INTEGRATED HEALTH AND MEDICAL SERVICES PROGRAMME IN MENIK FARM AND DISTRICTS OF VAVUNIYA AND JAFFNA

JUNE 2009 – JANUARY 2010

FUNDED BY

TISSA JINASENA FOUNDATION, SOLIDEAL LOADSTAR; MERCY MALAYSIA, AUSTRALIAN MEDICAL AID FOUNDATION, THE GOVERNMENT OF THE NETHERLANDS ; AND OFFER CEYLON

IMPLEMENTED BY

THE RELIEF AND REHABILITATION UNIT, CONSORTIUM OF HUMANITARIAN AGENCIES

SUPPORTED BY

THE MINISTRY OF HEALTH, SRI LANKA

8TH MARCH 2010

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A. Administrative Details

1.	**Programme Title**	**Integrated Health and medical services in Menik Farm; Eye clinics in Menik Farm and Jaffna**		
2.	**Project Starting Date**	May 2009	**Completion Date:**	January 2010
3.	**Project Goal**	To improve health care in Manic Farm for the recently displaced persons by supporting the Ministry of Health (MoH) with Primary Health Care centres (PHCs) and a Referral Centre		
4.	**Period of Report**	May 2009 - January 2010	**Date of Submission**	8th March 2010
5.	**Implementing Agency**	Consortium of Humanitarian Agencies (CHA) and Mercy Malaysia (MM)		
6.	**Donor Agency**	Mercy Malaysia (MM), Tissa Jinasena Foundation (TJF), The Australian Medical Aid Foundation (AMAF), and Solideal Loadstar (SL), Muslim Aid, Royal Netherlands Embassy, International Medical Health Organization (IMHO) and The United Methodist Committee on Relief (UMCOR)		
7.	**No. of Beneficiaries**[1]	Total approximate: 135,840	PHCs: 97,696 Eye Clinics: 3,144 Emergency Clinics: 35,000	
8.	**Geographical Areas**	Menik Farm Vavuniya		
9.	**Total project expenses**	Mercy Malaysia		LKR 9,604,354
		AMAF		LKR 4,042,548
		Offer Ceylon		LKR 1,962,539
		SLRT		LKR 14,310,291
		Muslim Aid		LKR 1,459,540
		Royal Netherlands Embassy		LKR 3,177,354
		IMHO		LKR 4,644,288
		UMCOR		LKR. 1,101,500
10.	**CHA contribution**	Staff time		LKR 2,161,256

		Overheads	LKR 3,180,000
11.	**Contact Person**	Programme Manager	Dhanya Ratnavale manager-reg-rehab@cha.lk

B. Needs and Justification

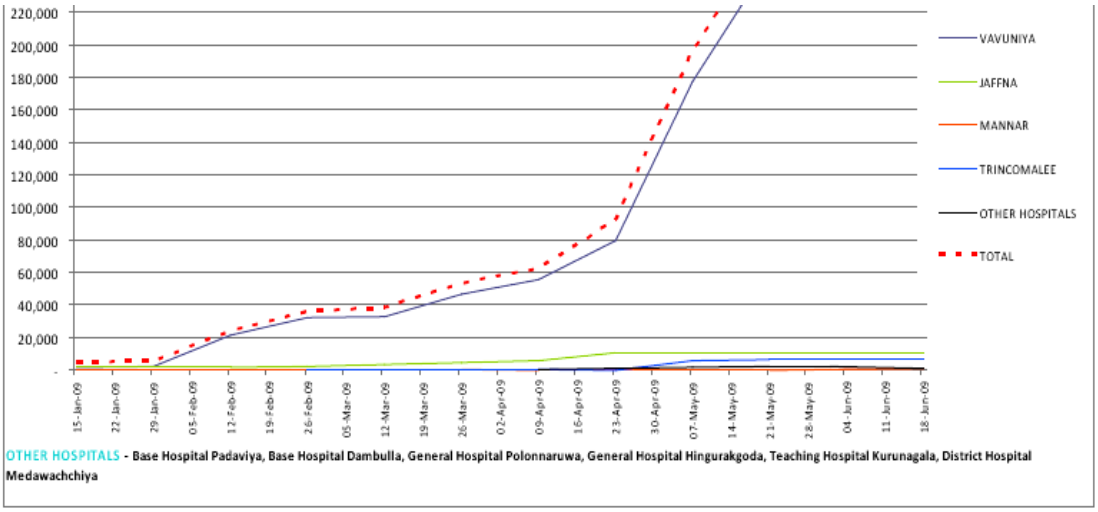
The final phase of the conflict directly affected the lives of over 300,000 persons, who had suffered multiple displacements and fled to Vavuniya, Jaffna and Trincomalee seeking refuge in Government controlled transitional camps in April and May 2009.

Vavuniya was identified as the location for most amounts of needs. The sudden arrival of thousands of Internally Displaced Persons (IDPs) created more needs for shelter, food, clean water, sanitation and medical care. Those who arrived at these camps had nothing but the cloths on their backs and have taken refuge in make shift tarpaulin shelters, which has left them particularly at risk for chickenpox, diarrhea, viral fever, sore eyes and coughs. Without adequate shelter, open defecation is widespread due to the lack of toilet facilities. Health officials have expressed concern at the likelihood of outbreaks of waterborne disease, unless conditions are improved, particularly with the prevailing weather. In addition many cases of malaria had been reported among the IDPs and authorities remain alert for possible additional disease outbreaks due to camps becoming overcrowded. The United Nations (UN) and other humanitarian agencies involved in health services in the Vanni have given warnings regarding the increased risk of water-borne and respiratory diseases with poor environmental health conditions.

A total of 282,380 people arrived at government controlled areas since October 2008. The numbers hosted by the North-eastern districts are as follows;

- Jaffna: 10,956
- Mannar: 225
- Trincomalee: 6,831
- Vavuniya: 260,000 in 12 schools and relief villages divided into zones[2]

According to UNOCHA reports on the initial situation in Vavuniya, about 26% of the total population in the camps was women of reproductive age urgently requiring basic hygiene care; Of this about 6,000 were pregnant[3]. On the 12th of June, 12,195 cases of chicken pox were recorded. However, the number of new cases were declining resulting in about 40-50 patients being admitted to hospitals. This applies to cases of Hepatitis A as well with the initial figure at 2,139.



The mission of the United Nations Office for the Coordination of Humanitarian Affairs (OCHA) is to mobilize and coordinate effective and principled humanitarian action in partnership with national and international actors.

Source: http://ochaonline.un.org/OchaLinkClick.aspx?link=ocha&docId=1111659

Meals were provided through communal cooking and some zones have individual cooking facilities. The system of the World Food Programme (WFP) rations and complementary items provided by agencies was not sustainable indefinitely. Coverage in terms of Food security requires a resolution on the issue of complementary food. Irregularities in food supply and having to queue in the scorching sun for food for hours makes it difficult or impossible for those who are sick, those with special needs, pregnant mothers and those with infants - to obtain adequate meals. Nutrition programmes are ongoing but cater to those under 6 years, the sick, the elderly requiring other special categories need to be included.

Health services continued to struggle to match manpower requirement and needs, in spite of considerable infrastructure support being provided by agencies both local and international. Each zone in keeping with the MOH health plan should have four primary health care

centres and one referral centre, each averaging care for about 8,000 - 10,000 people. But in actual practice they were not all operational due the lack of medical staff, doctors, proper medical surveillance and a system for early detection of emerging diseases – the latter which was an urgent requirement. Common diseases were hepatitis, diarrhea, chickenpox, dysentery and now meningitis and encephalitis. Being modest, on average the camp lost 10-15 people each day during the period of the program.

Food being the main necessity, the need for medical care closely followed involving minor illnesses to major injuries inflicted as a result of the conflict as well as disabilities etc. Another important aspect of medical care (or in the broader sense, general healthcare) which was not an 'immediate need' in the context of emergency situation was primary health care, which would be definitely a long term need for IDPs, who, in the given environment with lack of health conditions or proper facilities are more often than not susceptible to all types of contagious diseases and ill-health. Anticipating such an environment of health care facilities was deemed an important aspect of assistance.

The needs were overwhelming from food to medical care to housing and it was evident that the affected population was forced to restart their lives over again, for the time being in the IDP camps set up by the government in Menik Farm and basic facilities provided by the UN organizations and other International and Local Non Governmental Organizations (I/LNGO).

Thus the primary health care facilities set up intended to serve a purpose where basic health care needs are attended to in order to prevent outbreaks as best as possible and treated through basic tests and medication; also to ensure the wellbeing of pregnant mothers and others with specific ailments to ensure it did not worsen and to keep from contracting illnesses.

1. Objectives and Purpose

Overall goal: Provision of emergency health Triage facilities in Omanthai and Manic Farm with the provision of medical staff from Colombo . And IDPs in Menik Farm received medical assistance through integrated health and medical services provided by qualified staff recommended by the Ministry of Health (MoH) for a period of six months.

To serve the overall goal, the following objectives satisfy the different aspects of the program implemented;

Objective 1: Medical centres, specialized clinics and other related facilities are managed, staffed and equipped with required medical supplies

Objective 2: Medical staff's capacity built through treating patients and conducting health programs, work coordinated and logistic needs addressed in all centres

Objective 3: IDPs receive specific services from specialized clinics set up in the Primary Health Care centres such as health education and awareness, mental health programs through the empowerment of core groups

In addition to these, there have also been results of emergency camps conducted at the initial phase which did not come under the major programme as they had to be completed within weeks' time before the Menik Farm programme commenced. Six weeks of clinics were conducted in temporary tent facilities in Manic farm supported by doctors and medical staff sent from Colombo. Also, a hospital ward constructed in Chavakachcheri, Jaffna is also discussed as part of this health program, although it is not included in the above objectives since CHA was not involved in its direct implementation, but assumed a supervisory role and directed the relevant funds to the Regional Directorate of Health Services (RDHS).

