COMMUNITY MENTAL HEALTH TREATMENT, PROTECTION AND PROMOTION FOR WOMEN AND CHILDREN IN ACEH

Findings from an Evaluation of Programs Supported by the Health Services Program

Neil Boothby and Maggie Veatch

Program on Forced Migration and Health
Mailman School of Public Health, Columbia University

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USAID FROM THE AMERICAN PEOPLE

HSP Health Services Program

Columbia University MAILMAN SCHOOL OF PUBLIC HEALTH

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ABBREVIATIONS AND INDONESIAN TERMS

ADB	Asian Development Bank
ARC	American Red Cross
BCC	Behavior Change Communication
BPKJ	*Badan Pelayanan Kesehatan Jiwa* (provincial psychiatric hospital)
CMHN	Community Mental Health Nurse
DHO	District Health Office
GP	General Practitioner (Doctor)
ICMC	International Catholic Migration Commission
IMC	International Medical Corps
IOM	International Organization for Migration
INGO	International Non-governmental organization
JNPK	*Jaringan Nasional Pelatihan Klinik* (National Clinical Training Network)
MOH	Ministry of Health
MPH	Masters of Public Health
NAD	*Nanggroe Aceh Darussalam*
NGO	Non-Governmental Organization
Posyandu	*Pos pelayanan terpadu* (integrated community health post)
PHO	Provincial Health Office (*Dinas Kesehatan Propinsi*)
PMP	Performance Management Plan
PULIH	Indonesian NGO addressing psychosocial protection in disaster and conflict-affected communities
PTSD	Post-Traumatic Stress Disorder
Puskesmas	*Pusat Kesehatan Masyarakat* (Sub-District Health Clinic)
RPUK	Local NGO
RSMM	*Rumah Sakit Marzoeki Mahdi* (Bogor Psychiatric Hospital)
SIAGA	Alert Village
TOT	Training of Trainers
UI	University of Indonesia
USAID	United States Agency for International Development
WHO	World Health Organization

EXECUTIVE SUMMARY

Following the tsunami on December 26, 2004, United States Agency for International Development (USAID) asked the Health Services Program (HSP) to initiate program activities in Aceh even though this province was not initially included in HSP geographic coverage. Assessments began in June 2005, with activities and start-up occurring after the Aceh modifications were signed in November 2005. The modifications included funds for the post-disaster period in Aceh of October 2005 – September 2007 to address the psychosocial and protection needs of women and children.

The main objectives of the Aceh women and children protection program are to: (i) strengthen existing community structures to address the psychosocial needs of women and children; and (ii) build capacity of sub-district health center (*Puskesmas*) staff to recognize mental health and exploitation problems among women seeking primary health services, and provide appropriate services and referral. It was envisaged that through facilitating and reinforcing community, non-governmental organization (NGO), and government support for psychosocial protection and mental health promotion for vulnerable women and children, the capacity of communities to rebuild social infrastructure and accumulate social capital would be developed. HSP thus undertook a variety of training and community support activities to achieve those objectives during the period of the grant, which ends in September 2007.

This evaluation is in fulfillment of USAID grant requirements. Field work took place between June 15 and August 15, 2007. Two complementary evaluation methodologies were employed: an adequacy survey and a program outcome study.

The adequacy survey examined whether the project completed what it set out to do in terms of activities, trainings, material development and services that were planned to achieve specific objectives or results. It focused on key HSP 2006 and 2007 work plan tasks in the four districts where HSP works. The outcome study focused on what changes—if any—resulted from people's participation in the HSP supported program. It focused on Aceh Besar, because this is the district where HSP proposed to create a home-to-hospital continuum of mental health care that would be effective, sustainable and replicable.

The evaluation found that HSP has been fastidious in its implementation of its mental health and psychosocial protection program. It has met nearly all of its key work plan tasks and milestones on-time and with good-to-excellent quality. It has also achieved positive program outcomes—especially in the promotion of a highly effective mental health system—as well as in the area of psychosocial protection in communities.

Advocacy is required to raise the profile of mental health within the Ministry of Health (MOH) and to ensure the mental health programs continue in Aceh. It is also recommended that it be replicated in other parts of Indonesia, where mental health care is reported to be underdeveloped.

An additional 6 to 12 months support for cadres and psychosocial activities in tsunami-affected communities would solidify important gains. Promotion of PULIH as a national resource for disaster preparedness and response would be advantageous.

II. BACKGROUND

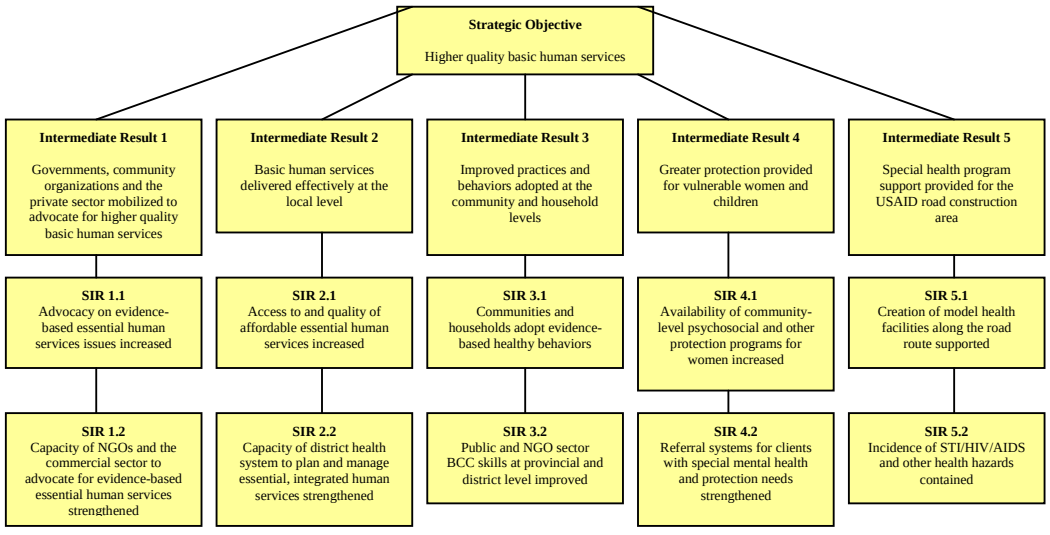
The Health Services Program (HSP) is a maternal, newborn and child health program that is working with the Indonesian MOH in six Provinces, funded by the United States Agency for International Development (USAID). Following the tsunami in December 26, 2004, HSP was asked to initiate program activities in Nonggroe Aceh Darussalam (NAP or Aceh) even though this province was not initially included in HSP geographic coverage. Assessments began in June 2005, with activities and start-up occurring after the Aceh modifications were signed in November 2005. The modifications included funds for the post-disaster period in Aceh of October 2005 – September 2007 to address the psychosocial and protection needs of women and children.

Program Design

The main objectives of this program are to: (i) strengthen existing community structures to address the psychosocial needs of women and children; and (ii) build capacity of sub-district health center (*Puskesmas*) staff to recognize mental health and exploitation problems among women seeking primary health services, and provide appropriate services and referral. It was envisaged that through facilitating and reinforcing community, NGO, and government support for psychosocial protection and mental health promotion for vulnerable women and children, the capacity of communities to rebuild social infrastructure and accumulate social capital would be developed. HSP thus undertook a variety of training and community support activities to achieve those objectives during the period of the grant, which ends in September 2007.

The diagram below places the Community Mental Health Treatment, Protection and Promotion Program in a context which includes other program initiatives in Aceh.

HSP Results Framework for Aceh



Program Rationale

The majority of tsunami victims were women and children. While many survivors appeared to be coping relatively well, a significant number suffered from psychological and behavioral problems ranging from anxiety and depression to poor concentration and antisocial behavior. Among the survivors are a large number of female-headed households who may also have suffered from economic and social problems. Impact also occurred on the supportive role traditionally provided by women's community groups to village women.

The majority of Acehnese in the post-disaster environment was clearly experiencing stress but was not showing signs of psychological dysfunction. However, strategies were needed to ensure that they maintained their ability to cope. Proposed activities were intended to strengthen social support systems, introduce group-based methodologies to address psychosocial and protection issues, and offer interventions that helped to improve people's future outlook – e.g. economic activities, skills-building programs, and improvement in living conditions.

Acehnese women traditionally have been supported by community-based women's groups. However, this capacity was disrupted first by decades of conflict, and second by the tsunami. Women's groups were not yet reforming and HSP believed great impact could be made by working with them to address psychosocial issues. HSP thus proposed to empower, resource, and support women at the village level (cadres) to respond to the psychosocial needs of women and children, with a focus on the most vulnerable.

At the same time, there were individuals who had severe psychological disorders and required specialized care. Mental health was identified as a post-tsunami priority, and the MOH, School of Nursing at the University of Indonesia (UI), Asian Development Bank (ADB) and World Health Organization (WHO) collaborated on the development of the Community Mental Health Nursing Program. HSP agreed to support this household-to-hospital continuum of care program in the district of Aceh Besar.

Finally, USAID had particular concern about the care of orphaned and vulnerable children in Aceh. Many international agencies had invested in child protection activities after the tsunami. HSP identified the Labui Children's Center as one which was operational in an area that had been heavily affected by the tsunami. The Labui Center, a program of Muhammadiyah Aceh, was operating with funds from UNICEF at the time the program started. Through discussions with their staff, Muhammadiyah, and the Provincial Department of Social Affairs, HSP agreed to provide technical assistance to help improve the staff and programmatic capacity of the Center, in view that it could serve as a model for other children's centers in Aceh, particularly those managed by Muhammadiyah. A PULIH staff member provided on-site support and in-service training to Labui staff on issues related to the psychosocial needs of children. Additionally, HSP responded to the request of Muhammadiyah to provide direct support to their children's programs, which included a small donation of equipment and funds to operate a computer course.

III. EVALUATION METHODS

This evaluation was undertaken by a faculty member and Master of Public Health (MPH) candidate of the Program on Forced Migration and Health of Mailman School of Public Health at Columbia University, as well as two Acehnese university graduates with post-tsunami psychosocial and mental health experience. The evaluation team also was actively supported by HSP staff. Field research was undertaken between June 15 and August 15, 2007. The final report was submitted to HSP on August 20, 2007.

Two complementary evaluation methodologies were employed: an adequacy survey and a program outcome study.

