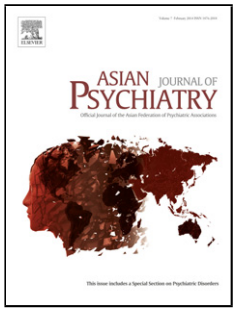


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Highlights

- Aceh has suffered heavily from perennial armed conflict and the Tsunami of 2004.
- Culture and stigma are also responsible for the heavy burden of mental illness in Aceh
- Good government policies and international supports are helping to rebuild Aceh from ruins.
- Aceh is viewed as a model of mental health system development after conflict and disaster

**Title Page**

**Country Report**

# Mental Health in Aceh - Indonesia: A Decade after the Devastating Tsunami 2004

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**Abstract**

The province of Aceh has suffered enormously from the perennial armed conflict and the devastating Tsunami in 2004. Despite the waves of external aid and national concern geared towards improving healthcare services as part of the reconstruction and rehabilitation efforts after the Tsunami, mental health services still require much attention. This paper aims to understand the mental healthcare system in Aceh Province, Indonesia; its main focus is on the burden, on the healthcare system, its development, service delivery and cultural issues from the devastating Tsunami in 2004 until the present. We reviewed those published and unpublished reports from the local and national government, from international instances (UN bodies, NGOs) and from the academic literature pertaining to mental health related programs conducted in Aceh. To some extent, mental health services in Aceh have been improved compared to their condition before the Tsunami. The development programs have focused on procurement of policy, improvement of human resources, and enhancing service delivery. Culture and religious beliefs shape the pathways by which people seek mental health treatment. The political system also determines the development of the mental health service in the province. The case of Aceh is a unique example where conflict and disaster serve as the catalysts towards the development of a mental healthcare system. Several factors contribute to the improvement of the mental health system, but security is a must. Whilst the Acehnese enjoy the improvements, some issues such as stigma, access to care and political fluctuations remain challenging.

Keywords: Mental Health System; Armed Conflict; Disaster; Human Resources.

## 1 Introduction

Aceh is a province of Indonesia that is situated at the northern end of Sumatra Island. The province consists of five autonomous cities and 18 districts. Banda Aceh is the capital and is the largest city in the province. According to the central bureau of statistics, it had a population of around 4.7 million in 2013. Around 17.72% of the population was under the poverty line, which is significantly higher than the national average (11.47%). The Human Development Index in Aceh was marked at 73.05, which was slightly lower than the measurement of the national index (73.81). The average life expectancy in Aceh was 69 years, slightly lower than the national average of 70 years (BPS, 2014). As health issues were evolving among the population of Aceh, problems relating to the burden of mental disorders and the limited availability of healthcare services also emerged.

The people of Aceh had suffered enormously from a series of unfortunate events; while perennial armed conflict already proved destructive, the Tsunami on Boxing Day 2004 brought previously unimagined devastation. The armed conflict between the Indonesian Military (TNI) and the Free Aceh Movement (GAM) lasted more than 28 years (1976 – 2005) and saw the killing of over 15,000 civilians, displacing over 30,000 households and impairing public and healthcare services. The earthquakes and the Tsunami in 2004 killed approximately 129,775 people and displaced around 504,518. Moreover, around 38,786 people were missing and more than a thousand children lost their parents (Doocy et al., 2007; UNDP, 2010). The total losses from the disaster in all sectors were estimated at around 44 trillion Rupiah (UNDP, 2010).