2. Program Design and Implementation

2.1 Initial Phase: Emergency health clinics/camps

Emergency Heath Camp in Omanthai : During the massive displacement, needs for emergency medical intervention and first aid were identified by MOH and they had requested to provide the facilities and resources such as medicine to conduct the health camp in Omanthai. CHA provided assistances such as medicine and required materials for patients, accommodation and transportation for Health Professionals from MOH to facilitate the clinic at the exit location in Omanthai. Injured IDPs and badly affected people benefited by the camp which was conducted over a week.

Emergency Heath Clinic at Manic Farm: The Health Clinic commenced in a tent in Menik farm Zone 2 when the IDPs first started to occupy the welfare centers. In collaboration with Muslim Aid and UMCOR, CHA has run 6 medical clinics in a tent set up temporarily at Zone 2, block 31 from 1st May to 17th of June 2009.During the period, most of the patients were suffering from Diarrhoea, Fever, Cold, Cough, Itch, Chicken pox, Scabies, Hepatitis, and fungal infections. Large quantities of medicines and milk packets for malnourished children have been issued during the clinics. Around 35,000 people benefited from these clinics. Doctors were released by MOH and all necessary arrangements such as transportation and accommodation were provided by CHA.

2.1.1 Memorandum of Understanding (MoU) with the Ministry of Health (MoH)

An MOU with the MOH was signed in June enabling work in Menik farm of a more permanent nature. CHA agreed to provide two Primary Health Care units and assist in the running of the centres .

The Primary health care centres were funded by Solideal Loadstalk (SL) and Tissa Jinasena Foundation (TJF). The running of the centres were enabled through multiple donor funding, including SL, TJF , Mercy Malaysia, AMAF and Offer Ceylon.

2.2 Secondary Phase: Intergrated Health Services at Menik Farm

The Memorandum of Understanding (MoU) was signed in June 2009 between the Malaysian Medical Relief Society (Mercy Malaysia) and the Consortium of Humanitarian Agencies (CHA) to implement the Integrated Health and Medical Services Program in Menik Farm, designed based on the needs and requirements of the occupants of the camps at the time. The initial objectives as stated in the MoU (before being grouped as listed in Section 3) were to:

- Source registered national medical staffing including doctors, nurses, medical assistants and midwives to place on MoH roster.
- Medical coordination and capacity development.
- Supplement existing medical supplies provided by MOH for above mentioned centres.
- Logistics support for the MOH staff i.e.: transportation, accommodation and meals in Vavuniya and provision of internal mobile services.
- Hold specific clinics in collaborations with MOH – eye, dental, pediatric, Clinics – Antenatal, Postnatal, Well baby, Well women clinics ,
- Health education facilities, counseling service
- Provision of basic night staffing, for specified functions subject to discussion and requirements
- Collect and produce health surveillance, data and trend analysis.
- Providing basic laboratory testing,of which expected outputs were;

- Six centres managed and coordinated effectively to provide an extended service daily.
- Complimentary medical supplies provided in coordination with MoH.
- Logistics for staff and service support in six centres.
- Conducting of specialized clinics.
- Health workers utilized for extended services
- Trends analysed and services adopted to meet needs.
- Regular health, disease surveillance in coordination with WHO and MOH

2.2.1 Services and program activities

The following services were provided by the program categorized by the revised objectives as specified in Section 3;

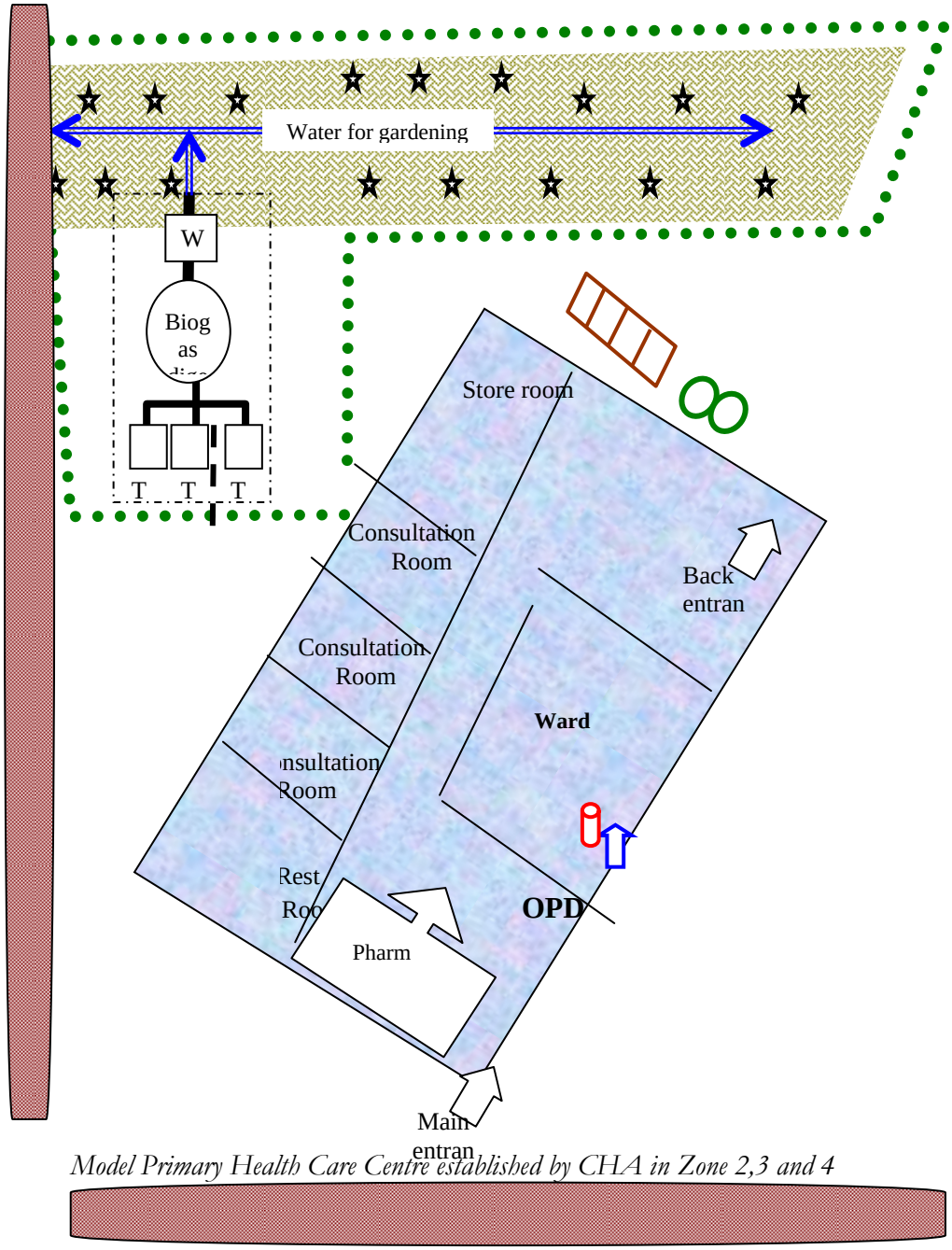
Objective 1: **Medical centres, specialized clinics and other related facilities are managed, staffed and equipped with required medical supplies**

Construction: For the establishment of primary health centers blocks were identified at the IDP locations in Manic Farm. MOU was signed with Ministry of Heath to establish Primary Health Centers at Zone 2, 3 and 4. The centers were to contain facilities such as consultation rooms, ward, pharmacy, and drug and equipment store room. Necessary furniture and equipment were provided at the primary health centers.

Initially six centers were constructed and maintained by CHA, of which three were taken over by Mercy Malaysia for operations from June 2009, whilst the other three were CHA's responsibility. Details of these centres are as follows;

PHC #	Location	Responsible organization	Special clinic type
1	Zone 2, Block 39	CHA	Eye, Heart
2	Zone 3, Block 10	Mercy Malaysia	-
3	Zone 3, Block 15	Mercy Malaysia	-
4	Zone 3, Block 23	CHA	Eye
5	Zone 3, Block 31	Mercy Malaysia	Eye, Heart / Referral hospital
6	Zone 4	CHA	Well woman and Child care

Note: Mercy Malaysia run 2 clinics in Zone 1, which were run by the MOH



Model Primary Health Care Centre established by CHA in Zone 2,3 and 4

: T1, T2: toilets for patients, T3: Toilet for Medical staff

W : Overflow water tank (suitable for gardening purposes)

: Water drainage

: Live fence (with *Glyricedia* or appropriate sp.)

: A set of two bins for degradable and non-degradable waste

: Mobile recyclable waste separation unit

: Needle burner

: Bin for Bio-Hazardous waste (dressings/ body removals)

: Land space for Gardening (water absorbing plants such as Banana)

: Eco-toilet system

Primary Health Care services: The three centres (with the exception of the referral hospital) were constructed by CHA, 2 by Mercy Malaysia in order to provide health facilities that diagnose curative and preventive prescriptions by qualified doctors. Each PHC was equipped with the necessary medical equipment for this purpose. A PHC consisted of 7 rooms, 2 of which were used for consultation, one for the administrator's occupation, another for pharmacy, another for storage facilities and two as wards. A general area was designated as the patient's waiting area where the numbers are kept track of by the administrator or other relevant staff. The wards usually consist of about 8-10 beds, which is usually kept to occupy weak patients for treatment whilst serious cases are referred to the referral hospital which is discussed separately. In addition, a sizeable verandah outside also serves as a patient waiting area when numbers are high

Laboratory and other tests: Equipments such as the Microscope, testing equipment etc. are available in the laboratory for performing necessary tests. Also, tests related to the special clinics for specific diagnoses are also performed. Examples of tests conducted including urine, blood and other tests discussed in later sections.

Medication: Medication prescribed by the doctor is available in the pharmacy within the same construction so that the patient will be able to simply walk across the room and obtain what they require. Though not all medication is available in these pharmacies, those required for common ailments seen among the patients is usually available.

Medicines were provided directly by CHA at the beginning stage; which was enabled with the financial contribution of donors. Donors such as UMCOR and Muslim Aid helped to provide medicine at this stage while Mercy Malaysia had been supporting for continuation of supply. Later on, MOH came to promises to provide basic necessary medicine from their store which has been done repeatedly up to now.

