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LESSONS FROM EXPERIENCE

Supporting persons living with trauma by rebuilding social and community links



**AN EXAMPLE OF A COMMUNITY-BASED
MENTAL HEALTH APPROACH AFTER
THE RWANDAN GENOCIDE OF THE TUTSIS**

**HANDICAP
INTERNATIONAL**

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Accentus Foundation and AFD



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This paper intends to draw lessons from experience. It was produced by Xuan Phan, Clinical Psychologist and Public Health Consultant, reporting to Marc Vaernewyck, Field Programme Director (Development Department, Rwanda Programme) and Guillaume Pegon, Technical Advisor in Mental Health (Technical Resources Division, Prevention and Health Unit), Handicap International.

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Picture 1: Group of beneficiaries presenting their life experience through a drama game sequence in the Kimihurura sector

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Picture 2: Intervention in a primary school in the Bushoki sector

Acronyms

IGA	Incomes Generating Activity
CAFOD	Catholic Agency For Overseas Development
IEC	Information, Education, Communication
HI	Handicap International
WHO	World Health Organisation
OMHA	Operational Mental Health Areas
PCS	Psychosocial Consultations Service
CMH	Community-based Mental Health
UNICEF	United Nations Children’s Fund
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome



Picture 3: A group of beneficiaries in the N'dera sector

For more than three years, as a Psychology Adviser, I accompanied the implementation of the community mental health project covered by this paper. I congratulate you on the work achieved. It shows both the commitment of the local team to listening to others, and to obtaining an in-depth understanding of the specificities of the Rwandan mental health context, as well as the subtleties of the project theory and practices.

This document manages to combine the requirements of a capitalisation document which aims to share field experience beyond the limits of HI, and in particular with mental health stakeholders, with more sensitive requirements, such as remaining true to the ways of thinking and the culture of the project's key protagonists: the Rwandans.

There was a substantial risk that they might feel dispossessed of their knowledge. Firstly, because the imperatives of legitimacy and transparency to which an NGO is subjected by its funding bodies and by international institutions are often greatly distanced from the mental representations of local cultures: in this case the Rwandan culture. Secondly, because HI needs to unify the transcription of its field experiences in order to share the knowledge constructed within the various cultural contexts in which it operates. Finally, the current trend towards standardising knowledge, combined with our more or less conscious propensity to believe our way of thinking is universal, could form a trap into which it would have been all too easy and natural to fall. This document clearly avoids this trap. The numerous personal accounts running through this document testify to this. These unedited accounts remind that our mental conception of the world is only one of many and that our particular intelligence is specific to us as westerners. As the philosopher Bergson stated, our intelligence never

really feels at home except among inert objects, and is therefore “incapable of representing the true nature of life” (Bergson, 1959).

However, during these three long years, in the course of which I accompanied my Rwandan colleagues, I relished listening to them multiply the images and metaphors used reveal to me their life experiences. Each time, a complete world would unfurl like a symphony, whose notes continue to ring out long after having left the concert hall. At these times, I felt it was possible to transcend the cultural differences, because their images and metaphors reached the deepest layers of my soul, where joy and suffering are found to be universal.

For this experience, I thank each and every one. If ever, despite everything, the Rwandan participants in the project, at times no longer recognised themselves in it, I ask them to forgive us and guide us so that in the future we will better be able to listen to them. Only then will we be able to work together towards a genuine universal development of knowledge with respect, equality and reciprocity in our exchanges.

Cécile de Ryckel,
Project Psychologist Adviser



Picture 4: A group of beneficiaries in the Bushoki sector

The genocide of the Tutsis in 1994, resulted in more than a million deaths in just a few weeks (including the murders and massacres that affected the other Rwandan communities, opponents, moderate Hutus and those who tried to prevent the genocide, human rights campaigners, etc.), was extremely brutal. It had significant ramifications, both on the community level (destruction of social fabric and traditional links of solidarity) and on the individual level (manifestations of psychological suffering – episodes of revivification, violent acts, avoidance behaviour). These symptoms come out in social, family and community life. In 2007, with more than thirteen years of experience in the field, Handicap International initiated a new project aiming to ‘promote mental health by strengthening community mechanisms for the preventative and curative care management of children and adolescents experiencing psychological suffering’. This project was implemented as a **joint action** with five Rwandan partner organisations and covers four sectors located in urban and rural areas. It is rooted in a **participatory approach** which brings together both public and private-sector stakeholders. Handicap International decided to adopt a community-based mental health approach. The actions target adolescents experiencing psychological suffering, and also include the adults involved with these adolescents. This involves **supporting the reference persons** (teachers, community workers, elected representatives, child heads of households, parents) so that they can set up **solidarity and care systems** for vulnerable people and/or refer them to the appropriate care providers. The action aimed to be **multidisciplinary**, bringing together the legal (the genocide having also undermined how people position themselves in relation to the law), the psychosocial (start of welfare system in Rwanda, work with families and close environment), economic development (income generating activities in

order to cover basic needs) and finally psychological aspects (support groups, individual therapies, use of generating activities as a therapeutic mediator).

After nearly three years of implementing this approach, we can see a number of changes, including: **the rebuilding of social links, the inclusion of individuals into the community; the reconstruction** of individual and community identity; a **change in community representations** of mental health and of vulnerable people; an **overall improvement in the living conditions** gradually giving people back their socioeconomic life.

We have been able to identify several **‘lessons learned’** from this approach, which relate, on one hand, to the way in which one can work on the involvement and the role of the various stakeholders (reference persons, focal points, local authorities, beneficiaries) in the care management of beneficiaries (joint action, self-empowerment, participatory approach) and, on the other, to the way in which one can adapt a clinical and organisational mechanism to local realities (sociological, cultural, geographical, political) for example by implementing a mobile multidisciplinary team, building the community’s capacity for self-management and working in networks.

Certain **‘limitations’** were also identified in terms of the implementation of the project. These concerned the geographical distribution of the beneficiaries in a dispersed habitat, an underdeveloped networking and referencing system, and the lack of availability of partner organisations due to their geographical location and insufficient resources (human and financial).

Finally, some **‘recommendations’** for the continuation of the project are proposed.

These aim to develop primary prevention materials (awareness-raising on mental health) and tools for monitoring and evaluation (progress of beneficiaries) as well as other therapeutic methods adapted to Rwandan sociocultural practices. In terms of capacity building, recommendations are proposed to strengthen

the referencing network in the intervention areas and the implementation of the Rwandan Collective of Parts Active in Mental Health by clarifying its remit and governance and to build the capacities of the project team by providing specialist training in their respective fields.



Picture 5: General view of Kimicanga, a deprived district located in Kimihurura

Why a learning-from-experience paper?

Handicap International (HI) has worked in Rwanda since 1994, just after the genocide. Over time, its interventions have closely followed the country's development moving from emergency strategies to reconstruction and then development. The areas of activity have also evolved over time and have been selected in line with the association's remit, for example, interventions in the field of functional and community-based rehabilitation (still underway), in HIV control, in epilepsy control, in the field of inclusive education and in the psychosocial field.

Handicap International has been strongly committed to working in the psychosocial field since 1994. Initially, this involved supporting the CENAs (Centres for Unaccompanied Children) which were taking in the vast number of unaccompanied children, found 'by the side of the road', when the guns fell silent. At that time, Handicap International became known for its psychological support activities, offered to the children in the centres, particularly based on forms of mediation using drawing and drama. The projects then multiplied but all focused on individual or group therapeutic care. This care was provided by HI psychologists and partner organisations to children and adolescents in psychological distress. Between 2002 and 2006, as well as therapeutic care, the projects also aimed to incorporate interventions in the psychosocial environment, particularly by providing training for teachers and psychosocial care for families.

In 2006, an evaluation of past practices resulted in the design of a project aiming to promote a community-based mental health approach (CMH). This 3-year project started in January 2007, to be completed in December 2009. This Community-based Mental Health project aims to be an innovative approach both for HI and for Rwanda: the initial objective

was to strengthen the community system for improving the mental health of children and adolescents experiencing psychological distress, by means of a comprehensive preventive and curative approach. The challenge was to increase the impact of our actions on the mental health of the children and adolescents, based on the 'lessons learned' from our earlier projects, implemented since 1994.

Today, this learning-from-experience initiative aims to share our approach, developed on the basis of work in the field and in the Rwandan context in order to inform people of the approaches and interventions set up. This involves sharing the knowledge produced about an approach, in response to the specific care provided, and the results of the project; both internally for the HI mental health project managers and externally for the national and international partners involved.

This document also aims to develop objectives and strategies for the 2010-2012 project cycle, as it constitutes a tool that can be used to improve the Rwandan mental health information stakeholders' awareness and understanding of the concepts, the intervention framework and the activities of our community-based health approach.



Picture 6: A beneficiary in the N'dera sector

This learning-from-experience document was drawn up on the basis of various sources and tools, including:

- ▶ the collection and analysis of existing documents (activity reports, field visits report, project documents, collection of personal accounts, etc.);
- ▶ working meetings with the project team;
- ▶ interviews with members of the project team, partners (associations, other mental health stakeholders) and target populations (reference persons, focal points, beneficiaries, local authorities);
- ▶ field visits.

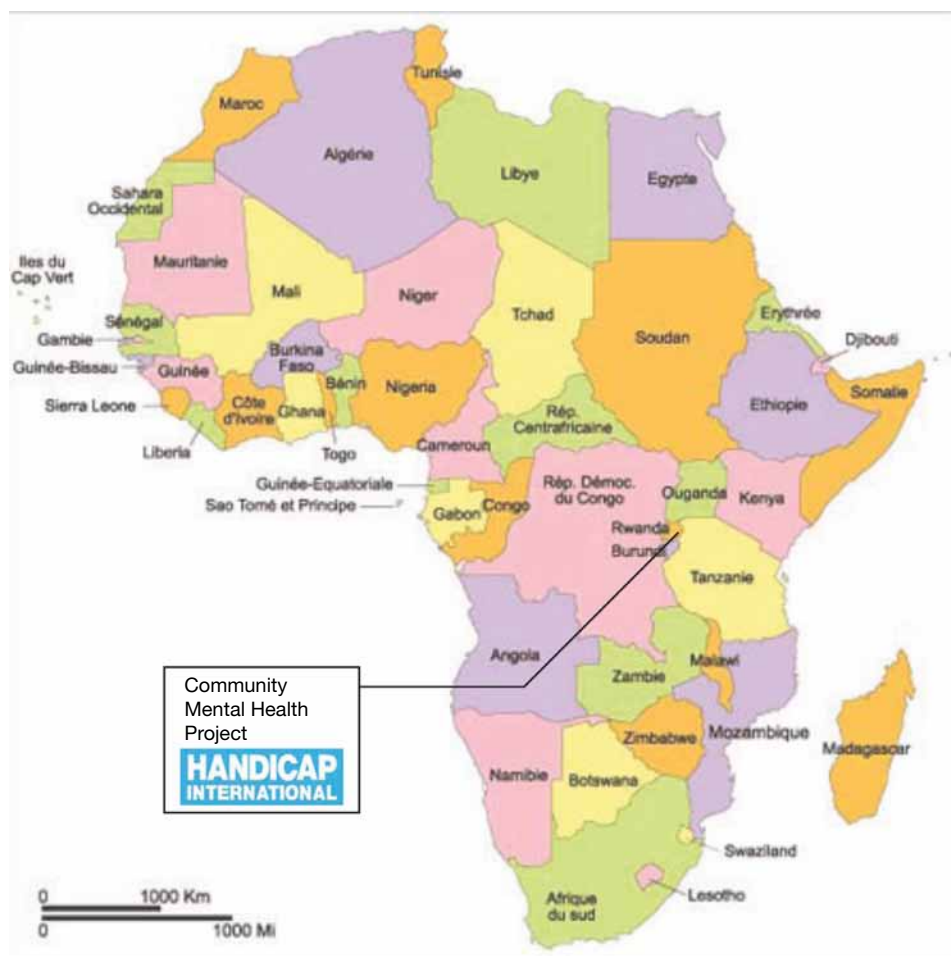




Figure 7: smiles all round at a meeting in the N'dera sector

PRESENTATION OF THE RWANDAN CONTEXT

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PSYCHOSOCIAL DISTRESS IN RWANDA: CURRENT SITUATION

DEFINITION OF MENTAL HEALTH PROBLEMS¹

“At that time, mental health was poorly perceived and associated with mental illness and insanity, and the Ndera psychiatric centre. People still did not know what mental health was. (...) After what happened in our country, after 94, the structure of society had gone, the social fabric was torn and everything that happened caused mental health problems” Focal point, Kimuhurura.