Before the Tsunami, several efforts had been established to diminish the conflict between the TNI and GAM. Among the earlier efforts was the introduction of the "humanitarian pause" between the both sides. The Switzerland-based Henry Dunant centre (HDC) facilitated this approach. The agreement was reached in 2000 and showed promising signs initially, but officially collapsed in April 2001. Another peace effort, the Cessation of Hostilities Agreement (COHA), was signed on December 2002, but lasted only for four months (Sukma, 2004). From then on, the Acehnese lived in uncertainty; gun shots were heard almost every day, and news about missing people, the finding of dead bodies and mass evacuation due to security threats were the subjects of daily headlines in the local newspaper until the massive earthquake and tsunami demolished the coastal region of the province on the 26th December 2004. The disaster hit not only the community, but also both of the military actors, TNI and GAM. Realising the enormous loss from the disaster and the need to reconstruct Aceh after the disaster, another peace agreement was initiated and the Crisis Management Initiative (CMI) of the former Finnish President Martti Ahtisaari mediated this time. After a long negotiation between both sides, the agreement was reached on August 15th, 2005 and signed in Helsinki. The Helsinki Memorandum of Understanding (MOU) was a promising new start and a turning point for the Acehnese to rebuild their lives and to catch up with other provinces of Indonesia which had left Aceh far behind in most sectors (Aspinall, 2005).

## 2 Methods

We reviewed published and unpublished reports from the local and national government, and international bodies (UN, NGOs) that described studies or programs related to mental health in Aceh province. We also reviewed the published academic literature in Medline (PubMed) searching with the keywords "mental health, psychiatry, Aceh, and Tsunami". Unfortunately, the number of academic studies was very limited and we therefore broadened our search to include the mass media using search engines and Google scholar. Additionally, several interviews with stakeholders and mental health practitioners were conducted to obtain information on service provision in Aceh.

## 3 Burden mental disorders in Aceh

According to the National Institute of Health Research and Development (NIHRD), in 2007, the rate in Aceh of severe mental disorders such as schizophrenia was around 1.9%, and the rate of mental emotional disorders was around 14.1%. These rates were higher than the national averages of 0.46% and 11.6% respectively (NIHRD, 2007). A follow up survey conducted in 2013 in Aceh found the rate of 0.24% of severe mental disorders and 6.6% of mental emotional disorders (Ridwan et al., 2013), lower than the rates reported in the earlier survey. Furthermore, schizophrenia was among the most commonly reported severe mental disorder. More than 92% of psychiatric patients in Aceh psychiatric hospital were diagnosed with schizophrenia (Marthoenis et al., 2014). The rate of other mental disorders such as major depression, bipolar disorder, personality disorders or anxiety disorders were rarely studied.

### 3.1 Tsunami and mental illness

Prior to 2004, research on mental health in Aceh was scarce, and evidence on the burden of mental illness thus also lacking. Conversely, the Tsunami disaster boosted the opportunity for researchers to conduct and publish their work on mental health and illness in Aceh. A study conducted two months after the Tsunami 2004 found that around 24% of the Tsunami survivors in a field hospital had at least four out of seven symptoms of Post Traumatic Stress Disorder (PTSD) (Redwood-Campbell and Riddez, 2006). Post-traumatic stress was also found to be more severe in heavily damaged areas, loss of kin, property damage and exposure to traumatic events being associated with post-traumatic stress (Frankenberg et al., 2008). One year after exposure to the Tsunami, 24.6% of children aged between four and ten and 35.6% of those aged between 11 and 18 were also found to be suffering from PTSD (Wiguna et al., 2010). Significant emotional distress and depression were found in around 69.8% and 60.3%, respectively, of Tsunami survivors who had been displaced and lived in camps. The study also highlighted that the number of family members who had died in the Tsunami was a significant predictor of total distress (Sauza et al., 2007). Children and adolescents living in the displacement camps were also three times more likely to suffer from fears related to the tsunami compared to those living in villages (Du et al., 2012). Four and a half years after the Tsunami, the long-term effects of mild, severe and very severe symptoms of PTSD were found in 40.7%, 21.4% and 1% of adolescents respectively (Agustini et al., 2011). The psychological impact of the

Tsunami also persisted years after the disaster, and was not significantly different to the rate of psychological distress among the survivors of the 2009 Tsunami in West Sumatra. Among the Acehnese survivors, the rates of stress, depression and anxiety were 19, 20 and 52 percent, respectively (Musa et al., 2013). Despite the fact that the Tsunami was an obvious burden on mental health, the long lasting armed conflict was also responsible for the high levels of mental illness in Aceh.

