Implementation of Mental Health Reform and Policy in Post-Conflict Countries: The case of post-genocide Rwanda

Courtney Sabey

A thesis submitted in partial fulfilment of the requirements for the Master's degree in the Faculty of Social Sciences

School of International Development and Global Studies of
Faculty of Social Sciences
University of Ottawa

© Courtney Sabey, Ottawa, Canada, 2019

TABLE OF CONTENTS

List of Tables .... *iv*

Abstract .... *v*

Acknowledgement/Preface .... *vi*

CHAPTER 1 - Introduction and Literature Review *1*

Introduction 1

Literature Review 3

Mental Health in Post-Conflict Countries 6

Mental Health Policy and Reform in Post-conflict Countries 8

Mental Health in Rwanda 11

Rwanda's Mental Health Policy and Questions regarding Implementation 13

Theoretical Framework 16

Research Questions 22

Methodology 22

Ethics 26

CHAPTER 2 – Context *30*

CHAPTER 3 – Process and best practices *39*

Decentralization and Integration 39

Sensitization 42

Accessibility and Affordability 44

Legislation 45

Community Involvement 46

Collaboration and Advocacy 48

Research and Data 51

Supervision, monitoring, and evaluation 52

CHAPTER 4 – Challenges and recommendations *56*

Challenge 1: Stigma, lack of awareness, and cultural barriers 57

Challenge 2: Institutionalized care 64

Challenge 3: Human resources 69

Challenge 4: Financial resources 71

Challenge 5: Research/Data 73

Challenge 6: Trans-generational/intergenerational trauma 74

Challenge 7: Facilities, services, and care 75

Challenge 8: Lack of understanding in leadership/top-down implementation 78

CHAPTER 5 – Analysis and conclusion *81*

Analysis **81**
Conclusion **101**
REFERENCES: ***104***

List of Tables

Table 1 - Rwanda Minister of Health Chart concerning Mental Health 36

Abstract

Mental health has been receiving increasing amounts of attention in recent years. Despite this, there are still many barriers to receiving mental health care in all parts of the world. Post-conflict countries have the dual challenge of increased mental health problems among their populations and trying to respond to these problems with low resources as their economies are often destroyed by the effects of war. This research studies the implementation of Rwanda's post-genocide mental health policy to assess the challenges and best practises of implementing mental health reform in a low-resource, post-conflict country. The thesis found that the implementation of Rwanda's mental health policy has relied on policies of rapid decentralization and integration to increase accessibility to mental health care. Decentralization has ensured that mental health services are available at every level and relies on a referral system. Mental health care is integrated into the general healthcare system by training generalists in hospitals and health centres to respond to mental health issues, therefore making these services available at nearly all health institutions. These policies were viewed positively by stakeholders, but there were still many gaps and challenges in the implementation of Rwanda's mental health policy. One of the major challenges was stigma acting as a barrier to accessing services while one of the largest gaps was that the implementation relies too much on institutionalized, individualized, and Westernized care, which participants pointed out is not always suitable in the Rwandan context. Recommendations included an increase in sensitization campaigns, shifting towards community-based mental health care, expanding personnel and services, as well as increasing funding. The analysis, relying on complexity theory, found that many of the gaps are missed by the government because of a lack of collaboration with local organizations and service providers working in the domain.

Acknowledgement/Preface

I would like to thank numerous people for their support during this process, but mostly my husband, Youssef, who endured three months of the Ottawa winter without me so that I could do my fieldwork in Rwanda, supported me emotionally through all the difficult moments (which there were many), supported me technically whenever I had a computer issue (which was often), and motivated me to write even when I was exhausted.

I would also like to thank my family for their continuous support throughout my education. Thank you to my sister, Madison, for always believing in me, and my brother, Luke, for always being there. Mostly, thank you to my parents, Dexa and Bill, who have continuously been there for me and supported me in every way possible not only in my academics, but in life in general. I could not have achieved any of this without them. In addition, I would like to thank my father-in-law, Ahmed, who gave me unwavering support and kept me on track during this process all the way from Morocco.

Finally, I would like to especially thank my supervisor, Marie-Eve, who guided me through this process. Thank you for supporting me academically and personally. Thank you as well to Eugène for being a great local supervisor in Rwanda and thank you to my interpreter, Samuel, for doing a great job and also being a great friend. Lastly, I would like to thank my participants who were so open with me and took time out of their day to talk to me. This research would not have been possible without you.

CHAPTER 1 - Introduction and Literature Review

Introduction

This thesis looks at the implementation of mental health policies and reform in post-conflict countries, focusing on Rwanda as a case study. While health has consistently been used as an indicator of development, it is only recently that we have seen mental health included in the conversation around development, albeit to a limited extent. Three of the UN Millennium Development Goals (MDGs) had a specific focus on health, but none mentioned mental health. In contrast, the third UN Sustainable Development Goal (SDG) is "Good Health and Well-Being" and includes mental health, along with non-communicable diseases, as one of nine indicators. As demonstrated through the difference between the MDGs and SDGs, it is only recently that we have seen mental health becoming a priority in the field of global health (Murray, Tol, Jordans, et al., 2014). This stems from the growing recognition of mental illness as an often-invisible ailment that affects millions around the world. It also stems from the recognition of the treatment gap regarding mental health, as many people do not have access to mental health care despite requiring it, especially in low or middle-income countries (Murray, et al., 2014, p. 2). Due to it only being recognized recently as a pressing issue, research on mental health from a development or political point of view has been limited, and most research tends to be undertaken by psychologists.

Mental illness is especially prevalent in conflict and post-conflict zones and has implications for stability: it has been found that psychological trauma in childhood, such as trauma experienced due to war, can contribute to intergroup conflicts decades later (Pevehouse & Goldstein, 2017, p. 99). There is also evidence that those suffering from poor mental health following a conflict are less likely to support restorative systems of transitional justice or peaceful methods of resolving conflicts (Corey, Joireman, 2004). For example, a study found

that individuals in northern Uganda with symptoms of post-traumatic stress disorder (PTSD) and depression favoured violent methods of resolving conflict over peaceful methods (Corey, Joireman 2004). All this suggests that future peace and stability in post-conflict countries could be in part dependent on mental health. Therefore, it is imperative that governments include a mental health policy/plan in their post-conflict development plan. As stated by the WHO (2017), "mental health issues cannot be considered in isolation from other areas of development, such as education, employment, emergency responses and human rights capacity building." The number of conflicts worldwide more than doubled between 2010 and 2017 (UCDP, 2018). While we do not know how long it will take for these conflicts to resolve themselves, it is important that there are evidence-based solutions available when they do. This issue is urgent as the number of people living in conflict affected and post-conflict states continues to increase.

This is the reason why this research focuses on the implementation of mental health policies and reform in post-conflict countries. Rather than focusing on mental health policies or interventions specifically, it looks at the implementation process. It is important to look at this process to truly understand how policy becomes action, and to recognize the different challenges in implementing mental health policies, especially in a post-conflict, low-income country.

I have focused on Rwanda as my case study because the Rwandan people experienced one of the most fast paced and extensive genocides of the 20th century. Much of the violence took place in public spaces, often within communities and it was perpetrated by community members on community members. As a result, many Rwandans are still suffering from mental health issues triggered by the genocide and the violence that accompanied it. A study in 2009 revealed that 26.1% of the population (1000 people sampled in all 5 provinces) suffered from post-traumatic stress disorder and co-morbidity dominated mainly by depression was measured

at 17.8% with depression alone being at 22.7% (Munyandamutsa & Mahoro-Nkubamugisha). The government of Rwanda recognized this problem and instituted a mental health policy in 1995, which was reviewed in early 2012 (Republic of Rwanda Ministry of Health, n.d., Ait Mohand & Kayiteshonga, 2015, slide 10). This research provides some insight on the challenges that arise when implementing a national mental health policy in a post-conflict country and identifies the main drivers of implementation.

This research is important because mental health, like physical health, contributes to thriving societies. Conducting scientific research on how to best implement mental health policies may assist other countries in implementing mental health policies, therefore contributing to healthier societies. As mentioned above, the development of mental health services is essential in post-conflict countries to ensure that the newfound peace is maintained as poor mental health can contribute to resistance to restorative processes as well as future conflicts. There is also increasing evidence showing that poor mental health is strongly associated with poverty and social deprivation in low and middle income countries (WHO, 2007, p. 1). In addition, evidence suggests that this relationship is cyclical: mental disorders increases the likelihood of falling into poverty and poverty increases the risk of mental disorders (WHO, 2007, p.1). This increases the importance of treating mental illness in order to protect vulnerable groups. Therefore, it is essential to ensure that mental health is addressed through policy in post-conflict countries to promote post-conflict stability and to protect vulnerable populations. The analysis of mental health policy implementation, specifically what has worked, what has failed, and what has been challenging to implement, can contribute to the understanding of the successes and failures of mental health policy implementation in post-conflict countries, which remains understudied.

Literature Review

Countries recovering from armed conflict face many challenges in terms of peace-

building, reconciliation, and reconstruction. Following conflict, and during the transition to peace, countries must focus on disarmament, demobilization, rebuilding infrastructure, restorative justice, and transitional politics. It is equally important, however, that countries focus on the mental health of their citizens, as conflict can result in trauma and lead to poor mental health. Many countries that have recently experienced armed conflict have recognized the importance of mental health by creating mental health policies or having undertaken mental health initiatives/reforms. This literature review will present the academic research that has already been completed on mental health in conflict and post-conflict countries, including Rwanda. Next, it will look at literature on the mental health policies and reforms previously developed in post-conflict countries and how they have been implemented. Finally, it will review Rwanda's mental health policy and propose research questions based on existing literature.

Firstly, it is important to define mental health. Mental health is not simply the absence of a disease or disorder (Baingana, 2003, p. 1). Rather, according to the World Health Organization (WHO), mental health is "a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community" (WHO, 2001, p. 1). However, it is important to recognize that good mental health does not mean that one does not experience sadness, anger, unhappiness or feelings of being unwell as this is all part of the human experience (Galderisi, 2015, p. 232). Therefore, for the purpose of this research, mental health is defined as a state of general well being, with normal fluctuations in mood that do not greatly disturb the individual or those around them or hinder their capacity to contribute to society. When evaluating mental health in post-conflict countries, we must also recognize that it is not unusual for traumatic events to cause symptoms of poor mental health, but this does not always equate to mental illness. Rather, mental illness is defined as health conditions

involving significant changes in thinking, emotions, and/or behaviour along with distress and/or problems functioning in social, work, and/or family life (American Psychiatric Association, 2015). People can have mental health concerns on occasion, but it becomes mental illness when continuous symptoms cause frequent stress and affect an individual's ability to function (Mayo Clinic, 2018).

In post-conflict countries, mental health problems as well as mental illness are extremely prevalent due to trauma experienced by individuals during and following the conflict. Trauma is defined as "the reaction of an overwhelming stress that surpasses an individual's ability to cope, or assimilate the emotions involved with the experience" (Amusan & Ejoke, 2017, p. 54). Situations that may be traumatic to one person may only be stressful to another person depending on factors such as previous history, age, and meaning associated with the event (Amusan & Ejoke, 2017, p. 54). In certain instances, major trauma can lead to post-traumatic stress disorder. The National Institute of Mental Health (2016) explains that symptoms of PTSD include flashbacks (reliving of the trauma) along with physical symptoms such as a racing heart or sweating, bad dreams, frightening thoughts, avoiding thoughts or feelings, and avoiding places, events or objects that trigger the memory of the traumatic experience. According to a study by de Jong, Komproe, and Van Ommeren (as cited in Munyandamutsa, Nkubamugisha, Gex-Fabry, Evtan, 2012, p. 1759), in low-income, post-conflict settings, PTSD is the most frequently reported mental disorder and it affects up to 37% of individuals exposed to armed conflicts. Symptoms of depression are also commonly found in people living in post-conflict countries. Symptoms of depression include persistent sadness, feelings of hopelessness, guilt, and worthlessness, loss of pleasure, difficulty concentrating and sleeping, aches and pains, and thoughts of death or suicide (NIH, 2016, p. 3). Kleinman (as cited in Munyandamutsa et al., 2012, p. 1759) found that both PTSD and depression are associated with higher rates of somatic and general medical complaints, especially in non-Western

cultures. However, it must be noted that these mental illnesses listed are all Western psychological concepts and that these labels may not always be applicable in other cultures as "every culture has its own beliefs and traditions which determine psychological norms and frameworks for mental health" (Summerfield, 2000, p. 233-234). Yet, Western psychological concepts, like Western culture, have seen a global expansion, leading people to view it as definite knowledge and displacing local understandings and beliefs (Summerfield, 2000). It is also important to understand that stigma may affect the way that mental health problems are labeled in developing countries, or even in the developed world (Summerfield, 2000). This research does refer to mental illness within the confines of a Western framework (especially because this is the way the Rwandan government refers to mental illness – see *Rwanda 2018 Mental Health Survey*), but also recognizes that not everyone may relate to this framework, and attempts to be sensitive to this.

Mental Health in Post-Conflict Countries

As mentioned above, armed conflict has a devastating impact on the mental health of citizens. The WHO estimated that 10% of people who experience traumatic events in situations of armed conflict will have serious mental health problems and another 10% will develop behaviour that hinders their ability to function properly (as cited by Murthy, Lakshminarayana, 2006, p. 25). Research on World War II and Holocaust survivors found that suffering continues decades after the crisis is over (Baingana, 2003, p. 1). Yet, traumatic events during conflict are not the only contributors to poor mental health: war destroys the social and economic fabric of countries and has long term effects including reduction in material and human capital, endemic poverty, malnutrition, and disability (Murthy, Lakshminarayana, 2006, p. 25), which can also lead or contribute to poor mental health.

Numerous studies have been completed with different sample sizes to determine the effects of war and conflict on mental health. The psychological effects of conflict appear to be

fairly universal and do not differ greatly based on the country or culture as studies in post-conflict and conflict regions around the world have had similar findings. Firstly, many studies have found a direct correlation between the degree of trauma and the amount of psychological problems: the greater the exposure to trauma, the greater the symptoms (Murthy, Lakshminarayana, 2006).

Secondly, these studies have found that women, children, the elderly, and the disabled are the most vulnerable to the psychological consequences of war (Murthy, Lakshminarayana, 2006, p. 25). Children are vulnerable due to their more sensitive neurological systems (Baingana, 2003, p. 2): a study of Kurdish children living in post-conflict Iraq found that 87% of them were affected by PTSD (Ahmad, Sofi, Sundelin-Wahlsten, von Knorring, 2000, p. 239). There is also a high correlation between mothers' and children's distress in conflict situations (Murthy, Lakshminarayana, 2006, p. 28). For example, a study in post-conflict Lebanon found that the level of depression in the mother was the best predictor of the child's mental health (Bryce, Walker, Ghorayeb, Kanj, 1989). Another study in Iraq (2000) found a strong relationship between the child and their caregiver's PTSD (Ahmad, Sofi, 2000, p. 239). This could be in part due to Baingana's finding that mothers who are depressed or suffering from PTSD during conflict may be unable to provide proper care or stimulus to their children (2003, p. 2). Additionally, studies on Cambodian genocide survivors also show that children and children's children are affected by the psychological impact of conflict (Baingana, 2003), demonstrating the intergenerational consequences of war.

Thirdly, and as mentioned above, studies have found similar rates and causes of PTSD and depression in post-conflict countries: among adults, studies have found the rate of PTSD and depression to be between 17% and 80%, with most rates falling somewhere in the middle (Ahmad et al. 2000, p. 239, Mollica, Donelena, Tor, Lavelle, Elias, Frankel, Blendon, 1993, p. 581). In addition, somatic complaints tend to accompany symptoms of depression in studies of

mental health in post-conflict countries: A survey of nearly 1000 Cambodians in a displaced persons camp completed in 1993 found that more than 80% felt depressed and had various somatic complaints despite good medical care (Mollica, Donelena, Tor, Lavelle, Elias, Frankel, Blendon, 1993, p. 581). These statistics demonstrate that mental illness and mental health problems are major issues in post-conflict countries and that these issues need to be addressed.

Mental Health Policy and Reform in Post-conflict Countries

Mental health has only recently become a priority in the field of global health (Murray, Tol, Jordans, et al., 2014). This importance was highlighted in 2005 when the WHO urged "support for implementation of programs to repair the psychological damage of war, conflict and natural disasters" (Murthy, Lakshminarayana, 2006, p. 25). Despite this, research on the development and implementation of mental health policies in post-conflict countries remains limited. Rather, research on mental health in post-conflict settings tends to be undertaken by psychologists and health professionals (as seen in the previous section) and it is difficult to find research done from a political or development lens, with the exception of a few studies on the former Yugoslavia and Cambodia.

De Vries and Klazinga (2006) wrote what they claim could be the first health policy analysis on the subject of mental health reform in post-conflict areas. The research was done on Bosnia Herzegovina and Kosovo. While their survey results showed a high prevalence of mental health disorders, especially PTSD, they found that there was reluctance to using mental health services for various reasons. Firstly, it was found that stigma existed around mental health and users of mental health services were thought to be delusional and dangerous (p. 248). It was also found that patients distrusted physicians from different ethnic backgrounds (p. 248), which is very important to consider following interethnic conflicts. However, the most central theme in their results was the role of foreign influence: funding and part of the operationalization of mental health reform was done by international organizations and this led

people within the country, including mental health professionals, to feel a lack of ownership over the process (p. 248-249). This in turn affected the sustainability of the reforms, as they were not locally produced and many local health professionals felt that they were reforms from abroad (p. 249). Finally, Western insurance models and rapid decentralization were introduced in the mental health reform process leading to problems of access to services (De Vries & Klazinga, 2006, p. 249). The key points to take away from this study are that while stigma did act as a barrier in the former Yugoslavia, the largest barriers were the lack of local ownership over the process and the Western neoliberal influence in the implementation process including policies of decentralization and privatization.

Despite very different geographical locations, culture, and history, many of the same issues arose in the development of the mental health policy in post-genocide Cambodia. Stockwell, Whiteford, Townsend and Stewart (2005) also found stigma surrounding mental health in Cambodia to be a factor detracting from mental health being prioritized and perceived as a serious health issue (p. 191). However, the greatest barrier was once again the fact that the policy was financed and designed mainly by the international community and was external to the Cambodian Ministry of Health (p. 193). Like in Bosnia Herzegovina and Kosovo, this has led to issues of sustainability and implementation feasibility (p. 193), as there was a lack of local ownership over the policy. Finally, there were issues of sustainability as Cambodia attracted large amounts of international aid directly following the violence, but aid allocation decreased with time, especially as other conflicts and tragedies around the world started to attract attention (Stockwell et al., p. 193).

Murray, Tol, and Jordans (2014) lay out additional challenges as well as strategies for implementing mental health policies in low-income, post-conflict countries. Some of the main challenges they cite include: lack of properly trained personnel, attrition of personnel, danger and instability, lack of facilities and transportation, lack of leadership, lack of trust in the

system, stigma, and shortage of funding (Murray et. al, 2014). Regarding lack of properly trained personnel, Murray et al suggest using non-specialists in task-sharing models to provide evidence-based psychotherapeutic treatments (p. 4). However, this can lead to the attrition of personnel, as the majority of countries do not have a formal job position or title for these non-specialists (p. 4). This is problematic because it means these workers have no formal place in the health infrastructure and this can lead to limited future work opportunities and skills not being utilized past a project life (p. 5). Murray et. al. have two suggestions for this problem: engaging policy makers to create a place in the system for these workers, or building the capacity of educational institutions so that there is a formal degree program (p. 5). In terms of lack of facilities and transportation, an approach recommended is for counsellors to meet clients in locations close to where clients live, including community centres or religious spaces (p. 6-7). Moving services further into the community has the added benefit of addressing the damage caused to the social fabric caused by conflict (p. 7).

In order to address these challenges properly, it is important to look at policy implementation and understand the process of translating policy into action, and how this is done in a low-income, post-conflict country. It is equally important to understand mental health policy implementation and reform in these settings as it can provide knowledge for future policy makers and implementers on a subject that is fairly new and not widely studied. This can provide information on what the challenges are in these settings such as responding to stigma, issues with capacity and infrastructure, outside influence and short-term funding, shortage of funding, and lack of properly trained personnel. Understanding these challenges can help governments and stakeholders to create and implement policies that are more likely to benefit their populations. In addition, regarding developed countries, it is vital they recognize and understand the effects of their role in the process, most notably in terms of aid allocation and country ownership.

Mental Health in Rwanda

Rwanda is a small landlocked country in East Africa that experienced civil war and genocide in the early 1990's. The civil war began in 1990 between the Hutu led government and the Rwandan Patriotic Front (RPF), an armed group composed mainly of Tutsi refugees residing in Uganda. There was a peace agreement signed in 1993 between the two warring factions, but the civil war resumed in parallel to a genocide in April 1994 when the Rwandan President, Juvénal Habyarimana's, plane was shot down, killing both him and the President of Burundi. The genocide was perpetrated by Hutu extremists against the Tutsi minority. Moderate Hutus who refused to cooperate with the extremists were also targeted. Both the civil war and the genocide ended when the RPF captured Kigali in mid-July of 1994. According to the Rwandan Ministry of Health, during the genocide, 99% of survivors[1] witnessed violence, 57% of survivors witnessed killings with a machete, 31% of female survivors suffered rape and/or sexual assault, and 90% believed that surviving the genocide was "a miracle" (n.d., p. ii).

In addition to survivors of the 1994 genocide in Rwanda, many Rwandans also survived violence perpetrated by the RPF in Rwanda and the Democratic Republic of Congo (Zaire at that time) in the late 1990s (Reyntjens, 2013, p. 98). Many of these Rwandans who witnessed horrific violence in Zaire returned to Rwanda in 1996 and many may also be suffering from mental health issues resulting from this violence (no study has been done on this specific population in regards to mental health, but based on the findings of the literature review in the previous section, it is likely there are mental health issues amongst this population).

These individuals who returned from Zaire are now living under the rule of an authoritarian government who had previously tried to target them. Riadh Abed (2004) has

[1] It is important to note that the RPF categorizes survivors and perpetrators in a way that does not account for many diverse experiences of violence lived by both Tutsi and Hutu Rwandans. Rather, the regime portrays the genocide as a "largely false and single story of Hutu perpetrators and Tutsi survivors" (Thomson, 2018, p. 93). Therefore, these statistics may only refer to Tutsi survivors, and exclude the experiences of Hutu survivors.

argued that living in a totalitarian regime can have the potential to cause severe psychological distress. This psychological distress can be caused due to direct damage of mental health through human rights abuses, indirect damage caused to the mental health of the general population through disempowerment, terror, and the normalization of violence, as well as damage caused to the perpetrators of state violence themselves (Abed, 2004). While Rwanda may not be a totalitarian regime, one can infer that its authoritarian nature may cause similar psychological effects, albeit to a lesser extent. It is important therefore to recognize that not all mental health problems in Rwanda can be attributed to the 1994 genocide, but can also be due to its aftermath, actions in Zaire, and authoritarian governance.

