4. Conclusions

MSF has successfully supported the introduction of a new concept of mental health at district and provincial levels. This could be verified through statements made by MoH staff at all levels and also by reviewing the content of the new MoH Mental Health policy, co-developed by WHO consultants.

Mental health services in South East Sulawesi were almost exclusively delivered through psychiatric programmes. MSF introduced the value and importance of a psychosocial approach through counselling and psycho-education. WHO did the same at Jakarta level and MSF joined their efforts.

The strategy chosen was to train district level (puskesmas) para-medicals and their supervisors in counselling and supervision techniques. In addition, the cadres of a government support agency PKK were trained to deliver psycho-education at the village and IDP camp level.

All MoH staff involved have clearly valued the, for Indonesia, innovative interactive training techniques and affirmed the positive impact this has had on their counselling, supervision and educational skills. All this was achieved through many hours of lobby at all levels, developing manuals, training, consultation, supervision, more training, and meetings. All CMT members, project teams and support staff both present and past deserve the credit for this remarkable achievement. But the concept also needed a receiver and credit is due to the Ministry of Health at all levels, for their open-mindedness. They allowed MSF to evolve the project and remained constructive (with the odd exception) and receptive at all times.

However, the project's objective was much more ambitious than introducing this concept. It was meant to be a sustainable project, through innovative training techniques, but sadly, the project purpose was not achieved.

4.1 Proximity/Coverage

Out of 162,000 IDPs, only a very small number attended counselling sessions over the 18 months of the project, due to an expressed lack of needs for these services, puskesmas and individual counsellor problems, which the project was unable to address or overcome.

Although it is too early to assess the coverage and quality of the psycho-education programme, staff expressed doubts about the possibilities, given the constraints within PKK.

Nevertheless, PKK has an existing outreach system, but it remains to be seen in how far psycho-education will be a priority, as it will have to compete with the 10 other national programmes of the PKK. Also the training was instigated by the President of the PKK's Bau Bau branch, who will leave her post in August 2001. MSF strategy for psycho education was flawed. Counsellors already proved to be an ineffective mechanism and there are strong doubts that the PKK will ensure a sustainable way into the community for psycho-education, given the lack of internal and external follow-up.

The proximity to the IDPs is extremely low. Even under "normal circumstances", according to MSF 20% (of 162,000) people need counselling and we reached only a very small number.

Possible Reasons for a lack of proximity:

LACK OF BENEFICIARY PERSPECTIVE DURING THE ASSESSMENT
Beneficiary representatives consistently reported during the evaluation that trauma counselling was not a priority for them. They acknowledged that due to the turmoil, there was some need for moral guidance, but they saw it as a task of the religious counsellors (imam) and the mosque to reinforce traditional Indonesian values. Still, the PKK also see itself as playing a role in this in psycho-education. But counselling was not seen as necessary. This may have resulted from the fact that IDPs were unaware of the causes of their stress, due to a lack of (psycho-social) education; but assumptions about trauma should have been verified in one way or another.

LACK OF MOTIVATION:
Although there are some exceptions, generally the counsellors are poorly motivated. They have to combine their counselling work with other community health activities and do not give much priority to psychological counselling. Almost none of them will, or are able to go out to the communities without being paid incentives or travel cost reimbursements.

LACK OF NEEDS FOCUS DURING THE PROBLEM ANALYSIS:
The original project proposal and analysis made a number of important assumptions without validating them in the field. It was assumed that people must be traumatised since they had experienced violent conflict in Ambon. Since there was no emergency situation in Buton, it would have been possible to verify the real situation in the displaced population. Not only would this have validated the assumptions, but also this would have introduced a beneficiary perspective on the needs analysis.

CAPACITY BUILD SYSTEMS ORIENTATION:
MSF's strategy to work completely in accordance with MoH structures caused late recognition of opportunities for reaching the population. It was also necessary, to ensure some form of sustainability. The decision to work with the PKK was a good one. Although the PKK has a mandate for supporting *government* policies and may be seen by some as an extension of the government, they do have an outreach strategy and a mandate for and experience in health education.

The possibility of training IDPs as counsellors (using perhaps MSF community health worker training models) was not explored. Sustainability could have been enhanced by connecting the PKK cadres with the counsellors.

