Mid-term evaluation of Direct Health and Psychosocial Assistance Project-2 of the Post-Conflict Reintegration Programme in Nanggroe Aceh Darussalam, Indonesia

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INTRODUCTION

IOM's Post Conflict Reintegration Program in Aceh included intensive medical services to amnestied prisoners and ex-combatants and to conflict-affected communities throughout Aceh province. IOM's Information, Counselling, and Referral Services (ICRS) served as an entry point for many beneficiaries where they learned about other aspects of the Post Conflict Reintegration Program, such as the peace dividend projects for conflict-affected communities.

While there is a great need for medical (including mental health) services to some of the most isolated communities affected by conflict, the capacity of government health clinics to provide such essential services is limited, despite the initiation of a community mental health nursing program (CMHN) supported by the government, WHO and ADB. The capacity to reach remote conflict-affected areas is particularly limited, due to lack of affordable transportation for clinicians and patients and continuing suspicion of residents of conflict–affected areas towards government-provided health services.

Envisioned as a confidence building measure to foster trust and goodwill among the stakeholders of the peace process, the Direct Health and Psychosocial Assistance Project (DHPAP) was designed to immediately fill the gaps in the delivery and access of vulnerable persons to a wide range of health services available in the province. Funded by the Canadian Government and the Decentralization Support Facility (World Bank), the Direct Health and Psychosocial Assistance Program (DHPAP) provided medical, surgical, mental health and psychosocial services to 4,204 vulnerable and underserved individuals in 22 districts of Aceh province in 2006. Based on lessons learnt from DHPAP, IOM in close coordination with Government health counterparts took the opportunity to refocus its efforts toward mobile outreach into former conflict areas with limited health services, in collaboration with community mental health nurses from the nearest health clinics (puskesmas).

The pilot project that is the subject of evaluation has concentrated activities in one district (Bireun) and on launching and testing a model for mobile medical care and provision of mental health services. It is intended that this model will be presented to the Indonesian health authorities and international community for implementation and replication in other conflict-affected areas throughout Aceh.

Pilot project implementation commenced in December 2006 and will end on 30 May 2007.

EVALUATION TERMS OF REFERENCE

Overall objective

To evaluate the pilot project's effectiveness and, if necessary, make a case to change program practices in order build up a replicable model for scale-up in other districts of Aceh and justify continued financial support.

Specific Objectives

Relevance

1. To determine whether the outreach model on which the project's intervention is based is appropriate for the target population.
2. To determine if the project's aims and objectives are still relevant and of same priority
3. To determine if the interventions are meeting the target groups' needs.

Progress

4. To determine if the project is being put into operation as planned.
5. To identify any difference in the understanding of the project's aims and objectives between the groups (DHO, Community) involved.
6. To what extent have any unplanned side-effects being taken into account during project implementation.
7. To determine if the project is receiving positive support from all the various groups involved, including other health centres.

Effectiveness

8. To determine whether the objectives been achieved in terms of quality of services, quantity of patients treated and time for delivering required health assistance.
9. To what degree was the intervention implemented according to plan.

Efficiency and cost-effectiveness

10. To determine if the financial management is appropriate and if the intervention is the most cost-effective option.

PROJECT DESIGN

Overall Objective

To contribute to the Indonesian Government's peace-building and reintegration efforts by providing direct medical assistance and establishing effective mechanisms for health care access, with emphasis on mental health, for vulnerable persons associated with the conflict.

Project Purposes

a. To provide immediate medical treatment and mental health/psychosocial assistance to vulnerable persons associated with the conflict at community level via the setting up of mobile medical teams,
b. To establish an appropriate health referral mechanism using community-based resources, and actively engaging health service providers by increasing the capacity of the district health services to deliver medical, mental and psychosocial services to vulnerable persons associated with the conflict,
c. In partnership with Harvard Medical School, to develop a replicable model for addressing health, mental and psychosocial needs in conflict-affected communities.

Target Beneficiaries

Direct

- Up to 1,000 vulnerable persons associated with the demobilization and peace building process in need of specialized medical treatment, with emphasis on mental health in Bireuen District of Nanggroe Aceh Darussalam
- Up to 125 village volunteers will be trained

Indirect

- Conflict affected communities in Bireun district
- Health care service providers in Bireun district

The project is based on the proposition that an outreach mental health service is essential in order to reach remote communities affected by the conflict. Remote communities are receiving very little or no health services from the puskesmas. The outreach approach is considered to be essential because:

- Travel from remote villages to puskesmas is difficult and expensive and the populations of most of the remote communities are very poor
- Communities affected by conflict have little trust in government health services provided through the puskesmas system

IOM, because of its DDR activities, is trusted by communities affected by conflict. The delivery of health services by IOM in a time-limited way can act as a bridge between the communities and the District health services. The intent of the project is to initiate and establish mental health services to remote communities (in the context of provision of

general health services) and then to transfer responsibility for the continuation of general and mental health services to the District Health Office.