In ‘traditional’ Rwanda, “mental health was firstly a community matter: the community was the primary care provider” (Simon Nsabiyeze, Director of CAFOD). Sufferers were taken care of by their own community. When a person was ill, the community took over and provided care: the population used ‘traditional’ methods, consulting their traditional healers. Kayiteshonga states that “the healer guaranteed the provision of mental health care”, whilst family members played a ‘supervisory role’ when one of them was in difficulty (Kayiteshonga, 2006, p. 19).

However, over time, with colonisation and the spread of Christianity, which considered traditional practices as pagan, “people were whipped if found performing rituals” (Dr Naason Munyadamutsa, Psychiatrist, Professor at the University of Rwanda, Butare). The population was obliged to renounce ancient methods in order to convert to ‘modern’ western practices, consuming medications to treat for their conditions: “the practice was like magic, they give you medicines and you are cured” (idem).

Mental health problems were associated with ‘madness’, with alienated people being

committed to the Ndera national psychiatric hospital. Some of them were exiled to Burundi then brought back to Kigali to be ‘cared for’ in prison, during the era of colonisation. Gradually, mental health practice was diminished, with the professionals disappearing from the community.

With the genocide² in 1994, mental health rapidly became a public health issue requiring a response: many people found themselves in severe distress, with traumas manifesting as depression, somatoform and hysteriform disorders³ (the individual expresses in the form of headaches and stomach-aches etc., the psychological distress they are unable to express verbally). The community and the family unit were no longer able to play a role in containing and protecting the sufferer, “the traditional nuclear family has been dismantled, (...) nobody can care for others because the suffering is both indescribable and shared, the criminal has been able to attack the whole group” (Kayiteshonga, 2006, p19). The psychological suffering associated with the trauma was also accompanied by socioeconomic problems. As individuals could no longer count on the solidarity and mutual support mechanisms

1. Mental Health is defined by Handicap International as ‘all vulnerabilities entailing psychiatric disorders and/or psychosocial distress reducing the ability of the person to look after himself and to adapt to the social, cultural and political requirements around him’. (Provisional version from policy paper Disability and Mental Health), 2010).

2. The word ‘genocide’ did not exist in kinyarwanda prior to the events of 1994. It was necessary to invent a term ‘jenocide’ (in kinyarwanda) which shows the extent to which this concept is alien and external to Rwandan culture (Kayiteshonga, 2006, p. 11).

3. Disorders that seem to be one of the specificities of the Rwandan clinic for psychological traumas (CAFOD, 2009).

that were characteristic of the Rwandan community, they have to meet their needs alone, in extremely poor living conditions, their homes having mostly been destroyed and with no financial resources to meet basic needs such as feeding themselves.

International emergency aid arrived in order to respond to the problems resulting from the traumas incurred⁴. Mental health then became a key challenge and in 1995 the State decided to implement a mental health policy and, with help from UNICEF, created a National Trauma Centre (which became the Psychosocial Consultation Service in 1999).

With regard to trauma, it is necessary in the Rwandan context to make the distinction between trauma directly resulting from the genocide, for the numerous individuals (both victims and killers) exposed to the atrocities of the massacres, and the trauma resulting from other forms of violence, indirect consequences of the genocide, which affects child heads of households, teenage mothers, etc. where the trauma is caused by rape, abandonment, HIV/AIDS, abuse, etc. These different categories of vulnerable persons are then subject to multiple psychosocial suffering.

Mental Health in Rwanda in Figures⁵ (2009)

- **79.4%** of the population has experienced a traumatic event in the course of their lives
- **28.4%** of the population suffer from trauma
- **53.93%** of the population suffer from depression and trauma

IDENTIFICATION OF GROUPS OF PEOPLE EXPERIENCING PSYCHOSOCIAL DISTRESS

Psychosocial distress⁶ covers a range of areas (social, economic, emotional, etc.) and affects various aspects of life creating situations in which the individual is excluded and made vulnerable; these include poverty, homelessness, lack of social links and social recognition, loss of self-esteem.

This psychosocial distress, as a direct or indirect consequence of the 1994 genocide, was notably identified in certain groups of vulnerable people⁷.

- **Child-headed⁸ households:** these households are for the most part headed by orphans who survived the genocide, but whose parents

4. Similarly, the term 'trauma' did not exist in Kinyarwanda prior to the time of the genocide. The professionals then needed to find an equivalent word, able to represent the weight of such psychological distress associated with the trauma. One of the items of vocabulary being the word 'ihungabana', from the verb 'guhungabana', which means: to be upset, distressed (Kayiteshonga, 2006, p. 16).

5. Munyandamutsa N., Mahoro Nkubamugisha P., Ariel E., Prevalence of PTSD among Rwandan population: clinical aspects, drug abuse and other co-morbidity, 2009, In press.

6. For Handicap International, psychosocial distress (or psychological distress of social origin) is reactive, caused by trying situations and by existential difficulties of social origin. This type of distress does not necessarily involve mental disorders (although it may be associated with them), it is not pathological but sufficiently serious to be able to be taken into account in a negative definition of mental health (extreme, incapacitating, disabling, alienating suffering etc.). (Provisional version from policy paper Disability and Mental Health, 2010).

7. There are many vulnerable population categories. Here we have chosen to deal with a certain number whose particular problems are dealt with by HI.

8. The definition and representation of 'Child' in Rwanda seems very wide. A person is considered a child until he/she reaches the age of 21. But a person can be considered a child (even after the age of 21) if he/she is not independent, not married and has not yet had a family of his/her own. The majority of children who are heading households here are aged between 20 and 25.

have died (including deaths from AIDS). These children experience a range of psychosocial problems such as isolation, thefts, rights violations, poverty, the inability to attend school, and the obligation to take on a parental role with their siblings. They suffer from trauma associated with loss of their parents and often show signs of depression and are then confronted with relational difficulties, and severed links with the community.

- **Women subjected to violence** (domestic violence, rape): during the genocide, women suffered violent and serious sexual assaults, which continued to be perpetrated even after the genocide. They have been humiliated and often live with the unmentionable secret of their rape. Their distress manifests itself as a loss of self-esteem, signs of depression and some present Rape Trauma Syndrome (RTS). The sexual violence suffered leaves 'unforgettable and permanent' scars should she become pregnant or contract HIV/AIDS.

- **Unmarried mothers:** these young girls have mostly become unmarried mothers as a result of abuse and sexual violence or due to lack of information on reproductive health. They then face difficulties of a legal and judicial nature with regard to the recognition and registration of the child in civil law. From a psychological point of view, the acceptance of an unwanted child creates ambivalent feelings towards the child. Given their young age, they are often not sufficiently mature to take on the parental role. Since the status of 'unmarried mother' has no social recognition in the community, they very often come into conflict with their families and are not supported by their parents, friends and families. Some also have to cope with sexually transmitted diseases (STD) including HIV/AIDS contracted during sexual abuse or relations.

- **Prostitutes:** these women, mostly living in towns rather than in rural areas, are poorly thought of by society and are widely stigmatised. They are mostly from underprivileged areas and have been abandoned by their families as children. They are also exposed to STDs, including HIV/AIDS, as a result of their high-risk behaviour with customers. These women often live in precarious situations, isolated and

rejected by their circle of family and/or friends.

- **Children and adolescents affected by HIV/AIDS:** as a consequence of rape and high-risk behaviour, HIV/AIDS has contaminated a number of families, infecting some children and affecting the others. These children suffer rejection and exclusion caused by the stigma associated with the illness (for example, other children refusing to play with them at school). They have problems associated with taboos surrounding the illness (absence of diagnosis), as well as problems complying to antiretroviral treatment.

- **Young people in precarious situations:** following the genocide, many children left the rural environment to take refuge in the towns and now find themselves in precarious situations. Left to themselves, they adopt high-risk behaviours, consuming addictive products (alcohol, drugs) and live by stealing and begging. Growing up without any parental guidance, considered to be marginal and rejected by their community, they have few opportunities to integrate into society.

- **Widows (from genocide, HIV/AIDS):** these women have to bring up their children alone on the death of their spouse and have to deal with the problems related to this (due to the absence of a paternal authority figure). Most of them suffer from problems due to having been unable to grieve or to complete the grieving process and show signs of depression and a lack of self-esteem. Some of them also have to live with the stigma of HIV/AIDS.

In order to better understand the psychosocial distress and difficulties facing these vulnerable people, it is necessary to look at the background to the society in which they live.

A COMPLEX SOCIOPOLITICAL CONTEXT

'Nothing and nobody has been spared. Women, children and elderly people were exterminated, not because of anything that they had done, but because of what they were.'

(Munyandamutsa (2001) in CAFOD, p.21, 2009).

The country has experienced a series of tragic events in its recent history. The war which started in 1990, lasted for four years. The genocide of the Tutsis in 1994 resulting in the extremely violent killing of more than a million people on the basis of the community they belonged to, or because they opposed the genocide. The massacres were carried out by the army and police force, and by extremist militias but also by a significant proportion of the population - a figure of 800,000 people who may have participated in the slaughter is cited by the authorities. This is the distinctive feature of the 'Rwandan case'. The genocide also triggered unprecedented population movements. In just a few weeks, 1.5 million people took refuge in bordering countries where they experienced extremely difficult living conditions with omnipresent violence resulting in numerous victims. Since 1995, more than one million people, both long-standing exiles and recent refugees, have returned to Rwanda and need to find their own space in a country that is already densely populated.

All taboos and boundaries were lifted; society no longer fulfilled its symbolic protective function. This resulted in acts of extreme violence such as 'rapes were committed systematically on Tutsis women used as a weapon of war by assailants carrying HIV/AIDS' (Kayiteshonga, 2006, p.12), the disembowelment of pregnant women, genital mutilation and the defiling of corpses, causing unthinkable and unspeakable distress.

The attack destroyed not only specific cultural characteristics (desecration of holy places, destruction of cultural objects) but also the 'culture in its most fundamental sense', i.e. that which gives human beings their humanity (Baqué, 2002).

The consequences of genocide are therefore unprecedented and seen on both individual and community scale:

Concerning the individual, the survivors are traumatised by the atrocities committed against and by their friends and relatives, they feel the distress and guilt of the survivor: they are disoriented and have lost all points of reference (temporal and spatial) and values. They are neither dead (having escaped the massacre) nor living (having lost the right to exist as a human being). Hence the painful question of identity: "Who am I?" accompanied by a feeling of shame at their existence. The resulting disorders are varied: some develop depressive conditions, anxiety, hypervigilance, intrusion phenomena related to memories of the traumatic event, revivification episodes, somatoform disorders and sometimes decompensation.

Concerning the community, the genocide destroyed every possible link between its members. Some manifest reactions of fear and mistrust towards others, their neighbour could well have been their killer. The so-called 'pillars' of the community (leaders, teachers, parents, etc.) were also affected, and are no longer

able to assume their 'containment'⁹ and 'social regulation' functions. The mechanisms (communication, solidarity, conflict management) that allowed the community to function have been destroyed. This tears apart the social fabric that forms the basis of Rwandan society.

The government implements a strategy for the reconstruction and development of the country.

The government has instigated a policy of Reconciliation¹⁰, implementing actions to rebuild links within the community, without forgetting the tragedy that has scarred the country and its people. This policy has resulted in the setting up of a National Week of Mourning - during these days of commemoration the Rwandans come together to mourn the loved ones they have lost (where bodies or bones have been found and identified) with ceremonies for the exhumation and burial of bodies. Grieving week is a sensitive time and often triggers revivification episodes in the survivors.

A NEED TO REBUILD COMMUNITY LIFE

'Kubaho (to exist, to live), Gutunga (to have), Gutunganirwa (to live happily, peacefully and in prosperity)¹¹ - these are the principles that define the meaning of life for Rwandans.

The individual, in order to implement these 'three principles of existence' relies on his family because he only has meaning through his relationships with others. He only exists through the community he belongs to and through his family: "The subject has only very little autonomous existence. He has no identity other than that which is assigned to him by the collective will." (Baqué, 2002, p. 8)

Due to this, in Rwanda, the family is the 'founding' nucleus of the individual and the community and "(...) is characterised by soli-

Still with the aim of rebuilding the country, the Rwandan State has maintained the tradition of the Umuganda (community work that takes place on the last Saturday in the month) assigning it with a more defined social function focused on reconciliation, where the inhabitants of the community come together to work on a single project (e.g. land clearance, bridge building).