It is important to note that labelling Rwanda as a post-conflict society was met with controversy in Rwanda. Many felt that labelling the country 'post-conflict', rather than post-genocide, was insulting to those who had lived through the atrocities. As one informant stated: "My younger brother was killed in the genocide. He was only five years old. Tell me, who was he in conflict with?" (field notes, February 2019). For the purpose of this research, Rwanda was categorized as a post-conflict state, considering that there was conflict between different parties prior to and during the genocide[2]. However, it recognizes the sensitive nature of labelling the genocide itself as a conflict, and therefore tries to be consistent in referring to Rwanda as post-genocide, rather than post-conflict, while still recognizing that armed conflict took place outside the confines of the genocide.

Studies on post-genocide Rwanda propose findings similar to other data on the effects of conflict, war, and violence on mental health: the Rwandan Ministry of Health's 2012 Mental Health Policy cites a study which found that 28.5% of the general population suffers from post-traumatic stress disorder (p. 5). It does not specify (due to the regime's ban of ethnic labeling)

[2] This statement was also controversial as some informants did not feel that the fighting on the side of the RPF should be labelled as a civil war or conflict, but rather as a justified and moral obligation of ending a genocide (field notes, January – April 2019). Needless to say, current politics in Rwanda play a role in how Rwanda's past is viewed.

whether those suffering are Hutu or Tutsi, but one can infer that both groups, as well as the Twa (an ethnic group making up approximately 1% of the Rwandan population) have been affected by mental health issues, and that this is not only an issue for Tutsi survivors. A study by Rieder and Heide (2013, p. 6) found that 25% of survivors and 16% of their descendants (including descendants born after 1994) suffered from PTSD, once again showing a correlation between the mental health of the parent and the child, as well as the intergenerational consequences of conflict and genocide. Interestingly, Rwandan women reported a higher trauma load regarding the period of the genocide whereas Rwandan men reported a higher trauma load regarding the aftermath of the genocide (Rieder, Elbert, 2013, p. 4). It must be considered, however, that the women in the study were predominantly survivors while the majority of men were former prisoners (genocide perpetrators) (Rieder, Elbert, 2013, p. 4).

A number of somatic symptoms were found to accompany PTSD and depression such as pain symptoms, which are fairly common among those living with PTSD or depression. However, some of the symptoms reported in Rwanda, such as hiccups and loss of speech, are not regularly found in the clinical presentation of PTSD nor reported in other post-conflict mental health literature (Munyandamutsa et al., 2012, p. 1759). Interestingly, Rwandan physicians are familiar with these symptoms, witnessing them in Rwandans during the annual commemoration of the genocide (Munyandamutsa et al., 2012, p. 1759). Therefore, with the exception of some unique symptoms, the experiences of individuals in Rwanda are similar to those in other post-conflict countries in regards to mental health.

Rwanda's Mental Health Policy and Questions regarding Implementation

One year following the genocide, the new regime in Rwanda instituted a mental health policy (Republic of Rwanda Ministry of Health, n.d., p. 4, Ait Mohand & Kayiteshonga, 2015, slide 10), therefore demonstrating recognition of the psychological damage inflicted on people by the violence. This policy is unavailable online and it is difficult to find references to it with

exception of the conference presentation referenced above. However, the policy was revised and the revised policy paper is available online through the Rwandan Ministry of Health. Information around it is scarce, however. For example, the policy itself does not contain a date.[3] There are also very few references to the policy in academic literature or in the media, suggesting that mental health is either not being prioritized or that it is being prioritized, but it is not garnering attention. Due to the scarcity and vagueness of information, the first step of this research was to find out what was really happening in Rwanda regarding this policy. However, implementation remains the main focus of this study.

The revised policy aims to promote mental health awareness, provide mental health care and accessibility, and ensure human resources for mental health (Rugema, et al., 2015). It contains 10 fields of intervention: mental health care (promoting equitable and quality mental health), accessibility of mental health care in the community, human resource development (quantity and quality of personnel in the mental health field), information, education and communication (IEC), legislation (having a legal framework in mental health practice), research, psychopharmacological treatment, epilepsy treatment, fight against drugs and other psychoactive substance abuse, and mental care for children and teenagers (Republic of Rwanda Ministry of Health, n.d.). The policy is ambitious as it addresses several important issues: it seeks to integrate mental health care into the community and increase its accessibility, educate the population to reduce stigma, and produce legislation to protect the rights of the mentally ill.

Despite the ambitions laid out in the policy, some scholars have suggested that there are still many barriers to receiving mental health care in Rwanda: for example, higher health insurance premiums were introduced in 2010 in an effort to support the national healthcare

[3] There is, however, a reference to it being from 2011 in the conference presentation written by Dr. Achour Ait Mohand, expert at the Mental Health Division in the Ministry of Health, and Dr. Yvonne Kayiteshonga, Director of the Mental Health division at the Ministry of Health.

program, which led to decreased access, especially for the poor (Rugema, et al., 2015, p. 2). Rwanda's mental health agenda has also been criticized for offering individualized and psychiatric approaches, which help some, but are not provided on a large scale as the government does not have the capacity (Mahr, Campbell, 2016, p. 291). Furthermore, these individualized approaches are Western in nature and may be unsuitable in the Rwandan context (Mahr, Campbell, 2016, p. 292). Less individualized methods in Rwanda, which from the government standpoint are supposed to lead to healing, include public testifying through gacaca processes[4], and annual genocide commemorations. However, it has been found that these methods can be re-traumatizing and may actually result in emotional pain (Brounéus, 2008 as cited by Mahr, Campbell, 2016, p. 292). A study of child survivors of the genocide found that the annual genocide commemoration day re-traumatized the boys and increased their will to leave Rwanda (Kaplan, 2013). One boy stated, "If possible, the government should abolish this commemoration day" (Kaplan, 2013, p. 105). A year after the gacaca process began, Die Friedens-Warte (2005, p. 123) wrote that gacaca jurisdictions bring disturbing issues to the surface and lead people to revisit the traumatizing past, dividing communities as a result. Another study on public testifying in Rwanda had similar findings: the women studied were threatened and harassed before, during, and after testifying and their lives were "dominated" by traumatization, ill-health, isolation, and insecurity (Brounéus, 2008, p. 55). In order to ensure services can be offered on a large scale, and to avoid the negative emotional consequences of more public methods,, Mahr and Campbell (2016) recommend small-scale community-level approaches. These approaches would have a wider reach and are more culturally sensitive than individual approaches, while also being less threatening than public

[4] Gacaca is a traditional form of justice in Rwanda that was readapted in order to speed up the process of trying genocide perpetrators and those who committed crimes during the genocide. Traditional gacaca processes were informal gatherings outside the formal political system where respected male elders settled conflicts within communities (Longman, 2010, p. 306-307). The new post-genocide gacaca courts could include women or young people as judges and were charged with "administering national law and trying all but the most serious genocide crimes" (Longman, 2010, p. 307).

approaches.

While there may be research evaluating mental health programs in post-conflict Rwanda (Ng, Harerimana, 2016), little can be found regarding the policy itself or its implementation, including its challenges and bottlenecks or on the contrary, some of its drivers. Researching this case was interesting as Rwanda is one of the few post-conflict/post-genocide countries within Africa to have a national policy on mental health (other countries include post-conflict Uganda and post-apartheid South Africa)[5]. If successful, Rwanda could be a leading example for the rest of the continent, especially as numerous unresolved conflicts within Africa continue that will no doubt affect mental health and many look to Rwanda as a health champion in other sectors[6].

Theoretical Framework

Policies, such Rwanda's Mental Health Policy, are created by government in response to the perceived needs of the country and its citizens. Once policy is created, there is the crucial step of implementation. Focusing on implementation is important because passing policies does not guarantee success if the policies are not implemented well (Cerna, 2013, p. 17). However, implementation can be a challenging process, especially when the policies are complex or when it takes place in a low-income or post-conflict country that has limited

[5] Gureje and Alem stated in 2000 that "most African countries have no mental health policies, programmes or action plans" (p. 475). However, the emergence of mental health policies in the aforementioned countries as well as specific mental health services beginning to be offered in others demonstrates that this trend is changing.

[6] Rwanda has been viewed as a champion in the health sector, especially in regards to its policy on Community Based Health Insurance (CBHI). This policy is based on obligatory enrolment and subsidies from the formal sector and has been recognized as a rare success of CBHI coverage in Sub-Saharan Africa (Chemouni, 2018, p. 88). The success of this policy has been facilitated by the regime's vertical distribution of power, making it easy to maintain user fees and to enforce compulsory enrolment (Chemouni, 2018, p. 94) Two ideas relevant to CBHI is that it is the role of the state to decrease dependency on the external world and that the state should not be dependent on donors' money in the long run for health financing (Chemouni, 2018, p. 96). Based on the experiences in Bosnia-Herzegovina and Cambodia described earlier, the fact that the regime is attempting to decrease reliance on external actors is positive and may have been a contributor to the policy's success.

capacity, such as Rwanda.

Various scholars have sought to define implementation over the years: Pressman and Wildavsky (1973, p. xxi-xxiii), who Paudel (2009) refers to as the founding fathers of implementation theory, viewed policy implementation as the process of interaction between the setting of goals and the actions done to achieve them. A decade later, Sabatier and Mazmanian defined implementation as "the carrying out of a basic policy decision, usually incorporated in a statute but which can also take the form of important executive orders or court decisions" (1983, p, 20). Finally, in 1995 O'Toole (p. 43) referred to implementation as the link between the "expression of government intention and the actual result" (as cited in Paudel, 2009). In essence, implementation is the process required to create the change in society that policy sets forth.

Implementation is more complicated however than simply translating words into action. Implementation involves complex questions of interpretation, conflict, decision-making, and "who gets what" in a society (Van Meter, Van Horn, 1975 p. 446 as cited in Grindle, 1980, p. 3). This is especially true in developing countries, where the implementation process could be a key arena for individuals and groups to pursue conflicting interests and compete for scarce resources (Grindle, 1980, p. 15). Smith (1973, p. 197) views policy implementation in general as a "tension generating force" in society. Tensions arise and are generated between the idealized policy, the implementing organization, the target group, and environmental factors (Smith, 1973, p. 197). Therefore, implementation is the result of unpredictability, the interactions between various actors and organizations, and their diverse motivations and interests (Santos Mendes & Aguiar, 2017, p. 1105).

In order for policy implementation to succeed, local will and capacity are key (Giacchino & Kakabadse, 2003). More specifically, "will" is seen as the commitment of the government to implement a policy/the disposition to see it through and "capacity" is having an effective

approach, including effective resources, effective planning, and an effective use of networks and stakeholder involvement (Giacchino & Kakabadse, 2003, p. 144-145). An additional challenge to implementation is finding an approach that takes regional aspects and social diversity into consideration, especially with universal policies such as public health policies (Santos Mendes & Aguiar, 2017, p. 1105). In 1979, Elmore identified four main components for effective implementation: clearly specified tasks and objectives, a management plan that allocates tasks to subunits, an objective means of evaluating progress, and a system that holds management and those under them accountable for their performance (p. 195). Giacchino and Kakabadse (2003) also point to strong management and team dynamics as important elements for successful implementation. Additionally, they view political responsibility for the initiative and commitment to the initiative as being key factors (Giacchino & Kakabadse, 2003). Matland (1995), however, has a more technical definition of success: compliance with statues' directives and goals, achievement of indicators, and improvement in the overall political climate around the program. While success relies on many factors, it is certain that the local context and the nature of the policy being implemented will determine which factors play the largest role.

When looking specifically at the implementation of mental health policies and reforms, Florence Baingana, Senior Health Specialist at the World Bank wrote in 2003 that the implementation of mental health care and psychosocial interventions in post-conflict societies must consider three different dimensions: cross-sectoral involvement, levels of care, and coordination among policies and stakeholders. Cross-sectoral involvement, the first dimension, refers to the many sectors that must be involved in mental health care/interventions, including health, education, social welfare, refugee and displaced persons' welfare, and legal and judiciary. The second dimension, levels of care, refers to the three levels of care where interventions must take place: the primary level such as family and the community, the secondary level such as therapy and counselling, and the tertiary level referring to hospital-

based mental health care. Each of these levels of care is vital to the implementation of interventions. Finally, the third dimension for successful mental health care interventions is coordination between stakeholders including government, donors, non-governmental organizations and UN agencies, and to ensure that there is consistency with the supervision, monitoring, and evaluation of the policy (Baingana, 2003).

In addition, the implementation of mental health policies/reform must involve the society at large and not only suffering individuals and caretakers for it to be successful. Summerfield (2000) emphasizes the fact that war is not a private experience, and therefore the suffering created by it must be resolved in a social context. This is contrary to Western psychological practices that often resolve mental health issues in individualized ways. Yet, Summerfield points out that health and illness have social and political roots and that post-traumatic reactions are "an indictment of the socio-political forces that produced them" (p. 234). The World Health Organization summarized the research in 2011 stating that "Mental health is produced socially: the presence or absence of mental health is above all a social indicator and therefore requires social, as well as individual, solutions" (WHO, 2011, p. V). The consequences of mental illness also go beyond the individual level, as a person suffering from mental health issues may be unable to participate in community activities, therefore constraining both access and contribution to social capital (Baingana, 2003, p. 2). Summerfield (2000) states that humanitarian interventions must be geared towards the weakened social fabric of survivor populations as this is where the capacity of recovery for all lies. This can also be applicable to national/domestic interventions. A study on 84 Iraqi male refugees illustrates this argument, as it found poor social support to be a stronger predictor of depressive morbidity than trauma (Gorst-Unsworth, Goldenburg, 1998). Supporting this model of gearing interventions towards the social fabric of communities, Scholte, Verduin, Kamperman et. al. (2011) found that a large-scale psychosocial intervention in Rwanda that was aimed at social bonding led to lasting

improvement of mental health in survivors.

Increasingly, this need to operate policy implementation across levels and to take into account relations across a variety of actors, but also context, has been recognized. Within studies of policy implementation processes, complexity theory reflects on tools and strategies for managing uncertainty. This theory is popular in the business world, but can also be applicable to policies in complex/challenging settings. Complexity theory is a branch of systems theory that aids “understanding of the mechanisms through which unpredictable, unknowable and emergent change happens” (Ramalingam & Jones, 2008, p. 61). While systems theory tends to assume that systems have dominant rules, clear feedback loops, and a control system, ultimately leading to predictable results, complexity theory emphasizes that systems in general often defy “calculated equilibrium” (Ramalingam & Jones, 2008, p. 5). More specifically, complexity theory “forces us to see the interdependence of the nature/meaning of individual elements and the context in which they are embedded” (Ramalingam & Jones, 2008, p. 5). Complex systems are characterized by interconnected and interdependent elements and dimensions. Within these elements, feedback processes shape how change happens, resulting in emergence whereby the behaviour of the system changes from the interaction of the parts (Ramalingam & Jones, 2008). As a result, the whole is different from the sum of the parts. Therefore, results derive from self-organization and complex feedback loops (Ramalingam & Jones, 2008, p. 5)

Recognizing problems as complex allows for a different, and often more efficient and fitting way to address the issue. While some systems function well with clearly defined and operating hierarchies, others require distributed capacities and negotiations at different levels (Ramalingam & Jones, 2008, p. 4). Additionally, while some systems have prior and stable knowledge on cause and effect, other systems are less understood and often unpredictable. Finally, while within some systems there is a consensus on the problem to be addressed as well

as the goals to be reached and the ways in which to reach them, in others there are many various and legitimate competing perspectives (p. 4). Therefore, complex systems are defined by limited knowledge on distributed capacities and cause and effect, as well as limited consensus on the goals and the means to achieve them (p. 5).

In terms of policy implementation, the issue to be addressed may sometimes be simple, the goals may be based on a consensus between actors, and the ways suggested to address it are based on data and research. In these cases, top-down hierarchical management and implementation may be appropriate as the system is well-defined and understood[7]. Other policies, such as Rwanda's Mental Health Policy, are complex as the issue to be addressed, mental illness and poor mental health as a result of genocide with trans-generational consequences, is far from simple. Hummelbrunner and Jones (2013) provide ways to identify interventions that will be complex and how best to plan interventions based on the level of complexity. Complexity is increased with uncertainty, which is important to acknowledge in order to plan well. One may expect that increased uncertainty should require increased planning, but Hummelbrunner and Jones (2013) argue that the opposite is true. This is because a large majority of the information required to inform action will only emerge during the implementation process and increased planning beforehand can lead implementers to pay little attention to ongoing learning and be in-adaptable (Hummelbrunner & Jones, 2013, p. 2). This is not to say planning becomes obsolete in the face of complexity; it simply must be managed differently. Planning must be participatory and adaptive to new developments during the implementation process (Hummelbrunner & Jones, 2013, p. 4). Robert Chambers (1997, p. 6, as cited in Ramalingam & Jones, 2008) summarized this well when he said that to manage complex systems “the key is to minimize central controls” and to “use rules which promote

7 However, it must be noted that some argue (Furtado et al., 2015) that all public policies are complex, as they are applied among a varied range of issues involving multiple stakeholders and communities and they are employed in sectoral issues which are “intertwined, asynchronous, and spatially superposed” (p. 7) and therefore policy implementation always requires a complexity perspective in order to be successful.

and permit complex, diverse and locally fitting behaviour”.

As mentioned above, the implementation of Rwanda’s mental health policy is fairly complex as it involves much uncertainty and relies on various interactions between different parts. There are, in addition, many challenges in the Rwandan setting that increase the complexity such as stigma regarding mental illness and the use of mental health services, the authoritarian nature of the current regime, and the fact that Rwanda is a low-income, post-genocide country.

Research Questions

The questions my study seeks to answer include: How has Rwanda attempted to implement its mental health policy? What are some of the obstacles and challenges of implementing Rwanda’s mental health policy as well as the best practices and successes? How is progress/success of the implementation of the mental health policy measured and do different actors define success differently?

Methodology

In terms of methodology, I adopted process tracing, a qualitative method. Process tracing focuses on the “unfolding of events *over time*”, (original emphasis) and relies on careful description of events and causal inference (Collier, 2011, p. 824). By characterizing key steps in the process over time and describing them in detail, one is able to have a good analysis of change and sequence. By adopting process tracing as my methodology, I have aimed to determine that (1) a specific event or process took place, (2) a different event or process occurred after the initial event or process and (3) that the former was the cause of the latter (Mahoney, 2012, p. 571). Furthermore, it was meant to allow me to see how different events in the implementation of the policy relate to each other. However, in order to understand causal links and how events unfold and situations change, one must be able to describe an event or situation at one point in time (Collier, 2011, p. 824). I used process tracing because this study

does not attempt to evaluate the policy nor its implementation, but rather it attempts to document the process behind its implementation in order to see what the challenges and successes are. Process tracing also helped to explain how these challenges are addressed and how these successes were achieved. It is not a rigid study simply looking at whether or not certain policy objectives were completed, but it gauges the opinions and experiences of stakeholders, implementers and service providers on the implementation of the policy.

Rwanda was chosen as a case study because as mentioned in previous sections, it is one of few post-conflict/post-genocide countries with an existing mental health policy. In addition, the mental health policy has existed since 1995, allowing me to document the progress that has taken place during this time. With regards to specific methods, I have primarily built on interviews with key stakeholders in Rwanda including government officials from the Ministry of Health/Rwanda Biomedical Centre, local NGOs working on mental health issues, international organizations, academics, as well as local service providers. Interviewing government officials from the Ministry of Health/Rwanda Biomedical Centre allowed me to gather information on how the policy is being implemented from the top, while interviews with local service providers gave insight into how the policy is being implemented on the ground and at the local level. No patients were interviewed as this brought up multiple ethical concerns, including the risk of traumatization. Although patient perspectives are vital in the implementation of health policies, they were not included in this specific study as I am not trained in counselling, psychology, or therapy, and therefore do not have the professional capability to lead this type of interview. This should be noted as a limitation and as something that should be included in future research on the implementation of this policy (if carried out by or with the assistance of a trained professional).

Interviews took place in two regions: Kigali and Ngoma. Kigali was chosen as it is the capital of the country and the Rwandan Ministry of Health and the Rwanda Biomedical Centre

(implementing body of the mental health policy) are located here as well as many prominent NGOs working in the mental health field. On the other hand, Ngoma was chosen as it is a more neglected district, having remained peripheral to feuds over power in the decades since independence. Interviewing service providers/local organizations in these two contrasting districts provided insight into how the policy is being implemented in regions with different trajectories in relation to the state. Originally, this research sought to include a third field location, Huye, but this was not possible due to time constraints. While including a third location would have added further substance to the study, it is not estimated that the study was greatly impacted by this decision as findings were very similar in both Kigali and Ngoma. It is not expected that a substantial amount of different ideas, thoughts, or themes would be raised in Huye[8].

Thirty interviews were conducted and these interviews ranged from 15 minutes to 1 hour. While more participants would have provided better insight into the policy's implementation, time and resources allowed for this number of interviews. The majority of the interviews (twenty-one) took place in Kigali while the remaining nine interviews took place in Ngoma, as there were fewer actors working in the mental health sector in Ngoma district. In terms of demographics, 18 of the interviewees were female and the remaining 12 were male. Five were implementers in government institutions, ten were service providers in either hospitals, health centres, or private practises, two were academics, and the remaining 13 were representatives from non-governmental organizations, both local and international[9]. While recording further demographical information (such as length of time in current position or the education/background of participants) may have added more validity to the data, this information was not requested (and in the cases where it was given voluntarily, it was decided

[8] However, it must be noted that there were some differences in responses/themes raised based on urban vs rural realities in Kigali and Ngoma.

[9] It should be noted that some of these representatives also acted as service providers within their non-governmental organizations while others were directors, researchers, team members or project leads.

not to be shared) in order to protect the confidentiality of participants and to make sure they were comfortable. As Rwanda is an authoritarian state, asking for this type of personal information may have led informants to feel vulnerable or more identifiable, and this also could also have resulted in participants sharing less. The interviews were comprised of ten open-ended questions developed by the primary researcher. One questionnaire was developed for implementers in government institutions and a different one was created for the rest of participants. Using a qualitative method such an open-ended interviews allowed for a "holistic understanding of complex realities and processes" (Desai, Potter, 2006, p. 134). These interviews were complimented by secondary literature as well as primary sources including Rwanda's Mental Health Policy, other official government documents, and documents and reports from NGOs and other organizations.

In order to recruit participants, I contacted the Ministry of Health, the Rwanda Biomedical Centre, NGOs, stakeholders and organizations through email and/or phone and then arranged a date and time for the interview. Recruitment material was distributed to organizations and individuals within organizations with my contact information. Participants were given the choice of where they preferred to conduct the interview, and the majority chose their place of work. In many organizations, it was necessary to seek formal permission to interview their staff. This was the case at the Rwanda Biomedical Centre, all hospitals, as well as in some NGOs.