The method employed in designing and implementing the project has been to:

- Together with the District Health Office map out remote communities into catchments areas for mobile outreach activities (based on ICRS data and activity).
- Identify and train community volunteers in the communities to be covered by the mobile outreach teams within each catchment area.
- Train community mental health nurses (CMHNs) for appropriate management of cases referred by community volunteers and to monitor the activities of community volunteers within designated catchments area.
- Provide clinical services, referral and mental health support by having the mobile outreach teams visiting the identified remote villages.

Each of three mobile teams to have responsibility for one of three catchment areas and to be stationed in the puskesmas serving that area. Each mobile team to be composed of a medical doctor, a nurse and a trained CMHN. (As there is an insufficient number of CMHNs in Bireun, train an additional 12 CMHNs, to ensure that there are sufficient CMHNs to provide counseling and support to identified cases.) Refer severe cases to the district hospital or, if necessary, to the mental hospital in Banda Aceh.

The composition of the project mental health team is as follows.

1 psychiatrist	Based at the district hospital to attend to referred cases, and to train and supervise the members of the mobile teams
3 doctors (GP+)	Responsible for medical assessment and treatment
3 nurses	Responsible for nursing assessment and treatment
12 CMHNs	Trained through the project and working as part of the mobile teams
125 village volunteers, 5 in each of the 25 villages to be served by the project team	The volunteers will play a central role in identification of people with probable mental illness and referral to mobile health clinics, and will contribute to the sustainability and integrity of the system established during the project.

Other resources

Project administration	Planning, project management, financial management, office space and equipment
Vehicles	For the mobile teams and for patients from remote villages to travel to the district hospital if required.
Drug supply	IOM to supply the required basic list drugs

Project Implementation

- DHO and IOM selected villages based on IOM's existing data and the results of the IOM/Harvard Medical School Psychological Needs Assessment study
- 12 CMHNs and 125 village volunteers for selected sub districts (Juli, Jeunieb, Pandrah, Peusangan Siblah Krueng and Makmur) and villages to be trained
- A training package for 'Community Based Approach to Case Detection and Management of Mental and Psychosocial Trauma among Conflict Affected Communities' is produced and shared with stakeholders
- Local health service providers (mainly selected puskesmas staff) to be trained on community based approach to detect and manage mental and psychosocial issues in conflict affected communities in their catchments areas
- Protocols to be applied by outreach teams developed.
- Data recording protocols to be developed
- Process of coordination with volunteers in each area to be developed, so that all visits scheduled are linked to their activities
- IOM to inform the Puskesmas of visits and inform them of referrals from the IOM mobile team
- IOM mobile teams to work closely with the CMHN and village volunteers during village visits
- IOM mobile teams to provide comprehensive medical services, clinical consultations and health education to patient and family members
- Counselling to be provided by the CMHN and IOM nurses depending on severity of condition
- All oral medications to be provided by IOM doctors
- Complicated and difficult cases and new cases that need psychotropic depot injections, to be referred to IOM psychiatrist at District Hospital by phone or scheduled visit. IOM doctors to follow up after two weeks, and after one month once stable
- All cases with mental disorder that are chronic and considered a threat to society and/or themselves to be referred to the Mental Hospital in Banda Aceh, with financial assistance from IOM

Indicators

1. Number of trained community mental health nurses and village volunteers.
2. Number of villages covered by the IOM outreach doctors
3. Treatment protocols developed under the guidance of Consultants from Harvard by the 1st month of the project.
4. Number of households pre-screened by village volunteers in 25 designated villages for mental health problems
5. Number of pre-screened/ referred clients attended consultation by outreach doctors.
6. Number of the patients who receive treatment (counselling / medication)
7. Number of patients referred to district hospital / Puskesmas for further management

8. Number of patients referred to Mental hospital in Banda Aceh.
9. Number of patients listed for follow-up by IOM outreach doctors and nurses.
10. Number and type of psychotropic medication distributed by the IOM outreach doctors.
11. Number of patients on medication endorsed by IOM outreach doctors referred to the district hospital/ Puskesmas who will provide continuous treatment and care.

Source of verification

1. Socio-demographic data provided by the DHO for the 25 villages comparing them with data collected by the outreach team.
2. List of villages visited by the outreach team.
3. Case report forms indicating treatment inline with the treatment protocols developed.
4. Medical records of the patients seen, screened and managed: counselling or on medication
5. Puskesmas medical records of referrals by IOM outreach doctors.
6. Monthly health information system records of the Puskesmas and IOM medical team.
7. Monthly inventory of drugs submitted to Project Manager/ DHO.
8. Record of referrals to Mental Hospital in Banda Aceh.
9. Mid-term evaluation report

OBSERVATIONS AND COMMENTS

Case finding

The process of case finding appears to have been generally effective.
Three methods for case finding were used.