Finally, the State has also applied the traditional judicial mechanisms of the Gacaca courts to judge people suspected of having been involved in the genocide.

These efforts towards reconciliation and reconstruction have not gone unhindered, some people still fear their neighbours (fear of denunciation) or are engaged in the difficult task of working through their grief and 'forgiving' the killers.

The trust and solidarity between neighbours within the community needs to be reinstated.

curity, mutual support, social visits and lifetime aspirations and has the ultimate purpose of perpetuating the human species. This is the basis for mental health and carries the meaning in the life of a Rwandan." (Nothomb (1965), in CAFOD, p.12, 2009). It is this meaning that has been damaged and destroyed by the genocide.

When families were destroyed, individuals were no longer able to rely on the community, as defined by S. Gasibirege (2008) in: "a process by which people spend time with each other and work together up to the point where they have formed a group with a sense of its own unity (geographical proximity, ethical, cultural and moral reference points) and come to feel united with each other and to erect a symbolic

9. Physical and psychological 'Containing' in the sense of the function of 'containing shell and excitatory shield' defined by Anzieu in Moi Peau (1985).

10. The National Commission for Unity and Reconciliation (CNUR) was created in 1999 to fight discrimination and to eradicate the harmful consequences of the genocide on the Rwandan population.

11. Penser le Dispositif Thérapeutique dans le Malaise d'une culture amputée (Consideration of the Therapeutic System in the Malaise of an amputated culture) Psychosocial Programme Publication from CAFOD and its Partners in Rwanda, p.4-5, Kigali, March 2009.

boundary which separates them from others and delimits their meeting place”¹².

Nevertheless, the community life damaged by the genocide is gradually being rebuilt, with links reforming and renewed trust between its members, with the ultimate aim of reestablishing the three pillars on which it rests: communication, solidarity and conflict management¹³.

Communication is the sharing of values and traditions, i.e. ‘everything’ that connects people. Civilities lost during the genocide are slowly returning, with neighbours exchanging greetings once again and asking after each other. These are formal or informal visits (gusura) to one’s neighbours to tell stories, the sharing of words but also of non verbal communication between people, simple gestures to increase closeness and share information.

Solidarity includes gestures for the community, doing favours for people and providing mutual support, collective activities such as ubudehe, which involves farming together the neighbour’s field, guheka, in which the neighbours get together to carry a mother-to-be on a stretcher from her home to the maternity hospital or ward, and umuganda, national collective work mobilising the whole community around a one-off project such as building a bridge, repairing a road, etc. For weddings (ubukwe), the family and neighbours are invited. Traditionally, the whole family must be represented and, if a member is missing, a willing neighbour steps in as a substitute, taking on the role of the absent member of the family at the ceremony.

Conflict management is the process used to deal with anything that may adversely affect solidarity within the community. When an incident occurs between two parts, they are brought together with a community leader, an honest and upstanding person, to discuss the conflict. At the end of the discussion, the injured party retains their dignity and obtains redress, whilst the guilty party receives a corrective punishment (icyiru). Order is thus re-established through a regulatory system within the community by community representatives, identified as being influential, respected and listened to within the community. Other more informal conflict management mechanisms exist - families and neighbours living close to each other help each other to resolve problems in the event of family conflict, for example.

In the context of the reconstruction of the country and of reconciliation, the community system and the different existing practices are gradually being restored to bring individuals back into the community and rebuild the links between them. At the same time, since the individual is no longer ‘held’¹⁴ by his community when dealing with traumatic distress, the Ministry of Health has decided to put into place a national mental health policy to try to respond to the psychological needs of the population.

12. Definition given by S. Gasigibere at a training session on Care for communities with trauma, for the professionals of HI and partners, Kigali, 2- 4 January 2008.

13. Gasibirege S., Approche Communautaire en Santé Mentale, (Community-based approach to Mental Health), Guides to Community Mental Health, Community Mental Health Programme, Rwanda National University, p. 19, 1998.

14. in Winnicott’s sense of ‘holding’ (Winnicott, 1969).

A COMMITMENT TO A NATIONAL MENTAL HEALTH POLICY

Following the terrible psychological consequences of the 1994 genocide, the number of consultations has increased dramatically, forcing the government to find an urgent response to a mental health problem that was becoming a public health issue. The government became aware of the scale of the psychological distress affecting the Rwandan population and decided to set up a system for the care management and promotion of mental health for the population.

Thus, the Minister of Health, with participation from the WHO, defined a National Mental Health Policy in 1995, for decentralisation which aimed to integrate mental health services into basic structures (health centres) to facilitate access to mental health care on the primary health care level.

The national mental health policy is managed by the national mental health programme, but its application has been somewhat delayed. The programme today includes two referral services (Ndera Psychiatric Hospital and Psychosocial Consultations Service - PCS). The district level comprises 6 Operational Mental Health Areas (OMHAs) and 43 District Hospitals.

At community level, it comprises of one Health Centre for each sector as well as several health

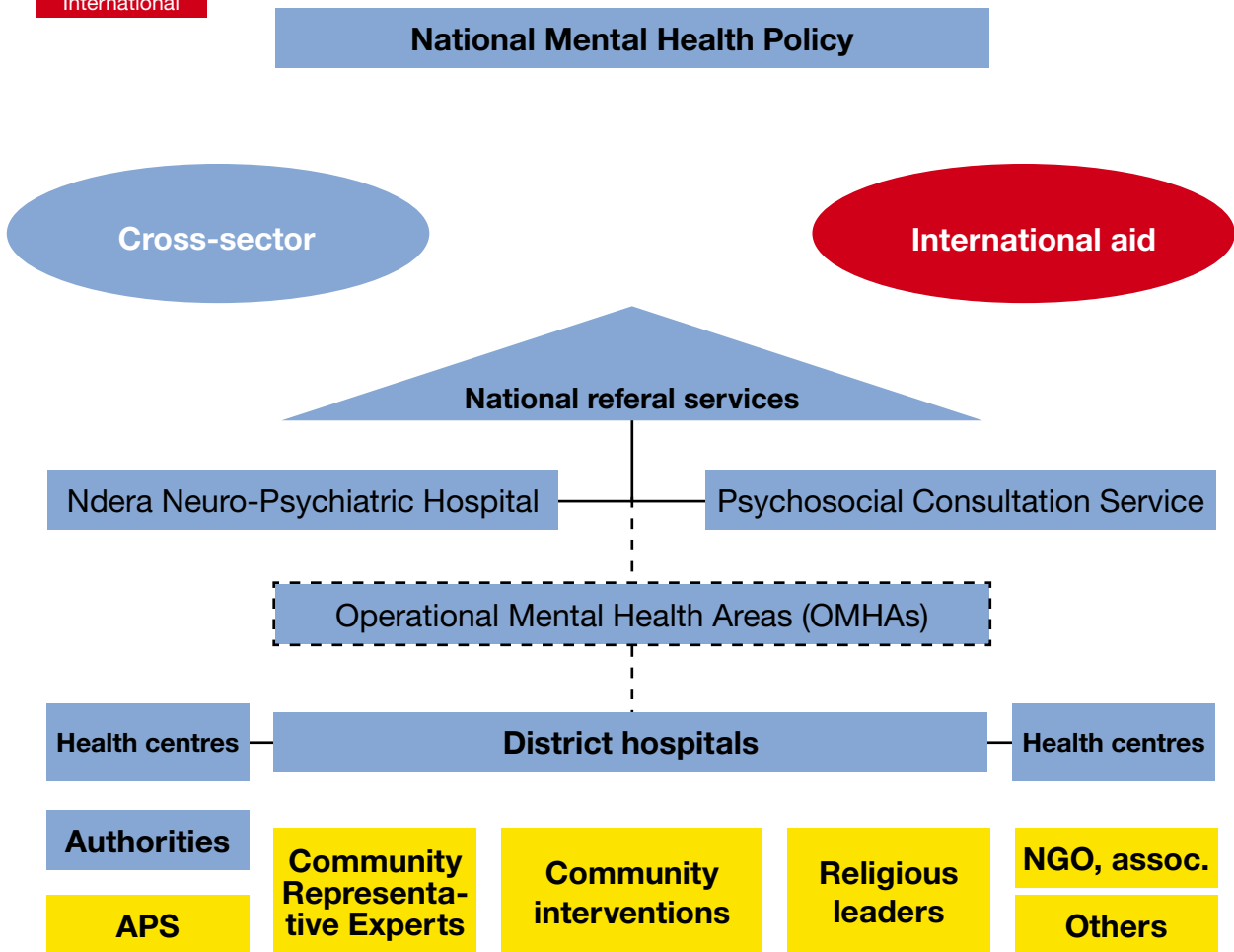
stations for the cells. The national programme has also trained community health workers (in reproductive health, hygiene, malaria, etc.) as well as psychosocial workers (in mental health, running support groups) to operate at community level.

The document 'Health Sector Policy - Government of Rwanda – February 2005' specifies in point 4.6.7 that "The Government of Rwanda will review the mental health policy and develop a strategic mental health plan for ensuring that mental health services are integrated into all health structures of the national system and that mental health problems are cared for at community level. The Government will develop standards and directives for integrating mental health into primary healthcare and establish a mental health service for children. Cross-sector collaboration between sectorial ministries and between the Government and the NGOs will be strengthened".

Currently, civil society is taking over at community level and several international and national organisations, some as a collective group¹⁵ are meeting the population's need for mental health care. This is the context, in terms of policy and national willingness to promote national health, in which the HI community mental health project is implemented.

Key :

Government
Community
International



Decentralisation of the national mental health policy¹⁶

¹⁶ This diagram is adapted from one taken from 'Reconstruction d'un système de santé mentale, Rwanda, 2007' (PDF), http://www.medecine.unige.ch/enseignement/apprentissage/module4/immersion/archives/2006_2007/travaux/07_p_rwanda.pdf; last accessed 11/10/09



Picture 8: A group of beneficiaries working the fields in the Mugina sector

THE CARING CAPACITY OF THE
COMMUNITY: THE FOUNDATION OF THE APPROACH

- ▶ An approach for community-based comprehensive trauma care management ----- PAGE 24
- ▶ Building communities' capacities by creating a 'network of focal points'----- PAGE 26

AN APPROACH FOR COMMUNITY-BASED COMPREHENSIVE TRAUMA CARE MANAGEMENT

The objective of this project is to improve the mental health of the Rwandan population in general and of children and adolescents in particular, in four intervention areas, using a community-based approach to respond to the various mental health problems associated with trauma.

In other words, this project aims to **deal with an issue in the field of Clinical Psychology, that of trauma, using a community-based approach to respond to individual problems and needs.**

The hypotheses of our approach are as follows:

- Our approach is based on one of the founding premises of the community-based approach that “any human community produces its own mental health, in the same way as it produces its own economy, political regime, judicial system, educational system, medical system, etc.” (S.Gasibirege, 1997, p. 87). We thereby assume that the **community can generate ‘good’ mental health through the actions that it undertakes in order to maintain and develop the well-being of its members.**
- Furthermore, as trauma generates psychosocial distress such as isolation, loss of self-esteem, a precarious social situation (professional instability, financial difficulties, homelessness) etc., we believe that **the community-based approach can respond specifically to these problems, using the existing positive resources within the community in question.**
- Finally, we have taken as our starting point the hypothesis that **psychosocial distress associated with trauma must be dealt with by comprehensive care management, i.e. by taking both preventive (primary prevention - raising awareness of mental health, trauma)**

and curative actions (secondary and tertiary prevention - individual and group therapeutic care).

In this way the project, by encouraging community participation and recognising the community’s care capacity, aims to restore social links and communication and to recreate mechanisms for solidarity within the community so that it can once again provide care for and ‘hold’ vulnerable people and improve their mental health.

This therefore involves identifying those persons who can take on the role of reference person in order to activate the ‘community lever’. As Gasibegere stated: “Any community has within it the specific local resources to react to an attack on mental health (...). Reconstruction of mental health for a community (thus) goes through an appropriate activation of its structures for communication and solidarity. These operate with the help of reference persons (...). Any person with influence in the community is a potential reference person, due to the actions that he can take with other members with the certainty of being heard”.

The approach therefore involves responding to the psychosocial distress associated with trauma, with a **community-based comprehensive (preventive and curative) approach:**

- directly: with individual and group therapies,
- indirectly: by raising awareness and training reference persons (in mental health, trauma, etc.) ; using a **psychosocial approach** implemented by a **multidisciplinary team**, dealing with economic, legal, psychological and social problems by means of acts of mediation with a ‘therapeutic aim’ (e.g. income generating activities).

