

REPUBLIC OF RWANDA



MINISTRY OF HEALTH

National Mental Health Policy

in Rwanda

FOREWORD

Over the past 18 years, Rwanda's health sector has made significant strides across major programs. The government has not only devoted its energy to bridging the gap in accessibility of health care services, but has also invested heavily in improving the quality of care provided.

As such, the battle against major infectious diseases is producing good results and the commitment to dealing non-communicable disease is gaining momentum. Among the NCDs, mental diseases have a special scheme due to our history.

1994 Genocide against Tutsi did not only claim one million innocent Rwandans, but also left large segments of our population with severe mental health disorders. Statistics show that close to 99 percent of the survivors had witnessed violence and 31 percent of women suffered rape or sexual assault. Fully 57% witnessed killings with a machete, and 90% believed that surviving was a miracle (MINECOFIN, 2000).

The outcome of this was a massive burden of post-traumatic stress disorder (PTSD) cases that persist today and which we need to consistently address. In 2002, a census done by the Ministry of Local Government and the Ministry of Health revealed that the prevalence of PTSD in genocide survivors population was estimated at 87.4%. An estimated 250,000 of women suffered rape during the Genocide (MINALOC 2002).

The consequences of the Genocide against the Tutsi are not the only cause of the burden of mental disorders. By 2010, we had slightly above 18,000 cases that had consulted at the six operational mental health services in the country. Epilepsy is the first cause of consultations, with 9,412 (or 52% of) visits. In Rwanda, the treatment of this pathology is integrated into the health care package delivered by mental health services at district hospitals.

Psychiatric disorders are the second cause of consultation with 3,334 cases (18%); psychosomatic disorders with 2,228 cases (12%); other neurological disorders with 1,403 cases (8%); various psychological disorders with 877 cases (5%) and other conditions with 3% and PTSD with 2% of total consultations.



During the post-genocide period, new challenges related to trauma problems and their complexity emerged within communities. Co-morbidities, dominated mainly by depression, were noted within 54% of the population suffering from PTSD. A 2002 study revealed serious depressions within the local population with 15.5% in Bugesera region (Bolton 2002).

Furthermore, misunderstanding about the nature of mental disorders and their treatment has remained a barrier to improved access and awareness. For example many people think that mental disorders affect only a small subgroup of the population, but the reality is that in the world 25% of people will have a diagnosable mental disorder at some point during their lifetimes. (WHO 2001)

Others think that mental disorders cannot be treated; however, effective treatments exist and can be successfully delivered in outpatient settings. Some may believe that all people with mental disorders are violent or unstable, and therefore should be locked away, while in fact the vast majority of affected individuals are non-violent and capable of living productively within their communities (WHO 2009).

Countrywide, Rwanda counts 5 psychiatrists, and all district hospitals have mental health services with at least 1 mental health nurse. Some hospitals have at least one clinical psychologist and other health professionals trained in mental health care.

The Ministry of health has continuous training in mental health care, for general nurse providers and medical doctors from district hospital, and nurses at health centers are currently being trained to assure capacity at decentralized level, and a training module on mental health has been integrated into the overall program for Community Health Workers to assure early referral of cases, advocacy and fight against stigma. With all these trainings, the gap in mental health care is mostly with regards with psychiatrists and skilled community interveners.

The objective is to heal mental disorders as early as possible, holistically and close to the person's home and community for better health outcomes. In addition, primary care offers unparalleled opportunities for the prevention of mental disorders and mental health promotion, for

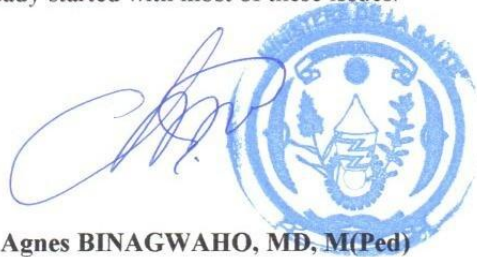


family and community education, through a multisectoral approach. To be fully effective and efficient, primary care for mental health must be complemented by additional levels of care.