Adequacy Survey

The adequacy survey examined whether the project completed what it set out to do in terms of activities, trainings, material development and services that were planned to achieve specific objectives or results. The adequacy survey focused on the key tasks and milestones proposed in HSP's 2006 and 2007 work plans. It examined these tasks and milestones in all four districts HSP works: Banda Aceh, Aceh Besar, Aceh Barat, and Aceh Jaya.

At the most basic level, the adequacy survey sought to verify the extent to which HSP and its implementing partners met their "input and output" commitments. Beyond verifying that such tasks were (or were not) completed, the adequacy survey also enabled a more realistic examination of the program design itself. By confirming that tasks were completed, it is possible to attribute outcomes not to missing inputs or outputs, but to the program design itself. If most aspects of the program were implemented, negative or positive outcomes are reflective of the program design. Conversely, if key tasks were not implemented, evaluation of the program's design is not realistic.

Outcome Study

The heart of this evaluation is an outcome study. It focused on what changes, if any, resulted from peoples' participation in the HSP supported program. It would not be sufficient, for example, to automatically assume that nurses who attended the mental health training sessions are subsequently capable of improving the health of individuals suffering from Axis I psychological disorders. A measure of change in mental health status is needed to claim improved mental health status as a program outcome. Moreover, it is too early to determine if any of the program outcomes are sustainable or have affected the community at large. An impact study is not possible at this time.

The outcome study focused exclusively on Aceh Besar. It did so because this is the sole district where HSP proposed its most ambitious goal: to create a home-to-hospital continuum of mental health care that would be effective, sustainable, and replicable.

A portion of the outcome study focused on health system development and sought to answer the key question: Is there a mental health system in place at village, sub-district, and district levels that is effective, sustainable, and replicable? Towards this objective, the study asked patients and their families (primary caretakers) if the patient's mental health and social functioning had changed since their involvement in the new mental health system. Structured interviews with community mental health nurses (CMHNs) and general practitioners (GPs) also explored these health professionals' perceptions of what was working and what was not working at different

levels. Field observations of nurses during home visits and of psychosocial cadres as they worked in their respective communities shed further light on the interplay between village and *Puskesmas*.

A second portion of the outcome study focused on HSP's psychosocial protection program. This examination proved to be especially challenging as, by design, the psychosocial protection component promoted a "menu of options" approach to community recovery. A uniform program outcome focus was not possible. Instead, the evaluation sought to document collective perceptions of changes in the psychosocial well-being of the 13 HSP-supported villages. It did so by asking the psychosocial cadres in these villages to rank their community's psychosocial well-being immediately after the tsunami as compared to now (July-August 2007). These group perceptions offer some degree of insight into community well-being issues, irrespective of different psychosocial activities and other agencies' involvement in these same communities.

The psychosocial protection portion of the outcome study also examined the following community psychosocial outcomes:

- Psychosocial volunteers were in place and functioning
- Psychosocial activities selected by the communities were taking place; the frequency of activities and number of participants per activity
- Which psychosocial activities were most likely to be continued by communities after subsidized support ends
- Muhammadiyah Children Center's role in its community

The study did not examine the content of psychosocial trainings, nor specific knowledge gained from cadres attending these trainings. Instead, it examined the extent to which psychosocial knowledge provided during training sessions was being transferred to the community through the day-to-day work of the psychosocial cadres.

A final portion of the outcome study looked at the technical assistance provided by PULIH to the Muhammadiyah Children's Center in Labui. This portion of the outcome study examined how the PULIH training influenced the development of Muhammadiyah Children's Center.

Establishing a Baseline

The evaluation team wanted to capture as accurately as possible the status of those intended to benefit from the project before the project was implemented. This is best accomplished when the status of those intended to receive services is measured prior to the start of the project; however this was not possible because the HSP initial assessment team did not establish baselines on relevant indicators before the program began.

The HSP original assessment included a nine-item mental health baseline that focused exclusively on depression. It did not include relevant indicators for general anxiety, post-traumatic stress disorder (PTSD) or schizophrenia. These oversights were pointed out by HSP psychosocial staff in their 2007 work plan. The evaluation team also agreed that early assessment indicators were unusable for baseline purposes.

The lack of an adequate baseline necessitated that such information be established retrospectively. Two clear time frames (before and after) were established, along with simple procedures for gauging perceptions of change between these time periods. For the mental health component, patients and their families (primary caretakers) were asked to describe their mental health and social functioning

status before and after meeting with the CMHN. For the community support component, psychosocial volunteers were asked to describe and rank the psychosocial well-being of their respective villages immediately after the tsunami and now (July-August 2007). A simple one-to-five scale was adopted because of its familiarity throughout Indonesia, including Aceh.

Specific Components of the Study

The outcome study is comprised of the following interrelated components:

Patients and caretakers

Have mental health patients and their families been well-served by HSP supported additions to the mental health system, namely the CMHNs and community volunteers? To answer this question, the study interviewed patients who were reported by the District Health Office (DHO) to have received at least one CMHN home visit as of March 31, 2007. When possible, both patients and family members who served as primary caretakers were interviewed to triangulate findings. Almost all of the patients were men, while the primary caretakers were women (i.e., mothers, wives, and sisters). Dual interviews enabled a better understanding of how mental illnesses- and new responses to them- were affecting individuals and families (and in particular, women and children).

The one-to-five ranking exercise sought to document patient and caretaker perceptions of the patient's mental health and social functioning status both before and after meeting with the CMHN. Patients were asked to rank the severity of their conditions before receiving treatment at the *Puskesmas*, with 1 being the worst problem that they had ever imagined, and 5 being no problem at all. Caretakers were asked to rank their perception of the patient's condition using the same scale. A total of 44 households, including 38 patients and 36 caretakers, were interviewed in their homes.

Structured interviews with the CMHN

Questions for the CMHN were designed to capture their insights into the new mental health system, and their roles within it. CMHNs were asked about the:

- quality and level of training they received
- strengths of the system
- challenges they face in their new positions
- working relationship with both the GP and the village cadres

In addition, the CMHNs were asked if they could recall a "success" and to describe it.

A total of six nurses from four *Puskesmas* were interviewed. However, in one *Puskesmas*, a nurse who had been working in a mental health capacity for less than a month was unable to answer many of the structured questions. Her responses were used qualitatively, but not included in consensus computations.

Structured Group Interviews with Psychosocial Cadres

Structured group interviews with the psychosocial cadres centered on their:

- roles as volunteers
- perceptions of community's psychosocial well-being
- community's psychosocial activities
- working relationship with CMHNs

Part of this structured group discussion called for the psychosocial cadres to describe and collectively rank the psychosocial status of their community in the aftermath of the tsunami, with 1 being the worst problem imaginable and 5 being no problem at all. They were then asked to rank the psychosocial status of their community today (July-August 2007) compared to immediately following the tsunami on the following scale:

1	2	3	4	5
No Improvement Tsunami	Little Progress Tsunami	Significant Progress	Same as before the Tsunami	Better than before the Tsunami

The ranking exercise was also designed to document whether or not particular villages were severely affected by the tsunami, and subsequent questions sought to clarify what factors contributed to collective psychosocial well-being outcomes. During these discussions, a number of psychosocial cadres offered their insights into internationally subsidized assistance practices that they believed hindered or, in some cases, undermined the psychosocial well-being of their village.

Interviews were conducted with psychosocial cadres in 13 villages in Aceh Besar's four sub-districts. All of these psychosocial cadres serve as mental health cadres as well. At least four out of five cadres per village participated in group interviews.

Focus Group Interviews with Staff of the Labui Muhammadiyah Children's Center

Focus group discussion with child care staff at Labui Muhammadiyah Children's Center sought to determine whether or not the Center was playing a vital child support role in the community. It also sought to identify changes in child care practice that could be attributed to PULIH trainings and seminars. This was particularly challenging as the Children's Center staff have received training from several different NGO's, and it proved to be impossible to pinpoint which NGO contributed to what. Additionally, low child attendance at the center also prevented meaningful direct observation of childcare workers and children. Five of the seven workers were present at the focus group discussions.

Site visits

Site visits were conducted at four *Puskesmas*, 13 villages, and the Muhammadiyah Children's Center. In addition, unannounced drop-in visits were conducted in eight villages to see if seed funding activities were taking place as described and scheduled. A site visit to the psychiatric acute care unit at the District Hospital also took place.

Key Government and Agency Staff Interviews

Clarification interviews took place with key staff of government, non-governmental organizations (NGOs), academic institutions, and donor agencies to seek their insights and resolve outstanding issues. These interviews included senior staff of:

- Ministry of Health (MOH); Provincial Health Office (PHO); District Health Office (DHO)
- Aceh Provincial Psychiatric Hospital (BPJK)
- Indonesia University (IU) Faculty of Nursing
- WHO
- PULIH
- HSP
- Agencies-Networks: American Red Cross (ARC); International Catholic Migration Commission (ICMC); International Medical Corp (IMC); and, International Organization of Migration (IOM)
- *Jaringan Nasional Pelatihan Klinis* (JNPK) National Clinical Training Network
- ADB
- USAID

Data Collection and Analysis

Household and community level data was collected by a team of trained nationals through structured interviews in the local language. All questionnaires were piloted with representative samples in Aceh Besar and appropriately adapted before being deployed. In one conflict-affected sub-district, villagers were reluctant to speak to the interview team, because they were viewed as "outsiders." On four occasions, a CMHN introduced the interviewers to the patient and caretaker and waited elsewhere in communities during these interviews.

Data was entered into a Microsoft Access database. In addition, a member of the Columbia University team debriefed field interviewers each day to ensure qualitative and observation information was recorded as well.

IV. ADEQUACY SURVEY

This section examines key tasks and activities as described in HSP's 2006 and 2007 work plans. Completion verification was done via site visits, quarterly reports and reviews of materials produced. Clarification interviews with key HSP and PULIH staff also took place.

Work Plan 2006

Community Support Component

Task 1 – Complete assessment of psychosocial needs of women and children in target sub-districts

Objective

To ensure that the HSP program addresses the real psychosocial needs of women and children, utilizing appropriate local partners and building on existing community structures.