The inclusion of the IDPS themselves, mosques, local NGOs and traditional healers in our strategy also could have strengthened our proximity:

1. Imams play a role in providing moral guidance to the community. Traditional Islamic values include concepts that strengthen community and individual coping mechanism against stress and other effects of trauma.

2. Indonesia has a strong voluntary sector and culture. A consortium of 9 national and regional NGOs (PMK) is active in Buton. PMK have a mental health programme, working with the mosque, but also displayed MSF posters in their office in Transit Camp. Local NGOs have a

lot of credibility in the community, because they are active at posko level and have an important role to play in any psycho-education campaign and in overall medical strategies aiming at proximity.

3. Traditional healers are widely trusted by the population to cure mental illness, both through a belief that spirits can be a cause and the belief that hypnoses and the use of incense and potions can be a cure. Traditional healers provide a potential way into the vulnerable sections of the community and therefore should be considered to become part of a strategy. The psychiatric hospital in Kendari uses traditional healers as part of their strategy to create the conditions for psychiatric treatment, something to be considered in psycho-education and training.

The fact that these actors played only a minor role at best, points at a lack of cultural focus during the assessment stages. A more systematic approach to assessing socio- anthropological specificities of coping would strengthen MSF mental health interventions.

4.2 Coherence and Independence

From the beginning of MSF's arrival in Indonesia, the MoH was chosen as our counterpart. The Ministry of Health in Indonesia takes responsibility for delivering health services in areas affected by conflict and consequently a more hands-on MSF approach was difficult to justify. MSF committed to comply with the government's main (mental) health strategies and worked within the structure and the policies of the Ministry of Health.

Although this has made MSF's interventions coherent with MoH policy, it may well have reduced operational and strategic independence. The question whether the MoH is part of an overall political government strategy was not within the scope of this evaluation, but needs to be answered in order to address MSF's political independence. Maybe a more important question is whether the target population *perceives* the MoH to be part of a political strategy.
The MoH now perceives MSF as a reliable partner and MSF is now more or less "locked" into its strategy of capacity building and coherence. The current CMT has embarked on a strategy towards more operational independence and a more hands-on approach. This is sometimes in conflict with MoH expectations, created by the former policy of strategic co-operation. The new approach requires a new Country Policy, including a medical strategy, based on MSF principles and in the spirit of the MTP.

4.3 Appropriateness

The MSF Mental Health policy says "under normal circumstances **20%** of the people need (counselling) support after a traumatic experience because they have developed PTSD".

A sample taken during the evaluation of a community of approximately 2,000 (IDPs both in camps and in host families) in the Puskesmas of Siontapina (65 kilometres from Bau Bau) indicated that the two counsellors trained by MSF had seen a total of 200 patients over the period October 1999 to June 2001. Although these figures are not reliable and this is probably a gross overestimation, this would indicate **10%** of people using the service. The supervisor of the counsellor and MSF expert staff both indicated that this was a highly motivated counsellor whose work was of excellent quality. The community leader in the Waconti IDP camp confirmed that the population does not need trauma counselling. He stated that IDPs are stressed because of a lack of clean drinking water, water in the latrines and unemployment and indicated several times unprompted, that there was no

need for counselling. According to the MSF mental health policy this would mean that this is not an " MSF area".

This raises the question, why a *pilot project in Buton?* The reason mostly cited by interviewees was the stable situation in Buton, but MSF is an emergency organisation. On the other hand, the introduction of the concepts in a sustainable manner does require stability and a long-term perspective. This raises the curious and confusing dilemma that in terms of MSF Mental Health Policy and Guidelines the approach was appropriate, but according to the MTP the intervention was not. The mental health approach in Buton was probably of limited value in emergency situations, because of the expected higher number of traumatised people and a possible collapse of the health system. Competing emergency public health needs may force a more integrated approach, during real emergencies.

Despite this, the project successfully supported the introduction of a broader perspective on mental health, as indicated by the unprompted recognition of the concept by many of the interviewed MoH staff. Although WHO have worked with the MoH for much longer at changing mental health policies, the MSF intervention in Buton encouraged this process and demonstrated that it is practically possible to implement a wider mental health concept. The main problem is that it is currently not implementable by the MoH due to institutional problems with the puskesmas, a lack of counsellors and supervisor skills and a lack of resources to address these problems.