Since trauma is “influenced by numerous interdependent conditions, such as econo-

mic, social, cultural, environmental and political conditions” (Bibeau (1999) in CAFOD, p.29, 2009), the provision of psychosocial care contributes indirectly to the psychological reconstruction of those suffering from the trauma. This intervention thereby makes it possible to act on the trauma, through acts of

mediation, because it is difficult, even impossible, for those who are in distress to work out and directly express (verbally) their traumatic experience (which is both unimaginable and indescribable), without risking getting ‘lost’ in it (threatening the newly-found sense of wholeness) and reliving the trauma.

BUILDING COMMUNITIES' CAPACITIES BY CREATING A 'NETWORK OF FOCAL POINTS'

As in many emerging countries, there are severe shortages of human resources in mental health (including psychologists and psychiatrists). With the aim of ensuring the sustainability of the actions implemented, the project includes **capacity building** through the training and supervision of professionals, based on the 'task shifting' model¹⁷. This pyramidal model is used for the training and 'professional development' of non-professionals in order to **incorporate access to mental health care for beneficiaries on the primary health care level**¹⁸.

From this perspective, the identification and training of reference persons and focal points is used to establish a '**network of focal points**' to ensure the sustainability of the actions implemented. These people (at the 'base' of the pyramid – i.e. the community) are supervised by professionals from the project team, who are trained, accompanied and supervised in turn by the professionals and expert advisers (psychologists, psychiatrists) present in Rwanda or from HI Head Office.

The three fundamental principles of the project

1. Joint action and Multidisciplinary teams

Working in joint action with partner organisations creates the alliances needed to facilitate the project implementation whilst building their technical and organisational capacities.

The intervention of a multidisciplinary team makes it possible to meet the different needs of the beneficiaries, including the economic, legal, psychosocial and psychological aspects.

2. The focal points network

The identification and training of reference persons and focal points to set up a 'network of focal points' in order to use local resources and ensure the sustainability of the project implemented.

3. Intervention in a limited area

Intervening in a limited area allows the project team to ensure the effectiveness of its actions. (This principle was taken from the lessons learned when setting up the psychosocial activities for the previous project).



Picture 9: A group of beneficiaries in the N'dera sector harvesting the first pineapples from their plantation

17. Task shifting aims to entrust a less-qualified group of professionals with the tasks of a higher level group and to build their capacities through training and supervision.

18. Patel V., Integrating Mental Health in Primary Care : Task-Shifting to Scale Up Services for People with Mental Disorders; in Mental Health in Primary Care: Enhancing Treatment and Promoting Mental Health, p. 34-35, World Mental Health Day, October 10, 2009.

▶	Increasing the active participation of the local authorities and reference persons in the community (exploration phase) -----	PAGE 28
	The facilitation role of local authorities -----	PAGE 28
	Reference persons as a ‘cornerstone’ -----	PAGE 29
▶	Analysing the problems and bringing people in peer groups (Identifying individual issues phase) -----	PAGE 30
	Analysis and selection of problems -----	PAGE 30
	Formation of peer groups -----	PAGE 30
▶	Involving the beneficiaries as stakeholders working with the reference persons to resolve the problems and apply solutions (implementation phase) ----	PAGE 31
	Involvement of the direct beneficiaries through active participation in the project-----	PAGE 31
	Integration of the solutions identified by the beneficiaries into concrete initiatives by the reference persons-----	PAGE 31
	Selection of focal points -----	PAGE 32
	Support and capacity building for professionals and the community -----	PAGE 32

**“We went in to reawaken the existing strengths, to enable the community to look after itself”
Member of the project team.**

This stage is a crucial time for setting up the project and establishing links in **joint action** with the partner organisations and at all levels of government, from the district to the cell²⁰. This phase makes it possible to precisely **map** the intervention areas, explain the approach (HI does not contribute financial/material support but an approach to render the community ‘competent’) and identify reference persons with help from the local authorities and the beneficiary population through **outreach work**. This approach method is fundamental in order to reach vulnerable people who live isolated and hidden.

THE FACILITATION ROLE OF LOCAL AUTHORITIES

The decentralised system makes it possible to work together effectively with the local authorities, this joint action work makes it easier to identify and access the target population (reference persons and beneficiaries). The local authorities play a facilitating role between the target populations and the project team.

“I helped to identify them, we helped to understand the administrative body, and the general

“We mapped the area, walking under the sun, climbing up and down the hills, wondering how much longer we were going to keep walking.(...) The authorities helped us by giving the names of reference persons and potential beneficiaries who would be able to take part in the project.(...) The community-based approach uses a mobile team who go out to people, we are present in the field, we go to approach people and groups, we aren’t waiting in offices for them to come to us.” **Project Team Area Manager.**

overview of the sector, and with communication between the vulnerable groups and the project. I facilitated communication between the group and the team and prioritising of groups. This is fundamental support from the local authority for working together and setting up the project.” **Local authority, Bushoki.**

19. The community stakeholders defined as ‘local authorities’ and designated as such in Rwanda are the heads of social affairs, the executive secretaries of the sectors, the cooperative managers, youth work managers, security managers.

20. Since 2000, Rwanda has implemented a policy of decentralisation of its administrative organisations which are structured as follows: Provinces and Town of Kigali (4+1), the provinces are divided into Districts (30), the Districts are divided into Sectors (416), the Sectors are divided into Cells (2148) and the Cells contain villages (Umudugus). Note de conjoncture : La décentralisation et services aux populations, Partenariat pour le développement municipal, September 2007, (PDF) http://www.pdm-net.org/fiches_pays/Rwanda%20_Sept07_.pdf, last consulted 19/10/09.

REFERENCE PERSONS AS A 'CORNERSTONE'

These persons identified within the community by the project team in liaison with the partner organisations and the local authorities are selected for their integrity and level of trust.

“This mother who is in this house, I think that if I am beaten by my husband, this mother will help me and won't talk about it in the community. She has this integrity. Everyone trusts this person; she has a positive image in society.”

Project Team Area Manager.

By raising awareness of mental health problems, they identify those at risk and vulnerable (child-headed households, unmarried mothers, etc.) and also have the function of helping to manage and resolve 'grass roots' conflicts and play a role in supporting people through the 'project induction'.

ANALYSING THE PROBLEMS AND BRINGING PEOPLE IN PEER GROUPS (IDENTIFYING INDIVIDUAL ISSUES PHASE)

This phase consisted of identifying the major problems in each area on which the project team and its partners have focused their actions

ANALYSIS AND SELECTION OF PROBLEMS

The areas are vast and the problems numerous. Meetings are organised to allow for the recording, analysing and prioritising of problems in each area, in collaboration with the local authorities and reference persons. Pro-

FORMATION OF PEER GROUPS

This aims to help them out of isolation and to restore communication within the community. In addition, working in a peer group helps to draw out the specific requirements and initiatives for each set of problems. Furthermore, the group training makes it possible for each individual to be recognised and identified by his peers, a necessary step towards rebuilding self-identity.

“Before the vulnerable groups were known to

as well as forming peer groups of vulnerable people.

blems concerning child-headed households, unmarried mothers, young people in precarious situations, children infected or affected by HIV/AIDS are raised.

be there but they weren't grouped together. The grouping allowed the children to be recognized, with their problems, as someone approaches them and meets them. The children have understood that they have problems and have begun to look for solutions. They are grouped into associations, in farming, crafts, and animal rearing cooperatives. We hope that they will be able to improve their living conditions using what they have.” **Head of Social Affairs, Bushoki.**

INVOLVING THE BENEFICIARIES AS STAKEHOLDERS WORKING WITH THE REFERENCE PERSONS TO RESOLVE THE PROBLEMS AND APPLY SOLUTIONS (IMPLEMENTATION PHASE)

This is the phase for implementing care management activities for the beneficiaries such as support groups, training and awareness raising, psychosocial support, etc. relying on the existing reference persons to rebuild the fabric of the community but this is not sufficient in

itself to achieve a lasting improvement in the psychosocial conditions of vulnerable groups. In order to fully activate the community lever, the beneficiaries must get involved and be active within the community, taking responsibility for their own care.

INVOLVEMENT OF THE DIRECT BENEFICIARIES THROUGH ACTIVE PARTICIPATION IN THE PROJECT

The support mechanism implemented allows beneficiaries to move from a 'passive' stance (receiving aid) to an 'active' stance (with power to act in their own lives - self-empowerment). The project induction sessions followed by support meetings bring people into a process of change highlighting their own ability to act in order to identify the 'field resources' (internal, external - human or material) for resolving problems. They change their status from 'passive and plaintive subjects' to an active stakeholders analysing and resolving their own difficulties.

“When we were in the process of developing the projects, I thought that they were going to fund us. But in the end, they showed us how we could obtain bank loans. They explained the process to us for taking out a bank loan and the banks came to explain to us too. The project personnel explained to us why they don't give money and that, on the other hand, they help people to find the means of working by themselves: we're really pleased about this and it has been very useful.” **Beneficiary, Ndera.**

INTEGRATION OF THE SOLUTIONS IDENTIFIED BY THE BENEFICIARIES INTO CONCRETE INITIATIVES BY THE REFERENCE PERSONS

The reference persons' initiate the project²¹ to identify the resources that they can implement to respond to the solutions found by the beneficiaries. This makes it possible to set up suitable interventions to respond to the needs of beneficiaries within the community itself, and to strengthen the solidarity mechanisms (e.g. a reference person offers to look after the child of an unmarried mother who has to go to work; or to give watering cans and hoes to a group that is starting to farm a field, etc.).

“It is necessary to have a link between what the beneficiaries want and what the reference persons can do to support the beneficiaries' life projects, thereby putting the beneficiaries themselves at the centre of the action.” **Rwanda HI Field Programme Director.**

21. The 'project induction' can be defined as a process of identifying and analysing problems with a view to finding realistic solutions that are applicable to 'act on' and resolve the problems encountered.

SELECTION OF FOCAL POINTS

Identified among the reference persons by the groups and the community, they have a **mediating function** between the beneficiaries and other bodies, making the appropriate referrals depending on the problems presented by the beneficiaries (e.g. family conflict, problem with administrative papers, etc.).

Each focal point is responsible for several 'groups' and plays an advisory role and a 'parental' role for orphans. This 'parental' function gives individuals structure and provides

them with reference points. The children can develop again within a protective framework on which they can rely in the event of difficulties.

"We are close to the groups for which we have responsibility. We help them in their ideas, they consult us when they have a life project. For those who have no parents, they are given guidance and support in the difficulties they face." Focal point, Bushoki.

SUPPORT AND CAPACITY BUILDING FOR PROFESSIONALS AND THE COMMUNITY

Awareness raising, training and various types of meetings allow the reference persons, focal points and local authorities to obtain information and to exchange their experience of practices on mental health problems and to think together about solutions to the problems.

Also, the different types of meetings (including supervisions²² and intervisions²³) are key moments for the project team professionals to think about how to exchange information about their clinical practice, to take a step back from it and to benefit from support for their practices.

Key Points of the Intervention Framework

Exploration phase:

- Mapping and outreach work
- Key role of local authorities
- Community representative experts as the "cornerstone"

Phase of identification of problems by area:

- Analysis and selection of problems
- Formation of peer groups of vulnerable people

Implementation phase:

- Active participation of direct beneficiaries
- The integration of the solutions identified by the beneficiaries into concrete initiatives from the reference persons.
- Selection of focal points
- Support and capacity building of professionals and the community

22. Supervision (individual or group) is a working method where the professionals explain the difficulties found in their clinical practice (relational, clinical, ethical, etc.) to an expert professional who leads the session assisting with the analysis of the difficulties described and suggesting areas of exploration and/or solutions, whilst relying on a framework of theory.

23. Intervision is a working session where a group of professionals supervise themselves without a supervisor (expert professional).

“It is not money that makes a man. I must first find out who I am.”

A partner organisation's (AFAK) vision of the HI Community Mental Health project.

“We were trained by HI and we brought these people together to discuss the problems that they have and problems are raised. How to find solutions? There were NGOs after the war who donated food and afterwards it was finished. But HI, what they have done by giving training is to help them to find a solution to the problem themselves - to understand their problem themselves and not to give money. (...)

The specificity of this project is to allow people themselves to identify their problems and to find the solutions themselves. (...)