The interviews in Kigali were conducted by the primary researcher without the use of an interpreter (with the exception of one interview), whereas the majority of interviews in Ngoma district required the assistance of an interpreter as the level of English or French was low in this part of the country. All participants gave permission to audio record the interviews, which were later transcribed by the primary researcher. A translator in Canada was used to translate interviews gathered in Ngoma. Following this step, the interviews were analyzed through

thematic analysis. This type of analysis was used in order to identify common themes emerging from the interviews and to identify patterns in participant responses in order to map out the process of the implementation of Rwanda's mental health policy. The initial codes used to analyze the interviews were predetermined based on the research questions and included 1) context, 2) process, 3) actors, 4) challenges/gaps, 5) successes/best practises, and 6) recommendations. In contrast, when it came to coding the challenges, the codes used were determined by the themes raised by the participants, that is inductively.

There are limits to this study in terms of the number of participants, but this has been mitigated by the quality of the data, as I was able to receive more detailed and personal responses from one-on-one interviews and by adopting a qualitative method. A second limitation was that I was not able to track down information on the designers of the policy nor was I able to find a copy of the original 1995 policy. I met with many high-level officials and requested this information, but always received vague answers (one stakeholder told me "the government" wrote the policy, while others simply said they did not know). In other cases, stakeholders did not even realize that the 2012 policy was a revision of a previous policy. One high level person I met in the field gave some insight into who was consulted in the drafting of the policy (this will be covered in later chapters), but this information was not confirmed by others. Design clearly influences the implementation process, and not understanding the design process is a gap in this study.

Ethics

This research was granted ethical clearance from the University of Ottawa as well as from the Rwanda National Ethics committee. A research permit and a research visa were also obtained once in Rwanda. In addition, research regulations in Rwanda required that I work with a local supervisor. Eugène Rutembesa, a Rwandan psychologist, took on this role and was theoretically given access to anonymized data, but never requested it. This research contained

some risks, but these risks were carefully assessed and all attempts were made to mitigate them. The first risk was that interviewees faced possible re-traumatization. However, this was largely mitigated by the fact that interviews were conducted with service providers and implementers rather than beneficiaries (as explained above), who are likely less psychologically vulnerable and who have different experiences. In addition, questions were specific to the policy and its implementation, and did not focus on sensitive topics such as the genocide or individual/personal mental health. The nature of Rwanda's authoritarian regime posed another risk in that criticizing the regime had the potential to lead people to feel uncomfortable or even have emotional or psychological stress. In order to minimize the likelihood of these risks, I ensured that participants knew that the information they provided would not be shared with others, that their names would not be used, and that all data would be protected on a password protected USB. They were aware that only my supervisors and myself have access to the data. Likewise, I attempted to prevent any negative emotional or psychological responses that could arise by ensuring participants knew that they could retract statements at any time prior to the thesis publication/defence. I also provided my participants with calling cards so they were able to contact me if they wished to retract anything they said or to ask me any general questions about the study/how their responses will be used.

In order to ensure that the privacy of participants was respected, pseudonyms were used to organize the data. Names are never used nor were they collected with the exception of the consent forms. When asking for consent, I explained to interviewees that if I use a direct quote from them, a pseudonym would be used and identifying information would not be used. This was done so that participants were confident that their information would be kept private.

In order to avoid the possibility of coercion, I consistently reminded the interviewees that their participation was optional and that they could end the interview at any time. I used a consent form to ask for written consent and these forms were kept in a locked cabinet in the

principal researcher's place of residence at all times. This consent form was given to participants in both English and Kinyarwanda in order to ensure full comprehension of the risks involved as well as their rights as participants. I reviewed the English version of the consent form with all participants before giving them time to review the Kinyarwandan version independently. I was also careful to watch how people reacted to my questions, and reminded participants that they could choose not to answer a question or to stop the interview at any time. As mentioned in the section above, I reminded participants at the end of the interview that they could retract information for a limited amount of time after the interview. I provided them with my contact information and calling cards so they were able to get in contact with me. With exception of the calling card, I did not provide money to respondents or any other form of material compensation that could be perceived as an incentive for participating.

Finally, it is important to raise the issue of positionality while also addressing reflexivity. Being a white, educated, Canadian woman with a self-acknowledged privileged background conducting research in a low-income, previously colonized, post-genocide African country, power relations were not always equal and I was given privileges that someone with a different background, especially local Rwandans, may not have received. A clear example of these unequal power relations arose in terms of access: I was often given access to institutions and people that a local may not have been given. Security let me enter government institutions/health institutions without proof of appointment and with little questioning. My privileged position became especially clear when my interpreter joined me for research activities, as I was immediately granted access while he was often searched and questioned.[10] Because of my position and these unequal power relations, it was especially important to emphasize the process of consent in order to avoid someone feeling obligated to participate

[10] This was not always the case as sometimes the presence of a local actually increased access, but overall it was evident to me during my time in Rwanda that my position as a white/Western woman often resulted in privileges.

due to my position.

In terms of reflexivity, I admit that my experiences as a privileged, white, Western woman make it impossible for me to ever understand the realities of a Rwandan, whether that be a Rwandan in the mental health care system, a Rwandan suffering from mental health issues, a Rwandan providing mental health services, or a Rwandan trying to implement this complex policy. I will argue, however, that due to the relationships I built, the conversations I had, the information I gathered, and the way I conducted my interviews, I was able to understand the issue as much as an outsider possibly could. But this by no means is an attempt to say that I can understand the Rwandan reality, or the realities of interviewees, as my position and privilege will never allow this to be the case.

Finally, I also have my own biases based on my life experiences that ultimately affect the results of my research. I have previous experience working in policy implementation in the Canadian government, and as a result I have a clear bias of how policy should be implemented. My own experiences in the Canadian healthcare system also make me biased in terms of how I think healthcare should be provided. I attempted to enter the research process with an open mind, erasing my biases resulting from previous experiences, but as humans we are imperfect and therefore I cannot claim that my biases are in no way reflected in this research. This is a limitation in this research as well as in all qualitative studies.

The following chapters will present, discuss, and analyze the data gathered, beginning with the context (the state of mental health care in Rwanda prior to the genocide/introduction of the mental health policy). Next, it will provide insight into the process and successes of implementing the policy, followed by an overview of the challenges and gaps in this implementation process. It will conclude with an analysis along with recommendations based on complexity theory.

CHAPTER 2 – Context

Prior to the genocide, mental health was not prioritized in Rwanda and there were many misconceptions regarding mental health and mental illness. As a result, services were limited. However, this does not mean that services did not exist: prior to independence, Rwanda sent its patients suffering from mental illness to Bujumbura (then Usumbura) Burundi, where a psychiatric hospital had been established in 1951 with the aid of Belgian funds (Ndera, official website). In 1968, Ndera Psychiatric Hospital was founded on the outskirts of urban Kigali by a religious organization, the Brothers in Charity. Once Ndera Psychiatric Hospital opened, it served both men and women and had a capacity of 60 patients. With time, it saw expansion in personnel and infrastructure and in 1978 an antenna hospital was created in the Butare region, with 20 beds capacity. However, mental health was not viewed as an important issue in the country. One psychologist currently working at Ndera hospital in Kigali stated that before the genocide, “it’s like if the hospital was on the side so there was not a lot of government aid... You work at Ndera with the mentally ill, and then we didn’t have access to things from the government like training” (Interview, March 2019). In addition, it was considered an “embarrassment” to work at Ndera Hospital during those years, let alone to be a patient.

Due to stigma and a lack of understanding of mental illness during this time, many of those suffering from mental illness were not medically treated. Instead, they were often brought by their families to traditional healers or treated at home. One actor working in a local NGO, Immaculée, emphasized the importance of family and how “before, for example, I can tell you that when we had problems, one could go talk to their mom” (interview, March 2019). However, being cared for during this period by family members or a traditional healer was not always the norm: often, those suffering from mental illness were outcasted. Anne, who works for a different local NGO explained: “a person who was suffering about the mental health disorder was considered as a foolish people and it was really something strange in society. It

wasn't really something familiar to our culture. They can say that he's attacked by demons and things like that. People couldn't realize that it's an illness like malaria or other things" (interview, March 2019). Other participants shared a similar representation of the treatment of those suffering from mental illness in the past. Charity, a psychologist, stated that "before there were mentally ill everywhere in the street... before when we saw a mentally ill on the road and we passed, we left them and one year, two years, three years, they stay there in the garbages everywhere". If they were not living on the streets, they were often hidden by their families: "we saw families, especially rich ones, who lock up their sick people so that the people who come visit cannot say "you have a mentally ill person here."" (Interview, March 2019).

Mental illness was not understood as a psychological disorder in Rwanda during this period and therefore people believed those exhibiting symptoms of mental illness were poisoned, possessed, or had a spell cast on them. Another psychologist, Michelle, stated: "anyone that accesses mental health services has been historically known as umusazi" (Interview, March 2019). Umusazi is the Kinyarwandan word for crazy, foolish or mad. According to interviewees, those suffering from mental illness also suffered numerous human rights abuses. One health implementer, Pauline, stated that "in the past, people used to chop people's (the mentally ill) arms off" (interview, March 2019). An implementer of the mental health policy, Bonaventure, said: "these people were neglected. They were neglected. They were facing stigmatization, they were facing harassment, discrimination. According to the history, these people were just put in jail" (interview, March 2019). In addition, those who did wish to go to the hospital to receive services faced challenges commuting, as Ndera and its satellite institution were the only two mental health facilities in the country. Many did not have resources, and therefore were not able to travel to Kigali or Butare.

When the genocide erupted in 1994, the psychiatric hospital was not immune to attacks. Ndera Hospital was destroyed, the personnel were massacred, and those that escaped the

violence went into exile. In addition, the equipment was pillaged and records disappeared. The mental health sector, which was very small to begin with, was destroyed.

Following the genocide, and as a result of it, trauma and mental health concerns were rampant: “Everything is rooted from the genocide and mental illness actually existed before the genocide, but the consequences of the genocide is that these problems became worse.” (interview, psychiatric nurse, March 2019). Participants emphasized that nearly all Rwandans were affected by the genocide and that many developed mental illnesses/poor mental health as a result. Others pointed out how the genocide destroyed the social fabric of the country as well as people’s social well-being. Most interviewees focused on the concerns of genocide survivors, but some also mentioned post-genocide mental health concerns among the perpetrators. For example, Honorine, who works in the NGO sector explained that: “there’s another thing: people also think it only applies for people who survived the genocide. But what happens for the perpetrators? Knowing that you – look at the guilt one feels when they’ve lied, just lying, you know? Now imagine the guilt that one has to live with when they’ve killed another human being. How do they live with that? How do they go about that?” (interview, March 2019). Others also mentioned mental health issues among other groups such as those who became refugees or those who were not targeted in the genocide but witnessed it. As one psychiatrist, Janvier, put it, Rwandans experienced “varied trauma” (interview, March 2019), meaning that everyone’s trauma and experiences were different depending on their position/role during the genocide. Some participants also mentioned that the trauma in Rwanda started before the 1994 genocide with the 1959 revolution and the subsequent massacres and episodes of violence that followed it[11], making the problem even more complex.

[11] Following colonial rule where Belgium supported the Tutsi monarchy, a Hutu Revolution took place, ending the monarchy and putting Hutus in power. Faced with the loss of power, around 10,000 Tutsis went into exile (Des Forges, 1999, p. 36). In the 1960's, these refugees began to attack Rwanda from outside, leading the Hutu government to engage in reprisal attacks against Tutsi civilians within the country (Des Forges, 1999, p, 27). During these years 20,000 Tutsis were killed (Des Forges, 1999, p. 36). By the late 1980's, the number of Tutsi exiles raised to 600,000 and attacks from the RPF continued to hit Rwanda (Des Forges,

Therefore, it was necessary to address mental health issues, especially following the genocide. A representative of a local NGO working on mental health issues, Cynthia, stated "I think there was really an emergency for how to deal with mental health issues" (interview, March 2019). Patient, a government implementer of the policy, also shared the same sentiment that post-genocide mental health care was about managing an emergency: "in 1995 we were managing emergency, it was about emergency... because it was just one year after genocide. You understand that our priority was to manage, especially in the genocide survivors. Because at that time trauma was very high" (interview, March 2019). Immaculée, who works in the NGO sector, stated: "the genocide left a lot of aftereffects for people like victims of violence and victims of genocide and so after all that there were a lot of traumatized people, children, women, others, everyone." She continued: "Me, myself, I lost everyone – I lost my family during the genocide, I lost my mom... So when I have a small problem, I say to myself, "oh if I had my mom I could confide in her the things that are in my heart", but now, I don't have her. We saw therefore how that affected the culture and the family." Mental illness, especially trauma (PTSD) skyrocketed, and those who lost their family members had no one left to take care of them. Therefore, it was necessary for the state to intervene: "there was no cultural understanding to understand what was the genocide, because we had never had it in our society. And then there wasn't the cultural understanding either to take care of people. It was necessary that the state invent something" (interview, Diane, representative of local organization, March 2019).

Yet managing this emergency was a challenge: there was a lack of mental health professionals trained and available to work, as many of those who worked in the field prior to 1994 had either been killed or fled during the genocide. As of 1995, there was one psychiatrist,

1999, p. 36). Tensions during this time raised between the RPF and the Hutu led government, eventually leading to the genocide that devastated the country.

five psychologists, and three psychiatric nurses in the country (Rutembesa, presentation, n.d.). As an implementer of the mental health policy, Bonaventure, stated: “Just after 1994... here in Rwanda we didn’t have some specialists even to know what is mental health. This concept... was strange or new in Rwandan population or community. But just after finding out we’re having some huge problems regarding mental health, as I told you: depression, traumatisme, anxiety... mental health problems like schizophrenia, like major-depressive. Do you understand that it was a challenge for the country to find how to address these issues?”.

As a response, in 1995 the first version of the mental health policy was drafted and published. As Linda, an implementer, stated, “For our case, right after the genocide it was urgent to have a mental health policy in order to guide the country, to guide anybody, to follow the priorities of the country. NGOs can come, partners can come with good will, but you can’t ensure that things are being done well if there is no national policy, which is a proof of good governance. Any country needs to develop a legal framework for anybody to follow” (interview, March 2019). According to one stakeholder, civil society, especially IBUKA, the umbrella association of genocide survivor organizations, were key actors in pushing for a mental health policy and it was subsequently instituted in collaboration with the government (field notes, April 2019)[12]. At this time, the Ministry of Health (MoH) was in charge of both creating the policy as well as implementing it. Although the MoH was in charge of its implementation, other ministries and non-governmental organizations contributed including UN agencies, local NGOs, the World Health Organization, the National Trauma Centre, research institutions, the Ministry of Local Government (MINALOC), the Ministry of Gender and Family Promotion (MIGEPROF), the Ministry of Education (MINEDUC), and the Ministry of Finance and Economic Planning (MINECOFIN) (Bilan et Communications du

[12] However, as mentioned in the first chapter, this information was not confirmed (or denied) by others. It has been included though due to the position of the stakeholder, which leaves little doubt that the statement is untrue.

Seminaire d’Initiation aux Problèmes de santé mental addressés aux Titulaires des Centres de Santé, 2002).

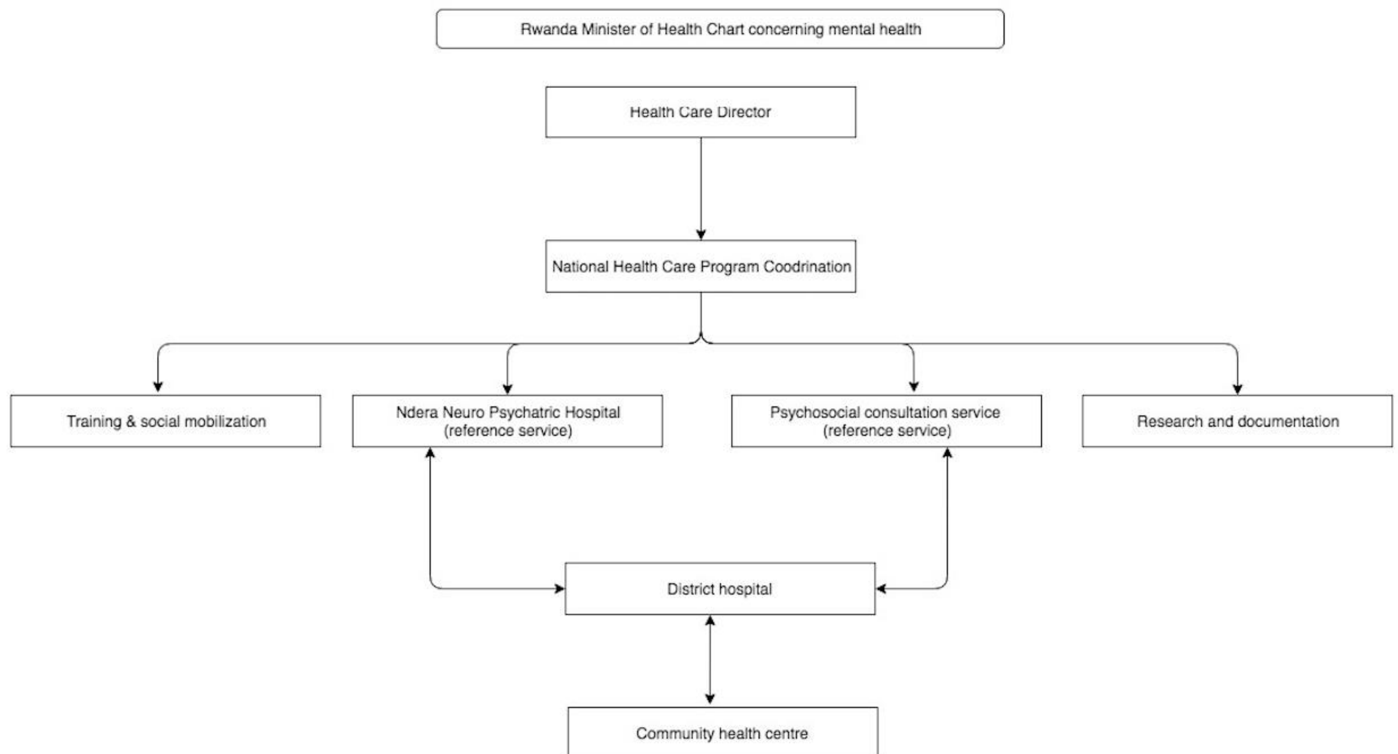
The objective of the 1995 policy was to promote mental health care for the Rwandan population within primary health care according to the approach recommended by the national health policy (Bilan et Communications du Seminaire d’Initiation aux Problèmes de santé mental addressés aux Titulaires des Centres de Santé, 2002). The specific objectives of the policy were to integrate mental health services in all structures of the national health system, ensure mental health care that is complete, continued, and integrated, favour intersectional collaboration, provide all levels with an institutional framework as well as human resources, materials, and finances, promote community care in the subject of mental health, create legislation in the subject of mental health, and to promote research in the subject of mental health.

Finally, the priority programs were information, education, and communication (IEC), training at all levels, improvement of mental health care, psychosocial care of the post-traumatic consequences of the war, essential mental health medications, fight against drug abuse, and research and development of mental health based on the Rwandan culture (Bilan et Communications du Seminaire d’Initiation aux Problèmes de santé mental addressés aux Titulaires des Centres de Santé, 2002).

Ndera Psychiatric Hospital reopened in 1996 with Swiss and Belgian aid. However, this time, thanks to the policy, rather than being the sole institution to offer mental health care, services became decentralized. Health centre' and district hospital employees were trained by the government to respond to mental health issues. If the health centre was unable to treat a patient (if it was a difficult case or it did not have the necessary medications/equipment), the patient was transferred to the district hospital to be treated. If the district hospital was also unable to treat the case, then the patient was either transferred to the psychosocial consultation

service (reference service) or Ndera neuropsychiatric hospital (reference hospital). This avoided burdening the psychiatric hospital with too many patients, as less severe/complex issues could be treated at lower levels. Only the most serious cases reached Ndera.

Table 1 - Rwanda Minister of Health Chart concerning Mental Health



(Chart recreated electronically based on chart found in Bilan et Communications du Séminaire d'Initiation aux Problèmes de santé mental adressés aux Titulaires des Centres de Santé, 2002).

The policy also introduced mental health care during the gacaca trials. The government created a strategic plan/action plan for psychosocial intervention during the gacaca process which emphasized the training of professionals to respond to those suffering from mental health issues as a result of gacaca as well as sensitization, meaning to increase awareness and reduce

stigma around mental health[13]. The two specific objectives were to "prevent and take care of trauma problems before, during, and after the gacaca process" and to "create a synergy of interventions among partners working in mental health domain during the gacaca process" (Bilan et Communications du Seminaire d'Initiation aux Problèmes de santé mental addressés aux Titulaires des Centres de Santé, 2002).

This 1995 mental health policy was revised in 2011 and published in 2012. The revised policy included ten fields interventions (specific areas where the government planned to intervene in the mental health domain) and states in the preface that the revision was necessary in order to "meet the evolution of the context and adequately respond to the challenges of mental health within the Rwandan community". Linda, an implementer, stated: "it was a need to align to those new challenges, new environment, the new questions raised from the community" (interview, March 2019). The policy makers consulted different actors in the field in the drafting of the revision, especially academics, but also local associations, community health workers, and traditional healers (informant, field notes, April 2019, interview, March 2019). Once again, the policy was released and owned by the Ministry of Health. However, the Rwanda Biomedical Centre (RBC) was established in 2011 as a branch of the MoH and became the implementing body of the policy (informant, field notes, March 2019, Rwanda Biomedical Centre website). The MoH is still responsible for monitoring and evaluation, however. The mental health division at RBC is divided into three categories: psychiatric care, drug abuse, and community mental health rehabilitation (interview, implementer of national policy, March 2019, field notes, January – April 2019):

13 Although it must be noted that in Rwanda sensitization by the RPF could also be seen as an authoritarian tool to conduct indoctrination.

Mental Health Division (11)
-Division Manager (1)
-Psychiatric Care Unit (3)
-Mental Health Rehabilitation Unit (4)
- Specialist is Charge of Subtance Abuse Disorders Coordination (1)
-Management of alcohol and drug use disorders Specialist (1)
-Prevention of drug abuse Specialist (1)

(RBC website, 2014)

This division is crucial given the state of mental health in Rwanda today. Rwanda's 2018 Mental Health Survey found that 12% of the general population is suffering from major depressive disorder, 8.1% suffer from panic disorder, 3.6% from PTSD, and 3.6% from obsessive compulsive disorder (OCD). Global statistics state that depression effects 3.4% of people worldwide (WHO Global Health Observatory, 2015), making 12% a very high number in one given country. Likewise, globally only 3.8% of people suffer from anxiety disorders (WHO Global Health Observatory, 2015). The statistics regarding genocide survivors show even higher prevalence: over 28% for major depressive disorder, 28% for post-traumatic stress disorder, 27% for panic disorder, 11.6% for OCD and 4% for alcohol use disorder. Nationally, only 1.6% of Rwandans suffer from an alcohol use disorder, similar to global rates of 1.4% (WHO Global Health Observatory, 2015). Therefore, 4% is a very high percentage and represents a significant number of genocide survivors who are abusing/dependent on alcohol. In addition, the 2019 World Happiness Report, published annually by the United Nations Sustainable Development Solutions Network, ranked Rwanda 152nd, only five spots away from last place. Rwanda even ranked below countries which are currently experiencing conflict such as Yemen and Syria, as well as below the majority of other post-conflict and post-genocide countries. While this current research cannot explain why mental illness is so prevalent in Rwanda/why the country ranks so low on the World Happiness Index, it will lay out the process of implementing the mental health policy, which was designed to address this issue and increase

well-being among the Rwandan population.

