, lack of recognition, lacking capacity and knowledge and lacking empowerment.

Mothers' Groups are those where all the mothers attending clinics for pregnancy, lactation or with children under 5, all become members of the group and carry out certain tasks based on plans.

Several Agencies have in recent times assisted with the mobilization of these groups. These are mainly UNICEF assisted MSGs in certain Divisions of Trincomalee, Batticaloa and certain Divisions in the North, the Japanese Social Development Fund assistance through the WB where MSGs in 22 MOH Divisions of the North have been initiated, WV supporting similar groups under its HEARTH program, PLAN Sri Lanka supported groups in Moneragala and MOH system initiated groups without any external assistance in various parts of the island.

1.3 UNICEF SUPPORTED PROGRAM TO PROPAGATE MSGS AND THE CURRENT REVIEW

UNICEF initiated the MSGs in the afore mentioned areas through partner organizations and in collaboration with the Public Health System of the respective area. The setting up of Community Support Groups interchangeably called Mother Support Groups (MSGs) was designed in 2012 under the EU – SEM Project by UNICEF with the following expected Output under the Health and Nutrition pillar:

		Province	District	Baseline	2012 Target	Result	2013 Target	Result	2014 Target
Communities have improved knowledge on health and nutrition issues	% of community support groups established in the project area with improved knowledge on breast feeding and complimentary feeding practices.	North	Mannar	33	60	-	83	67	100
			Vavuniya	25	50	-	90	50	100
		East	Trinco	63	78	75	95	100	100
			Batti	60	75	79.5	98	100	100

2014 Targets were to form 100 MSGs in each District.

2 partners were identified for implementing the formation, capacity building as well as progress monitoring of the MSGs in the Trincomalee and Batticaloa Districts. These were 3CD in Trincomalee and SEDO in Batticaloa for a period of 25 months – 2012 to 2014

1.4 THE OBJECTIVES OF THE UNICEF PROJECT PARTNERSHIP WITH 3 CD

1. Community empowerment through community support groups and involvement of key community influencers.
2. Integrated communication strategy with area specific innovative approach.
3. Identification of vulnerable families/risk households for targeted interventions through establishment of appropriate linkages with various departments such as social service department, samurdhi, agriculture etc.
4. Strengthening of integrated nutrition package through multi- sector approach.

The objectives of the UNICEF project partnership with SEDO were

1. Targeted population (including children under five, pregnant and lactating woman and adolescents) have access to health services through rehabilitated and reconstructed health facilities
2. 50% of health facilities in the selected areas provide nutrition intervention packages
3. Formation of community support groups (75), trained and functional.
4. Empowerment of community leaders on maternal & child health including nutrition

1.5 OBJECTIVES OF THE PROGRAM OF SETTING UP MSGS OVERALL

The main **objectives** of assisting the facilitation of MSGs was to enhance and increase

1.5.1 Output level

- Nutrition screening coverage (growth monitoring) which was around 55-60 percentage to reach above 95% in the targeted areas.
- Antenatal registration before 8 weeks PoA which was 43% in the target areas. The target was to reach above 60% in two years time.
- The weak link between community monitoring mechanism and information exchange through formal groups. This has created a gap between service providers and community in all the PHM areas.

1.5.2 Outcome level

- To reduce Anaemia among pregnant women which was around 20% and anaemia among under 5 children is 16-23% in the target area.

1.6 THE PURPOSE OF THIS REVIEW

1.6.1 Primary objective

The primary objective of the review will be to assess if the MSGs have been effective in their core purposes for which they were set up and will measure:

If the MSGs have met the demand side of Maternal & Child Health and Nutrition service provision in the community and if the following issues are addressed.

- Improved nutrition screening coverage and active case finding of malnourished children in each public health midwife area including tracing of defaulters.
- Improved early registration of ante natal mothers and ensured regular clinic attendance.
- If anaemia rates have improved since the initiation of the MSGs
- Improved information exchange between community and the service providers.
- Dissemination of simple key messages on maternal & child health and nutrition in the community.
- Enhanced community monitoring

1.6.2 Secondary objective

The secondary objective of the review was to assess and observe the management and functioning (internal dynamics) of the MSGs. This section includes the mechanism of forming MSGs, turnover, empowerment especially from a decision making point of view, organizational management and leadership aspects – including the appointment of office bearers, conduct of meetings, planning and implementing activities in the short term and long term, record keeping and knowledge on basic aspects of nutrition.

1.6.3 Other objective

Other objective of the review will be to assess the external relations of the MSGs

- Their ability to communicate with stakeholders in development (Networked with other development actors and functioned as an information hub to plan and implement community based interventions on livelihood and economic development)
- MSGs perception about what the community feels towards them

CHAPTER 2

METHODOLOGY

2.1 ASSESSMENT AT MOH LEVEL

a) Perusal of nutrition and health related information which are submitted by PHM on screening (growth monitoring) coverage and early identification of antenatal mothers

MOHs were requested for information on the following indicators in person as well as through UNICEF.

1. Trends and comparisons in Growth Monitoring coverage in the PHM area where the MSG is located since the MSG started vs June 2014 – trends can be year to year in %s of under 2s attending growth monitoring. (Under 2 years only was selected as part of the indicator as this is the most important stage of growth under 5. Furthermore age groups above this have different frequencies. Also the first 1000 days are considered as one of the two important stages of growth

2. Numbers of pregnant mothers detected before 8 weeks since MSGs started in that particular PHM area. – first 1000 days. It is also easy as age groups above 2 years have a different frequency of monitoring and that can confuse the indicator on coverage)

3. Ante partum and postpartum anaemia rates since the MSGs were initiated.

b) Focus Group Discussions with MOH staff regarding their PERCEPTIONS of MSGs contribution to increased growth monitoring coverage, pregnancy detection before 8 weeks, improvement of dissemination of messages, networking with other development actors, solving problems with their own initiative, participation at meetings by MSG members, overall assistance to PHM, empowerment and power dynamics between males and females, how MOH staff is capacitated to guide MSGs.

2.2 ASSESSMENT AT MSG LEVEL (PURPOSIVELY SELECT 10 TO 15% OF THE TOTAL NUMBERS OF MSGS IN THE MOH DIVISION)

a) Focus Group Discussions. The participants from the MSGs were explained the purpose of the review and who had commissioned it. The team too was introduced. The participants were made to be at ease with a few ice breaking questions and anecdotes before starting the discussion.

b) Group Knowledge Nutrition Knowledge Evaluation known as a self assessment tool with 11 questions asked in the areas of breast feeding, complimentary feeding, pregnancy related health and nutrition.

2.3 ASSESSMENT AT COMMUNITY LEVEL (IN SAME LOCATIONS COVERED BY MSGS REVIEWED)

a) Completed Village walks where possible and requested for informal feedback regarding MSG's from households with children under 5 years as well as few members from the community which included older persons as well as men – **one to one or in small groups** casually. Usually the team consisting of one evaluator and one interpreter either went to the furthest perimeter of the Village starting from the centre of the village. The MSG was requested to point out the boundaries of the village with landmarks. No health staff nor field officers nor MSGs accompanied the team as this would blur and bias the findings.

2.5 SAMPLING

18% of the total number of MSGs in 12 MOH Divisions (5 MOH Divisions in Batticaloa and 5 in Trincomalee, 1 in Vavuniya and 1 in Mullaitivu) have been reviewed as part the study. The critieria for selecting the MSGs are as follows:

a) MOH's judgement, where half the number selected will be performing adequately and the others which are underperforming.

b) Combined with the number of interventions made for the improvement of the MSG.

CHAPTER 3

FINDINGS

3.1 GENERAL

3.1.1 Number and spread of Mother Support Groups reviewed:

Table 1: Eastern Province

District	Trincomalee	Batticaloa	Total/no and %
Divisions	Echchalampattu, Gomarankadawala, Muttur, Kinniya, Serunuwara	Eravur, Chenkalady, Vellavely, Pattipalai, Vavunativu	
Total No of functioning MSGs	105	84	189
Total number reviewed and %	21 MSGs, 20% of total	15 MSGS, 18% of total	36, 19%
Total No of Focus Group Discussions	13	14	27
Total Number and % participating of MSG membership	126 out of 209 members** (Average 10 per group)	117 out 144 members*** (Average 10 per group)	243 out of 353 69%
Average Number participating	6	8	7

** As MSGs had been combined at a few FGDs in Trincomalee and the focus was reduced somewhat, feedback was given to Government and UNICEF after assessment in Trincomalee.

***In Batticaloa, participation of MSG members and confining discussions to single groups improved

Table 2: Northern Province (MSGs were assisted under UNICEF facilitation in 1 Division each in Vavuniya and Mullaitivu)

	Vavuniya Vavuniya North (Nedunkerny)	**Mullaitivu** Odusuddan	**Total/no of MSGs in both Divisions**
Total No of MSGs (unsure if functioning properly)	38	42	80
Total No reviewed and % ****	10 MSGs, 26% of total in Division	11 MSGS, 26 % of in Division	21 MSGs, 26 % of total in the 2 Divisions
Total No of Focus Group Discussions	6	6	12
Total Number and % participating of MSG membership	31 out of approx. 180 members** (Differing numbers per group. average 30 per group)	58 out approx. 180 members (Differing numbers per group. Average 30 per group)	89 out of 360 24% approx.
Average No participating	5	10	8

**** The original groups had fragmented and then been reformed in a combined manner

Overall No and % reviewed from both provinces: 57 MSGs out of 269, 21 % of total.

3.2 ANALYSIS OF MOTHERS SUPPORT GROUP MEMBERS' PROFILES – EASTERN PROVINCE

DETAILS IN FOLDERS WERE ONLY AVAILABLE IN THE EAST. THIS ANALYSIS HAS BEEN DONE FOR ALL GROUPS AND NOT CONFINED ONLY TO THOSE REVIEWED AS IT IS USEFUL FOR FUTURE ACTIONS.