1. Identification of cases by village volunteers and referral to mobile team. This involved a process whereby VVs would classify each household in the village into one of three categories:
    a. households in which a family member is known to have a mental illness;
    b. households in which the family is at risk of mental illness because of the effects of conflict or for other reasons;
    c. households not at risk (normal). Although the project design envisaged that most case finding would be through village volunteers this proved in practice to be the least efficient method. After the first few weeks of implementation the majority of village volunteers became inactive. It was thought by the IOM team members that this was because there were no practical incentives for the VVs to participate in he process.
2. Carrying out general clinics in each village during which cases of physical illness and mental illness were identified. The village would be informed at least two days before scheduled visit to the village by the mobile team. Cases previously identified and under treatment would be reviewed. Any other member of the village community would be free to come to the clinic for assessment. This proved to be the most productive method for identifying new cases of mental illness and engaging those people in treatment
3. Referral to the mobile team by people already identified of other members of their family or fellow villagers. Although this was reported to have happened by the teams it was not a frequent occurrence.

There was considerable variation across sub-districts and across villages in the number of cases identified, from 0.9% of the population of Makmur sub-district to 8.3% of the population of Peusangan and Sibiah Krueng sub-district, with a total treated prevalence of 3.9%. (Table 1)

Table 1: Case finding by sub-district

Sub-District	Population			Number of Cases of Mental Disorder			Female / Male Ratio	Treated Prevalence (% of population)		
	Male	Female	Total	Male	Female	Total		Male	Female	Total
Jeunib	1164	1176	2340	37	109	146	2.9	3.2	9.3	6.2
Juli	2308	2320	4628	39	105	144	2.7	1.7	4.5	3.1
Makmur	1406	1635	3041	9	17	26	1.9	0.6	1.0	0.9
Peudada	1276	1367	2643	41	38	79	0.9	3.2	2.8	3.0
Peusangan and Sibiah Krueng	1016	1225	2241	66	120	186	1.8	6.5	9.8	8.3
Total	6462	7191	14893	192	389	581	2.0	3.0	5.4	3.9

Comment

Although some variation in treated prevalence would be expected the magnitude of variation across the sub-districts requires explanation. Such variation may be accounted for by:

1. Variation in the underlying prevalence of mental disorder in the different sub-districts
2. Differences in the effectiveness of case finding according to:
    a. Level of activity and effectiveness of those responsible for active case finding
    b. Level of trust / readiness of community members to consult IOM medical team

It is most unlikely that differences in prevalence are of such magnitude as would explain the observed variation in treated prevalence. It is more likely that the differences are to be explained by differences in effectiveness of active and passive case finding and in the level of readiness of people in various villages to engage with the mobile teams.

Exploration of this issue would provide information that could lead to improvements in case finding methods and the reach of service provision. These might include changes in training of VVs, changes in methods to more actively engage VVs, better understanding of the reasons that community members with mental illness, and their families, choose to engage or not to engage with health services.

Table 2: Case finding by diagnostic group (lower population prevalence estimates)

Diagnostic Category	Total cases identified	Treated Prevalence (% of population)	Expected Prevalence[1] (% of population)	Expected total number of cases[1]	Number of 'missing' cases[1]	Efficiency of case finding (%)[1,2]
Depression	98	0.66	5	745	647	13.2
Anxiety	193	1.30	5	745	552	25.9
PTSD	136	0.91	10	1489	1353	9.1
Schizophrenia & Acute Psychosis NOS	39	0.26	1	149	110	26.2
Bipolar Disorder	2	0.01	1	149	147	1.3
Mental Retardation	11	0.07	1	149	138	7.4
Epilepsy	13	0.09	1	149	136	8.7
Organic Mental Disorder	14	0.09	1	149	135	9.4
Total	**506**	**3.40**	**25**	**3723**	**3317**	**13.6**

[1] Higher estimates of expected prevalence of depression, anxiety and PTSD
In Tables 2 and 3 cases of Somatization Disorder, Child Psychiatric Disorder and Substance Abuse have been removed from consideration because there is no basis for estimating population prevalence of these disorders in this population. The total number of patients is therefore 506 rather than 581.
[2] Efficiency of case finding is percentage: [Total cases identified / Expected total number of cases]*100

Table 3: Case finding by diagnostic group (higher population prevalence estimates)