CHAPTER 3 – Process and best practices

The implementation of Rwanda's mental health policy is based on large-scale decentralization and integration of mental healthcare into the primary healthcare system in order to make mental health care more accessible to Rwandans. The policy itself has many subgoals, such as research, education and capacity building, which contribute to accessibility and sustainability. Therefore, the goals are all intertwined and actions taken to complete one goal can also contribute to the achievement of another goal. The process of implementation is complex and involves various actors including the government, NGOs, universities, and service providers. This chapter will explain how these actors, especially the government, attempt to implement the policy. It will go through the various actions undertaken to achieve the goals of the policy, and what participants believe to be successes and good practices as a result.

Decentralization and Integration

In order to achieve rapid and large-scale decentralization in the mental health sector, the government of Rwanda has been training non-specialists in hospitals and health centres to treat mental health issues. In addition, the government is currently completing mental health training for community health workers, bringing mental healthcare to the lowest levels of the healthcare system. Bonaventure, as well as another implementer, Linda, mentioned that this was being done partially via e-training(interview, March 2019). Patient explained that the Mental Health Division chose this method of training general practitioners, general nurses and community health workers as training specialists takes time, and it allowed them to address a pressing issue quickly (interview, March 2019). However, in order to address the challenge of sustainability, Bonaventure, another implementer, explained that a Department of Clinical Psychology was created at the University of Rwanda in 2014 and a public university, Kigali

Health Institute, was established in 1998 (interview, March 2019). Michelle, a psychologist, mentioned that Mount Kenya University has also created a counselling program. Another organization, Trauma Counsellor Rwandan Association (ARCT-Ruhuka) also developed a one year training program for counsellors from various organizations (presentation, Rutembesa, n.d.). Finally, another psychologist explained that her organization offers a 6 months applied counselling course. These last two examples demonstrate how non-governmental organizations contribute to the implementation of the policy as well in terms of building human resource capacity. I also asked how Rwanda managed to have specialists in the country prior to the establishment of a clinical psychology program. Bonaventure explained that some medical doctors were sent abroad to study, especially in psychiatry (interview, March 2019). However, the main method was still through training generalists (nurses and doctors) to work in mental health. Many service providers were happy with the increase in educational opportunities in this sector as it allowed them to find employment. They, and other participants, were also happy to have increased personnel on the field. However, many clinical psychology graduates remain unemployed, which will be discussed in the next chapter. Overall though, decentralization via integration and the training of generalists was perceived as a very successful part of the policy.

When participants were asked what they knew about the policy, many focused on decentralization and how it has brought services down to various levels and that this has allowed people to receive services close to home. Participants confirmed that every district hospital has a clinical psychologist and that mental health services are often (but not always) available at the health centre level. Three health centres in Ngoma district were randomly selected to participate in this research and all of them offered mental health care. In one health centre the care was offered by a trained psychiatric nurse whereas in the other two health centres the directors were trained to respond to mental health issues. Participants also appreciated how decentralization has gone down to the level of community health worker. Gael,

a psychologist, stated “they are currently collaborating with health facilitators to help those who have mental health problems close to them, like in the villages” (interview, March 2019). Diane, an NGO representative, confirmed this: “they trained those who we call community agents (community health workers) because they know already that at the community level there are people suffering... And in mental health, they are trained on basic care taking: isolate someone, try to calm them, call the hospital” (interview, March 2019). Anne, another NGO representative, was happy with this practice: “Another good practice is as I have mentioned as a challenge, we have few professionals in mental health. Our government has put in place, or has trained, community health workers. Although they are not professionals in that domain, at least they try to help people who are in need and they refer them to the services” (interview, March 2019).

A service provider at Ndera Psychiatric Hospital summarized how decentralization works in the mental health sector: “in community when people show the sign and symptoms of mental health disorders, it starts with community health workers, and they took patients to health centre and then he/she may be transferred to district hospital. From the district hospital, they bring patients here (Ndera Psychiatric Hospital).” (interview, March 2019.) Different services and medications are available at each level.

In addition to offering services at lower level medical facilities and within communities, practitioners and implementers also went into the field to care for the mentally ill. Pacifique, a local level implementer of the policy, shared that “once in a while, we take our truck and we go in the cities to take anyone we can find then we bring them to the health centre... at our centre we give them treatment, but for some cases we transfer them to Ndera”. Implementers also entered the community by visiting schools and creating anti-drug clubs for students, therefore targeting the youth and focusing on prevention (interviews, March 2019).

Many participants agreed that decentralization has been a very successful part of the

implementation of the policy, especially in rural areas, as now people are able to receive services close to home and from people in their own communities. As Alice, a psychiatric nurse, explained: "You'll have testimony from villagers saying my child was diagnosed with a mental illness. I used to go all the way to Kigali to get services for a long period of time, and then the child got better, but when I heard that in my community I can have the same service whenever I want, it was a relief. Now I can see that the Ministry of Health has done something good for us. The villager said we feel good that the government cares about us small villagers..." (interview, April 2019). Likewise, a health centre representative stated that "It has worked because before patients used to go get their medicine at the hospital and now they come to us... Our facility is closer to the patients than the hospital and some patients know that they are suffering from mental illness, they receive help faster" (interview, April 2019). Likewise, staff at Ndera hospital appreciated the policy of decentralization as it lowered their burden of cases and allowed them to focus on more complex ones: "I think that we have more mental health patients, without this mental health policy, all people will go directly to here, they can not be helped well... it is good that it can start down on health centres and go up and then here we can receive cases which are more difficult" (interview, March 2019).

Sensitization

While decentralization is a key part of the implementation process, sensitization has also been an important aspect as people will only use services if they know about them and are educated on mental health issues. There have been various methods used to achieve this. For example, according to a national implementer, Linda, every week the mental health division has twenty minutes of radio talk to sensitize the population to mental health issues. These talks are done by the division itself, young people in the community, specialists, and beneficiaries of mental health care who give their testimonies in order to educate the population, all following the guidelines of the Rwanda Health Communication Centre (interview, March

2019). Linda also mentioned that the division tries to educate the population by celebrating World Mental Health Day each year (interview, March 2019). Bonaventure spoke of sensitization sessions conducted by the Mental Health Division with local leaders, religious leaders, and high level authorities in order to raise awareness and "to try to say that mental health people are having rights to live, rights to medication, rights to live in the families, and so on" (interview, March 2019).

A psychiatric nurse in Ngoma district, Alice, explained that knowledge was also shared online and that there was a program where people could ask questions through their phones by typing a special code and they would receive a text back with a solution. Pamphlets aimed at sensitizing the population were also developed and sensitization meetings with district opinion leaders on mental health and homeless mentally ill people also took place (1 day meetings in Kicukiro, Nyarugenge, Gasabo, Kamonyi, Ruhango, Gakenke, Burera, Kayonza, Kirehe, Ngororero, Rutsiro, Nyabihu, Gicumbi, Gatsibo, Nyamasheke, Gisagara, Nyaruguru) (2018-2019 activities chart, mental health division, Rwanda Biomedical Centre).

Many interviewees mentioned that this sensitization process was bringing results, and that stigma was lowering in the general population due to the policy. For example, Frank, a health centre representative, said that "the population is more open to bringing us their loved ones as soon as they see the first signs of disorder. They stopped thinking that the symptom comes from evil spirits. The population accepts that mental health diseases can be treated and people can heal" (interview, March 2019). Pauline, an implementer, stated that "the implementation of the policy improves the life of every day Rwandans because it stopped them from having wrong beliefs like witchcraft, being poisoned. It helped them to be aware of the reality of mental illness. Now Rwandans know that if there's a specific illness, we have some doctors specialized in treating that. They are now open minded enough to bring a family member to the doctor and explain to the doctor the symptoms and what's going on. Now they

understand the problem of the mental illness and they know where they can go get help" (interview, March 2019).

Innocent, a health centre representative, stated that "there's more and more people that will go to health centres to get information and learn more about mental health and their health and that is a great progress and has a positive impact on the community" (interview, April 2019). Jacky, another health centre representative, explained that knowledge about services also transfers among community members through word of mouth: "the people that receive help will talk about it to their community and then they bring more people" (interview, April 2019). Alice, a psychiatric nurse, reinforced this: "And the other beneficial thing is that people refer other people to see professionals that are located close to their homes so it's a word of mouth way of promoting mental health services. The fact that more and more people know that there are mental health services, the more the policy promotes opening more clinics and health centres as well as training more professionals" (interview, April 2019).

Accessibility and Affordability

As we can see, the implementation focuses on ensuring that services are available and that people are aware of this. However, another crucial aspect has been ensuring that they are also affordable. The implementation of the policy has ensured that mutuelle health insurance (the community-based insurance model in Rwanda) provides coverage for mental health care. Interviewees gave various answers when asked about what is covered by mutuelle health insurance and what is paid for by the patients when they receive treatment at a health centre or hospital. While some implementers and local organizations stated that everything (medication, therapy sessions, etc.) was 100% covered, those working at health centres and hospitals offered a different story: "we categorize people according to their economic capacity. So when you are really, really poor, you are in the first category, there it's the government who pays everything but still when you advance in economic category there are things that you have to pay for

yourself. Like people who are in the third category pay 10% of their bill so it depends on the category you're a part of." (interview, psychologist, March 2019). Janvier, a psychiatrist, stated that the government covers "a good portion" and that medication is "accessible enough" (interview, March 2019). Jean Pierre, who was working for a local NGO, raised the important point that only counselling in hospitals is covered by mutuelle health insurance, whereas private psychologists currently are not.

It is important to note, however, that regardless of the extent of coverage offered by mutuelle, those who have not signed up for the community-based health insurance do not receive coverage. As Pauline, a local implementer stated: "The first problem we have in the community is mental health cases requires insurance." Another local level implementer, Pacifique, explained that those who have not signed up for mutuelle health insurance do not have their services covered, but that in some cases the district receives a budget to help pay. However, he (and others) still mentioned that these expenses are a burden for the families of the patients suffering from mental illness as well as the districts.

Legislation

Another key part of the policy is to create a legal framework around mental health in order to protect patients accessing mental health services and ensure their rights are maintained. In order to implement this, implementers, as well as other participants in the field, confirmed that legislation on mental health was in the process of being drafted, but it has not yet been published. However, in August 2018 a patient's rights charter was created and can now be seen posted on the walls of all hospitals and health centres. This charter is not exclusive to mental health patients, but applies to anyone seeking health services. As NGO representative Eric said: "I think what they've tried to do at the Ministry of Health level is to be able to make sure that patients' rights are upheld in terms of not violating their rights, or like being rude to them. There's a whole patients' rights charter that is at every health facility and the charter is really

to educate patients on their rights and to educate service providers on the rights of the patients. The enforcement has not been consistent in case of breach of that charter. But people are supposed to respect – you know, ethically – they're supposed to do that. But there's no enforcement as it should happen. Now I think the Ministry is trying to enforce the charter, as of last year there was a little bit more stringent and kind of refused such abuse and patient right abuse" (interview, March 2019). Josephine, a psychologist, stated that "because the patient is aware of their rights, they know to expect a good service and if this service is not good, they were informed when they learned about the policy that they can actually complain about it" (interview, March 2019).

Community Involvement

Beyond hospitals and health centres, part of Rwanda's Mental Health Policy is also to make the community more competent in trauma response. Therefore, preparation for trauma response during the genocide commemoration was undertaken by the mental health division at the Rwanda Biomedical Centre (RBC). Many participants reported that someone in their organization had recently attended a training provided by RBC on interventions during the commemoration. Intervenors were trained, a toll free hotline was requested (it is unclear if this request was granted), helpline responders were recruited, logistic support was provided for psychological intervention during the commemoration, and the coordination of interventions were also supported by the Mental Health Division (2018-2019 activities chart, Mental Health Division, Rwanda Biomedical Centre). I attended the 25th genocide commemoration and I was surprised at the number of first responders available in the stadium. There was at least one Red Cross responder for every 10-15 rows of people, and they had cleared out aisles in the stadium so that people could be brought out easily if they started to suffer from an episode. According to one individual coordinating the response, each year approximately 100-200 people are brought out of the stadium for trauma-related issues, mostly aged 25-40 (field notes, April

2019). Professionals try to treat them in the makeshift centre, but if they are unable to ground[14] them, then an ambulance brings them to the nearest health centre or hospital (field notes, April 2019). At the commemoration I heard two screams of people suffering from traumatic episodes, one who happened to be sitting right beside me. According to Rwandans, as well as the Minister of Health, Diane Gashumba (meeting, April 2019), this was an extremely low number compared to previous years. She viewed this as a success of the policy and the efforts put in by the mental health division for commemoration.[15]

Many interviewees considered the way RBC prepared for the genocide commemoration to be a good practise: "I think that one of them (good practises) is this business of having so many volunteers trained to support people who break down during the commemoration. I don't know if it's in their policy, but I think they, RBC and the Ministry of Health, really do a good job in preparing for addressing issues that come up during genocide commemoration" (interview, NGO representative, March 2019). Anne, another NGO representative, agreed: "And I really like the way in commemoration period the key people, government, CSOs, private institutions, try to join their effort and help people who are in need. Because it's a sensitive period for us Rwandese, and I see how people are cared for" (interview, March 2019). Alexis, another NGO representative, emphasized the role of the community during commemoration: "if I take the example of the intervention during the commemoration... Today it is known as, seen as maybe a tragedy when one, maybe gets into a crisis... before, people would say that one is crazy, maybe he has evil spirits or whatever, and then they would even chase or maybe tie him or her in chains. So people understand that trauma is normal for people

14 A technique used to bring someone who is experiencing an episode (traumatic episode or anxiety related episode) back to the present moment.

15 It must be noted, however, that this is not necessarily an indicator of success as it does not measure traumatic episodes outside the stadium or following the ceremony. It also does not assess the mental health of people in general during commemoration, as someone can be experiencing mental health issues and express it in a way other than a trauma episode. In addition, as can be seen in the literature, people continue to find the day traumatic.

who have gone through traumatizing events and actually people are themselves responsible to take care of others. And that is thanks to the policy" (interview, March 2019). While attending the commemoration, I watched as one volunteer intervened with the young Rwandan woman sitting beside me who was experiencing a traumatic episode. My interpreter and I were sitting beside this woman for a couple hours prior to the start of commemoration, as we arrived early. She started talking with us and ended up telling us that she was homeless and orphaned. When she started to cry during the ceremony, Rwandans around her were quick to signal a first responder. The first responder approached and held the woman, asked her to breathe, and tried to comfort her. He also brought her a bottle of water. These techniques worked for about an hour, but then something triggered the woman and it appeared impossible to end her episode within the confines of the stadium. The first responders carried her out of her seat and out of the stadium against her will as she was screaming and flailing. While the first part of the intervention seemed positive and helpful, I worried that the way they forced her to exit the commemoration may have made the episode worse, and could have been a traumatic experience in itself.

Collaboration and Advocacy

Overall, the activities listed in this chapter demonstrate how the implementation has attempted to make services accessible to the community and close to people's homes. However, the implementation of the policy has still been criticized for relying on institutionalized care. Though where the government is not focusing its efforts, NGOs and civil society are attempting to fill in the gap: "the government looks at most of the things from a macro-level, but then most civil society organizations will look at issues such as mental health from community level" (interview, NGO representative, March 2019). Likewise, Alexis, an NGO representative said "what is not done by the public services, we are doing... And we are trying to involve the community in our work, in our approach, and also knowing to link with the public services. So

I would say we are playing the role of maybe filling in the gap."

The policy also stipulates for the government to work with other organizations to achieve its goals. While some organizations felt they collaborated a lot with the government, and the Mental Health Division in particular, others felt they were working in silos, that they did not have a strong partnership with the government and that interventions were not always coordinated with the input of all organizations.

Based on the data gathered, it appears that engagement is done between various stakeholders and sometimes with the community as well, but the reach of this engagement does not always go far enough to satisfy stakeholders such as NGOs or service providers. Linda, an implementer, explained that consultations are often held with the community, sharing the example of consultations held to come up with terms for mental illnesses in their local language, Kinyarwanda, as illnesses such as PTSD and depression currently have no translation from English (interview, March 2019). Many participants also referred to "coordination meetings" hosted by the Mental Health Division at the Rwanda Biomedical Centre (RBC) which began this year. These are meetings hosted by RBC with NGOs working in the domain where they discuss mental health care and the mental health policy. According to a psychosocial representative from another local organization, RBC invites all those working in the domain to reflect together during these meetings on "best practises, what they can adapt, what they can do, what can be useful in our organizations..." (interview, March 2019). While this representative confirmed that the meetings were open to everyone, she doubted that all organizations in the country were known by the government, a statement suggesting that only certain organizations are invited. While some other local organizations confirmed attendance at these meetings, not all participants were aware that they took place. Others were aware, but said they had never been invited (interviews, March 2019). Another NGO representative further explained the nature of these meetings: "we have had some meetings on a regular basis,

and I believe that that is really going to make sure that the policy is going to be known, but also implemented in the way it should be. But also being informed by practices... really there is that kind of engagement of the experts in the field" (interview, March 2019).

While these meetings allow for actors to share their experiences and ideas, one actor working in an international organization, Eric, stated that the Rwandan government has a "strong presence" in the country (interview, March 2019). He concluded that it is the government that defines the interventions of the state, not the NGOs, which often have a very strong presence in other countries. Eric described how NGOs are obligated to follow the priorities of the state and help the state in implementing its goals and that the policy provides these organizations with guidance (interview, March 2019). Others also echoed this sentiment that the policy gave them guidance on how to implement their interventions and that they do not go out of the boundaries of the state and the policy. Marie-Louise, an NGO representative, stated "If there is a policy, we are working through the policy, we will not go out. We will know what to do and where we have to focus" (interview, March 2019). Likewise, Honorine said that "us who are in civil society are not competing with the government, the policy makers. We are actually... joining efforts to implement what should be done" (interview, March 2019).

However, many organizations also emphasized their role in advocacy and influencing the implementation of the policy. For example, one NGO representative stated that "when I see a gap... which is not mentioned in the policy, is where we do advocacy – we conduct research, we collect all evidence, then we elaborate a policy brief and we try to meet with policy makers and tell them this is a gap that we have found in mental health policy, try to see how to adapt it or change something." However, she also said that "in Rwanda I can say that we don't go beyond the national policies, we try to go in line with the policies". Other organizations also confirmed conducting research and using it to conduct advocacy. One actor working in an NGO gave an example of civil society advocacy resulting in change in the implementation of the

policy. He explained how the policy emphasized decentralization, but did not stipulate to what extent. Therefore, he explained that his organization influenced the implementation so that certain medications were available at lower levels such as health centres. He stated that they also negotiated with the insurance companies in 2015 so that mental health services were also covered at these levels (they had previously only been covered at the hospital level according to him).

Patient, an implementer, reinforced this idea that other stakeholders contribute to the implementation when he said that “When we talk about policy, the implementation of policy is not only the government side. We are together with the other organizations” (interview, March 2019). Patient also spoke about collaboration with traditional healers: “At the beginning I remember that we even trained the traditional healer. Because we found that if people continue to go first to traditional healers before they come to us, and there still are traditional healers are not aware of what is happening, it will cause problems. And we did a kind of desensitization, kind of training, so that those people, they do not keep some patients even if they do not understand”. He continued: “Where we put our focus is to make sure that we are giving information to that people in need of care so those traditional healers can advise their patients to also come and seek care in our health facilities” (interview, March 2019). However, collaborating with traditional healers in regards to mental health still remains a challenge in Rwanda, which will be covered in the next chapter. Overall,, while it still appears to be in its early stages, and not all organizations/stakeholders are actively involved, collaboration is taking place.

Research and Data

Finally, in order to ensure that the implementation process is evidence-based, the education sector and the government worked together to conduct mental health research. The study was titled “Rwanda 2018 Mental Health Survey”. Yvonne Kayiteshonga, division

manager (Mental Health Division, Rwanda Biomedical Centre), was the principal investigator of the study and Vincent Sezibera, Associate Professor of Clinical Psychology and Director of the Centre of Mental Health at the University of Rwanda, was the co-investigator. There was also a technical working group consisting of 22 actors in the field who contributed to the study. Diane Gashumba, Minister of Health, told me that the 2018 Mental Health Survey is evidence of political will at the highest levels to implement the Mental Health Policy as the survey was mandated by a committee chaired by Paul Kagame (meeting, April 2019). This survey is the first government mandated national epidemiological study of the prevalence of different mental disorders and co-morbidity in both the general population and genocide survivors.[16] In Diane Gashumba's preface to the survey, she states that the study "is critical for defining mental health package and strengthening the quality of mental health services at each level of service delivery across the country, and will help to develop prevention programs" (Rwanda Mental Health Survey, 2018). Patient supported the idea that interventions are evidence-based: "we look at datas. Data, information in our information system so we can see what is the most prevalent problem so that we can take as priority" (interview, March 2019). Participants explained that the 2018 Mental Health Survey will allow implementers to make decisions that are evidence-based. Overall, they appreciated the fact that such a large-scale survey took place and saw it as a success that will continue to improve implementation of the policy.

Supervision, monitoring, and evaluation

While this study on the implementation of Rwanda's Mental Health Policy did not seek to measure success, it did look to undercover how success was measured. In regards to supervision, monitoring, and evaluation of the policy, it was difficult to retrieve precise information. When speaking with someone in the monitoring and evaluation department at the

[16] Prior studies have been conducted on the prevalence of mental health in Rwanda, but this is the first study at this scale.

Ministry of Health, I was told that there is no individualized assessment of the Mental Health Policy, and that it is integrated into the overall assessment of all health policies (field notes, March 2019). One way, however, that implementers, service providers, professors and NGOs alike are measuring their success is through the number of mental health consultations at hospitals and health centres as well as by the increase in services and professionals available. Patient said "In 1994 there was zero psychiatrists. Now we are counting 12 psychiatrists. Today, we have 11 residents. How many are psychologists? As I told you, there was no clinical psychologists, now we had counting more than 2000. Mental health nurse, they are around 500. That is one area, you see. Another area as we are talking about integration and decentralization, before the genocide we had one psychiatric hospital in the whole country which was able to provide mental health, and now every health facility. We have now around more than 45 hospitals, all those hospitals they have a mental health unit. The health centre as I'm talking now, today I'm going to train in charge of mental health in health centres. We have around 500 health centres" (interview, March 2019). Bonaventure explained further: "We have figures shows how the number increased from 960 patients, increased from this number up to 1960 patients from 1994 to 2000. So with this awareness, with this capacity, understanding capacity, just increased, people started to consult... For us, when you find that some people are increasing in consultation, we are not saying that there is a problem that many people are consulting. But no, it's just due to that these people from the community are just understanding the role of making consultation" (interview, March 2019). When I visited Ndera Psychiatric Hospital, I was surprised by the number of people in the waiting room. Despite being a fairly large waiting room, people were sitting tightly together with little space in between them and others were standing as there was not enough room for everyone. One member of the hospital elaborated: "So we have had a huge number of patients coming. I think you passed by the reception earlier, you have seen that there are a lot of people who are there in the waiting room. So these last

years, we have had consultations, also hospitalizations, increase, doubled, tripled, specifically because of the accessibility to medication and so that (the implementation of the policy) has clearly had an impact on our work" (interview, March 2019).

