Save the Children

Pulang Kampung

The Coming Home Program
Final Report to USAID

Improving the well-being of Acehnese children, women and their families

Grant Information

1.	Recipient's Name:	Save the Children Federation, Inc.
2.	Total Grant Budget:	US$ 3,212,918.90
3.	Total Obligated Amount	US$ 3,212,918.90
4.	Cost Sharing Amount:	US$ 30,000
5.	Grant Title:	"Pulang Kampung – Coming Home Program"
6.	Location:	Aceh Province, Indonesia
7.	Grant Number:	497-G-00-00-00029-00
8.	Project Number:	4980001.11
9.	USAID Project Office:	Health, Population and Nutrition

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Acronyms and Abbreviations

Akbid	*Akademi Kebidanan*
APN	*Asuhan Persalinan Normal*- Normal Delivery Care
ARI	Acute Respiratory Infection
BAPESREM	*Badan Pemberdayaan Ekonomi dan Sosial Perempuan dan Remaja* – Women and Youth Economic and Social Empowerment Board
BKPSM	*Badan Koordinasi Pemberdayaan Sosial Masyarakat*- Coordinating Board for Social Community Empowerment
BPSM	*Badan Pemberdayaan Sosial Masyarakat* – Social Community Empowerment Board
CHB	Community Health Board
CHP	Coming Home Program
CI	Class Instructor
CT	Class Trainer
CTS	Clinical Trainer Skills
Dasolin	*Dana Sosial Bersalin* - Community Birth Preparedness Savings Funds
DHO	District Health Office
DOH	Department of Health
EO	Economic Opportunity
FGD	Focus Group Discussion
GAM	*Gerakan Aceh Merdeka* – Free Aceh Movement
GGLS	Group Guaranteed Lendings and Saving
GOI	Government of Indonesia
HIS	Health Information system
IAMI	Inisiatif Anti Malaria Indonesia
IBI	*Ikatan Bidan Indonesia* – Indonesian Midwives Association
IDPs	Internally Displaced Persons
IEC	Information, Education, and Communication
INGO	International Non-Governmental Organization
IRs	Intermediate Results
ITN	Insecticide Treated Bednets
JNPK	*Jaringan Nasional Pelatihan Klinis*- National Network for clinical Training
KODAM	*Komando Daerah Militer* – Regional Military Command
KSP	Kelompok Swadaya Perempuan
LNGOs	Local Non-Governmental Organizations
MNH	Maternal and Neonatal Health
MNH-JHPIEGO	Maternal Neonatal Health- John Hopkins Program for International Education in Gynecology and Obstetrics
MOH	Ministry of Health
NAMRU-2	Naval Medical Research Unit-2

NERP	Nutrition Education Rehabilitation Program
NERS	Nutrition Education Rehabilitation Session
NGO	Non-Governmental Organization
P2KS	*Pusat Pelatihan Klinis Sekunder*- Secondary Clinical Training Center
PD	Positive Deviance
PDMD	*Penguasa Darurat Militer Daerah*- Local Martial Law Administrator
PIN	*Pekan Imunisasi Nasional* – National Immunization Program
PMI	*Palang Merah Indonesia*- Indonesian National Red Cross
POLRI	*Polisi Republik Indonesia*- Police of Republic Indonesia
Posyandu	*Pos Pelayanan Terpadu*- Village Integrated Health Post
PR	Parasite Rate
PRA	Participatory Rural Appraisal
Puskesmas	*Pusat Kesehatan Masyarakat*- Community Health Center
Pustu	Puskesmas Pembantu- sub Puskesmas
SC	Save the Children
SC-CHP	Save The Children- Coming Home Program
Sekneg	*Sekretaris Negara* – State Secretary
SIAGA	Siap Antar Jaga
SOAG	Strategic Objectives Grant agreement
SOW	Scope of work
TA	Technical assistance
Tabulin	*Tabungan Ibu Bersalin*- Family Birth Preparedness Savings Account
TNI	*Tentara National Indonesia*- Indonesian Military
TOT	Training of Trainers
TV	Television
Unsyiah	*Universitas Syiah Kuala*- Syiah Kuala University
USAID	United States Agency for International Development
WHO	World Health Organization
YAB	Yayasan Anak Bangsa
YDUA	Yayasan Daur Ulang
YIBHA	Yayasan Ibnu Hasyim

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Executive Summary

From June 2000 through April 2004 Save the Children (SC), in collaboration with the Department of Health (DOH) at the national, provincial and district levels, implemented the USAID-funded ***Coming Home Program*** (CHP) in the province of Aceh, Indonesia. The program sought to improve the well-being of Acehnese children, women and their families and fell under the Strategic Objective Grant Agreement (SOAG) between USAID/Indonesia and the Government of Indonesia, *Protecting the health of the most vulnerable women and children*.

The constantly changing political and security situation in Aceh over the past four years has presented a challenging work environment. As a result, Save the Children has needed to be flexible in adapting CHP strategies and implementation plans so as to best support the program's objectives. Likewise, the program's implementation areas fluctuated over the duration of the program. Starting out in the Banda Aceh and Aceh Besar districts, by 2002 the program was able to expand into the more conflict-affected district of Pidie. When martial law was imposed in May 2003, the program withdrew back to Banda Aceh and Aceh Besar, and also implemented in the Simeulue district, an island that has not been affected by conflict.

Broadly, the Coming Home program worked in the areas of health, economic opportunity, and addressing the psychosocial needs of women and children. In the area of health, activities included Posyandu revitalization, midwife training, Positive Deviance child nutrition programs, participation in national immunization days, malaria control, health policy advocacy and community mobilization to support safe motherhood. In the area of Economic Opportunity (EO), the program supported activities for women and youth and extended microcredit in addition to providing vocational training and business development services. To address the psychosocial needs of children, youth and women, the program supported psychosocial activities for children, established community daycare programs, provided support to youth programs, and promoted women's civic participation.

In health, one of the most significant contributions the program made was to build the capacity of the Provincial Secondary Clinical Training Center to be certified to provide midwife training in Normal Delivery Care. In addition to training 63 midwives in Normal Delivery Care, the program certified 10 midwives as Classroom Trainers and 8 midwives as Clinical Instructors (CI), which will allow the province to continue training up to 20 midwives a month in this important skills training.

Comparing baseline and endline survey results, several statistically significant changes related to maternal health were observed in target communities. There were significant increases in the percent of women reporting having received 4 or more antenatal visits during their last pregnancy, being vaccinated for tetanus during their last pregnancy, and having taken iron supplementation. In addition, the average number of days after childbirth women reported that their health was checked dropped from 3.01 to 1.64. These key changes indicate that there is an increased demand for and access to maternal health services in areas where the program worked.

In addition to maternal health, CHP worked to improve child health. The program was successful in increasing access to and utilization of Posyandu and neonatal health services. Secondary data collected from the target Posyandu showed a consistent increase in attendance. Qualitative data from FGDs carried out with Kaders also indicated that Posyandu kits distributed to 61 villages were still in good condition and being used by all, with the exception of the Puskesmas in Pulo Aceh. Data also indicated that utilization of neonatal health services increased, as evidenced by the increases in the percent of children weighed at birth and the percent of newborns whose health was checked within the first 7 days after birth in target communities. Moreover, evaluations found statistically significant differences in behaviors related to hygiene and diarrhea. Results show that the target population is washing their hands more regularly than they did at baseline and that knowledge of how to prepare ORS and overall how to treat diarrhea has improved.

Programs utilizing Positive Deviance to address child malnutrition also showed promising results. After 8 months of implementation in Alue Naga and 5 months of implementation in Simeulue Timur, a total of 176 malnourished children had participated in the program, 105 in Alue Naga and 71 in Simeulue Timur. Results showed that 89.5% of the participants in the Alue Naga program had improved their nutritional status and the program was able to graduate 52.3% of the participants by the end of the CHP program. In Simeulue Timur, after only 5 months of implementation, 29.5% had improved their nutritional status and 21.1% had graduated.

Economic opportunity (EO) and microfinance programs were implemented through a combination of direct implementation and implementation through LNGOs. Save the Children provided assistance to 1,958 vulnerable women and their families in 61 villages spread over three districts; Pidie (Tangse), Aceh Besar (Lamteuba/Lampanah, Pulo Aceh) and Banda Aceh (Kecamatan Meuraxa and Syiah Kuala). The CHP provided skills training and material resources to 665 women to establish livelihoods in food processing (e.g., fried coconut, shrimp crackers, Tempe making, cookies baking, Oyster Sauce), embroidery, sewing, agriculture, and poultry farming. Beyond training, SC provided materials such as sewing and embroidery machines, cloth, thread, needles, materials for oyster sauce, and chicken for poultry farming to six groups of 30 women and 23 female youth to assist them in starting their businesses.

SC also facilitated the establishment of a forum, known as BAPESREM *(*Badan Koordinasi Pemberdayaan Sosial Masyarakat- Coordinating Board for Social Community Empowerment), consisting of representatives of each EO group supported by CHP. SC then utilized this mechanism to extend revolving fund credit to 200 economiically active women in three villages (Tibang, Alue Naga, and Ulee Lheu). SC built local capacity to utilize the Group Guaranteed Savings and Lending (GGLS) methodology, targeting funds based on a survey conducted by SC and BAPESREM.

Finally, the CHP evaluated programs to improve the psychosocial status of women. Interestingly, quantitative results indicate that the psychosocial status of at-risk women in target areas improved despite the conflict. This is supported by data that show that women are more often making decisions regarding household expenditures and when to visit health clinics. This was further supported by data that showed statistically significant increases in how often women reported that they feel safe outside of their homes. Finally, the comparisons between baseline and endline data showed a statistically significant difference in the level of hope reported by at-risk women. Interestingly, the level of hope women reported became more moderate with fewer women reporting high or low degrees of hope. Taking into account the volatile political environment, it was expected that the degree of hope reported by women would fall, even with CHP activities, as opposed to what the data revealed, a sort of emotional median.

While the CHP has accomplished a great amount in spite of the unstable political and security environment in Aceh, there is still much that needs to be done. Nearly 30% of women were not vaccinated for tetanus during their last pregnancy, almost 20% of women still did not receive four or more antenatal visits and ~13% did not take iron supplementation during their last pregnancy. Likewise, while the average number of days after childbirth that a woman's health was checked decrease, the percent of women whose health was checked did not show any improvement. In addition, although mothers of under-five children have improved hand washing practices and knowledge of how to prepare ORT, there has not been any improvement in the percent of mothers giving under-five children experiencing diarrhea ORT, increased fluids or food.

SC has secured funding from USDA that it will use to build on the programming established under the CHP, and will continue to address these important social welfare issues, improving the lives of the Acehnese people.

Introduction

From June 2000 through April 2004 Save the Children (SC), in collaboration with the Department of Health (DOH) at the national, provincial and district levels, implemented the USAID funded ***Coming Home Program*** (CHP) in the province of Aceh, Indonesia. The program sought to improve the well-being of Acehnese children, women and their families. Over the nearly four years of the program, SC worked closely with many local and international non-governmental organizations (NGOs) to optimize implementation. The CHP fell under the Child Health and Nutrition component of the Strategic Objective Grant Agreement (SOAG) between USAID/Indonesia and the Government of Indonesia (GOI), *Protecting the health of the most vulnerable women and children*.

Justification for Working in Aceh

The Aceh province has been affected by internal conflict for over two decades, resulting in large numbers of individuals and communities affected by conflict. The conflict has resulted in the collapse of basic health services, destroyed health and education infrastructure, and caused psychological trauma in communities with little capacity to address the psychosocial needs of those affected.

Health Issues: As a result of the internal conflict, accurate information on basic health indicators such as maternal, under-five and infant mortality are difficult to obtain. Estimates for maternal mortality are similar to national rates (373/100,000 live births) during times of relative peace, however during times of civil unrest it is expected that this rate is increased due to lack of access to adequate maternal health care. This can only be speculated, as the reporting systems in Aceh are inadequate. The CHP was able to collect some secondary data on child health. According to MOH data for the Aceh Province (1999), the major childhood cases of illness are reported by the government as follows:

Diarrhea	45 %	TB	21 %
Acute Respiratory Illness	42 %	Bronchitis	10 %
Dysentery	12 %	Typhoid	9 %
Malaria	12 %	Measles	1 %

In addition to these high rates of childhood illness, according to provincial 1999 data for children, the percentage of children suffering from some degree of malnutrition was 38.8% (2.5 % severely, 9.43 % moderately and 26.87 % mildly malnourished). Because of the internal conflict, trainings and supplies needed to address health concerns are often not accessible to the Acehnese.

Psychosocial Issues: Living through violence, displacement, and social repression can have long-lasting negative effects on a child's psychological and social development. Many Acehnese children have seen family members or neighbors killed or kidnapped. As the violence continues, other less tangible stresses also enter the child's life: food shortages cause family strife, loss of adult family members requires a child to make an economic contribution to supporting their family, and fear of being recruited into a militia curtails normal social activities. As the community and family structures disintegrate, the child loses a sense of security and protection. Adolescents experience similar trauma as children with regards to loss and disruption. During their transition to adulthood they need to learn life skills, model their behaviors on other successful adults, and develop their own identity within society. Conflict interrupts this development during a critical stage for adolescents, and at a time when they are looking for opportunities for growth.

Women are also severely affected by the conflict. Either loosing a husband or child to violence, and/or becoming a victim of sexual abuse and violence, most women in Aceh live in fear and depression. This mental stress worsens when women have to take over the role of their husbands as the head of household.

History of Save the Children's Work in Aceh

The Aceh province has been and continues to be a priority for Save the Children. SC began working in Aceh in 1976 with rural development programs focused in the Pidie district**.** Save the Children worked to establish community development committees, some of which still exist as NGOs working for social welfare in Aceh. By 1997, Indonesia was considered a success story and SC, handed its program over to a local NGO. Shortly thereafter, the economic crisis hit, and in 2000 SC returned to Indonesia and began implementing the Coming Home Program.

Activities by Result

The constantly changing political and security situation in Aceh over the past four years has presented a challenging work environment. As a result, Save the Children has had to be flexible in adapting CHP strategies and programming so as to best support the program's objectives and intermediate results.

Initial Strategy and Operating Environment

The intermediate results (IRs) of the Coming Home Program evolved with the constantly changing and volatile political and security situation to best support the goal of the program and USAID's IRs. The original IRs for the CHP, used to guide programming from July 2000 through June 2003 were:

- Community based preventive health care system re-vitalized;
- Psychosocial needs of children and their families addressed;
- Special needs of at-risk women addressed (women who as a result of conflict are traumatized, sexually abused, have become single heads of households or are subject to domestic violence);
- Youth participation in their own development and that of their communities enhanced.

In July 2000, at program start-up, Aceh had just experienced a wave of internally displaced persons (IDPs) and communities were experiencing social hardship and infrastructure disruption upon returning to their villages. However, the political and security situation looked promising. A 3-month cease fire agreement – known as the "humanitarian pause" – had been signed between the Government of Indonesia and the Free Aceh Movement (GAM) in attempt to reduce violence and start towards a peace agreement. Internally displaced persons throughout Aceh began to return home. The "humanitarian pause" was extended in September 2000 and was to remain in place through mid-January 2001. The program determined it feasible to work in sub-districts in the vicinity of Banda Aceh, including Syiah Kuala and Meuraksa (Banda Aceh district), and Pulo Aceh and Baitussalam (Aceh Besar district).