During the war, the community and the social fabric were torn apart, they do not want to work together, there is a gap. HI has tried to identify the problems working together with the community. Even the local authorities at the start did not understand but now they are well informed. (...)

It is not money that makes a man. I must first find out who I am.”

▶	Guiding people through a process of reconstruction, by offering comprehensive care management (preventive and curative) from a multidisciplinary team	PAGE 36
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	Psychological support	PAGE 38
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▶	Building the clinical and organisational capacities of community mental health stakeholders (project team, partner organisations, focal points and reference persons)	PAGE 43
	Training of focal points	PAGE 43
	System for liaison between the focal points and professionals from partners organisations	PAGE 43
	Experience sharing meetings for reference persons and focal points	PAGE 43
	Supervision (group and individual), intervision, personal development and "time out" for members of the HI team	PAGE 44
	Cross-sector meeting	PAGE 44
	Meeting of Rwandan Collective of Parts Active in Mental Health	PAGE 44
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	In terms of clinical and organisational capacity building for community mental health stakeholders	PAGE 46

To tackle the psychosocial problems associated with trauma, a **multidisciplinary team** works to strengthen comprehensive care management, by looking at the various economic, psychosocial, legal and psychological aspects of the **psychosocial problems** people encounter. Indeed, psychosocial problems associated with poverty and instability dimi-

nish the effectiveness of therapeutic work with people suffering the after-effects of trauma and in some cases may even aggravate their condition. As long as the basic conditions for survival (food security, housing) are not met, it is difficult for people to think about and do something about their traumatic experiences to begin the process of reconstruction.

The preventive and curative activities undertaken by the multidisciplinary team include:

RAISING AWARENESS IN REFERENCE PERSONS AND FOCAL POINTS

All key persons identified in the community (teachers, priests, parents, school class leaders, community health officers, etc.) attend mental health and trauma awareness raising sessions (e.g. to control the spread of revivification episodes in classes). These awareness raising sessions also allow the reference persons to share their experiences, and encourage them to exercise a positive influence in the community and to increase their awareness of the problems it faces.

“I was affected by the awareness raising. I thought that if someone has a problem, he

needs to cry with others. I began by myself, I was ill and maybe these people there are also ill. The children who live in the street have problems, there is a reason they are living in the street. I had conflicts in my family, with my husband, children and neighbours. (...) I felt I should continue in this way to approach others and to make my friends and family aware. I was very moved and I wanted to approach young people, prostitutes, I dared to approach these young people because I had just been trained and I had developed enough self-esteem, I felt I had strength to help at home and then to help others.” **Reference person, Kimihurura.**

‘PROJECT INDUCTION’²⁴ FOR GROUPS

The ‘project induction’ for groups, led by an associative development counsellor and a psychologist, is used to induce a constructive dynamic for their future, through the identification then the analysis of the problems that they experience (e.g. literacy problems) and also of the solutions that would allow them to resolve these problems (e.g. finding people within the community - priest, teacher, etc. - willing to teach them).

Through the ‘self-empowerment’ process, these project induction sessions lead the groups to move beyond the problems they face, to recover their self-confidence and to believe in their capacity for action. This process leads the groups to change and to integrate into the community, particularly by developing rational alternative thought processes and reappraising their beliefs about themselves. Once the solutions have been identified, the beneficiaries

24. The ‘project induction’ can be defined as a process of identifying and analysing problems with a view to finding realistic applicable solutions to ‘act on’ and resolve the problems encountered.

are followed up on and supported by the focal points in the application of the solutions.

“One can grow with the little one has. With the work that they [the groups] do, they can be productive if they are at peace with themselves. A

LEGAL SUPPORT

Legal support takes the form of awareness raising sessions led by the Psychosocial Counsellor, also trained in law, who informs the people of their rights and duties as well as through advocacy with the local authorities (cell, sector) and district authorities. These activities reestablish people’s rights and fulfil a ‘therapeutic’ function by recognising that their rights have been violated (e.g. recovery of stolen land, registering the child of an unmarried mother). Some cases are defended at district level.

“They have gained awareness of their rights especially as many of them lost their parents whilst they were still very young. And we found that some of them were unaware that they had been subject to rights violation. A concrete example is the situation of a child whose inheritance had been stolen. He was helped to seek justice and recover his land.” **Focal point, Mugina.**

“At birth, children are registered in the father’s name but unmarried mothers do not want to go

person can smile even if he doesn’t have very much. But as long as he has confidence, he will grow if he knows that there is someone encouraging him. (...) With someone helping you and caring for you, you can rejoin the community.”

Project Team Development Adviser.

to the authorities. With legal support, the focal points have show that it is a child’s right to be registered on the register of births. If the father agrees to recognise the child, they will bear the father’s name.” **Focal point, Bushoki.**

In this way, in the event of legal problems, the Psychosocial Counsellor acts with the beneficiaries to help them defend their rights. The function of the **Law as a ‘compensating third party’** (symbolically represented by the Psychosocial Counsellor) acts as a **mediator** to manage existing conflicts (rape, theft, abuse, etc.) by verbal means, rather than resorting to the violence of a physical confrontation. This mediating role also allows members of the community to ‘reinternalise’, to reappropriate the prohibited²⁵ and to distinguish ‘right from wrong’.

“We have become aware and informed that our rights were not respected and were violated by our families. We are fighting for our rights to be respected and E*** [Psychosocial Counsellor] has supported us.” **Beneficiary, Bushoki.**

25. It should be remembered that, during the genocide, many taboos and prohibitions were broken, resulting in a number of instances of rape, abuse and despoliation of goods within the community.

PSYCHOSOCIAL SUPPORT

The purpose of the psychosocial support is to 'promote the exercise of citizenship' and to reduce social inequalities by means of **mutual support** between members of the community (system of common funds for health insurance contributions, or for the reconstruction of a roof, etc.). The mutual support and community **solidarity** then make it possible to improve living conditions, quality of life and individuals' mental health.

The Psychosocial Counsellor visits people in their homes to help to resolve family conflicts, to support people approaching the local

authorities in the event of problems (access to schooling, membership of health insurance scheme, etc.).

For antenatal consultations for example, pregnant women can only access care by going with their husbands. This is problematic for unmarried mothers, since often the father does not acknowledge his paternity. In this case, the focal points accompany unmarried mothers to health centres and ensure their pregnancy is properly monitored.

PSYCHOLOGICAL SUPPORT

► **Individual and group consultations:** the therapeutic mechanism proposed firstly consists of care management through support groups for the beneficiaries/reference persons who require it; the purpose of this mechanism is to bring isolated people together in order to share their problems, the distress associated with the trauma and to recreate social links. Some beneficiaries also request individual consultations or these may be proposed by the psychologist where he identifies a person who finds it difficult to express themselves in the group. Where necessary, the psychologist refers the persons concerned to the appro-

priate care structures (district hospitals, partner organisations, etc.)

"I loved (the support group) because I was drained at the end, it released me from my isolation. I left behind this situation of vulnerability for one of well-being. It allowed me to leave my discomfort behind. I was like a 'sick man', I wasn't well." **Beneficiary, Bushoki.**

"The support group was a window that has now allowed me to have a family and children and to gain weight. It was as if I was non-existent, before the group, but with the support group, I



Picture 10: Support group in the Mugina sector

exist. I wondered who was going to accept me in the state I was in before. I had confidence in myself.” **Beneficiary, Kimihurura.**

Other therapeutic mechanisms, closer to Rwandan practices, have been considered and adapted such as “youth solidarity and sharing meetings”²⁶ or the National Week of Mourning.

► **Youth solidarity and sharing meetings (Inkera):** these therapeutic groups bring together children and adolescents for ‘sharing sessions’. The groups of young people meet up in order to recount and share personal histories, to tell of their experience and to express their distress but also to exchange ideas on solutions or strategies to deal with these things. This meeting constitutes a form of ‘**brief therapeutic intervention**’: the simple fact of coming together with one’s peers, being able to identify oneself and recognising oneself in another’s stories already in itself provides ‘relief’.

► **Preparation and support for National**

Mourning ceremonies: the team is present at the commemoration sites in its sector and plays a support role to **prevent revivification episodes**²⁷ or to provide care if they occur. This distress can appear in the days preceding the commemoration at the point of exhumation of the body or during the days of commemoration when the bodies are buried.

► **IGA: a therapeutic activity**

“I like to see them [children] when they go to farm the land. They tell each other about their lives, their stories from the past and share their experiences whilst working the land. There is something therapeutic about it. It was difficult before, they didn’t talk about it in the support group. They share their problems and it’s therapeutic.” **Project Team Area Manager.**

The income generating activities are used as therapeutic support for working indirectly on the trauma. The Associative Development Counsellor leads this activity with a psychologist. The psychologist is responsible for encou-



Picture 11: Group of beneficiaries basket weaving in the Bushoki sector

26. These meeting sessions are inspired by the ‘solidarity camps’ organised in Rwanda by the National Unity and Reconciliation Commission. The solidarity camps (Ingando) bring together Rwandans who have been repatriated after having been exiled for taking part in the genocide, in order to get them to reflect on their acts, to introduce them to the principles of tolerance and to prepare them for social rehabilitation.

27. The revivification episodes are repetitions of the traumatic experience, reactivated suddenly by a stimulus/external factor (noise, smell, anniversary date, etc.). In Rwanda, these crises occur frequently as part of the Commemoration celebrated each year. They are expressed as hallucinations, nightmares, violent emotional outbursts (anxiety attacks, panic attacks, aggressive reactions, crying, screaming) often ‘distressing to see’ and difficult for ‘witnesses’ to cope with. The phenomenon of revivification episodes observed during this period often spreads from one person to another, particularly in school classes.

raging each of them to express themselves, notably concerning the suffering (obstacles, frustrations, discouragements, etc.) experienced during these activities. As everything is connected in the psyche, this is inevitably related to the trauma suffered.

By supporting the person in **constructing their account** of the suffering they experience on a daily basis, the psychologist sets up the conditions in which the subject will be able, step by step, to distance themselves from what has happened, and in particular from the events at the source of their trauma.

The setting up of the IGA meets people's 'survival' needs (eating, drinking, sleeping), providing the beneficiaries with a certain level

ECONOMIC SUPPORT

► IGA: socioeconomic inclusion

When the 'project induction' sessions, identify an economic problem, the groups of beneficiaries often opt for the creation of income generating activities (growing pineapples or rice, basket-weaving, selling coal, etc.) to resolve their problem. The Associative Development Counsellor trains and supports these groups to prepare a microproject, request funds etc.

These IGA have thus allowed several groups

of material security. This then makes it possible to tackle other (non-material) problems in the support group (because it is more difficult to think and speak with an empty stomach).

"There were less questions regarding poverty in the support groups and we were able to talk about more psychological issues. Before the team organised awareness-raising session when [the children] didn't have any food to eat, and the children asked "Can you eat words?"
Project Team Area Manager.

Therefore, growing things together and working the fields, brought people together in a common action leaving them space to 'think' at other times.

(e.g. child-headed households or unmarried mothers) to gradually reintegrate the community and to provide for their everyday needs.

"The hauliers trade coal and the profit is invested in another project. They will explain their project. At the start, these young people were taking marijuana and now they are developing their community. These young people have changed."
Project Team Associative Development Counsellor.



Picture 12: A group of beneficiaries working the fields in the Bushoki sector



Picture 13: A plot of land put to good use by a group of beneficiaries in the N'dera sector

► Capacity building for beneficiaries

The Associative Development Counsellor teaches the beneficiaries about the concept of saving, group organisation (leadership and management), the organisation of cooperatives to build their capacity to manage their money and to prioritise spending to save money.