Referral hospital: Out of the six hospitals which are jointly facilitated by CHA and Mercy Malaysia, one was selected by MOH to run as referral Hospital which is in Zone 3 block 31. Large numbers of patients are being treated here and this has more beds to treat the patients at the ward. Generally, patients with major illnesses from other primary health centers in zone 3 were referred to this hospital for additional treatment. Lab facilities also were available in the referral hospital.

Objective 2: **Medical staff's capacity built through treating patients and conducting health programs, work coordinated and logistic needs addressed in all centres**

Staffing: Each PHC was staffed with an administrator, pharmacist, cleaner and translators, some of whom were employed from the camp itself. The doctors were, as per agreement with the Ministry of Health (MoH) were provided by same in a roster method where atleast about 2-3 doctors were available on a day on any given PHC. Also, as per agreement, the

doctors were provided with transport, accommodation and meals to enable them to provide their services with minimum hassle.

During the latter part of the program, since staff members reduced considerably due to the resettlement process (discussed in detail in section 5) nurses who were trained by CHA and NAITA under a different training program funded by JDC commenced work in the PHCs. Although many who commenced training left the program due to resettlement, about ten are remaining in the camps working in PHCs as their aim is to make nursing their profession.

Logistics for staff: Staff transport from Colombo to Vavuniya was taken up by the program initially, in addition to transport to and from the place of accommodation Menik Farm. At the initial stage, a group of doctors and support staff were released from the Colombo Hospitals by the ministry of Health to serve in the Menik Farm whilst transportation, meals and accommodation facilities were provided by CHA. A minimum of 6-10 resource personals traveled each week from Colombo to Vavuniya for this purpose. However, later on CHA provided transport only from Vavuniya to Menik farm and back. The MOH provided the human resources at Menik Farm itself. This took place from September 2009 onwards.

Accommodation for the doctors was provided at the fully furnished CHA Guest House in Vavuniya, where all facilities such as water and electricity were provided as well as regular meals thrice a day, all free of charge. The CHA guest house is a two-story house located in Vavuniya town and consists of 9 rooms (of which one is currently being used as a store room), 2 bathrooms, dining room, kitchen, large living rooms in the ground and first floor and a large verandah outside with a balcony on the first floor. A cook and a watchman were available on the premises around the clock.

Employment: Employment opportunities were provided for residents of the camps for the non-medical positions. A watcher in the PHC in Zone 2 has cultivated a small eggplant farm in the premises which he uses as a means of livelihood, which is a

good example of an unintended benefit of the program. As described earlier, currently the nurses are also of the displaced population who wait to return to their homes.

Objective 3: **IDPs receive specific services from specialized clinics set up in the Primary Health Care centres**

Special clinics: The following special clinics are being conducted in certain PHCs as described above. Note that the clinics are not so in the physical sense, but are held during specified periods of time in one of the PHCs.

Well woman and Childcare clinic: This was held once a week where prenatal, pregnant and antenatal women visit the centre as well as their children. Usually treatment is in the form of relevant tests such as Urine tests, Sean, HB tests, RBS, Albumin, Scans, Soc and family planning depo injections

Eye clinics: This programme was implemented in view of the urgent need for eye care for the people displaced from the war. Due to security restrictions IDPs were unable to leave the camps to get the care they need. Understanding the condition, Eric Rajapakse Optometrist willingly came forward to offer their services for the people in IDP camps whenever possible, in collaboration with CHA. This programme was funded by AMAF. All costs of Eric Rajapakse was supported under this program

Eye clinics were also been held outside the camps in Vavuniya and Jaffna districts, especially with a view of providing eyewear to schoolchildren. Details of beneficiaries are provided in the achievements and challenges section below.

Mental Health Programme: The psychosocial intervention programme took place 3 days a week. Interested volunteers, befrienders, counselors and therapists were invited from several local institutions and trained into a common intervention programme call "Help to heal". This programme is technically facilitated by Mental Health Unit of Vavuniya Hospital.

2.3 Other

Chavakachcheri Hospital Construction: The hospital construction project funded by AMAF was handed over to the hospital authorities following successful completion. This ward is currently implemented by the Hospital Development Society under the supervision of the RDHS of Jaffna.

The ward has about 33 beds, a pharmacy, staff toilets, patients' toilets, a storeroom and a panty. The nurses and the doctor in charge find the assistance provided very useful. They informed that the beds are usually sufficient for the patients who arrive for treatment.

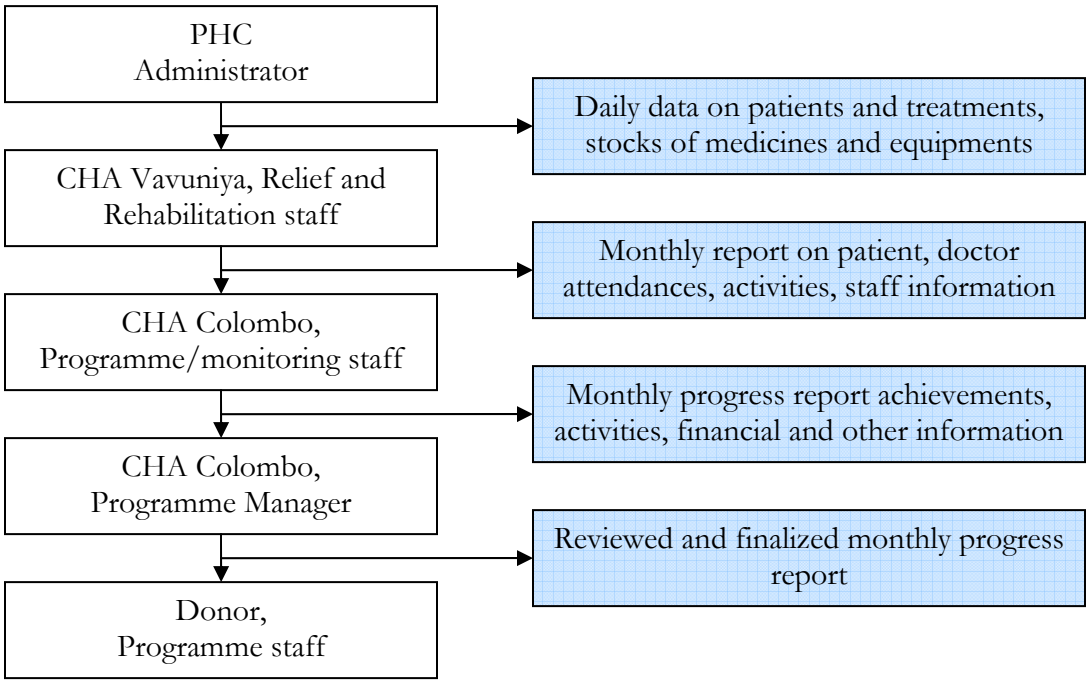
Their only problem is the staff shortage. There is a general shortage of medical staff in Jaffna, as also confirmed by the RDHS. The staff in the ward are employed on a rotational basis which would leave at least one nurse in charge of the ward at any given time. There is also a shortage of drugs and medicine but the ward seems to be managing with the limited resources for the time being. Apart from the nurses a cleaner is also employed to ensure the cleanliness of the ward.

3. Auditing and Reporting

The auditing and reporting requirements specified in the MoU with Mercy Malaysia are as follows, documents which the donors and CHA were to reflect and share;

1. Monthly narrative and financial reports
2. Copy of consolidated narrative report
3. Copy of the Annual Statements of Accounts audited by the CHA auditors

In line with these agreements and with CHA's own reporting purposes for monitoring activities, deriving feedback and lessons learnt, the flowing information reporting flow was implemented;



4. Monitoring and Evaluation

Monitoring and Evaluation was conducted through the setting up of the reporting structure shown above. This ensured that data was regularly collected (as regularly as an emergency

situation would allow) and used for compiling information which assured the program team that activities were progressing as planned. The use of monthly reporting formats (attached in annex C) ensured that monthly activities could be checked upon and feedback or checked back with the field for discrepancies on a regular basis, rather than awaiting the close-up of program. Further more, since the resettlement process began in mid-November, situations such as patient information changed rapidly which needed to be monitored, and where such monitoring tools came to be of use. Monitoring, however, was usually restricted to CHA-implemented PHCs.

A log frame was set up to provide a basis on which the programme would be measured, from which the goal and objectives described in Section 3 were derived. Each of these objectives has its own outputs which the programme must show as well as process indicators that measure such outputs. Outcome indicators have also been developed for each of the objectives as well as the goal which is measured by an impact indicator. Details of the logframe is provided in Annex B

Apart from monthly monitoring, a final quick-evaluation was conducted in mid-January using one of the CHA-implemented PHCs as a sample, where quick interviews were conducted with the nurses, a few patients and the doctor who was present at the time. It is important, however, to note that the evaluations alone cannot be used as valid information due to the fact that the interviewees at the end of the program were not present during the 'peak' periods of same and therefore could not present an accurate picture of the entire program. In the next section where the achievements and results are discussed, these evaluation results are combined with monitoring information collected throughout the period in order to arrive at a more realistic conclusion.

Clinical services and activities of all primary health centers were closely monitored by the donor representatives mainly from Mercy Malaysia. They were provided accommodation by CHA for long term stay at Vavuniya to make easier the field visits. Other contributors; made frequent visits to the sides.

5. Major outcomes and challenges

The results – be it positive or negative - of this program is described in both qualitative and quantitative expressions using the data collected throughout the program period. The log frame is used as a basis to describe the outcomes of each aspect of the program in order so that conclusions can be easily reached on what could be repeated in future programs, what should not and what should be modified as part of feedback and lessons learnt. To facilitate understanding the indicators and their results are worked up from the process to the outcome level for each separate objective. Finally, the impact of the overall goal is discussed.