Table 3: Composition of office bearers vs number of groups

Total no of members – 1506, Trincomalee– 960, Batticaloa – 546

Category	**Trincomalee (Total no of MSGs - 105)**	**Batticaloa (Total no of MSGs – 84)**	**Total**
President	95 (10 not stated)	35 (49 not stated)	130 stated (Gap of 59 not mentioned)
Vice Presidents	84	1	85
Secretary	89	5	94
Treasurer		3	3
Members	692	502	1194
Total	960	546	1506

Average age 27.7 minimum age – 15 years, maximum age 56 years

The preparation of member profiles in individual electronic files is good practice, both from the point of view of getting to know the member and for effective communication as some contact details are included. However the profiles must be complete, in describing if the member is an office bearer. Also these can be checked at regular intervals to see if they have moved from place of residence or dropped out for some other reason. Therefore the replacement of drop outs can be monitored .Vacancies of office bearers also could be filled, included in the profile and members should know what office they hold.

Fig 1: Education Level of Members

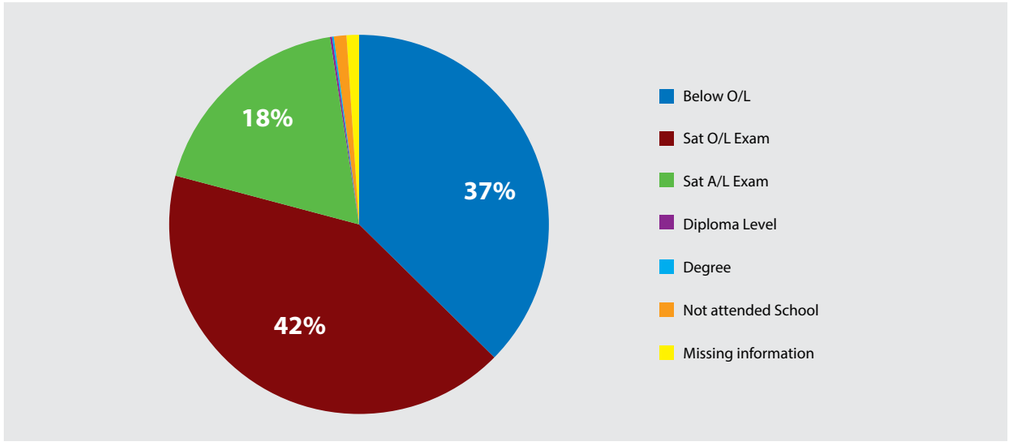


Table 4: Education Level of Members

Category	**Trincomalee**	**Batticaloa**	**Total No and %**
Below O/L	353	210	563, 37%
Sat O/L Exam	399	230	629, 41%
Sat A/L Exam	191	86	277, 18%
Diploma level		1	1, 0.06%

Category	Trincomalee	Batticaloa	Total No and %
Degree		2	2, 0.12%
Not attended School	16	-	16, 1.06%
Missing information	1	17	18, 1.1 %
Total	960	546	1506

A large proportion, more than 1/3 do not possess even O'L qualifications. This has implications for understanding and imparting nutrition messages in a correct manner. On a more positive note for the tasks required by the MSGs, less qualifications mean that many do not qualify for employment, and therefore may have time at their disposal to serve in these groups. As qualifications do not represent levels of knowledge nor intelligence, many of these women may perform very well given the right kind of training, recognition and incentives.

Table 5: Employment Status

Category	Trincomalee	Batticaloa	Total
Not engaging in any form	724	415	1139, 76%
Preschool teacher	37	4	41, 2.7%
Self-employment	44	12	56, 3.7%
Vocational training	1	1	2, 0.13%
Unmarried – school leavers	133	113	246, 15.3%
Volunteers	15	1	16
Daily labourers	6		6
Total	960	546	1506

76% of members who are not engaged in any employment may have the time to engage in MSG activities. This is quite a large proportion and maybe why they joined. Unmarried school leavers may qualify and migrate out of the area, so their training strategy must take this eventuality into account. Preschool teachers are extremely useful to have in these groups as parents respect them for the knowledge they possess. The self- employed too have initiative and this is a good quality that can be utilized in the effective functioning of groups.

Table 6: Marital Status

Category	Trincomalee (No and %)	Batticaloa (No and %)	Total (No and %)
Unmarried	160, 16.6%	126, 23%	286, 18%
Married	799, 83.2%	418, 76.5%	1217, 81%
Missing Information	1	2	3
Total	960	546	1506

The implications of 81% being married are that they would be more sensitive to the needs of mothers as well as the burdens carried by women. This would breed empathy and an inclination to volunteer. The difference in % of married and unmarried women has no significant difference between the two Districts.

Fig 2: Marital Status of Members

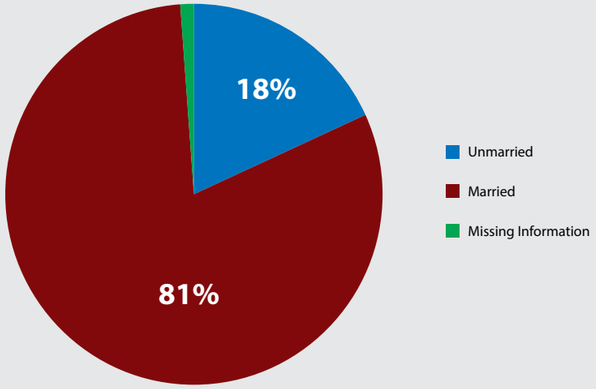
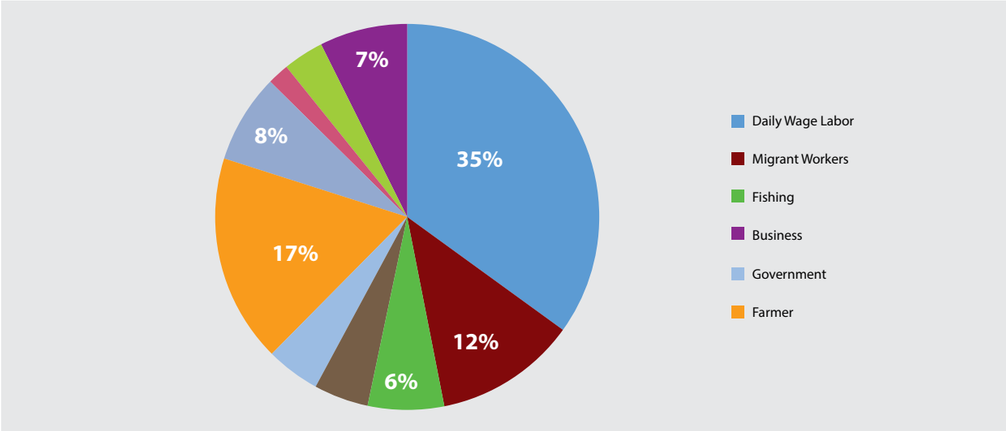


Table 7: Occupation of Husband

Category	Trincomalee (No and %)	Batticaloa (No and %)	Total
Daily Wage Labourer	249, 26%	279, 51%	528
Migrant workers	75, 7.8%	106, 19.4%	181
Fisherman	83, 8.6%	12, 2.1%	95
Businessman	47, 7%	20, 4%	67
Government	66, 6.8%	4, 0.7%	70
Farmer	209, 22%	53, 9.7%	262
Skilled workers (including driving)	96, 10%	17, 3.1%	113
Security forces	27, 2.8%	-	27
Other	47, 7%	4, 0.7%	51
Missing data	61	51	112
Total	960	546	1506

Fig 3: Occupation of Husband



The analysis of livelihoods in general does not give a satisfactory picture, as people do not have sufficient means of income. (See Table 8 below) on number of Samurdhi beneficiaries among MSG members). The % is very high. However when comparing the livelihood profile of husbands in the MSGs of Trincomalee, it is much better than Batticaloa. There could be negative as well as positive implications of this in relation to women's ability to participate in MSGs. This will be discussed in relation to performance of MSGs later.

There are very few members who are those of female headed households which are a total of 30, Of this number 24 are in Trinco and 6 in Batticaloa. This is very low compared to the usual % of female headed households in the East, which is over 30%. It could be inferred that many women of these households are unable to be members of MSGs owing to the constraints of time due to household burdens, lack of money and safety as well as mobility.

Table 8: Samurdhi Beneficiaries

Category	Trincomalee (No and %)	Batticaloa (No and %)	Total
Yes	404, 42%	256, 47%	660, 43%
No	552, 57%	290, 53%	842, 57%
Missing	4	-	4

These figures cannot be reconciled with the livelihood profile of husbands especially in Trincomalee District, where the poorest seem much less. The percentage of 47% correlates well in Batticaloa where 51% of husbands are daily wage labourers, with no fixed income and as a result are eligible for Samurdhi assistance.

3.3 FINDINGS ON THE OBJECTIVES OF THE REVIEW

The responses at FGDs with MSGs and Health staff together with field observations, provide the following insights,

3.3.1 Objective No 1 of the Review: To assess if the MSGs have been effective in their core purpose

3.3.1.1 Increase in Growth Monitoring Coverage

Table 9: Eastern Province Response on MSG contribution towards increase in growth monitoring coverage

Question: Do you think you have improved growth monitoring rates? Yes or No, If Yes- approximately by how much since before the work of the MSG?