### 3.2 Armed conflict and mental disorders

Throughout 2006, another larger study was conducted in 16 districts of Aceh. The study focused on the community's traumatic experience as a consequence of the armed conflict that occurred repeatedly between 1989 and 2005. The study suggested that 17% of the population suffered from a high level of PTSD and 44% suffered from depression. PTSD rates were also observed as being significantly higher among women than men. Apart from PTSD and depression, the study also highlighted that during the conflict, 25% of men reported having experienced knife or gun attack, compared to only 11% of women. Beating of the body was also experienced by 44% of men, compared to only 13% of women (Grayman et al., 2009). Furthermore, another study also revealed the presence of depression, anxiety and somatic symptoms among conflict survivors (Poudyal et al., 2009). These findings provide clear evidence of the magnitude of suffering that impaired the mental health of the population.

## 4 Cultural issues related to mental health

### 4.1 Local "treatment" of people with mental illness: *Pasung*

Practices performed by lay people related to mental illness in Aceh were similar to the situation in other provinces in Indonesia. Due to various reasons, the family and the villagers sometimes tend to treat people with a mental illness (PWMI) inhumanly. The practice of *pasung* in Aceh is common, culturally acceptable and has existed within the community for a long time. *Pasung* is an exemplary Indonesian word that means to restrain and to confine the psychiatric patient by chaining or locking them in wooden stocks. *Pasung* usually happens within the person's local community. In 2010, the government of Aceh declared its intention to fight against and end *pasung* practices in Acehnese society. Since then, almost one hundred of PWMI have been released and transferred to psychiatric hospital for further treatment (Puteh et al., 2011). Nevertheless, around 64 patients were still found in *pasung* at the end of 2014 (PHO Aceh, 2014). Several explanations were cited as the reason for which they were still shackled; either they had not been released at all, or they had been released once and had returned home after treatment in the psychiatric hospital. However, because of poor medication, their illness relapsed and they had begun to behave abnormally, and had therefore been restrained again by their family. Low literacy on mental illness and outdated attitudes and stigma towards PWMI might explain why these inhumane practices still exist in this society.

4.2 The community attitude: a brief experience of *pasung*

People's attitudes towards PWMI vary, and are largely subject to the patient's condition. The people tend to keep a distance from the PWMI who are homeless, live on the street, are untreated, wear shabby clothes, or who are known to have previously exhibited aggressive or *amok* behavior. One of the authors (MM) accompanied a team from Aceh psychiatric hospital to release a patient from *pasung* in 2010, and witnessed a good example of community apprehension towards the PWMI. The patient who was about to be released had been in chains for around 15 years. He was placed in the kitchen of his decrepit wooden house, sitting on a wooden bed with both of his legs chained. He lived only with his wife, who has her own bedroom. All of their children were married and had moved out to their own homes. When the team from the hospital asked the family and villagers for help to cut the chains off from the patient's legs, they approached the patient with hesitancy, and MM saw how frightened they were. A family member told MM that he was among those villagers who had initiated the restraint of the patient. He said that the patient was extremely aggressive and dangerous. It took some time for the team to convince the family and villagers that the patient was no longer dangerous, as he had been restrained for years. The patient could barely even move as the result of long-term immobilisation. However, the villagers repeatedly questioned whether the patient would behave strangely or attack them after he was released from the chains. Only after the team began to cut the chain did the villagers approach the patient and offer help. This experience explains how society can isolate and maintains a distance to those with mental disorders when they perceive them to be dangerous.

On the other hand, PWMI may serve as the subject of entertainment. When they are perceived as less risky, people show less hesitation in approaching them, sometimes cheating or making fun of them. One study reported PWMI being the subject of entertainment in another part of Indonesia (Broch, 2001). Whether the community tries to keep its distance or approach PWMI is linked to the level of stigma they attach to and beliefs about mental illness.

4.3 Stigma and beliefs about mental illness

Link and Phelan (Link and Phelan, 2001) proposed that stigmatisation occurs when the components of labeling, stereotyping, separation, exclusion, rejection and discrimination converge. Stigmatisation of mental illness could be seen either as self-stigma or as public stigma, both of which include components of stereotyping, prejudice and discrimination (Rüsch et al., 2005). Both public and self-stigma are obvious in Aceh, and several determinants are responsible for it.