“The Handicap International partnership took me out of isolation. This was also a great opportunity for my own development since we were trained in the development of microprojects. We were also put into contact with micro-finance institutions to give us more training and prepare us for coping with life.” **Beneficiary, Ndera.**

ADVOCACY

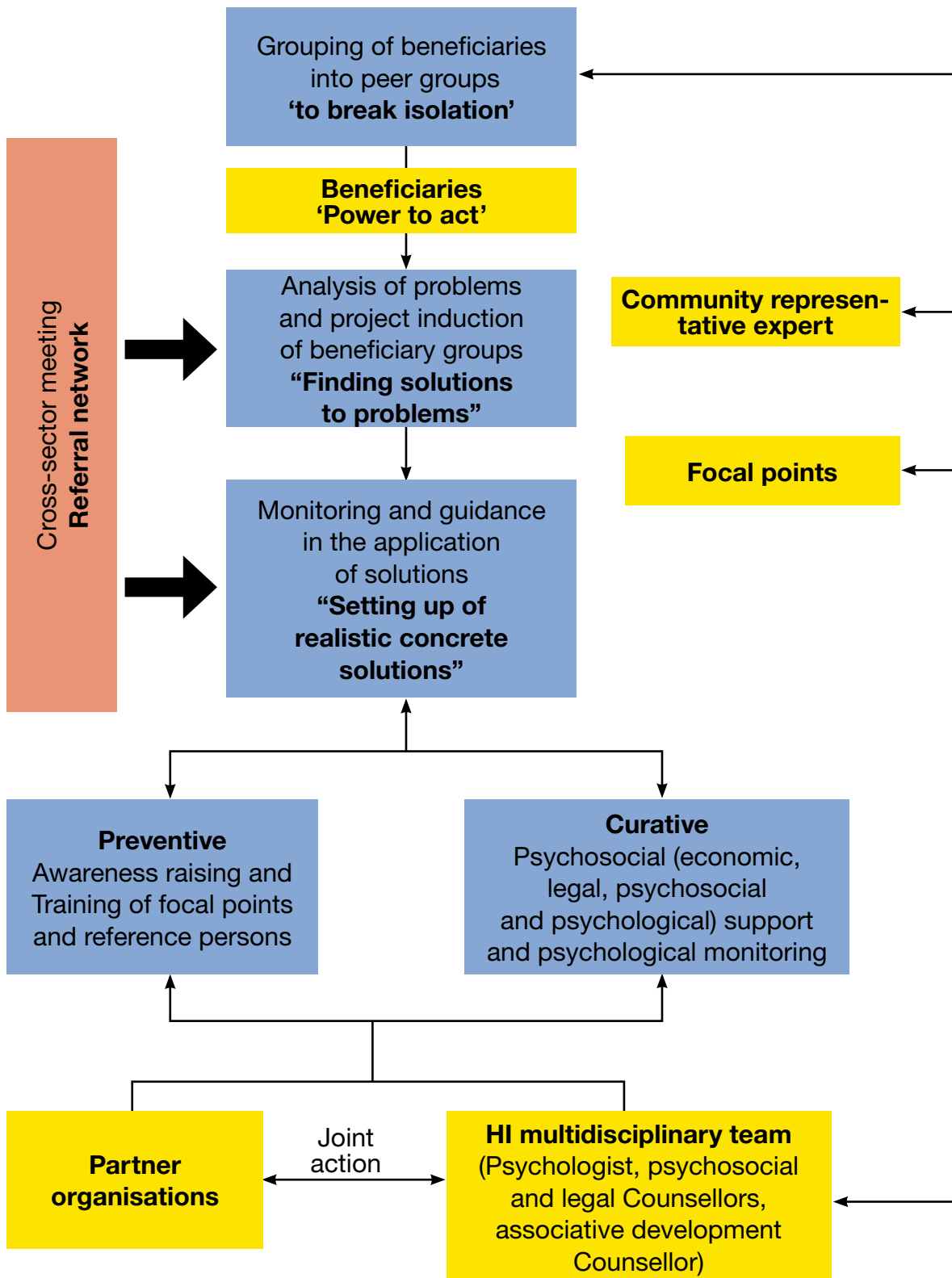
This is a cross-cutting activity, performed by the Psychosocial Counsellor, in the various economic, legal, psychosocial and psychological intervention areas. Concerning economic support, this involves advocacy to banks for funding, to the authorities to find land etc. Advocacy to the community to reduce the stigma of mental health is also undertaken by the psychologists of the project team.

“A child has a mental illness. It is necessary to help the community to recognise the situation of the child, to advocate with the community for understanding of what is happening around this child and to see what care provision to adopt. It is necessary to act and to help this child and support him.” **Project Team Area Manager.**



Picture 14: Visit of a group of beneficiaries in the Kimihurura sector

System for community mental health care management



Legend

	Capacity Building Activities
	Care Management Stakeholders
	Care Management Activities

TRAINING OF FOCAL POINTS

This involves training the focal points in various subjects related to mental health (trauma, psychological development of the child, abuse, active listening, etc.) thereby building their capacities both to raise the awareness of the reference persons, and to identify, provide care for and/or refer the beneficiaries.

“At my level too, something has changed. One day I was a community health officer. Then something small but important changed due to

the training that we had on mental health. We spoke a lot about the trauma, because you can see someone who appears to be in good health even though their mind is overwhelmed. But they still give certain indications of trauma. I find that if I can meet an isolated child and approach him to find out what is wrong; I have all the skills I need to allow me to help and he will definitely open up to me.” **Focal point, Bushoki.**

SYSTEM FOR LIAISON BETWEEN THE FOCAL POINTS AND PROFESSIONALS FROM PARTNER ORGANISATIONS

When monitoring and supervising the beneficiaries the focal points have close contact with professionals from partner organisations to inform them of referrals or provisions made in the intervention area (e.g. in the event of revivification episodes in the schools, the focal

points and a trauma counsellor from a partner organisation act together to provide care for the pupils, then to refer serious cases to specialist structures). This system encourages the exchange of information and strengthens the dynamic of the joint action.

EXPERIENCE SHARING MEETINGS FOR REFERENCE PERSONS AND FOCAL POINTS

These meetings allow reference persons and focal points to discuss the psychosocial consequences related to the genocide for both individuals and the community, to exchange their experiences concerning the most difficult cases that they encounter, to give them confidence in their role as an influential person and a representative expert for the members of their community.

“We practice in the same area, the problems are similar, but my skills allowed me to resolve

the problem. My colleague had the same problem but he hadn't resolved it. This was the time to share our knowledge, our successes, our failures, we come away with new working methods that we exchange with others. From the analysis of our practices, we can identify our limitations and call on the HI team to play their role and to act if we can't manage something.” **Focal point, Bushoki.**

SUPERVISION (GROUP AND INDIVIDUAL), INTERVISION, PERSONAL DEVELOPMENT AND “TIME OUT” FOR MEMBERS OF THE HI TEAM

With different frameworks and varying frequency (twice monthly, monthly, quarterly, and annual meetings) these meetings held to consider and share clinical practice are indispensable for supporting the professionals in the team in their interventions, strengthening their skills and preventing professional burnout. These meetings are led by different experts from various institutions (a Psychiatrist from Kigali University, HI Psychology Advisers, a Psychiatrist from the Mental Health Policy

Unit of the Ministry of Health).

“We talk about the difficulties encountered in the field, we need to discuss certain cases that pose a problem, I don’t know what to do any more, I’m overwhelmed and I don’t know what to do next, then I go to tell the group about my case. He [the supervisor] will develop theories related the practices, will help us to analyse the situation with areas for further consideration.”

Project Team Area Manager.

CROSS-SECTOR MEETING

This is organised with the various mental health stakeholders and makes it possible to constitute a network of professionals for each

intervention area and to set up a referral system.

MEETING OF RWANDAN COLLECTIVE OF PARTIES ACTIVE IN MENTAL HEALTH

A collective was formed in 2006 to set up a network of parts (religious entities, NGOs, State) active in mental health thus allowing them to speak about mental health issues and the progress in mental health in Rwanda. One of the objectives of the collective is to set up

advocacy for a mental health policy but this collective is not yet officially recognised by the authorities. One of the major obstacles is that the collective cannot group together both state structures and civil society organisations.

STRUCTURAL SUPPORT FOR PARTNER ASSOCIATIONS

The partner organisations receive support visits/advice from the Associative Develop-

ment Counsellor to train them in designing, managing and implementing IGA projects.

INVOLVEMENT IN ORGANISING WORLD MENTAL HEALTH DAY

HI provides technical support for the National Mental Health Programme organising committee (attached to the Ministry of Health), in order to prepare and share its expertise in mental health practice on this day. This event takes place once a year (in October), to raise

awareness amongst health services and civil society and government institutions to increase their involvement in promoting mental health. Participation in this event shows the legitimacy and recognition of HI’s mental health activities.

INTERMS OF COMPREHENSIVE CARE MANAGEMENT: PREVENTIVE AND CURATIVE**► The involvement and role of the various community mental health stakeholders (reference persons, focal points, local authorities²⁸, beneficiaries) in the care management system**

- It was necessary to bring together the beneficiaries in peer groups in order to take them out of isolation and strengthen the mechanisms for solidarity within the community.
- The beneficiaries can become reference persons and/or focal points. The identification and selection of focal points among the beneficiaries has been necessary to facilitate communication and collaboration with the groups of beneficiaries.
- The focal points played a 'parental' role then a mediating role, providing a protective framework on which the beneficiaries can rely.
- It should be noted that the local authorities were key stakeholders in mobilising the community and vulnerable groups. The legitimacy of and trust in the local authorities make them an effective channel for communication and awareness raising.
- The local authorities are qualified to play the role of reference persons but they are not sufficiently available (to accompany beneficiaries) to act as focal points.
- The direct and active involvement of the beneficiaries as stakeholders in care management has proved necessary to improve their living conditions (and therefore their mental health) and ensure the sustainability of the actions undertaken.
- The creation of an alliance and collaboration with the beneficiary's neighbours during visits to his home has proven necessary to facilitate the resolution of problems and provision of care for the beneficiary.

► Adapting the therapeutic system for care management and clinical practice

- In order to respond to all the human aspects that were fractured by the genocide, the care management of trauma using a traditional clinical approach is insufficient. It is necessary to offer psychosocial care management from a multidisciplinary team to help the person to rebuild.
- It was necessary to adapt the therapeutic systems and activities to the Rwandan context and practices (e.g. support during the National Week of Mourning).
- It was necessary to adapt the 'conventional' stance of the psychologist to the realities of the field (flexible working hours, environment and methods).
- The IGA were used as a therapeutic mediator to facilitate verbal expression and to lift the psychological obstacles (ramifications of the trauma) to professional exercise. These IGA thus indirectly treat the trauma.
- The actions were focused on limited areas but it was necessary to go 'outside of the area' in order to provide the beneficiaries with satisfactory care management (e.g. referral to a district hospital, recovery of stolen land in other territories).

28. Note: the 'local authorities' are the heads of social affairs, the executive secretaries of the sectors, the cooperative managers, youth work managers, security managers.

INTERMS OF CLINICAL AND ORGANISATIONAL CAPACITY BUILDING FOR COMMUNITY MENTAL HEALTH STAKEHOLDERS

► The intervention framework for a community-based approach

- The community-based approach that we have initiated is a way of ‘darning’ the social fabric of the community torn by the genocide. Before implementing any community actions, it is therefore necessary to understand the motivations on which sociocultural links in a given locality are based.
- The outreach work undertaken by a mobile multidisciplinary team working in joint action with the partner organisations and local authorities was essential in setting up activities and providing care management for beneficiaries.
- This community-based approach is based on the principle of joint action in partnerships. The presence of civil society stakeholders with a minimum capacity to express themselves is therefore vital.

► Setting up a variety of frameworks for sharing on clinical practice

- The cross-sector meetings were effective for managing and resolving community problems and creating a referral network. This is an important creative and decision-making space in which the various community stakeholders (local authorities, partner organisations, focal points, representatives of vulnerable groups) confront and exchange their ideas on a problem in order to draw out realistic solutions.
- It was necessary to adapt the frequency of meetings of the reference persons and focal points for sharing experiences and good practices to suit specific requests and requirements (e.g. more meetings during the national mourning period).

► The community’s capacity for ‘self-management’

- The reference persons receive no financial compensation for their work with the community. The more the community can take responsibility for itself, the more it can provide for itself.
- A community in a post-conflict period can rebuild itself without material aid and can implement projects using its own existing resources.

Elisabeth²⁹, project beneficiary, is a young girl of about 20 years old, mother to two children, she lives with her partner in Kimihurura. She tells of the changes in her life after meeting Jeanne, a reference person (now a focal point) and how the HI team approached her.

‘I had just spent 5 months on the streets before meeting Jeanne who explained and told me about mental health. I was with a group of prostitutes, drug addicts and thieves that I met under the bridge. (...)

Before, I was a street child, I begged, stole and sniffed glue. I had a child when I met Jeanne, it was raining at that time. I was a street child, I was hungry and a man approached me and in exchange for food I had to have sexual relations with him. That’s how I had my first child. (...) The big group lived under the bridge [52 people]. Jeanne asked us to join the group of adults but I refused.

