COUNTRY PROFILE

INDONESIA

Analysis for mental health campaigning and advocacy

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THE PURPOSE

of these profiles is to inform effective mental health advocacy by identifying and documenting national priorities for mental health campaigning efforts. This country profile is the culmination of desk research and interviews with experts in Indonesia. Based on the PESTLE[1] framework of analysis, covering Political, Economic, Social, Technological, Legal and Environmental factors, it seeks to outline issues relevant to mental health, identifying resource gaps, challenges, opportunities and priorities of people affected, leading to recommendations for key actors working in mental health campaigning and advocacy in Indonesia. The development of country profiles was implemented through a partnership between the Speak Your Mind Campaign and the Mental Health Innovation Network.

1 Perera R. 2017. The PESTLE analysis.

Photo: Stenly Lam. Jakarta, Indonesia. 2011 LINK

Political Factors

Institutional Framework: Indonesia is a constitutional republic located in Southeast Asia. At the national level there are two sets of major policy processes; regular development planning and budgeting and the development of more ad hoc laws and regulations. Since 1999, Indonesia has also undergone a decentralisation process, which transferred control of public expenditure and service delivery to provincial and district governments. Indonesia has a hierarchy of interrelated long term-medium term and annual plans, from central to provincial and district level[2]. The planning process combines top-down with bottom-up participation from communities and local agencies. In 2014, Indonesia strengthened their decentralisation with local government law (no.23/2014) and village law (no.8/2014). Village law opens the participation in community level government to regulate community policy and allocate funds for implementation.

Since 2014, Indonesia has started the implementation of Universal Health Insurance Scheme, managed by National Security Agency (Badan Penyelenggara Jaminan Sosial-BPJS)[3]. Since the Presidential Regulation no.82/2018, mental health has been included in the National Health Insurance Scheme. Suicide is excluded from the service due to the self-harm perspective evoking personal responsibility. The Central Government prioritises covering about 40% of the citizen health insurance for financially vulnerable groups. The Local Government also aims to increase the coverage or benefit of the National Social Security System;

2 The World Bank. 2019. Indonesia Economic Quarterly 2019, Investing in People.

3 Indonesia Law No.40/2014 on National Social Security System

by 2019, 7 out of 34 Provinces gradually implemented Universal Health Coverage.

Health System: Since 2004, Indonesia has been building a National Social Security system within their health component under the National Social Health Insurance Scheme (started in 2005)[4]. Indonesia's health system is a mixture of public and private providers and financing. The public system is administered altogether by the central government, provincial and local government. The Ministry of Health (MoH) lead the central policy and grand design of health policy and implementation. In line with decentralisation, provincial and district governments (under the Ministry of Home Affair) take on task sharing responsibility for local regulation, and ensuring the availability of financial and human resources.

Since 2016, Indonesia implemented a major shift towards integrating mental health care into primary care and community care units called Puskesmas[5]. In the same year, a Human Rights Watch report on mental health institutions exposed the prevalent practice of shackling (pasung) in people with severe mental disorders. The Indonesia National Health's research study in 2018 showed 14.3% people with mental illness experienced pasung[11]. Since 2017, an anti-pasung movement increased dramatically and the subsequent campaigning for more humane treatment of people with psychosocial disabilities was incorporated in the national agenda (2019)[6]. Health system mandate is managed by the Ministry of Health, with the Directorate of Mental Health and Substance Abuse taking part in mental health management.

BREAKDOWN OF MENTAL HEALTH SERVICES AND RESOURCES[7]	
MENTAL HOSPITAL	51 Mental Health Hospital (32 public hospitals and 19 private hospitals) in 27 out of 34 provinces 0.02 per 100.000 population
MENTAL HOSPITAL STAFF	7,751 Mental health professionals form private and public staff 3.00 per 100.000 population
PSYCHIATRIC UNITS IN GENERAL HOSPITALS	269
MENTAL HEALTH REHABILITATION UNITS	Not reported
GENERAL MENTAL HEALTH STAFF (RATE PER 100,000 OF THE POPULATION)	Psychiatrists: 0.31 Child Psychiatrists: Not reported Psychologists: 0.17 Social workers: reported as number, 15,522 personnel[8] Mental health nurses: 2.52 Occupational therapists: No reported

4 Mboi, N., et al. 2015. Indonesia on the way to Universal Health Care.
5 Strategic Planning Ministry of Health Indonesia 2015-2019
6 Human Right Watch. Living in Hell: Abuses against People with Psychosocial Disabilities in Indonesia (2016).
7 World Health Organization. 2017. Mental Health Atlas Indonesia 2017
8 Ministry of Health Research Development and Database. Accessed from LINK in May 2020