FGD Number	Comment on Response	By
001 – From 50 to 80%	They were confident about the coverage before	60%
002 – By 25 %	This is an estimated increase rather than coverage from baseline.	25%
003 – From 50 to 100%	They were confident about the coverage before	100%
004 – By 10 %	This is an estimated increase rather than coverage from baseline	10%
005 – Yes. But do not know how much	Unclear	-
006 – Do not know. PHM said 20 to 30%	This is an estimated increase rather than coverage from baseline. Not the MSG response	25%
007 – Yes, improved by 10 to 20%	This is an estimated increase rather than coverage from baseline	15%
008 – yes, by 30%	More confident estimated increase rather than coverage from baseline.	30%
009 – 25% to 50% coverage	They were confident about the coverage before	100%
010 – GM has improved by 30 to 40%.	This is an estimated increase rather than coverage from baseline	35%
011 – Little but unable to say the rate. According to PHM 10%	Unsure	-
012 – 01 – Yes, improved		-
013 – Do not know		-

FGD Number	Comment on Response	By
014 – Do not know		-
015 – 70 to 90%	They were confident about the coverage before	30%
016 – GM – 25% to 90%	They were confident about the coverage before	360%
017 – GM – 75% to 100%	They were confident about the coverage before	30%
018 – 50 to 100 %	They were confident about the coverage before	100%
019 – improved , but unable to report rate of increase or numbers.	Do not know how much	-
020 – improved	Do not know how much	-
021 – improved and growth monitoring rates are currently 90%	Do not know how much	Cannot estimate the degree of improvement as only current coverage is cited
022 – improved, but don't know as a number	"	-
023 – improved, but don't know as a number	"	-
024 – improved, but don't know as a number	"	-
025 – improved – but don't know as a number	"	-
Average degree of increase as a proportion of base coverage (Base coverage = just before MSGs were initiated up to time of review)		**37%**

The average degree of increase has been determined by taking the aggregates of % increases from baseline in the areas where the MSGs were able to estimate a figure and dividing the aggregate by total no of discussions. Where MSGs could not cite a figure the change was taken as 0.

As the responses from FGDs are based on perceptions, verification is required with MOH Data on the increase in the actual growth monitoring coverage in the areas covered by the MSGs which were reviewed. However the increase in growth monitoring has undoubtedly increased as responses from both MSG members and health staff unanimously agree that this is so. All of the FGDs have positive answers. During the FGDs at MOH offices (3 in number) they stated that growth monitoring coverage is over 90%.

Table 10: Northern Province Response on MSG contribution towards increase in growth monitoring coverage

Question: Do you think you have improved growth monitoring rates? Yes or No, If Yes- approximately by how much since before the work of the MSG?

FGD Number	Comment on Response	By
026 – Yes, by 90%	More confident estimated increase rather than coverage from baseline	90%
027 – Talks about SAM and MAM, not Growth Monitoring	Does not know the increase in coverage	-
028 – Talks about SAM and MAM, not Growth Monitoring	Does not know	-
029 – Yes, but does not know how much	Does not know	-
030 – Unable to say	Does not know	-
031 – Yes but does not know rates	Does not know	-
032 – 90% increase from baseline	More confident estimated increase rather than coverage from baseline	90%
033 – Talks about SAM and MAM, not Growth Monitoring	Does not know	-
034 – Yes, 8 underweight children now its 3.	Does not know	-
035 – Unable to say	Does not know	-
036 – Unable to say.	Does not know	-
037 – Yes, it has increased, but don't know rates.	Does not know	-

Only two FGDs yielded any firm response on the degree of increase in growth monitoring coverage. While MSG members feel that it has increased this cannot be substantiated as they have no idea of the proportion. This can only be confirmed with MOH data.

3.3.1.2 Improved early registration of ante natal mothers and ensured regular clinic attendance.

Table 11: Eastern Province Response on MSG contribution towards increased early detection of pregnancies

Question: Have you detected more pregnancies before 8 weeks? How many was it when you started the MSG and how much has it increased to now?

FGD Number and Comment	Comment on Response	By
001 – Increased, do not know by how much		-
002 – Increased,	Does not know by how much	-
003 – Increased, do not know by how much	Does not know by how much	-
004 – 80% are detected now	Improvement cannot be gauged as base value is not known by the MSGs	-
005 – in 2011 – 40% registered 2014 2nd qtr – 68% registered.	Figures are given clearly	**Increased by 28%**
006 – Yes. But No reports. All groups do not know how to detect less weight gain Muslim community mothers are at home for 42 days after pregnancy. So difficult to detect.	Does not know by how much	-
007 – 40% to 60%		Increased by 20%
008 – Increased	Does not know by how much	-
009 – Pregnancy detection before 8 weeks in creased though we cannot exactly say how much.	Does not know by how much	-
010 – Claim to have increased.	But they did not know how much	-
011 – Yes, now mothers register before 8 weeks. Earlier they waited till 4 months. But if unmarried mothers do not come such cases are informed to the MSG by other community members.	But they did not know how much	-
012 –They know how to identify. The number has increased 01 – 4 detected 02 – 6 detected	But degree of increase cannot be ascertained	-
013 – Do not know	They have a feeling that it has increased but working on numbers and % seem alien.	-
014 – Culturally not sensitive to ask in Muslim community if one is pregnant		-
015 – Yes. How much we do not know		-
016 – Yes. How much – do not know		-
017 – Yes. we do not know how many or how much as % increase		-
018 – Yes. we do not know how many or how much as % increase		-

FGD Number and Comment	Comment on Response	By
019 – Yes, we have detected 16 pregnant mothers before 8 weeks in the last 3 months	Cannot determine increase as baseline is not known	
020 - Yes. But we do not know the % increase		
021 – Yes, but we do not the increase		
022 – Yes, increased	The same as above. Not used to working with numbers	
023 – Yes, but we do not know how much		
024 – Yes, it has improved, but we do not know by how much		
025 - Yes, but we do not know how many or how much as % increase		
026 – Yes, but do not know numbers. Pregnancies detected in 2013 are 3 and 1 in 2014, All were detected before 8 weeks.		

Note: Abortions are done in Muttur by subagents for women who want to migrate.

The fact that there is an increase in detection of pregnancies before 8 weeks was the response in 93% of FGDs , both on the part of MSGs and 100% of MOH staff who participated in separate FGDs. However the numbers and degree of improvement can only be determined with MOH records as this provides hard evidence.

Table 12: Northern Province Response on MSG contribution towards increased early detection of pregnancies

Question: Have you detected more pregnancies before 8 weeks? How many was it when you started the MSG and how much has it increased to now?

FGD Number	Comment on Response	Proportion of increase
026 – 90 %	This is the status now. Increase cannot be determined. It can be assumed that most are detected, as numbers are not given.	-
027 – 100%	Increase cannot be determined as baseline figures are not known. Assume all are detected.	-
028 – 100%	"	-
029 – Detected 3 in 2013 none in 2014	This is an anomaly that there is no pregnant mother in 2014.	-

FGD Number	Comment on Response	Proportion of increase
030 – Don't know	They do not know if there is an increase	-
031 – Don't know	"	-
032 – 100%	Assume all are detected.	
033 – 100%	"	-
034 – Yes, but don't know numbers	Increase cannot be determined	-
035 – Don't know	They do not know if there is an increase	-
036 - Don't know	They do not know if there is an increase	-
037 – Yes, but don't know numbers	Increase cannot be determined.	- 66% of FGDs received a positive answer, there is an increase. Other participants in the rest of the FGDs were unaware.

** This too needs verification through MOH data.*

3.3.1.3 Improvement in anaemia levels among pregnant mothers: Data required from MOH offices

3.3.1.4 To assess if the MSGs have met the demand side of maternal & child health and nutrition service provision in the community

A) Time allocation and activities implemented by MSG

First of all it was important to ascertain the amount of time the MSG members had at their disposal to carry out these activities. MSGs reported the activities they carried out in relation to maternal and child health and nutrition after discussing the time they spent on these duties. As,

a) hours per day

b) hours per week

c) days per week.

The total was converted to hours per month in order to compare. This was determined after discussing how they spent their day.

Table 13: Eastern Province

Categorisation of time spent on MSG work	Trincomalee no of Groups and % within Districts	Batticaloa	Total hours/month
No of hours per day	3 groups (14%) 1.5 hours	4 groups (27%) 3.5 hours	30 (19%)
No of hours per week	14 groups (67%) 3.5 hours	9 groups (60%) 3.5 hours	14 (64%)
No of days per week	4 groups (19%) 2.5 (5 hr) workdays	2 groups (13%) go to Poly clinics and 2 to 4 weighing posts every month.	12.5 hrs/month spent at clinics and weighing posts + time spent on home visits – unquantifiable (17%)

Table 14: Northern Province

Categorisation of time spent on MSG work	Vavuniya north no of Groups and % within Districts	Mullaithivu	Total hours /month
No of hours per month	5 groups (83%) 4 hours at clinic	6 groups (100%) 4 hours at clinic	11 (91%)
No of hours per week	1 group (17%) 2 hours	-	1 (8%)
Total	6	6	12

Of these the most verifiable categorization is the time spent at clinics and weighing posts. The hours spent on household visits are unverifiable.

It was mentioned during most FGDs in the East that 5 houses are allocated per MSG member. Most often these are the houses in close proximity and not necessarily those with problems. Sometimes these houses are visited in pairs. The exception regarding the number of houses covered was only in Mahiladitivu, Kokkadicholai in Paddipalai MOH Division of Batticaloa District. Here each MSG member covers 50 houses, but visits only those with problems and under 5 children as well as pregnant mothers.

The time spent on nutrition and health related activities by members in the Northern Province was less than the East.

MSG members on average spent an 18 hour day with the usual time of waking up at 5 am. The average hours they spent on various chores (household duties) is as follows:

Table 15: How the day of 75% of MSG members is spent (Northern and Eastern Provinces)

Activities	Number of hours spent/day
Cooking	4 hours (1/2 hr for breakfast, 2 hours to prepare lunch and 1.5 hrs to prepare dinner)
Child related duties – preparing them for school in the morning and giving breakfast	2 hours
Child related duties – giving their meals, preparing them for tuition and/or religious school in the afternoon, taking them for classes	3 hours
Child related duties – giving their meals in the night, assisting with homework and preparing school bag and clothes	3 hours
Cleaning the house, garden, spending time in the home garden	4.5 hours
MSG duties averaged per day	NOT more than 1.5 hours (certain days are more eg: clinic and weighing post days), but these members do not do MSG work on most of the other days.
Sleep and rest – afternoon and night	6 hours – 5 hours at night, sometimes 1 hour in the afternoon

B) Information exchange between the community and service providers

The consistent information that has been provided by the MSG from the service providers to the community is with regard to the dates of clinics and weighing posts. The proof of this could be in the increased coverage in growth monitoring if this can be verified with secondary data as well. Other information provided by the MSGs are about special campaigns such as clean ups (shramadana) to reduce dengue. This was mentioned in 100% of the FGDs with MSGs as well as MOH staff. The imparting of key messages will be described below.