Mental illness has numerous names in Aceh. *Gila* is a common word in *Bahasa Indonesia* (Indonesian language) that means "crazy". In *Bahsa Aceh* (Acehnese language), it is called *pungo*, which is also literally means "crazy or craziness". Nevertheless there are numerous terms used to identify someone with a mental problem. Local terms such as *seudeng, sihet, bulut, putoh saraf,* and *hana pah* have distinctive meanings and are often used to label the PWMI (Saad, 2010). *Hana pah* for instance literally means "not in order"; inherited from the words *hana* (not) and *pah* (fit or order). These words attempt to explain that a PWMI

is not like a normal person who behaves in a proper and acceptable manner. Likewise, the words *putoh saraf* literally mean "off nerve" which might be derived from the lay understanding that in a PWMI's brain, nerves are in some way interrupted. Consequently, the Acehnese tend to take family members with a mental disorder to a neurologist rather than to a psychiatrist.

The vast majority of the Acehnese populations are Muslim, and their religious belief also influences the way they perceive mental illness. In this society, mental disorder is often regarded as a test from God. This belief is also common among Muslim society in other countries (Ciftci et al., 2013). Any disorder that someone suffers from is viewed as a test to improve the *iman* (faith) to God, including mental illness. Furthermore, there are also beliefs that a PWMI is a special creature, gifted and sinless. They are regarded as a person "who has no more responsibility in the world" - unlike normal people who have to pray (shalat) five times a day, the PWMI has no obligation to perform any Islamic religious practices.

The belief that mental illness is instigated by black magic, demonic possession or other supernatural causes is also common in this society, a belief that is also customary among other Muslim societies (Pridmore and Pasha, 2004). Some also believe that mental disorder appears as the consequence of imbalance between expectations and ability, when a person has too high expectations that they are unable to fulfill. This might refer to the grandiose delusion symptoms seen in schizophrenic patients. Losing a loved one, wealth, power, position and even trust are sometimes cited as the cause of mental disorders. A wide variety of these causal beliefs, hardly any of which are related to the biological cause, determine people's behavior in terms of seeking treatment.

### 4.4 Mental Disorders and Traditional Healers

Arthur Kleinman divided the medical system of a community into three sectors; folk, popular and professional (Kleinman, 1980). The professional sector includes trained medical doctors, nurses or psychologists who treat the mental disorder according to Western bio-psychological science. Human resources in this sector are scarce, less accessible and mostly located in the urban area of Aceh. Folk sector are those traditional and religious healers who play important roles in treating psychiatric patients based on his inherited and non-western knowledge. Despite this sector is not part of the "official' medical system (Helman, 2014), in fact, they are mostly accessible and widely available as they live within the Acehnese community. As previously discussed, the vast majority of Acehnese believe that mental illness has supernatural causes. For this reason, it is believed that those who understand or even have supernatural powers, namely the traditional healers, should also perform the treatment (Jones et al., 2007).

A traditional healer is called a *dukun* or *tabib* in Aceh. *Dukun* is a local word, while *tabib* is inherited from an Arabic word that literally means "a doctor". In terms of the practice of healing, *dukun* and *tabib* have distinctive approaches. A *Tabib* usually uses herbs to treat a patient, while a *dukun* might use the "white magic" that he has obtained with the help of the spirits. Nevertheless, a religious healer, who is usually an Islamic scholar, is more

often regarded as the best healer for a mental problem. He usually uses Quran verses that he recites to the patient face to face, or a bottle of water that is meant to be drunk by the patient. Among inpatients in Aceh psychiatric hospital, apart from taking the regular antipsychotic, some families bring water from the religious healer that they say has been recited with prays to treat the patient. There is no further study on the extent to which this recited water helps to improve the patient's condition, while beliefs about its effectiveness remain strong within the community. As a final point, the presence of both traditional and religious healers in mental illness treatment enriches the diversity and scope of the Acehnese mental health system (Jones et al., 2007). Their presence should be seen as an opportunity to improve mental health services in the community (Patel, 2011).