Activities	***Yes***	***No***
Visit at least four target villages where HSP community-level health programs are being initiated; meet with village leaders, local community-based organizations, and women to assess psychosocial and protection needs of women and children.	**X**	
Map presence and capacity of local partners in HSP target sub-districts, and determine their experience and interest in working on psychosocial programs.	**X**	
Meet with PHO and DHO to assess their interest and concerns in expanding psychosocial programs and services for women and children.	**X**	
Milestones		
Assessment report: March 2006.	**X**	

Summary

HSP met with four target villages where programs were initiated. Additionally, four one-day workshops were conducted in each DHO. The Head of the Mental Services from Aceh's PHO attended all of the workshops in all four districts. The head of the PHO and the head of the family health offices rotated their attendance, but one was always present. HSP's project strategy closely follows the recommendations of the assessment.

Task 2 – Work with DHO to design a training program on protection and psychosocial issues for community-based organizations

Objective

To develop an appropriate training tool on protection and psychosocial issues for vulnerable women for community-based organizations.

Activities	*Yes*	*No*
Build on PULIH's ongoing work to develop training-of-trainers (TOT) manual on community-based activities to promote protection of women (leveraging Ford Foundation grant).	***X***	
Develop a "Facilitators Guide" to be given to those trained, outlining how to implement series of semi-structured psychosocial and protection activities that can be implemented through existing women's groups.	***X***	
Develop a training package for above activities, including: instructional video, activity manual, flipcharts, posters, newsletters, and other learning aids.	***X***	
Milestones		
Facilitator's Guide completed: March 2006.	***X***	
Trainers prepared to roll-out training methodology based on activity manual: April 2006.	***X***	

Summary

The Facilitators Guide was completed in June 2006. Twenty participants from 15 NGOs participated in two 10-day trainings. Of these, 12 participants from 10 NGOs completed both trainings and were "certified" as a Trainer of Trainers (TOT), capable of providing subsequent training to psychosocial cadres. The TOT approach aimed to develop the capacity of local NGOs and also to develop the capacity of community cadres.

Task 3 – Build capacity of women's groups to initiate psychosocial activities

Objective

To increase the capacity of community-based organizations in HSP target areas to offer programs for women that emphasize self-help, prevention of exploitation, and psychosocial healing, with an emphasis on female-headed households and the most vulnerable women.

Activities	*Yes*	*No*
Identify NGOs and community structures with potential to address psychosocial and protection of women such as religious groups, *Posyandu*, and Safe Village (SIAGA) community.	***X***	
Identify community members who will be trained to facilitate psychosocial and protection activities of women.	***X***	
Identify appropriate local trainers who can assist HSP to roll out training.	***X***	
Conduct TOT through modeling approach where PULIH trainers co-facilitate training of facilitators from at least 18 target villages.	***X***	
Provide materials to community groups to implement activities.	***X***	
Milestones		
Six villages have at least one women's group implementing psychosocial and protection programs: June 2006.	***X***	
Twelve additional villages have at least one women's group implementing psychosocial and protection programs: September 2006.	***X***	

Summary

Village work in Aceh requires the approval of both village and religious leaders. HSP engaged both sets of leaders in identifying community members to serve

as psychosocial cadres. A local NGO, Tammi, also worked with each village to identify the "effective cadre criteria." Village leaders were asked to conduct a village meeting to nominate and elect cadres. In two villages in Aceh Besar, however, the village leaders selected the cadres themselves. This was determined by HSP staff to be ineffective and HSP thereafter offered additional support to ensure that other villages employed democratic processes to select their cadres. A total of 245 cadres in 49 villages were identified and trained to address psychosocial issues facing women and children.

The 10 NGOs "certified' as TOT conducted the training for psychosocial cadres. PULIH supported this process and organized a technical training session that covered the fundamentals of psychology, child development, and the intersection of religion and psychosocial issues, among other topics.

After their two-week training course, psychosocial volunteers returned to their villages for nine days to identify community psychosocial needs. HSP's community facilitators assisted the cadres during the assessment period. The psychosocial cadres then returned for two more days of training where they developed action plans based on their community assessments.

Task 4 – Field test and finalize community-based training materials

Objective

To field test and finalize training materials for use at the community level, exploring and developing materials for including religious leaders in promoting protection of women and children.

Activities	***Yes***	***No***
Support local trainers to implement at least two more trainings of village facilitators, giving feedback to trainers to improve their performance.	***X***	
Make regular visits to a sample of villages using training materials to get feedback, to observe use of materials, and to gather ideas about how to make materials more specific to the Aceh context.	***X***	
Modify and finalize TOT manual, Facilitators Guide, and support materials (poster, flipchart, etc.).	***X***	
Identify opportunities to develop psychosocial and protection messages via religious structures and individuals, and develop messages that reflect Islam and the culture of Aceh.	***X***	
Create materials (posters, pamphlets, flipcharts, etc.) for use by religious leaders	***X***	
Work with local partner to hold workshops for religious leaders on how to deliver messages.		***X***
Milestones		
TOT manual, Facilitator's guide and support materials for religious groups finalized: July 2006.	***x***	

Summary

PULIH identified a local NGO partner with credibility among local religious leaders, and trained them to work with the leaders to develop messages on the protection of women and children. However, during a review of the materials and their channels of distribution (the mosque), the local NGO partner was not sure whether the delivery of messages would be perceived as "foreign assistance" meddling in Acehnese religious affairs. Therefore, HSP determined not to invest

further in producing print materials targeting religious leaders, and support for this program was discontinued.

Task 5 – Initiate facilitator-led, community-based protection activities for women

Objective

Utilize PULIH-trained community psychosocial facilitators to promote activities that restore and strengthen women and children's psychological and social ecologies.

Activities	***Yes***	***No***
Initiate a six-month program of intensive psychosocial activities for women in three villages that have community health committees that are interested in having a psychosocial women's program facilitated by PULIH community facilitators.	***X***	
Identify six additional HSP-intervention villages with community health committees that are interested in having a psychosocial women's program facilitated by PULIH community facilitators.	***X***	
Milestones		
Community-based protection activities for women in three villages initiated: April 2006.	***X***	
Community-based protection activities for women in an additional six villages initiated: July 2006.	***X***	

Summary

PULIH and a local NGO (RPUK) worked together and completed all Task 5 activities. They facilitated community sensitization meetings to introduce psychosocial concepts and common concerns, and discussion groups on domestic violence, child abuse and economic issues. Community members were also provided information on where to seek help and services.

Task 6 – Produce feature-length film promoting community mental health and the protection of women and children

Objective

To develop a feature-length film grounded in the reality of current tsunami-affected communities, promoting community mental health and the protection of women and children.

Activities	***Yes***	***No***
With local partners and communities working on psychosocial issues, develop storyline and key messages for film.		***X***
Select appropriate production house to produce film in Aceh, using all Acehnese actors.		***X***
Edit and produce film.		***X***
Start utilizing film for community-based discussions about protection of women and children.	***X***	
Milestones		
Film on protection of women and children produced: September 2006.	***X***	

Summary

In its initial program design, PULIH had proposed to develop a film on women's protection, based on its previous experience developing a popular child protection film, Anak-anak Fajar, with funds from Save the Children. After considering the cost and level of effort required, the program decided not to produce a separate film and instead to copy, distribute and utilize the Anak-anak Fajar film already available. The video was distributed to all 49 HSP villages. In addition, the film aired on a local television station.

Task 7 – Promote livelihoods options for the most vulnerable women

Objective

To investigate the need for targeted livelihoods support for the most vulnerable women, and respond, as needed, to increase women's psychosocial well-being and create a safety net against exploitation.

Activities	***Yes***	***No***
Review Mercy Corps' current livelihoods programs to determine whether livelihoods of the most vulnerable women are being met.	***X***	
Milestones		
Assessment of the livelihoods needs of vulnerable women in 36 villages where the program will operate: March 2006.	***X***	
As needed, livelihood program targeting the most vulnerable women implemented and reaching 12 villages: September 2006.		***X***

Summary

The livelihoods assessment was completed; however, a full fledged livelihood program never materialized. Instead, Task 7 was integrated (and significantly reduced) into smaller seed funding projects as described below (2007 Work Plan, Tasks 1 and 2).

Mental Health System Component

Task 1 – Finalize a psychosocial training program for *Puskesmas* doctors, nurses, midwives

Objective

To finalize an appropriate training tool for *Puskesmas* staff on how to recognize mental health and exploitation problems (such as domestic violence and forced marriage) among women seeking primary health services, and provide appropriate information and referral services.

Activities	***Yes***	***No***
Coordinate to ensure materials developed reflect MOH and WHO standards for psychosocial services in primary health care settings.	***X***	
Ensure provincial and district health offices are aware and supportive of this training program and have opportunity for input.	***X***	
With provincial and district health office, ensure program is able to appropriately refer to mental health services (e.g., *Puskesmas*-based mental health nurses).	***X***	
Adapt existing training manuals to address broader psychosocial and protection context of	***X***	

Aceh (e.g., MOH/PULIH manual for training health workers to address domestic violence, JNPK manual on counseling skills, MOH manual on post-traumatic stress management in post-conflict contexts). Develop (1) TOT Guide (2) Participants Workbook and (3) Learning Aids. Ensure competencies in gender sensitivity, basic communication skills, recognition of psychosocial and exploitation problems and referral services for women are addressed.		
Seek review and concurrence from the PHO for training materials and program.	***X***	
Develop complementary IEC materials appropriate for *Puskesmas* waiting room (posters, leaflets, etc.).	***X***	
Ensure provincial and district health offices are involved in selection of trainers.	***X***	
Train local trainers in training materials.	***X***	
Co-facilitate two batches of training for *Puskesmas* staff (bidans, nurses, doctor) using curricula developed.	***X***	
Milestones		
Training manual adapted: July 2006.	***X***	
Training for 50% of staff in target *Puskesmas* (30 people): August 2006.	***X***	

Summary

HSP's psychosocial team met with the PHO to share the standards of care developed by MOH, WHO, and the UI. They worked with the DHO to conduct a one-day workshop in each of HSP's four districts as well as for staff of the PHO. Four people from each DHO were trained. DHO staff, in turn, adapted the materials and trained *Puskesmas* staff in their respective districts. HSP distributed posters to 16 *Puskesmas* in four districts. Posters were visible when the evaluation team visited the four *Puskesmas* in Aceh Besar.

Task 2 – Develop and disseminate "Guide to Psychosocial Services in Aceh"

Objective

To develop and disseminate a comprehensive "Guide to Psychosocial Services in Aceh."