Diagnostic Category	Total	Treated Prevalence (% of population)	Expected Prevalence (% of population)[1]	Expected total number of cases[1]	Number of 'missing' cases[1]	Efficiency of case finding (%)[1,2]
Depression	98	0.66	2[1]	298	200	32.9
Anxiety	193	1.30	2[1]	298	105	64.8
PTSD	136	0.91	5[1]	745	609	18.3
Schizophrenia & Acute Psychosis NOS	39	0.26	1	149	110	26.2
Bipolar Disorder	2	0.01	1	149	147	1.3
Mental Retardation	11	0.07	1[2]	149	138	7.4
Epilepsy	13	0.09	1[3]	149	136	8.7
Organic Mental Disorder	14	0.09	1[3]	149	135	9.4
Total	**506**	**3.40**	**14**	**2085**	**1579**	**24.3**

[1] Using very conservative estimates of population prevalence of depression, anxiety and PTSD (and removing somatization disorder for which no reasonable estimates of population prevalence can be made). It is likely that the actual population prevalence of these disorders is substantially higher than indicated in this table in the column 'Expected Prevalence'. This estimate of prevalence is more in line with the van Ommeren et al (2006) estimation of the prevalence of severe mental disorders (10%) at 12 months post-tsunami.
[2] Mental retardation is common in poor populations who are subject to nutritional deficiencies, perinatal injuries due to absence of good ante-natal and post-natal care, absence of skilled delivery, and the prevalence of CNS infectious diseases.
[3] PNA-1 reported that a very substantial proportion of the population (particularly young males) has experienced head trauma and other forms of potential neurological injury (e.g. asphyxiation due to partial drowning). On this basis the expected prevalence used here for Epilepsy and Organic Mental disorder may be considered as very conservative.

Comment

There was, as one would expect, considerable variation in efficiency of case finding across diagnostic groups. As information on severity of illness was not available no comment could be made on whether severity of illness is a significant contributor to the likelihood of a case being identified.

The prevalence of PTSD that is severe enough to warrant medical attention appears to be substantially lower than would be expected given the experience of trauma of this population and the findings of the Psychosocial Needs Assessment study (PNA-1).

Identification of cases of bipolar disorder appears to be extremely low.

Identification of schizophrenia (acute and chronic) and acute psychotic disorder not otherwise specified, is substantially lower than one would like to see. In a project of this kind it is not unreasonable to expect most cases (80%) of psychotic disorder to be identified.

Even when the lower population prevalence estimate is used (Table 3) there is a significant number of people with probable severe mental disorder (i.e. mental disorder that warrants, and would benefit substantially from, psychiatric treatment) who have not been identified.

A population prevalence of such disorder for the total population of Bireun (360,000) means that there are approximately 12,240 people in Bireun requiring psychiatric treatment. Responding to this need is far beyond the capacity and current resources of the public health system in Bireun.

Referrals

Sub-District	Psychiatric cases referred to puskesmas	Psychiatric cases referred to mental hospital Banda Aceh	Total psychiatric cases referred
Jeunib	1	0	1
Juli	0	0	0
Makmur	0	0	0
Peudada	0	0	0
Peusangan and Sibiah Krueng	1	0	1
Total	2	0	2

Comment

This is an extraordinarily low rate of referrals. The reasons for this low rate should be carefully explored, particularly since one of the objectives of the project was “To establish an appropriate health referral mechanism using community-based resources, and

actively engaging health service providers by increasing the capacity of the district health services to deliver medical, mental and psychosocial services to vulnerable persons associated with the conflict."

Community Mental Health Nurses

The IOM project provided the funds to have a further 12 CMHNs trained so that they could participate as members of the mobile mental health teams. However, members of the mobile teams (IOM doctors and nurses) reported that the level of involvement of CMHNs was very low. This appeared to be due to lack of practical incentives for CMHNs to be involved as part of the mobile teams.

Comment

The issue of engagement of GP+ and CMHNs working in puskesmas in provision of mental health services to these communities must be resolved during the process of transition from an IOM-delivered mental health service to a puskesmas-delivered mental health services prior to the end of the project.

Village Volunteers

125 Village Volunteers (VVs) were trained, 5 from each of the 25 villages that were part of the project. Initially the VVs were actively engaged in the process of case finding – classifying households and identifying people with mental illness for referral to the mobile teams. It would seem that there was a sharp decline in the level of activity of VVs within only a few weeks of the commencement of the visits to villages by the mobile teams. Members of the IOM mobile teams expressed the view that this was because there were no practical incentives for the VVs to remain active in the roles for which they had been trained.

Comment

The Village Volunteers program is an important component of the developing community mental health service in Bireun. Clarification of the reasons for the low level of involvement of the Village Volunteers in the IOm project will be helpful to the DHO in strengthening this important program. This must be seen in the broader context of village health volunteers in a number of areas of health concern across all of Indonesia. The general opinion is that these volunteer programs do not run well. If Village Volunteers are to be an important component of mental health service provision in Bireun in a sustained way then a solution to the observed low level of involvement must be found.