Community verification on visits by MSG members:

There were two levels of community from whom feedback was received. These being households with children under 5 years and other community members. Men were also interviewed.

Question: " Do you know of the work of the MSGs? If yes, what do they do? If an under 5 household, do they visit you and what do they do" (The question was first asked as MSG and then further probed by telling the names of the members)

Table 16: Feedback from community on MSGs' work (CM = Community Member) - Trincomalee

Location Trincomalee	Yes	No	% Yes	% No
001	-	1		
002	2	2		
003	3	1		
004	4	-		
005	3	1		
006	1	2		
007	-	1		
008	-	3		
009	-	1		
010	-	3		
011	1	2		
012	-	4		
Total	**14**	**21**	**40%**	**60%**

Table 17: Feedback from community on MSGs' work (CM = Community Member) - Batticaloa

Location Batticaloa	Yes	No	% Yes	% No
014	1	2		
015	-	2		
016	2	-		
017	-	3		
018	2	-		
019	3	-		
020	4	-		
021	2	2		
022	2	1		
023	3	1		
024	2	1		

Location Batticaloa	Yes	No	% Yes	% No
025	1	2		
026	2	-		
027	3	-		
Total 41	**27**	**14**	**66%**	**34%**

From Total Number - interviewed: Yes, we know about the MSGs

Trincomalee

Yes - 40% of those interviewed in the selected MSG areas in Trinco - we know the MSG

No - 60% - we do not know of any such group

Batticaloa

Yes - 66% of those interviewed in the selected MSG areas in Batti - we know the MSG

No - 34% - we do not know of any such group

Of the total number of 76 community members interviewed from both Districts in the East; Those who knew of the MSGs was 14/76 in Trincomalee, amounting to 18% of the total and those who knew of the MSGs was 27/76 in Batticaloa amounting to 35% of the total. This is exactly double that of Trincomalee.

When the community who answered as "yes, we know about the MSGs" were questioned on what the MSGs did, the top 4 answers are given under dissemination of messages section ©

Table 18: Feedback from community on MSGs' work (CM = Community Member) - Mullaitivu

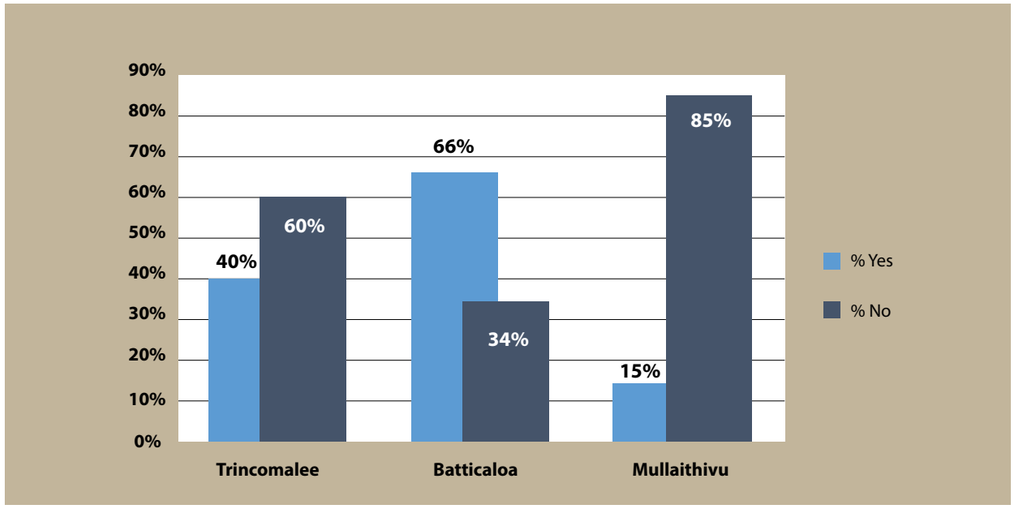
Location Mullaithivu	Yes	No	% Yes	% No
1	-	4	-	
2	-	3		
3	-	3		
4	1	1		
5	-	-		
6	1	-		

Location Mullaithivu	Yes	No	% Yes	% No
Total	**2**	**11**	**15%**	**85%**

Table 19: Feedback from community on MSGs' work (CM = Community Member) - Vavuniya

Location Vavuniya North	Yes	No	% Yes	% No
7	-	-		
8	2	-		
9	-	2		
10	-	-		
11	-	-		
12	1	-		
Total	3	2	Numbers are too small to interpret through % within the District.	

Fig 4: Feedback from community on MSG work overall



As a total in the North out of 28 community members 5 or 18% have said yes, they know about the MSGs. 82% do not know.

C) Dissemination of simple key messages on maternal & child health and nutrition in the community.

As related by the community who said, yes, the MSG members visit us

C.1) They inform us about the dates of the clinics and weighing posts

C.2) They visit our homes and advise us to eat properly. On probing it could be ascertained that messages were given mainly on exclusive breast feeding, being compliant in consuming the supplements given to pregnant mothers, on vaccinating children at the correct time, and feeding children "properly", especially those who were below the optimum growth line. The mothers and community members could not define "properly" with any specific answers. Some stated that vegetables and green leaves should be given, some stated the word "protein".

C.3) They talk to us about the cleanliness of the garden, toilet and house. The other message was on washing hands after using the toilet.

D) Cooking demonstrations

These have mainly taken place where the World Vision Hearth Program is implemented. Of the areas visited the Hearth Program is implemented in 3 out of the 5 MOH Divisions where the MSG review was done in Batticaloa and 2 out of 5 Divisions in Trincomalee. Participants in 1 out of 6 Focus Group Discussions mentioned that, as they were assisting with duties at PHM clinics, they were part of the HEARTH cooking demonstrations. The demonstrations continued for 7 days and were comprehensive. None of the MSGs mentioned that they were doing demonstrations of their own accord nor were they assisting the demonstrations carried out by PHMs. The questions on activities of MSGs were asked as open ended, where they could freely explain what they were doing. None of the MOH staff mentioned the fact that MSGs were conducting cooking demonstrations.

E) Home visits to identify high-risk children

The main approach used by 75% of MSGs participating in the FGDs in the East, has been to allocate 5 houses in close proximity to the particular member to look after the nutritional and health wellbeing of the whole household. These households most often have children under 5 or a pregnant/lactating mother, but are not targeted mandatorily. The North does not practice the allocation of 5 houses. Only one MSG in the East - Batticaloa, had a member looking after 50 households each, obvious not necessarily with a young child nor pregnant nor lactating mother.

Out of 25 FGDs in the East only 2 gave feedback on purposively selecting households with at risk mothers or children under 5 years.

For purposes of nutrition improvement, at risk children or mothers to be visited are allocated by the PHM. According to the feedback received during FGDs it is very rare for MSG members to identify the nutritionally at risk except for instances where unwed teenage or older mothers have been brought to the attention of the PHM. A few instances were mentioned where malnourished children were identified and followed up. But these were not more than two or three instances.

In both the North and East **other** risks have been identified by the MSG members. These are unwed mothers, alcoholism in the household, a few of the many incidents of DV, vulnerability of FHH and child abuse. In the North, 5 out of 12 FGDs provided insights into these risks that they had identified.

F) Discussions with mothers to improve feeding practices and share knowledge

The main approach to communication seemed to be more one way and prescriptive, rather than two way discussions. In fact there did not seem to be a creation of a platform for exchange of information. MSG members who had duties at weighing posts and clinics were helping in the essential functions rather than on educating mothers or even helping with these sessions.

G) Sharing success of other children with mothers

This did not reflect in any of the FGDs, even though it may have happened in a rather informal way.

3.3.1.5 Enhanced community monitoring

During the time of the review, most of the MSGs were nonfunctional as the nutrition project where formation and guidance of MSGs, were one of the activities of the NGO partnerships had ceased. Table Nos 15 to 18, above, serve as evidence of the degree of field visits carried out by the MSGs. From the Tables it can be gathered that the intensity of field visits were very low. Some of the basic activities for monitoring such as the list of targeted families, mothers and children were not maintained by any one of the MSGs covered under the review, nor were there records of numbers of children malnourished and the degree of malnutrition under each indicator of stunting, wasting and underweight. Therefore it cannot be concluded that community monitoring had been enhanced.

3.4 OBJECTIVE NO 2 OF THE REVIEW: MANAGEMENT AND FUNCTION OF MSGS

3.4.1 Mechanism of forming MSGs

In general the PHM together with field staff of the partner organizations have conducted meetings at village level and introduced the concept of the MSG. Thereafter formation of the group has been;

a) as suggested or directed by the PHM and/or field health staff of the partner organization

b) volunteering by the females of the community.

c) selected by the community at a gathering convened by the PHM

Table 20: Eastern Province: The method of co-opting members for MSGs

	Trincomalee no of MSGs and (%) of District total	Batticaloa no of MSGs and (%)	Total No
as suggested or directed by the PHM and/or field health staff of the partner organization	16 (76%)	5 (33%)	22
volunteering by the females of the community	5 (24%)	6 (40%)	11
selected by the community at a gathering convened by the PHM	None	2 (13.5%)	2
Missing Data	None	2 (13.5%)	2

Table 21: Northern Province: The method of co-opting members for MSGs

	Vavuniya no of MSGs and (%) of District total	Mullaitivu no of MSGs and (%)	Total No
as suggested or directed by the PHM and/or field health staff of the partner organization	-	-	-
volunteering by the females of the community	6 (100%)	6 (100%)	12
selected by the community at a gathering convened by the PHM	-	-	-

There seems to be a greater degree of self mobilization on the part of the women of the community in Batticaloa compared to Trincomalee where PHM driven selections were 76% in Trincomalee compared to Batticaloa which is 33%.