The initial strategy aimed to improve the health environment for women and children within their villages. In the context of tremendous societal upheaval, the program sought to establish a sense of safety and health empowerment for internally displace persons (IDPs) who had been displaced and traumatized, as well as for those who remained in their villages. Its emphasis was to restore primary health care services and provide psychosocial activities to promote emotional well being. *Pulang Kampung* was a community based training program, with the objective of transferring skills to at-risk women and adolescents, so that even if they were to become displaced again, or for the first time, they would be able to carry their internalized new skill set with them. The program was designed to help vulnerable populations in their villages maintain their health, both physical and mental, as the environment around them remained unstable.

The program also sought to strengthen the health care system by re-creating the village health outreach system through the retraining of Kaders and the re-establishment of the Posyandu system in target communities. The forming of village level support groups of targeted high-risk populations enabled people to identify their greatest needs and work towards maintaining a safe community. The transfer of skills to families included skills in nutrition, psychosocial development, sexual violence coping skills, life-building and emergency preparedness.

In September 2000, Save the Children's Banda Aceh office officially opened, and it was expected that staff would be fully operational by November. Program start-up progressed with the first major external training planned for

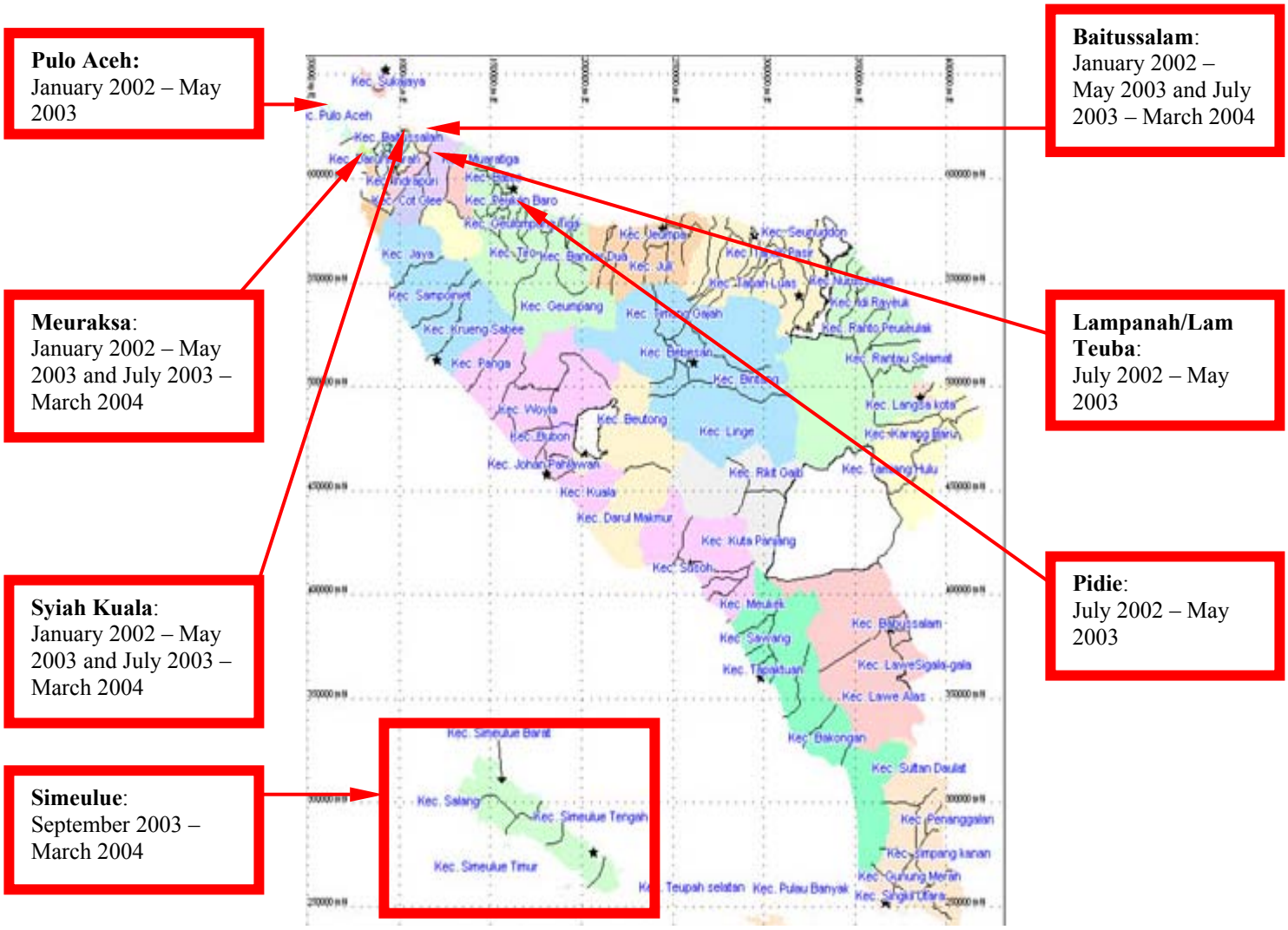
November. However, by November 2000, the security situation had deteriorated. There was increasing social unrest, a natural disaster (flooding), and an increased threat of political upheaval, which made the atmosphere restrictive and volatile, forcing SC to restrict activities to the Banda Aceh area. In late December 2000, six months into program implementation, expatriate work visas were refused and SC expatriate staff were relocated to the Jakarta office in January 2001.

The situation described above would be only one of many times the Coming Home Program would need to regroup and re-strategize to ensure optimal program implementation. Though the objectives remained the same throughout the program, *Pulang Kampung* was forced to evolve with the ever-changing political and security environment. This meant pulling back to safer "white" areas in and around Banda Aceh in times of civil unrest and constantly re-evaluating the progress of the program, adapting the strategy as necessary and integrating lessons learned. Despite the formidable obstacles the program has faced, it has made great strides towards achieving its objectives.

Pre-Martial Law Programming

As described above, by December 2000, the political and security situation had deteriorated. Expatriate staff were relocated to Jakarta and the Aceh field office was shut down. The next six months were used to advocate for and negotiate the re-start of the program, which required a revised program and impact area strategy approved by the GOI. At the end of June 2001, SC was given permission to restart its program in Aceh. In the second half of 2001, SC began to rebuild the program, finished the start-up process and began implementing very limited programming in the initial impact areas agreed upon by the Government of Indonesia, USAID and SC. During the first part of 2002 the CHP was in full swing, implementing program activities in support of all IRs, and by the second half of 2002 the security situation had improved enough for the CHP to be expanded to the harder hit Pidie and Aceh Besar districts. SC would continue to implement program activities in Pidie, Aceh Besar and the initial impact areas around Banda Aceh through May 2003, when the program was temporarily suspended and then required to pull back to the safer "white" areas around Banda Aceh due to the imposition of martial law. Figure 1 presents CHP implementation areas throughout the life of the program.

Figure 1: Map of Implementation Areas Throughout the Lifetime of the Program



The original IRs developed for the CHP guided programming from July 2000 through May 2003. Programs developed to support the IRs included building capacity to improve health services through revitalization of the Posyandu system, improving the health information system, support of national immunization days, building community capacity in emergency preparedness, micro-finance programming for at-risk women and youth, psychosocial programming for women, youth and children affected by conflict, civic participation and protection of at-risk women and youth, and the formation of community health boards to advocate for more responsive health policy. The following specifically shows how each of these program activities supported the original IRs.

Table 1: CHP Activities By Result
December 2000 - May 2003

RESULTS:	IR1: Community based preventive health care system re-vitalized	IR2: Psychosocial needs of children and their families addressed	IR3: Special needs of at-risk women addressed	IR4: Youth participation in their own development and that of their communities enhanced
ACTIVITIES:	Improved health information system (HIS)	Built community capacity to address the psychosocial needs of children.	Provided economic opportunities	Provided economic opportunities
	Built the capacity of Posyandus to improve basic health services	Implemented normalizing activities for children and youth	Addressed the psychosocial needs of at-risk women	Supported civic participation and protection of at-risk youth
	Supported the national immunization campaign			Implemented normalizing activities for youth
	Built community capacity in emergency preparedness			
	Promoted responsive health policy			

The following provides a brief description of the activities implemented under the CHP in support of the goal and IRs agreed upon by SC, GOI and USAID between July 2001 and May 2003.

IR1: Community based preventive health care system re-vitalized

Improved Health Information System (HIS)

In order to improve Aceh's ability to report on basic health indicators, enabling health officials to better understand what the health problems are in Aceh and their magnitude, the CHP worked to improve the health information system. The CHP organized a HIS workshop in April 2002 attended by Puskesmas doctors, midwives, community leaders, and 18 Kaders from 9 villages in Baitussalam. The objective of the workshop was to review the existing reporting systems and provide technical assistance to simplify them, making them easier to use and thus more effective. The workshop resulted in a new revised format for the health information system form. In May 2002, the 18 Kaders who participated in the initial workshop were trained on how to use the new HIS form and appropriate field testing techniques. The new format with the assistance of the 18 selected Kaders was pilot tested in 9 villages of the Baitussalam sub-district. Local health officials reported that the format is still currently being used and that they found it helpful in improving reporting.

Built the capacity of Posyandus to improve basic health services

Due to on-going conflict in Aceh, the health system had deteriorated making health services inaccessible to much of the population. The Posyandu system and Kaders became inactive and even Puskesmas, which were responsible for community health, were not functioning as expected. Puskesmas doctors and midwives did not stay in the locations to which they were assigned.

In response to these issues, the Coming Home Program worked to revitalize the Posyandu system in 61 villages in CHP impact areas by providing training to 620 Posyandu Kaders. These included trainings in: 1) Posyandu management, 2) community facilitation, and 3) topics related to maternal and child health carried out through special trainings and regular monthly Kader meetings. Village midwives and other Puskesmas staff were included in the trainings as appropriate. In addition, the CHP distributed Posyandu kits (consisting of hanging weight scale, trodden scale for pregnant women, trouser for baby weighing, stethoscope, sphygmomanometer, laennec phitoscope, middle upper arm circumference tape, tailor measurement tape, stainless steal bowl, small towel, liquid hand soap, suitcase, disposable syringes 5ml, disposable syringes 10 ml , disposable needle G 23, disposable needle G 25, vest for Kader, health reading books for Kaders, MCH records, Posyandu record form, ball point pens, pencils, and notebook for posyandu documentation) to 61 villages in Tangse, Lampanah/Lamteuba, Baitussalam, Syiah Kuala, Meuraksa, and Pulo Aceh to support the work the Kaders were doing and the increased demand for Posyandu services.

Supported the National Immunization Program (PIN)

In effort to improve childhood vaccination coverage in Aceh, the CHP supported the National Immunization Program. Save the Children participated in National Immunization Days in September and October 2002 by providing banners, posters, and Information, Education and Communication (IEC) materials. In addition, the CHP assisted in distributing vaccines to 61 villages in the CHP impact areas. CHP staff also participated in monitoring the immunization process to ensure that it met World Health Organization (WHO) standards.

Built Community Capacity in Emergency Preparedness

The CHP worked to enable communities to better respond to common health emergencies, a skill set especially useful during times of conflict when health facilities and personnel may be inaccessible. To achieve this, between August and October 2002, Save the Children in partnership with Fakultas Kedokteran Unsyiah, trained 240 volunteers from 61 villages in a Training of Trainers (TOT) on first aid basic life support techniques.

Promoted Responsive Health Policy

To empower communities to have a greater influence on local health policy, starting in January 2003, Save the Children facilitated a health intervention planning workshop, attended by 47 stakeholders from Tangse and Lampanah/Lamteuba. The workshop recommended the establishment of Community Health Boards (CHB), which function as committees that identify community health problems, and review and provide input on the existing local health policy in order to produce health policies that are more responsive to local needs. The CHP, together with local stakeholders, created and defined roles and member composition of Community Health Boards in Tangse. Unfortunately, due to internal conflict and imposition of martial law SC was not able to follow up on these activities after June 2003 because SC was forced shift all program activities to Banda Aceh and Aceh Besar.

IR2: Psychosocial needs of children and their families addressed

Built community capacity to address the psychosocial needs of children

From January 2002 through June 2003, SC built local capacity to address the psychosocial needs of children affected by conflict to help children cope with the psychological effects of conflict and normalize their lives. The CHP carried out psychosocial training for staff and partners including YAB, YDUA, Ibnu Hasyim, Al-Adnin, DOH and Puskesmas staff (~22 participants).

In the first half of 2003, Save the Children worked with local partner PULIH to develop a more structured psychosocial curricula that could be implemented in schools. This curricula was designed to reduce post-traumatic stress among children affected by conflict. However, just as the capacity-building was to start, martial law was imposed. After martial law, SC agreed with USAID to discontinue psychosocial activities until access to post-conflict areas was possible. SC sought and received funding from USDA to utilize the psychosocial curricula developed under CHP in programming that started in June 2004.

Implemented normalizing activities for children and youth

From 2001 – June 2003, SC partnered with LNGOs Yayasan Anak Bangsa (YAB), Yayasan Daur Ulang (YDUA), and Yayasan Ibnu Hasyim to organize activities for urban children, orphanages, and street children. Activities included: non-formal education in basic science, music, drawing, painting, drama, and morals; team sports, cultural field trips; festivals; competitions designed to stimulate free expression; publication of monthly bulletins; English instruction; education about children's rights; and creation and operation of an 830-volume library.

Save the Children also trained 90 village volunteers from 12 villages to conduct normalizing activities for children and youth, including recreation, games and youth clubs.

IR3: Special needs of at-risk women addressed

Provided economic opportunities (EO)

Save the Children implemented economic opportunity (EO) and micro-finance programs starting in June 2002. These activities were one strategy that the program was able to continue after martial law, and up through the end of the program implementation period in March 2004. EO programs were implemented through a combination of direct implementation and implementation through LNGOs. The objective was to create economic opportunities for at-risk women and youth to enable them to take responsibility for their own well-being, including their health. Between June 2002 and June 2003, Save the Children provided assistance to 1,958 vulnerable women and their families in 61 villages spread over three districts; Pidie (Tangse), Aceh Besar (Lamteuba/Lampanah, Pulo Aceh) and Banda Aceh (Kecamatan Meuraxa and Syiah Kuala). The CHP provided skills training and material resources to 665 women to establish livelihoods in food processing (e.g., fried coconut, shrimp crackers, Tempe, cookies, Oyster Sauce), embroidery, sewing, agriculture, and poultry farming.

Addressed the psychosocial needs of at-risk women

From July 2002 through June 2004, the CHP also worked to build the self-confidence and basic skills of at-risk women and youth through implementing civic participation and protection activities. Some of the activities targeting at-risk women included non-formal education, publication of monthly bulletins about women's issues, and carrying out

regular support/discussion groups to discuss gender equality, maternal and child health, women's rights, reproductive health, and business issues. After martial law, women's groups continued to be supported through January 2004.

IR4: Youth participation in their own development and that of their communities enhanced

Provided economic opportunities (EO)

CHP's strategy to address EO for youth was the same as it was for women, and in the field was often combined. The CHP provided skills training and material resources to 580 at-risk youth (boys and girls) to establish livelihoods as motorcycle mechanics, welders, poultry farmers, wire-fence fabricators, and chili farmers in the same implementation areas.

Supported civic participation and protection of at-risk youth

To increase youth participation in their own and their community's development, the CHP created 10 Youth Associations spread over the districts of Pidie (4 in Tangse), Aceh Besar (1 in Lamteuba, 1 in Lampanah, 2 in Baitussalam, and 1 in Pulo Aceh), and Banda Aceh (1 for Mueraska and Syiah Kuala). Through these associations, youth were taught leadership, business and management skills, social and community development methods, gender equality, reproductive health, and human rights. Additionally, the youth associations worked to implement normalizing activities such as traditional dance, art, and sports competitions. They also conducted a 12-episode radio campaign against drugs. These activities were carried out from July 2002 through April 2003.