Engagement of Puskesmas

There was a very low level of engagement of puskesmas in provision of care to the communities in the 25 villages that were served by the mobile teams. This was confirmed by members of the community with whom we spoke during the field visit to one of the villages in Juli sub-district, who said that they did not receive any significant health services from the puskesmas. Puskesmas staff generally do not have the transport required to visit remote villages and members of the communities living in remote villages could not go to the puskesmas because transport is too expensive.

A view that was expressed by one of the IOM team doctors was that the puskesmas staff took the attitude that "those villages are the responsibility of the IOM teams" and did not engage. This is one example of an un intended negative consequence of the project, particularly of a project that is seen by public health staff as being very well-resourced from external sources.

Comment

There is a need to engage puskesmas staff, particularly GP+ and CMHNs, in provision of care to communities in remote villages. This will of course require the provision of resources to ensure that the necessary arrangements (particularly transport) in place that will enable this to happen.

Acceptance of mobile teams by village communities

Discussions held with members of the community during a visit a village in Juli sub-district made clear that the mobile medical teams are well accepted and welcome in that village. Members of the community expressed anxiety about the coming end of the project and about whether the services that had been initiated would be continued. They also made clear that the community has many needs – for general as well as mental health services, for educational opportunities for their children, income-generating activities and for improvements in infrastructure, particularly the rods to Bireun which are virtually impassable during the rainy season.

It appeared to be clear that those members of the community who were present during this discussion and the clinic that followed had confidence in the medical team. There was no indication of mistrust or reluctance to engage with the team.

Reports from the IOM clinical teams and the Harvard consultants, suggested that the attitudes observed during this visit are general and that the mobile teams are very well accepted by all of the communities in which they work.

Comment

One of the key objectives of the project, as part of the broader IOM objectives, is to build trust of village communities in the health system and to act as a bridge between remote communities affected by conflict and government provided health services.

Although we observed that such trust clearly exists in relation to the IOM teams, the relative lack of engagement – up to this time - between the communities and health services based in the puskesmas means that it is not possible to comment on whether the trust that is displayed in the IOm teams will be transferred to the puskesmas. FGostering such trust and confidence in the puskesmas system should be an explicit goal of the process of transition from the IOM-operated mental health services to services operated by the District Health Office, particularly those delivered through the puskesmas system.

Indicators / Targets / Outputs

	Indicator	Target	Achieved	Comment
1.	Number of trained community mental health nurses	12	12	These additional CMHNs (potentially) improve the capacity of DHO to provide community-based mental health care
2.	Number of trained village volunteers	125	125	These additional Village Volunteers (potentially) improve the capacity of DHO to carry out case finding and social support in the target villages
3.	Number of villages covered by the IOM outreach doctors	≥ 75% of the total identified (25) villages covered by the outreach team	25	
4.	Treatment protocols developed under the guidance of Consultants from Harvard by the 1st month of the project.		✓	These treatment protocols are a valuable tool for use by DHO throughout its community mental health service in Bireun
5.	Number of households pre-screened by village volunteers in 25 designated villages for mental health problems	≥ 75% of the households prescreened by village volunteers in 25 designated villages for mentally health problems	✓ 4,105 households were 'screened'	The meaning of screening is not clear. Nor is the reliability of any categorizations of households carried by Village Volunteers

6.	Number of pre-screened/ referred clients attended consultation by outreach doctors.	1,000 ≥ 50% of the prescreened clients receive consultation by outreach Doctors by the 3rd month of the project	1,700	This is the total number of people who consulted the IOM medical teams. Only a small number as a result of 'screening' by village volunteers. The graet majority people who attended the open medical clinics conducted in villages
7.	Number of the patients with mental disorder who receive treatment (counselling / medication)	≥ 50% of the prescreened clients receive consultation by outreach Doctors by the 3rd month of the project	581	Inadequate information available on the type of treatment and its clinical effectiveness
8.	Number of patients referred to district hospital / Puskesmas for further management	70% of the patients who are severely ill are referred to Puskesmas for further management or further referral to Mental hospital in Banda Aceh	2	Extraordinarily low rate of referral to puskesmas and to Mental Hospital Banda Aceh
9.	Number of patients referred to Mental hospital in Banda Aceh.	-	0	No patients were referred to Mental Hospital Banda Aceh
10.	Number of patients listed for follow-up by IOM outreach doctors and nurses.	100% of the patients on treatment would have had a follow-up every two weeks by IOM outreach Doctors & Nurses	63	The meaning of this number "of mental cases on follow-up" is not clear
11.	Number and type of psychotropic medication distributed by the IOM outreach doctors.	At least a minimum stock of psychotropic and other mental health drugs for three months at IOM Medical unit at Bireun	?	No information available on prescription patterns, although there has always been an adequate stock of IOM-supplied psychotropic medicines available
12.	Number of patients on medication endorsed by IOM outreach doctors referred to the district hospital/ Puskesmas who will provide continuous treatment and care.		2	Treatment reviewed by IOM psychiatrists during visits to villages