29. For reasons of confidentiality, all names have been changed.

I wanted to create our own mixed group because we have our own problems that mean we don't want to mix with adults. We accepted being together, meeting up for activities, getting together in the fields. (...) After the death of my parents after the genocide, I went to the town and I didn't know how to use the hand hoe to work the land. (...)

One month after having met Jeanne, Marie [Area Manager] came to see us to talk about mental health and to chat with us. I agreed to take part in the activities and chat with people and form a support group. At the first meeting, we thought we were going to receive money but that wasn't the case. (...)

The support group, it was a window that has now allowed me to have a family and children and to gain weight. It was as if I was non-existent, before the group, but with the support group, I exist. I wondered who was going to accept me in the state I was in before. I have confidence in myself.”



Picture 15: Group of beneficiaries making good use of a plot of land in the Kimihurura sector

CHANGES OBSERVED IN THE COMMUNITY

- ▶ **The rebuilding of social links:
towards community reintegration** ----- PAGE 50
 - From isolation to grouping----- PAGE 50
 - Restoration of communication ----- PAGE 50
 - Reconstructing solidarity and mutual support mechanisms --- PAGE 50

- ▶ **Reconstruction of individual
and community identity**----- PAGE 52
 - Recognising and raising awareness of individual rights
and vulnerable groups ----- PAGE 52
 - Building self-esteem and self-confidence ----- PAGE 52

- ▶ **Towards a change in the representation
of mental health and of vulnerable people
within the community**----- PAGE 53
 - Reduction in the stigma of mental health and
in the marginalisation of vulnerable people ----- PAGE 53
 - Reduction in problems in the community ----- PAGE 53
 - Integration and cooperation of marginalised populations
within the community ----- PAGE 53

- ▶ **Improved living conditions:
towards socioeconomic inclusion**----- PAGE 55

THE REBUILDING OF SOCIAL LINKS: TOWARDS COMMUNITY REINTEGRATION

“The major change that has occurred in my life is that before, I lived in isolation, but they helped me to leave that condition: I have met people who I share problems with and together we live a community life. When we have a problem, we call a colleague; when I’m ill, other people come to visit me; if a child falls ill, you don’t need to worry about whether there is someone to look after him: we have had time to get to know each other and to create solidarity.” Beneficiary, Kimihurura.

Through the various interventions and activities put into place, community mechanisms are gradually being restored.

FROM ISOLATION TO GROUPING

The action of bringing vulnerable people together in peer groups breaks the isolation and allows people to approach each other, share common experiences and learn to live together.

“At the start the children were isolated. Since being in the groups, they visit each other, think things through together and consider themselves as people of value, who can speak out and are respected. They no longer live in isolation, are no longer rejected and marginalised by the community.” Focal Point, Bushoki.

RESTORATION OF COMMUNICATION

Community members start communicating again with each other, speech ‘recirculates’ relatively freely, ‘informal’ conversations (kuganira) allow people to speak out particularly through support groups but also through com-

“First of all, before I was living in isolation and I couldn’t meet people to share problems with. What Handicap International has done for us, first and foremost, is to put us into contact with each other: we have had the chance to share our life experiences. For example, I live alone with no brothers or sisters. There were times when I felt discouraged but when I met other people and we exchanged stories I felt a certain release, discovering that there are others who have the same problems as me or even worse was a relief.” Beneficiary, Mugina.

munity activities (IGA, community work). The return of communication helps to improve relations (comprehension and trust in each other) between neighbours and within families, particularly for families fostering orphaned children.

RECONSTRUCTING SOLIDARITY AND MUTUAL SUPPORT MECHANISMS

Psychosocial support has encouraged people to exercise their citizenship (each person becoming more aware of their rights and duties) and has thus strengthened the links within the community. The community has thereby become increasingly capable of taking action for individual and collective causes.

“I was alone and afterwards I saw that there were others with the same difficulties as me. We try to resolve our problems, we visit each other and give each other mutual support. In one of our groups for child-headed households, there is a girl who looks after her three brothers and she is HIV positive and pregnant. She had a

baby and they lived all together with the goats and the kitchen all in the same place. With the brothers and the baby there was not enough room for everyone. It is necessary to separate the areas and we consulted together and with the young people of the parish we decided that we could build a new house to provide the space. We asked other young people and we were able to build her a lovely house.”

Beneficiary, Bushoki.

“A child who is the head of a household falls ill, the neighbours have realised that it is up to them to deal with this. Who will transport this child from their home to hospital? Who will stay at home with the child’s brothers? The community starts to build its links, to provide mutual support, to care about its neighbours.” **Project Team Area Manager, Bushoki.**

RECONSTRUCTION OF INDIVIDUAL AND COMMUNITY IDENTITY

By reconstructing social links, individual and community identities are gradually rebuilt, in various dimensions.

RECOGNISING AND RAISING AWARENESS OF INDIVIDUAL RIGHTS AND VULNERABLE GROUPS

The legal support activities allow individuals to understand and exercise their rights, and the community (including local authorities) to officially recognise the existence of these people, by respecting their rights.

“A family had adopted me after the death of my parents but I eventually realised that they

wanted to take my family’s property and I decided to leave them. They wanted to destroy our family home and take the tiles. The project approached me and I was able to talk about my problem. I was advised to take it to the court, and I did. So the project helped me to protect my family’s property.” **Beneficiary, Mugina.**

BUILDING SELF-ESTEEM AND SELF-CONFIDENCE

The project induction sessions, the setting up of IGA and also the sharing in support groups are all mediators through which individuals and groups have been able to find and strengthen their self-esteem and self-confidence, having reawakened their awareness of their ‘existence’ and therefore of their identity. By forming an association and building projects together, the beneficiaries have given themselves new

models for identification – free of the stigma that society often assigns to them.

“The project took us out of isolation, and gave us self-esteem and self-confidence. I was scared to go to the local authority, to approach well-off people. Now I’m not scared of approaching someone.” **Beneficiary, Bushoki.**

REDUCTION IN THE STIGMA OF MENTAL HEALTH AND IN THE MARGINALISATION OF VULNERABLE PEOPLE

The work on raising the reference persons and focal points' awareness of mental health and the problems of vulnerable people made it possible to make community members aware of these issues and change their view of them. Mental health is no longer associated with madness, but is considered as part of a person's overall well-being. Vulnerable people are therefore less commonly marginalised.

"We understand our neighbours better. There were those that we called 'mad' but when we received proof to the contrary, we started to raise awareness even among our neighbours so that they understand their human condition; for those who needed medical treatment, we

took them to the appropriate centres and for those who needed counselling, we got it for them." **Focal Point, Kimihurura.**

"It is not a mental health problem; it is simply the fact that he is an orphan of the genocide and this means he was abandoned to delinquency. But now things have changed; he has come back home and he doesn't have a problem. If he was given the opportunity to study and somebody promised to cover the cost of his studies and his mental health problems were treated, he would be fine. I think that his life would be good especially if he will have obtained by himself what he has to ask of others." **Focal point, Kimihurura.**

REDUCTION IN PROBLEMS IN THE COMMUNITY

The awareness raising and capacity building for reference persons and focal points allows them to prevent and manage problems at the "grass roots" level and to use the referral network to address the beneficiaries' problems.

"The changes are there. There are less grievances presented to the community. The trained focal points deal with requests at the commu-

nity level and problems are resolved locally (e.g. family conflicts, theft). (...) On the hill, the children live in isolation and are depressed, it is necessary to look out for them. It is the focal point who looks after the problem at local level. But when this goes beyond the competence of the focal point, he/she refers back to the HI team." **Head of Social Affairs, Bushoki.**

INTEGRATION AND COOPERATION OF MARGINALISED POPULATIONS WITHIN THE COMMUNITY

The community recognises that a category of people considered as 'vulnerable and marginalised' are capable of changing and integrating into the community. These people count as resources and now work with the local authorities on the 'proper' functioning of the community.

"This person has changed in the way he acts. He has learnt to grow things, to work for his own advancement. Before, he was a street child who just roamed around: he didn't do anything beneficial at all. But now he has changed. He helps us with the housework, he has become a member of the household. He takes part in cooperatives like the others and no longer has

the bad habit of hitting other children at home for no reason. He has changed enormously.”

Focal Point, Bushoki.

“Firstly, there is this solidarity between the groups who have emerged from their hiding places. They participate in community activities. Secondly, they no longer have the police following them, and thirdly they are recognised

by the authorities on the sector level and the grouping activities. Today people can go to the authorities, there is no longer any stigma. Fourthly, there is no more insecurity. The young people today form part of the security system and they go on patrols. Today they protect the cabbage fields, whereas before they were stealing.” **Focal Point, Kimihurura.**

The ‘peer groups’ have observed an improvement in living conditions due to creation of IGA. This is a motivating and encouraging activity which allows groups to live in more stable conditions. These activities provide them with a certain stability which allows them to look to the future and ensures their gradual social rehabilitation.

“In general life, we learned how to create an income-generating project... living in solidarity, they grouped us into a community and then they taught us what we could do to develop... Today we have capacity to create micro-projects and we have hope that the future will be good for us.” **Beneficiary, Kimihurura.**

The story of the ‘Hauliers’ group of Kimihurura, based on the Area Manager’s account.

Identification of the problem

The ‘hauliers’ are young people of the district who transport coal and unload the vehicles transporting their goods.

Not everyone can be a haulier even if they want to because it is an environment which lives by the survival of the fittest. On the arrival of the goods vehicles, those who knew how to fight and were physically the strongest ran behind the lorries to unload coal, whilst the weakest, left to one side, continued to live by stealing and taking drugs. Those who were able to work as ‘hauliers’ in the day went to spend their money in the evening, on alcohol and ‘wasted money with girls.’ This situation thereby created insecurity within the district.

Analysis of the problem

When the HI team came to set up activities in the Kimihurura district, the Area Manager met a trader (who has now become a reference person) who asked ‘what can we do for these young people who were always fighting in front of his shop, how can we get them together and calm the quarrels and find a positive solution.’ The trader, with the help of the Area Manager, then decided to get them together in front of his shop to propose that they should get together and stop this fighting, which they accepted, after a few awareness raising sessions.

Tackling the problem through support groups and project induction

The Area Manager then started up support groups for the ‘hauliers’ and offered ‘project induction’ for them at the same time.”

“First we thought about creating links between them, then they applied the rules for protection and conduct themselves at work. They have divided the shops between them and each was responsible for an area of shops.”

From a decrease in high-risk behaviours and insecurity...

These young people, mostly orphans and street children, had high-risk behaviour, abusing drugs and alcohol and stealing. “These attitudes were worked through in support groups. We looked at their attitudes, the insecurity in the districts.” The young people then gradually abandoned these behaviours and a climate of trust was restored in the district. “Before people were

afraid of them, they feared them because they ran away with the merchandise, but someone from the district told me: “you have transformed them, before we could not trust them.”

... to managing money and building a future...

“A support group was set up for alcoholics and smokers”, in which young people decided and learnt to save their money, deciding to put the ‘rest’ [money that would have been intended drugs] into the bank to accumulate. They thought about contributions, they tried to each put something aside every evening. The sums increased and they created an account, each person has to contribute each day and they reduced their consumption of drugs.”

This money allowed them to pay for and take out health insurance, with the knowledge that the continual exposure to the vehicles in their work did constitute a risk.

... via the creation of an income-generating activity...

The Development Counsellor supported them in the project induction.

“Gradually, the account grew and one day they said: “we’re transporting sacks of coal. Why not set up an IGA (Income-generating activity)?” They then decided to create a stock of their own coal. Today, they are coal suppliers. Everyone in the district buys from them, they are always there and they have direct access to the stock. They have plenty of customers and have been able to progress.”

... to inclusion within the community.

Today, within this group, “there are some who have been able to stop smoking and their number includes someone who provides security for the district and from the coal stock sales, they have been able to invest in selling drinks. They have two projects and continue to take part in support groups.” (...)

“Those who do not know how to read are in the process of learning, and some are in the process of asking “what can we do now in order to stop working in transport.” They are in the process of thinking about what they want to do next. Some have started a family and had children, they no longer want to do this work. It is time to think about tomorrow and the day after.”

LIMITS OF THE COMMUNITY-BASED
MENTAL HEALTH PROJECT

Part 6

LIMITS OF THE COMMUNITY-BASED MENTAL HEALTH PROJECT

Some limitations in the implementation of this approach to community mental health have been identified.