Post- Martial Law

The Coming Home Program continually re-assessed program direction and activities as the political and security situation and thus ability to implement were in a constant state of flux. Martial law was imposed in Aceh on May 19, 2003. Shortly thereafter, expatriates were expelled and barred from the province and program activities were suspended. Through private diplomacy by Save the Children at local and central levels, SC became the only INGO given permission to restart operations in July 2003. Permission to work was only given for "white" areas around Banda Aceh. The CHP was required to discontinue program activities in Pidie. Martial law also suspended the work of local NGOs, and even after some LNGOs were allowed to continue their work, SC was not allowed to collaborate with them. So, the CHP had to start directly implementing all program activities.

In response, SC shifted the program direction to make the best use of the human and material resources available and to better align with USAID's IRs. In doing so, the CHP adopted the following IRs to guide the last year of program implementation:

- Promote more responsive health policy;
- Increase access to higher quality maternal and child healthcare;
- And, empower individuals, families, and communities to take responsibility for their own health.

Some of the funding originally allocated to program activities in the Pidie district was, after consultation with USAID, re-allocated to malaria and nutrition programming in Simeulue, an island in the Aceh province largely unaffected by the conflict, and additional programming in the initial impact areas. In modifying the CHP implementation plan, SC aligned new programming and refocused existing programming to better support USAID's intermediate results while still taking into account the original objectives of the program. The modified IRs were used to guide the final year of program implementation, from June 2003-March 2004. Programming to support these IRs included continuation of

EO and civic participation and protection for at-risk women and youth activities in "white" areas approved for program implementation. In addition, several new projects including a modified version of the INGO MNH's Desa SIAGA program, standardization of midwife skills, malaria control and PD-nutrition programs were implemented in safe areas around Banda Aceh and in Simeulue. The following gives a more detailed description of the new activities and how they support the modified IRs.

Table 2: CHP Activities by Result
July 2003 – March 2004

RESULTS:	IR 1: Promote more responsive health policy	IR 2: Increase access to higher quality maternal and child healthcare	IR 3: Empower individuals, families, and communities to take responsibility for their own health
ACTIVITIES:	Built Capacity to Implement Desa SIAGA	Built local capacity to strengthen midwife skills	Built Capacity to Implement Desa SIAGA
			Mobilized Communities to Improve Child Nutrition
			Supported community-based malaria control
			Implemented Economic Opportunities (EO) program
			Supported Women's Civic Participation programs

IR 1: Promote more responsive health policy

Built Capacity to Implement Desa SIAGA

With technical support from the MNH-JHPIEGO program, SC implemented a modified pilot version of the *Desa SIAGA* (*Siap Antar Jaga; or the "Village Ready to Refer and Protect'*) program. This model was developed by the Maternal Neonatal Health (MNH) program to mobilize communities to advocate for community health needs, with a focus on maternal health. SC staff received training from MNH, and visited SIAGA programs in Cirebon, West Java. SIAGA facilitators were trained in 14 target villages and then advocated for improved health services and engaged community participation in establishing emergency preparedness systems related to maternal health. All of the findings of the community assessment of village needs and priorities were presented to sub-district and district officials to help inform health policy and planning. A more detailed description of the Desa SIAGA program can be reviewed under IR 3.

IR 2: Increase access to higher quality maternal and child healthcare

Built local capacity to strengthen midwife skills

Increasing demand for assisted delivery will only have impact if there are enough skilled midwives to ensure safe delivery. To complement SIAGA activities, SC focused on building local capacity to improve and standardize the basic delivery skills of village midwives. Initially, SC requested that MNH training staff provide Normal Delivery Care (APN) training to the 14 midwives who are posted in communities where the SIAGA program was operational. The idea was to improve the quality of and accessibility to services being provided while increasing community demand for them. After consultation with MNH staff, it was concluded that the best way to ensure program impact and sustainability was to build the capacity of the Provincial Center for Secondary Clinical Training (P2KS, *Pusat Pelatihan Klinis Sekunder*) to train midwives.

The provincial P2KS provides in-service training for midwives. P2KS staff were already advanced trainers in family planning, but had not yet been prepared as APN trainers. SC and MNH sent three P2KS trainers and five village midwives to attend a Jakarta APN training, with the thought that additional support could be given in Banda Aceh to ensure the APN was standardized. SC also supported a visit by the P2KS Director, Dr. Aboe Bakar, to Budi Kemuliaan hospital in Jakarta, where APN training is standardized. Several weeks later, a MNH staff started conducting TA visits to Banda Aceh in order to establish the clinical sites required for this competency-based training to occur. Five sites were selected, and MNH helped connect SC with the National Health Training Network, JNPK, (*Jaringan Nasional Pelatihan Kesehatan*) and its provincial chapters to provide the follow-on training and technical support needed to bring the Banda Aceh clinical sites up to JNPK standards.

Starting the last week of December 2003, SC started receiving technical support from P2KS/JNPK trainers from West Java, East Java and Jakarta. From January 2004 through March 2004, SC-CHP with JNPK/P2KS supervision completed 4 APN (Normal Delivery Care) and 2 Clinical Trainer Skill (CTS) trainings. The 4 APN trainings improved and standardized skills of 63 midwives and P2KS staff in Normal Delivery Care. The 63 trained midwives include midwives in Desa SIAGA implementation areas, Provincial DOH staff, DOH Banda Aceh staff, P2KS staff, Provincial IBI (Midwives association), IBI Aceh Besar, Pustu staff (sub Puskesmas), Puskesmas staff in Aceh Besar and Banda Aceh, Akbid Poltekkes staff, and Akbid Muhammadiyah staff. SC-CHP also included three midwives from IBI North Sumatra in APN IV. Of the 63 midwives trained, 19 have also been trained in Clinical Trainer Skills (CTS), 10 have qualified as Class Trainers (CT), and 8 midwives as Clinical Instructors (CI). In addition to training, SC also provided some of the basic delivery equipment needed to bring the clinical training sites up to JNPK standards (e.g., Partus kits, delivery models, disinfection systems, etc.).

After three months of providing assistance to the training sites, the consultant from MNH-JHPIEGO reported that the clinics met JNPK standards of operation to function as delivery clinics and clinical training sites. The classroom trainers and clinical sites now have the capacity to train up to 20 midwives each month in APN. Save the Children has secured USDA funds to start utilizing this training capacity in July 2004, and will support the roll-out of APN training for village midwives in the Pidie district.

IR 3: Empower individuals, families, and communities to take responsibility for their own health

Built Capacity to Implement Desa SIAGA

The SIAGA approach addresses maternal mortality by preparing communities for possible emergencies during and immediately after child birth. It also promotes safe delivery assisted by a village midwife. SC equipped facilitators from 14 villages for the *Desa SIAGA* program with a series of trainings (e.g. concept of Desa SIAGA, TOT facilitator,

and social mobilization) to enable them to implement and sustain the program once the grant ended. The facilitators formed a facilitator's forum through which they collaborated and shared experiences.

Each village facilitator was responsible for recruiting and training volunteer Kaders to assist in program implementation at the village level. Through the CHP, 72 SIAGA Kaders were recruited and trained in the SIAGA concept, reproductive health, community facilitation and effective communication techniques. Facilitators, with the support of Kaders, then facilitated community participation in identifying priority health issues and responding to them. Emergency preparedness systems were established in each target community based on identified need and preference. The possible systems included: 1) family birth preparedness savings account (*Tabungan Bersalin*, or *Tabulin*), 2) community birth preparedness savings fund (*Dana Sosial Bersalin* or *Dasolin*), 3) blood donor system (included blood typing), and 4) emergency transportation system. In several villages, information on reproductive health was also identified as a priority, and steps were taken to support this issue as well.

As part of the blood donor system, the Facilitator's Forum worked in collaboration with the PMI (*National Red Cross*) to conduct blood typing of donors in the 14 pilot target villages, with about 1,000 people participating. The opportunity was also used to promote the need for blood donors, debunking myths that giving blood is against Islam,[1] and beliefs that blood donors will be unable to work for days after giving the donation. As a result 95 community members donated blood, and while no maternal emergencies requiring a transfusion arose, three other cases needing transfusions were assisted. SIAGA facilitators now have an agreement with PMI to regularly collect blood from these communities, with PMI providing the medical supplies and supplemental food that donors receive.

An interesting aspect of the pilot Desa SIAGA program in Aceh was that facilitators mobilized communities to take over un-used public buildings, such as clinics and birthing posts abandoned due to the conflict, as SIAGA "posts". These not only gave SIAGA a place to host activities, but also raised the profile of the safe motherhood movement in villages.

Mobilized Communities to Improve Child Nutrition

Save the Children utilized a Positive Deviance (PD) approach to mobilize communities to find sustainable solutions to malnutrition in under-five children in target areas. Initially, the child nutrition program was to be implemented in Tangse, Pidie District. However, due to increased conflict and the imposition of martial law just two weeks into implementation, SC was forced to change the program location. The new location targeted under-five children in Alue Naga in Syiah Kuala, Banda Aceh and in Simeulue.

The PD Nutrition program combines the positive deviance approach to behavior change with Nutrition Education Rehabilitation Sessions (NERS). Using the PD approach, a community investigates what enables some people – positive deviants – to find better solutions to prevent childhood malnutrition than their neighbors who have access to the same resources. In Alue Naga, a total of 105 children have been enrolled in PD-NERS since July, of which 89.5% have improved their nutritional status and 52.3% have graduated. PD-NERS provide opportunities for caregivers to practice PD behaviors in a hearth setting, attending the NERS for 2 weeks right after the Posyandu. Caretakers then practice on their own for 2 weeks. For a child to graduate from the PD-NERS program, the criteria until December was that the child be in the well nourished status for two months. Because Kaders running the PD-NERS were keeping children in the program longer than necessary, the criteria was further specified after December. The new criteria for graduation became a weight gain of 400g indicating catch up growth and two consecutive months of weight gain.

[1] While not stated in the Quran, some blood donors have concerns that their blood will be used for a non-Muslim patient, which they think is not *halal*.

In Simeulue, SC also built local capacity to implement PD nutrition programs. SC hired and trained a PD program officer who is affiliated with the District Health Office, and who will continue on with the DHO once the program is finished, thus institutionalizing PD capacity. SC also trained village Kaders in the PD Approach, as well as village midwives and Puskesmas staff. SC then provided technical support to implement the PD Nutrition program, identifying PD behaviors that were relevant to well nourished children in Simeulue. The PD-Nutrition program started in October in three villages of the Simeulue Timur sub-district. In the five months of program implementation, 71 children were enrolled in PD-NERS, of which 29.5% improved their nutritional status and 21.1% graduated.

Supported community-based malaria control

In effort to control a malaria outbreak in Simeulue identified by the national DOH, the CHP worked with the district DOH, the Indonesian Anti-Malaria Initiative (IAMI) and the Naval Medical Research Unit-2 (NAMRU-2) to develop and implement a malaria control program. IAMI, in collaboration with NAMRU-2, donated 20,000 insecticide treated bednets (ITNs) to address the malaria outbreak in Simeulue, and asked SC for support in delivering them and providing an effective malaria education and community mobilization campaign.

The CHP, in collaboration with IAMI-trained master facilitators from the DOH, trained 16 facilitators in Simeulue on malaria control. The facilitators in turn trained 210 Kaders and 269 community leaders from 73 villages on malaria control and community mobilization, totaling 479 participants. The newly-trained Kaders and community leaders formed task forces in each target village that were responsible for mobilizing the community around malaria prevention and control. SC worked in collaboration with IAMI and DOH to develop and produce malaria control IEC materials to support a malaria education and community mobilization campaign carried out in each target village with the help of Kaders and malaria control task forces. As part of this campaign, each target village was required to make efforts to reduce mosquito breeding sites in their community as a pre-requisite to receiving the free ITNs.

SC worked closely with DOH to prepare an ITN distribution plan/guideline book, distribute 20,000 ITNs to 73 villages and take blood sample from 21 villages that did not yet have Parasite Rate data (PR). To build the district's capacity to better diagnose malaria, 2 laboratory technicians were sent to Jakarta to attend a laboratory diagnosis of malaria training conducted by NAMRU-2. Through this program the capacity of the district to prevent and control malaria has improved. Health officials as well as the communities have increased knowledge and awareness of malaria, how it is transmitted, how to diagnose it, and how to control it. In addition, community mobilization to prevent and control malaria has improved and ITN coverage has increased in target villages.

Implemented Economic Opportunities (EO) program

Between June 2003 and March 2004, SC continued to support EO program activities for at-risk youth and women. However, due to the imposition of martial law, SC was forced to end EO programming in the Pidie and Aceh Besar districts and terminate relationships with LNGOs due to military regulations. SC hired several staff from LNGO partners to facilitate continued implementation of the EO program in four villages in the "white zone" in the Syiah Kuala subdistrict of Aceh Besar (Alue Naga, Tibang, Deah Raya, and Ulee Lheu), with the caveat that LNGO staff would return to their local organizations when martial law ended. The CHP provided training to more than 200 at-risk women and 100 youth in the Syiah Kuala subdistrict in micro finance and business development to build and improve their capacity in income generation. To conduct training, SC involved external facilitators such as expert trainers in business planning and marketing analysis. Beyond training, SC provided materials such as sewing and embroidery machines, cloth, thread, needles, materials for oyster sauce, and chicken for poultry farming to six groups of 30 women and 23 female youth to assist them in starting their businesses.

SC also facilitated the establishment of a forum, known as BAPESREM *(*Badan Koordinasi Pemberdayaan Sosial Masyarakat- Coordinating Board for Social Community Empowerment), consisting of representatives of each EO

group. This community forum was responsible for promoting and coordinating EO activities. The forum has plans to increase their role in other programs such health promotion and protection.

It became apparent that training and materials without capital made it difficult for women and youth to successfully start their businesses. In response, the CHP set up a revolving fund benefiting 200 women who are economically active in three villages (Tibang, Alue Naga, and Ulee Lheu) in February 2004. SC developed a savings and credit methodology modeled on Group Guaranteed Savings and Lending (GGLS), modified to the local cultural context. Locally, it is known as *KSP* (*Kelompok Swadaya Perempuan* or Self-Sufficient Women's Groups). KSPs are self-managed groups of 25 women who operate cooperative savings and lending activities. KSPs are comprised of solidarity groups of 5 to 7 women who agree to guarantee each other's loans and to support each other in developing their businesses.

Targeting of the funds was based on a survey conducted by SC and BAPESREM. Before disbursement of funds, all beneficiaries are required to attend savings and credit methodology and credit record keeping systems trainings. BAPESREM manages the revolving fund disbursed to the beneficiaries as capital loans. The forum charges each beneficiary 1.5% interest per month. This allows BAPESREM to finance their operating costs and ensure sustainability of the program. SC conducted a workshop on performance management to improve BAPESREM's capacity in program management and strategic planning.

Supported Women's Civic Participation programs

Between June 2003 and March 2004, the CHP continued to support at-risk women and youth civic participation and health protection activities. SC-CHP supported the establishment of task forces for women and youth in three villages. These groups met regularly to identify problems and bridge gaps in the community. In 3 months of operation, the task forces have inspired a number of activities that improved the welfare of women and children. For example, in three villages in the Syiah Kuala sub-district, the task force determined that there were not enough activities for young people, and established youth interest clubs that facilitate activities in art and culture, sports, discussions, and drama. Local youth now host weekly youth discussion groups, attended by about 20 young people per meeting. The task forces also established soccer teams for boys, and softball (*bola kasti*) teams for girls. They supported local youth taking the initiative to learn handicrafts as a way improve life skills, and perhaps supplement family income. On average, approximately 20 youth participated in this program, making hand bags (*tas rajut*) and other handicrafts. After identifying the need for child care of younger children, task forces started involving older youth in facilitating play groups and day care for children of working mothers. Families pay Rp.100 per child per day for the service, which is used to support material needs. Approximately 50 children benefit from the play group. None of these activities existed before the task forces were established.