Other participants also shared how what a successful implementation of the policy meant to them. Some gave rather logical answers (for example, if the proposed indicators were being achieved) while others had more specific ideas of what success would look like: "I think success would be, the same way that every household today has a mosquito net, success would be for people to understand what mental health is, have that awareness already, because they can choose to do anything about it or not. But success would be for someone, somewhere, very far in the country, to know that this is a thing, know how they can navigate it, and then what they choose to do with it.... That would be success" (interview, NGO representative, March 2019). A psychologist working in a local organization stated "if there was success, there would no longer be traumatized people in the hills", referring to Rwanda's highly populated hills. An implementer said success would be if "we had this department functional, we had our psychiatric doctors trained on duty at that station, we have our health centres and district hospitals having mental health clinics running. We have also our medicine available at all levels. We have our patients capable of getting care at an affordable, they are accessing care" (interview, March 2019). Finally, another participant stated that "Success can be – we can have all these services, but then they have poor quality. So the new challenge from this success of having services available is now how can we give a better quality of services? How do you keep patients in care? How are you supposed to follow up? How do you account for proper support for even the staff while dealing with mental illness? So I'd say success, but success that calls for new challenges in terms of the next level of what is waiting for the program to achieve" (interview, NGO representative, March 2019). In defining success, others spoke of a decrease in the prevalence of mental illness, others said increased consultations, some said

increased awareness/decreased stigmatization, and others said more synergy among different actors would all be definitions of success. Some participants even used the amount of people on the street decreasing as an indicator for success.

Implementers were also asked about some lessons learned in implementing a mental health policy, and shared some valuable responses: “The lesson to learn, you don’t need necessarily big things, a lot of money, to start doing and solving the problem of your people. It is also possible using little means so that you start to do something. Another thing is that the challenge of genocide and related trauma was impacting on the life of all population, so that people, they should know every trauma events can impact their mental and physical health of the population. Another lesson learned: it’s not necessary to expect at every area a specialist. Even general and even lay people, the population itself, can be taught how to support people to improve mental health. That is the lesson learned” (interview, March 2019). Other implementers agreed that political will and political ownership are two key factors in implementing the policy successfully. Not all interviewees agreed that political will was currently strong enough in implementing the policy (as will be covered in the following chapter), but many were very grateful that political will seemed to be increasing. As one participant put it: “The Ministry of Health is starting to value more and more the importance of mental health and the well-being of the country” (interview, March 2019).

To conclude, Rwanda has made a lot of efforts in implementing its mental health policy and this chapter has shared some of the specific activities undertaken as well as the thoughts of various stakeholders on these activities. Evidently there have been many successes, but as NGO representative Eric said, “those successes call for big other efforts to be made because today it puts you at a different level of challenge. I think every finish line is the beginning of a new race” (interview, March 2019). In addition to the successes, there have also been areas that have been challenging to implement, as well as gaps in the policy and implementation, which

will be covered in the next chapter. Eric continued: "I think the policy implementation has actually opened a flood gate, but in a good way, because it has helped to unearth many issues, many areas that we didn't think about..." (interview, March 2019). The next section will speak to these issues.

CHAPTER 4 – Challenges and recommendations

Prior to the interviews, one concern for the research was that participants would not be openly critical about the implementation of the policy. This was not the case. While the majority of participants were extremely happy that a policy existed and that there was the political will to implement it, they also had a lot of remarks on the current gaps and how the policy and its implementation could be improved. Participants were also extremely open about the challenges they face in the field and the ways in which the policy is not meeting the needs of their organizations and Rwandans in general. The challenges raised included stigma, top-down implementation, weak government-civil society organizations (CSO) partnerships, lack of financial and human resources, lack of awareness, insufficient local willingness, issues with the policy itself, cultural barriers, over-reliance on medication, institutionalized and Westernized care, lack of understanding in leadership, trans-generational trauma, lack of research/data in the mental health domain, lack of facilities/services readily available, and finally, issues relating to post-care and reintegration into the community following care. While it may be a long list, participants expressed a lot of gratitude for the policy and thought the country was making progress. In addition, they insisted that like anything else, the implementation of this policy is a process and a learning experience and that it is natural for challenges and gaps to remain in this setting, and that they hoped raising these issues would contribute to improving the policy and its implementation. This section will provide an overview of each of these challenges/gaps, focusing on the biggest two challenges raised: stigma and institutionalized care. It will also share some of the suggestions given by

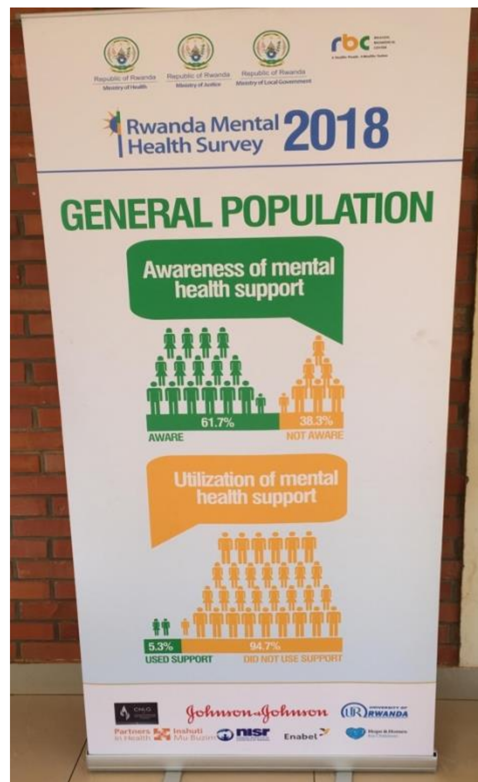
participants to address the various challenges.

Challenge 1: Stigma, lack of awareness, and cultural barriers

As mentioned in the context chapter, prior to the genocide there were many misconceptions regarding mental illness and mental health in Rwanda. Following the genocide, and with the implementation of Rwanda's mental health policy, people started to prioritize mental health more, especially in leadership (evidenced by the continued implementation of a mental health policy). Many participants acknowledged that as a result of the policy, the population also gained a better understanding of mental health and that stigma has decreased. However, they also emphasized that there is a long way to go, as those understanding mental health and the mental health policy are mainly limited to academics and those working in the field. As Marie-Louise, a psychologist working in an NGO stated: "So about policy, the population, only who are studying, the student, the professionals, they know about the policy, but the population in general, they don't know" (Interview, March 2019). Lack of awareness was also evident whenever I shared my research topic with Rwandans I met who were not involved in the mental health sector. The majority of them did not realize their country had a mental health policy. However, this may be normal, as it is typically government and academics who are aware of policies, whereas the population sees the results.

While awareness of the policy itself among the general population may not be a huge issue, awareness of the services available is a challenge. Various participants mentioned that many Rwandans do not know that there are services available for mental health/where they can receive services. Others emphasized that the population does not know where to go for services as they do not even understand what they are going through: "I don't believe that having a psychologist at the health centre will help someone who is going through mental health issues alone because... mental health clinics is where people go if they are experienced in mental health concerns... and if because of lack of awareness, if people don't know what they're going

through, that it's a mental health concern, then how would they go to a clinic?" (interview, NGO representative, March 2019). Likewise, Divine, a professor, asked "How can people know what resources are available if they're not informed?" (interview, April 2019). However, even those that are aware of the services and where to go to receive them are unlikely to use



them: according to Rwanda's 2018 Mental Health Survey, 61.7% of the population are aware of where they can seek mental health support, but only 5.3% reported utilization of these services. This figure is extremely low, especially considering the rate of the general population experiencing mental illness (as covered in the context chapter).

There are many reasons why even those who are aware of mental health support and are suffering from mental illness may not be using services, but interviewees suggested stigma and a lack of understanding of mental illness itself have a role to play. As Diane shared "it's not in the culture to go consult because... they think that we're going to consider them like crazy people" (interview, NGO representative, March 2019). In addition, many of the beliefs regarding mental illness present in pre-genocide Rwanda still exist today: "some people systematically associate mental illness with possession by demons and witchcraft... they don't

believe that the illness is provoked by neurological problems, or be transmitted in the brain...” (interview, psychiatrist, March 2019). In addition to possession, demons, and witchcraft, there are also remain beliefs that those suffering from mental illness have been poisoned, cursed, or affected by bad spirits, and as a result, some of these people are still being hidden by family members rather than being cared for by the services available (interviews, March-April 2019). One participant working for an NGO, Eric, relayed a story of a person in the town of Musanze in the Northern region of Rwanda who was known to suffer from mental illness, but would sometimes become functional. He explained that even when this person was functional, he was denied access to places such as hotels, as anyone who experienced mental health issues at any point is automatically seen as a person “non grata” (original words, interview, March 2019). Supporting this, Charity, a psychologist, stated of recovered patients that “you can’t give your opinion because you were once a mentally ill person” (interview, March 2019).

Participants also mentioned difficulties getting patients and those around them to accept treatment even once they had accessed services due to stigma surrounding mental illness. For example, Michelle, a psychologist, shared a story of a Rwandan patient she was seeing who was highly suicidal, but her family refused medication when it was recommended for her because of the stigma associated with it (interview, March 2019). Alice, a psychiatric nurse, shared similar sentiments: “So you will have people saying “I don’t need your drugs, witchcraft, to get better, I don’t believe in it and I want nothing to do with it.”” (interview, April 2019). Josephine, a psychologist, added: “It takes a lot of strength to convince them of the services we can offer such as welcoming our patients, treating our patients, providing them medication, and to heal and get better soon so they can go back to their normal lives” (interview, April 2019).

In addition to what interviewees shared, I also witnessed stigma towards the mentally ill during my fieldwork in Rwanda. When people in the streets were acting in an irregular way,

Rwandan friends of mine would tell me that the person was "mad". This was a common occurrence. In addition, when I told a Rwandan friend I was going to Ndera Hospital, he laughed and said that if someone heard me say that they would think I must be mad as only crazy people go to Ndera Hospital. Finally, I was shocked when visiting the mental health section of one of the hospitals as the hospital worker who was guiding me twirled his finger next to his head, making the symbol for crazy, when explaining why we needed the guard to open the gate for us. He did this right in front and in clear view of the patients. Based on these experiences and those shared by interviewees, it is not surprising that Rwandans are hesitant to consult for mental health issues.

In addition to stigma, participants expressed that the Rwandan culture itself is a barrier to accessing services. When I asked about how the policy was implemented/how services were provided in order to take culture into consideration, it was rare that a participant explained how the culture was incorporated. Rather, I consistently heard that the culture is a barrier in the implementation of the policy due to stigma and a "culture of silence" among Rwandans (interviews, March-April 2019). Participants explained that Rwandans do not like to share their problems with strangers. In particular, they do not want other Rwandans (besides in some cases their family) to know that they are suffering, as they fear being perceived as weak. Clearly, this is also due to stigma in the community. As Honorine, representative of an NGO, shared, "We are a very secretive people in that no one wants to share their own personal things" (interview, March 2019). Jean-Pierre, working in a different NGO, concurred: "in Rwanda we have a culture of holding on to things, things are not coming out because we don't want to seem as we are weak or being open" (interview, March 2019). Divine added "nobody knows what happens in people's personal lives, we don't talk about those things. You'll never hear a woman complaining about her man, and you'll never hear a man complain about his woman and they'll never show that they're facing challenges in public..." Innocent, a health centre representative,

explained how this affects those coming in for services: "Because they don't want us to know what's going on in their personal lives, so he tells you indirectly that he needs this information, but he doesn't want to give you more details, and he doesn't want you to know that he is suffering from mental illness" (interview, April 2019).

In addition to the public institutions interviewed, I also interviewed some representatives of private practices. Due to health insurance not covering these services, one can hypothesize that it is mainly those in higher economic classes accessing these specific services. Interestingly, there was a common theme that they were not able to employ Rwandans, as Rwandans did not trust other Rwandans and preferred to seek psychological services from a foreigner. As one interviewee stated, "to get someone to accept to see a Rwandan is a challenge because people don't believe that their story won't be on the street before they reach home" (interview, March 2019). Another participant also raised this issue, explaining that "they think Kigali is very small. If they see a local psychologist, maybe it's someone they'll meet at the wedding or another event. Someone who knows now who they are and what they're going through. So they'd rather see someone who doesn't know them and who is totally from different culture and background to receive support... that's one of the challenges we are facing, that the clinic is running, but we do not have work for local psychologists because people don't want to see a local psychologist" (interview, March 2019). When the interview was finished, this participant told me that Rwandans think muzungus (East African term used to describe a person of European descent) are more capable and this is also why they do not wish to see a Rwandan. Therefore, it seems that both the stigma of someone from their own community knowing they are going through problems as well as a lack of trust in the confidentiality as well as the competency of their fellow Rwandans are barriers to seeking services.

As a result of the stigma associated with classic mental health services, many Rwandans consult traditional healers or faith leaders. In the Rwanda Mental Health Survey, traditional

healers and religious leaders were included as types of mental health services. Of those that reported using mental health services, 78.7% used healthcare facility services and 25% used community health workers. However, 32.8% consulted religious healers and 29% received services from traditional healers (Rwanda Mental Health Survey, 2018). While consulting religious healers and traditional healers can be beneficial in some cases, participants also raised the risks of relying solely on these types of practitioners. They explained that many will consult traditional healers and then be transferred to the hospital once their illness has worsened. As Ruth, a psychiatric nurse, explained: "it is affecting the patients because when he came later, it is obvious that he cannot easily heal. It leads to chronicity, spend more time in the hospital and the family pays more money for him" (interview, March 2019). And as Patient, an implementer at the national level, shared, "there is still an issue in regards to the collaboration between traditional healers and hospitals" (interview, March 2019). In contrast, there are also instances where patients consult hospitals/health centres, and then after prefer to see traditional healers as they do not heal as quickly as expected: "you cannot come today and tomorrow say you are healed. And there are sometimes where the families have had enough, you see? They say: "people told us that it's not a sickness so we made a mistake. We should have gone to see traditional healers..." You see? It takes time and maybe it's like that they tell themselves that it's true that it's demons. Because if it's been a week, but we don't see any change, you see ?" (interview, March 2019).

Finally, stigma was identified as a huge barrier when it came to reintegrating people who had sought mental health care back into the community. As Charity, a psychologist, shared "We treat them here, but when you go in their village... they are treated like crazy people. And with this stigma, patients relapse easily so they always have relapses and come back here" (interview, March 2019). Ruth, a psychiatric nurse, also stated that patients relapse due to stigma: "some patients come back here like two or three times in a year... It means when

patients left here for treatment, he/she went in community, and their community is stigmatizing her/him. People said "this is a foolish person, he is unable to do anything" and sometimes he lost his job and value" (interview, March 2019). Pauline, a local level implementer, explained further: "It's very difficult for people at the bottom of society to understand that a person who is suffering from mental illness is also part of the fabric of the community. Same as having a doctor giving him prescription and having nobody to follow up on them or how they take their medication and you find that later they go back wandering in the street. And then you'll have people pointing the finger at the doctors while also in reality we can point the finger at the community's role" (interview, April 2019).

In order to address the issue of stigma, participants emphasized the need for more sensitization campaigns. Some compared the stigma surrounding mental illness to the stigma that existed in regards to people living with HIV and aids 20-30 years ago. They insisted that the country had effectively reduced stigma around HIV and aids and suggested the government take a similar approach in regards to mental health. More specifically, Jean-Pierre said "maybe we can do free screening for mental health concerns the way we do for HIV tests. Maybe we can do radio programs, have important people firstly to talk about it the way they talk about HIV and aids" (interview, March 2019). Charity gave the suggestion of using umuganda, a public work day that takes place once a month in Rwanda, to educate people on mental health: "It's small, but I would say that if psycho-education increases in the population – like in days of umuganda... After umuganda there are meetings in each village and we talk about government policies. It depends on what is chosen that month... It's the suggestion I'm giving: They organize a theme on mental health and discuss after umuganda" (interview, March 2019). Participants also stated that there is a need for people who have lived experiences with mental illness to speak out more. As Eric said, "look at HIV: the patients were the main, main drivers of changes" (interview, March 2019). Overall, participants felt that sensitization needed to be

more emphasized in the policy and its implementation in order for other parts of the policy to succeed.

Challenge 2: Institutionalized care

The second major challenge consistently raised by participants was the fact that mental health care in Rwanda is currently institutionalized and not community-based. This critique came primarily from NGO representatives and professors. These participants felt that rather than incorporating society in the healing process, people suffering from mental illness were receiving individualized treatment in hospitals and health centres, and that this treatment was a form of crisis management relying heavily on medication rather than a form of holistic healing. Some attributed this to being a problem with the policy itself, while others said it was a problem with the implementation. Fidèle, a professor, was so upset with the policy that he stopped reading it half-way through: "To be honest, I have read and I found many elements which were not up to date. You know? I found some old elements. For example, the privilege was given to chemotherapy and I didn't appreciate it and I stopped reading it" (interview, March 2019). Specifically, participants stated that the policy puts too much emphasis on clinical care, psychologists are not properly considered in the policy nor its implementation, medication is being over used, and that the policy will not succeed if it does not incorporate the family and the community in the care of those experiencing mental illness.

In terms of the policy being focused on hospitalizations, many agreed that clinical care in institutionalized settings was necessary for severe cases. However, they did not believe it was necessary for all cases and felt that there were other approaches more appropriate for the Rwandan society. Many NGOs I spoke with were implementing community-based approaches and appeared to be filling in a gap that the government was not addressing. These NGO representatives believed these approaches were more appropriate and wanted the policy to take them into consideration. For example, Valentine, a representative of a local NGO, stated that

"in Rwanda, the people, we're used to living in the community. Problems are resolved at the community level. And it wasn't really a hospital that took care of [suffering] before... it was really in the community level. Now this structure that is going to take care of mental health, it's not easy at all" (interview, March 2019). Diane, another NGO representative, concurred: "they adopted the classic styles, you know the people who go to a health centre and all that...if we continue to do things how we were doing them, welcoming people to the hospital, who come consult, it's not easy, for me, to create a society, because really it's a society who suffers..." (interview, March 2019). Eric, representing a different NGO, added: "we're coming from a very institutionalized mental health practice – we have psychiatric hospitals where you have these rooms and injections, psychiatrists, and it's really all the post-colonial countries, that's like the European old way of mental health care. We just failed for the most part..." (interview, March 2019). Finally, Divine, a professor, said: "The concept of the mental health policy is foreign for Rwandans. It's only viewed as people from foreign countries doing mental health research. And those are the people who make the decisions. And that's why we can't find a way to help people that suffer from mental health issues resulting from the genocide. And that's being that the mental health policy is such a foreign thing...It really hurts us a lot... the policies that are in place are not catered in a traditional way to help local people." (interview, April 2019).

Cynthia, another NGO representative, agreed that the policy has valued institutionalized care over community-based care and explained that in order to address this issue "they (the implementers) have started training some of the community (health) workers, who are working on other community related issues..." (interview, March 2019). The Rwandan Minister of Health, Diane Gashumba, told me that 90% of community health workers are currently trained (meeting, April 2019). Many participants said during interviews that they believed this to be a good practice: Honorine, an NGO representative, spoke of community health workers, stating:

"I love the fact that the policy makers or the policy is putting in place a way of working with community health workers... That way it's someone you live with in the same neighbourhood, it's someone you grew up with, it could even be your relative, you know? So it's easy, it becomes easier, to talk to those people, and those people to implement the work, because they are in our neighbourhoods" (interview, March 2019).

Another way the implementation is focusing on more holistic and community-based approaches (as mentioned in the process chapter) is that implementers are creating anti-drug clubs in schools. This demonstrates efforts to go into the community and focus on prevention. However, drug treatment, which is included in the mental health policy, still seems to rely on institutionalized care. Rwandans with substance abuse disorders, especially children, are sent to facilities that are often far away from their families for rehabilitation (the most notorious being Iwawa, an island on Lake Kivu).

As a result of some of these efforts (training community health workers, setting up ant-drug clubs), some participants believed the implementation of the policy was making progress towards community-based care, but were still advocating for the implementers and policymakers to take it a step further. As Fidèle stated: "As I say every time, the mental health is not in hospitals. It's in local communities. So if policy makers think that mental health is in hospitals, there will be problems. If they don't come down here in the communities to tackle those problems at their roots, there will be problems" (interview, March 2019).

In addition, a large number of participants felt that practitioners were resorting to medication as a quick fix and that psychotherapy was not being valued in the implementation of the policy. Many interviewees expressed that people suffering from mental health issues simply needed someone to talk to/listen to them and that medication was not always the answer. Jean-Pierre, a local NGO representative expressed exactly this: "the only thing they'll get at mental health hospitals is not counselling, they give them medication which many of them do

not need medication, but maybe someone to speak to" (interview, March 2019). Eric added: "we have resorted a lot to drugs – to antipsychotics. Which has its own, you know, set of challenges: the side effects, quality of life, and it hasn't been patient centred care... People were trained in that model of fighting crisis: someone who is agitated, aggressive, the first phase is to pump him with drugs to make him sleep and feel like you know, fluffy and all that. But not really thinking of the long-term effects of those drugs" (interview, March 2019). In support of this statement, Michelle, a psychologist, stated that "haloperidol is one of the number one interventions that is being used on mental health clients" (interview, March 2019). Haloperidol is a heavy, first generation anti-psychotic with strong side effects including (but not limited to) headaches, dizziness, drowsiness, tremors, uncontrolled muscle movements, and muscle stiffness. In regards to the policy itself, Divine, said "they haven't understood how to include psychology in the policy. Do you see it? Do you see it? We send our students to complete internships and we are realizing that they're more focused on psychiatry. Things like prescription of pills is seen as a cure. Through drugs" (interview, April 2019).

As mentioned above, it was mainly NGO representatives and academics who were concerned with the over-medication of patients. Hospital and health centre representatives did not mention this as being a problem, and rather spoke about not having enough medicine available. When talking about how they treat patients, they often talked about drugs and medication and few mentioned psychotherapy. In addition, when visiting the mental health sections of hospitals, I also noticed that patients seemed highly medicated as they did not seem present, many were staring into space or sleeping on the ground in mid-day, and a large number of them had visibly dry mouths and were trembling, which are classic side effects of these drugs (field notes, April 2019). However, I am not a medical professional, and therefore cannot validate that this was as a result of over-medication.