- ▶ The geographical distribution of the beneficiaries over a dispersed habitat has not made it possible to:
 - Monitor beneficiaries using monitoring tools and individual assessments.
 - Propose extended and diversified care management for the problems.
- ▶ Since the referral network and system are still underdeveloped (lack of training of personnel and of specialist infrastructure) it has not been possible to:
 - Refer sufficiently autonomous IGA groups that no longer need psychological care to specialist organisations for economic inclusion projects.
 - Diversify the psychosocial activities by offering the beneficiaries and/or referring them for professional training (sewing, masonry, mechanics, etc.).
- ▶ The lack of availability of partner organisations involved in the actions due to their geographical location.
- ▶ The primary healthcare and social structures at sector level not trained in mental health have meant it has not been possible to set up a referral network for psychological care management.

RECOMMENDATIONS FOR
CONTINUING THE PROJECT

- ▶ In terms of comprehensive care management: preventive and curative ----- PAGE 60
- ▶ In terms of clinical and organisational capacity building ----- PAGE 61

IN TERMS OF COMPREHENSIVE CARE MANAGEMENT: PREVENTIVE AND CURATIVE

- ▶ Strengthen the primary prevention sector of activity, particularly by developing IEC (Information, Education and Communication) tools and equipment for raising awareness in mental health.
- ▶ Implement monitoring and evaluation tools in liaison with the partners at individual and collective level (for groups) on the state of progress, the progression of each beneficiary.
- ▶ Define the 'weaning' indicators, i.e. signs of beneficiaries becoming autonomous or of their well-being in order to support them when leaving the project at the end.
- ▶ Create other therapeutic mechanisms adapted to the local culture and practices.

IN TERMS OF CLINICAL AND ORGANISATIONAL CAPACITY BUILDING

- ▶ Readjust the ‘stance’ of the reference persons and focal points, whose role changes with the needs of the beneficiaries.
- ▶ Consolidate cross-sector meetings in order to strengthen the referral network to the adapted care services in the intervention areas.
- ▶ Increase the presence of partner organisations at the meetings for sharing experience and good practice with reference persons and focal points.
- ▶ Build the planning and organisational capacities of the project team psychologists working as Area Managers by providing them with training in coordinating and managing activities.
- ▶ Increase the number of people working on the legal sector of activity and strengthening their skills with specialist training.
- ▶ Provide training during working hours for the multidisciplinary team (economic, legal, psychosocial, psychological) to improve their skills and knowledge (e.g. in the contextual therapeutic approach, prevention of abuse and gender-based violence, etc.) in their respective areas of intervention.
- ▶ Strengthen the implementation of the Rwandan Collective of Parts Active in Mental Health by first clarifying its remit and governance then obtaining recognition on a national level.



Picture 16: A group of beneficiaries in the Bushoki sector

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Picture 17: Group of beneficiaries presenting their life experience through a drama game sequence in the Kimihurura sector



Picture 18: A plot of land put to good use by a group of beneficiaries in the Bushoki sector

INFORMATION SHEET FOR EACH INTERVENTION AREA

BUSHOKI, district of Rulindo	
HI Project team Staff	<ul style="list-style-type: none"> • 1 Psychologist • 1 Psychosocial Counsellor • 1 Associative Development Counsellor
Partner organisations	<ul style="list-style-type: none"> • Uyisenga n'Manzi (association for the care of orphans, civil society organisation)
Number of reference persons	150 people
Number of focal points	30 people
Number of direct beneficiaries	2,000 people
Type of groups and problems:	<ul style="list-style-type: none"> ▶ Child heads of households Problem: isolation, rejection by members of extended family, family conflict, poverty ▶ Unmarried mothers Problem: isolation, rejection by members of extended family, family conflict, poverty, non recognition of the child by the father, HIV, lack of self-esteem ▶ Children representing pupils within primary and secondary schools Problem: stress associated with studies, poverty in families ▶ Children infected or affected by HIV/AIDS Problem: isolation, rejection by members of extended family, family conflict, poverty, non recognition of the child by the father, depression
Types of activities:	<ul style="list-style-type: none"> • Interviews with psychologists • Running of support groups • Participation in intervision • Meetings for young people • Project induction • Home visits • Meeting to monitor initiatives • Conflict management • Support, fundraising • Cross-sector meetings • Inter-area visits • Analysis of practices • Legal support

KIMIHURURA (Kimicanga), district of Gasabo, Kigali

HI Project team Staff	<ul style="list-style-type: none"> • 1 Psychologist • 1 Psychosocial Counsellor • 1 Associative Development Counsellor
Partner organisations	<ul style="list-style-type: none"> • AFAK (association of foster families and vulnerable children, local organisation)
Number of reference persons	110 people
Number of focal points	30 people
Number of direct beneficiaries	1,800 people
Type of groups and problems:	<p>▶ Child heads of households Problem: traumatic episode, psychological distress with introversion, behavioural problems, family conflicts, poverty, dropping out of school, etc.</p> <p>▶ Unmarried mothers Problem: prostitution, drug abuse, isolation, rejection by family, family conflicts, poverty, non recognition of the child by the father, HIV, lack of self-esteem</p> <p>▶ Street children Problem: identity problems, rejection by members of extended family, family conflict, poverty, depression, use of drugs and alcohol, promiscuity, crime</p> <p>▶ Mixed group of street children, prostitutes, thieves, etc. Problem: Psychological distress, drug abuse, prostitution, HIV/AIDS, identity problems, problem associated with parenting, etc.</p> <p>▶ Children and adolescents living in foster families Problem: Problem: Traumatic episode, psychological distress with introversion, behavioural disorders, family conflicts, poverty, dropping out of school, etc.</p>
Types of activities:	<ul style="list-style-type: none"> • Interviews with psychologists • Running of support groups • Participation in intervision • Meetings for young people • Project induction • Home visits • Meeting to monitor initiatives • Conflict management • Support, fundraising • Cross-sector meetings • Inter-area visits • Analysis of practices • Legal support

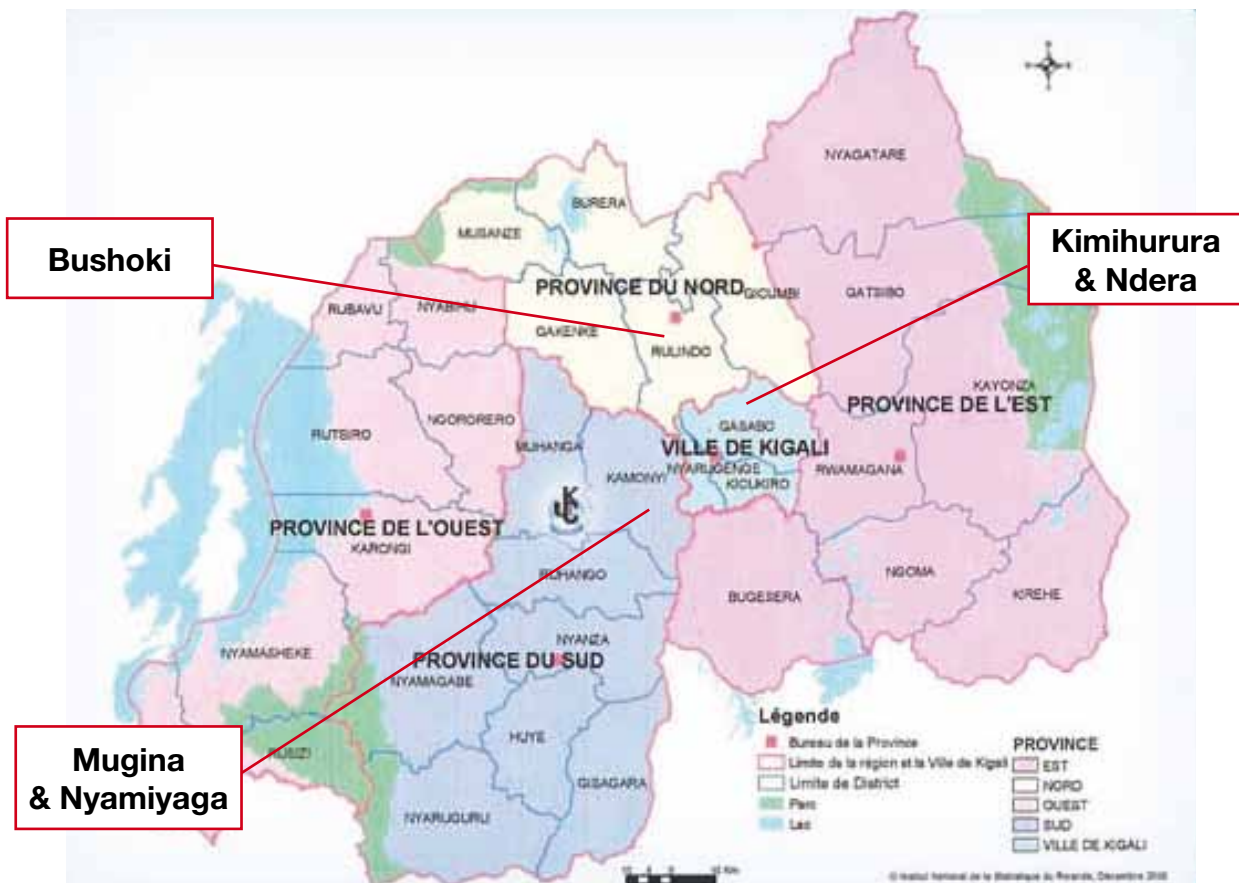
NDERA, district of Gasabo, Kigali

HI Project team Staff	<ul style="list-style-type: none"> • 1 Psychologist • 1 Psychosocial Counsellor • 1 Associative Development Counsellor
Partner organisations	<ul style="list-style-type: none"> • Icyuzuzo (association of widows of the genocide, civil society organisation) • Tumurere Foundation (association of widows and orphans of the genocide, civil society organisation)
Number of reference persons	150 people
Number of focal points	30 people
Number of direct beneficiaries	2,000 people
Type of groups and problems:	<p>▶ Widows of the genocide, of AIDS and others Problem: bringing up children, lack of male support, conflict with foster children, poverty</p> <p>▶ Child heads of households Problem: isolation, rejection by members of extended family, family conflict, poverty</p> <p>▶ Unmarried mothers Problem: isolation, rejection by members of extended family, family conflict, poverty, non recognition of the child by the father, HIV/AIDS, lack of self-esteem</p> <p>▶ Children having lost a parent and vulnerable Problem: family conflict, isolation, rejection by members of extended family, poverty, non recognition of the child by the father, depression</p>
Types of activities:	<ul style="list-style-type: none"> • Psychological support for individuals • Running of support groups • Participation in intervision • Meetings for young people • Project induction • Home visits • Meeting to monitor initiatives • Conflict management • Support, fundraising • Cross-sector meetings • Inter-area visits • Psychological analysis of practices • Legal support

MUGINA, district of Kamonyi

HI Project team Staff	<ul style="list-style-type: none"> • 1 Psychologist • 1 Psychosocial Counsellor • 1 Associative Development Counsellor
Partner organisations	<ul style="list-style-type: none"> • Icyuzuzo (association of widows of the genocide, civil society organisation) • CUSINAM (Centre Universitaire de Santé Mentale, public body under control of Rwanda National University)
Number of reference persons	110 people
Number of focal points	30 people
Number of direct beneficiaries	2,200 people
Type of groups and problems:	<p>▶ Child heads of households Problem: traumatic episode, psychological distress with introversion, behavioural disorders, family conflicts, poverty, dropping out of school, etc.</p> <p>▶ Unmarried mothers Problem: prostitution, drug abuse, isolation, rejection by family, family conflict, poverty, non recognition of the child by the father, HIV, lack of self-esteem</p> <p>▶ Street children Problem: identity problems, rejection by members of extended family, family conflict, poverty, depression, use of drugs and alcohol, promiscuity, crime</p> <p>▶ Children and adolescents living in foster families Problem Problem: traumatic episode, psychological distress with introversion, behavioural disorders, family conflicts, poverty, dropping out of school, etc.</p>
Types of activities:	<ul style="list-style-type: none"> • Psychological support for individuals • Psychological support sessions for groups • Participation in intervision • Participation in clinical supervision for individuals and groups • Experience sharing meetings for young people • Setting up and monitoring of project induction activities • Home visits • Transfer of cases to competent structures • Meeting to monitor initiatives implemented • Conflict management • Support, fundraising • Cross-sector meetings • Inter-area visits • Analysis of practices • Legal support • Various meetings with authorities and others

MAP OF INTERVENTION AREAS IN DISTRICTS



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