Economic Factors

Budget and Expenditure for Health and Mental Health:

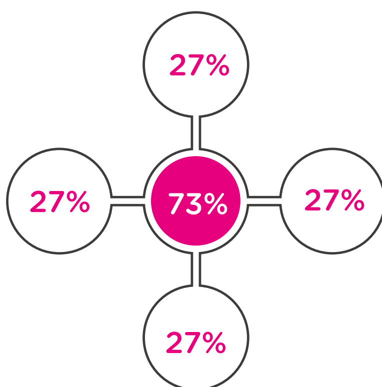
Classified as a lower-middle income country, Indonesia has made enormous gains in poverty reduction on cutting the poverty rate gradually from 23.4% in 1999 when overcoming Asian financial crisis to 9.41 % in 2019.

25.1 MILLION INDONESIAN STILL LIVE BELOW THE POVERTY LINE, AND APPROXIMATELY 20.6% OF THE ENTIRE POPULATION REMAINS VULNERABLE TO POVERTY

Indonesia's economic planning segmented into five-year medium term plans (in local term called RPJMN), with the current phase (2015-2020) focused on infrastructure development and social assistance programs related to education and healthcare.

THE COUNTRY SPENDS AROUND 3.3% OF ITS GDP ON HEALTH EXPENDITURES[9].

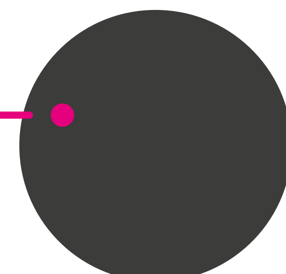
In 2019, Indonesia allocated **5%** of its total National Budget to the health sector with **5.8%** increasing the total budget from last year[10]



Approximately **73%** of the health budget is controlled centrally

27% sent to be managed by the local government.

Mental health spending is an approximate **2.9%** of the total health allocation - three times higher from the reported spending in 2015[11].



9 WHO. 2019. Global Spending on Health: A World in Transition.
10 Indonesia National Health Budget. 2019. Accessed from LINK in May 2020
11 Ministry of Health. Directorate Mental Health Action Planning 2015-2019. accessed from LINK in May 2020

In 2019, the Directorate of Mental Health and Substance Abuse's top five spending targets were on medical rehabilitation claims (49.8%), monitoring and evaluation (12.3%), mental health education and prevention for children and adolescents (11.4%), capacity building (4.8%), and supervision on prevention and control of substance abuse program (4.8%). The budget for rehabilitation claims was largely influenced by compulsory reporting and rehabilitation programs for substance abuse that put medical rehabilitation as a key strategy for decriminalisation[12]. The Mental health law (no.18/2014) also influenced the Ministry of Social Affairs to spend on social rehabilitation which still focused on infrastructure. There is no public record on health and mental health expenditure by the local government.

International Financial Assistance: There is no systematic record on international assistance specific to mental health in Indonesia. Since the Aceh tsunami in 2004, many international funders focussed on investing in psychosocial interventions as part of Indonesia's humanitarian aid package from multiple countries (US, Australia, Germany), UN Bodies, and international NGOs. Another bilateral funding mechanism in the health sector includes supporting distinct mental health interventions through the Australia-Indonesia partnership and UKRI – Indonesia's joint partnership for health. Since 2015, Indonesia managed international aid, grants, and funding to be assessed, consulted, and reported to the Ministry of National Development Planning to make sure all international funds and intervention are connected to the national development agenda[13].

Social Factors

Social Demographics: Indonesia is the largest country in Southeast Asia with 17,491 islands in the archipelago. In 2019, Indonesia stood as the world's fourth most populous country with 237.6 million people, contributing 3.5 per cent to the world's population. There are more than 633 ethnic-group with 1331 sub-ethnic groups[14] however, the classification of ethnicity and indigenous population in Indonesia is not rigid and in some cases unclear due to migrations, cultural and linguistic influences. The most practiced religion in Indonesia is Islam (87.51%), Christianity (9.90%); Hinduism (1.69%), Buddhism (0.72%) and other minorities. Indonesia started to recognise belief systems in its civil registration and vital statistics in 2019[15] in order to practice more inclusion in development and planning.

Vulnerable Population: Indonesia has specific regulations that impact the identification of vulnerable groups. The Ministry of Home Affairs and the Ministry Social Affairs regulation[16] strengthened civil registration to cover all groups within the population[17], based on 26 constructed definitions on vulnerable populations. These included persons with disabilities, persons with mental disorders, persons with AIDS, victims of disasters/trafficking/social conflict, remote ethnic groups and the homeless to be contacted, registered, and provided access to basic services (civil registration, health, education, and social protection).