## 5 Mental Health Service Provision

The history of mental health services in Aceh can be traced back to 1924, when the Dutch colonial government built the first psychiatric hospital in Weh Island. The hospital had around 1200 beds within an area of 20 hectares. The colonial rulers brought not only psychiatric patients to the island, but also those who had a strong warrior spirit to fight against colonialism. Currently, these historical buildings are part of the Indonesian navy hospital in the town of Sabang.

As for many other provinces in Indonesia, the government is the primary and the only official service provider for mental healthcare in Aceh. There is no private psychiatric hospital, but most psychiatrists who actually work for the government run their private outpatient clinics in the afternoon. Mental health services are primarily situated in a psychiatric hospital and public health centres. Some general district level hospitals are also starting to provide outpatient mental health services.

### 5.1 Psychiatric hospital

Aceh psychiatric hospital is the main psychiatric hospital and the only referral psychiatric hospital in the province. Its capacity is approximately 350 beds, but in 2013, it served around 650 patients. Some patients have been moved to Jantho filial, a general hospital whose nursing wards are utilised to treat psychiatric patients. Nevertheless, the number of patients in the main hospital remains twice the bed capacity. Aceh psychiatric hospital serves both in and out patients, offers drug addict rehabilitation and on-site rehabilitation for psychiatric patients. In 2011, it served 14,569 outpatient consultations, 2658 admissions and 2,505 discharges from the hospital. The bed occupancy rate was 193,23 and the average duration of hospital stay was 66 days (RSJ Profile, 2012). The median duration of hospital stay was approximately six months, ranging from two weeks to 61 months (Marthoenis et al., 2015). Furthermore, the majority of the patients were diagnosed with schizophrenia (92%), including paranoid type, residual, disorganized and undifferentiated schizophrenia. More than half of patients (55.3%) suffered from residual schizophrenia. Other types of psychiatric diagnoses were depression (0.4%), bipolar disorder (0.8%) and mental and behavioural disorder related to psychoactive substances (4.1%) (Marthoenis et al., 2014).

To resolve the high demand for mental health services, a new psychiatric hospital has been built in the district of Aceh Utara (Northern Aceh); however it is not yet operational. Psychiatric patients who live in the rural area and cannot afford to travel to the main psychiatric hospital in Banda Aceh, usually seek the treatment at a public health centre (PHC). PHCs exist in almost every sub-district throughout Aceh.

### 5.2 Public Health Centre

Public health centres (locally called *puskesmas)* are the first line health service provider for the community. Their services range from pre-natal care, delivery, school health, dental care, vaccination, family planning, to elderly healthcare. Apart from running an emergency unit and outpatient clinic, some PHCs also have inpatient wards. The community mental health (CMH) program is organized by *puskesmas* in their area of services. In 2014, there were 334 puskesmas in Aceh, 292 of which had been implementing the CMH program (PHO Aceh, 2014).

The General Practitioner Plus (GP+) and Community Mental Health Nursing (CMHN) are two programmes that were initiated only after the Tsunami. These programs are aimed at improving the mental health service deliveries in Aceh (Kakuma et al., 2011; Prasetiyawan et al., 2006). The medical doctors who worked at the *puskesmas* were given refreshing courses to improve their skills in providing mental health services, and so they become a GP+. Nurses obtained a longer duration of training to become a CMH nurse. Each PHC usually has one to two trained psychiatric nurses that responsible to look after the PWMI. Currently, Aceh has the highest CMH nurse ratio to the population compared to other provinces in Indonesia (Epping-Jordan et al., 2015). There were 466 CMH nurses and 196 GPs working in the PHCs across Aceh in 2014 (PHO Aceh, 2014).

A limited number of essential medicines for the treatment of mental disorders are also available in the PHC. These include haloperidol, chlorpromazine, amitriptyline and diazepam. Atypical antipsychotics are only accessible in the psychiatric hospital. Consequently, complaints about the adverse effects of the typical antipsychotics were common from the patients, resulting on the increasing reluctance to taking medicines prescribed at the PHC.