In addition to the issue of patients seeking care being overly medicated, there were

problems raised with the medication itself. Rwanda currently only has access to first generation medications, which have been abandoned virtually everywhere in the developed world. As psychiatrist, Janvier, shared: "using classic medications, first generation, like haloperidol, which are abandoned practically everywhere in Europe and the United States, it's a challenge for us, it's a challenge" (interview, March 2019). Eric explained: "we have old generations of drugs which have a lot of side effects, and really with less of good outcomes for patients. And we don't know if we are under-dosing them or we are overdosing them with those drugs" (interview, March 2019). Patient, the implementer at the national level explained further: "most of medication are under strict control by international laws, and the suppliers are not really motivated to supply us with those medications. It is a problem, yes." Therefore, the issue is not simply that medication is being too heavily relied upon, but also that the medication itself is outdated and the country does not have access to more appropriate forms of drugs that would improve patient outcomes.

To tackle this issue of institutionalized care relying on medication, many participants advocated for community-based approaches, as they saw these approaches as more fitting to the Rwandan culture. They also argued that it allowed many people to be healed in one place at one time. Some explained that they had even collected evidence on the efficacy of these methods, and hoped the policy-makers and implementers would consider their research. In response to the issue, others simply emphasized the role of empathy and listening: "Let's not see everything as a psychosomatic disorder. Or everything as something that needs a quick fix, a quick medication for someone to be better. Let's also be tuned to hearing them out, listening, you know? It goes a long way when you sit and listen to somebody" (interview, March 2019). Finally, Gael, a psychologist, suggested dispersing services beyond hospitals and also including them in schools and various state institutions, in order to bring them closer to the heart of the community (interview, March 2019).

Challenge 3: Human resources

The next issue raised by participants was a lack of human resources in the country as well as the fact that many of the personnel in the field are not properly trained or that many of those that are trained are jobless. First of all, although there has been an increase from one psychiatrist to twelve psychiatrists in the country since 1995, and this is surely an improvement, it is still an incredibly small number comparing to the Rwandan population and the number of people suffering. For this reason, nurses have been trained to fill in this gap, as Rwanda currently does not have a psychiatry department and one must be sent abroad if they wish to become a psychiatrist. This has been seen as an efficient and cost effective way to address this issue, but many still feel that it is not enough. Linda, an implementer, bluntly said: "We don't have the manpower needed to develop or to implement a mental health policy" (interview, March 2019). Josephine, a psychologist agreed: "there's not enough technicians such as psychologists and mental health specialists. There's not enough will to follow that professional path" (interview, March 2019). Some participants also spoke specifically of needing more professionals in rural areas, as specialists are generally concentrated in the capital, Kigali.

However, many claimed that the problem was not a lack of human resources, but rather a lack of properly trained professionals/lack of professionals trained in different areas/specializations. Bonaventure, an implementer, explained: "we are having some psychologists, but sometimes they are not trained – they are academically trained, but sometimes when they come into practice you find that there is a gap" (interview, March 2019). Janvier, a psychiatrist, spoke of the lack of specializations among professionals: "there are psycho-therapeutic interventions, psychologists on the field, but we need specialists in different types of therapy like behavioural therapy, family therapy... or even therapy in the trauma domain, eyes movement, desensitization" (interview, March 2019). Valentine, an NGO representative, concurred: "sometimes people do not have enough skills on how to deal with trauma, so we feel as though one of the things again that can be done is to ensure like a lot is

done with these individuals in terms of helping them understand different wounds, different traumatic episodes, because most of them have these backgrounds in mental health, but there are some specific things that we realize that are important for someone working in mental health, which include of course knowing the different types of wounds in the Rwandan society" (March, 2019). Therefore, it is clear that the current training available for mental health workers is not sufficient and there is a need for more specialization among professionals in order to satisfy the goal of patient centred care.

The most common theme in regards to human resources, however, was not a lack of them nor that they are improperly trained, but rather that there is actually an abundance of them, but they are jobless. Gael, a psychologist, stated that "I think that the policy hasn't done enough because there are a lot of people with mental health problems and there are a lot of graduated students who have done their studies in the subject of mental health or clinical psychology who don't have work" (interview, March 2019). Going a step further, Fidèle, a professor said "clinical psychologists are affected a lot by the unemployment here in Rwanda. Why? Because some policy makers – those policy makers – do not have the will of recruiting them" (interview, April 2019). Fiston, an NGO representative added: "I can say that even psychologists who are well trained, they do not have job, they are not providing psychological interventions to the community. However, the community needs those people who are trained in mental health promotion" (interview, March 2019). Anne, another NGO representative, spoke of this challenge and stated in regards to the unemployed graduates: "I think most of them are questioning why that department is being really, is not advocating for their employment in community" (interview, March 2019). It is not completely clear why these professionals are not being utilized.

To resolve this, participants asked that more psychologists be recruited in hospitals and health centres as well as at lower levels such as villages. As Ruth, a psychiatric nurse, said:

"normally you see there are two mental health nurses and one psychologist and they must receive the people in region. For me the district hospital should have six mental health nurses and four psychologists. I wish even on health centre, they should have mental health nurse and psychologist because they can help" (interview, March 2019). Frank, working in a health centre, also asked that the government provide health centres with more professionals based on the demand in the region (interview, April 2019). Josephine, a hospital-based service provider, explained that having more specialized doctors would allow people to be treated closed to home, and decrease the amount of transfers to Ndera Hospital. Similarly, many suggested having professionals integrated in the community: Fidèle suggested recruiting psychologists at the sector level in order to tackle mental health problems (interview, March 2019). Immaculee, on the other hand, shared how powerful it would be if people in villages were trained in the policy: "you can find someone who can... drink alcohol to try and forget his problems... But if this person's neighbour was trained in this policy... then they could help them" (interview, March 2019). Jacky also encouraged training locals to help each other. Overall, participants wanted an increase in personnel and an increase in decentralization to the lowest levels, including community members (interviews, March-April 2019).

Challenge 4: Financial resources

As expected, funding and financial resources is a challenge in implementing the Mental Health Policy, especially because Rwanda is a developing country with limited means. In addition, while some leaders have prioritized mental health, other health issues are still seen as more important. Linda, an implementer, explained this by saying "we have our Ministry of Finance in charge of allocating a national budget to different ministries, institutions, and departments. So we have, on one hand we have infectious disease, and on the other hand we have non-communicable disease. So to prioritize, the focus was given to infectious diseases because they have prevalence of morbidity and mortality" (interview, March 2019). The same

challenge was present at the NGO level. Marie-Louise, who worked at an NGO focusing on multiple health issues, explained that when they ask for money for mental health, donors/sponsors do not respond: "they say that mental health doesn't kill person. But if someone suffer from physical disease, they respond directly. But about mental health? Oh, can wait. Everyone still think that mental health can wait" (interview, March 2019).

Financial resources were a challenge at the implementation level, but also at the hospital and patient level. Participants explained that patients have difficulty covering the expenses of mental health care, and that the burden often falls on the family. In cases where the family cannot afford to pay for the treatment or the family has abandoned the patient, the burden falls on the hospital or the district. As Pauline, an implementer, stated: "the first problem we have in the community is mental health cases requires insurance... If the family of the individual didn't do their best to find an insurance for the family member, it is up to us to do our best to find it for them" (interview, April 2019). Pacifique, another implementer, further explained the burden placed on districts by these cases: "We do have a program that takes care of anyone having any mental issue in this area... We take them and bring them to the hospital. Us we take care of them, some of them came here naked, now they are accepting to dress up. The district takes care of feeding them, and provides clothes. So the biggest challenge that we do have is the budget" (interview, April 2019). Pacifique also explained that there is a budget given to districts for these cases, but that it is not sufficient to cover all expenses.

In addition, interviewees said that there are many cases where mental health patients arrive and they do not even know their name. These people have been abandoned by their families and are often living on the streets, and therefore even if they do have mutuelle health insurance, they are unable to access it without identification/any idea of who they are. Charity, a psychologist, explained: "someone who doesn't even know his name, we always have these cases here, someone comes here who doesn't know his name and he stays here. We give him

food, we give him clothes, we give him hygienic products, and then we treat him as well. You see, it’s a big bill.” The other issue is related to the chronicity of mental illness and the fact that patients suffering from mental illness often require care for life. Innocent, a health centre representative, explained: “Sometimes you see people with critical mental illnesses, and that requires that they have to go to hospital at least once a month. And sometimes they have just enough money for the cost of their medicine and not the other costs associated with the hospital fees. And you can see how that if they had the means, it would be beneficial for them so that they can fully have access to these resources for their well-being” (interview, April 2019).

Participants felt that mental health needed to be more prioritized in the country and that funding needed to be increased. It is difficult to offer a concrete solution to this issue as Rwanda is a low-income country with many competing health issues to finance. However, interviewees did offer compelling arguments as to why mental health needed to be more prioritized, stating that mental health can be the base of everything, including economic activities and development, as citizens cannot contribute to the development of their country if they are dealing with debilitating mental health issues.

Challenge 5: Research/Data

Another challenge raised was that there is a lack of research and data available to inform the policy and its implementation. This was especially true immediately following the genocide when the first version of the policy was created. In the years following there were some independent studies conducted in various regions, but none that were country wide. Eric, an NGO representative, explained that “so that policy, to have gaps, is just natural. Because we’re starting from a point of no data at all and using estimates, maybe overestimation or underestimation... coming from that background where you have no data, you have to kind of putting out fire if you will” (interview, March 2019). The Rwanda Biomedical Centre made big strides with regards to this challenge last year by conducting the 2018 Rwanda Mental Health

Survey (discussed in the process chapter), a quantitative study on the number of people suffering from mental illness in the country, divided into the categories of general population and genocide survivors. It measured rates of morbidity, co-morbidities, awareness of services and utilization of services (Rwanda Mental Health Survey, 2018). Diane, an NGO representative appreciated the research done, but mentioned that it is still necessary to conduct a qualitative study in order to determine the root causes of the diseases. In February 2018 I attended a presentation in Kigali at the Remera Campus of the University of Rwanda on the results of the survey, and this gap was acknowledged by the research team. Another gap heavily focused on at the presentation was that the survey did not determine why people were not using services despite knowing about them, and that it would be necessary to conduct research on this in the future.

Challenge 6: Trans-generational/intergenerational trauma

Some participants felt that not mentioning trans-generational trauma in the policy was a major gap, and were advocating for more of a focus on this issue. They emphasized that trans-generational trauma is cyclical, and that trauma is likely to continue being passed down through generations if it is not addressed. Explaining the phenomenon, Fiston, an NGO representative, explained "we are dealing with the mental issue, let's say what we call trans-generational trauma. Currently, even the children who were born after genocide, they were affected indirectly, there's a transmission of mental problems or trauma from the parents or the people who were living during genocide, and they are transmitting their trauma, their mental problems to their children who were born after genocide" (interview, March 2019). Alexis, another NGO representative, explained that the transmission of trauma was not only happening through generations, but in other settings too: "it is like people who have mental health problems they transfer them to others. Like in school, in community settings..." (interview, March 2019). Valentine, representing another NGO, spoke of the consequences of this transmission of

trauma: “if you’re living in a population where the majority of them are young people, then you have those numbers of high levels of trauma, because you know trauma can take you to very many places... it can lead to mental breakdowns... It can lead to revenge in worst case scenarios... Because you see these young people who were young at that time, most of them are now reaching the age where you’re a young adult, you can get married, some of them are actually already married, but then if that trauma isn’t dealt with, then you’ll still transfer it again back to your kid” (interview, March 2019).

Clearly, this is an issue that needs to be addressed in the next revision of the policy, and this is exactly what participants asked for: “we see that addressing intergenerational trauma is something that can be included in the next revision of the policy on mental health. Really, I strongly recommend that because our young people are facing so many psychological issues and you can’t see where it’s mentioned in mental health policy” (interview, March 2019). Fiston (along with other participants) suggested that the policy address trans-generational trauma by focusing on the family: “there is also a need of potential support and interventions to look into the family. The family is the cell. The family is the source of everything. If a child is not well educated in his family, it means that also he may not perform well in the education, his development social, sexual, and so on, will be affected” (interview, March 2019).

Challenge 7: Facilities, services, and care

Participants agreed that the number of services available are still not sufficient to treat the number of people suffering, and as mentioned previously, that programs and specialists were concentrated in the capital. Fiston explained: “Like yesterday I was in the fieldwork... there is a community which was highly affected by genocide against the Tutsi of 1994, there are many genocide survivors. When I asked them if they have access to mental health program or if they know at least one or two programs which are in their community... they answered “there’s no program within our community. Your program is going to be the first”... That is

showing that there is many genocide survivors and some perpetrators, but they don't have access to mental health programs" (interview, March 2019)." Alice, a psychiatric nurse agreed that there were not enough services available: "we still have people suffering from mental illness that are not looked after. Because some people don't have support to be looked after, treatment, follow-ups by a professional, it becomes a weight over time. Because of that lack of service, you will often find them wandering in the street" (interview, April 2019). Finally, Jean-Pierre also advocated for more mental health services due to the number of people suffering: "if RBC says that 35% of the people of Rwanda have mental health concerns, that's what the report says, and then we have less than three mental health hospitals. If 35% was ebola, would we have less than three ebola centres to address the issue?" (interview, March 2019). While it was easy to find organizations working in the mental health sector to interview in Kigali, I did not find a single non-governmental organization (or private practise) working in mental health/offering mental health services in Ngoma district. The only services available in this part of the country were hospitals, health centres and community health workers.

Another issue raised specifically by interviewees at Ndera Psychiatric Hospital was that they felt that services, facilities, or options for treatment external to Ndera were not being valued and that Ndera was seen as the fallout solution for all mental health problems in the country. Two participants from Ndera Hospital spoke of the government viewing people suffering from mental illness as "the property of Ndera" (interviews, March 2019). One explained further: "because if they see someone on the street, they don't even go look for their family or anything, they bring them directly here. And when he gets here no one visits him, you see ? And when they will be treated and healed we will need to send him back to his place in society. And in these cases there we always have problems" (interview, March 2019). Another interviewee from Ndera Hospital explained that the population had the same attitude, and that those suffering from mental illness wanted to bypass community health workers, health

centres, and district hospitals and come directly to Ndera as “they assume that Ndera is a place where all mental health issues end. And they seem good and we asked them that we see that you have good progression in healing, why do you want to come to Ndera? And we told them that those health care providers were studying like what we have studied and the patients said “no, at Ndera is where every issues in mental health must end.” You understand that population are not yet understanding that policy and they said that the most important is to reach treatment at Ndera” (interview, March 2019).

To resolve the issues of lack of facilities and the burden placed on current reference hospitals, one psychiatric nurse asked that the amount of referral hospitals in the country be increased. While many mental health issues can be resolved at lower levels of care, more serious cases cannot as district hospitals and health centres do not have access to the same medication or specialists as referral hospitals such as Ndera. Frank, a health centre representative, asked that the implementers provide better training for psychiatric nurses working in health centres so that they can administer more medication for patients, therefore avoiding the cost of travel for patients to referral hospitals. One psychologist working at Ndera had similar recommendations: “Here as a reference hospital we often have we do transfers towards lower hospitals. But to arrive there, patients don’t find medication, in those cases they have to return here. That, that’s not decentralization. So there are limits in the decentralization of mental health care so we must disperse the means and the materials that people need for basic care close to his home” (interview, March 2019). Josephine concurred, stating that district hospitals require more specialists, medication, and tools so that patients can be treated close to home.

Finally, another issue raised by participants in terms of services and quality of care was a lack of follow-ups for mental health patients once they are released from hospitals/after their visit at a health centre. As a result, participants explained that patients often relapsed. Some

said follow-up care needs to come from the facilities while others put responsibility on the families and the community. A common theme seemed to be a missing link between facilities and families in terms of follow-ups. As Josephine stated, “Because of having no people to come home to, no one to care for them and do follow-up, no one keeping tabs on them and helping them take their medication regularly, they return to wandering in the streets because they are not close to a grounded environment” (interview, April 2019). Gael, another psychologist, explained that the health facility where he works does do some follow-ups and home visits, but that it is not all the ill that are cared for in this way. In order to improve follow-up care, participants insisted that the family and community needed to be aware of the policy and mental health in general so that they can be involved. As Pauline said, “If family members don’t get involved in the process, that person will get sick and regress” (interview, April 2019).

Challenge 8: Lack of understanding in leadership/top-down implementation

While participants were happy with the efforts put in by leadership, they also felt that sometimes they lacked understanding compared to the practitioners working on the ground. Participants stressed that they simply wanted to be more involved in the process as they believed that their experiences in the field could contribute to a better implementation of the policy. In addition to mentioning high-level leaders, they also spoke of local leaders and the need for them to gain a better understanding regarding mental health and trauma and how good mental health can contribute to the growth of the community. For example, Anne, an NGO representative, stated that “another gap is that I cannot really stop to mentioned that in Rwanda... there is still a lack of ownership and awareness at a higher level about mental health. Many people, many local leaders are focusing much on economic activities and social activities and pay less attention on mental health related issues... And we used to tell them, but the mental health can be like a foundation of everything. When a person is not psychologically well, he cannot be engaged in economic activities or in social activities.” (interview, March 2019).

Valentine continued: “you find sometimes the leadership, let’s say the executive secretary of some of these cells or sectors, they don’t have the knowledge and skills about trauma, about mental health, and yet these are the same individuals that are representing our needs at the district level or even at the country level when they come for these big meetings” (interview, March 2019).

When interviewees were asked about how they worked with the government to implement the policy, many reported working in silos. Many stated that the policy was designed to coordinate mental health actors, but when asked how this took place, few had examples to share. However, some did provide examples: Marie-Louise stated that RBC provides her organization with information on the communities they are working with and orientation for psychosocial support programs. Immaculée said that the psychologists in her organization studied at the University of Rwanda, and that the establishment of the Department of Clinical Psychology was part of the policy. A few others seemed more involved through their participation in the coordination meetings hosted by RBC and through their advocacy roles. Many also stated that they were there to fill in gaps the policy and its implementation did not address. Those employed by hospitals or health centres were directly affected as they attributed their employment to the policy. However, in general, participants reported a lack of collaboration and wanted to play more of a role in the implementation. For example, Michelle said that “we’ve never run into any conflict with them, and we’ve never worked very closely” (interview, March 2019). Honorine shared similar sentiments: “I think there’s nothing our organization is trying to do that is against the policy... I don’t see us colliding in any way” (interview, March 2019). Jean-Pierre said that “I must say that first I don’t know very much about this policy and so I cannot comment on the contribution it has made in our work” (interview, March 2019). Many others admitted to knowing little about the policy, despite working in the domain and therefore being indirect implementers of the policy. Lastly, Fiston

explained that "there is a need of reinforcing the partnership between private institutions which provide mental interventions and also the governmental institutions" (interview, March 2019).

When asked how the next policy revision could best respond to the needs of their organizations, many simply asked to be involved: "I feel as though the policy would best respond to our needs... if there would be able to be room for people to bring in new ideas... they'll always bring in external personnel, academics, researchers in this field of study, but then sometimes organizations are left out, yet these are the actual implementers" (interview, March 2019). Others shared similar sentiments: "I do believe that there's more need for RBC to engage more practitioners... here we do work a lot with the local organizations, we have built a lot of knowledge about the issue, but I never see someone maybe inviting staff to a meeting" (interview, March 2019).

Others concurred, but took it a step further, stating that there was a need to not only collaborate with local organizations and practitioners, but also with the mental health patients themselves and the community at large. Eric explained: "the next revision would be very, very key to have a broader patient perspective. Patient and those who have lived experience being patients. Because they speak best to their experience, to how they want the service to look like, and what they see as gaps in their rehabilitation" (interview, March 2019). Pauline, a local level implementer, said "The implementers have to know their responsibilities to reach out, that means starting from the high level to the second level to the lower level...All the levels have to collaborate together so those patients are taken care of" (interview, April 2019). Likewise, Jacky, a service-provider, stated that "the policy has to come from the bottom so that people will pay attention to it and it can be updated using feedback coming from below...that way the policy will be reflecting population needs" (interview, April 2019). Overall, interviewees saw the need for the implementation and policy revision to be "decentralized too so that the decisions are not just coming from the top" (interview, April 2019), and simply asked to be

included in the process.

CHAPTER 5 – Analysis and conclusion

Analysis

Rwanda has made great strides towards implementing its mental health policy, especially considering the challenges it faces. It is significant in itself, as many participants emphasized, that the country has seen the value of mental health, especially given its post-genocide status, and has put in place a policy to try and care for its people. It is especially significant given its geographical location as few countries on the continent have prioritized mental health to this extent. While some of the challenges faced by Rwanda are unique, many are not new in the setting of post-conflict mental health reform. The challenges that appear to be common in other post-conflict settings such as stigma, capacity, and sustainability can be found in Rwanda as well. However, some of the best practices and methods to overcome these challenges are unique, such as the way that Rwanda prepares for its genocide commemoration. Despite some of the successes and best practices that have emerged, there remain many gaps. This chapter will use literature presented in the introduction as well as complexity theory to analyze the process of implementing a mental health policy in a post-conflict setting. This analysis will go through the three main research questions to determine what the data has found and to develop some recommendations.

The first question to answer is: How has Rwanda attempted to implement its mental health policy? What was found was that Rwanda has chosen a method of rapid and large-scale decentralization and integration to implement its mental health policy. While other cases studies (notably Bosnia and Herzegovina) found that rapid decentralization was not successful and that it was foreign to them (a Western concept), in Rwanda it was viewed positively for the mental health sector. When interviewees were asked what they knew about the policy or what they thought was the most important part of the policy, they consistently emphasized

decentralization. Based on the current number of consultations, it is also evident that more people are receiving treatment as a result of this decentralization. It is possible that decentralization works in this case because Rwanda has engaged in policies of decentralization in nearly all sectors, so it is familiar to Rwandans and therefore easy to implement. Rwanda is also known for having very efficient governance thanks to these policies of decentralization. However, decentralization has also been criticized in Rwanda for actually increasing central control, rather than decreasing it, and therefore limiting local autonomy and decision making (Loffler, 2017). The Rwandan government uses decentralization to increase its control by using a system of local governments that respond to heavy-handed control, therefore expanding the reach of the central government to "the remotest hills of the country" (Loffler, 2017, p. 12). This could also apply to the implementation of the mental health policy as decisions are taken at the top (by the government) and these decisions are implemented through to the bottom as a result of the hierarchical system created by decentralization where lower level authorities respond actively to higher level authorities. As a result, ideas do not travel to the top and the government maintains tight control over the implementation of the policy.

Despite decentralization being criticized in Rwanda as a means of control and despite it being viewed as a neoliberal intervention in countries like Bosnia-Herzegovina, participants viewed it very positively and thought it was appropriate for mental health care in Rwanda. This could be because despite some of the critiques decentralization raises and the mixed results it produces, due to its familiarity in Rwanda, it may lead to an increased sense of ownership. As many of Rwanda's policies are based on decentralization, the initiative may feel more locally driven and less like a foreign intervention, which was a problem in other post-conflict/post-genocide states. In terms of domestic ownership, the majority of organizations I met working in the mental health domain were local and the implementation, although having external funding in addition to its domestic funding, was done by a Rwandan government institution.