COMMENTS AGAINST EVALUATION OBJECTIVES

Specific Evaluation Objectives	Comment
Relevance	
• To determine whether the outreach model on which the project's intervention is based is appropriate for the target population.	The target population is people living in remote communities that have been particularly affected by conflict. Such communities have high levels of need in all areas of life since they are generally very poor and suffer all of the disadvantages associated with poverty, as well as the many additional needs that arise out of having been directly affected by conflict. The results of the PNA-1 study suggest that the prevalence of mental disorders and mental health problems is very high in these communities as is the need for mental health treatment and care. The poverty that is so common in these communities means that individuals who require medical treatment often cannot afford the costs of transport to visit the local puskesmas. In addition it has been suggested that another barrier to seeking medical treatment from the puskesmas is the common suspicion and mistrust of government provided health services. In this context, a model of provision of general health and mental health services that is built on capacity for outreach to these communities is appropriate and may be the only way to overcome the problems identified above. The experience so far from the pilot project is that: • Active case finding is necessary to identify people with mental disorders who require treatment • Case finding is most effectively done by offering a general medical clinic in the village • Outreach services are well accepted by the people living in remote conflict affected communities
• To determine if the project's aims and objectives are still relevant and of same priority	The projects aims and objectives are relevant and continue to be of high priority since remote communities appear to be receiving very little or no services at all from puskesmas.
• To determine if the interventions are meeting the target groups' needs.	The fact that many people are making use of the services provided through the pilot project suggests strongly that the services provided are responding to the needs of a significant proportion of these communities. The question of whether these needs are being adequately met cannot be answered by this evaluation since there is insufficient data available on patterns of drug prescription, clinical outcome of treatment, whether treatment results in reduction in disability and improved productivity, etc. The figures in Tables 2 and 3 suggest that there are likely to be many people with severe mental disorders who have not been identified and have not received mental health services through the mobile mental health

	teams. This is to be expected as the task of achieving full coverage in case finding and provision of services if difficult even in circumstances where there are much higher levels of resources and better community understanding of mental health and illness.
Progress	
• To determine if the project is being put into operation as planned.	Implementation fidelity is, in general, quite high, with the exception of the level of engagement of CMHNs and Village Volunteers. The project is being faithfully implemented as planned, with necessary adjustments being made to the details of implementation on the basis of field experiences and realities.
• To identify any difference in the understanding of the project's aims and objectives between the groups (DHO, Community) involved.	There is a shared understanding by IOM and DHO of the project's aims and objectives.
• To what extent have any unplanned side-effects being taken into account during project implementation.	Apparently Puskesmas staff have regarde these villages as "IOM's responsibility". If it exists this is a perception that, of course, must be changed.
• To determine if the project is receiving positive support from all the various groups involved, including other health centres.	The project does not appear to have had as much support as was expected from the CMHNs and the village volunteers. Reasons for this ought to be clarified. They may include the fact that the project has only been operating for a very short time (a number of months only), the absence of any incentive structure that would encourage engagement, the fact that the puskesmas already have a high load of responsibility for provision of general health care, and the understandable preoccupation of village volunteers with meeting the substantial challenges of everyday life in a very poor region.
Effectiveness	
• To determine whether the objectives been achieved in terms of quality of services, quantity of patients treated and time for delivering required health assistance.	The necessary clinical and other relevant data that is required to answer these questions of effectiveness and quality of services has not been analysed. However, much of the the relevant data has been collected and is available for analysis. The data collected through the clinical case forms should be analysed at the first opportunity to enable this issue to be addressed.
• To what degree was the intervention	The project is being implemented according to plan, except for the low level of involvement of CMHNs and VVs. It should be noted that this low