5.1 Objective 1: Primary Health Care Centre operations

Primary Health Care centres with related facilities are constructed, managed, staffed and equipped with required medical supplies

Overall outcome of Objective 1: Of the six PHCs established, 3 were implemented by CHA and the other 3 handled by Mercy Malaysia. Two additional centres which belong to Mercy Malaysia are run by the MoH in Zone 1, which did not come under the purview of CHA.

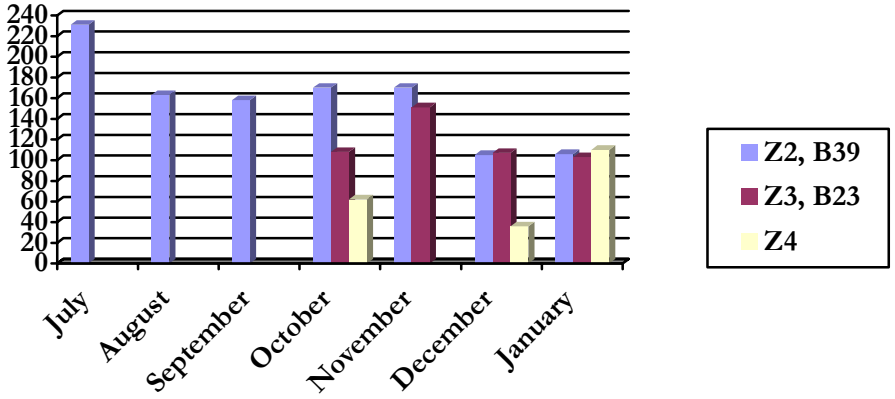
Speaking to a few patients who arrived at Zone 2, Block 39 around the end of the program, where almost all had made several visits to the PHCs. Most problems mentioned were aches in the leg, ear, fever, non-digestion, cough, wheezing, etc. The prescriptions are mostly in the form of medicines which are usually available at the pharmacies. Certain illnesses however require repeated visits to the PHC and could be also attributed to the fact that no permanent treatment can be provided given the environment, except for referrals. In this same zone another PHC exists (operated by the government) in Block 44, however, there seems to be no specific preferences for a certain PHC as the patients visit the PHC based on the convenience; some patients have also received the benefits of mobile health clinics operating in the area.

Expected outcomes of this objective and its results are provided as follows;

5.1.1 Output 1.1: 6 Primary Health Care centres equipped and functioning

An average of 165[4] patients per month were treated at each PHC. An analysis patient data throughout the program period are provided below and the numbers given in Annex A.

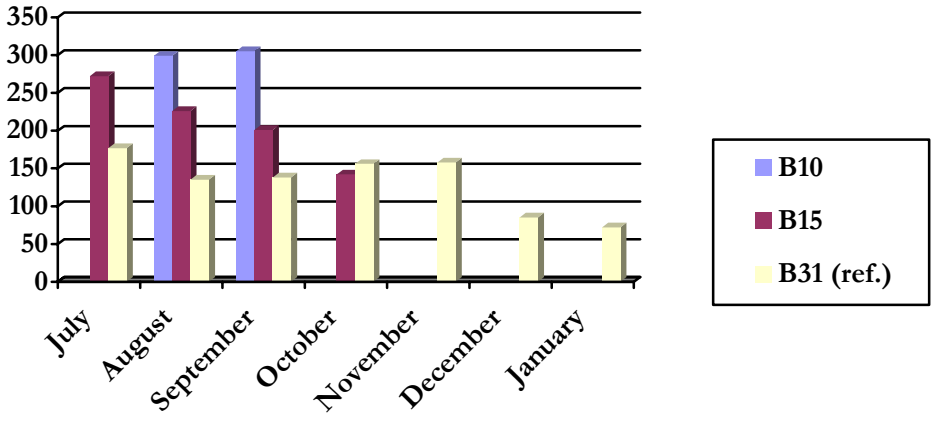
Average daily patient arrival information at CHA-implemented PHCs - July 2009 to January 2010



The program commenced in June and data for July was not collected for most of the PHCs. From August onwards data of the PHC in Zone 2 were collected consistently; Zone 4 (which operates for only 4 days) was problematic from November onwards as most of its residents were resettled in other zones due to heavy rains which caused flooding, although it has shown increased numbers in January of this year. The levels of the other two PHCs remained the same in January. This could have been due to the fact that since other PHCs were shutting down, more people may have arrived to the one implemented by CHA.

Patient arrivals in Zone 2 PHC show a steadily increasing trend which could be attributed mostly to the fact that diseases and ailments began to spread throughout the camps as time went by. The PHC in Zone 2 has the highest numbers of patient arrivals consistently averaging from about 150-170 per day. The few data collected from Zone 4 shows that arrivals were much lower than others, reasonably so, as the relative population residing in the said zone was much lower – although the pattern has changed early this year.

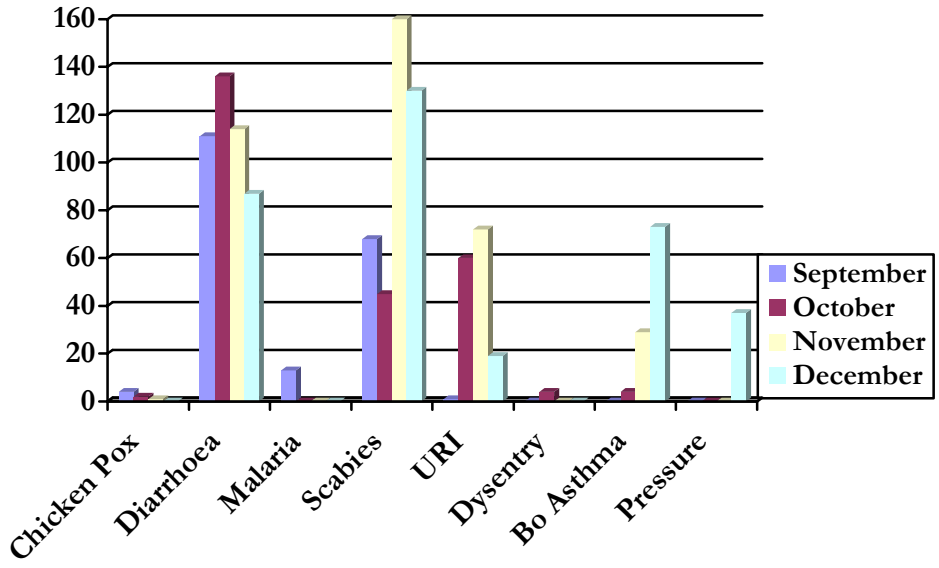
Average daily patient arrival information at MM-implemented PHCs (Zone 3) - July to December 09



As can be observed, the MM implemented PHC data has not been collected consistently (with the exception of the referral hospital), as the decision was taken halfway through the program. Reasonable conclusions can be reached that Block 15 was on a declining trend within a period of four months. It is surprising to note that whilst PHCs discussed of the previous chart showed increases specially that of the same Zone, Block 15 results in the very opposite with quite sharp drops.(see previous chart).

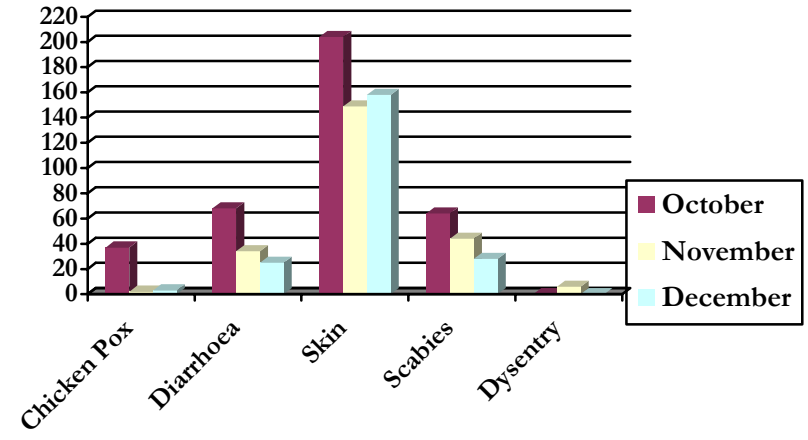
Block 10 shows consistent increases throughout the period. The referral hospital fluctuates, dropping in August and picking up in September and then again dropping in December/January due to lack of residents. Overall, the arrival rates in MM-implemented PHCs are higher than those of CHA's.

Cases of diseases reported among patients in Zone 2 Block 39



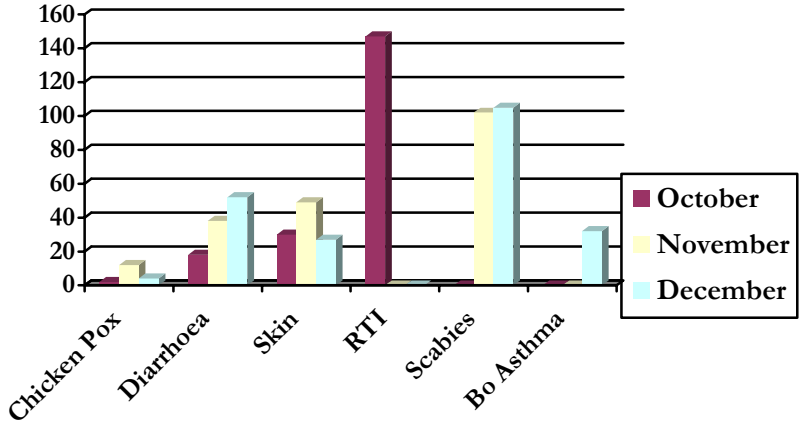
Scabies seems to be the most frequent disease measured in this block followed by Diarrhoea, Bo Asthma and URI. All diseases seem to be on the reducing trend across the timeline with the exception of Bo Asthma and Pressure. However, the reduction in diseases would not mean that the situation was getting better, it should be kept in mind that the population in these camps were also reducing.

Cases of diseases reported among patients in Zone 3 Block 31



In the referral hospital figures, skin disease has the highest occurrences. All others are quite low compared to zone 2, and are also on a decreasing trend. The RTI figures are extremely high and therefore given separately since it will distort the figures if included in the chart; October – 1,968; November – 1,816; December – 905.