Both in terms of needs and in terms of the MTP this was not an appropriate intervention and the 18 months allowed were not nearly enough to reach the project purpose of a sustainable intervention.

5. Recommendations

5.1 MoH

The formulation of the MoH mental health policy with the support of WHO was an important first step to disseminate the broader concept of mental health in the system. The policy will take time to generate the necessary changes in the system, particularly at the district level, where it really matters. There is an active network of innovators within the MoH represented at all levels, who understand the importance of the necessary changes to mental health. MoH, WHO and MSF all contributed substantially to empower this network.

A national MoH public information campaign, promoting an understanding about community support mechanisms for those suffering from trauma and stress should be considered. The objective of such a campaign should be to change the stigmas currently associated with mental health problems into community attitudes of acceptance and active support. MSF has already produced some useful materials like posters. However mass media, schools, local NGO networks, traditional healers and mosques also need to be involved to reach a much wider audience and new materials will need to developed in close consultation with such community organisations.

Assuming that the transition in Indonesia towards more public accountability will continue, a successful campaign will also create pressure on policy makers, health practitioners and politicians to implement the policy. After decentralisation resources for district mental health programmes will need to come from the province. The provincial governor and provincial parliament are those who decide on the allocation of resources and therefore are of particular interest to the strategy. The two key technical departments are the provincial health authority (Dinas Kesahatan) for advising on health programme priorities and the Inspectorate, for monitoring the allocation of budgets.

5.2 MSF

MSF has played an important role in dissemination of new ideas, by addressing mental health problems through psychosocial activities. The message would have been far more powerful and convincing if we would have been able to demonstrate the results or impact on the health of the population of such an approach.

Client counselling, lobbying at all MoH levels and psycho-education needs to continue for some time, to ensure that the new government policy will be implemented. However, it is not recommended for MSF to take this on, as this is not consistent with its mandate and core emergency public health activities. Policy development and lobby was well placed with the World Health Organisation in this case, as evidenced by their role in the MoH's new mental health policy.

MSF needs to look at closer integration of mental health and emergency public health at policy, strategy and implementation levels. We need to be more realistic and define objectives achievable within our means and capacities, through our core activities.

The MSF Mental Health Policy and Guidelines needs to be considered by the Management Team as a matter of priority and reviewed in order to ensure consistency with the Mid Term Policy.

More direct information exchange and cross fertilising findings across MSF mental health projects in various countries, provides cheap and direct opportunities for learning.

The Indonesia Country Policy needs to be reviewed as soon as possible and needs to include an emergency public health strategy. Mental health needs to be integrated into this overall strategy. This process needs to be overseen by the Country Manager and implemented by the Medical Coordinator and Mental Health advisor. Given MSF's focus on the humanitarian rights of displaced populations as a result of flashpoints of conflict, factors to be considered are:

1. the "narrow" windows of opportunity for MSF to become medically operational, both in terms of time and considering that the government takes responsibility for the implementation of (emergency) health programmes;

2. the lack of accessibility of the medical system for the most vulnerable sections of the population and their strategy to seek health through their community, voluntary and traditional service providers; and

3. the need to link the delivery of psycho-education to priority needs as perceived by the affected population (water and sanitation, economic activities, housing etc.) in order to make the population more receptive for psycho-education.

MSF needs to strengthen its capacity and systems for analysing the political and social aspects of public health, during the crucial assessment stage. The Ministry of Health was assumed as the only way into the community. Key community institutions (mosques, traditional healers and local NGOs) were overlooked in the original assessments and only included in the programme at the very end when psycho-education was introduced. This will contribute to more appropriate projects and to a more independent approach.

The MSF mental health programme in Buton is an example that system capacity building strategies are still prevalent in MSF programmes, indicating problems with planning, project approval, but also training and briefings. ODs need to look at proposals (logframes) more closely in order to ensure that indicators measure the impact of our activities on the health of the target population, rather than on numbers of people accessing MSF services or facilities. Medical Coordinator and health advisors can facilitate a more people oriented approach by ensuring that problem trees consist of the target population's needs, rather than the health system's needs.

The project lacked a systematic approach to project cycle management. MSF needs to strengthen its capacity for project planning, and use planning to focus projects on people rather than on systems, in order to strengthen proximity. Approval of project time frames, budgets and the length of staff contracts needs to be more closely linked to a planning based on problems analysis, rather than on assumptions and institutional needs.