Activities	***Yes***	***No***
With input from provincial and district health offices, WHO, and other members of interagency psychosocial working group, collect information on mental health, domestic violence and other critical services and activities.	***X***	
Design and print 5,000 copies of guide.	***X***	
Assist Provincial Health Office in the distribution of guide.	***X***	
Milestones		
Print 5,000 copies of guide: September 2006.	***X***	

Summary

The guide was distributed through the DHO and PHO, cadres, village leaders, and other stakeholders. The guide identifies common psychosocial and protection issues and potential service providers and activity programs.

Work Plan 2007[1]

Community Support Component

Objective

To ensure that the HSP program addresses the psychosocial needs of women and children, utilizing appropriate local partners and building on existing community structures.

Task 1 – Continue providing support and supervision to community-based psychosocial and protection programs in 37 villages in three districts

Activities	*Yes*	*No*
Facilitators trained by PULIH visit villages to supervise activities where there are community-based psychosocial and protection programs in place.	***X***	
Seed funding for community activities is set in place for 37 villages in four districts. These activities focus on sports, art, culture and livelihood and are intended to strengthen levels of psychosocial resilience in communities.	***X***	
Distribute IEC materials to village communities.	***X***	
Support village meetings on mental health and psychosocial needs of women and children.	***X***	

Summary

HSP's Community Facilitators conduct monthly meetings with the psychosocial cadres. Community facilitators assist cadres in communication with the *Puskesmas*, and in navigating the process of reporting problems, such as domestic violence, to the police.

Task 2 – Expand community-based psychosocial and protection programs to an additional 12 villages in an additional one district

Activities	*Yes*	*No*
Train 60 cadres for psychosocial and mental health protection.	***X***	
Facilitators trained by PULIH visit villages to provide supervision to cadres.	***X***	
Distribute seed funds for community activities.	***X***	
Support village meetings on mental health and psychosocial needs of women and children.	***X***	

Summary

Seed money was distributed to 49 villages in Aceh Besar, Aceh Jaya, Banda Aceh, and Aceh Barat. Cadres selected from a menu of activities - ranging from small economic projects to children's play groups to women's support groups - to support with these funds. Average reported participation rates for these activities ranged from five to 30. Unannounced evaluation team "drop-in-visits" in eight villages revealed that seven villages were conducting the activities as scheduled and with participant levels that closely approximated reported numbers. A wedding in the eighth village took precedence over its scheduled activity.

[1] HSP's 2007 Work Plan did not include specific objective or milestones for each task (as its' 2006 Work Plan had done) and are not included in the second part of the adequacy survey.

Task 3 – Support seven "community dialogue forums" at the district level to provide support and refresher education for psychosocial cadres

Summary

Community and dialogue forums are scheduled to begin in August 2007. Some forums were taking place during the evaluation period.

Task 4 – Pilot test, finalize and print "psychosocial kits" for use by DHO and NGOs to replicate the community-based psychosocial programs for women and children

Activities	***Yes***	***No***
Materials prepared by PULIH are pilot tested and finalized.	***X***	
The materials, comprising manual, flip board, and brochures, are packaged as a kit. At least 200 kits are prepared and distributed to local partners (NGOs and DHO) who will utilize them to replicate psychosocial activities.	***X***	

Summary

200 Psychosocial Kits were distributed to psychosocial cadres and DHO staff in Aceh Besar and Banda Aceh in July of 2006. The kits included domestic violence (spousal and child abuse) posters and booklets on gender based violence, positive parenting, the importance of play for children, and strategies for resolving marital conflict. Cadres in Aceh Jaya and Aceh Barat have yet to receive these kits; it is anticipated that distribution in these two districts will take place in September 2007.

Task 5 – Conduct qualitative assessment of orphaned and other vulnerable children living outside institutional care in Aceh

Activities	***Yes***	***No***
In partnership with the University of Muhammadiyah (UM), develop trigger questions for focus groups of children, care providers, and coordinators of three Mohammadiyah Child Centers.	***X***	
Develop with UM a questionnaire for in-depth interviews with children, caregivers and coordinators of three representative Child Centers.	***X***	
Pilot questionnaire and trigger questions with 10 children, 10 care providers, and one coordinator from each of three representative cadres.	***X***	
Collect and collate pilot data.	***X***	
Analyze data and prepare and disseminate a report.	***X***	

Summary

Report was completed.

Task 6 – Create a learning center within Muhammadiyah Labui Child Center for children to develop new skills and cope with psychosocial issues

Activities	*Yes*	*No*
In partnership with PULIH, build capacity of Center staff to develop model for community child care.	***X***	
Six fully loaded computers are placed at Labui Children's Center.	***X***	
With UM, develop computer training program and manual.	***X***	
In partnership with UM, provide computer training.	***X***	
In collaboration with UM, develop program for learning journalism and publishing skills.	***X***	
Develop, in partnership with PULIH, Center staff and children, an activities' curriculum for remainder of funding cycle.	***X***	

Summary

HSP has encouraged changes in PULIH's approach to training - away from didactic methods and towards interactive processes and on-site support. Interactive sessions were offered to Children Center's staff two times a week from February to June 2007. Center staff attendance was sporadic, as childcare workers were frequently attending other trainings. In addition, seven child care workers from the Labui Childcare Center and one representative from the other Muhammadiyah Child Centers (a total of eight participants) attended two five-day workshops in May and June 2007. Six computers were installed at the Labui Center. A manual was developed, and approximately 30 children are reported to have received training on how to use basic computer programs.

Mental Health System Component

Task 1 – Implement intermediate-level Community Mental Health Nurse training for nurses in 24 *Puskesmas* clinics

Summary

Since May 26, 2006, 40 GP's have received training; 90 nurses have completed the basic course; and 48 of these 90 nurses have also completed the intermediate course. 47 of the 53 *Puskesmas* in HSP districts have a CMHN who received basic training; 35 of these nurses also completed the intermediate course.

Task 2 – Renovate and equip Aceh Besar district hospital to provide acute care psychiatric services

Activities	*Yes*	*No*
Inspected location.	***X***	
Met with MOH to obtain standards for building inpatient mental health facilities.	***X***	
Joined newly established working party to develop national standards for inpatient mental health facilities.	***X***	
Commissioned preliminary architectural drawing to brief.	***X***	
Inspected Banda Aceh Psychiatric Hospital (BPKJ), Nanggroe Aceh Darussalam (NAD) psychiatric facility.	***X***	
Inspected Bogor Psychiatric (RSMM) facility.	***X***	
Stakeholder meetings.	***X***	

Feasibility workshop.	***X***	
Obtained signed Agreement from the Pupate of Aceh Besar, Head of PHO, Head of BPKJ and Head of DHO Aceh Besar, Head of DPRD Aceh Besar, Director of Yankeswa MOH.	***X***	
With ADB, support a psychiatrist to provide mentoring to Jantho Hospital Director and Director of mental health unit during startup of acute care services.	***X***	
To support Director of unit, six start-up nurses, security staff, administrative staff to undertake in-service training at BPKJ, NAD, and for Head Nurse and Director of unit at RSMM, Bogor for two weeks.	***X***	
To provide support for the start-up nurses to complete all levels of CMHN training.	***X***	

Summary

The acute care psychiatric unit, which is attached to the district hospital in Jantho (Aceh Besar), is scheduled for completion at the end of September 2007. It is designed to be a safe, healing and restorative environment which is also capable of " creating a safe, secure and contained space for both acutely ill and potentially dangerous patients. Nurse working quarters are designed to facilitate active engagement with patients during their brief stays at this inpatient unit and contrasts sharply with the custodial style of care at the BPKJ.

Task 3 – Work with the ADB and University of Indonesia Academy of Nursing to develop referral protocols for mental health from the *Puskesmas* to the district and provincial hospitals

Summary

ADB and UI met to develop protocols for referrals. This protocol was integrated into CMHN training. CMHN's are routinely applying these protocols when referring patients to the psychiatric hospital. However, the BPKJ is not informing the *Puskesmas* when patients are discharged and return home.

V. OUTCOME STUDY: MAIN FINDINGS

This section presents the main findings from the evaluation's outcome study. While the program operated in an integrated fashion, the findings are divided into two main sections: (1) the mental health component, which strengthened the provision of mental health services through the *Puskesmas* clinic and (2) the psychosocial and protection component, which strengthened NGO and village volunteer capacity to implement psychosocial protection and promotion activities. Outcome study findings are limited to Aceh Besar where HSP proposed to develop a model program as described in the methods section above.

Mental Health Component

This section presents the study's main findings on the mental health nursing portion of HSP's program. In Aceh Besar, the program was operational in 14 *Puskesmas*, with HSP supporting the basic and intermediate training of one general practitioner doctor and two nurses per clinic.

Finding One: A model program has been developed

HSP has achieved its most ambitious goal: the development of a household-to-hospital continuum of mental health care. It is a "model" program in that it has clear methodologies, competent professionals, high quality training, and quality assurance standards. Because the technical and implementing partners for this initiative are established Indonesian agencies (i.e., the University of Indonesia Faculty of Nursing, the NGO partner PULIH, and a range of local NGOs in Aceh), it is capable of being replicated on a wider scale. Moreover, the program is fully integrated into the Indonesian public health system structure, increasing replication potential.

What is different? Prior to this program, Aceh's two psychiatrists and sole mental health treatment facility were located in Banda Aceh. The mental hospital, BPKJ, was notorious for its overcrowded, under-resourced, and inhumane conditions. There was no mental health expertise at the district or sub-district level. Medications were available only in Banda Aceh, and there was no community support for individuals with serious psychological disorders or their family. Moreover, the civil conflict and tsunami had disrupted social structures that had historically provided support and protection to women and children, making them more vulnerable to psychosocial problems.