The CHP also trained 28 women and girls in gender, gender mainstreaming, and gender equality with the objective of increasing their self confidence and self image within their communities. Participants collected materials and conducted interviews to publish a local bulletin, "*Sinar Desa"* (Light of the Village). The bulletin was distributed to local stakeholders, and the content was discussed in subsequent women's meetings. SC also sponsored 7 women and girls to attend training in reproductive health campaign techniques, which resulted in two pilot campaigns focusing on reproductive health and the dangers of drug use targeting youth.

Program Results

Monitoring and Evaluation Methodology

SC utilized a number of monitoring and evaluation methodologies to optimize program development, monitor the progress and evaluate the impact of the CHP.

Baseline and Endline Studies

The CHP collected data through a variety of qualitative and quantitative research methodologies at baseline and endline including focus group discussions, in-depth interviews, key informant interviews and quantitative surveys. These studies were conducted to gather information to optimize program development and to evaluate impact of the program. SC contracted out studies conducted to local research teams associated with the school of public health at Muhammadiah University in Aceh in order to minimize bias. Though the CHP did not directly carry out studies, SC maintained control of research instruments and methodology. The CHP also collected a substantial amount of secondary data to better understand the health issues in the impact areas and evaluate change.

Baseline data collection was carried out in the initial impact areas (Pulo Aceh, Meuraksa, Baitussalam, and Syiah Kuala), as SC did not have access to other potential implementation areas at that time. At baseline, SC carried out focus group discussions and conducted an assessment of Posyandu needs. In addition a baseline quantitative survey was carried out with a sample of 673 mothers of children under the age of two and 661 youth aged 12-18 by a research team from the school of public health at Muhammadiah University. This sample size was large enough to detect a 5% change in key variables with 99% confidence. SC developed the questionnaire and data collection protocol and supervised data collection, entry, cleaning and analysis. Data were entered using Epi Info 6.0 and analyzed using SPSS 10.1. Basic frequencies and descriptive analysis were run at baseline to gain a better understanding of the knowledge and practices of the target populations regarding health seeking behavior, antenatal and postnatal care, childhood illnesses and danger signs. In addition, data was collected to evaluate the level of hope of at-risk women and youth in target populations and to gather basic sociodemographic information.

At endline, the quantitative survey was repeated by PEKA, using the same questionnaire to ensure comparability, with a sample of 664 mothers of children under the age of two. This sample size was sufficient to detect a 5% change in key variables with 99% confidence. The quantitative survey was not repeated with youth due to changes in program implementation. The areas and types of activities that were carried out with youth changed significantly between baseline and endline and thus baseline and endline data for youth would not have been comparable or able to show impact of the program. The endline quantitative survey was carried out in Baitussalam, Mueraksa and Syiah Kuala. Unfortunately, SC was not able to continue program implementation in Pulo Aceh due to security reasons and therefore did not carry out the endline survey there.

Data from the endline survey were entered using Epi Info 6 and analyzed using SPSS 10.1. Frequencies and descriptive analysis were first run, followed by T-tests to test for statistically significant differences between baseline and endline data for continuous numeric variables and chi-squared tests to test for statistically significant changes for categorical variables. Data were checked for internal consistency and validity as well as comparability between baseline and endline study samples. In general there was good agreement and no significant differences in the study populations sampled.

In effort to evaluate program activities in implementation areas that the CHP no longer had access to, SC carried out qualitative research including FGDs with Kaders, mothers of under-five children, youth, and women involved in income generation activities**,** in-depth interviews with community leaders, health officials, SC program officer and SC

field staff and local NGO partners, and key informant interviews with SIAGA Kaders, mothers of under-five children enrolled in PD NERS activities, Puskesmas directors and bidans.

Malaria KAP Survey and Monitoring

The CHP hired a research team from the District and Provincial Health office to conduct a malaria KAP survey. The objective of the survey was to explore knowledge, attitudes and practices regarding malaria. This study was carried out before program implementation, in October 2003, with a sample size of 724 to assist in program development and provide some baseline data for the malaria control program. The sample size was sufficient to detect a 5% change in key variables with 99% confidence. SC worked with the research team to develop the questionnaire and data collection methodology. Data was analyzed using frequencies and basic descriptive analysis. Due to time constraints, CHP was not able to repeat the survey at endline, but was able to carry out a shorter survey with 20% of the target population to monitor the progress of the malaria control program. Monitoring was carried out in two phases to mirror implementation. The first phase was carried out in January, 2004 and the second phase in March 2004.

Evaluation of PD Nutrition programs

The PD-Nutrition program collected nutritional status data for all under-five children that attended Posyandu at baseline in each of the target villages. Each month thereafter, data was collected on those children who participated in the PD-NERS program to monitor their progress and evaluate the impact of the project. Results can be reviewed in the results section of this report.

Other Program Monitoring

CHP monitoring and evaluation staff made frequent trips to the field to monitor on-going program activities on mainland Aceh as well as in Simeulue. They also collected data on a monthly basis and submitted monthly reports to the Jakarta office for review describing progress made towards program objectives, activities carried out, financial and administrative updates and challenges faced. As described above, some programs such as the PD-Nurtrition program had monthly monitoring mechanisms built into their programs. In addition, when SC was allowed to collaborate with LNGOs, they were required to submit monthly and quarterly progress reports to the Aceh field office.

Over the nearly four years of program implementation, the CHP has made significant progress towards achieving the intermediate results agreed upon by the Department of Health, USAID and SC. While the political and security situation has slowed and at times halted program activities, the persistence of the CHP staff has ensured that tangible results were achieved. Qualitative, quantitative, and secondary data show improvement in some of the key indicators. It should be noted that there were also several key indicators for which little or no progress was made. Reasons for this and recommendations will be discussed below.

Program Results

IR 1: Promote more responsive health policy

Given martial law and restricted access to the Pidie district, Save the Children was not able to do an evaluation of progress made as a result of the Community Health Boards the program helped establish.

While advocacy on maternal health was conducted by 14 villages through the *Desa SIAGA* program, at the time of the end of the program no concrete changes in government policy had emerged. Emergency preparedness systems related to maternal health were established in all 14 intervention villages, however.

In Simeulue, as a result of the malaria control program, the district level government developed a Qa'nun (or a local policy) regarding malaria control. In addition, the district level department of health is now working to develop a malaria control topic to be integrated into the primary, junior and senior high school curriculum.

IR 2: Increase access to higher quality maternal and child healthcare

One of the main focuses of the CHP was to improve the quality, access and utilization of health services. As previously mentioned, due to the on-going conflict and most recently imposition of martial law, there was a breakdown in basic health services. Posyandus and Kaders became inactive and Puskesmas were dysfunctional because Puskesmas staff were not staying in the locations to which they were assigned. Through CHP activities, important advancements were made towards improving quality, access and utilization of health services.

Maternal Health Services

As described above, the CHP worked to revitalize the Posyandu system, increase community demand and utilization of maternal health services, prepare communities for possible emergencies during and immediately after childbirth, and improve the quality of care bidans are able to provide. As a result, several statistically significant changes were observed. The percent of women reporting having received 4 or more antenatal visits during their last pregnancy increased from 68.1% at baseline to 81.1% at endline. (p-value<0.001). The percent of women that reported they were vaccinated for tetanus during their last pregnancy increased from 45.9% at baseline to 71.6% at endline (p-value<0.001). The percent of women that reported they took iron supplementation increased from 77.0% at baseline to 85.1% at endline (p-value<0.001). In addition, the average number of days after childbirth women reported that their health was checked dropped from 3.01 to 1.64 (p-value= 0.001). These key changes indicate that there is an increased demand for maternal health services, and that women are able to access them when they need them. Refer to Table 3 for more information. Figure three describes how one woman and her baby were assisted by the Desa SIAGA program.

Table 3: Improvements in key maternal health indicators

	Baseline %(n)		**Endline %(n)**		**P-Value**
	Yes	No	Yes	No	
Greater than 4 antenatal visits during last pregnancy	68.1% (458)	31.9% (215)	81.1% (523)	18.9% (122)	P<0.001
Vaccinated for Tetanus during last pregnancy	45.9% (309)	47.8% (322)	71.6 (462)	27.3 (176)	P<0.001
Took iron supplementation during last pregnancy	77.0% (518)	23% (155)	85.1% (565)	13.1% (87)	P<0.001
Average number of days after child birth a woman's health was checked	3.01 days		1.65 days		P=0.001

While it is evident that important progress has been made in maternal health in the target areas, there is still significant room for improvement. Nearly 30% of women were not vaccinated for tetanus during their last pregnancy, almost 20% of women still did not receive four or more antenatal visits and ~13% did not take iron supplementation during their last pregnancy. In addition, while the percent of women that reported taking iron supplementation increased, the number of days of supplementation remained the same, on average 39.6 days at baseline and 37.4 days at endline, as compared to the recommended 90 days. Likewise, while the average number of days after childbirth that a woman's health was checked decreased, the percent of women whose health was checked remained

low, only 65.2% at baseline and 65.8% at endline. It is recommended that these health issues continue to be addressed in future programming in order to make further progress in improving maternal health.

Figure 3: Maternal Health Success Story

Mrs. Zainabon, a 28-year-old woman, is a poor mother living in the Klieng Cot Aron village in the Baitussalam sub-district of Aceh Besar. She was 7 months pregnant when the Desa SIAGA program was launched. She was actively participating in the program, especially in the Tabulin (Tabungan Ibu Bersalin) system, saving Rp 2,500 per month.

Two months later when she went into labor, Aisyah, the SIAGA facilitator, accompanied her to the village midwife. The midwife referred her to the hospital due to complications. She was afraid because she had only had enough time to save Rp.5,000, which was not enough to pay for the hospital services she would need. The facilitator encouraged her, telling her that they would find a solution to the problem. Aisyah helped Ibu Zainabon access the "Social Safety Net-Jaringan Pengaman Sosial (JPS)" fund to pay for the hospital services. As a result of Aisyah's assistance, Ibu Zainabon gave birth to a healthy baby at the hospital. She was very happy that Desa SIAGA was there when she and her baby needed help.

Child Health Services

In addition to maternal health, CHP worked to improve child health by increasing demand, access and utilization of health services targeting under-five children. Specifically, the CHP worked to improve nutrition, and utilization of Posyandu services to monitor growth and health of under-five children. In addition because the CHP worked to increase the percent of women receiving antenatal care, it was expected that an increase in neonatal health services would be observed as well.

The CHP was successful in increasing access to and utilization of Posyandu and neonatal health services. Secondary data collected from the target Posyandus, collected on a monthly basis, showed a consistent increase in Posyandu attendance. Almost all target Posyandus showed an increase in attendance, with individual results ranging from an increase of 1.9 to 55.0 percentage points. In addition, qualitative data from FGDs carried out with Kaders indicated that Posyandu kits distributed to 61 villages were still in good condition and being used by all, with the exception of the Puskesmas in Pulo Aceh. In addition, data indicated that access to and utilization of neonatal health services increased, as evidenced by the statistically significant increases in the percent of children weighed at birth and the percent of newborns whose health was checked within the first 7 days after birth in target communities. There unfortunately as no change in percent of children receiving Vitamin A supplementation. Tables 4 and 5 provide further detail.

Table 4: Increase in Posyandu Attendance over the Lifetime of the Program

No	Sub-district	Village	Estimated total number of <5 children (These are the best estimates available at this time)	Posyandu Attendance in Jan. 2002 %(n)	Posyandu Attendance in May 2004 %(n)
1	Syiah Kuala	Alue Naga	213	6.6% (14)	30.0% (64)
		Tibang	158	6.3% (10)	9.5% (15)
		Deah Raya	110	2.7% (3)	5.5% (6)
2	Baitussalam	Cot Paya	129	62.0% (80)	62.0% (80)
		Lambeda Lhok	191	19.9% (38)	74.9% (143)
		Lam Ujong	78	24.4% (19)	74.4% (58)
		Lam Pineung	83	80.7% (67)	100.0+% (96)
		Klieng Meuria	165	15.1% (25)	17.0% (28)
		Klieng Cot Aron	286	12.6% (36)	34.3% (98)
		Labui	78	43.6% (34)	85.9% (67)
		Lam Asan	89	20.2% (18)	46.1% (41)
		Mineuk Lam Redeup	109	23.9% (26)	98.2% (107)
3	Meuraksa				
		Ulee Lee	287	26 %(76)	32 % (92)
		Deah Baro	92	17 %(16)	38 % (35)

Table 5: Neonatal Health Indicators and Vitamin A Supplementation

	Baseline %(n)		Endline %(n)		P-Value
	Yes	No	Yes	No	
Infant health was checked within 7 days of birth	73.3% (321)	26.3% (115)	84.4% (362)	15.2% (65)	P<0.001
Infant weighed at birth	78.9% (531)	21.0% (141)	92.8% (616)	5.6% (37)	P<0.001
Received Vit A supplement in the last 6 mo.	65.2% (437)	34.8% (233)	64.4% (415)	35.6% (229)	P=0.766

IR 3: Empower individuals, families, and communities to take responsibility for their own health

Child Health

The nutrition program was implemented in several hamlets in Alue Naga (Banda Aceh district) and Simeulue Timur (Simeulue district) with the objective of finding sustainable solutions to malnutrition in under-five children. After 8 months of implementation in Alue Naga and 5 months of implementation in Simeulue Timur, a total of 176 malnourished children had participated in the program, 105 in Alue Naga and 71 in Simeulue Timur. Results showed that 89.5% of the participants in the Alue Naga program had improved their nutritional status and the program was able to graduate 52.3% of the participants by the end of the CHP program. It usually takes 9- 12 months to graduate all participants and may take even longer in a relatively new program. In the Simeulue Timur program 29.5% of the participants improved their nutritional status and the program was able to graduate 21.1% of their participants in just 5 months. Further details can be reviewed in tables 6 and 7.

Table 6: PD NERS Participants and Impact (Banda Aceh Site)

Hamlet	<5 children in Alue Naga July 2003		# Of children participating in NERS over 8 months of implementation	% NERS participants that graduated %(n)	% Of NERS participants with Improved nutritional status %(n)	
	Total # of <5 children (Posyandu data)	Severely malnourished %(n)			Severe to moderate	Moderate to well-nourished
Bunot	25	60% (15)	17	47.1% (8)	64.7% (11)	35.2% (6)
Musafir	82	52.4% (43)	27	59.2% (16)	56.8% (15)	33.3% (9)
Kutaran	88	38.6% (34)	48	50.0% (24)	37.5% (18)	45.8% (22)
Podiamat	19	57.8% (11)	13	53.8% (7)	53.8% (7)	46.1% (6)
Total	**214**	**48.1% (103)**	**105**	**52.3% (55)**	**48.5% (51)**	**40.9% (43)**
				Total	**89.5% (94)**	

Table 7: PD NERS Participants and Impact (Simeulue Site)

	<5 children in Simeulue October 2003			# Of children participating in NERS over 5 months of implementation	% NERS participants that graduated %(n)	% Of NERS participants with Improved nutritional status %(n)	
	Total # of <5 children (Posyandu data)	Moderately Malnourished %(n)	Severely Malnourished %(n)			Severe to moderate	Moderate to well-nourished
Kuala Makmur	58	29.3% (17)	6.8% (4)	26	11.5% (3)	23.0% (6)	7.6% (2)
Ujung Tinggi	34	29.4% (10)	8.8% (3)	15	13.3% (2)	20.0% (3)	13.3% (2)
Air Pinang	112	17.8% (20)	8.0% (9)	30	33.3% (10)	16.6% (5)	10.0% (3)
Total	**204**	**23.0% (47)**	**7.8% (16)**	**71**	**21.1% (15)**	**19.7% (14)**	**9.8% (7)**
		Total: 30.8% (63)			**Total:**	**29.5% (21)**	

Figure 4: PD-Nutrition Success Story

Safrina is a 26-month-old little girl from Bunot. She is the 3rd out of four children and when she first came to the Posyandu she only weighed 6.8 kg. Her mother, Faridah, agreed to attend the NERS and bring contributions. During the first NERS she was referred to the Puskesmas or health clinic "Cempaka" because she was fussy and couldn't walk, eat or sleep. She was diagnosed with worms and received de-worming medication. Unfortunately, during this time, the conflict in Aceh prevented the NERS from being held. But Ibu Faridah remembered what she had learned during the first week of the NERS and fed Safrina meals with vegetables and fish as well as healthy snacks. When the NERS began again she had gained 2.8 kgs. Now Safrina has a big appetite. She loves to eat all kinds of food like carrots and spinach. Her father is a sailor and sometime brings home "sabee" or small shrimp. Ibu Faridah cooks them for her family and Safrina loves that. She can now eat 3 meals a day plus healthy snacks like peanuts and fried banana. She is really energetic, active and now sleeps well at night and takes a good nap during the day.