implemented according to plan.	level of involvement is not unique to this project. The training of village volunteers to assist in a number of different areas of health has been a method used in many parts of Indonesia and has met with limited success. This is not to say that this is an inappropriate strategy but that methods need to be developed that will enavourage and enable the engagement of village volunteers in a continuing and productive way.
Efficiency and cost-effectiveness	
• To determine if the financial management is appropriate and if the intervention is the most cost-effective option.	The evaluation team did not receive information on project budget (other than the total sum available for the project over 6 months) or actual expenditures. Therefore no comment can be made on financial management or cost-effectiveness of the project.
Overall evaluation objective	
• To evaluate pilot project's effectiveness and if necessary make a case to change program practices in order build-up a replicable model for scale-up in other districts of Aceh and justify continued financial support.	The objectives of the project are to: 1. provide immediate medical treatment and mental health/psychosocial assistance to vulnerable persons associated with the conflict at community level via the setting up of mobile medical teams, 2. establish an appropriate health referral mechanism using community-based resources, and actively engaging health service providers by increasing the capacity of the district health services to deliver medical, mental and psychosocial services to vulnerable persons associated with the conflict, 3. develop a replicable model for addressing health, mental and psychosocial needs in conflict affected communities. These are ambitious objectives for a project that has, by design, a total duration of 6 months. ***Objective 1*** In the first 4 months (and only 3 months of actual roll-out of the service delivery component) the project has, to a very considerable degree, achieved Objective 1. A very respectable proportion of all those in the target communities who suffer from a mental disorder have been identified and engaged in treatment. The one exception to this is in the case of psychosis where one might have expected a larger proportion of people with psychotic disorders to have been identified. Data on clinical effectiveness / appropriateness / quality have not been analysed. In particular data on prescription patterns is important. Much of the clinical consulting is done in a rather public fashion with many people around the clinician and patient. Greater attention needs to be paid to the issue of respect for privacy. ***Objective 2*** Very few people with mental illness have been referred to puskesmas, the district hospital or to the mental hospital in Banda Aceh. It is not clear whether this is because virtually all the patients identified (even those with the most severe illness) could be adequately managed within the community (which would be a very good outcome and an indicator of the

	value of this kind of outreach program) or whether there were obstacles to referral which could not be overcome by the mobile teams. Pusekesmas-based GP+ and CMHNs have not been engaged to any significant degree in the provision of care and support to people with mental illness in the target villages. The capacity of the district health services to deliver medical, mental and psychosocial services to vulnerable persons associated with the conflict has been increased primarily through the training of 12 additional CMHNs who are based in the relevant puskesmas and 125 village volunteers in the 25 villages. However, neither the CMHNs nor the village volunteers have been sufficiently engaged in the provision of treatment and support or in the identification of new cases after the first few weeks of the project. ***Objective 3*** Although this model of services may well be replicable in other conflict affected communities if there are substantial and continuing external funds the more appropriate test of replicability must include affordability and sustainability by the government public health service system. Is the district health office in each district where it is intended that such a program of services should operate able to: • Make available in a continuing and escalating fashion the necessary funds for staff salaries, staff training, provision of psychotropic drugs, and provision of transport to enable such a mobile outreach program of service delivery to occur. • Recruit, train and retain the skilled staff required to provide the services. • Build the confidence and engage participation of conflict affected communities in such government-provided mental health services. On the basis of the experience so far from the pilot project it is not possible to answer these questions, although there seems to be a strong commitment by the DHO to take over the care of patients identified by the mobile teams. They may be at least to some extent answerable by the time of the completion of the project at the end of 6 months if the following things are done: • A detailed analysis is carried out of the cost of providing mental health services according to this model. These costs (at the least) include: staff salaries and incentives (if any); cost of supply of psychotropic drugs; costs of providing the necessary transport (for staff and patients); costs of sustaining the village volunteers program; additional costs of administration of the program (in puskesmas and DHO; …. • Full transition is achieved by the end of the project from IOM-team provided mental health services to puskesmas-provided mental health services at the same level to the same communities. It will become clear whether full transition is possible and, if not, it will be possible to identify the obstacles to full transition. Clear identification of these obstacles will be a very clear indication of the extent of replicability of this model of service provision. The possible obstacles include: lack of funds, shortage of skilled staff, limited capacity to train additional staff

	and to recruit and retain the necessary staff, lack of funds for drugs and transport, reluctance of communities to make use of government-provided mental health services, insufficient capacity to retain active village volunteers and CMHNs, etc.

SUMMARY

What has been achieved so far?

The pilot project has achieved a number of important outcomes. These include the following:

1. The project is focused on the mental health needs of remote communities that have clear needs for mental health services and that have had no access to such services and every limited access to general health services. This is significant (regardless of whether the pilot project succeeds in creating a replicable model for delivery of mental health care for Aceh) because there is a moral imperative to provide mental health care to people who have been extensively traumatized by a long and often brutal conflict.

2. The communities living in the villages in which the program has been operating now have a much clearer understanding of the existence of mental illness among significant numbers of members of those communities, and of the fact that such mental illness is amenable to medical treatment and to psychosocial support. Such creation of awareness of the importance of mental health and of the effectiveness of psychiatric treatment is a critically important component of building strong advocacy for mental health services by informed communities.

3. Despite the limited contact between government-provided mental health services and the participating villages the process of building trust in this services has commenced. This contributes to fulfilling one of the core mandates of IOM of re-integrating conflict-affected communities into the mainstream of life in Bireun District.

4. The District Health Office has accepted responsibility for continuing to provide mental health services to these villages as part of its program of mental health service delivery in Bireun District. Although it is unlikely that the puskesmas system can provide mental health services at the same level of intensity as has been done through the project this is a significant advance in engaging the DHO in responding to the mental health needs of the residents of Bireun, including the residents of remote conflict-affected communities.