Cases of diseases reported among patients in Zone 3 Block 23

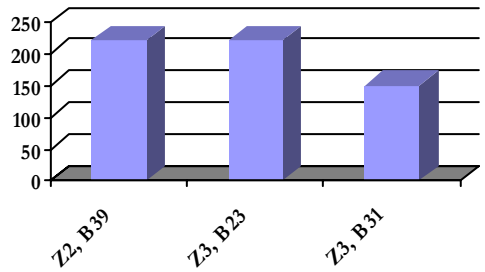


The diseases are in moderation in this block, with RTI the highest followed by Scabies and then skin disease and diarrhea. Scabies, diarrhea and Bo asthma have been on the rise across the timeline. Data for other PHCs are as follows;

	Diarrhoea	Chicken pox	RTI	Scabies	Dysentry	Typhoid
Zone 3, Block 15						
October	79	24	3	70	-	-
Zone 4						
September	3	29	-	-	9	5

The number of medicine types available during the month of October is as follows;

Medicine types available for October



Medicines out of stock have been recorded only for PHC Zone 2, Block 39 where two required types were lacking during the month of October.

Challenges: Some of the major challenges faced are the lack of coordination in obtaining medicines, lack of lab facilities at most of the PHCs and difficulties of transporting patients for referral purposes due to lack of resources and security reasons.

5.1.2 Output 1.2: National medical staff sourced and additional staff employed

As per the MoU agreement signed with the MoH (attached in annex D) medical doctors were placed in the PHCs on a roster basis handled by MoH authorities. Recommendations of doctors depended solely within the MoH.

The average doctors per day of each month have been provided below;

Zone	Block	2009						2010
		July	August	September	October	November	December	January
2	39	2	1	1	2	2	2	2
3	10	-	4	4	-	-	-	-
3	15	2	2	3	1	-	-	-
3	23	-	-	-	1	2	2	2
3	31	2	1	2	2	3	2	2
4	-	-	-	-	2	-	1	1

**The dashes represent data that was not collected for the particular PHC*

It can be safely assumed that the doctor numbers have been in proportion to the patient numbers as far as increasing and decreasing trends are concerned. As discussed in the above chart, patient numbers have been increasing in the PHCs of Zone 2, Block 39 and fluctuating in Zone 3 Block 31, which, according to the above table, is matched by average doctor /day increases. Also, Zone 3, Block 15 shows a reduction, corresponding with the reduction in the chart. The doctor numbers of the PHC in Zone 3, Block 10 is relatively high since the population is comparatively high.

Information on other staff in the PHCs are as follows;

Type of staff	Z2, B31	Z2, B39	Z3, B15	Z3, B23
Administrator	1	1	1	1
Storekeeper	N/A	1	N/A	N/A
Cleaner	1	1	1	1
Pharmacist	1	1	1	1
Translator	2	2	4*	3

*varied as per requirement; an average figure is provided

The information taken above is as of 31st of October 2009. Information is lacking beyond this point due to resettlement and staff moving away from the camp, since most were IDP workers. Therefore, October was deemed to best represent the maximum point of performance of the PHCs.

Non-medical staffing information is quite uniform across all PHCs, except for the translators who have been required more at Zone 3 possibly due to more number of doctors serving a higher population. The storekeeper applies to only one PHC since in other center stores are managed with the help of MOH.

One of the challenges of staffing was the turnover of non-medical staff during the last two months and the inability to replace them. This, however, cannot be taken as a challenge as such since they were mostly IDPs themselves and returned home. Nevertheless, the PHCs continued operating with the small numbers of staff remaining as well as the nursing trainees who joined as staff during the latter part of the program.

Other initial challenges include the arrangement of medical professionals continuously from Colombo, language issues and the lack of interpreters in the PHC, security issues of movement in and out of the camps, transportation difficulties, and the lack of effective follow ups since doctors were placed on a roster and changed every week.

5.1.3 Output 1.3: Storage and clinic space facilities provided for use of PHC and other activities

PHC Location	Purpose	Organization
Zone 2, Block 31	Dental clinic	MoH
Zone 3, Block 23	Medicine storage	MoH
Zone 4 Block E6	Nutritional progs	MoH, Family Health Unit

5.2 Objective 2: Staff Capacity and Logistics

Medical staff's capacity built through treating patients and conducting health programs, work coordinated and logistic needs addressed.

According to a doctor who was interviewed (in Zone 2 Block 39), the number of patients seen in a day ranges from 150-180. The doctor puts in 20 days of work in a given month. The number of patients referred amounts to about 5 or less a day. The medical equipment is usually sufficient to treat the patients as well as the capacity of the facilities which is able to handle the inflow of all patients. The doctor felt that the number of support staff available in the PHC is sufficient. The main requirement lacking was an ECG machine according to this doctor. Overall, she felt that the PHC, given its circumstances, functions quite well.

As described elsewhere in the document, the nurses who currently work at the PHCs are students who underwent a nursing training programme under a different programme implemented by CHA. Most have related experiences and also value their current work as a doorway to further opportunities in hospitals in their places of resettlement. They also function as pharmacists at the PHCs. In their opinion the medicine and equipment supply is sufficient; however, staff was lacking to handle these facilities.

Expected outcomes of this objective and its results are provided as follows;

5.2.1 Output 2.1: Increased capacity of staff to provide necessary services

The number of patients consulted by a single doctor per day is provided as follows;

Zone	Block	Jul 09	Aug 09	Sep 09	Oct 09	Nov 09	Dec 09	Jan 10	Overall average per PHC
2	39	116	163	158	85	85	53	53	102
3	10	-	75	76	-	-	-	-	76
3	15	136	113	67	142	-	-	-	115
3	23	-	-	-	108	76	54	52	73
3	31	86	135	69	78	53	43	16	69
4	-	-	-	-	31	-	36	110	59
Overall average per month		**113**	**122**	**93**	**89**	**71**	**47**	**58**	**84**

Using the average figures calculated, the relative number of patients per doctor efficiency is displayed in December (following resettlement). The trends is where the efficiency seems to have increased, interestingly, since the previous charts recorded patient and doctor growth in some PHCs and reduction in others, which have counter-balanced with each other. Looking at the PHCs, Zone 4 has shown the most efficiency due to the fact that patient numbers are always low and the clinic does not operate daily; other notable PHCs include ones in Zone 3 Block 31, Block 10 and 23.

Doctor work hours are provided as follows (measurements only for the month of October);

PHC Location	Avg. # of doctors /day	Avg. Hours worked /day	Days worked for the month	Total estimated work hours per month
Z2, B39	2	4	30	240
Z3, B15	1	8	31	248
Z3, B23	1	4	10	40
Z3, B31	2	6	29	348

5.2.2 Output 2.2: MoH staff provided with logistics arrangements

Data available only for the months of October and November;

PHC Location	Month	# of vehicles provided	# of MoH staff receiving logistic services	# of vehicles provided for internal mobile services
Z2, B39	October	1	3	1
	November	1	-	-
Z3, B15	October	1	10	1
Z3, B23	November	1	-	-
Z3, B31	October	1	10	1
	November	1	-	-

The total accommodation and meals costs for doctors is LKR 825,000 as of end January. The salaries of personnel employed for the entire program is given as follows, with total figures for the period June 2009 – January 2010;

PHC Staff	LKR 1,363,700
Guest house staff	LKR 274,050

5.3 Objective 3: Special clinics

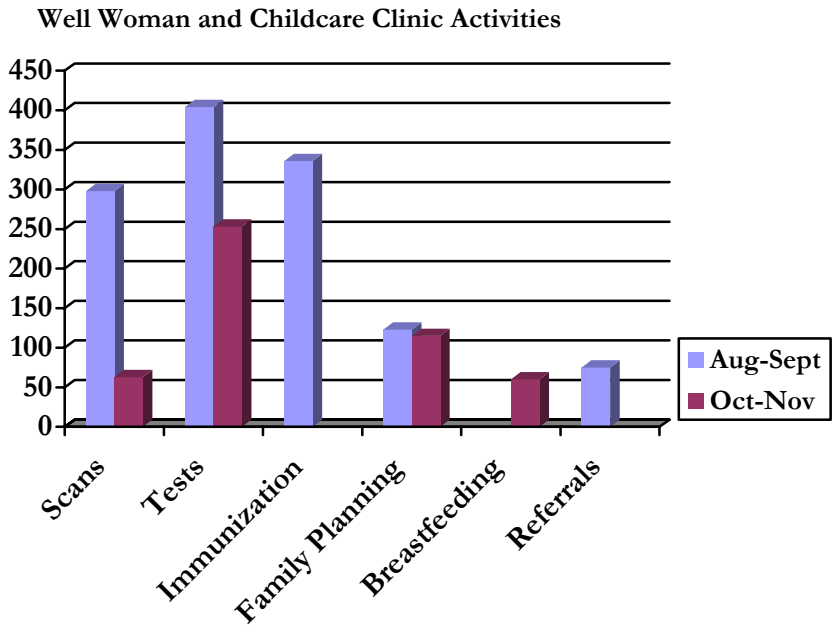
IDPs receive services of special clinics set up in PHCs in Zones 2, 3 and 4

As described in the program services and activities section, the eye clinics, mother and childcare and mental health programs were quite successful, not only within the camp but outside in other districts in the case of the eye clinics. Many benefited from necessary diagnosis for which the relevant aids were provided. The beneficiary group that most benefited of this are schoolchildren for whom it was an utmost necessity to continue their education without hindrances. Mother and childcare services were provided within the camp which was immensely useful given the facts and statistics of pregnancy rates described in the first section of this report. These services enabled to make the best of the adverse conditions in the camp for antenatal, delivery and postnatal care for the mothers and their newborn. Mental health units were also important since this was an issue that most do not identify, since the most urgent requirements and resources are concentrated on care for physical illnesses. Identification of those affected mentally was of great importance since there were many who did not know they were affected and in general nearly all residents of the camp

had undergone trauma in varying diseases. Therefore, it is evident that this programme has effectively targeted the deserving sects of the population.