In addition to the PD nutrition program, the CHP worked to revitalize the Posyandu system to improve access to, quality and utilization of basic health services. SC provided regular training to Kaders, which among other things included information on how to mobilize communities and address community behaviors that impact key health

issues in Aceh through health education. Training sessions included health education topics such as hand washing, early recognition of danger signs and preparation of ORS. The CHP placed specific emphasis on promoting health education messages related to prevention of diarrheal diseases and ARI, as these are two of the most common illnesses under-five children suffer from in Aceh. Additionally, left untreated, these types of childhood illnesses can lead to pneumonia, chronic malnutrition, developmental delays and even death. Kaders were to cover these topics with the community as a part of the monthly Posyandu. In addition, hand washing was promoted through the PD-Nutrition program, as prevention of diarrhea is extremely important to ensuring that children stay well nourished. Results detailed below in Table 8 show statistically significant differences in behaviors related to hand washing and treatment of diarrhea when necessary in the target population. Results show that the target population is washing their hands more regularly than they did at baseline and that knowledge of how to prepare ORS and overall how to treat diarrhea has improved.

Table 8: Adoption of healthier behaviors to prevent, and if necessary, treat diarrheal diseases

	Baseline %(n)		Endline %(n)		P-Value
	No	Yes	No	Yes	
Never wash hands	88.3% (594)	11.7% (79)	93.8% (623)	6.2% (41)	P<0.001
Hands washed before food preparation	55.9% (376)	44.1% (297)	43.4%(288)	56.6% (376)	P<0.001
Hands washed before feeding child	58.5% (394)	42.5% (279)	47.3% (314)	52.7% (350)	P<0.001
Hands washed after defecation	63.4% (427)	36.6% (246)	48.9% (325)	51.1% (330)	P<0.001
Hands washed after helping a child defecate	61.5% (414)	38.5% (259)	47.4% (315)	52.6% (349)	P<0.001
Know how to prepare ORS	47.5 (320)	52.5% (353	38.3 (251)	61.7% 404)	P= 0.001
Treated last case of diarrhea child experienced	13.6% (16)	86.4% (102)	4.3% (6)	95.7% (133)	P=0.008

As the data shows, there has been a statistically significant decrease in the percent of respondents who reported never washing their hands. Reported hand washing has also statistically significantly increased for priority hand washing behaviors that specify when hands should be washed. In addition, the percent of mothers that correctly reported knowledge of how to prepare ORS increased from 52.5% to 61.7% showing that more mothers know how to care for their children if they do experience a diarrheal disease. Though progress has been made on key diarrhea prevention and control indicators, there are several indicators that still need work. There are still misconceptions within the community regarding homecare of diarrhea episodes. This is evidenced by the fact that no change was observed in the amount of liquids, food, or breast milk given during a diarrhea episode. Percentages remained low with only 33.9% of mothers of under-five children giving more breast milk at baseline and 28.9% giving more at endline. In addition, 48.3% and 48.1% gave more fluids and 12.7 and 5.2 gave more food. None of the changes were statistically significant. Likewise, though knowledge increased regarding how to make the ORS solution, there was not an increase in use of ORS, packaged (30.2 % at endline 30.5% at baseline) or homemade (9.4% at baseline and 7.6% at endline).

Unfortunately, the CHP was not successful in increasing knowledge of the danger signs of acute respiratory infections in under-five children. The percent of respondents that could not accurately site the danger signs of ARI actually statistically significantly increased from baseline (68.5%) to endline (76.5). This could be due to the fact that not as much emphasis was placed on this health issue. In contrast to hand washing and diarrhea prevention and control in which Kader health education training was supported by the PD-Nutrition program, there was no programmatic support for health education training Kaders received in prevention and control of ARI. Because ARI is often cited as one of the top five causes of death in under-five children and in Aceh is cited as one of the illness that

under-five children most often suffer from, more emphasis should be placed on this health issue in future programming.

Improved Economic Opportunities (EO)

The micro-finance program is still relatively new with the revolving fund being implemented in the last few months of program implementation. Therefore, there is not yet quantitative data to analyze the impact this part of the program had on improving the well being of at-risk women, youth and children. That being said, qualitative data was collected and indicated that EO activities have been sustained even after the CHP ended. In addition, the micro-credit system has continued and it was reported that repayment is running smoothly. Figure 5 describes one woman's success as a result of the micro-finance program.

Figure 5: Micro-finance Success Story

Butet is a 35 year old widow with two children living in Ulee lheu in the Meuraksa sub district of Banda Aceh. She sells "gula asam" candy that she makes herself. With the small amount of money she had, she was only able to buy 1-2 kgs asam and then buy another 2 kgs of asam after she had sold all of the gula asam she had made from the previous bag. She was able to earn approximately Rp300,000 – Rp500,000 per month and was limited to selling the product in her neighborhood.

Seeing that her business had potential, the Matahari foundation, a SC-LNGO sub-grant partner, assisted the woman in obtaining a license from Dinkes to expand the market to which she was allowed to sell her product. Butet was happy that she could sell the product in any market, but she was also sad because she did not have enough money to expand her business. The CHP gave her a small loan, about Rp 300,000, which she was able to use to buy 25 – 30 kgs asam jawa. That enabled her to sell the product in super markets and shops in Banda Aceh. As a result, she has increased her earning ability to Rp1,500, 000 – Rp 2,000,000 per month.

The CHP implemented program activities aimed at improving the psychosocial status of women affected by the on-going conflict in the Aceh province. The objective was to increase women's self confidence and self image within their communities and provide them with the skills they need to maintain their physical and mental health while living in a volatile political and security environment. Quantitative results comparing baseline and endline data indicate that the psychosocial status of at-risk women in target areas has improved despite recent internal conflict leading to the imposition of martial law. This is supported by data that show that women are more often making decisions regarding household expenditures and when to visit health clinics. In table 9, a statistically significant difference is observed between how often women reported they made decisions about the amount of money spent on food and school supplies at baseline and at endline ($p<0.001$). The differences are seen most dramatically in the never (significantly decreased) and often (significantly increased) categories. The same trend can be observed in table 10, showing a statistically significant increase in the percent of women who reported making decisions about when to go to the health clinic ($p<0.001$).

Table 9: Increase in how often at-risk women reported making decisions regarding amount of money spent of food and school supplies

	Food %(n)		School Supplies %(n)	
	Baseline	Endline	Baseline	Endline
Never	24.2% (163)	13.6% (90)	23.2% (156)	15.1% (100)

Sometimes	39.7% (267)	39% (259)	38.8% (261)	36.2% (241)
Often	9.2% (62)	21.4% (143)	10.1% (68)	23.0% (153)
Always	26.6% (179)	25.8% (171)	27.5% (185)	25.2% (167)
Don't know	0.3% (2)	.2% (1)	.4% (3)	.5% (3)
Total	100.0% (673)	100.0% (664)	100.0% (673)	100.0% (664)

Chi-squared = 53.648 p-value<0.001 Chi-squared = 46.601 p-value<0.001

Table 10: Increase in how often at-risk women reported making decisions regarding when to go to the health clinic

	Baseline %(n)	Endline %(n)
Never	10.1% (68)	4.1% (27)
Sometimes	31.5% (212)	25.9% (172)
Often	21.0% (141)	31.0% (206)
Always	37.0% (249)	38.6% (256)
Don't know	.4% (3)	.5% (3)
Total	100.0% (673)	100.0% (664)

Chi-squared =34.075 p-value<0.001

This was further supported by data that showed statistically significant increases in how often women reported that they feel safe outside of their homes and day-to-day when baseline and endline data were compared (p<0.001). Table 11 shows an increase in the percent of women who reported that they always feel safe outside the home and day-to-day.

Table 11: Increase in how often at-risk women report feeling safe

	Outside the home %(n)		Day to day %(n)	
	Baseline	Endline	Baseline	Endline
Never	1.0% (7)	0.3% (2)	0.9% (6)	1.1% (7)
Seldom	.7% (5)	0.3% (2)	1.3 (9)	0.5% (3)
Sometimes	18.2% (122)	6.2% (41)	15.6% (105)	5.4% (36)
Often	13.8% (93)	15.4% (102)	15.4% (104)	11.6% (77)
Always	65.3% (439)	73.6% (489)	62.0% (417)	77.9% (517)
Don't know	1.0% (7)	4.2% (28)	4.8% (32)	3.6% (24)
Total	100.0% (673)	100.0% (664)	100.0% (673)	100.1% (664)

Chi-squared =59.967 p-value <0.001 Chi-squared = 52.662 p-value <0.001

Finally, the comparisons between baseline and endline data showed a statistically significant difference in the level of hope reported by at-risk women (p=0.001). Interestingly, the level of hope women reported became more moderate with fewer women reporting high or low degrees of hope. Taking into account the volatile political environment over the last few years, it was expected that the degree of hope reported by women would fall, even with CHP activities, as opposed to what the data revealed, a sort of emotional median. Table 12 provides further clarification.

Table 12: Increased percent of women reporting a medium degree of hope.

	Baseline %(n)	Endline %(n)

Low degree of hope	7.9% (50)	4.5 (29)
Medium degree of hope	40.2% (253)	48.8% (314)
High degree of hope	51.9 (327)	46.7% (301)
Total	100.0% (630)	100.0% (644)

Chi-squared=13.069 p-value=0.001

Even though the indicators discussed above have statistically significantly improved, they still have a long way to go. The unstable political and security situation continue to make women feel insecure resulting in reported levels of hope, % women that reported feeling safe and how often women make decisions in their household less than ideal. It is hoped that further programming in Aceh will continue to work to improve the psychosocial status of at-risk women.

Since it is impossible to ask young children to reply to a quantitative questionnaire, mothers were asked to discuss the effects of normalizing activities targeting children in focus group discussions. They responded by saying that playgroups were "very successful". They allowed for an environment in which children "can get rid of stress". They also perceived the activities to improve the self-confidence of children involved in the activities. One woman said, "…before, children were not self-confident, however, with these children's activities they started to regain self-confidence."

Lessons Learned and Recommendations

Lessons Learned

The many challenges the CHP faced throughout program implementation and feedback obtained through an end of program workshop produced some very valuable lessons learned that will be used in future programming. Through the end of program workshop key stakeholders had the opportunity to express what they felt was successful and what they felt could be improved. They felt that the CHP was successful and expressed appreciation to the CHP staff. Stakeholders described the following as strengths of the program:

- Involved communities in program planning and implementation
- Strengthened existing systems instead of creating new ones
- Worked closely with government in implementing programs, specifically DOH, and was able to add value to their work and services to the community
- Empowered communities to address their needs and find solutions to their problems instead of SC solving the problems for them (e.g. PD-Nutrition and Desa SIAGA programs)
- Focused on Community Development
- Used simple and appropriate methods and systems in working with communities

Stakeholders also had some suggestions regarding how to improve program implementation. Some of these suggestions included:

- Work more closely with all levels of the local government in planning programs
- Improve coordination with local DOH
- Expand and scale-up well tested pilots to other areas (PD-Nutrition and EO), as opposed to implementing a lot of small pilot projects
- Provide more comprehensive EO training, including topics such as marketing and packaging
- Make sure all programming is in line with community priorities.

Stakeholders also pointed out some weaknesses:

- The CHP experienced a lot of starts and stops, and could not continue in some of the neediest, most conflict affected areas
- The CHP was a bit confusing because the program, strategy and location kept changing
- Very short effective time of implementation which caused inability to scale up

In addition to the above, CHP learned some valuable lessons through program implementation.

- Maintaining neutrality in an unstable political and security environment was essential to SC's work in Aceh. It allowed SC to continue to work in Aceh and facilitated implementation by building trust between SC and target communities, DOH, local authorities and the military.

- SC was the only INGO allowed to restart activities in Aceh after the imposition of martial law. This was in part due to the strong relationships SC had formed with the military, police, and local government authorities. In addition, once the CHP was allowed to re-start, these relationships were important to maintaining the safety of SC staff.
- One of the most important factors in being able to continue program implementation after the imposition of martial law was having capable and motivated national staff. After martial law was imposed, expatriate staff were barred from the province. Though expat staff continued to support efforts in Aceh, the program could not have succeeded if it were dependent on having an expat running the office. It is crucial that field offices located in conflict areas be capable of operating without their expatriate staff to ensure that activities will continue if expats are denied access.
- Working in conflict areas requires a significant amount of creativity and flexibility in program implementation.
- Economic opportunities and business development activities, while appreciated by the communities and the government, could not optimally succeed without access to credit. The CHP added a revolving fund towards the end of the program to address this.
- The involvement of DOH in program implementation was important in creating ownership of the program and aided in smooth program implementation. This ultimately resulted in the DOH adopting the Desa SIAGA and PD-Nutrition models tested by Save the Children. They are hoping to be able to allocate some of the local health budget to continue implementing these activities on their own.
- Start up of the PD-Nutrition program was quite difficult. However, by working closely with local stakeholders and Puskesmas staff, the program was successfully pilot tested.
- SC modified the training system for Kaders early into program implementation as it became clear that the level of instruction the Puskesmas doctors were providing was too complicated for most Kaders. As a result, midwives and senior Kaders were added to the training team to facilitate subsequent trainings.
- It became apparent that for future PD-Nutrition programming DHO staff need to be included in PD-NERS training to effectively monitor activities and ensure sustainability.

Recommendations

For future programming in Aceh SC has the following program management recommendations:

- Since the security and political environment is still unstable, a field office in Aceh should be capable of running activities without expatriate staff present to ensure the program can continue even if expats are banned from being there.
- In the ever-changing political/security environment in Aceh make sure to maintain close relationships with the military, police and local government authorities to ensure safety and continuity of program implementation.
- Continue to use a community development approach that involves communities in planning, implementation, monitoring and evaluation.
- Maintain and improve coordination with local government, especially in program planning and implementation. This is crucial to building the capacity of the local government to sustain activities beyond the life of the program.
- Expand the Desa SIAGA and PD-Nutrition models that have already been successfully pilot tested to other areas of Aceh.

In addition there are important maternal and child health issues that still need to be addressed. Some possible ways to do so are:

- Provide more comprehensive training to Kadars and/or Puskesmas staff on integrated management of childhood illnesses to address the still high levels of ARI, TB, malaria, and diarrhea.
- Facilitate APN training for midwives who have not yet received the training in order to standardize midwife skills throughout the province.
- Incorporate asphyxia training into APN training for midwives.
- Implement programming specifically addressing neonatal health issues.