HSP support has, with prior WHO investments, enabled three new levels of mental health and psychosocial care and support:

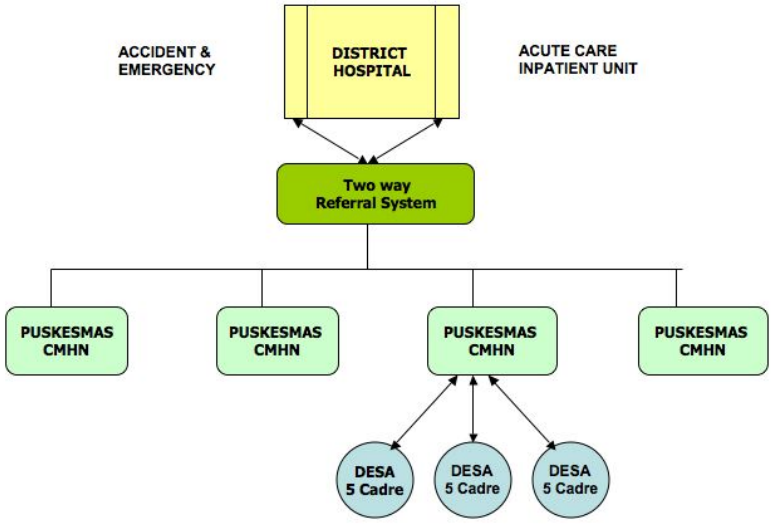
Puskesmas: The program calls for two CMHNs per 30,000 residents. Nurses attend a rigorous, highly structured and sequential training program (with beginning and intermediate courses already completed, and advanced courses planned). The curriculum has been reviewed by WHO and senior psychiatrists working in Indonesia. Trainers receive a high level of support and supervision from senior mental health nurses from the University of Indonesia Faculty of Nursing. Standards have been established for the role of the CMHNs, including for case load management, community outreach, home visitations and referral procedures. The training is competency-based, and includes classroom learning, fieldwork, and 2-6 months of supervised case management (depending on the level of training).

Village: The program calls for the establishment of volunteer psychosocial/mental health cadres at the village level. Through HSP's support to PULIH and local Acehnese NGOs, cadres first received training on psychosocial issues for women and children, learning to address issues such as domestic violence. These cadres also received additional support for activities designed to promote psychosocial well-being, primarily through women's and children's groups (see findings in next section). The cadres were subsequently also trained to work with the CMHNs to identify villagers with mental health issues; raise awareness and reduce stigma about mental illness; provide referral advice to CMHN services; and conduct home visitation and outreach to families that require extra support for mentally-ill members.

District: The program calls for the creation of an intensive acute care unit at the district level. A 10-bed unit, adjacent to the Jantho Hospital, is nearing completion (end of September 2007). It represents state-of-the-art standards for inpatient care facilities, with interactive workstations, tranquil spaces for patients, and, safe, secure and –as needed- contained spaces to manage responses to care crises. Staffing will include 6 CMHNs who have completed the advanced training program and one psychiatrist who initially will be supported by ADB. In addition to work at the acute care unit, these seven staff will provide regular support to *Puskesmas* staff. Practicum placements also will be created for nursing students.

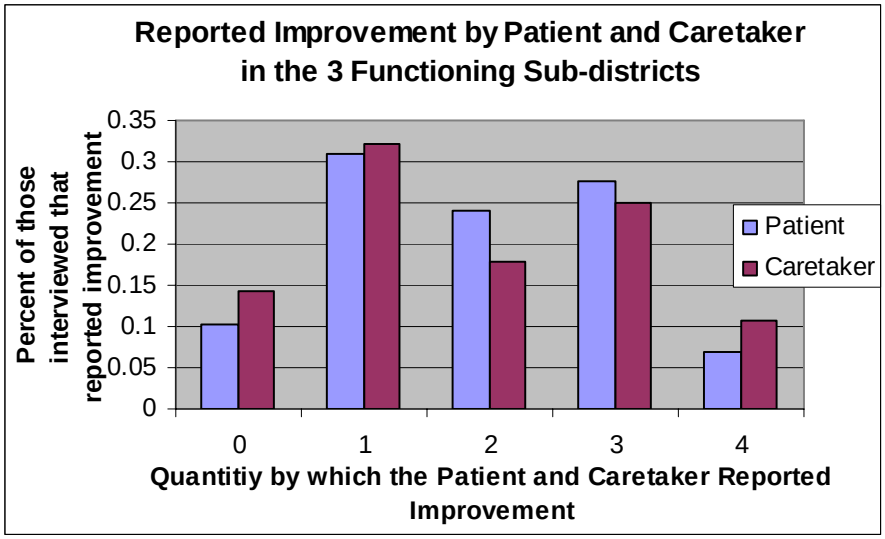
These additional levels of care are represented in figure below:

Mental Health System in Aceh Besar



Finding Two: The new mental health system is restoring health, human rights and human dignity

In three of four sub-districts in Aceh Besar, the new mental health program is achieving significant results. 90% of the patients and caretakers surveyed reported improvements, with an average improvement of 1.85 on a scale of one-to-five. 85% of patients and their caretakers agreed on the patients' mental health and social functioning status. However, where there were differences (15%), caretakers reported their perception of the patient health as better than the patients themselves. In such cases, patients almost always reported side effects from the medication or hallucinations that had not subsidized completely; while caretakers reported improved social functioning to the point that the patient could now be safely left home alone, without immediate supervision (or confinement). The vast majority (70%) of these patients reported having these problems before the tsunami, indicating that the tsunami was neither a trigger nor a cause of their mental illness.



None of the patients or caretakers in the three functioning sub-districts reported a worsening of mental health or social functioning. One patient, who temporarily stopped seeing the nurse after he moved, reported significant improvement when receiving home visits, but returned to a "worst problem ever" evaluation after losing contact with the nurse. He was recorded as "no improvement."

"She used to just cry and cry, now the nurse comes and she's happy. She does dishes and prays."
-Sister of patient

Patients were asked an open-ended question about what changes they had experienced since receiving care from various levels of the new program. Changes described ranged from simply being less disruptive, on the one end, to significant and positive alterations in the quality of life for both the patients and the caretakers, on the other end. 16% of the households reported that the program enabled the patient to be employed when he had never been employed before the treatment and support plan came into effect. The health and social functioning changes that patients reported fell into three categories.

Dramatic Improvements

Patients moving up the scale the most (by three or four rankings) were frequently characterized by dramatic reduction or elimination of auditory and visual hallucinations and dramatic reductions in aggressive behaviors. Most of these patients were amongst the most severely disordered before receiving treatment and care from the new mental health system. Family members reported the need to lock these patients in the house - or even chain them down to beds - to prevent them from engaging in dangerous and life-threatening behaviors. During interviews, caretakers and patients also listed dramatic improvements in social functioning, including the ability to work in village rice fields and home gardens, socialize in local cafes, ride motorcycles alone and, in some cases, maintain employment. While still receiving support from a CMHN, many of these patients also obtain medications from the BPKJ that are not available at the *Puskesmas*.

"About five months ago, this particular patient was hallucinating a lot. He walked around the village naked and would eat feces. After regular visits and medication the patient improved significantly. He started dressing properly, taking a bath and doing other things like that. I think that the reason for this was that the patient was able to take his medication regularly and had full support from his family during his recovery. I also think that it helped that we told him how to deal with his hallucination and reintegrate into the community."
-CMHN

Significant Improvements

While not as dramatic as those who moved up on the scale by three or more rankings, the changes in the lives of patients who improved by two rankings are significant. These patients were most likely to report an increase in participation of daily household activities, including washing dishes, cooking, and engagement in the daily prayer rituals. Most of these patients were suffering from symptoms of depression or anxiety rather than psychosis, which may account in part for a less dramatic description of the improvement. Those who were suffering from psychosis were more likely than their counterparts in the dramatic improvement group to rely on the medication regimen at the *Puskesmas* rather than the more sophisticated medications available at BPKJ.

"I couldn't leave my son alone before, now I can leave him alone for as long as a week."
-Mother of patient

Some Improvement

Patients with increases of only one rank reported mental health and social functioning "ups and downs." They frequently did not take their medication either due to negative side effects or "running out." During post-interview debriefings, interviewers commented that most of the caretakers of these patients seemed overwhelmed, indifferent or incapable of providing adequate support.

Finding Three: The mental health program has not materialized in Lhoong

The mental health program has not materialized in the sub-district of Lhoong. Several reasons may be responsible for this failure: the remote location and high tsunami mortalities; frequent staff absence and turnover at the *Puskesmas*; and, saturation of NGOs and subsidized activities that may have undermined collective self-reliance and volunteerism. Whatever the causes, this sub-district provides an unfortunate glimpse into how mentally-ill individuals fared prior to the new system being put in place elsewhere in Aceh Besar. Major deficits include:

- No active outreach or surveillance
- Poor diagnosis and treatment
- Medications accessed at BPKJ, not at the Puskesmas
- No support to families
- Locking/chaining mentally-ill to homes-beds
- Widespread stigma
- Superstitious beliefs regarding causation of mental illness
- Security situations that require police intervention

Residents of Lhoong with serious psychological disorders are tormented by frightening delusions and voice commands, while their families struggle to maintain safety and dignity on their own.

Finding Four: CMHN outreach and home visitation are critical

The principal parties for this initiative - MOH, UI, ADB and WHO - took into account the prevalent belief that psychological disorders result from "God's wrath" or possession by supernatural "spirits." Many villagers are unaware of science-based explanations of mental illness or of the benefits of medications. Families hide mentally-ill members from the wider community, sometimes by locking them in home or even chaining them to beds.

Community outreach, public education and home visits were established as key roles of CMHNs. This evaluation, in turn, found community outreach and home visitation to be important factors in the improved mental health status of patients in the three functioning sub-districts. Effective practice includes:

- Regular community outreach (three to four days a week), including to distant and remote villages
- A "personal approach" in advising patients and their families on treatment and social reintegration concerns
- Active monitoring of medication regimes - and alerting village cadres when patients failed to renew their prescriptions on time
- Maintaining MOH standards on case loads, home visitation sequence-frequency
- Regular meetings and ongoing support for village cadres
- Active and systematic public education, in partnership with secular and religious village leaders, village health committees, midwives, and others
- Careful identification - in partnership with village cadres - of families and primary caretakers in need of social support

In Lhoong, fewer than 50% of patients reported by the *Puskesmas* as receiving home visits had actually received them. Lhoong is the only sub-district in Aceh Besar where the evaluation team also found large numbers of patients with repeat admissions and discharges from the BPKJ.

Finding Five: Village cadres play important roles in supporting the CMHN

In an effort to provide support for patients and their families at the village level, the program called for the establishment of mental health cadres. Cadres received training on approaches to public education and on how to identify individuals in need of psychological care and treatment. In HSP-supported villages, five mental health volunteers also received training, support and resources to address broader psychosocial concerns, rebuild women's groups and promote psychosocial activities.