Out of 37 FGDs, in 11 it transpired that women came forward voluntarily. This amounts to 30.5 % where groups were formed by volunteering. Of these in Batticaloa, 40% were formed voluntarily compared to Trinco which was only 24%. Advancing in the direction of participation, Batticaloa went further in selecting MSG members through community selection.

When asked about aspects of strengthening the MSGs, they were unanimous in requesting that

a) all the groups be registered as individual CBOs

b) a generic constitution be formulated and

c) that all members have an identity card.

3.4.2 Leadership and proceedings – appointment of office bearers, conduct of meeting, maintaining records and planning of activities.

3.4.2.1 The appointment of office bearers:

The positions of office bearers is not uniform across all the MSGs. The only constant is the appointment of the President. In certain groups there are all 4 positions of President, Vice president, Secretary and Treasurer. In others there are two or three positions into which appointments have been made. There is no obvious function for a Treasurer as the MSGs do not possess bank accounts.

Appointments have been by selection and not election. Selection has been through various modes. In certain instances the group has assessed capability, leadership qualities, skills, availability of times and experience and selected the office bearers. In some cases the PHM has handpicked office bearers. Yet in other instances Field Health Workers and Health volunteers have helped in selection.

3.4.2.2 Conduct of meetings:

Meetings seemed regular at the early stages, being conducted once a month. In the recent past regularity seems to have waned somewhat in line with the "project mentality" and withdrawing of partner organizations' field staff who guided these groups. This questions sustainability of approaches, if the groups disintegrate upon the withdrawal of the "anchoring "partner organizations and the support of development agencies.

3.4.2.3 Recording of proceedings:

The availability of Agenda and Minutes

Not a single Agenda could be seen in the minute books. Very few minute books were produced. These showed the recording of very scanty minutes, which did not reflect much follow up nor planning.

Availability of data regarding target groups

The MSG members did not have a register of targeted persons/families – under 5s, pregnant and lactating women, households with social issues etc. Therefore the efficient use of their time could not be seen as targeting of activities at those who needed assistance, would have been much better. Maintaining name and household lists as well as village maps with households of such populations would have been most useful.

Planning

The members have not been trained on problem analysis and long term planning. Though this was not part of the mandate of the MSGs which were set up mainly to provide auxiliary services in order to assist PHMs, planning ability would enhance development activities which are generated and driven by the community according to their own identification of needs.

3.4.3 Turnover of members of the MSG

Turnover is defined as the number of members dropping out of the groups. 100% = all 10 members dropping out and being replaced, 10 % = 1/10 dropping out and being replaced. If there is no replacement it is known as a "drop out".

The average turnover in Trincomalee is 10 %. Batticaloa is also – 10%. Therefore the average is 10 %. Reasons for the married and leaving the area, internal migration and external migration to work, the pressure of household duties.

3.4.4. Decision making and empowerment

During the course of the FGD the following question was asked:

"What is the biggest problem you solved collectively on behalf of your village? If the answer is yes, How did you do it?"

The members understood this question, more, as any issue they had resolved even at household level rather than one that was a common problem affecting the whole village eg: the lack of infrastructure or the lack of a weighing post that located far away. Their response ranged from individual health and social issues that they had referred to PHM such as

a) "3 members attended to a 1 and1/2 year old malnourished child. The child is 5 years now, and looks good"

b) "Located a pregnant, unmarried mother and referred to PHM"

c) "intervened in the case of DV of a pregnant mother by informing PHM – but DV is NOT a COMMON PROBLEM"

d) "Addressed 2 big issues related to child protection, obtained a birth certificate for 1 child, registered one marriage"

On probing they described social and health issues that were more common in the community and stated that

e) shramadana campaigns were conducted to prevent dengue

f) they had tried to assist women who had been abandoned by their husbands to the best of their ability. Abandonment was a common social issue.

Their answers to the question " **On your own initiative have you approached other entities like Govi Jana Kendra, WV or 3 CD to get support for livelihood or any such project?"**

No other entities which assist with development activities have been approached except for 3 groups who have met with;

a) a local MP regarding quality of water in wells and

b) an agriculture extension officer to request an agro well.

It was mentioned earlier that MSG members have not been trained in analyzing problems, prioritization and resolving issues in a systematic way. However upon discussion they seemed to understand the different dimensions of issues from individual to common social, economic and problems of infrastructure.

In the absence of comprehensive recording of minutes it was not easy to ascertain how and what decisions were taken. It was possible to glean through the various discussions that even small decisions are generally made with the guidance and suggestion of the PHM or field staff.

Even though members in a majority of discussions stated that husbands were supportive, their limited time on MSG duties had to be spent after completing all the household chores. There was even one instance where husbands had asked them why they were volunteering for unpaid work. Therefore it can be inferred that male domination within the home is the determining factor on women spending time on these kinds of activities. These dynamics would definitely prevent the empowerment of women and their decision making ability both at and individual and household level. Since DV also seemed to be an issue in these areas, it can be speculated that this fear also would obstruct the freedom of these women to give of their best to the activities of the MSG.

Table 22: Knowledge of Nutrition among women's groups in the East

Village Name/No	Score/110 marks
Trincomalee	
001Echch/Illangathurai/Muhaththuwaram	70
002Echch/Valaithottam - 216 B	70
003Echch/Mavadichenai/Mavadichenai	50

Village Name/No	Score/110 marks
Trincomalee	
004Echch/ /Poonagar	60
005/Kinniya/Periyakinniya (2185/01,2283)	90
006/Kinniya/Soorangal)PHM2185/18	90
007/Kinniya/Mahamar(PHM area 2185/17)	90
008/Serunuwara/Thanganagar	40
009/Muttur/Periyapalam	40
010/Gomarankadawela/ Group 01 – Mahadivulwewa (Stage 1) Group 02 – Rotawewa Group 03 – Swarnajayanthipura Group 04 – Nochchikulama	Combined groups 85
011/Muttur/Patalipuram	90
012/Muttur/Santhosapuram	No time to assess
013/Gomarankadawela/Morawewa	90
Average Marks – Trincomalee	**66%**
Batticaloa	
014/Eravur/193 A	80
015/Eravur/Michnagar	55
016/Chenkalady/Pandukavuly	75
017/Vellavely/Thumpankerny – Suravanayadiyuttu	55
018/Paddipalai/Mahiladitivu	70
019/Chenkalady/Arumugathankudiirippu	No time to assess
020/ Vellavely/Kovilpoorativu	No time to assess
021/Paddipalai/Munaikadu	No time to assess
022/Chenkalady/Saukady	80
023/Vellavely/Vellavelly	60
024/Paddipalai/Bandariavelly	80
025/Vavunathivu/Koththiyapulai	70
Average Marks – Batticaloa	**63%**
Average Marks for East	**65%**

Empowerment of MSG members and women as a whole needs a lot of facilitation and mentoring. Speculative reasoning and observations will be included under cross cutting themes as to why this situation exists.

3.4.5 Capacity of members (group evaluation of knowledge, training received and community mobilization capability)

3.4.5.1 Group evaluation of knowledge:

As described above a self evaluation tool was used with questions relevant to the knowledge required for the work of the MSG. This was answered by the groups that participated in the FGD.

Table 23 : Knowledge of Nutrition among women's groups in the North

Village Name/No	Score/110
Mullaitivu	
026. Paninkankulam	60
027. Kathsilaimadu	70
028. Periyasalamban	60
029. Olumadu	70
030. Chinnasalamban	70
031.18 Acrc MC	90
Average Marks Mullaitivu	**64%**
Vavuniya North	
032.Pattikudirippu	60
033.Velankulam – Kulavisuddan	80
034. Nainamadu	70
035.Sinnadampan	-
036. Nedunkenai	70
037 Thanduwan – Othiyamai	70
Average Marks Vavuniya	**64%**
Average North	**64%**

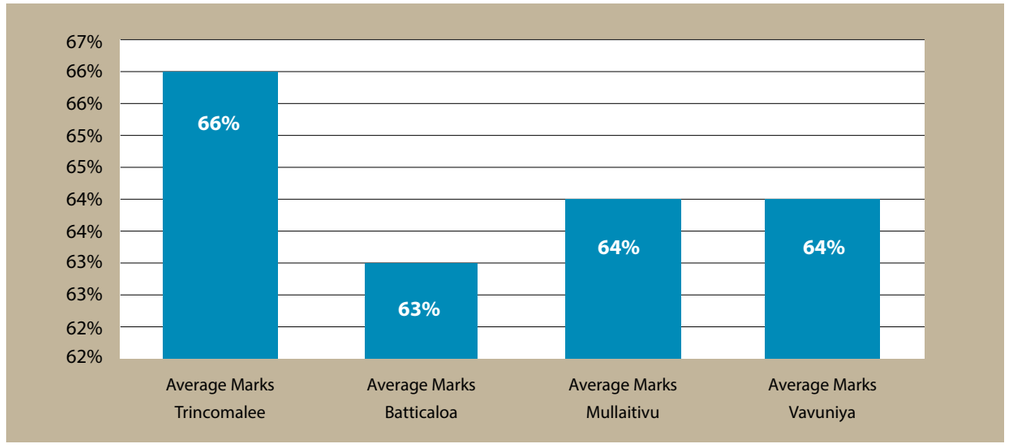
The scores from all 4 Districts are almost the same. This is a relatively good indicator therefore to assess the quality and content of training received by MSGs as a whole.

When considering the distribution of correct answers the set of questions on breast feeding were answered correctly by all groups except the time period within which the new born should be first put to the breast, 90% knew the different supplements given during pregnancy, but very few could tell the use of the supplements. 80% were aware of the birth weight of the infant and approximate range of weight gain during pregnancy. However none were aware of the reason for testing for anaemia during pregnancy.

While all the groups were aware that CF should commence upon the completion of 6 months or 180 days, none could provide the correct information on the parameters of CF - quantity, quality, frequency and consistency as a set of information.

The findings of this assessment of knowledge is a good verification on the type of messages that had been conveyed to the community as mentioned under section 2.3.1.4. The messages provided to the community had been very broad, based on the knowledge they had acquired through association with the clinics and weighing posts, rather than the knowledge based on training as only few members of MSGs had been provided with training by NGO partners and the MOH Offices in the respective areas.