Both the micro finance and psychosocial programs were well received and seemed to improve the lives of the target populations, however the neediest populations most affected by the conflict could not be reached due to requirement that the CHP restrict activities to the Banda Aceh area. It is recommended that when other harder hit areas become accessible programs implement:

- Micro finance activities to provide women the means by which to fulfill their basic needs.
- Psychosocial activities to address psychosocial needs of women, children and youth affected by conflict.

Conclusion

Throughout the nearly 4 years of implementation, the Coming Home program has made significant progress towards accomplishing its objectives despite a volatile political/security environment. The constantly changing political and security situation in Aceh required the CHP to be flexible in its implementation and use the resources at hand to best support the objectives and IRs of the program. Through the CHP, SC has improved access to higher quality health care for women and children, addressed the psychosocial needs of at-risk women, youth and children affected by conflict, enabled communities to take responsibility for their own health, advocated for more responsive health policy, and increased economic opportunities for at-risk women and youth. This is evidenced by statistically significant changes in key indicators such as the proportion of women receiving at least 4 antenatal visits during their last pregnancy, increase in the proportion of newborns who received a health checkup within seven days after birth, and improvements in psychosocial status of at-risk women. Through the CHP, improvements were also detected in Posyandu attendance and a notable percentage of malnourished children improved their nutritional status through participation in the PD-NERS program. In addition, data indicated that mothers of under-five children had improved priority hand washing behaviors and care of children experiencing an episode of diarrhea.

SC-CHP, throughout implementation, worked to ensure sustainability of the progress made by building local capacity at each step. The CHP leaves behind a permanent APN training program, capacity to implement PD-NERS, improved ability to diagnose malaria using laboratory techniques, and communities that knows how to ensure that their children are well nourished. In addition, the improved functionality of the Posyandu system has improved access and utilization of maternal and child health services. SC-CHP's close collaboration with the provincial, district and sub-district level DOH in addition to its close relationship with the police, military and local government authorities has been key to the CHP's success and will pave the way for future programming in Aceh.

While the CHP has accomplished a great amount, despite the political/security environment in Aceh, there is still much that needs to be done. Nearly 30% of women were not vaccinated for tetanus during their last pregnancy, almost 20% of women still did not receive four or more antenatal visits and ~13% did not take iron supplementation during their last pregnancy. Likewise, while the average number of days after childbirth that a woman's health was checked decreased, the percent of women whose health was checked remained low, only 65.2% at baseline and 65.8% at endline. In addition, less than half of the women interviewed reported having a high degree of hope and though mothers of under-five children have improved hand washing practices and knowledge of how to prepare ORT, they are still not giving under-five children experiencing diarrhea ORT, increased fluids or food. SC has secured funding from USDA through which it will continue to address these important social welfare issues, improving the lives of the Acehnese people.

Appendix 1: Details of Program Implementation

Table 1: Timeline of program (Gantt chart)

	2000		2001				2002				2003				2004
	Jul-Sept	Oct-Dec	Jan-Mar	Apr-Jun	Jul-Sep	Oct-Dec	Jan-Mar	Apr-Jun	Jul-Sep	Oct-Dec	Jan-Mar	Apr-Jun	Jul-Sep	Oct-Dec	Jan-Mar
Site Selection															
Launch															
Development of Teams															
Baseline Survey															
Puskesmas Assessment															
Nutritional status assessment															
Health Policy Strategy															
Development of Community Health Board (CHB)															
Conduct Health Intervention Planning workshop															
Create CHB															
Desa SIAGA															
Advocated for more responsive local health policy															
Maternal and Child Health															
Posyandu Revitalization															
Trained Kader in Posyandu management and Basics on childhood illnesses (2 Phases)															
Provided In-service Training to Kaders (Monthly meeting)															
Distributed Posyandu kits															
Improve HIS															
Review and updated the existing HIS format															
Pilot test new up-dated format															
PD Nutrition															
Conducted PD workshop															
Trained SC staff and Kaders in PD NERS															
Implement PD NERS															
Monthly and quarterly meeting															
Midwives Training															
TOT APN training															
APN training															
Clinical Trainer Skill Training															
Created and advanced Clinical															

training sites															
Desa SIAGA															
Select and trained village Facilitators															
Establish facilitator Forum															
Established Emergency preparedness systems															
Blood mapping and blood donors															
Supported National Immunization Campaign															
Emergency preparedness															
Conducted TOT for First Aid in Emergency to local youth															
Women and Economic Opportunity															
Income generation activities															
Civic participation															
Health Promotion (Protection)															
Micro credits															
Youth Development															
Livelihood skill															
Promote youth participation in Community Development activities															
Health promotion															
Psychosocial Programming for Children Affected by Conflict															
Psychosocial workshop															
Training Community Volunteers															
Distributed Psychosocial kits															
Organized recreational activities for children															
Malaria Control															
Coordination meeting (SC, DOH, IAMI, NAMRU)															
Trained Master Facilitators in Jogyakarta															
Trained microscopic skill to DOH staff															
Trained Kaders and community taskforces (2 phases)															
Produced and distributed IEC materials (2 Phases)															
Distributed 20,000 bednets (2 phases)															

Malaria KAP															
Monitoring of malaria control program															
Monitoring and Evaluation															
Monitoring															
Evaluation															

Narrative Detail of Program Implementation

Program Start Up: August –December 2000

From August through December 2000, the main focus was program start-up. The three month "humanitarian pause" signed between the GOI and GAM provided for a promising political and security environment during the start-up phase of the CHP. By September 2000, the office was officially opened and the following major activities were carried out:

1. Office Mobilization

- Start-up activities initiated by SC consultants
- Office space located and equipment purchased
- Core staff team recruited and oriented
- Official letters for operations and travel secured (Governor, Health and Humanitarian Pause), or verbal permission obtained (Police, Military)
- A variety of consultants visited to assist with program start-up

2. Program Socialization

- Program socialization (all relevant government departments, authorities, institutions)
- Daily coordination meetings with the Department of Health and other INGOs

3. Program Development

- Development of results framework with DOH
- Development of detailed implementation plan in conjunction with the DOH
- Development of logical framework and performance indicators
- Stakeholder analysis
- Development of project briefing materials
- Carried out health center resource and training needs assessment in conjunction with DOH
- Conducted 2 3-day community workshops (18-20 Sept) at the SC office to share experiences, expectations, and plans for the future – identified major health and social concerns
- Developed training modules for health outreach workers and community leaders
- Collected secondary data
- Developed formative and baseline research instruments and pre-tested
- Carried out Focus Group Discussion (FGDs) in two communities
- Progress towards a formalized establishment of a working group that focuses on the needs of children affected by conflict
- Began development of Psychosocial assessment tools within the "working group"
- SC/US sponsored a street children's theater group to perform a drama entitled "Children in Conflict" – received media coverage
- Coordination meetings conducted in effort to establish a support network between organizations furthering women's issues
- Conducted coordination meetings with the education department.
- Visited religious group Muhamadiah

- Conducted meetings to explore opportunities for developing partnerships
  - Identified potential local partners
  - Identified international agencies with potential to forge working partnerships

4. Training and Staff Development

- Trained staff in security and guidelines development
- Staff attended
  - Humanitarian and protection training
  - Grant compliance workshop
  - Psychosocial training
  - Advanced conflict first aid training
  - Computer training (Finance manager, project manager, logistician and women's support coordinator)

One of the outputs of the activities in these first six months was a logical framework with the following detailed results for the program agreed upon by SC and the Department of Health

- **Result 1:** Community-based preventive health care systems revitalized
- **Result 2:**Psychosocial needs of children and their families addressed
- **Result 3:** Special needs of at-risk women addressed
- **Result 4:** Youth participation in their own development and that of their communities enhanced

In the ever changing political and security environment in the Aceh province, the program regularly re-assessed whether or not its objectives and intermediate results addressed the needs of the target populations the program was given access to. As previously mentioned, the above IRs were used to guide program implementation through May 2003. In May, those IRs were modified due to the changed working environment as a result of martial law. The IRs that guided program implementation from May 2003-March 2004 were modified to make the best use of human and material resources available and to better align programming to support USAIDs IRs.

Though the "Humanitarian Pause" was extended through January 2001, by November of 2000 the security situation had deteriorated such that SC was forced to restrict its activities to Banda Aceh. This was further complicated by a natural disaster (flooding). The continuing power outages resulting from the floods and the coming of the fasting month resulted in further program activity restrictions. As a consequence of these disruptions, activities were slowed into December. In late December 2000, six months into program start-up and implementation, violence towards expatriates increased and work visas were refused, forcing SC to relocate expatriate staff to Jakarta in January 2001.

Regrouping and Rebuilding: January – December 2001

The worsening security situation, confusion over the program approval process, and the relocation of senior management staff to Jakarta forced SC to make the decision to close the Aceh field office and temporarily suspend program activities in the first half of 2001. Communications between international staff and national staff in Aceh were also suspended due to security reasons. All program communication was passed via the field office director and national program manager. Staff were asked not to come to the office in Aceh, but remained in contact with each other, meeting frequently at the finance manager's residence.

Save the Children in close collaboration with USAID and government counterparts began what would become a 6-month process of re-instating the Coming Home Program to its original operational status. The tedious process, which required countless consultations, negotiations and program revisions on the part of many people culminated in

a gratifying success as the Coming Home Program action plan secured final approval from Sekneg on June 21st, 2001. It was agreed that the re-establishment of a fully operational Aceh field office could be achieved by July 2001.

The security situation in Aceh remained unpredictable with reported clashes between the GAM and the Indonesian Army (TNI). The majority of incidents occurred in remote Aceh areas. In April 2001, Aceh faced the possibility of an all out war. Markets became difficult to access during this time period. Transportation between Medan, Central Aceh, and Banda Aceh was disrupted. Prices in Aceh rose to two to three times higher than prices in neighboring North Sumatra, and essential items such as fuel were rationed. In addition, electricity, telephone and postal services were often disrupted.

Both international and local NGOs were forced to restrict their movements outside of Banda Aceh. As a direct result, SC decided to change the original impact areas from Tangse (Pidie) and Lam Teuba (Aceh Besar) to the Banda Aceh area, thus reducing security threats to SC staff.

In addition to the security and political problems being experienced in the Aceh province, the second part of 2001 brought with it problems related to 'the war on terrorism' and possible retaliation actions against US partnering organizations. There were two evacuations of expatriate employees and their families. Though this time period ended without serious incident, common temporary re-locations of SC expatriate staff made their work more difficult. However, long distance management was maintained throughout.

Due to program suspension, significant progress towards program objectives was hampered. SC staff utilized their time for professional development, program planning, and re-planning program strategies as the scenarios for operation changed in parallel to the difficulties with the action plan approval and security context. A revised 6-month implementation strategy was submitted to USAID in May 2001 and in the second half of 2001 some steps forward were made towards implementation of the Coming Home Program.

Though this time period proved to be frustrating, it ultimately resulted in some long-term positive outcomes. The CHP was stronger, better supported and less susceptible to security fluctuations than before. The CHP staff became a strong and determined cohesive team. Even faced with these obstacles, the Aceh field office continued to make limited progress towards its objectives in 2001. The following details specific accomplishments of the CHP in 2001.

1. Regrouping

- Held a series of meetings with BKSN and National DOH
- Given permission to re-open office and return national staff to work – though activities were to remain suspended until a new action plan was submitted and approved by Sekneg
- Held an official re-opening ceremony in March
- Still evacuated expat staff re-established contact with national staff.
- A new action plan was developed and submitted to BKSN and MoH in April
- June 21st – SC received confirmation in writing from Sekneg that the action plan was approved.

2.Rebuilding: January-June 2001

- Aceh national staff collected information and secondary data to provide input into re-planning process
- Aceh national staff conducted assessments to identify new impact areas
- Aceh national staff conducted a rapid assessment of IDP camps/communities
- Developed internal training sessions for staff development
- Compiled IEC materials and national guidelines used by DOH and other NGOs
- Maintained relationships with stakeholders
- Aceh national staff monitored on-going youth activities and initiatives in Aceh, youth involvement in conflict and street children needs

3. Rebuilding: July-December 2001

- Identified 'initial impact areas' around Banda Aceh
- Identified health problems outside of Posyandu activities
- DOH and SC agreed on main objectives of the program
- Initial impact areas approved by September
- Assessment within initial impact areas completed
- Baseline data collected on Posyandu system
- Mother and child (Posyandu) implementation strategy developed in collaboration with DOH in November
- SC in collaboration with DOH completed recruitment of Kaders for Posyandu activities in impact areas in December
- SC in collaboration with DOH reviewed and developed curriculum and participatory methods of training for Posyandu Kaders
- Started development of a psychosocial needs assessment tool
- Signed a contract with a local NGO, YAB, in December to carry out a mapping exercise with regards to street and labor children

4. Training and Staff Development

- Aceh national staff:
  - Developed individual staff development plans
  - Attended TOT training on participatory training and community mobilization techniques
  - Attended finance management training
  - Attended community mobilization training
  - Attended community approaches to psychological needs training addressing children in crisis/psychosocial issues relating to children in war and trauma
- Trained 54 participants from initial impact areas in community mobilization using participatory methods. Participants included community leaders, local NGOs, and health center staff
- Trained 38 participants from 14 local NGOs in proposal writing and financial grant regulations in December.

By the end of 2001, the Aceh field office, despite the many challenges faced, was operational again. Slow progress was being made towards implementing program activities that would contribute towards making an impact in the result areas agreed upon. By the first part of 2002, activities were being successfully implemented in initial impact areas with plans of expanding to other areas of the Aceh province in motion.

Program Implementation in Initial Impact Areas: January-June 2002

Though the political and security situation remained tense, humanitarian organizations were able to operate in almost all parts of the Aceh province. In February 2002, KODAM military administration was established in the province and by March, the governor had implemented Syariah law in accordance with autonomy agreements. Though these new changes were initially concerning, in the end, they did not have significant implications for the Aceh community.

During this time period, TNI successfully executed several operations, which gave them a noticeable advantage over GAM. Several months after the GAM commander was killed, several small-scale but effective attacks were carried out on strategic targets (electric lines, communications centers and police stations). Clashes between GAM and TNI became commonplace and despite statements about not targeting the civilian population, collected figures showed that more civilians were killed that year than in the first six months of the previous year. Both sides declared that the second round of peace talks in May were positive, however the situation on the ground did not improve and the frequent road blocks organized by GAM made program implementation outside of the "white" areas challenging.

While the political and security situations were far from stable, conditions were improved enough for NGOs to begin providing humanitarian assistance again.

In the first half of 2002, the Coming Home Program began implementing program activities in 22 villages in the initial impact areas around Banda Aceh (Baitussalam, Syiah Kuala, Meuraksa, and Pulo Aceh) that were recommended by local stakeholders. According to the results of an assessment completed in June 2002, the CHP had reached 9,500 women and 2,052 children under the age of five in the initial impact areas during this time period. As security continued to improve, plans were made to expand to an additional 38 remote villages located in Tangse (Pidie) and Lam Teuba – Lam Panah (Aceh Besar District).

With the Aceh field office now fully operational, SC staff were able to focus on implementing program activities to begin making progress towards the achievement of the objectives agreed upon for the program. Key accomplishments for the first six months of 2002 included the following:

1. Result 1: Community based preventive health care system re-vitalized

- 220 Kaders (community health volunteers) from 22 villages in the initial impact areas were trained in basic Posyandu skills (immunization services, growth monitoring, prenatal care, nutrition counseling, and health education).
- Provided in service trainings to Kaders through monthly Kader meetings covering topics such as breastfeeding, diarrhea management, ARI,etc.
- SC Aceh conducted a workshop, attended by 18 Kaders from 9 villages in Baitussalam, Puskesmas doctors, midwives, and community leaders to evaluate existing reporting systems. As a result, a revised and simpler health information system (HIS) form was developed to be pre-tested.
- Trained 18 Kaders on how to use and field test the new HIS form.