### 5.3 Community mental health programs

Although the CMH nurses are considered as PHC staff, they are also expected to work in the community. Their task includes conducting mental health awareness campaigns for villagers, community and religious leaders. They also recruit and train volunteers from villages, who then become so-called *mental health cadres*. Until 2014, there were around 4403 mental health cadres who had been recruited and trained in basic knowledge about mental health (PHO Aceh, 2014). In their daily practice, the cadres collaborate with the CMH nurse to look after the patients. They perform simple tasks such as detecting cases of mental disorders in their neighborhood, visiting the patient's home and ensuring that the patients take the medicine. The challenges of this project were that most of the cadres were young, and were liable to leave the village to study or get married, and because they were unpaid, they could leave their voluntary positions easily.

Another interesting program that has been conducted in Aceh is called Desa Siaga Jiwa (mental health alert village). The recruitment of village cadres, and awareness campaigns for the villagers, community and leaders are part of the establishment of this program. The villagers are expected to be aware of early signs and symptoms of mental disorders, and know where to seek help when someone is suffering from a mental problem; most importantly they are taught not to stigmatise the PWMI. Recently, 1089 of the 6746 villages in Aceh (16.14%) were declared as the mental health alert villages (PHO Aceh, 2014). Nevertheless, despite the promise shown by community mental health programs in the long term, no study has been conducted to evaluate their effectiveness.

5.4 Local government policy

Given the status as one of the special provinces in Indonesia, enables Aceh to create opportunities to improve its health system without having to wait for national instruction. Decentralisation also allows the local government to establish policies that are not available on a national level. One of the most significant products of this local governance system was the issuance of a local regulation (called *Qanun*) on health. The Acehnese government *Qanun* no. 4 year 2010, regulates many aspects of health services in Aceh, including mental health (DPRA, 2010). The population's right to access health treatment through social health insurance was guaranteed in the regulation, by which the government later provided a local health insurance for the Acehnese. The *qanun* also secures the funding allocation for mental health programs, making Aceh the only province in Indonesia that has this kind of policy on a provincial level.

5.5 Financial issues

On the first of June 2010, the government of Aceh introduced and started a local insurance scheme called JKA or *Jaminan Kesehatan Aceh* (Aceh Health Insurance). The insurance scheme targeted those who were not covered by another nationwide insurance for the poor (*Jamkesmas*). The premium of the insurance is fully paid by Aceh government from the local budget. By 2012, more than 1.2 million members of the population were covered by the JKA, another 2.6 million by the national *Jamkesmas* scheme, and the rest by employee or private insurance. Additionally, in 2014 the national government implemented a new social insurance scheme (BPJS) that enables all Indonesians to be covered by health insurance.

The JKA insurance was not specifically targeted at PWMI, but helps them to gain better access to psychiatric care. Before the JKA, patients barely had access to proper care due to their financial shortcomings. Data from Aceh psychiatric hospital suggests that more than half of the current inpatients were covered by the JKA (RSJ Profile, 2012). Furthermore, around 40% of psychiatric ex-*pasung* patients were also covered by the JKA scheme (Puteh et al., 2011), clearly suggesting that health insurance is a tremendous benefit to PWMI. Nevertheless, despite the “free” treatments, there were complaints from patients'

families about the cost of transportation to the hospital, which some of them could not afford. Thus, transportation costs partially explain why the family put some patients in pasung after the treatment at the hospital.

Lastly, humanitarian aid from the international community helps towards improving mental health services in Aceh. The Norwegian Red Cross, for instance, rebuilt the only psychiatric hospital in Aceh (Warsidi, 2009), while other non-government organisations focus on providing mental health services (Bass et al., 2012; Jones et al., 2007), or improving human resource capacity via trainings (Epping-Jordan et al., 2015; WHO, 2013).

## 6 Discussion

### 6.1 Mental Health Development: Enabling Factors

Having discussed a wide variety of factors that determine mental healthcare and the mental health system in Aceh, the authors put forward four "must have" factors that contribute towards the improvement of the mental health system, at least according to the case of Aceh.