Fig 5: Knowledge of Nutrition among MSG members



3.4.5.2 Capacity building of MSG members

The Question that was asked " If training had been received, if so in what areas did they receive training and if capacity development should be done through the public health system?, in what areas." Answers to these:

Table 24: Summary of Capacity Building of MSG members in each of the 4 Districts

	Training received - Topics/ areas	Received by	Training requested in the future	Mainstreaming the capacity development trainings through the public health system.	Comments
Batticaloa	Topics: BF, CF, vaccination, nutrition.	7 trainings of one hour each. All group members have received training	Same topics again as well as Family Planning, more on pregnancy related nutrition, more on other aspects of child care in addition to health and nutrition.	Yes, through the public health system as well as other organizations and resource persons.	Training is not uniform and not targeted to all members.
Trincomalee	One set of MSGs had been given training on Topics: BF, SF, teenage pregnancies, vaccination, child protection, home economics by the NGO partner in Trincomalee in this project, 3CD. Another set of trainings on nutrition, leadership, family planning, child abuse, DV have been given by Sarvodaya. This was reported only at 1 FGD	Mainly office bearers: Some for 4 x 2hr sessions Some for3 whole days. In one Division Viluthu has given nutrition and food security training.	More details required on the same topics that they were trained on as well as planning and managing small organizations and DV and prevention of child abuse.. All members should be trained not only office bearers.		
Vavuniya North	All six MSGs reviewed had received training Topics: Breast Feeding. CF, Hygiene, Pesticide usage, DV, Communication skills	In all six MSGs reviewed, only two or 3 members in a group	All MCH subjects including nutrition, family planning, prevention of child abuse, home gardening, DV, leadership	All 6 groups said yes.	
Mullaitivu	All 6 MSGs reviewed had received training **Topics:** 3/6 could not remember 3/6 remembered: Food and Nutrition (not specific), importance and types of vaccination, Hygiene, use of pesticides, counselling, DV, child abuse, family planning (1 group had received training)	3 groups – some members only 1 group – 5 members 1 group – 2 members 1 group – majority of members	All MCH related subjects including child care, first aid, how to write minutes, counselling	All 6 groups said yes	Requested substance abuse training for men. Coverage of persons trained not stream lined.

3 CD, the partner in Trincomalee had provided training on a fairly large range of topics. Nevertheless, it is obvious from the self evaluation that MSG members did not have adequate knowledge, even to deliver messages to their target group to create basic awareness. Therefore to develop target communities in depth to change their behaviours, a considerable amount of indepth training would have to be done for MSG

members themselves. This is obvious when an analysis of the self evaluation shows that basic messages are known under certain topics, but the reasoning behind the message is not known.

3.4.5.3 Community mobilisation capability

The ability to physically mobilise the community at a very short moment's notice, is a strong aspect of all the MSGs.

The question asked in this regard is" how long would it take for you to get 25 to 50 people to one place during an emergency or some quick activity?

40% of members said that they could get people to one common area within 1 hour. 60% stated that they could do so within 1/2 hour or even less. This is a very strong aspect in the day to day functioning of the MSG, which could be utilised for the development of the community and the surroundings. However meaningful mobilization is when a community can be moved to take decisions and act on them. This is only seen in a few instances.

3.4.5.4 Facilitation by NGO partners

It was evident that one NGO partner – 3CD has done fairly systematic training for MSGs in Trincomalee, even though it had been mainly for office bearers. This training had been done in collaboration with the MOH office and covered a range of topics, though it had been not at depth. In the North too some amount of training had been done by the MOMCH. In the North there was no trace of the MSGs formed with WB support. However the TORs of the NGO partners were not clear and there had been no systematic monitoring, nor guidance in management aspects such as record keeping of minutes, formulating agenda nor were the lists of beneficiaries and duties monitored. SEDO also had done some training and more close supervision which seems to have resulted in the performance of MSGs in Batticaloa being somewhat better.

3.5 ASSESSING THE EXTERNAL RELATIONS OF THE MSGs (ASSESSED AGAINST THE TWO PARAMETERS DESCRIBED BELOW)

3.5.1 The ability to communicate with stakeholders in development

The question that was asked – "On your own initiative have you approached other entities like Govi Jana Kendra, WV or 3 CD to get support for livelihood, or any such project?"

In the East, of the 25 FGDs held, only 2 MSGs participating in FGDs had approached any other organizations. One group had approached WV, another had connected with Divineguma. The group had approached WV for an individual matter of a child and not for a project. Divineguma had really been approached individually.

In the North not a single MSG had approached another organization of their own volition.

There may be several reasons for this situation in both provinces. This is in despite of the burning need for accessing livelihoods, as income generation was very poor especially among females. One reason could be that the MSGs had a very narrow focus , when they were started. The fact that they were not yet trained on problem analysis and decision making, the lack of information on the different partners and what they have on offer could be some of these reasons.

3.5.2 MSGs perception about what the community feels towards them

Table 25 : MSG perception about what community feel towards them in the Northern Province

Northern Province	
Village	**Response**
01. Paninkankulam	Moderate
02. Kathsilaimadu	Good
03. Periyasalamban	Moderate
04. Olumadu	moderate
05. Chinnasalamban	Low
06. 18 Acrc MC	moderate
07.Pattikudirippu	moderate
08.Velankulam – Kulavisuddan	moderate
09. Nainamadu	moderate
10.Sinnadampan	Low
11. Nedunkenai	Low
12. Thanduwan – othiyamai	Moderate
Total	**3 low, 8 moderate, 1 good**

Moderate is an indication that the MSG either feels there should be improvement in the degree and quality of serving the community, low means drastic improvement is necessary and good means that they are relatively satisfied. This can be confirmed against the community verification, where in Mullaitivu the

community stated that 85% of MSGs do not serve them, as 10 out of 11 groups have said that they should improve.

Table 26 : MSG perception about what community feel towards them in the Eastern Province

Eastern Province	
Village	**Response**
001Echch/Illangathurai/Muhaththuwaram	Moderate
002Echch/Valaithottam 216 B	Moderate
003Echch/Mavadichenai/Mavadichenai	Good
004Echch/ /Poonagar	Good
005/Kinniya/Periyakinniya (2185/01,2283)	Moderate
006/Kinniya/Soorangal)PHM2185/18)	Moderate
007/Kinniya/Mahamar(PHM area 2185/17)	Moderate
008/Serunuwara/Thanganagar	Moderate
009/Muttur/Periyapalam	Good
010/Gomarankadawela/ Group 01 – Mahadivulwewa (Stage 1) Group 02 – Rotawewa Group 03 – Swarnajayanthipura Group 04 – Nochchikulama	Good
011/Muttur/Patalipuram PHM handpicked active community members	Low
012/Muttur/Santhosapuram	Moderate
013/Gomarankadawela/Morawewa Batticaloa	Low
014/Eravur/193 A	Moderate
015/Eravur/Michnagar	Good
016/Chenkalady/Pandukavuly	Good
017/Vellavely/Thumpankerny – Suravanayadiyuttu	Moderate
018/Paddipalai/Mahiladitivu	Good
019/Chenkalady/Arumugathankudiirippu	Moderate
020/ Vellavely/Kovilpoorativu	Good

Eastern Province	
Village	**Response**
021/Paddipalai/Munaikadu Munaikadu West Munaikadu South	Moderate
022/Chenkalady/Saukady	Moderate
023/Vellavely/Vellavelly	Moderate
024/Paddipalai/Bandariavelly	Good
025/Vavunathivu/Koththiyapulai	Moderate
026/Vavunathivu/Aaithiyamallai North	Good
Total	**Good - 10 Moderate – 14** **Low – 2**

Perceptions are more positive on the part of the MSGs of the East, based on the manner they have served the community. Even though perceptional assessments have their limitations, these scores are a relatively good assessment of how people feel about their performance. The community verification of the MSGs work in the East matches quite well with this scoring of perception, where the average in both Batticaloa and Trincomalee is approximately 50%. The positive perception of the MSGs is 10/26 = 39%.

CHAPTER 4

SOCIAL FACTORS LIMITING THE PERFORMANCE OF THE MSGs AND THEIR IMPACT

It is well understood that the generic factors outlined below hamper various development programs. When considering the specific socio economic observations in the areas where the review was conducted it is clear that more indepth analysis is required to quantify reasons for this situation if the correct solutions are to be activated. Below are observations only.

4.1 DOMESTIC VIOLENCE

Domestic Violence was reported to be very common in the study areas but was only disclosed after much probing. This could be due to Focus Group Discussion respondents themselves being in denial or trivializing the issue of DV in the community as this is a common problem faced by a majority of women. Despite large numbers of women encountering Domestic Violence in the study area, the participants had did not perceive the resultant economic deprivation and psychological aspects to be negative factor. This also holds true for the perceptions of PHMs regarding DV. These attitudes are held despite several of these respondents receiving training and awareness on DV provided by Sarvodaya, World Vision, and others.

On inquiring as to how they respond to such detected cases, the respondents stated that these cases were very often reported to the PHM by MSG group members. The SPHM of Kinnya, PHMs attached to Eechalampathu, Morawewa and Nedunkerny confirmed this and stated many DV victims seek their services as they are the primary care providers. Also there are no other nongovernmental service providers to refer such cases to the respondents said. They further said that the PHM is not adequately equipped with necessary skills and knowledge on counseling to address DV and manage the cases properly. It was further reported that even when such cases are brought to their attention and although they intervene no follow up and data management are done due to time and resource constraints.

Even pregnant women were reported to be victims of DV. Physical abuse during the pregnancy can result in pre-term delivery, low birth weight, birth defects, miscarriage, and fetal death. () In one case, a woman's husband had destroyed the clinic card and the PHM had to seek redress from the Police. According to the SPHM, Perriyakinnya the MOH Division of Kinnya is one of the areas where DV is highly prevalent.