5. During the process of transition from IOM-delivered mental health services to puskesmas-delivered mental health services the puskesmas in the project area and

the DHO will learn a great deal about the mental health needs of remote conflict-affected communities and about the obstacles to provision of adequate care top those communities. This knowledge will be valuable in the further planning of District-wide mental health services.

6. The protocols that have been developed to guide provision of clinical mental health services will be very useful to the DHO.

7. Even in areas where the project has been less successful, such as in the full engagement of CMHNs and Village Volunteers in the mobile outreach program, a careful examination of the reasons for this relative lack of success and the search for solutions to problems identified will be very valuable in improving the CMHN and Village Volunteer program throughout the district.

What has still to be done?

There is still a considerable amount of work to do in a number of areas.

1. The process of transition from the IOM-provided mental health services to puskesmas-provide mental health services needs to begin immediately and be completed by the end of the project on May 30 2007. (This is based on the Reviewers' understanding that the funds for the project will soon end and that continuing funding beyond the life of the current pilot project is not assured.) This process of transition will further clarify strengths and weaknesses in the capacity of the DHO to provide such services. Where problems are identified the DHO and IOM team will need to work closely together to identify acceptable solutions.

2. Ways need to be found to fully engage the CMHNs from the relevant puskesmas and the Village Volunteers in the process of mental health service delivery to remote communities. This includes: case identification; provision of psychiatric treatment (including affordable methods for providing and monitoring psychotropic drugs); and provision of psychosocial support.

3. The question of affordability of a mobile outreach model of psychiatric treatment needs to be answered. It will be necessary to do detailed costings of the provision of services by the IOM team, and to produce estimates of the costs of provision of such services by the DHO.

4. Although process information about the program is available – e.g. the number of patients who consulted the team during the past 6 months – there is insufficient analysis of the clinical data that has been collected. An analysis of the available data is necessary to answer questions concerning appropriateness of treatment (particularly drug prescribing) and effectiveness of treatment.

RECOMMENDATIONS

1. Begin immediately the process of transition from the IOM-delivered clinical outreach program to a DHO-managed program of mental health service delivery to the identified villages. We emphasise again that this recommendation is based on the Reviewers' understanding that the funds for the project will soon end and that continuing funding beyond the life of the current pilot project is not assured.

2. Carry out a clinical chart review of all patients who consulted the IOM teams. The purposes of this review are to:
    a. determine the appropriateness and effectiveness of the psychiatric treatment that has been provided ; and
    b. determine the level of severity of mental illness among the case-load and to allocate priority for transfer to the DHO-managed services

3. Carry out a detailed costing exercise to determine the cost of providing services according to the IOM outreach model.

4. Carry out an end-of project evaluation in order to answer the important questions that could not be answered by this mid-term review. These include questions about appropriateness, effectiveness, and replicability of the outreach model of mental health service provision to remote communities. This end of project evaluation should include a detailed review of the clinical data referred to in Recommendation 2, and the costing exercise referred to in Recommendation 3, and can be appropriately carried out by IOM staff and their technical advisers.

5. It is important to keep in mind when reading this evaluation report that this is a pilot project that has been running for a very short period. A great deal has been achieved. The applicability of the model of service - mobile teams working in close collaboration with community mental health nurses and doctors based in the puskesmas and the involvement of village volunteers – is worthy of closer and longer-term exploration.

6. If the project is to continue consideration should be given to the establishemnt of close collaboration with other mental health system development projects that are focusing directly on building the capacity of District Health Offices to fund, develop and manage mental health services for the whole population of their districts.

APPENDICES
Appendix 1 : Activities

5th April, 2007	**DHPAP Phase 2 Workshop**	Jakarta (Mandarin Hotel)
Workshop goals: 1. To update the participants on the activities carried out by the outreach project. 2. To identify key knowledge gaps in the area and outline activities designed to address these identified gaps. 3. To discuss and explore collaborative activities between MOH, WHO and University of Indonesia within existing resources. 4. To identify the path "where to from here". 5. To develop a strategic plan for developing proposals for scaling up.		
Program		
09:00-09:15	Introduction and welcome	
09:15-09:45	Dr. Mursyidah (District Health Office)	Bireun mental health presentation
09:45-10:15	Team presentation (Dr Tarun Mallick, Prof Byron Good, Dr Ibrahim Puteh)	Project activities
10:15-10:30	Coffee Break	
10:30-11:00	Team presentation (Dr Tarun Mallick, Prof Byron Good, Dr Ibrahim Puteh) contd.	Project activities
11:00-12:00	Prof. Harry Minas & Dr Pandu Setiawan	Evaluation presentation
12:00-13:00	Lunch Break	
13:00-14:00	Facilitator: Dr. Andrew Mohanraj (CBM)	Where to from here?
14:00-16:00	All participants	Discussion
16:00	Workshop Close	