12 Ministry of Health regulation no.50 /2015 on Technical Implementation on Compulsory Reporting and Rehabilitation of Substance Abuse
13 Ministry of National Development Planning. 2015. Policy analysis on the utilization of foreign grants and loans.
14 Indonesia Population Census 2010 and Inter-Census Population Survey 2015
15 Government Regulation no.40 year 2019 on Technical implementation of civil registration law.
16 Ministry of Social Affairs Letter no.8/2012 on Registration of People with Social Welfare Problems

Photo: Ana Maria Heilbron. Sanur Bali Indonesia. 2019

Prevalence of Mental Health: Indonesia's National Health surveys revealed an increase in the number of people with common mental health disorders above 15 years old from 6% in 2013[18] to 9.8% in 2018 (self-reported statistics). Surveys also show that the prevalence of psychotic disorders has risen from 1.7 to 7 per 1,000,000 of the population from 2013 to 2018. Pasung or shackling of people with severe mental health disorders still persists, with at least 31.5% people with psychosis having experienced forced restraint. Only 15.1% people with psychotic disorders have access to medication, and half of them (51.1%) have reported poor adherence to medication[19].

17 Law no 23/2014 on Civil Registration and Population Administration

18 National Health Survey 2013 accessed from pusdatin.kemkes.go.id in May 2020. National source to predict prevalence of mental health in Indonesia provided by National Health Survey (Riset Kesehatan Dasar, 2007, 2013, 2018), measured with self reporting questionnaire (SRQ-20) with Indonesia's cut point >6

19 National Health Survey 2018 accessed from pusdatin.kemkes.go.id in May 2020

Social movement: Mental health has had a major awakening in Indonesia. A long-neglected treatment gap and inequality in care has in recent years triggered social movements for action towards better mental health care and social support. Active mental health movements that played a key role included the Community of Indonesian Care for Schizophrenia-KSPI, Bipolar Care, Into the Light, Wellbeing Shelter, Depression Warriors Indonesia, Sehat Mental.id and Get Happy. They supported users, survivors, and created support systems for stigma reduction, suicide prevention, awareness campaign, and psychoeducation, mostly initiated by youth in big cities.

Technological Factors

Awareness campaigns, psychoeducation and suicidal prevention programmes in Indonesia have progressively utilised social media for increased reach and coverage. Mental health movements have increasingly invested in digital technology to carry out activities from volunteers' recruitment and peer consultation, to online interactive discussions which have been utilised more comprehensively in the recent COVID-19 pandemic lockdown situation. Yet, while the strategy is effective in potentially reaching 64.8% (171.17 millions[20]) of the active internet users in Indonesia, there is no integrative case management and referral case strategy to build on system strengthening.

Indonesia's strive towards innovating digital solutions for mental health is evidenced by public sector buy-in. In 2015, the Indonesian Ministry of Health in partnership with WHO launched an android-based application named Sehat Jiwa that sought to increase mental health literacy in addition to providing information on mental health services based on users' geolocation, guidance and services for mandatory drug reporting, reporting cases of pasung, suicidal behaviour and mental health self -assessment tools.

Social welfare and protection systems in Indonesia are also utilising technology for outreach, identification, registration, and monitoring services for vulnerable groups, including people with psychosocial disabilities to aim for social inclusion in poverty alleviation. However, several Ministries are leading their own data information management systems (such as Ministry of Social Affair on Social Welfare Information System (SIKS), Ministry of Health with Community Health Care information system (SIMPUS) and Health information system (SIK), Ministry of Home Affair with Civil Registration information system (SIAK), creating duplication of efforts and a fragmented user experience for people in their programmes. The Ministry of National Development Planning is leading the process on a One Data policy and system to integrate the big data around management information systems in ministries to accelerate identification, registration, and providing services to the most needed[21].

Legal Factors

Mental health legislation: Indonesia passed a Mental Health law in 2014. The law was established to provide protection and services to the public in accordance with human rights principles through promotive, preventive, curative and rehabilitative care. The associated costs with accessing mental health services is also addressed by the law wherein it looks to ensure the availability and affordability of mental health services and resources.

20 Indonesian Internet Service Provider Association, apjii.or.id
21 Government Regulation no.39/2019 on One Data Indonesia

Innovation and research of mental health topics is embedded in the law through the Centre of Excellence for the development of science and technology of mental health[22].

Legal advocacy: After six years of the passing of the Mental Health law, there are still issues on implementing the law. As of date, the National Centre of Excellence is yet to be identified by the government and there is still a lack of awareness on mental health and the adoption of the law among government ministries. Although being formally instructed by the president, several ministerial bodies listed in the law have yet to amend their own policies according to the law. This presents a barrier for any multi-stakeholder approaches to provide services.