2. Result 2: Psychosocial needs of children and their families addressed

- YAB, a local NGO, was subcontracted to carry out a mapping exercise to identify the number of street children and children working in the informal sector. 306 children were identified, of which 141 were street children and 165 were children working in the informal sector.
- 22 people (SC staff and local partners) attended a four day psychosocial programming workshop
- Awarded a subgrant to YDUA, a local NGO focused on improving the lives of disadvantaged children, to work in collaboration with SC to implement children's activities.
- Children's normalizing activities were directly implemented in 2 villages, reaching 80 children aged 5-16.

3. Result 3: Special needs of at-risk women addressed

- Awarded a sub-grant to the Matahari Foundation, an LNGO focusing on women's empowerment, to train women to increase their income-generating capabilities and generate peer support among at-risk women.
- Conducted two PRA trainings covering the four initial impact areas in order to assess women's needs and plan future program interventions.
- Conducted group discussions in 2 villages with ~30 women each to discuss problem solving approaches, steps women would like to take to address their specific needs.

4. Result 4: Youth participation in their own development and that of their communities enhanced.

- Introduced the youth program to four villages by meeting with community leaders and youth representatives.
- Awarded a sub-grant to Al-Adnin, a local NGO with a mandate to empower youth and communities, to work in collaboration with SC to establish a youth activity center, conduct training in management, skills development, and facilitate sports and art activities.

- Sent two youth representatives from Aceh to a seminar on issues for disadvantaged youth in Indonesia held by PLAN International.

Staff Development:

Save the Children Aceh staff attended the following trainings and workshops to continue to build staff capacity:
- Institutional development framework training series
- Child rights protection workshop
- Security and risk assessment training
- Global monitoring and evaluation training

In the first part of 2002, SC was finally able to start implementing program activities in initial impact areas in effort to achieve the agreed upon objectives of the program. As the security situation continued to improve throughout 2002, activities were expanded to Pidie in order to reach the most vulnerable women and children.

Program Implementation Expanded to Pidie and Aceh Besar: July 2002 – June 2003

In the second half of 2002, the security situation improved enough to expand program activities to an additional 40 villages in Tangse (Pidie) and Lam Teuba/Lam Panah (Aceh Besar). SC continued to implement program activities in the initial impact areas and ultimately had to withdraw to those safer areas in the second half of 2003 due to the imposition of martial law.

Security continued to affect implementation from July 2002 through June 2003. From July until December 2002, the security situation was very tense. Government departments had trouble performing their duties and some international staff were given 2 weeks notice to leave Aceh. Movement of international staff came under added scrutiny in September when two foreigners were charged with immigration violations and fraternization with separatist forces. In December 2002 a truce was signed, providing some temporary relief.

However, internal conflict resumed in April 2003 between the Government of Indonesia and GAM. Programming was restricted in April and the ability to partner with LNGOs ended. In May 2003, martial law was imposed, expatriates were expelled from the province and program activities were suspended. Private diplomacy by Save the Children at local and central levels resulted in Save the Children being given oral permission in early July to resume limited activities around Banda Aceh and in Simeulue. Formal approval from the military and the police followed later in the month. No other INGO was allowed to restart operations.

Though the security situation had badly deteriorated by the end of the first half of 2003, the Coming Home Program (CHP) made significant progress between July 2002 and June 2003 towards achieving the program objectives in both the initial impact villages and the 40 newly added villages in Pidie and Aceh Besar. The following details the key accomplishments by result area between July 2002 and June 2003.

1. Result 1: Community based preventive health care system re-vitalized
- Pilot tested revised HIS form in 9 villages in Baitussalam with assistance from 18 Kaders
- trained 240 volunteers from 61 villages in TOT on first aid basic life support techniques
- Trained 400 Posyandu Kaders in Tangse and Lampanah/ Lamteuba (40 villages) in Posyandu management, five tables, community facilitation and common childhood illnesses.
- Provided mentoring to 600 Posyandu Kaders through regular monthly meetings
- Distributed Posyandu kits to 61 villages containing hanging weight scale, trodden scale for pregnant women, trouser for baby weighing, stethoscope, sphygmomanometer, laennec phitoscope, middle upper arm circumference tape, tailor measurement tape, stainless steal bowl, small towel, liquid hand soap, suitcase,

disposable syringes 5ml, disposable syringes 10 ml , disposable needle G 23, disposable needle G 25, vest for Kader, health reading books for Kaders, MCH records, Posyandu record form, ball point pens, pencils, and notebook for posyandu documentation.

- Participated in immunization day campaign by providing posters, banners, and IEC materials to 61 villages in SC impact areas.
- Supported cold chain for Puskesmas in Pulo Aceh
- Observed immunization program to ensure that it met WHO standards

2. Result 2: Psychosocial needs of children and their families addressed

- Trained 293 community volunteers to organize normalizing activities for at-risk children
- Awarded sub grants to 3 LNGOs (YAB, YDUA, and YIBHA) to organize normalizing activities for at-risk children.
- Distributed psychosocial kits to 61 villages containing sport materials (soccer ball, volleyball, volleyball net, baseball, and whistle), drawing materials (pencils, drawing books, colored pen, colored pencil), stationery, traditional dance cassettes, and children's movie.
- Implemented weekly team-building activities in collaboration with LNGOs in all 61 communities in SC impact areas (Activities included: sports, traditional games, non-formal education in basic science, music, drawing, painting, drama, and morals)
- Organized, in collaboration with LNGOs, team sports, cultural field trips, festivals, competitions designed to stimulate free expression.
- Facilitated, in collaboration with LNGOs, publication of monthly bulletins, English instruction, education about children's rights; and creation and operation of an 830-volume library
- Conducted, in collaboration with LNGOs, vocational training for older working children (composting natural fertilizer training)
- Supported, in collaboration with LNGOs, Early childhood development by supporting equipment and operational costs of pre-school activities in Lamteuba and Lampanah
- Distributed, in collaboration with LNGOs, school packs consisting of school bag, books, school uniform, and shoes to 100 children
- Developed structured psychosocial activities to reduce post-traumatic stress among children (these activities ultimately had to be abandoned due to imposition of martial law.)

3. Result 3: Special needs of at-risk women addressed

- Trained staff and 4 LNGOs (Matahari, Pugar, BKPSM, and BPSM) to organize activities to help vulnerable women.
- In collaboration with LNGOs trained, provided 665 at-risk women economic opportunities through skills training and provision of material resources to establish livelihoods in food processing (e.g., fried coconut, shrimp crackers, tempe making, cookies baking), agriculture, and poultry farming
- In collaboration with LNGOs, provided non-formal education to at-risk women
- In collaboration with LNGOs, published bi-monthly bulletins about women's issues
- In collaboration with LNGOs, held regular support groups and focus groups to discuss gender equality, maternal and child health, women's rights, reproductive health, and business issues.

4. Result 4: Youth participation in their own development and that of their communities enhanced.

- trained staff and 4 LNGOs (YASMA, Al-Adnin, BKPSM Tangse, and BPSM Lamteuba) to organize activities to help vulnerable youth
- In collaboration with LNGOs trained, provided economic opportunities to 580 youth (boys and girls) through skills training and provision of material resources to establish livelihoods as motorcycle mechanics, welders, poultry farmers, wire-fence fabricators, and chili farmers

- In collaboration with LNGOs, created 10 Youth Associations spread over the districts of Pidie (4 in Tangse), Aceh Besar (1 in Lamteuba, 1 in Lampanah, 2 in Baitussalam, and 1 in Pulo Aceh), and Banda Aceh (1 in Meuraxa and Syiah Kuala) to teach leadership, business and management skills, social and community development methods, gender equality, reproductive health, and human rights,
- In collaboration with LNGOs, hosted traditional dance, art, and sports competitions
- In collaboration with LNGOs, conducted a 12-episode radio campaign against drugs

In addition to program activities planned in support of the original result areas of the program, after completing a CHP strategy review, the implementation plan was modified to include additional activities that would better respond to the needs of the target population and further support USAID intermediate results. The following details those activities.

- Trained 47 stakeholders from Tangse and Lampanah/ lamteuba to create Community Health Boards to advocate for health policy that would respond to the communities needs.
- Pilot tested a modified Desa SIAGA Model in 14 villages to increase access to higher quality maternal healthcare and empower individuals, families, and communities to take responsibility for their own health.
- Pilot tested Positive Deviance to address childhood malnutrition to increase access to higher quality child healthcare and empower individuals, families, and communities to take responsibility for their own health. The project, which was originally to be implemented in Tangse, was moved to Syiah Kuala due to imposition of martial law.

Due to the imposition of martial law in May 2003, all program activities were suspended. SC was the only INGO allowed to continue activities in mid July 2003 upon receiving first oral and then written approval to restart. However, the CHP was forced to pull back to Aceh Besar and discontinue program activities in Pidie.

Pull Back to Aceh Besar and Expansion to Simeulue: June 2003 – March 2004

On May 19, 2003 martial law was imposed. Expats were expelled and barred from Aceh and SC was forced to suspend all program activities. As previously explained, in the weeks after martial law declaration SC suspended field operations. Private diplomacy by Save the Children at local and central levels resulted in Save the Children be given oral permission in early July to resume activities in limited areas around Banda Aceh and in Simeulue. Formal approval from the military and the police followed later in the month. SC was the only INGO given permission to restart operations.

Since the imposition of martial law and through the present declaration of civil emergency, the security situation in Banda Aceh has greatly improved. Clashes between GAM and TNI/ POLRI are rare, and public transportation is available both during the day and in the evening. During marital law, SC improved coordination and partnerships with local government institutions such as the Department of Health, Department of Social Affairs, the PDMD (*Penguasa Darurat Militer Daerah*), and local police. SC keeps these institutions aware of program activities, and ensures that correct operational permits to continue work are obtained.

Permission to work was only given for "white" areas around Banda Aceh. The CHP was required to discontinue program activities in Pidie. Martial law also suspended the work of local NGOs, and even after some LNGOs were allowed to continue their work, SC was not allowed to collaborate with them. So the CHP had to start directly implementing all program activities.

Due to these drastic changes in the operating environment, SC once again re-evaluated the CHP implementation plan and its ability to execute it. The implementation plan was modified to best address the health and social issues within the existing political and security situation with the human and material resources available. Some of the funding originally allocated to program activities in the Pidie district was, after consultation with USAID, re-allocated to

malaria and nutrition programming in Simeulue, and additional programming in the initial impact areas. In modifying the CHP implementation plan, SC aligned new programming and refocused existing programming to better support USAID's intermediate results while still taking into account the original objectives of the program. The following modified IRs were used to guide the final segment (June 2003 through March 2004) of program implementation:

- Promote more responsive health policy
- Increase access to higher quality maternal and child healthcare
- Empower individuals, families, and communities to take responsibility for their own health

Pull back to Aceh Besar and Banda Aceh June 2003 – March 2004

The following details the activities and the shift in program concept for program activities implemented in the Aceh Besar area.

1. Promote more responsive health policy:

Continued efforts to pilot test a modified version of MNH's Desa SIAGA program in 14 villages of Baitussalam, Syiah Kuala, and Meuraksa sub districts.

- Trained community facilitators in the concept of Desa SIAGA
- Conducted a facilitator TOT on social mobilization and reproductive health
- SIAGA facilitators recruited and trained Kaders to assist facilitators at the village level.
- Facilitators held community meetings in each of the 14 villages to discuss the emergency preparedness systems to be established.
- Communities chose emergency preparedness systems (Tabulin, Dasolin, Transportation, Blood Donor, and Notification) based on their needs and preferences.
- The Facilitator's Forum in collaboration with PMI (National Red Cross) conducted blood typing of donors in 14 target villages and set a regular schedule for blood donation
- CHP in collaboration with MNH provided TA to the facilitator forum

2. Increase access to higher quality maternal and child healthcare

Improved midwives skills in normal delivery practice through the following activities.

- In collaboration with MNH- JHPIEGO, JNPK, and P2KS Jakarta, the CHP conducted 4 APN (Normal Delivery Care) and 2 CTS (Clinical Trainer Skills) trainings to build local capacity to improve midwives' skills.
- CHP prepared and advanced 5 clinical training sites (4 in Banda Aceh and 1 in Aceh Besar) meeting JNPK standards.
- Provided some of the basic delivery equipment needed to bring the clinical training sites up to JNPK standards (e.g., Partus kits, delivery models, disinfection systems, etc).

Addressed childhood malnutrition through implementation of PD-NERS in Syiah Kuala

- Trained 12 local health Kaders in PD-NERS concept and implementation
- Conducted 6 NERS in Alue Naga, involving a total 105 malnourished children.
- Facilitated monthly and quarterly meetings with the objective of sharing progress and discussing barriers that were encountered by Kaders, community leaders, Puskesmas, district & Provincial DOH, and the head of the sub-district (camat)
- Provided refresher training for 12 kaders in community facilitation skills and effective communication techniques

3.Empower individuals, families, and communities to take responsibility for their own health.

- piloted an integrated EO model to provide economic opportunity to at-risk women and youth, improve health promotion and health protection
- provided training to more than 200 women and 100 youth in micro finance and business development. Details of training can be reviewed in table 2.

Table 2: Economic opportunity training provided

TRAINING TOPIC	# PARTICIPANTS	OBJECTIVES
Embroidery	8 women and 7 youth	To improve capacity of the beneficiaries in embroidery before they received working material supports (such as Embroidery Machines, Clothes etc).
Oyster Sauce-Making	14 women and 14 youth	To improve capacity of the beneficiaries in making oyster sauce before they receive working material supports (such as Kerosene stoves, blenders etc).
Introduction to Business Plan	39 women and 64 youth	To give better understanding of how to start a. business and its marketing strategy
Introduction to Market Analysis	40 women and 63 youth	
Micro-finance Methodology and Record keeping	200 women	To build capacity of the beneficiaries in organizing savings and lending groups and record keeping systems.

- Facilitated the establishment of BAPESREM, a forum that consists of representatives of each EO group, to coordinate EO activities.
- Provided training in savings and credit methodology, and credit record keeping systems.
- provided a revolving fund using a savings and credit methodology based on GGLS to 200 women who are economically active in three villages (Tibang, Alue Naga, and Ulee Lheu).
- Supported the establishment of task forces for women and youth in 3 villages to identify problems and bridge gaps in the community.
- Task forces established youth interest clubs that facilitate activities in art and culture, sports, discussions, and drama.
- Task forces supported working women by involving older youth in facilitating play groups and day care for children
- CHP trained 28 women and girls in gender, gender mainstreaming, and gender equality
- Participants then collected materials and conducted interviews to publish a local bulletin, "*Sinar Desa"* (Light of the Village)
- Sponsored 7 women and girls to attend training on reproductive health campaigns

Expansion to Simeulue: September 2003 – March 2004

In September 2003, with approval from USAID, SC-CHP expanded its program to the Simeulue District with a focus on Malaria Control and PD Nutrition.

The CHP implemented the following PD-Nutrition activities in Simeulue starting in October 2003:

- Built local capacity in Simeulue to implement PD nutrition programs by training Kaders and Puskesmas staff.
- Hired a PD program officer who is affiliated to the District Health Office to build institutional capacity
- Provided technical support to conduct PD-NERS in Simeulue
- Implemented 6 PD-NERS in three villages in Simeulue Timur, involving a total of 71 malnourished children

In September 2003, the CHP, in collaboration with the DOH, IAMI and NAMRU-2, implemented the following activities to respond to an on-going malaria outbreak.