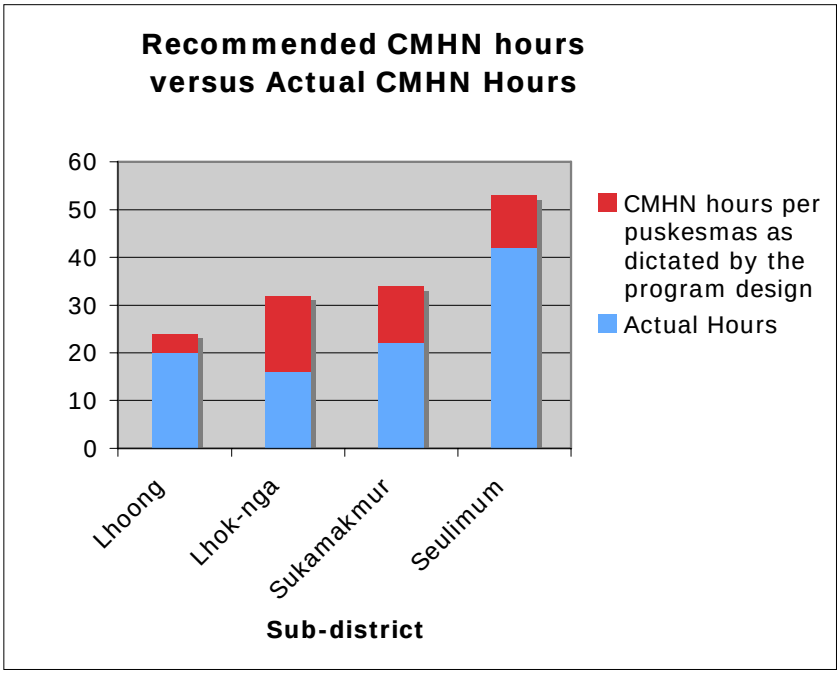
For patients who reported dramatic and significant improvements (see Finding Two above), cadres had played key support roles, including the provision of mental health and referral information and home visits. CMHNs in the three functioning sub-districts, in turn, were asked to rank the importance of village cadres to their work. The average ranking was 4.3 on a scale of one-to-five, with five being vital and one being no help. 70% of village cadres in these three sub-districts engaged in home visits and awareness campaign (patients and caretakers corroborated). In contrast, in Lhoong, the CMHN spoke of difficulties with cadre availability, while none of the patients reported any contact whatsoever with a mental health or psychosocial cadre. The following emerged as cadre good practice:

- Dedicated time and weekly schedules for cadre functions
- Provision of referral advice to individuals, families and community groups
- Active support to vulnerable families
- Direct assistance with medication regimens (for difficult patients)
- Alerting CMHN when patients leave for BPKJ
- Co-facilitating community forums with village leaders and health professionals
- Regular contact with CMHN

Finding Six: Quality assurance standards need to be maintained

The program calls for two full-time CMHNs per 30,000 residents**.** Given the tsunami-related death toll, all four of Aceh Besar's sub-districts now have resident populations under the 30,000 threshold. At the same time, however, three of four sub-districts only have one CMHN with proportionate caseloads that exceed this quality assurance threshold.

Moreover, no CMHN works full-time on the mental health program. The following graph compares required versus actual working hours:



Community outreach and home visitation is not always supported by the *Puskesmas'* GPs. In one sub-district, for example, the CMHNs have been instructed to remain at the *Puskesmas* during regular working hours. As a result, they undertake home visits before and after normal working hours.

Finding Seven: The two-way referral system is broken

The BPKJ is not notifying the *Puskesmas* when patients are discharged and sent home. The patient is provided documentation pertaining to the nature of the problem and recommended medication; however, neither this documentation nor a discharge notification is transferred to the *Puskesmas*. Patients are "dropped" back into their communities without any adequate assurances that follow-up support is in place.

Finding Eight: Continued decentralization of care and treatment regimes would enhance the patients' health and well-being even more

As discussed in Finding Two above, patients who reported "dramatic" improvements (four and five rankings) often received medications at the BPKJ that currently are not available at the *Puskesmas*. Indeed, current medications at the *Puskesmas* are rudimentary. They include:

- Diazepam
- Clozapine (CPZ)
- Haloperidol
- Amitriptyline
- Triheksi Prienidil (THS)
- Carbamazepam
- Presium

11 additional medications have been recommended. These include:

- Phenobarbital
- Barzepin (Oxcarbazepin)
- Chlorpromazine
- Trifluoperazine
- Carbamazepine
- Phenytoin
- Clobazam
- Cetabrium (Chlorziaxepoxide)
- Alprazolam
- Perphenazine
- Noxetin (Fluoxetine)

The availability of these medications at the *Puskesmas*-level would continue the effective practice of decentralized care. In addition, regular psychiatrist visits to the *Puskesmas* would enhance patient care as well.

Many cadres reported that some village residents openly question their knowledge and competence. All of these cadres believed that CMHN and GP involvement in community forums and public awareness events would improve their status and effectiveness, and create stronger links between village and *Puskesmas* levels of care.

Finding Nine: The lack of transportation undermines community outreach and home visitation- especially in more distant and remote villages

Two CMHNs in Sukamakmur awake early in the morning and ride their motorcycles 30 minutes (each way) to visit clients in mountainous villages in their sub-district. They also have to pay for the fuel. They do this out of commitment to the health and well-being of their clients. In contrast, in Lhoong, similarly remote villages are never visited. Scenario one could easily become scenario two, because it is predicated solely on an individual's character rather than system support. Motorcycles and fuel allotments are needed to ensure key CMHN functions are possible.

Psychosocial Protection Component

This section presents the study's main findings on the psychosocial protection component of HSP's program. The component was operational in 13 villages and focused on the empowerment of women, revitalization of community groups, and promotion of social cohesion. It also provided technical support to the Labui Children's Center, which was working with orphaned and vulnerable children in Aceh Besar. The task of identifying outcomes that could be attributed to HSP's work was challenging, complicated both by the relatively short implementation period (less than two years) and the presence of other actors and projects in many of the same communities. Nevertheless, a number of noteworthy outcomes were identified.

Finding Ten: Psychosocial cadres are operational in all HSP supported villages

The program in Aceh Besar called for the creation of a total of 65 psychosocial cadres - or five per village. The target goal of 65 was achieved; however, two cadres have dropped out of the program (one moved out of the district and a second is pregnant and not working) and have not been replaced.

A key responsibility of the psychosocial cadres is raising awareness of protection and psychosocial concerns. In six of 13 villages, cadres have initiated community forums on domestic violence, child abuse, mental health or another relevant concern. All psychosocial cadres also serve as cadres in the mental health program. A second key function is thus identification, referral, and home visitation of residents with psychological disorders. As noted above (Finding Five), 70% of the psychosocial cadres have engaged in these tasks. CMHNs identified cadres as being important to their own work.

The evaluation identified two factors that influenced psychosocial cadres' activity levels: how the cadres were selected in the first place, and whether or not they work in a severely crisis-affected community.

Leaders in two villages did not follow recommended guidelines and directly appointed cadres on their own. In contrast, the leaders in 11 villages (with more support from HSP) followed the recommended procedures. They instructed community members to nominate individuals for service as cadres based on the following criteria:

- Reliable-trustworthy
- Dedication-commitment to community service
- Competence
- Available time
- Willingness to serve in this role

Cadres who were selected by the community were more active in carrying out their responsibilities than their counterparts who were selected by village leaders. CMHNs reported higher satisfaction and a higher volume of home visit rates for elected versus non-elected cadres. Activity groups were also affected by this variable: elected cadres promoted social activities that benefited 25-30 women and children per activity; while non-elected cadres promoted economic activities that benefited small numbers of village committee members or members of their own families. Home visitation rates for non-elected cadres were lower than for elected cadres; while their attendance rate at subsidized (per diem) trainings and workshops was equal to that of elected cadres.

Secondly, cadres in tsunami-affected communities valued psychosocial activities more than their counterparts in non-crisis affected communities. Looking at the community-selected cadres as a whole (e.g. excluding the two non-elected groups), cadres in tsunami-affected communities described their work as ranging from "very important" to "critical" to the recovery efforts of their communities; while those in communities that were not directly affected by the tsunami described their work as "somewhat important" to "not very important". Cadres in tsunami-affected communities promoted three or four activity groups per village as compared to two to three in non-tsunami affected communities. Cadre groups in tsunami-affected communities also described the importance of these activities as transcending the activity itself by providing opportunities to rebuild social relationships as well. Child

play groups, for example, were described as important to children as well as parent-to-parent interaction and discourse.

Nearly all cadres found PULIH-produced public awareness materials to be especially useful. They also cited CMHN involvement in their work - especially co-facilitation of community awareness forums and joint home visits - as enhancing their roles as psychosocial cadres. All cadres reported "credibility" challenges as the main obstacle to effectiveness, and identified additional public education materials and regular GP and CMHN participation in awareness forums as important to their work.

Finding Eleven: Psychosocial activity groups are operational in all HSP-supported villages

A key element of HSP's psychosocial program was the stimulation of women's groups and community activities. A menu-of-options approach was utilized to meet this objective. Psychosocial cadres worked with fellow villagers to select group activities that were subsequently supported by HSP seed money ($500) grants. The chart below outlines activity developments:

	Psychosocial Activities in Aceh Besar								
	Women		Economic			Children			
	Marhaban Singing group	Support group	Handi-craft	Agriculture/ Home gardening	Food Vending	Play group	Traditional dance Group	Traditional Music Group	Sports
Villages that chose activity	4	5	4	3	4	4	5	1	4
Villages that plan to continue activities	3	3	0	0	0	3	0	0	3
Average reported participants	15	30	15	10	10	25	15	10	50

Women's groups and children's groups achieved the highest average participation rates across the 13 villages. Economic projects, in contrast, achieved the lowest average participation rate. Economic projects also tended to benefit members of the cadres families or members of the village health committee - for example, in one village, providing 15 ducks to every committee member (15 members).