5.3.1 Output 3.1: Pregnant/feeding mothers in IDP camps receive medical assistance and care

The Well Woman and Childcare clinic commenced on the 17th of August 2009 in the PHC located in Zone 4.



5.3.2 Output 3.2: IDPs with eye related ailments have them diagnosed and provided with spectacles

Eye clinics are held around once a month, where patients are screened for eye defects and recommended the appropriate spectacles. The spectacles and consultation are provided by Eric Rajapakse Opticians who also sent in their eye care specialists to the field to do the needful.

The Eye clinics were also held in the Jaffna district on the 02nd and 03rd of October 2009 for the school students at the Department of Education and for IDPs from the camps of

Sabapathippaillai, Pillaiyaar, Kappanda, Inuvil station, Courts, Ikkiraan and Aalady. Those who needed additional treatment and surgery were referred to the hospital for further treatment and awareness was created among the targeted population.

Recently, an eyewear distribution event took place in Jaffna, where students from several schools were selected based on screening tests performed earlier. About 200 students from more than 15 schools participated for screening from which 101 were selected for providing eyewear. The event was headed by the Director of Education, Mrs. Vedanayagam.

The number of patients screened is as follows;

Month	No. of patients
July	411
August	870
September	1,030
October (Off camp)	400

Number of patients provided with spectacles which includes, CR39 SV, CR39 Bifocal, Reading only and P/G glass;

Month	Area/Zone	No. of eyewear distributed
July	Vavuniya, Zone 2	392
August	Zone 2 & 3	609
September	Vavuniya, Zone 2	489
	Vavuniya, Zone 3	578
October	Vavuniya, Zone 4 & 5	759
	Jaffna	216
January	Jaffna	101

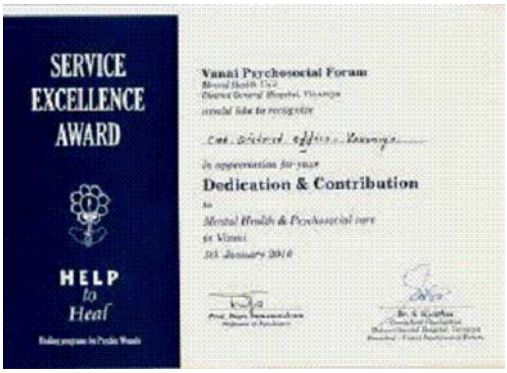
5.3.3 Output 3.3: IDPs with psychosocial needs receive the benefits of mental health programs

Mental health programme/clinics was conducted at the Manic Farm Zone 2, 3, and 4. The following interventions were made through this programme

- Identification of affected people
- Sharing , counseling and relaxation activities
- Core group formation with the IDPs to create self help groups in the camps
- Special activities for children
- Clinical care for identified major mental disorder patients.

The Mental health clinic activities took place every Thursday at the PHC in Zone 3. During the period of 1st to 23rd October, a total of 203 patients arrived for treatment, with 2 doctors to provide treatment. The intervention group is being supervised through monthly work shops by the consultants.

As a token of appreciation, the Mental Health Unit of the Vavuniya General Hospital awarded CHA for its contribution to the mental health wellbeing of affected populations.



6. Staffing

CHA implemented this programme through the Relief and Rehabilitation Unit. The overall implementation was in under the responsibility of a Programme Officer based in Colombo, and managed by a Programme Manager. The Monitoring and Evaluation Officer also based in Colombo, along with the Programme Officer conducted regular visits to the field for implementation and monitoring purposes and also data collection and evaluation.

In the field, CHA operated a district office in Vavuniya consisting of a dedicated Releif and Rehabilitation Programme Officer who was in charge of ensuring that planned program activities took place at the camps, arranged transportation for the doctors and collected monthly progress monitoring data along with other administrative staff based in the field. The district officer, also based in the field, oversaw matters that needed to be dealt with the government or other authorities.

The PHC staffing and doctor appointments have been discussed earlier in the document and therefore will not be repeated here.

7. Conclusion and Recommendations

It is clear that the integrated health program in the Menik farm has been quite effective, and has been more still due to the fact that this was a multi donor program and therefore more services were provided for the beneficiaries. The goals and objectives of the program were relevant to the situation – a Primary Health Care centre was of great use despite the fact that many other organizations were also operating similar clinics. The unhealthy environment provided for the camp's residents almost always ensured a spread of a disease or common ailments, etc. The referral hospital was also mostly full of patients who were referred from the PHCs – another important strategy in the programme for diseases or injuries that could not be treated in the PHCs. Although the PHCs were not fully equipped nor perfectly efficient the doctors and staff were usually able to make do with existing resources. Medicines were usually available and no major shortage was reported during the period.

Using the MoH doctors turned out to be a good strategy in that it involved the main government body in the given situation – such collaboration would ensure future partnerships for similar programs. There were, however, quite a few challenges in this area of the program especially in the coordination of activities such as transport for doctors, which arose due to resources being stretched to the maximum. In an emergency or relief programme, not everything runs according to plan, but the best use was made of every opportunity available. Another major challenge was the reduction of IDP staff in the PHCs who went back to their homes during resettlement. Currently the PHCs run on limited staff resources and faces challenges such as lack of translators and other necessary personnel. However, the IDP staff felt that they have been able to learn quite a few things during their stay at the camp and have put their time to good use.

Conducting special clinics was also a good decision, and as described in the document, the eye, mother and child care and mental health services were quite beneficial to the population not only within the camp but also outside of it (in other districts). Although the mental health clinic was somewhat of a late start, it did achieve in identifying and empowering of core groups, and others went according to plan. The lack of resources, especially of specialist doctors, resulted in these clinics being only held once or twice a week.

CHA is gradually exiting the programme at the moment, with handovers of PHCs to the MoH who are appointing their doctors and operating them as usual. There is also contemplation of moving one or two of the PHCs directly operated by CHA to other resettlement areas where they could be made better use of. Although health authorities in the camps initially requested for these PHCs to continue operating as health needs are still prevalent for the remaining population, the Government Agent (GA) of Vavuniya has requested that the centres be moved if needed, if not it will be made state property. The issue is being looked into by CHA and no final decision has been made as yet.

In conclusion, lack of resources has been a continuous issue affecting most of the program activities, however, it should be noted that all efforts were made to make the best use of limited resources. Better coordination with other similar agencies and bodies could have been made at the field level to make the programme more efficient in terms of obtaining

necessary resources (eg: working with NAITA's training programme enabled partly trained nurses to occupy the PHCs once resettlement began). Such coordination would have been effective if it was planned from the beginning of the intervention.

Also challenges were faced relating to proper data collection as relevant systems for same had not been established (with the exception of arrivals and disease data) at the beginning of the programme due to the nature of the intervention. As can be observed in the report, most complete data is available for October and November since it took some time to have the formats and reporting in place. In December and January, due to resettlement most residents moved out, not leaving much data to be collected. This has also resulted in data not being provided in the exact format that is specified in the log frame. However, it should be noted that the information provided in this report overall covers the information as per the log frame.

Overall, however, the program activities have provided CHA with relevant experience to conduct similar programs using the outcomes of these activities as lessons learnt and to apply such learning to ensure better service to the beneficiaries.

8. Annexures

The annexures include the raw data on patient and doctor arrivals, the logframe and formats used for data collection and evaluations.

Annex A: Patient / Doctor Arrivals

Patient and doctor arrivals recorded throughout the program have been provided here, per month per PHC. At the bottom of each table the averages per day for each PHC is provided. Note that data for all days is not available therefore the averages have been calculated excluding the days which did not record any patient arrival data assuming that the PHC was not in operation in those days. According to this definition the days that the PHC has been operating has been given below the averages to get an idea of the total numbers that would have arrived for the month.

July 2009

	Patients			Doctors		
	Zone 2	Zone 3		Zone 2	Zone 3	
Date	Block 39	Block 31	Block 15	Block 39	Block 31	Block 15
1	373	-	295	5	-	2
2	254	116	-	5	2	-
4	-	-	282	-	-	3
5	166	178	267	2	2	2
6	101	-	145	1	-	1
7	163	176	268	2	2	2
8	-	-	248	-	-	2
9	-	123	207	-	2	1
10	-	167	-	-	2	-
11	-	241	200	-	2	1
12	123	219	102	2	2	1
13	52	132	86	1	2	2
14	175	152	446	2	2	5
15	167	-	427	5	-	5
16	386	-	303	5	-	3
17	322	176	336	5	2	4
18	255	205	356	2	2	4
19	202	154	142	2	2	5
20	203	187	265	1	2	2

21	389	207	317	2	2	3
22	280	144	346	2	2	2
23	193	-	288	2	-	2
24	127	135	214	2	2	1
25	-	-	98	-	-	1
26	-	-	225	-	-	2
27	261	175	412	1	2	3
28	354	278	388	2	2	3
29	-	206	408	-	2	3
30	264	219	396	1	2	2
31	264	130	142	1	1	1
Avg.	**231**	**177**	**272**	**2**	**2**	**2**
Days	**22**	**21**	**28**			

August 2009

	Patients				Doctors			
	Zone 2	Zone 3			Zone 2	Zone 3		
Date	Block 39	Block 31	Block 15	Block 10	Block 39	Block 31	Block 15	Block 10
1	-	123	142	-	-	1	2	-
2	-	167	265	-	-	3	2	-
3	-	241	317	-	-	3	2	-
4	-	219	197	-	-	2	2	-
5	-	-	180	-	-	-	2	-
6	-	202	326	-	-	2	2	-
7	-	176	314	-	-	2	2	-
8	225	205	330	-	2	2	2	-
9	220	116	122	-	2	2	1	-
10	161	269	344	-	1	2	2	-
11	161	166	339	-	2	2	3	-
12	218	178	220	-	2	2	2	-
13	114	118	208	-	1	2	2	-
14	144	-	275	-	1	-	2	-
15	167	-	335	-	2	-	2	-
16	126	79	157	225	2	2	3	4
17	264	189	355	443	2	2	3	5
18	220	119	235	302	2	1	2	5
19	291	146	217	263	2	1	2	4
20	198	13	257	399	2	1	2	6
21	206	134	190	353	2	1	2	4
22	119	142	113	251	1	1	1	3
23	-	90	112	244	-	1	1	3
24	305	-	195	292	2	-	1	3
25	145	-	77	316	1	-	1	5
26	244	-	116	224	2	-	1	4