The members of MSGs in the Muslim areas themselves stated that verbal abusive and tight controls are more common than physical violence. In these areas, women were reported to be housebound as their partners were said to be controlling the mobility of these women. As a result these Muslim women are deprived access to training on livelihood projects and from actually engaging in any income generating activity outside their homes. This also hampers them from participating in activities such as MSGs.

Both group members and PHMs are of the view that alcohol and drug use cause domestic violence. This attitude is held amongst PHMs and women in the MSGs despite receiving training on DV. It should be noted that, although alcohol and drug use do not cause DV, the risk of victim injury increases if a batterer is using alcohol or drugs.

4.2 TEENAGE PREGNANCY AND EARLY MARRIAGE

The teenage pregnancy rate was reported to be high by both MSG respondents and PHMs in all study areas. Particularly high rates are in Santhosapuram and Patalipuram Grama Sevaka areas in Muttur DS There was one MSG member from Santhosapuram who was a teenage pregnant mother with low BMI. In Mulathivu and Vavuniya a high number of teenage pregnancy was reported from Sinnadampan, Nedunkenai and Thanduwan (according to PHMs)

The high rate of teenage pregnancy was attributed to several factors including:

- The absence of the teenagers' own parents who have sought employment elsewhere due to poverty. Due to unavailability of remunerative economic activities locally, many mothers migrate to the Middle Eastern countries to work as domestic servants;
- High number of fathers too migrate to urban cities within the country and to foreign courtiers seeking employment mainly Qatar.
- There is considerable number of widowed mothers in the study areas due to the war. These widows are vulnerable and not in a position to provide protection and guidance to their teenage daughters and prefer to give their daughters in marriage at an early age for economic security;
- Teenage girls dropping out of school in order to help at home due to poverty;
- Teenage girls engaging in irresponsible sexual activity in casual affairs with equally irresponsible partners who most often desert them.
- The high presence of civil security forces, engaging in casual affairs with teenage girls in the villages;
- The mushrooming of video parlors in the villages selling pornographic videos which are easily assessable to young children and teens; as well as the media emphasis on sex-appeal and the portrayal of irresponsible lifestyles of promoting lustful, sexual behavior;
- Easily available home brewed alcohol in the villages.

The respondents' attitude towards such pregnancies and early sexual activity of teenagers was that of victim blaming stating that the mothers should be more protective of their teenage daughters. They also blamed the teenage mothers themselves for engaging in sexual misconduct and being sex crazy.

The respondents stated that very often it's the young mother and her family that has to deal with problems associated with such pregnancies as their male partners evade responsibilities.

PHM attached to Morawewa stated that they conducted programmes for school children to increase awareness of appropriate sexual conduct and healthy relationships. However such programmes are not encouraged and infrequent due to lack of resources. The PHM further stated that such programmes are mainly attended by girls and attendance of boys is poor. There was no attempt made to conduct sexuality education within the home environment due to negative attitude and social taboos with regard to sexuality and sex education.

4.3 MARGINALISATION OF UNWED MOTHERS

It was reported that unwed mothers were also detected by the respondents during their field visits. They were not registered as these mothers were hiding due to stigma attached to unwed mothers in the society. It should also be noted that for some women, especially for teenage mothers, their very pregnancy may itself be a form of abuse, having resulted from sexual assault, marital rape, or from the woman's inability to negotiate contraceptive use. The respondents stated that these detected cases were referred to the PHM. This information is more from word of mouth rather then detection through household visits.

4.4 FEMALE HEADED HOUSEHOLDS (FHHS) AND FEMALE MAINTAINED HOUSEHOLDS (FMHS)

Although FHHs and FMHs were high due to the war, there is an emerging new category of both FHHs and FMHs in the villages. It was reported that the number of children under five years of age who are living in these households has increased lately due to the high number of males migrating to other cities and abroad seeking more stable employment.

The unusually high rates of male migration were evident in all the Districts visited for this review.

This male migration trend is not seen in this intensity in the South.

Female maintained households are in existence mainly because of male migration. This is so, as the work available in Sri Lanka is not sufficient to live. However, during field interviews it was reported that though remittances are received these were not regular as these men were not given the salaries promised by the agents who recruited them, placing these households in an economically vulnerable state.

Therefore the fact that the participation of women from FHH and FMH being limited, both in the case being members of MSGs, as well as attending programs initiated by MSGs, should be taken into consideration.

Furthermore the increase in number of FHHs could create other social and health issues such as STD and HIV/AIDS. During the discussions some group members raised the issue of STDs and requested awareness on this topic.

4.5 HOUSEHOLD ECONOMIC HARDSHIPS AND LIVELIHOOD CRISIS

Improvement in nutrition and food security is severely hampered by a lack of income stemming from impaired livelihood. So if the root cause is not alleviated, nutrition awareness programs alone cannot address malnutrition. The logic behind including this section in the report therefore, is valid.

Income from participation in informal economy as daily wage labourers was stated to be the major source of income for both men and women in the study areas. Available work is physically demanding and very poorly remunerated. Their daily wage ranged from Rs 700 to Rs 1000 and work was not guaranteed daily. Poor public transport links are also obstacle to accessing employment in the nearby towns. This was especially stated by respondents in Patalipuram in the Trincomalee District.

Informal employment in the areas consisted mainly of daily agriculture workers (seasonal nature), hired labourers, street vendors, and many other low income types; as well as semi skilled self-employed three wheel drivers and masons, carpenters etc.

Several respondents' concerned was that even on completing their O/L or A/Ls, there was little by way of employment or opportunities accessing skills training.

The drought this year was said to be severe and accessing water in several villages was a burden for the women and girl children. The crops too were said to be severely affected thus impacting on their food security.

It was reported that many poor village households are recipients of "Samurdhi" welfare benefits and majority of MSG members were recipients as well. However, the moment a family member migrates his or her name is deleted from the recipient list and even if the migrant member returns prematurely the name is not included thereafter.

The paddy and vegetable farmers are not able to engage in profitable farming having to cope with drought and floods; and even in good years very often are burdened by debt.

Hence, the people in the areas are experiencing extreme economic hardships due to unavailability of formal employment which guarantees a permanent income. This economic instability and extreme poverty has forced young fathers to migrate abroad or to the other cities seeking permanent source of income for cheap labour.

It was observed that no remedial action has been taken to address livelihood and employment related issues by service providers.

The incidence of all these pressures is most acutely manifested in the lives of women especially that in childbearing age. They bear the full burden of these pressures while being subject to multiple exclusions and vulnerabilities.

4.6 CHILD HEADED FAMILIES

During field observations and interviews, the researchers came across a family headed by a girl child in kovilpoorative area in the Vellaveli Division. The seventeen year old girl had dropped out of school and was taking care of her four siblings; the youngest was just six years old. Their mother had migrated to Saudi Arabia and their father was an internal migrant working in Polonnaruwa.

There could be more such single parent families in these areas in which the children are not protected. The remaining parent could migrate or abandon the family. Abandonment by fathers was reported to be common in the villages so migration by women may have resulted in more child headed families.

It was reported that CRPO or the WDO do not visit the villages and the Village Child Rights Committees are not functioning in many of these study areas. Majority of MSG members were unaware of these two categories of State service providers and the GS too has not attempted to link these services.

4.7 SUBSTANCE ABUSE

High use of alcohol in the study areas was reported by all members of MSGs and PHMs. They stated that moonshine is easily available at low cost and many men consume alcohol. They justified this by saying that due to the nature of physical work the men are engaged in; boredom and lack of entertainment in the areas men consume ore alcohol. Other forms of drug use were reported in Muslim areas by the PHMs. The respondents strongly believe that this was the root cause for DV and other violence in their areas.

Being housebound due to incapacitation and lack of leisure were reported to be reasons for consuming high levels of alcohol on daily basis.

Some NGOs working in the areas have attempted to address the issue by providing awareness on substance abuse but this was not adequate the women said.

The reasons given for not seeking counseling for substance abuse were reported to be lack of time and geographical isolation, non availability of counselors, lack of public transport in the villages, lack of knowledge, denial, trivialization and embarrassment.

4.8 RELIGIOUS AND TRADITIONAL PRACTICES REGARDING MATERNAL HEALTH

The two dominant ethnic groups in the study area were mainly Tamil and Muslims and it was observed that religion and cultural practices play an important role in the lives of women in these communities with regard to their reproductive health.

Few constraining factors were reported by the respondents in the Muslim areas which were confirmed by the PHM as well. It was stated that Muslim women follow a practice of remaining in the house for 45 days following a birth of a child. Therefore they do not seek MOH services during this period and depend on the group members to bring private female medical practitioners home.

Also with regard to detection of early pregnancy (before 8 weeks), it was stated that such questions cannot be asked of Muslim newlywed mothers due to cultural reasons.

Some group members belonging to Tamil areas stressed that they avoid visiting homes where there are mothers who have delivered due to the belief that such women were considered to be 'impure'. These women said that they are cannot enter the Kovil if they do visit such homes.

CHAPTER 5

CONCLUSION

5.1 ACHIEVEMENT OF CORE OBJECTIVES

- The team of consultants are satisfied that the review covered 57 MSGs out of a total of 269 MSGs within a short time span. This is equal to 21% of the total number of MSGs set up under this program and has exceeded the target coverage of 15 to 20%. 39 FGDs were held with the MSGs. In addition 3 FGDs were held with MOH staff.
- There is no doubt that MSGs are a positive community development entity especially in remote settings such as the rural dry zone of the North and East. Even though there has been no access to hard evidence (%) on achievements of the core objectives of increasing growth monitoring coverage of children under 5 years, early detection of pregnancies and reduction in anaemia among pregnant mothers, feedback through FGDs, both with the MSGs and the MOH staff suggests that there is improvement in the first two. Assessing if there is improvement in anaemia requires hard evidence of regular biochemical tests as this cannot be proven through qualitative research methods, such as FGDs. This has not been made available to the team of consultants.
- The lack of easy access to secondary data at the MOH level, means that MSG group members never see the immediate results of the work they do in the field. Secondary data needs to be disseminated, so that corrective action can be taken immediately by field teams including the PHM, MSGs and officers of other sectors in a multi sectoral approach. The lack of sex disaggregated data is also a problem.
- However the MSGs have been on a mode of service delivery, rather than empowered decision making and implementing a community participatory action plan. This is due to the fact that in the East the project was not designed with these greater objectives in mind. It is unclear as to how the MSGs were generated in the North and the original objectives for which they were intended.
- Most often members have been selected by the PHM, a few women have volunteered. There are only two instances where the members have been selected by the community. Office bearer positions are not consistent throughout the groups. Training has not been based on a particular curriculum and all members have not received training.
- The last core objective of setting up MSGs which is to enhance communication between service providers and the community has happened as far as delivery of messages on the dates of PHM clinics, weighing posts and shramadanas (community clean up campaigns) are concerned. With regard to messages on nutrition, education on breast feeding has been quite intensively done together with the delivery of broad nutrition messages on eating properly as well as on hygiene. However there is no evidence of technically correct, specific nutrition messages given in other stages of the life cycle, which includes the important area of complementary feeding. This is also somewhat reflected in the evaluation of knowledge on nutrition within the groups.