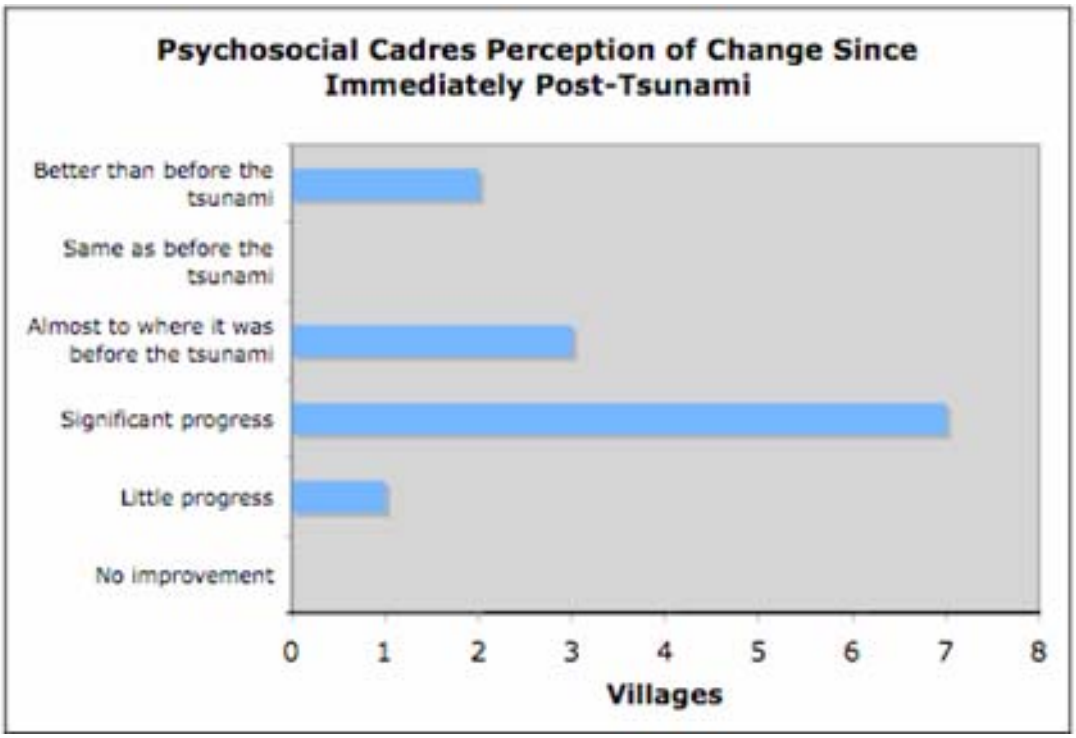
Sports groups (100%), *marhaban* singing groups (75%), children's play groups (75%) and women's support groups (66%) are the activity sets that are most likely to continue when HSP support ends. Recreational and social groups existed before the tsunami, and HSP support has reactivated them with the likelihood that they will become self-sustaining. Child playgroups, however, did not exist in these villages prior to the tsunami. While a high percentage of these groups would like to continue, psychosocial cadres believe additional training on child development and age-appropriate activities is required to maintain and improve program quality. None of the economic activities are likely to continue on a group basis, although the evaluation team "spot checks" observed individuals from the group who were engaged independently in making and selling baskets and cakes.

Finding Twelve: The psychosocial well-being of tsunami-affected communities has improved

Psychosocial cadres were asked to rank the collective psychosocial well-being of their communities immediately after the tsunami and now. Not surprisingly,

seriously affected communities were all ranked as a one ("worst problem ever") immediately post-tsunami, with loss of life and devastation of homes and livelihoods listed as most damaging to individual and collective psychosocial well-being. Communities that ranked themselves a two ("very bad") were typically affected by severe flooding or death from the tsunami, those that ranked a three ("bad") may have had some flooding, but few people in their villages died, and those that ranked a four ("not bad") had an influx of refugees who ranked themselves a five ("no problems").

What is more surprising, however, is that the most significant perceived improvements in psychosocial well-being were recorded for severely tsunami affected villages. 66% of these villages were now perceived to be "almost as good" or "better" than before the tsunami.



Key indicators of collective psychosocial well-being improvements reported by communities included:

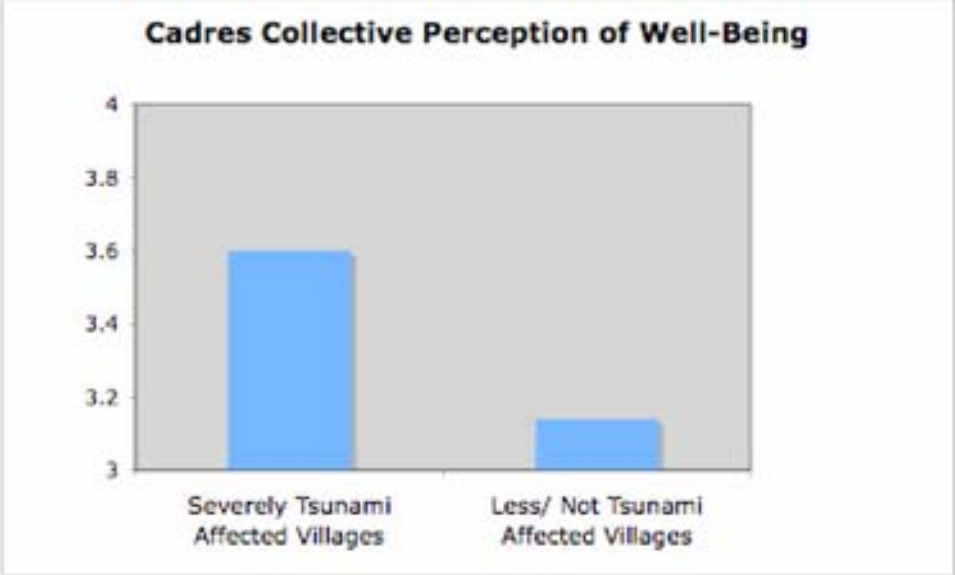
- Orphans are cared for
- Schools are operating
- Families have employment (i.e., livelihoods)
- Religious and social support groups are functioning

In contrast, in only one out of seven (14%) non-tsunami-affected villages was there a perception that collective psychosocial well-being was equal to, or better than, before the first-time benchmark. Psychosocial cadres who reported little-to-no progress in the psychosocial well-being of their communities identified the following obstacles:

- Too many NGOs competing for time and resources for the same activities
- Resident competition for per diem money to attend trainings, etc.

- Divisive nature of resident competition for pay-for-work programs for infrastructure projects.

These cadres believed that NGO saturation and competition for compensation undermined community cohesion.



Finding Thirteen: The Muhammadiyah Children's Center has yet to define a vital role for itself in Labui

The Muhammadiyah Children's Center has an ample and well-resourced facility as well as enthusiastic staff. The staff has considerable knowledge about child development, play- and age-appropriate activities, active listening, behavioral problems, and stress management. Indeed, the Children's Center at Labui has received considerable attention and support from UN and NGO agencies alike - and its staff has been the beneficiaries of numerous subsidized psychosocial training programs. They are a technically competent group, and a valuable "psychosocial" resource.

The problem is that very few children come to the Center on a regular basis. Members of the evaluation team made four visits at times that children would most likely be present. Only once were there any children at all (five). Staff did not keep attendance records or offer daily attendance estimates when asked to do so. One activity that increased child attendance for a period of time was computer training (30 children are reported to have completed the training). Power blackouts, lack of technical support (computer viruses), and lack of access to the internet appear to limit children's use of computers over the long term. A PULIH staff member confirmed that daily attendance at the Center was minimal, but also reported that more than 100 children have attended parties and events hosted by international NGOs.

While the staff is competent, the Center itself has yet to define a vital role for itself. Recently, Center staff has engaged in community outreach work by organizing a forum on domestic violence. Women have organized sewing classes at the Center, and religious and secular leaders use the Center's computers. There may be potential for the Center to evolve into a broader community resource and to develop a more

relevant child-focused program. To date, however, the Center exists as an "untapped" resource.

Finding Fourteen: ***PULIH is emerging as a national resource***

PULIH, HSP's main implementing partner for its community support program, has progressed in its capacity to provide psychosocial support. This is evident in reviewing the psychosocial materials PULIH has developed over the past 18 months. Early material production focused on training materials and guidebooks. The theoretical and technical nature of these materials limits their applicability to university educated individuals with pre-existing knowledge of psychology. In contrast, recently produced materials, such as those contained in the "Psychosocial Kit," are materials that are well-suited for public information campaigns, psychosocial cadres and other village actors.

This evolution from technical manuals to behavioral change materials is accompanied by a shift in PULIH's training practices. Early knowledge transfer occurred through NGO trainings and workshops. Some of the workshops were quite interactive, and also involved applied learning assignments. Recently, PULIH has also employed a "real-time," consultative approach to capacity building where its' staff have advised and supported psychosocial cadres and child care workers directly in communities and at the Children's Center. Both groups of beneficiaries - cadres and center staff - have found this later approach to be especially useful.

VI. RECOMMENDATIONS

In collaboration with the PHO and its partners, HSP has been fastidious in its implementation of its mental health and psychosocial protection program. It has met nearly all of its key work plan tasks and milestones on-time and with good-to-excellent quality. It has also achieved positive outcomes - especially in the promotion of a highly effective mental health system - as well as in the area of psychosocial protection community. The following recommendations are offered within the context of these notable achievements.

Mental Health

Recommendation One: Advocacy is required to maintain and expand the mental health program.

The HSP supported mental health program is an example of a stellar emergency response in that it promoted health care developments that exceed what existed prior to the crisis. The problem is that the emergency is over and funding for this province-wide program is ending. Despite both the ongoing availability of the UI Faculty of Nursing to continue providing technical assistance, and positive evaluation of the program by WHO, ADB, and USAID, none of the initial donors plan to use development-oriented aid to continue the mental health program. At the same time, mental health is not a priority within the MOH or the PHO and is unlikely to receive adequate financial support without a strong advocacy campaign being launched. Senior policymakers and MOH officials need to become aware of the significant accomplishments achieved in Aceh, and the opportunities for replication to other parts of Indonesia. Concerned parties such as USAID, WHO, ADB, among others, need to continue to support the mental health program, while working together to raise awareness amongst senior ministry officials and policy makers. A public communication and media campaign should be considered. The launch of the acute care unit at the Jantho Hospital would be a unique opportunity to mobilize government, donor and public support.

Recommendation Two: Promote efforts to establish legislation in support of mental health systems development.