27	204	149	248	389	1	1	2	5
28	-	133	190	242	-	1	2	4
29	190	-	254	304	1	-	3	3
30	-	-	115	256	-	-	2	4
31	-	-	253	283	-	-	2	5
Avg.	**196**	**153**	**226**	**299**	**2**	**2**	**2**	**4**
Days	**20**	**22**	**31**	**16**				

September 2009

	Sum of Patients				Sum of Doctors			
	Zone 2	Zone 3			Zone 2	Zone 3		
Date	Block 39	Block 31	Block 15	Block 10	Block 39	Block 31	Block 15	Block 10
1	175	219	366	348	1	3	4	6
2	58	215	306	355	1	2	3	5
3	154	187	291	376	1	2	3	5
4	-	83	173	202	-	2	3	3
5	-	139	310	363	-	2	2	4
6	-	66	138	356	-	2	4	5
7	204	177	174	457	2	2	3	5
8	158	210	291	398	1	2	3	3
9	225	66	267	329	2	2	3	4
10	86	128	251	425	1	2	3	7
11	-	-	131	190	-	-	3	2
12	-	-	199	271	-	-	4	6
13	-	-	191	366	-	-	2	6
14	160	65	298	299	1	2	3	4
15	-	-	-	182	-	-	-	2
16	-	-	165	252	-	-	1	2
17	-	-	60	148	-	-	1	2
18	-	-	181	252	-	-	2	4
19	-	-	-	190	-	-	-	2
20	86	70	100	230	2	3	1	4
21	131	123	119	248	1	3	2	5
22	231	169	265	238	2	2	3	4
23	153	105	144	424	1	2	2	4
24	167	157	199	430	3	3	3	9
25	182	192	165	-	2	2	2	-
26	151	100	137	-	1	2	2	-
28	206	139	109	-	1	1	1	-
29	152	150	-	-	2	1	-	-
Avg.	**158**	**138**	**201**	**305**	**1**	**2**	**3**	**4**
Days	**17**	**20**	**25**	**24**				

October 2009

	Patients					Doctors				
	Zone 2	Zone 3			Zone 4	Zone 2	Zone 3			Zone 4
Date	Block 39	Block 31	Block 15	Block 23	Block E6	Block 39	Block 31	Block 15	Block 23	Block E6
1	172	122	148	-	-	2	2	2	-	-
2	-	126	55	-	79	-	2	2	-	3
3	203	113	137	-	-	2	2	2	-	-
4	75	-	97	-	-	2	-	2	-	-
5	161	156	174	-	-	2	1	2	-	-
6	232	166	223	-	-	2	2	2	-	-
7	176	144	196	-	-	2	2	2	-	-
8	196	139	150	-	-	2	1	1	-	-
9	179	120	-	-	58	2	1	-	-	2
10	110	89	65	49	-	1	1	1	1	-
11	70	61	88	37	-	2	1	1	1	-
12	168	201	97	144	-	2	1	1	1	-
13	193	246	127	120	-	2	2	1	2	-
14	180	-	129	134	-	2	-	1	1	-
15	185	150	114	162	60	2	2	1	1	2
16	161	137	114	154	51	2	2	1	1	2
17	81	75	114	48	-	1	3	1	1	-
18	95	133	84	99	-	1	1	1	1	-
19	253	213	132	131	-	1	3	1	2	-
20	200	195	189	-	-	1	3	1	-	-
21	151	189	127	-	-	1	2	1	-	-
22	126	230	144	-	-	1	3	1	-	-
23	247	234	126	-	-	1	2	1	-	-
24	62	138	107	-	-	1	2	1	-	-
25	121	141	-	-	-	2	2	-	-	-
26	328	240	137	-	-	2	4	1	-	-
27	186	243	155	-	-	1	3	1	-	-
28	222	122	306	-	-	1	2	6	-	-
29	189	117	243	-	-	1	2	2	-	-
30	186	173	188	-	-	1	2	2	-	-
31	199	101	140	-	-	1	2	1	-	-
Avg.	**168**	**156**	**142**	**108**	**62**	**2**	**2**	**1**	**1**	**2**
Day	**30**	**29**	**29**	**10**	**4**					

November 2009

Date	Patients			Doctors		
	Zone 2	Zone 3		Zone 2	Zone 3	
	Block 39	Block 31	Block 23	Block 39	Block 31	Block 23
1	-	95	75	-	2	2
2	117	122	119	1	3	1
3	313	203	147	2	3	1
4	194	191	160	2	3	2
5	170	172	211	2	2	2
6	186	137	212	2	2	2
7	134	102	126	2	2	2
8	170	151	109	2	2	2
9	161	274	176	2	3	2
10	181	210	186	1	3	2
11	165	220	168	2	3	2
12	194	218	204	2	3	3
13	131	171	135	2	3	1
14	-	132	92	-	2	1
15	68	125	90	1	3	1
16	208	137	128	3	3	3
17	183	184	171	2	2	3
18	179	150	180	2	3	3
19	200	180	173	2	8	3
20	204	94	115	3	3	3
21	90	81	102	2	4	3
22	52	98	112	2	2	3
23	276	225	183	2	4	3
24	266	237	241	2	5	5
25	174	198	195	2	4	3
26	86	128	201	2	4	3
27	247	167	126	2	1	2
28	74	89	132	1	1	2
29	112	98	94	2	1	1
30	235	-	172	2	3	1
Avg.	**170**	**158**	**151**	**2**	**3**	**2**
Days	**28**	**29**	**30**			

December 2009

	Patients				Doctors			
	Zone 2	Zone 3		Zone 4	Zone 2	Zone 3		Zone 4
Date	Block 39	Block 31	Block 23	Block E6	Block 39	Block 31	Block 23	Block E6
1	95	146	76	-	2	2	2	-
2	40	110	158	-	1	2	5	-
3	131	14	70	60	1	1	1	1
4	167	127	126	-	2	4	3	-
5	78	83	109	-	1	3	2	-
6	104	97	51	-	2	4	2	-
7	166	157	145	-	2	4	2	-
8	193	121	99	-	2	3	2	-
9	169	117	110	-	2	4	2	-
10	114	120	188	36	2	4	4	1
11	117	114	99	-	2	5	4	-
12	74	31	61	-	2	1	2	-
13	49	-	61	-	2	-	2	-
14	-	15	65	-	-	1	2	-
15	139	77	131	-	2	4	3	-
16	106	125	142	-	1	5	2	-
17	105	40	95	29	1	3	2	1
18	88	101	105	-	1	4	2	-
19	-	66	80	-	-	3	1	-
20	56	49	83	-	1	2	4	-
21	137	-	116	-	2	-	2	-
22	-	122	135	-	-	2	2	-
23	114	20	-	-	2	1	-	-
24	93	69	183	19	1	1	5	1
25	56	19	52	-	1	1	2	-
26	73	74	103	-	1	1	2	-
27	50	57	80	-	1	1	1	-
28	-	82	114	-	-	1	2	-
29	-	110	146	-	-	1	2	-
30	-	123	140	-	-	1	4	-
31	-	71	77	-	-	1	1	-
Avg.	**105**	**85**	**107**	**36**	**2**	**2**	**2**	**1**
Day	**25**	**29**	**30**	**4**				

January 2010

Date	Patients				Doctors			
	Zone 2	Zone 3		Zone 4	Zone 2	Zone 3		Zone 4
	Block 39	Block 31	Block 23	Block E6	Block 39	Block 31	Block 23	Block E6
1	-	17	21	-	-	1	2	-
2	-	76	120	-	-	1	2	-
3	-	75	101	-	-	1	1	-
4	189	115	163	-	2	1	2	-
5	138	105	106	177	2	1	2	1
6	58	117	141	-	1	2	4	-
7	147	73	142	-	2	3	2	-
8	99	62	96	-	2	2	2	-
9	-	77	93	-	-	2	3	-
10	70	-	79	-	2	-	2	-
11	166	106	116	-	2	2	2	-
12	81	87	88	36	2	2	3	1
13	95	75	117	-	2	3	5	-
14	13	-	-	-	1	-	-	-
15	126	86	127	-	2	2	2	-
16	92	73	90	-	2	2	2	-
17	67	51	94	-	2	1	2	-
18	82	82	130	-	2	1	2	-
19	158	84	107	69	2	1	2	1
20	131	31	29	-	2	1	3	-
21	84	91	129	-	2	1	2	-
22	137	75	109	-	2	2	2	-
23	83	51	104	-	1	2	2	-
24	-	48	58	-	-	2	2	-
25	-	44	103	-	-	2	2	-
28	-	-	163	-	-	-	2	-
29	-	48	62	157	-	1	1	1
30	-	54	107	-	-	2	3	-
31	-	-	100	-	-	-	2	-
Avg.	**106**	**72**	**103**	**110**	**2**	**2**	**2**	**1**
Day	**19**	**25**	**28**	**4**				

Annex B: Logframe

Logical Framework: Integrated Health and Medical Services Program
Donors: Mercy Malaysia, TJF, JDC and AMAF