The fact that the policy was locally owned and implemented appeared to be a major driver for its implementation. Participants appeared really passionate about their work and to be helping their country. Many had studied abroad in developed countries within Europe or North America, but returned to Rwanda to use their newfound knowledge to help heal their fellow citizens. While a lot of health funding comes from outside of the country, the policy and its implementation appear to be overall locally driven, which according to Giacchino & Kakabadse (2003) is key to success.

The implementation of the policy has also sought to ensure that mental health care is affordable. Rwanda has negotiated with community based insurance companies to include mental health care in their coverage. Studies on other post-conflict countries implementing mental health policies/reform found that insurance models were a challenge to appropriately implement in a mental health context and therefore, Rwanda's insurance system could be seen as a rare form of success. However, it was also presented as a challenge as it has increased coverage for many, but others are still not benefiting from it. Various studies in Rwanda have found that community based health insurance (CBHI) has greatly ensured access and that as of 2015, 91.6% of Rwandans are covered by it (Chemouni, 2018). The issue is that according to participants, those suffering from mental illness have more of a chance of falling into the category of the 10% that do not have coverage due to their conditions resulting from mental illness, such as being abandoned by their families or living on the streets. In addition, service providers raised the issue of the costs of staying in the hospital, which are not covered by the community-based insurance scheme. Therefore, while CBHI has greatly increased accessibility, and it has surely been a step forward to include mental healthcare in coverage, there are still many who have difficulty affording mental health care.

Another key strategy in the implementation of Rwanda's mental health policy is the training of non-specialists to treat mental health issues. This allowed the country to increase

the number of services rapidly as training specialists through a degree program would have been expensive and time consuming. In addition, by training non-specialists in general facilities, mental health care has been integrated into the general healthcare system. A clinical psychology program has also been established at the University of Rwanda to ensure sustainability and increase the number of specialists. As a result, people are able to receive services close to home and there are many more of them available, which solves both the issues of lack of facilities and lack of transportation to facilities, challenges brought up by Murray et. al. In addition, training community health workers has brought mental health care into the community, which has the potential to address the damage caused to the social fabric as a result of conflict, also suggested by Murray et. al. (p. 7). There is still a challenge, however, with the quality of people trained in the field, the number of specialists, as well as the number of trained people who are unemployed following graduation from the clinical psychology program.

Sensitization was also found to be a key component of the implementation process. Consistent with the literature, participants in Rwanda found stigma to be a huge barrier to implementing a mental health policy and providing mental health services. While it is unclear if the mental health policies in these other countries mentioned sensitization as an implementation strategy, Rwanda emphasizes the importance of it and has many activities in support of it. While we do not know how effective these strategies are, as there are no studies measuring the success of them, and that is out of the scope of this study, it is important that Rwanda has recognized combatting stigma as a key area to place efforts. This sensitization has been aimed towards the population in general, but also towards local leaders. Educating local leaders is important as Giacchino & Kakabadse (2003) said in policy implementation, local will is key, and leaders can only have the will to implement something if they are educated on it and why it is important. Having people aware at these levels about mental health can also contribute to combatting stigma as local leaders have the ability to share their knowledge with

other people and have a direct influence on people in their commune, cell, sector, or district. However, it must be noted that sensitization can also be used as a tool of an authoritarian government and therefore we must view it with caution. The Rwandan government has an extremely strong presence in the country and it can use sensitization to spread its own message. While it may seem like mental health is depoliticized, and therefore sensitization is not dangerous in this domain, this is not true. The Rwandan government centres its rhetoric on mental health on the impacts of genocide. It has been shown in the introduction that the Rwandan government has a very rigid and one-sided interpretation of what happened during the genocide, therefore erasing the experiences of many. For example, even mental health research is divided based on the categories of "survivors" and "general population", differentiating between the two based on a very narrow definition created by the government. The policy itself also refers specifically to survivors when talking about mental health issues. As a result, mental health and sensitization could be used as another arena to enforce the regime's interpretation of the country's past and to impose their political rhetoric on the general population. Therefore, while sensitization is an important part of the policy, and important for any state to implement in order to ensure usage of services, in Rwanda it could also be a dangerous tool used to impose the government's vision on the population.

Overall, to answer the first question, Rwanda has relied on the policies of decentralization and integration in an attempt to ensure availability of services, as well as a community-based insurance model covering mental health care to increase accessibility. The implementation of the policy also approached mental health from other angles, aiming to sensitize the population, conduct research, and bring services closer into the community. While these methods have been effective at achieving certain goals, these goals are not necessarily in line with those of many stakeholders (e.g. clinical care vs community care). In addition, policies such as decentralization and sensitization have been used as means of control in the

past and therefore it is necessary to be cautious.

The second research question, which was partially answered above, is: What are some of the obstacles and challenges to implementing Rwanda's mental health policy as well as the best practices and successes? While many challenges, especially stigma and institutionalized care, were found to exist, a huge barrier to overcoming these challenges is a lack of collaboration and adaptability on the side of the government. Complexity theory suggests that implementers should learn and be adaptable to new developments throughout the process. In terms of learning throughout the process, this is clearly being done, evidenced by the completion of the 2018 Mental Health Survey. As emphasized in the context chapter, the policy was initially based on very little data, but needed to be implemented nonetheless as Rwanda was experiencing a mental health emergency. Since then, knowledge has greatly increased due to the survey mentioned above, as well as other studies conducted by independent researchers, NGOs, and the government itself. While there is still very little research in the domain overall, the fact that the government mandated this study shows that there is a will to learn. However, it is unclear at this point how much the government adapts based on this learning (especially due to the fact that the survey was completed so recently).

While research is a great source of knowledge, the best source, which the government has arguably not tapped into enough, are the people working on the ground. According to the literature covered in the theoretical framework, as well as complexity theory in general, genuine stakeholder engagement and collaboration are key when implementing any policy. Not only does it ensure that various opinions and knowledge are being shared, but it also increases capacity when the government uses its network effectively (Giacchino & Kakabadse, 2003, p. 144-145). Many of the stakeholders I talked to had experience on the ground that implementers were not aware of, and having the chance to share this information would surely contribute to improvement. For example, there were discrepancies between implementers and service

providers on what is and what is not covered by community based health insurance. Implementers emphasized that everything was covered, while service providers pointed out that there are hospital fees besides medication and therapy that are not covered and that are a burden to the patient, family, hospital, and district. Understanding this issue and putting in place an intervention like an emergency budget for these cases for the district or negotiating with mutuelle health insurance to provide more coverage could ease access to services, and therefore contribute to improving access to services. Another example of knowledge being concentrated at the bottom is that many stakeholders mentioned the benefits of community-based mental health care and even provided evidence of its success, yet many of the current approaches implemented by the government continue to be individualized and institutionalized. If implementers took these suggestions into consideration through more in depth stakeholder engagement, it could potentially yield better results. To manage complexity, it is necessary to have space for learning or the intervention may not meet its goals. Engaging in more collaboration with stakeholders would allow for these issues to be raised and acted upon as otherwise opportunities for success may be missed. In addition, it would ensure that stakeholders are not duplicating efforts and that means are dispersed properly throughout the country to various beneficiaries.

The coordination meetings are a positive way to achieve this goal, but they would be more effective if more organizations were invited, even those with different trajectories from the government. This would allow for more discussion among diverse opinions and increased learning. It could also potentially broaden decision-making power by promoting participatory decision-making. Jones (2011) emphasizes that to effectively implement complex policies, implementing agencies need to be decentralized and facilitate decentralized action and self-organization. Again, in 2013, Jones along with Hummelbrunner argued that management in general needs to be decentralized in order to promote participatory decision-making. Although

the coordination meetings seem to provide opportunities for discussion, participants still emphasized that decisions are centrally made. They stated that despite these meetings allowing for collaboration and the sharing of ideas, decisions ware still taken by the government and the organizations followed. Due to the country's authoritarian nature, it is likely that decision-making will remain hierarchal for some time, but the meetings still allow for various opinions to be heard by the government and potentially acted upon, which is a step in the right direction. It may be difficult to shift towards participatory decision-making within the confines of an authoritarian regime, but managing complexity requires a major shift in the mind-set of the key decision-makers in order to be successful (Hummelbrunner & Jones, 2013)

It must also be noted that due to the low budget allocated to the mental health policy and the fact that the division is already incredibly busy, an additional challenge in shifting towards collaboration and participatory decision-making would be time and resources. However, it may be worth it in the long-term as increased spending on reforms that are not necessarily in line with evidence from the ground level could be more costly as they may lack sustainability. Furthermore, avoiding the duplication of efforts could save money for all stakeholders, the government included. As Hummelbrunner and Jones (2013, p. 6) say in relation to complex systems, "overly hierarchical decision-making is not suitable in the face of this kind of issue due to the need to value inputs from lower levels".

In addition to hierarchal management and decision-making affecting organizations and the way the policy is implemented, many organizations are withdrawn completely from the official system and are working in silos. In addition to not working with the government, many stakeholders working in the domain were not sensitized to the policy, and many admitted that they had never even read it. While these organizations still have similar goals to the policy and to the government (increased access to services, sensitization, decreasing the prevalence of mental illness, etc.), efforts could be more properly dispersed and more efficient if they were

unified and if everyone was aware of the common goals, once again promoting the need for more collaboration.

In addition, if organizations and the government make all of their information and data open and public (which some organizations told me they are already doing[17]), it will be easier for organizations to share information and to know which areas of the country are underserved and therefore where they should concentrate their efforts. Open data can also go beyond collaboration and be used for advocacy. For example, if there was data on the number of unemployed graduates from the University of Rwanda clinical psychology program, graduates could better advocate for their right to employment, especially when more personnel are required in the field. Likewise, data on the prevalence of mental illness[18] could be used to advocate for more funding for the mental health program, from both the Ministry of Health and donors (in the case of NGOs). Finally, sharing data can compliment ongoing learning and adaptation by making information available, therefore addressing complexity. It must be noted, however, that while this would be a step in the right direction, once again it may not be plausible under an authoritarian regime.

While stakeholder engagement was viewed as both a success (due to the coordination meetings) and also a big challenge in the implementation of the policy, the institutionalization of mental health care was noticed as a clear gap. This could have potentially been avoided if the suggestions of complexity theory, namely collaboration and participatory/decentralized decision-making, had been taken into consideration. Participants felt strongly that there was a need for more active involvement at the family and community level in patient care for reforms to be successful in the long run. In addition, they were not sure how effective individualized

[17] Many organizations informed me that all of their reports, including the results of their initiatives, were available online when I requested them.
[18] As a result of the 2018 Mental Health Survey, this information exists. However, the report has not been published online. I was given access by an informant, and then given permission by the Mental Health Division to cite it.

approaches were in the Rwandan culture. Yet, these opinions remain concentrated at the bottom levels. These suggestions support literature (Baingana, 2003) that says mental health reform must include three dimensions of care, including the 1) family and the community, 2) therapy, and 3) hospitals. Hospital-based care is evidently being used and therapy is being used to a certain extent as some healthcare institutions have psychologists. Therapy is also being offered by NGOs and private practices. However, the family and community are not always included. According to the literature, the suffering created by conflict needs to be resolved in a social context, and this is not the currently the case in Rwanda. For example, various participants stated that mental health patients continuously regress due to rejection and stigma in their communities and come back to the health facility repeatedly due to multiple relapses. This is not sustainable healthcare, as it does not provide the best outcomes for patients.

While implementers made it clear that they are trying to include prevention in the implementation of the policy, including the community at large, as suggested by stakeholders, would be a more effective method of achieving this as it would reduce funds being allocated to the same patient who relapses several times as there is more likelihood that the patient would have a positive reintegration into the community. This would also improve the life of the patient and be an improved form of patient-centred The World Health Organization (2011, p. V) said that "Mental health is produced socially: the presence or absence of mental health is above all a social indicator and therefore requires social, as well as individual, solutions". Supporting this, Summerfield (2000) said that health and illness have social and political roots and that post-traumatic reactions are "an indictment of the socio-political forces that produced them" (p. 234). Therefore, the importance in the literature of involving society at large is clear. It is also evidence-based as a study on 84 Iraqi male refugees found poor social support to be a stronger predictor of depressive morbidity than trauma (Gorst-Unsworth, Goldenburg, 1998). As a result, mental health reform must include everyone and not only sick individuals. Because

the social environment is such a big predictor of mental health, the social environment must also contribute to recovery. Many NGOs instituted community-based care to try and address this, and as mentioned in sections above, compiled reports demonstrating the effectiveness of this approach. Implemented on a large-scale, these methods could be more effective than hospital-based care. Summerfield (2000) states that war is not a private experience. This is true in relation to the genocide in Rwanda: violence happened within the community and by community members against community members. Therefore, it is essential that the community be involved in resolving mental health issues. This can also assist in reconciliation, as poor mental health can lead people to be less supportive of restorative justice (as seen in the introduction).

Finally, it is important to emphasize how important involving the community is when it comes to preventing relapses and promoting reintegration. If a family members assists their loved one to take their medication, go to their regular hospital visits, and also gives them love and support, treatment is more likely to work. Likewise, if patients are not outcasted by their communities following a diagnosis or hospital stay, it is more likely that they can also contribute to their community. This could be in a social way, but also in an economic way. As mentioned in the interviews, patients found it hard to return to their old lives following treatment, including finding jobs or returning to their past jobs. Sadly, returning to the hospital seems to be a best case scenario when patients regress as other times they are found wandering on the streets. Sustaining jobs, and therefore having access to capital, can assist in the maintaining of good health as poverty and mental illness have been found to be correlated. In addition, having an economic generating activity gives one a sense of purpose in their individual lives, but also in the community. However, it is difficult to find jobs if the community does not accept them. Once again, stakeholders and practitioners working on the ground pointed out these issues and how they could be resolved, demonstrating how collaboration and

participation could greatly benefit the implementation of this complex policy.

The next major challenge in the implementation of the mental health policy was stigma. This was an issue that all actors, from the government down to the service providers, and everyone in between, were well aware of. As shown in the literature review, stigma has been a deterrent from successful mental health policy implementation in other post-conflict/post-genocide countries, as it leads people to be reluctant to accessing services. As seen in Rwanda, it has also led to issues in sustainability as stigma led patients to relapse repeatedly. No country in the world has found a way to completely eliminate stigma regarding mental illness, and it clearly takes time to reduce it. Even in developed countries, it is only recently that the trend of talking about mental health has emerged and that people are starting to accept and view mental illness in the same way that they would regard a physical illness. Rwanda has made efforts to sensitize people to mental health and increase awareness among the population, but increased emphasis on the fight against stigma is needed in order to make other parts of the policy successful. Activities such as radio shows, which are done every week by RBC, can contribute to reducing stigma, but not everyone has access to the radio and not everyone listens to the radio. Likewise, celebrating World Mental Health Day is extremely important, but the day mainly includes those who are already knowledgable and active in the mental health field, and does not have a lot of reach to the regular citizens, especially rural Rwandans. Training community health workers seems to be a very effective way, however, to not only provide services within communities, but also to combat stigma as having someone knowledgable about mental health near your home and educating others can normalize mental illness. In support of this statement, research has found that community health workers are closely involved in the community and widely respected by beneficiaries (Condo, Mugeni, Naughton, Hall, Tuazon, Omwega, Nwaigwe, Drobac, Hyder, Ngabo, Binagwaho, 2014).

However, although this study cannot speak to the results of this initiative, educating

local leaders seems to be an effective method currently being used by Rwanda to reduce stigma. Many organizations spoke of the need for local leaders at all levels of government from the cell to the sector to the district to have an understanding of mental health and to promote good mental health in their communities. Local authorities, such as police, also seem to have increased understanding as participants said they have been trained to bring patients wandering on the street to hospitals rather than jails. Training local leaders in mental health will lead them to have a better understanding as well, therefore increasing their ability to effectively advocate for the people they represent. This could also increase bottom-up implementation as ideas from the bottom could be listened to and their ideas can be brought up to authorities with decision-making power. However, even if local leaders are trained, it is uncertain if those in higher levels of the governance structure would adapt (as complexity theory suggests they should) as mentioned many times previously, decisions tend to be centralized and hierarchal in Rwanda.

Another way that the government could have a far reach and help reduce stigma would be if the government could introduce a section on mental health and well-being to its education curriculum. As mentioned by Baingana (2003), implementation must involve many sectors, including the education sector[19]. The reduction of stigma among 12 million people cannot be done by the mental health division alone, and requires the assistance of multiple sectors as well as other government departments, non-government organizations and other stakeholders. This could also help with the issue of financial capacity if government ministries are working together and distributing their funds in an effective way. However, in order for this to take place, there must be much more political will as this involves going beyond the Ministry of Health and including government as a whole. While there is a certain level of political will, evidenced by the fact that there is a policy being implemented, there is a mental health division

[19] The education sector has been involved in the implementation to a certain extent, but this section is arguing for it to play a much more prominent role.

at the Rwanda Biomedical Centre, there was a nation-wide mental health study conducted, and by the amount of government effort put into trauma response at commemoration, it requires the will of many sectors as well as those in high-level positions within the government for this trend to continue.

In addition to the will of various sectors, will from those with mental health concerns can be important for combatting stigma. As one participant said, patients can be the drivers of change, similarly to how it was in the fight against HIV and aids. This also means that those who have suffered from a mental illness should be considered stakeholders in the implementation process and should be consulted. As the same participant stated, they can be the best advocates for what needs to be changed in the system because they have experienced it first-hand. First-hand knowledge could greatly contribute to an implementation that is patient-centred and would also allow those who are actually suffering to be advocates for their own recovery as well as the recovery of others.

Mental health issues/illness can also be de-stigmatized and care can be improved by including actors outside of the traditional mental health care sector in the implementation process. The 2018 Rwanda Mental Health Survey showed that rather than going to hospitals, many were going to churches and seeking help from their local faith authority or from traditional healers. This suggests that there is a lot of stigma present when it comes to consulting official mental health services[20]. While consulting non-traditional actors can be helpful in some cases, traditional healers and faith authorities are not always equipped to deal with more severe/complex mental health issues. A possible way to increase consultations, as well as to improve care, would be if faith healers and traditional healers were directly included in the implementation process as stakeholders. They could work with the government by sharing their experiences as well as methods that they have found to be successful. For

[20] It could also suggest a lack of trust in the system.

example, I learned during my time in Rwanda that many churches offer counselling services, and that there is a degree program for faith authorities who wish to be trained in this. Yet for some reason (and likely because of stigma), there is a disconnect between this kind of counselling and mental health services[21]. In return, the government could train them on the policy as well as some additional techniques to help people suffering from minor issues, but also how to recognize when an issue is more severe and requires a different kind of treatment or needs to be sent to a health care facility[22]. Having these actors trained in mental health (beyond their traditional methods) and the policy would bring services to the places where people were already consulting. In this way, mental health care would be brought closer into the community, restoring the social fabric, and would help increase knowledge in the community about the local services. Additionally, church figures can use their platforms to talk about mental health and reduce stigma as many Rwandans are religious and attend church every Sunday.

In regards to traditional healers, although it is apparent that the mental health division has tried to collaborate with them in the past, continued and increased collaboration could also yield positive results as the survey makes it evident that people are still consulting traditional healers at large rates. Implementers spoke of attempting to collaborate with traditional healers in the past through sensitization and teaching them about the policy. However, collaboration may be more effective if the true spirit of collaboration was embraced, meaning that implementers are willing to learn from and listen to them as well[23]. Complexity theory suggests

[21] For example, I spoke to a Rwandan friend of mine who was a pastor about integrating mental health services/care into the church. Immediately, he told me that the mentally ill need to go to the hospital. It was clear that he associated mental illness with the most severe cases, and he did not consider his counselling services as mental health services. I found this interesting as in my own perspective, his services were clearly mental health services as he was contributing to helping people solve/manage their personal problems, therefore contributing to better mental health.

[22] It should be noted, however, that this could be challenging as it means these figures would have to admit that they are unable to help in some cases, and not all figures would be ready to do this.

[23] This does not by any means, however, mean embracing harmful practises (there is testimony from people who suffered from mental illness and visited traditional healers who made them eat/drink dangerous substances or who engaged in dangerous practises such as cutting patients with knives in their efforts to heal

that everyone should have the same goals, they should be aware of the methods to achieve those goals, and that the planning of these methods be participatory. Therefore, including non-traditional actors outside of the official mental health care system in the implementation process (in a truly collaborative, rather than one-sided manner) could allow for more synergy and cohesion, potentially preventing the harming of patients in the long run. This would not be easy, as there is likely to be disagreement in many instances, but it is a better solution than continuing to work separately.

In addition to institutionalized care and stigma, another challenge found in the implementation of Rwanda's mental health policy was combatting the transmission of trauma. Based on participants' responses, the policy does not put a great enough focus on trans-generational trauma. And once again, embracing the strategies outlined to manage complexity, namely collaboration and incorporating feedback from all levels, would allow for this issue to be better incorporated and managed. Participants recognized that children are highly vulnerable and the mental health of their parents can be an indicator of their mental health, which is also supported by research (as shown in the literature review). In order to be sustainable, children must continue to be considered in the policy, but to a greater extent, and specifically by focusing on intergenerational trauma. Other studies (such as in Cambodia) found that even the children of children of genocide survivors (their grandchildren) are impacted psychologically by the genocide in Cambodia. The genocide in Rwanda happened 25 years ago, and therefore many survivors who were young during the genocide either have kids now or are starting to have kids. Therefore, now is a key moment to stop the transmission of trauma. Another area where Rwandans mentioned poor mental health/the transmission of mental illness or trauma to young people was in the children of genocide perpetrators. Some said that the children were ashamed that their parents engaged in these acts, leading to poor

them).

mental health, while other children were angry that their parents were in jail and did not always know the reason why. Many of these kids were also living in poverty as a result of not having a male figure in the house to work and bring in capital. As a result, the situation is complex as there are multiple mental health issues arising among different populations that the implementation of the policy needs to address.

Rwanda has an extremely young population, and it was evident through talking with interviewees that the Rwandan culture really values the youth and sees them as the future of development and the future of their country. Therefore, it is important that the government invest more in the well-being of the youth, including their mental well-being. Ways that the implementation could target youth is through education, specifically through the school system, but also by focusing on the family, as suggested by participants. Implementers did mention the importance of a healthy family and how healthy families result in healthy individuals. Therefore, continued focus on the family unit in order to work on prevention is key to sustainable reform. However, it is interesting that the implementors emphasized the focus on the family as it is contradictory to some of their practices. For example, as shared in earlier sections, the implementation of the mental health policy responds to drug and alcohol abuse among teenagers by taking them to rehabilitation centres, such as Iwawa, where they are far away from their families. This can be seen as another authoritarian method to address mental health issues, especially as the re-education portion is a form of indoctrination.