#### 6.1.1. Security

Security of the state, through freedom from conflict, intimidation and war is the most important factor that enables the improvement of a healthcare system. This ensures health service delivery, training of health staff and warrants the supply of medication. We belief that without ceasefire in Aceh, there would be neither training, nor services for psychiatric patients in the region.

#### 6.1.2. Good Governance

The issuance of a governor's decree on mental health services in Aceh, along with local regulations, were a significant first step forwards to the establishment of basic policy on mental health services. This not only secures the annual funding for mental health programs in the province, but also provides mental health workers with reasonable remuneration for their daily work.

#### 6.1.3. International Support

Rebuilding Aceh from the ruins of the Tsunami would have been impossible without the support of the international community. Apart from rebuilding the PHCs, psychiatric hospital, general hospital and other health-related infrastructures, a series of training courses for mental health nurses and GPs was obvious evidence that support from the international communities helped to rebuild the province and achieve better conditions. International collaboration and support should be a global agenda for mental healthcare development in developing countries, comparable to what the international community has been doing on HIV/AIDS and other communicable diseases in developing worlds.

#### 6.1.4. Availability of Human Resources

Finally, a series of training courses on mental health provide the province with a large number of community mental health nurses, who later contribute towards the implementation and improvement of the community-based mental health nursing system. The increased availability of skilled human resources in mental health is also expected to improve the access of PWMI to psychiatric care, minimise the treatment gaps, reduce the stigma attached to mental illness, and maintain post-hospital treatment. Nevertheless, to what extent the CMH nurses and GP+s help to improve the mental healthcare in the province requires further research.

### 6.2 Further challenges

With regards to the improvement of mental health service delivery in the province, some issues remain challenging. Decentralisation sometimes conflicts with the interests of official leaders at the district level and provincial health service goals. Sub-districts that have strong concerns about the health service seem to follow the blueprint that had been planned and agreed at the provincial level, whereas some sub-districts consider non-health related issues as more important than health issues. Therefore, the variance in the quality of mental health services between sub-districts in the province is unavoidable. Additionally, decentralisation also leads to frequent changes in staff positions. A well-trained psychiatric nurse might suddenly be posted to a new position that has nothing to do with mental health services, leaving his or her previous post unattended and the psychiatric patients untreated. Solving this problem requires the training of new psychiatric nurses, and this is both time-consuming and costly. Lastly, coordination between institutions (psychiatric hospital, PHC and CMH nurse) is lacking to some extent. A psychiatric hospital might discharge a patient to return to their family without informing the PHC or CMH nurse who is supposed to be responsible for the area in which the patient resides. Later, when the patient runs out of medication, he or she has no idea where to go or whom to contact for the continuation of medication. The patient might relapse and be sent back to the psychiatric hospital. The provincial health office regularly conducts coordination meetings between mental health services; nevertheless, the issue often remains unsolved as yet.

Last but not least, low attitude, stigma and discrimination towards PWMI remain an enormous challenge. The practice of *pasung* should be ended, without exception. Stigma and discrimination should be fought on all levels, so that PWMI have the same rights as others. These issues should be the agenda of all stakeholders.

## 7 Conclusion and lessons learned

Mental health in Aceh, Indonesia, is in some ways comparable to the situation in other (developing) countries. Poverty hinders the family in accessing proper psychiatric care. Stigma often forces the family to hide the patient and his or her illness, while the lack of

mental health literacy causes them to make choices such as seeking non-professional treatment such as traditional and religious healers. The people of Aceh have also suffered enormously from the long-term armed conflict, as well as from the devastating natural disasters in 2004. Nevertheless, despite those experiences and a number of socio-politic and economic issues, Aceh has shown its ability to improve its mental health services. In fact, "*Aceh is considered as a role model for mental health for other provinces in Indonesia, and serves as a prime example of how the influx of resources following an emergency can be used to strengthen the mental health system*" (Epping-Jordan et al., 2015).

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