Objective	Indicators	Means of Verification	Assumptions
Goal: **IDPs in Manik farm receive medical assistance through integrated health and medical services through qualified staff recommended by the Ministry of Health for a period of 6 months**	**Beneficiary perceptions on access to health & medical services**	**Interviews with beneficiaries**	A conducive work environment prevails External actors in the IDP region provide fullest support Environmental conditions remain stable.
Objective 1: **Medical centers with related facilities are constructed managed, staffed and equipped with required medical supplies**	**1.1 Beneficiary perceptions on receiving effective treatment from the specialized clinics** **1.2 # of medical equipment types available**	**Interviews with beneficiaries** **Program / inventory records**	**Permission to work and construct are obtained** **Access to IDPs is available**
Output 1.1 6 Primary Health Care centers equipped and functioning	1.1.1 # of medical centers established *(by zone)* 1.1.2 # of patients treated in the	Program records / count of centres / clinics	Access to patients and non-patients is available Medical supplies required are available and can be procured

	clinics *(monthly; by Centre, by zone,)* [target:2,000]	Monthly monitoring form	
	1.1.3 # of types of medicines available *(monthly; by centre, by zone)*	Monthly monitoring form	
	1.1.4 # of types of medicines out of stock *(monthly;, by centre, by zone)*	Monthly monitoring form	
Output 1.2: National medical staff sourced and additional staff employed	1.2.1 # of medical staff sourced and placed on MoH roster *(Monthly; by type of staff, by centre, and by zone)*	Program records on medical staff	There are no restrictions to selection of quality medical staff Medical staff information and access is made available
	1.2.2 # of IDPs employed at PHCs *(Monthly; by type of staff, by centre, and by zone)*	Monthly monitoring forms	
Output 1.3: Storage and clinic space facilities provided for use of PHC and other activities	1.3.1 # of rooms used for activities *(monthly; by activity type, by zone, and by centre)*	Monthly monitoring form	
	1.3.2 # of agencies using the facilities *(by facility type, by zone, and by centre)*	Monthly monitoring form	

Objective 2: **Medical staff's capacity built through treating patients and conducting health programs, work coordinated and logistic needs addressed**	**2.1** **Staff perceptions on effectiveness of facilities provided for effective work *(end of progam)***	**Focus groups with centre staff**	Staff are willing to have their capacities built Permission to use vehicles for transportation requirements obtained. Requests to provide this service
Output 2.1: Increased capacity of staff to provide necessary services	2.1.2 Average # of patients assisted per staff *(monthly;, by centre and by zone)* 2.1.3 Average # of hours spent per day treating patients *(monthly;by staff type, by centre and by zone)* [target:4.5]	Monthly monitoring form Monthly monitoring form	
Output 2.2: MoH staff provided with logistics	2.2.1 # of vehicles provided for transportation *(monthly; by centre and by zone)* 2.2.2 # no of staff received logistics services *(monthly; by staff type, by centre and by zone)* 2.2.3 # of vehicles provided for internal mobile services *(monthly; by centre and by zone)*	Monthly monitoring form Monthly monitoring form Monthly monitoring form	

	2.2.4 Average actual cost (LKR) of accommodation and meals per staff per day *(monthly; by centre and by zone)* [2.2.5 Average earnings per staff *(monthly; by staff type, by centre and by zone)*	Financial records Financial records	
Objective 3 **IDPs receive specialized services from special clinics set up in the PHCs in Zones 2, 3 and 4**	**3.1 Types of specific services provided *(by zone, by target group)*** **3.2 # of beneficiaries of specialized services *(by zone, by PHC, by specialized service)***	**Program records** **Program records**	**Permission to conduct necessary programs and trainings** **Availability of able staff from the MOH**
Output 3.1 Pregnant/feeding mothers in IDP camps receive medical assistance and care	3.1.1 Types of tests conducted *(by zone, by target group)*	Program records	
Output 3.2 IDPs with eye related ailments have them diagnosed and provided with spectacles	3.2.1 # of spectacles distributed *(by zone, by PHC)* 3.2.2 Types of ailments diagnosed *(by zone, by PHC)*	Monthly monitoring form Monthly monitoring form	

Output 3.3 IDPs with psychosocial needs receive the benefits of mental health programs	3.3.1 # of psychologists/psychiatrists working in the PHCs *(by zone, by PHC)*	Monthly monitoring form	
	3.3.2 # of cases referred *(by zone, by PHC)*	Monthly monitoring form	

Annex C: Monitoring and Evaluation Tools

CHA-RRU-M01: Monthly Monitoring Form for Health Programme (Vavuniya)

Zone		**Filled by:**
PHC		_____
Month		_____

PART 1: MEDICAL CENTRE INFORMATON					
PATIENT/DOCTOR INFORMATON					
1. # of patients arrived for treatment			2. # of doctors present		
MEDCINE INFORMATON					
3. # of types of Medicines available			4. # of types of medicines out of stock		
STAFF INFORMATON					
5. # of medical staff worked in the centre		IDP worker ? (Y/N)	# of hours worked		IDP worker ? (Y/N)
Doctors			Doctors		
Pharmacists			Pharmacists		
Administrator			Administrator		
Translator			Translator		
Storekeeper			Storekeeper		
Cleaner			Cleaner		

PART 2: LOGISTICS FOR STAFF AND OTHER SERVICES			
VEHICLE INFORMATION			
6. # of vehicles provided		7. # of staff received logistics services	
8. # of vehicles provided for internal mobile services			
USAGE OF CENTRE			
9. External activity	**# of rooms used**	**Agency**	

PART 3: DISEASE OCCURENCES		
10.Types of diseases	***# of cases***	***Comments***
Diarrhea		
Scabies		
Chickenpox		
Dysentery		

PART 4: SPECIALIZED SERVICES (for tests, scans, etc.)				
11. Pediatric Clinic *(leave blank if not applicable)*	***Types of tests completed***	***# of pediatricians***	***# of patients***	***Other Activities***
12. Well woman and Child Care clinic *(leave blank if not applicable)*	***Types of tests completed***	***# of doctors***	***# of patients***	***Other Activities***

13. Optical clinic *(leave blank if not applicable)*	***Types of eye related diseases diagnosed***	***# of opthal mologis ts***	***# of beneficiaries***	***Other activities***
			# of spectacles distributed	
14. Mental health programs	***Types of mental health problems diagnosed***	***# of mental health doctors***	***# of patients***	***Other activities***
			# of cases referred	

CHA-RRU-HEALTH-Q01: Questionnaire for Doctors for Medical Health Program in Vavuniya

PHC		**Block no.**		**Zone No.**	
Name of Doctor			**Specialization**		
Provided consulation at a special clinic?	□Yes □No	**Which clinic(s)?**	□Eye clinic □Mental clinic □Well woman and child care		

A. Patient consultations	
1. How many times have you visited the PHC?	□ >10 □ 5-10 □ 1-4
2. Approximately how many patients do you see each day?	□ >100 □ 50 – 99 □ <49
3. Is the patient inflow within your capacity?	□ Within capacity □ Beyond capacity □ Varies from time to time
4. Approximately how many patients do you refer each day?	□ >100 □ 50 – 99 □ <49
5. Do the patients require regular re-visits to the clinic?	□ Mostly □ Sometimes □ Rarely
Medical equipment	
6. Is the medical equipment sufficient to treat the patients? If rarely, what types of medical equipment are mostly unavailable?	□ Most of the time □ Sometimes □ Rarely _____ _____
Lab and Storage facilities	
7. What type of activities/treatment is provided in the lab, clinic and storage facilities?	

8. Is the capacity of these facilities sufficient to handle inflow of patients?	□ Most of the time □ Sometimes □ Rarely
9. Is cleanliness maintained at these facilities?	□ Most of the time □ Sometimes □ Rarely □ Never
10. What do you think of the capacity of the support staff?	□ Very Good □ Satisfactory □ Poor □ Unsure/no comments

General

11. What do you feel are the strengths of the PHC?
12. What do you feel are the major problems of the PHC?
13. What could have been done better to solve these problems at the PHC?
14. Do you have any feedback on the system of implementing this programme?

CHA-RRU-HEALTH-Q02: Questionnaire for Administrative staff for Medical Health Program in Vavuniya

PHC		**Block no.**		**Zone No.**	
No. of Administrative staff in the focus group		**No. of Pharmacists in the focus group**		**No. of lab staff in the focus group**	
Other staff					

Pharmacists / lab staff	
1. For how long have you been working at this PHC/clinic?	□ > 6 months □ 3-6 months □ < 3 months
2. Is the medicine / lab supply sufficient to provide the medicines according to the prescriptions?	□ Most of the time □ Sometimes □ Rarely □ Never
3. Have you felt that your capacity has been built while working in the PHCs?	□ Yes □ No □ Unsure
4. What were the new things that you learnt while working here?	
5. What are the frequent problems that you encountered while working here?	
6. What are further improvements that you can suggest in your area of work?	

Administrative staff	
7. For how long have you been working at this PHC/clinic?	□ > 6 months □ 3-6 months □ < 3 months
8. What types of activities/treatment are provided in the lab, clinic and storage facilities?	
9. Is the capacity of these facilities sufficient to handle inflow of patients?	□ Most of the time □ Sometimes □ Rarely
10. Is cleanliness maintained at these facilities?	□ Most of the time □ Sometimes □ Rarely
11. Have you felt that your capacity has been built while working in the PHCs?	□ Yes □ No □ Unsure
12. What were the new things that you learnt while working here?	
13. What are the frequent problems that you encountered while working here?	
14. What are further improvements that you can suggest in your area of work?	

CHA-RRU-HEALTH-Q03: Questionnaire for Patients for Medical Health Program in Vavuniya

PHC		Block no.		Zone No.	

Name		Age		Sex	
Has the patient arrived to receive services from the Special clinics?				□ Yes □ No	
If so, what is the special clinic?				□ Pediatric clinic □ Well woman and child care □ Optical clinic □ Mental health clinic	

Question	Answer
15. What is the reason of your visit?	
16. How many times have you visited the clinics?	□ >5 times □ 2-5 times □ Once
17. What was the treatment you received?	□ Medication □ Tests □ Referral to hospitals □ Spectacles □ Other _____
18. What is the status of your problem now? **<u>If improved, skip question 6</u>**	□ Improved □ Remained the same □ Worsened □ Unsure
19. If it has not improved, why do you think it is so?	□ Insufficient or ineffective medication / tests □ External factors such as environment, lack of facilities □ Other _____
20. Were you given any awareness on health and hygiene related topics from this PHC? Please give details	

21. What is your opinion of the PHC and its facilities?
22. What were the problems you encountered whilst receiving treatment?
23. Is there anything that could be done better or in a different way?