To answer the second part of the second research question, some of the best practices/successes included the coordination meetings hosted by RBC, increased accessibility to services as a result of decentralization and integration, and commemoration preparation. The fact that services are available and have been brought close to people's homes thanks to the training of non-specialists was also seen as a big success. While services are still not being used to the extent that people working in the field would like to see (when they compare the rates of

use to the prevalence of mental disorders), people now have the choice to seek mental health care close to home, and at a lower cost. According to service providers, and witnessed by myself in the places I visited, the health care facilities had many mental health patients consulting. It is highly impressive the way the country managed to exponentially increase its mental health services in such a short time period, and it is a practice that other post-conflict or post-genocide countries can surely learn from. When one considers that prior to the genocide there was only one mental health hospital in the country, and now every hospital, nearly every health centre, and even most community health workers are equipped to treat mental health issues, it is a huge success. This success was especially evident in rural parts of Ngoma district. While they were still facing many challenges in terms of effectively treating mental health, and still there were no NGOs in the district, they were so grateful for the policy because they said it was greatly facilitating their work and that it put many rural Rwandans at ease knowing they could now receive services close to home.

Finally, the preparation for the genocide commemoration was seen as overwhelmingly positive. It was organized, efficient, and participants felt it really considered the needs of those who find the period of commemoration difficult. Participants also felt that the way they worked together with RBC to prepare for commemoration was positive, contributing to a well-planned intervention that was evidence-based, demonstrating how collaboration can lead to success in complex situations. Of course there were still some areas where participants thought they could do better during commemoration, but the overall management of it was perceived highly well. Planning started far in advance, and multiple organizations were involved, whether it be through direct involvement or providing input, or benefiting from a training provided by RBC for trauma response. Commemoration can be a difficult period for Rwandans, and therefore the response is highly valued. Many people told me that in the past trauma episodes were frequent during commemoration period, especially the ceremony and that the stadium was overwhelmed

with the sounds of screams of those re-traumatized by the ceremony or someone giving testimony. This re-traumatization often takes place in a public space during commemoration, resulting in traumatic episodes which can include symptoms such as shaking, crying, or screaming. Rwandans are sensitive to this and perhaps because the commemoration affects everyone, there is public understanding and empathy. It is possible that this understanding of trauma issues during the genocide commemoration has increased the success of mental health interventions during this period as many understand the need of responding to these issues. Therefore, resources are allocated. Mainly though, it shows how the principles of complexity theory, such as participation, collaboration, learning, and adaptation, can lead to success. Beyond that, it shows that it is possible to implement these methods even in the confines of an authoritarian state.

The third question the research sought to address was how is progress/success of the implementation of the mental health policy measured and do different actors define success differently? While there were definitely common themes in responses, participants seemed varied in their definitions of success and what they hoped to achieve, once again demonstrating how complex the system is. However, the main theme was simple: participants wanted people to get better and for mental health to improve in their country. Receiving varied responses for how to achieve the same goal could be viewed as positive or negative. It is positive because they are all focusing their efforts in different areas, therefore potentially avoiding the overlapping of work, but it could also be negative as it means organizations and the government are not necessarily aligned and working together in a horizontal direction. Among the different levels (implementer, NGO representative, service-provider, professor), there was a lot of cohesion in their thoughts (implementers had similar ideas to each other as did NGOs and service providers). However, between these four levels, thoughts and ideas varied greatly in regards to the implementation of the policy (what should be done, what is most important, what

are the challenges and gaps, etc.). According to complexity theory, different definitions of targets, success, and progress can lead to barriers to the development of a joint understanding (Hummelbrunner and Jones, 2013, p. 4). This was evident in Rwanda as different participants were working towards different goals using different methods. In some ways, NGOs were filling in the holes of government work, but overall it would be more effective if they were working together to achieve the same goals.

In terms of how success is measured, as mentioned in previous sections, it was hard to gather this information. I was told there were some indicators, but I was also told that the overall assessment was integrated into the overall health sector assessment, making it difficult to measure exactly what came as a result from the policy and what was a result of another health policy. For example, one implementer said a proof of success of the mental health policy is that life expectancy has greatly increased in Rwanda over the last couple decades. However, this is clearly also the result of many other policies and it is difficult to measure exactly how much of this can be attributed to the mental health policy. Another indicator of success raised was the decrease in homelessness, but is this due to the mental health policy or an economic policy? Another measurement used to determine success is the rise in mental health consultations. Consultations could be increasing because of a rising number of mental health concerns in the community, or they could be increasing because the government as well as other stakeholders have effectively reduced stigma and increased the number of services available. As shown through these three examples, it is hard to clearly measure the progress of the mental health policy. Baingana (2003) states that it is important to to have consistency with the supervision, monitoring, and evaluation of the policy in order to be successful. Complexity theory also states that clear methods of monitoring and evaluation, as well as holding management and those involved responsible for their actions, will lead to better results. Therefore, clearer indicators and more research is needed in order to effectively measure the

impacts of the policy and to hold those responsible for it accountable. As it is a complex setting, targets need to be clearly measured in order to make progress.

Conclusion

While a large amount of implementation challenges emerged during the research as well as apparent gaps in the policy and its implementation, participants generally agreed that the mental health policy has succeeded in many ways. It was also found that shifting to more collaborative, participatory, and decentralized management/implementation would be an effective way to overcome these challenges and gaps. An interesting theme that arose in the research was that participants felt that all countries should have mental health policies, regardless of their past. Even upon asking the Minister of Health, Diane Gashumba, what advice she would give to other countries in regards to implementing a mental health policy, she laughed and said “you should have one!” (meeting, April 2019). Although it may seem like a light and simplistic answer, it underlines the importance of just getting started, and doing this by creating a policy, as so few countries have yet to take this crucial first step. Participants truly saw the value of their mental health policy, and really recognized the importance of mental health care for all. Many cited the World Health Organization’s 1948 definition of health, which has been embedded in the WHO’s constitution: “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”. They emphasized that even since 1948, mental health has been recognized as an integral part of health by the most known and respected health institution in the world and therefore must always be considered, regardless of whether the country has experienced war or genocide. As Alexis said: “Yeah, maybe one thing is it would be good whenever and wherever there are health policies, they should also think about mental health policies... Not because of the genocide, just because of life” (interview, March 2019).

As we have seen, mental health policies are extremely important in any country, but

especially in a post-conflict/post-genocide country. War and genocide can cause extreme trauma for those who witness it and can result in debilitating mental health issues, which can be transmitted through generations. Poverty can also increase the chance of having poor mental health and having poor mental health increases the chances of poverty, demonstrating the importance of having mental health policies in place to protect vulnerable populations. Good health includes good mental health. And having people at their full capacity can also contribute to economic development as it means more people can access and spend capital. Overall, there are many arguments and increasing evidence as to why it is important to consider health holistically, with mental health included. Rwanda has done a lot in regards to implementing its mental health policy, especially evidenced by the fact that it is one of the few countries on the continent to even have a policy. Their model could surely be replicated in other countries with some adaptations based on the challenges experienced by Rwanda, but also based on the culture of the individual country and how those within the country want to work towards good mental health and well-being.

This research has also shown how authoritarian governance in Rwanda affects all sectors, including the health sector and mental health care. Decentralization has been criticized in Rwanda as being a way to increase central control, and it is a key component of the implementation of the mental health policy. In addition, though sensitization is necessary, it is the government's version of the country's past that is being promoted through these sensitization sessions. In addition, we can see how the implementation is top-down and does not incorporate enough ideas from the ground level. However, Rwanda has also been credited as having very effective governance due to its authoritarian regime. The speed at which services were decentralized and made available demonstrates this efficacy. At the same time, efficiency is not important if the goals being achieved are not in line with the needs of the population, which to a certain extent appears to be the case.

While this research did not focus on the results or measure the success of Rwanda's Mental Health Policy, it has provided an inside look at the dynamics, thoughts, and opinions of implementers, service providers, NGOs and other various stakeholders. This has allowed us to see how different actors collaborate during the implementation process and how activities are divided among organizations and the government. It also allowed us to see how various actors from the top of the implementation to the lowest levels felt about the implementation process and what could be done to improve it. Finally, it gave insight into mental health policy implementation in general, a subject rarely studied. This is important not only because of the prevalence of mental illness in Rwanda, but because of the prevalence throughout the world. Mental illness can be debilitating, and the services available worldwide do not match the need based on the data and estimations. Looking at what Rwanda has done in this field and continuing to research their progress, challenges, and successes will provide examples of what does and what does not work when implementing a mental health policy. This will hopefully encourage other countries who want to institute a mental health policy as they will be more likely to implement something that is evidence-based and they will have more ideas for how to accomplish it. It will also demonstrate to other countries that it is possible to do a lot with little means, especially when you are managing an emergency. However, it will also show how in the long-term reforms need increased funding and political will, more collaborative and less authoritarian implementation, as well as to involve the community at large in the healing process in order to be sustainable. This sustainability will result in better care for patients, protection of vulnerable populations, and more economic and social development of the country.

REFERENCES:

Abed, R. (2004). Tyranny and mental health. *British Medical Bulletin, 72*(1), 1-13.

Ahmad A. Sofi MA. Sundelin-Wahlsten V, et al. Posttraumatic stress disorder in children after the military operation "Anfal" in Iraqi Kurdistan. Eur J Child Adolescent Psychiatry. 2000;9:235–243.

American Psychiatric Association (2018). What is Mental Illness? Retrieved January 3, 2018 from https://www.psychiatry.org/patients-families/what-is-mental-illness

Amusan, L., & Ejoke, U. P. (2017). The psychological trauma inflicted by Boko Haram insurgency in the North Eastern Nigeria. *Aggression & Violent Behavior*, *36*52-59. doi:10.1016/j.avb.2017.07.001

Baingana, F. (2003, October). Mental Health and Conflict. *The World Bank Social Development Notes: Conflict Prevention & Recovery.* Retrieved January, 3, 2018 from http://hpod.org/pdf/wb-mental-health-conflict.pdf

Brounéus, K. (2008). Truth-telling as a talking cure? Insecurity and retraumatization in the Rwandan Gacaca courts. Security Dialogue, 39, 55–76.

Bryce JW. Walker N. Ghorayeb F, et al. Life experiences, response styles and mental health among mothers and children in Beirut, Lebanon. Soc Sci Med. 1989;28:685–695.

Buckley-Zistel S., Konfliktforschung, H. S. F., 2005. '"The truth heals?" *Gacaca* jurisdictions and the consolidation of peace in Rwanda', *Die Friedens-Warte* 80, 1–2:1–17

Cerna, L. (2013). The Nature of Policy Change and Implementation: A Review of Different Theoretical Approaches. *Organization for Economic Co-operation and Development:* 18-20. Retrieved January 19, 2018, from https://www.oecd.org/edu/ceri/The%20Nature%20of%20Policy%20Change%20and%20Implementation.pdf

Collier, D. (2011). Understanding Process Tracing. *Political Science and Politics,* 44, No. 4: 823-30

Condo, J., Mugeni, C., Naughton, B., Hall, K., Tuazon, M., Omwega, A., Nwaigwe, F., Drobac, P., Hyder, Z., Ngabo, F., Binagwaho, A. (2014). Rwanda's evolving community health worker system: A qualitative assessment of client and provider perspectives. *Human Resources for Health, 12*(1), 71.

Corey, A. & Joireman, S.F. (2004) Retributive Justice: The Gacaca courts in Rwanda, *African Affairs*, 103:73-89.

De Vries, A. K., Klazinga, N.S. (2006). Mental health reform in post-conflict areas: a policy analysis based on experiences in Bosnia Herzegovina and Kosovo, *European Journal of Public Health*, Volume 16, Issue 3, 1 June 2006, Pages 246–251, https://doi.org/10.1093/eurpub/cki092

Desai, V., & Potter, R. (Eds.). (2006). Doing development research. Retrieved from https://ebookcentral.proquest.com

Elmore, R. (1979), 'Backward mapping', *Political Science Quarterly* 94: 601-616

Eytan, A., Guthmiller, A., Durieux-Paillard, S., Loutan, L., Gex-Fabry, M. (2011) Mental and physical health of Kosovar Albanians in their place of origin: a post-war 6-year follow-up study. Soc Psychiatry Psychiatr Epidemiol 46(10):953–963

Firestone, W. (1989). Educational policy as an ecology of games, *Educational Researcher* 18(7):18-24.

Galderisi, S., Heinz, A., Kastrup, M., Beezhold, J., & Sartorius, N. (2015). Toward a new definition of mental health. *World Psychiatry, 14*(2), 231-233.

Giacchino S. & Kakabadse A. (2003), Successful Policy Implementation: the Route to Building Self-Confident Government, International Review of Administrative Sciences 69(2), 139-160pp.

Gorst-Unsworth C. Goldenberg E. Psychological sequelae of torture and organised violence suffered by refugees from Iraq. Trauma-related factors compared with social factors in exile. Br J Psychiatry.1998;172:90–94. Karam EG. Howard DB. Karam AN, et al. Major depression and external stressors: the Lebanon wars. Eur Arch Psychiatry Clin Neurosci. 1998; 248:225–230.

Grindle, M. S. (1980). Politics and Policy Implementation in the Third World. *Princeton University Press.*

Gureje, O., & Alem, A. (2000). Mental health policy development in Africa. *Bulletin of the World Health Organization, 78*(4), 475-482.

Hummelbrunner, R., Jones, H. (2013). A guide to managing in the face of complexity. *Overseas Development Institute.* Retrieved December 4, 2019 from https://pdfs.semanticscholar.org/9978/b1d01872031d34d26ee1961dee9b4eb149d7.pdf

Kaplan, S. (2013). Child Survivors of the 1994 Rwandan Genocide and Trauma-Related Affect. *Journal Of Social Issues*, *69*(1), 92-110. doi:10.1111/josi.12005

Kiser, E. (1999). Comparing varieties of agency theory in economics, political science and sociology: an illustration from state policy implementation, *Sociological Theory* 17(2):146:170.

Löffler, G., Smoke, Paul, Coslovsky, Salo, Iskander, Natasha, Vaillancourt, François, & Yilmaz, Serdar. (2017). *The Politics of State-Building in Rwanda: Three Essays on the Role of Decentralization and Local Taxation in Rebuilding a Post-Conflict State with a Centralist Vision,* ProQuest Dissertations and Theses.

Longman, T. (2010). Trying Times for Rwanda: Reevaluating Gacaca Courts in Post-Genocide Reconciliation. *Harvard International Review, 32*(2), 48-52.

Lopes Cardozo, B., Bilukha, O. O., Crawford, C. G., Shaikh, I., Wolfe, M. I., Gerber, M. L., & Anderson, M. (2004). Mental Health, Social Functioning, and Disability in Postwar Afghanistan. *JAMA: Journal Of The American Medical Association*, *292*(5), 575-584.

Lopes Cardozo B. Vergara A. Agani F, et al. Mental health, social functioning, and attitudes of Kosovar Albanians following the war in Kosovo. JAMA. 2000;284:569–577.

Mahoney, J. (2012). The Logic of Process Tracing Tests in the Social Sciences. *Sociological Methods & Research, 41(*4), 570-597. https://doiorg.proxy.bib.uottawa.ca/10.1177/0049124112437709

Mahr, I., & Campbell, C. (2016). Twenty Years Post-genocide: The Creation of Mental Health Competence among Rwandan Survivors Through Community-based Healing Workshops. *Journal Of Community & Applied Social Psychology*, *26*(4), 291-306. doi:10.1002/casp.2263

Matland, R. (1995). Synthesising the implementation literature: the ambiguity-conflict model of policy implementation, Journal of Public Administration Research and Theory 5(2): 145-174.

Mayo Clinic (2015). Mental illness. Retrieved January 07, 2018, from https://www.mayoclinic.org/diseases-conditions/mental-illness/symptoms-causes/syc-20374968

Mohand, A. A. & Kayiteshonga, Y. (2015). The set-up of a national mental health program in Rwanda. Retrieved at https://www.researchgate.net/publication/282184087_The_set-up_of_a_national_mental_health_program_in_Rwanda November 27, 2018

Mollica RF. Donelena K. Tor S, et al. The effect of trauma and confinement on functional health and mental health status of Cambodians living in Thailand-Cambodia border camps. JAMA. 1993;270:581–586.

Murray, L. K., Tol, W., Jordans, M., Sabir, G., Mohammed Amin, A., Bolton, P., & ... Thornicroft, G. (2014). Dissemination and implementation of evidence based, mental health interventions in post conflict, low resource settings. *Intervention (15718883)*, *12*94-112.

Murthy, R. S., & Lakshminarayana, R. (2006). Mental health consequences of war: a brief review of research findings. *World Psychiatry*,*5*(1), 25–30.

Munyandamutsa, N., Mahoro Nkubamugisha, P., Gex-Fabry, M., & Eytan, A. (2012). Mental and physical health in Rwanda 14 years after the genocide. *Social Psychiatry & Psychiatric Epidemiology*, *47*(11), 1753-1761. doi:10.1007/s00127-012-0494-9

National Institute of Mental Health. (2016) *Depression*. Retrieved January 3, 2018 from https://www.nimh.nih.gov/health/topics/depression/index.shtml

National Institute of Mental Health. (2016) *Post-Traumatic Stress Disorder.* Retrieved January 3, 2018 from https://www.nimh.nih.gov/health/topics/depression/index.shtml

Ng, L., & Harerimana, B. (2016). Mental health care in post-genocide Rwanda: Evaluation of a program specializing in posttraumatic stress disorder and substance abuse. *Global Mental Health (Cambridge, England), 3*, Article e18.

Oxford Dictionary. (2018). *Trauma*. Retrieved January 07, 2018, from https://en.oxforddictionaries.com/definition/trauma

Paudel, N. R. (2009). A Critical Account of Policy Implementation Theories: Status and Reconsideration. *Nepalese Journal of Public Policy and Governance,* vol. xxv, No2. Retrieved January 20, 2018 from https://pdfs.semanticscholar.org/96cb/1a5f553dfe89767763005fa65f474af8e6d3.pdf

Purdeková, A., Reyntjens, F., & Wilén, N. (2018). Militarisation of governance after conflict: Beyond the rebel-to-ruler frame – the case of Rwanda. *Third World Quarterly, 39*(1), 158-174. doi:10.1080/01436597.2017.1369036

Pevehouse, J.C.W., Goldstein, J.S. (2017). International Relations, Brief Seventh Edition. “Conflict, War and Terrorism.”

Pressman, J. and Wildavsky, A. (1984), Implementation (3rd ed.), Berkeley: University of California Press.

O’Toole, L. (1995), Rational choice and policy implementation: implications for interorganisational network management, *American Review of Public Administration 25:43-57*.

Ramalingam, B., Jones, H. (2008). Exploring the science of complexity: Ideas and implications for development and humanitarian efforts. *Overseas Development Institute, Working paper 285.* Retrieved December 4, 2019 from https://www.odi.org/sites/odi.org.uk/files/odiassets/publications-opinion- files/833.pdf

Republic of Rwanda Ministry of Health (n.d.). National Mental Health Policy in Rwanda. Retrieved from http://www.moh.gov.rw/fileadmin/templates/Docs/Posted-National-Mental-health-Policy-1.pdf November 27, 2018

Reyntjens, F. (2011). Constructing the truth, dealing with dissent, domesticating the world: Governance in post-genocide rwanda. *African Affairs, 110*(438), 1-34. doi:10.1093/afraf/adq075

Reyntjens, F. (2013). Human Rights – A Dismal Record. In *Political Governance in Post-Genocide Rwanda* (pp. 98-123). Cambridge: Cambridge University Press. doi:10.1017/CBO9781107338647.005

Rieder, H., & Elbert, T. (2013). Rwanda - lasting imprints of a genocide: trauma, mental health and psychosocial conditions in survivors, former prisoners and their children. *Conflict & Health*, *7*(1), 1-13. doi:10.1186/1752-1505-7-6

Rugema, L., Krantz, G., Mogren, I., Ntaganira, J., & Persson, M. (2015). "A constant struggle to receive mental health care": health care professionals’ acquired experience of

barriers to mental health care services in Rwanda. *BMC Psychiatry*, *15*1-9. doi:10.1186/s12888-015-0699-z

Sabatier, P., & Mazmanian, Daniel A. (n.d.). *Can regulation work? : The implementation of the 1972 California Coastal Initiative* (Environment, development, and public policy. Environmental policy and planning). New York: Plenum Press.

Santos Mendes, V. P., & Aguiar, F. C. (2017). Implementation of public health policy and its challenges in the digital age. *RAP: Revista Brasileira De Administração Pública*, *51*(6), 1104- 1121. doi:10.1590/0034-7612169426

Schaal S et al (2011) Rates of trauma spectrum disorders and risks of posttraumatic stress disorder in a sample of orphaned and widowed genocide survivors. Eur J Psychotraumatol 2:6343

Scholte, W. F., Olff, M., Ventevogel, P., de Vries, G., Jansveld, E., Lopes Cardozo, B., & Crawford, C. G. (2004). Mental Health Symptoms Following War and Repression in Eastern Afghanistan. *JAMA: Journal Of The American Medical Association*, *292*(5), 585-593.

Scholte, W. F., Verduin, F., Kamperman, A. M., Rutayisire, T., Zwinderman, H., Stronks, K. (2011). The Effect on Mental Health of a Large Scale Psychosocial Intervention for Survivors of Mass Violence: A Quasi-Experimental Study in Rwanda. PLoS ONE 6(8): e21819. doi:10.1371/journal.pone.0021819

Smith P. Perrin S. Yule W, et al. (2002). War exposure and children from Bosnia-Herzegovina: psychological adjustment in a community sample. J Traum Stress. ;15:147–156.

Smith, T.B. (1973). The Policy Implementation Process. *Policy Sciences.* 4: 197. https://doi.org/10.1007/BF01405732

Stockwell, A., Whiteford, H., Townsend, C., & Stewart, D. (2005). Mental health policy development: case study of Cambodia. *Australasian Psychiatry*,*13*(2), 190-194. doi:10.1111/j.1440-1665.2005.02187.x

Summerfield, D. (2000). War and mental health: a brief overview. *BMJ : British Medical Journal*, *321*(7255), 232–235.

Thomson, S. (2018). *Rwanda : From Genocide to Precarious Peace*. New Haven: Yale University Press. Retrieved from https://search-ebscohostcom.proxy.bib.uottawa.ca/login.aspx?direct=true&db=nlebk&AN=1720133 &site=ehost- live

Thornicroft G, Alem A, Dos Santos RA. WPA guidance on steps, obstacles and mistakes to avoid in the implementation of community mental health care. World Psychiatry (2010) 9:67–77.

United Nations Division for Social Policy and Development Disability (n.d.). Mental Health and Development. Retrieved February 26, 2019 from https://www.un.org/development/desa/disabilities/issues/mental-health-and-

development.html

Upsalla Conflict Data Program (UCDP) (n.d.). Number of conflicts: 2010-2018. Retrieved December 5, 2019 from https://ucdp.uu.se/

World Health Organization (2001a). Strengthening mental health promotion. Geneva, World Health Organization (Fact sheet, No. 220)

World Health Organization, Department of Mental Health and Substance Abuse. (2011). Rwanda. Retrieved November 8, 2017 from http://www.who.int/mental_health /evidence/atlas/profiles/rwa_mh_profile.pdf

World Health Organization (2007). Breaking the vicious cycle between mental ill-health and poverty. Retrieved November 29, 2019 from https://www.who.int/mental_health/policy/development/MHPB1.pdf