5.2 MANAGEMENT AND FUNCTION OF MSGs

- A considerable proportion of MSG members seem to think that some degree of improvement can be brought about by these kinds of groups. However the time available to members of MSGs for doing nutrition and health promotion work is limited. This is approximately one hour per day or 3 to 4 hours per week. They are also hampered by issues of existence and dynamics of family life in many ways. This results in limited mobility and issues of family harmony. A good insight to the situation of members is provided by the profiles of members done in the Eastern province.
- As mentioned above MSG members' capacity and current mandate is limited to imparting limited messaging on nutrition and assisting with the PHM clinics and weighing posts. The identification of nutritionally at risk mothers and children has also been confined to a few such cases. There seems to be no systematic approach of the 3 A approach of assess, analyse and act. Allocating 5 houses or different sections of the village for members to look after is not productive. At the moment very few MSGs allocate families according to risk of vulnerability. Some of the groups have been good at identifying social vulnerability and referred such cases to the relevant service providers.
- Training has been done mainly for office bearers. There is no evidence of casacade training to other members. Duration and topics of training do not seem to be uniform. Given the health, social and economic issues in these areas, confining training only to topics of basic health and nutrition will not have the desired outcome in addressing the social determinants of health. Reproductive health, GBV and livelihood issues as well as management of the group, leadership, problem analysis and maintaining records are very important and should be included in training. Management and leadership training as well as problem analysis will serve as a spring board of action for empowerment. The capacity in the health system to undertake the training of MSGs seems limited.
- Minutes of meetings have been maintained but none of the MSGs conduct meetings according to a planned Agenda. Very few MSGs have any sort of record (list) of their target families, mothers and children and there is no recorded follow up of progress.
- The data base of profiles of MSG members in the East is a useful activity that can be strengthened to have accurate information which is timely and part of a feedback loop on progress of members.ur

5.3 EXTERNAL RELATIONS OF THE MSGs

- The members seem to be known better by their own name, rather than as members of the MSG. These women are also members of other established village level organizations such as WRDS and Death Donation Society, Farmers' Societies and Women's Societies under Samurdhi or Sanasa.
- They seem to have excellent physical mobilization capability with the ability to convene members of the village community to a central place, within half to one hour. However their ability to mobilise these communities for longer term resolution of issues needs to be studied.

- They seem to be confident that their standing in the village ranges from moderate to good. However the lack of registration of the group as a CBO with a proper constitution, and not having an identity card as well as financial resources makes them lag behind other organizations such as WRDS. Communication with men on addressing these problems seem to happen at the MSG member's household , but not with the men of the targeted population and in the greater community.
- The outcome in 100% of the FGDs conducted was that the MSG needs to have actions on livelihood improvement. This is the best way of creating credibility and a sense of need for an MSG. Also the deep seated causes of malnutrition requires addressing quickly and in concert with other organizations.
- It was evident through the communication with villages that there is a need for such an organization, but the presence of members at field level, covering all the households who need their assistance needs much improvement.

5.4. MEETING THE DAC CRITERIA

Effectiveness: The MSGs have been effective (even though it cannot be proved yet with statistics) in forging a closer connection between service providers and target beneficiaries, even though this maybe for very basic activities. The attendance of mothers and children at clinics and weighing posts seems to have increased at least partly owing to the work of the MSGs. However total attribution of this only to MSGs seems difficult. Effectiveness does not go as far as empowering communities and internalizing the importance of nutrition at a higher level in the minds of the community.

Efficiency: It is difficult to comment on the results of the work of the MSGs in relation to the costs incurred through the EU- SEM project as the value of this component is not available. However the observation of the efficiency of the MSGs themselves, is that these groups are not utilized at optimum, with proper targeting to households that are at risk and need very close assistance. The groups can be much more efficiently utilized with proper training on resolving problems. It is also not contextual to expect total volunteerism from people who are economically very vulnerable. The first priority of such communities is to earn an income for daily existence.

Relevance: There is no doubt that there is a need for such groups as the PHM has a large amount of work. Also if a multisectoral approach needs to be activated to address root causes of malnutrition, these groups can work with all sectors in a participatory manner.

Sustainability: Some of the groups have already stopped their work as the "project" is finished. This was conveyed to the team during field visits. There also seems to be a lack of clarity on the role of the MOH offices in supervision, capacity building and with regard to the real vision for the MSGs in order to optimize their role. If the MSGs are to be sustainable a number of actions needs to completed, It is also worth considering the use of well established organizations already in existence that can be utilized to play this role. If the socio economic context is not reordered the members would not be able to participate in these activities.

CHAPTER

6

RECOMMENDATIONS

SHORT TERM			
Action	**By**	**When**	**Triggering action**
1. Undertake an analysis of secondary data on the achievement of mandated objectives of setting up the MSGs coverage (data on growth monitoring, increase in detection of pregnancy before 8 weeks and anaemia rates among pregnant mothers)	UNICEF sub offices assisted by UNICEF CO	31st January 2015	Confirm that MSGs have made some change Disseminate this among members of MSGs and commend them
2. Conduct a quick meeting between all stakeholders at field level including community and a few MSG members and confirm if they are prepared to continue with the MSGs or if it is better to use existing organizations such as WRDSs or Women Societies to carry out MSG duties.	MOH	Mid February 2015	**Confirm the way forward** and start on the actions hereafter.
3. Effective Capacity Building - Design or make use of existing manuals to formulate an effective, practical training program using participatory approaches for adult training with sound pre and post evaluation. Include all the related topics mentioned under conclusions. As part of the training include a module on village mapping and selecting at risk houses (A well-designed, sexual and reproductive health education program should be provided to young people both men and women. In addition, information on conflict resolution and communication skills should be included in the program) as well as on Behavior Change communication AS part of this NGO partners as well as MOH staff should be trained as TOTs.	UNICEF/HEB/ NGO partners	End March 2015	Pilot test with a few MSGs, make corrections
4. Capacity Building - Start retraining existing MSG members as well as new members if they agree to go forward.	Consultants and NGO partners/ MOH staff	Complete by 30th June 2015	Earmark TOTs from this training for future
5. Reorganize and streamline MSGs - Concurrently start registering these MSGs as CBOs. Design robust, simple, practical constitutions and provide ID cards to all members, print record books and minutes books, so that recording is a guided process. Set up a database on all aspects of MSGs including profiles, activities completed, changes in the community	DS Office together with MOH staff and Presidents of MSGs	Complete by 30th June 2015	Start planning process with MSGs

MEDIUM TERM			
Action	**By**	**When**	**Triggering action**
6. Nutrition and health improvement plans to be implemented using a multisectoral approach To support this complete rapid socio economic studies in all 4 Districts which will assist the addressing of root causes and design plans from centre to grassroots accordingly.	Nutrition Coordination Division and DS office to take the lead assisted by UNICEF sub offices and office bearers of MSGs and other grassroots organizations	By 31st August 2015	Plans and M and E framework to be implemented. M and E indicators for MSGs also should be included.
7. Design an evaluation scheme with rewards and recognition for MSGs and their members. Study tours can be part of the rewards.	UNICEF and Ministry of Health	By July 2015	This will be a trigger for intensive work by MSGs
LONG TERM			
Action	**By**	**When**	**Triggering action**
8. Evaluate the progress of all MSGs according to a systematic process and if success is shown a) multiply to other areas b) classify MSGs and certify standards. This will serve as a performance standard to which the MSGs that are not performing too can aspire.	UNICEF/Ministry of Health	2016 March	

CHAPTER 7

BEST PRACTICES AND LESSONS LEARNED

LESSONS LEARNED

1. NGO partners when used as facilitators for this kind of program, should have well thought out TORs and specific action plans with parameters for evaluation. Without these the implementation becomes rather vague and there is no systematic implementation.

2. Capacity building of MSGs should be indepth and systematic. Desired objectives and more could have been achieved if this was done. Also training only office bearers is detrimental as those persons do not have the capacity for doing TOT as they have not gone through a rigorous process of training. This training must have a practical food demonstration component that is creative and interesting.

3. A socio economic study and nutrition baseline should have been undertaken before setting up the MSGs. These could have been rapid studies.

4. In the socio economic backdrop of these MSGs, some sort of remuneration is necessary. Remuneration could be in kind. Evaluating and rewarding is essential to keep up the momentum.

BEST PRACTICES

1. Having an NGO partner to anchor and support the MSGs is prudent for sustainability. This should be continued, however with certain aspects modified as mentioned above under lessons learnt. There should also be open and consistent communication between the NGO partner and the MOH office.

2. The profiling of MSG members in a data base as has been done in the Eastern Province is very useful, provided the data is accurate, complete and current. It should be constantly updated.

3. Dividing the households of the villages between MSG members is a good system. But it has to be based on at risk households rather than covering all.

REVIEW OF THE FUNCTIONING AND IMPACT OF MOTHER SUPPORT GROUPS in Northern and Eastern Provinces of Sri Lanka

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Ministry of Health,
Nutrition and Indigenous medicine

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