Community based support: In Indonesia, effective mental health care also starts at the community level. Yakkum Rehabilitation Center and CBM Indonesia have been initiating work on community based mental health in Aceh (since 2018) and Yogyakarta Province (since 2017). The initiative provides community rehabilitation to people with psychosocial disabilities by creating a holistic environment to support better access to health care, community support groups, campaigns to reduce stigma, and advocacy targeted towards policy makers at the village and district level. Supported by the village fund, community mental health cadres are trained to bridge the health and social care system by providing care through the social protection scheme[23]. Such community based initiatives are included within the law but there still exists a need to further develop the governments' infrastructures, mental health system, and funding mechanisms. Similar community based program came from a top-down approach in form of Village Mental Health Readiness initative (Desa Siaga Sehat Jiwa) from the Ministry of Health[24].

Environmental Factors

Natural disasters: Indonesia is located along the Pacific Ring of Fire where it is exposed to various hydro-meteorological and geophysical hazards. Indonesia as one of the countries with a higher scores of national disaster risk[25]. Bearing this in mind, Indonesia is prone to experience natural disasters which could lead to significant economic and social costs across its levels of society. From 2012-2019, Indonesia experienced 63% of all disasters that had occurred within the ASEAN region[26]. Post-disaster recovery and reconstruction efforts cost the Government of Indonesia between $300 - $500 million annually and up to 45% of the local provincial GDP.

COVID-19 impact and response: Following an interview with a key stakeholder, the number of mental health issues are expected to rise during the pandemic period. Medical services were delivered through tele-medicinal initiatives but psychotropics were not approved by the government as a treatment option suitable to be delivered through such initiatives. The distribution and supply of psychotropics is regulated by the government and this is raising some paranoia amongst psychiatrists as government policies may restrict its availability. In May 2020, a joint task force of social workers with the Ministry of Social Affairs launched a psychosocial service during the pandemic.

22 Interview with Dr. Nova Rianty Yusuf, former legislator who led the development of Indonesia's mental health law
23 Interview with Ari Sasongko, Head of village Temon Kulon, one of village implement the community-based mental health
24 Ministry of Health Program. 2018. Accessed from LINK in May 2020
25 Pasific Disaster Centre.2018. ASEAN Regional Risk and Vulnerability Assessment Guidelines
26 AHA Centre. 2019. ASEAN Risk Monitor and Disaster Management Review.

LOCALLY-LED AND EVIDENCE INFORMED RECOMMENDATIONS FOR INDONESIA MENTAL HEALTH CAMPAIGNING EFFORTS

1 Put the Policy into Accountable Action

Indonesia needs to strengthen the national technical policy and decentralisation from mental health law. The new mental health law can be operational and delivered locally in the form of technical policies at ministerial level and a clear implementation road map on local government to make sure mental health systems are implemented equally and integrated. Decentralisation in the village level needs more authority delegation on budgeting platforms, due to difficulties of villages to recruit, train, employ, and account for the need-based bottom-up initiatives, like mental health cadres or mental health frontliners.

2 Encourage evidence production on mental health

a. National Center of Excellence: Developing this essential mandate from mental health law will bring strategic and multidisciplinary think tanks to make sure what is work and relevant mental health systems. A center can influence large surveys on mental health, or mainstream it to priority surveys.

b. Mental Health information system: with mental health services, referrals, and continuum of care running from different levels of bureaucracy, a mental health information system alongside the health information systems will ease the business process and systematic evidence based production on monitoring and evaluation systems.

3 Increasing and reframing mental health investment

Indonesia has variative potential task forces on the mental health arena in many levels of government, from national to community level, from clinician to frontliners and advocates, also government and civil organisation. Creating a task-sharing mechanism on national roadmap implementation and increasing mental health capacity among the task forces will reduce the treatment gap. While mental health is the awakening topic in Indonesia, engaging the private sector, education, social protection, and youth movement will increase the system coverage.

4 Increase investment in child and adolescent

With the evidence on increasing prevalence among adolescents, their treatment and approach on mental health should be differ from the adult method. Due to pre-bonus demography and investing the biggest proportion of age structure in Indonesia, mental health needs to add preventive, child protection, and family wellbeing approach rather than only care and rehabilitation points.

5 Encourage participation and empowerment

Stronger alliances and social accountability from community organisation need to be nurtured and nudged toward the law and technical policies. However, the participation of people with mental disabilities needs to be adapted with empowerment perspectives and stigma reduction rather than only care, medication, and rehabilitation.