Indonesia is engaged in a process to establish legislative "canons," including emphasis on prioritized health concerns. Part of the advocacy effort should thus focus on the establishment of legislation on mental health care. In doing so, caution must be paid to the need for legislative support for the home-to-hospital continuum of care, and not just a psychiatric hospital component.

Recommendation Three: Continue to decentralize and improve mental health care in Aceh Besar

Clear and measurable outcomes have been achieved through the development of a decentralized mental health care system in Aceh Besar. It is therefore important that the deficits identified in the Outcome Study Main Findings section above be addressed. Continued support for the village and *Puskesmas* components of this continuum-of-care is required, as there is palpable resistance in some quarters of the MOH to decentralization and involvement of village cadres. Additional resources to

support the advanced level of the CMHN training program and for the district level psychiatrist (beyond an initial six months) are priorities as well.

Recommendation Four: Replicate the program elsewhere in Indonesia

Mental health services throughout Indonesia are reported to remain at a low level of organization and development. The Aceh model is recommended as a highly suitable model and master plan for other provinces throughout Indonesia. The infrastructure, personnel, standards and materials have been developed and there is evidence that it is successful.

Psychosocial

Recommendation Five: Continue support for psychosocial cadres and women and children's groups in tsunami- and conflict-affected communities

HSP's psychosocial program has established psychosocial cadres, revitalized women's groups, and stimulated new child play groups. Cadres are most active and psychosocial activities most valued in the most severely tsunami-affected communities. Whereas women's support and music groups existed before the tsunami and are most likely to continue on their own, child play groups are a new development and would benefit from another six-to-twelve months of support.

Recommendation Six: Provide strategic planning support to Muhammadiyah

Muhammadiyah is the nation's leading "modernist" Islamic social organization. It has branches throughout the country and some 30 million followers. *Muhammadiyah* runs mosques, prayer houses, orphanages, schools, public libraries and universities, and recently engaged in a presidential campaign for the first time. It has the potential to be a positive influence in the lives of children in Aceh, with a group of seven well-trained staff at the Labui Center, but has not yet defined a vital role for itself or for its community based children's centers. It therefore would be important to engage *Muhammadiyah* in strategic planning to identify clear objectives and work plans for its community centers in Aceh, by eliciting input from children and caretakers in the community.

Recommendation Seven: Support PULIH as a key national resource for disaster preparedness and response

PULIH has acquired considerable experience in developing psychosocial responses to disaster-affected communities. Even before its tsunami-related work, PULIH was active in Aceh around conflict concerns. It also provides psychosocial support (through UNHCR) for refugee populations.

Given the potential for earthquakes, floods, conflict, avian flu, and other disasters in Indonesia, it is important to support PULIH's continued development as a national resource for disaster preparedness and response. Partnerships with the Red Cross, MOH and NGOs would enable PULIH to assume a more central role in disaster preparedness and response. Scholarships for advanced training of key staff in disaster management, psychology and social work would contribute significantly to the growth and development of PULIH as an important national resource.

Appendix A
CMHN Questionnaire

Thank you for taking the time to sit down and talk with us today. We want to hear about your thoughts and experiences as a CMHN, what you think is working well and what you think could be changed. These responses are confidential. Your participation will not change—improve or reduce—any services. Rather, it will be used—along with many other people's responses—to review how well the program is working and what areas need to be improved.

1) How did you become a CMHN?

2) What level of trainings have you done?

___ Basic
___ Intermediate

3) What percentage of your time do you spend on mental health nursing?

4) About how many patients for the CMHN do you see in a week?

5) How are these patients referred to you?

6) Do you ever visit patients?

7) If yes, how many home visits have you done in the last week?

8) Can you tell me about a case where you feel that you have been very successful with a patient?

9) Why do you think that you were able to be successful with that patient?

10) What do you think the biggest challenges of your job are?

11) Think of the doctor that you work with the most. On a scale of 1-5, how easy is it for you able to coordinate with that doctor?

12) What things work well with the doctor that you work with?

13) What are some of the challenges that you face in working with the doctor?

14) How important do you think that the mental health cadres are to your job? Scale of 1-5

15) What do you find helpful about the mental health cadres?

16) What do you think that the cadres could do to be more helpful?

17) Is there anything else that you'd like to tell me about your work as a Community Mental Health Nurse?

Appendix B
Patient & Primary Caretaker (Household) Questionnaire

We want to talk with you and your primary care taker to see hear about your experiences with the *Puskemas* Mental Health Services program here in Aceh. You were chosen randomly for the interview because we were told that you met with a Community Mental Health Nurse. The interview will take approximately 30 minutes and is confidential which means that your name will never be used. Your participation will not change—improve or reduce—any services you receive whatsoever. Rather, it will be used—along with many other people's responses—to review how well the program is working and what areas need to be improved. Do you understand? Do you have any questions? Are you willing to participate?

ID #
LK –Lhok'nga
SK-Sukamakmur
LG- Lhoong
SL-Seulimeum

1. We were told that you visited the *Puskesmas* for a mental health problem. Is this accurate?
__Yes
__ No

2. What did you learn about your problem there?

1.

2.

3.

5. What did the CMHN recommend that you do to resolve the problem?

__ Take medication
__ Other_____

IF YES to medication: How often are you supposed to take your medication?

_____

Have you been able to take the medication everyday?
___ Yes
___ No

If not, why not?
__ Unpleasant side effects_____

___ Didn't work
___ Can't afford it
___ Not available
___ Other

6. Has anyone visited you in your home about the problem?

__ Yes
__ CMHN (How many times____?)
__ Mental Health Cadre (How many times__?)
__ Psychosocial Cadre
___ Other
__No

7. Can patient & caretaker describe how the problem was affecting him/her before meeting with CMHN?

1.

2.

3.

8. Ask the patient; on a scale of 1-5 how big of a problem was this for you before you met with the CMHN? With one being affecting all aspect of my life and 5 being not a significant problem at all.

1 2 3 4 5
most difficult problem of my life no problem at all

9. Ask the caretakers, on a scale of 1 to 5, how difficult it was to care and protect the patient before visiting the CMHN?

1 2 3 4 5
most difficult problem of my life no problem at all

10. What did the caretaker have to do to care and protect the patient? (specifically ask if the patent every had to be locked-up or chained for any reason)

11. Since meeting with the CMHN has the problem changed?
__ Yes
___ No

12. How would patient rank the problem now? (Show them where it was ranked before).

1 2 3 4 5
most difficult problem of my life no problem at all

13. Ask the patient to describe the change? (Patient well-being, care and protection functions)

14. How would the caretaker rank care and protection issues now? (ask specifically if the patient has to be locked up or chained)

1 2 3 4 5
most difficult problem of my life no problem at all

15. Is there anything else that you would like to share with me?

16. May I ask your (patient's) age:

Sex:
__ Male
__ Female

17. How did you first find out about the Community Mental Health Nurses?

___ Mental Health Cadre
___ Psychosocial Cadre
___ Family Member
___ Someone in the *Puskesmas*
___ Iman
___ Village leader
___ Other _____

18. Did you have this problem before the tsunami?
__ Yes

Appendix C
Focus Group Discussion with Psychosocial Volunteers

Thank you for meeting with us. We are evaluating an HSP program on psychosocial well-being and mental health. We want to understand what is working and what could be improved. We want to ask you--in your role as psychosocial volunteers—some questions. Your answers will be kept confidential, and not increase or decrease any services currently being offered. Do you understand? Do you have any questions? Are you willing to participate in this group interview?

Number of volunteer present: Name of Village:
Date: Interviewer:

1. How were you selected as psychosocial volunteers?
   Village leader held meeting?
   Nominated and voted?
   Qualities: trustworthy, ability; commitment?
   Other?

2. What do you do as psychosocial volunteers?
   - Seed money activities
     1. List the 2-3 activities
     2. How many participants per activity
     3. How often do they meet – what times and where

   - Community Discussions or forums
     How many
     Subjects (e.g. mental health, domestic violence, etc) addressed

   - Home Visits or Mental health Awareness Raising
     Screening

3. Do you work with the CMHN? If so, what do you do with the CMHN? How would you rate the working relationship?
   Yes ---------- No ----------
   What is done?
   How effective is it?
   How could this work be improved?

4. After tsunami, what were the biggest psychosocial problems faced by people in your community? Please list them and describe how they affected members of your community.
   1. Many deaths
   2. Trauma/shock
   3. Separated children/orphans
   4. Other

5. After the tsunami, how would you rank – on a scale of 1-5, the severity of these psychosocial problems?

1	2	3	4	5
Worst ever	Very bad	Bad	Not Bad	No problem

6. Today, how would you rank – on a scale of 1-5, change or improvement of these same problems?

1	2	3	4	5
No change	Little change	Progress	same as before	Better than before

7. If things have improved, what are the main reasons for improvement? If things have not improved – or in fact are worse, what are the main reasons for this lacks of progress? Please list and describe.
   1.
   2
   3

8. What importance do you attach to the activities you perform as psychosocial volunteers (rate each one)
   - Seed projects
   - Their work on mental health issues
   - Other

9. If HSP stops its support of psychosocial projects, which projects will the community continue if any?

Appendix D
Key References

Aceh Work Plan Protection of Women and Children Fiscal Year 2007, Health Services Program, JSI Research and Training Institute: Jakarta, Indonesia.

Frazer, N., Assessment Report to HSP USAID. 2006, Health Services Program, JSI Research and Institution, Inc.

Hunter, E., "The Tsunami is Over"*: Report on mental health-related activities and opportunities in Aceh. 2005, University of Queensland: Queensland, Australia.

Kelleher, K., Community Mental Health Nursing: Basic Modules Review and Evaluation. 2007, JTA International.

Psychosocial Needs Assessment of Communities Affected by the Conflict in the Districts of Pidie, Bireun and Aceh Utara. 2006, International Organization for Migration (IOM): Jakarta, Indonesia.

Psychosocial Needs of Vulnerable Women and Children in Aceh. 2006, HSP, JSI Research and Institution, Inc.

Recipient Perceptions of Aid Effectiveness: Rescue, Relief and Rehabilitation in Tsunami Affected Indonesia, India and Sri Lanka, 2005, Fritz Institute.

Work plan for Nanggroe Aceh Darussalam FY2006, in Health Services Program-Program Kesehatan Ibu, Bayi Baru Lahir dan Anak. 2006, Health Services Program, JSI Research and Training Institute, Inc.: Jakarta, Indonesia.