- In collaboration with IAMI, trained 2 master facilitators in malaria control
- In collaboration with DOH master facilitators trained by IAMI, trained 16 facilitators in Simeulue in Malaria Control.
- Facilitators trained 210 Kaders and 269 community leaders to form malaria control taskforces in 73 villages
- Worked closely with DOH to prepare a net distribution plan/guideline book

- In collaboration with DOH, distributed ~20,000 insecticide treated bednets, donated by IAMI/NAMRU-2, to 73 villages
- Assisted DOH in testing blood samples from 21 villages (conducted in 2 phases) that did yet have Parasite Rate (PR) data.
- In collaboration with IAMI and DOH developed and produced malaria control IEC materials.
- Mobilized communities to clean up their environments in effort to reduce mosquito-breeding sites.
- Collaborated with Kaders and community taskforces to carry out education and community mobilization campaigns on Malaria control and instruction on how to use and maintain ITNs before bednet distribution.
- Distributed IEC materials in support of these efforts
- Sent 2 lab technicians to NAMRU-2's laboratory diagnosis of malaria training.

Appendix 2: Partnerships

In order to optimize program implementation, the CHP worked closely with INGOs and local partners. Partners provided TA to the CHP, collaborated with SC staff to develop program activities, implemented program activities, provided material resources, and worked to ensure the safety of SC staff in Aceh. The following provides a brief description of the CHP partners and their roles in program implementation.

Military, police and local government
Due to the unstable political/security situation in Aceh and the on-going conflict resulting in imposition of martial law, authorization and approval from local police and military were crucial to program implementation. In order to receive authorization to resume program activities and ensure smooth implementation, SC-CHP coordinated closely with local police and military from the provincial to the sub-district level. In addition to military and police, the CHP coordinated program activities with the local government and updated them on progress.

Department of Health
SC-CHP worked closely with the Department of Health in planning, implementing, monitoring and evaluating program activities. Regular meetings were held between the CHP and the DOH to maintain a close working relationship.

Jaringan Nasional Pelatihan Klinis- National Clinical Training Network (JNPK)
To assist in building provincial capacity to improve midwives' skills in Normal Delivery Care-Asuhan Persalinan Normal (APN), SC- CHP collaborated with JNPK. They provided technical assistance in standardizing 5 Clinical training sites, and qualifying 10 Class Instructors (CI) and 8 Clinical Trainers (CT). This built the local capacity to train 120 midwives per year.

Pusat Pelatihan Klinis Sekunder- Secondary Clinical Training Center (P2KS)
To build the capacity of the local health system to train midwives in Normal Delivery Care (APN) and sustain the program when the grant ended, SC built the capacity of P2KS in APN. They then worked with P2KS to train other midwives and monitor the standardized clinical sites.

MNH-JHPIEGO
MNH-JHPIEGO facilitated technical assistance by with JNPK to train midwives and standardize clinical training sites in Aceh. In addition, MNH provided TA to the CHP in preparing and mobilizing a modified version of the Desa SIAGA model.

Inisiatif Anti Malaria Indonesia (IAMI) – Naval Medical Research Unit-2 (NAMRU-2)
SC- CHP collaborated with IAMI and NAMRU-2 to combat Malaria in Simeulue. IAMI and NAMRU-2 donated 20,000 ITNs to be distributed in Simeulue and provided training in microscopic diagnosis of malaria. In addition, IAMI trained 2 master facilitators in malaria control and worked with SC and DOH to develop culturally appropriate IEC materials.

Indonesian Midwives Alliances – Ikatan Bidan Indonesia (IBI)
The CHP worked closely with IBI in Aceh to identify midwives to be trained in APN. The CHP met regularly with IBI to coordinate and provide progress updates.

Sub-grant Partners

In order to build local capacity to assist vulnerable women and children, SC-CHP implemented program activities directly and through LNGOs. SC provided sub-grants to LNGOs to implement specific program activities. SC also provided implementation, monitoring and evaluation TA to sub-grant partners.

Yayasan Anak Bangsa (YAB)
The CHP in collaboration with YAB carried out a mapping exercise to determine how large and where the street children populations were. They then provided assistance to street children identified in the mapping exercise in Banda Aceh through a CHP sub-grant.

Yayasan Daur Ulang (YDUA)
YDUA, through a CHP sub-grant provided Educational support and livelihood skills to urban and working children in Banda Aceh

Matahari Foundation
The Matahari Foundation implemented, through a CHP sub-grant, income generating, civic participation, and health promotion activities for vulnerable women and children in Meuraksa, Banda Aceh.

Al-Adnin Foundation
Al-Adnin provided life skills training for youth and promoted youth participation in community development activities in Baitussalam, Aceh Besar through a CHP sub-grant.

Yayasan Ibnu Hasyim (YIBHA)
YIBHA, through a CHP sub-grant, provided educational support to children living in orphanages in Banda Aceh

Pugar Foundation
The Pugar Foundation provided support to vulnerable women in income generation, civic participation, and health promotion activities in Baitussalam, Aceh Besar

Badan Koordinasi Pengembangan Sosial Masyarakat (BKPSM)
BKPSM implemented activities for vulnerable women and youth in Tangse, Pidie in income generation, civic participation, and health promotion through a CHP sub-grant.

Badan Pengembangan Sosial Masyarakat (BPSM)
BPSM carried out income generation, civic participation, and health promotion activities for vulnerable women and youth and provided support in early childhood development in Lamteuba, Aceh Besar, through a CHP sub-grant

YASMA
YASMA implemented income generation activities for youth and promoted their involvement in community development activities in Pulo Aceh

Badan Pemberdayaan Ekonomi dan Sosial Perempuan dan Remaja (BAPESREM)
To implement an integrated model that coordinated economic opportunity (including management of a revolving fund), civic participation, and health promotion activities, SC-CHP worked with BAPESREM, a community task force established by the communities. The task force continued its role even after the CHP grant had ended.

Forum Fasilitator Desa SIAGA (F2DS)
The facilitator forum “F2DS” facilitated the Desa SIAGA program.

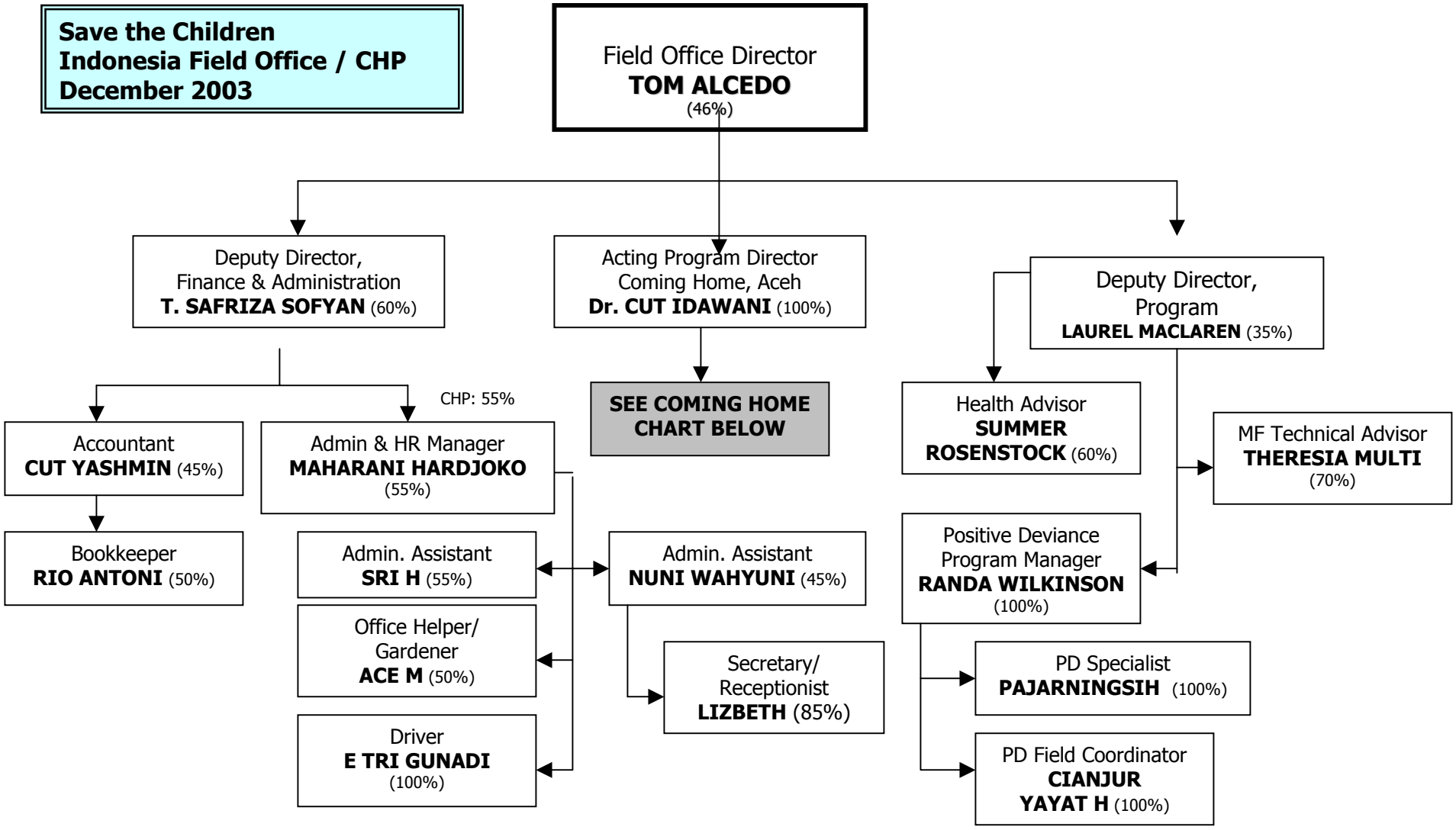
Bantuan Medik Universitas Syiah Kuala
Bantuan Medik UNSYIAH assisted the CHP in conducting first aid training for community volunteers in order to equip them with the skills they need to respond to emergencies.

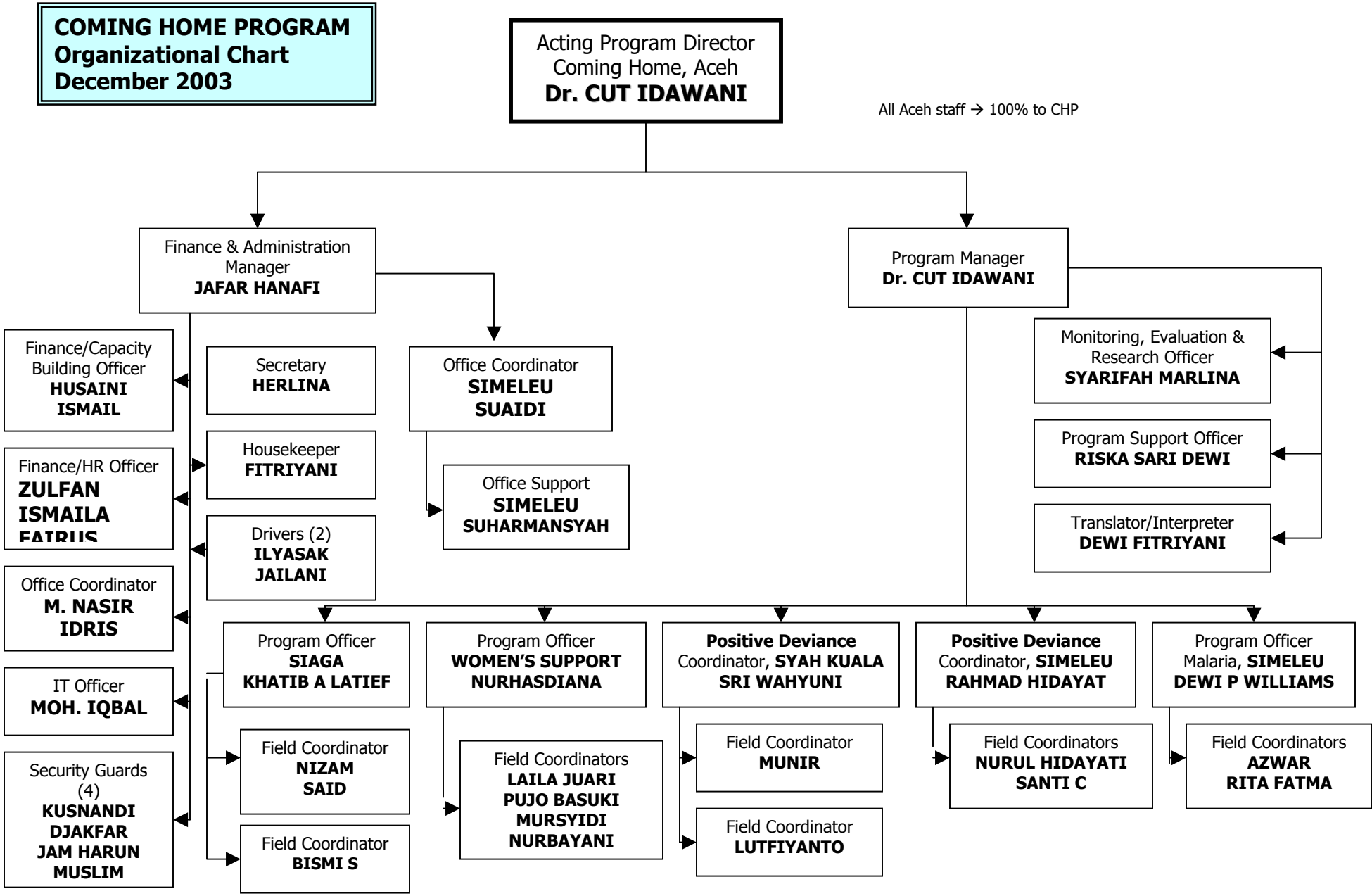
Fakultas Kedokteran Universitas Syiah Kuala
To identify Puskesmas needs for capacity building (e.g. management, public relations, etc.), SC in partnership with Syiah Kuala University carried out a Puskesmas needs assessment in all CHP working areas.

Yayasan Aceh sehat (YAS)
SC-CHP collaborated with Yayasan Aceh Sehat to conduct a nutritional status assessment in order to determine the level of childhood malnutrition in Lamteuba and Lampanah (Aceh Besar).

Universitas Muhammadyah & PEKA
SC-CHP partnered with the local university and other local research partners to carry out baseline and end line surveys. The baseline survey was conducted in collaboration with Muhammadyah University, and the endline survey was carried out by PEKA, a local research partner.

Appendix 3: Staffing




COMING HOME PROGRAM
Organizational Chart
December 2003
Acting Program Director
Coming Home, Aceh
Dr. CUT IDAWANI
All Aceh staff → 100% to CHP
Finance & Administration Manager
JAFAR HANAFI
Program Manager
Dr. CUT IDAWANI
Finance/Capacity Building Officer
HUSAINI ISMAIL
Secretary
HERLINA
Office Coordinator
SIMELEU SUAIDI
Monitoring, Evaluation & Research Officer
SYARIFAH MARLINA
Housekeeper
FITRIYANI
Program Support Officer
RISKA SARI DEWI
Finance/HR Officer
ZULFAN ISMAILA
Office Support
SIMELEU SUHARMANSYAH
Drivers (2)
ILYASAK JAILANI
Translator/Interpreter
DEWI FITRIYANI
Office Coordinator
M. NASIR IDRIS
Program Officer
SIAGA KHATIB A LATIEF
Program Officer
WOMEN'S SUPPORT NURHASDIANA
Positive Deviance Coordinator, SYAH KUALA
SRI WAHYUNI
Positive Deviance Coordinator, SIMELEU
RAHMAD HIDAYAT
Program Officer Malaria, SIMELEU
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AZWAR
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KUSNANDI
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