These include secondary care components to which primary care health workers can turn for referrals, support, and supervision. Linkages to informal and community-based services also are necessary. Stigma and discrimination surrounding mental disorders is an important human rights violation for mentally ill persons and a barrier to accessing mental health services. Community sensitization around mental health prevention and promotion should be strengthened in this regard.

The Government of Rwanda is dedicated to promoting mental health awareness, preventing mental health problems and drug abuse through advocacy, education, research and developing mental health services in Rwanda.

In order to develop an appropriate mental health care system at all levels and eliminate complex barriers to improved access and outcomes, the document concentrates efforts on the followings priorities: Mental Health Care, Accessibility of Health Care in the Community, Human Resource Development, Information, Education and Communication (IEC), Legislation, Research, Psychopharmacological Treatment, Epilepsy Treatment, Fight against Drug and Others Psychoactive Substance Abuse, and Mental Health Care for Children and Teenagers. We have already started with most of these issues.

The image shows a handwritten signature in blue ink on the left, and the official seal of the Ministry of Health of Rwanda on the right. The seal is circular with a blue border containing the text 'MINISTRE DE LA SANTE' at the top and 'RWA' at the bottom. Inside the seal, there is a central emblem featuring a caduceus (a staff with two snakes) and other symbols, surrounded by a wreath.

Dr Agnes BINAGWAHO, MD, M(Ped)

Minister of Health

TABLE OF CONTENTS

Abbreviations and Acronyms list 2

Context 3

 General context 3

 Health context in general 3

 Mentalhealth Context 4

 Generalobjective 6

 Specificobjectives 6

 Fields of intervention 7

 Generalconclusion 26

 References 28

Abbreviations and Acronyms list

AA : Anonym Association

APS: Psychosocial Mobilizers

AS : Community Health Workers

CAMERWA: Central Drugs Purchasing Agency for Rwanda

CIM: Classification Internationale des Troubles Mentaux

CITSM : Centre d'Intervention Thérapeutique en Sante Mentale

DGSM : Direction Générale de Santé Mentale

DSM: Diagnostic and Statistical Manuel of Mental Disorders

EDPRS: Economic Development and Poverty Reduction Strategy

KHI : Kigali Health Institute

HDS: Health demographic survey

HIS : Health Information System

MDGs : Millenium Development Goals

MYICT: Ministry of Youth and ICT

MPPD: Medical Production and Procurement Division

NGO : Non Gouvernemental Organisation

NPSM : National Programme of Mental Health

NPH : Neuro-Psychiatric Hospital

NUR : National University of Rwanda

PBF : Performance Based Financing

POSM : Pole Opérationnel de Sante Mentale

PRSP: Porverty Reduction Strategic Plan

PTSD : Post Traumatic Stress Disorder

RBC : Rwanda Biomedical Center

SCPS: Psycho-Social Consultations Service

Context

For any aspect of health to be dealt with, one has to be aware of the context in which the action to be undertaken will occur. That context certainly has to do with the country's history, the history of its health system through the ages but also with the socio-economic situation that has a direct influence on the quality of health and access to care within a community. Equally, with regard to mental health, that context has to specifically take into account the values and anti-values of a particular society, any types of beliefs there might be, the families' competence and that of a community in general, but also the history that a given society has had to go through.

General context

Rwanda is a small country (26,338 km²) that is among the developing countries. It has the advantage of an efficient administrative and territorial organization, easy access to population, telephone and road infrastructure that are relatively favorable. However, the country is landlocked and is therefore far from intercontinental connections other than its airport that could be improved. It also has to deal with overpopulation and a serious weakness in its jobs sector. Its population growth is around 2.6% (2002 census), with a fertility rate of (4.6) children per family according to the (2010) health demographic survey (DHS). In addition, 56.9% of the population is below the poverty line, i.e. living on less than a dollar a day, and 37% of households live in extreme poverty.

Due to bad governance, Rwanda went through a series of major periods of violence that culminated into the genocide. This slowed down and destroyed the momentum of development that was already weak, but also tore apart the social fabric, with mistrust among citizens reaching the highest level humanly imaginable. Despite tremendous efforts in socio-economic reconstruction, Rwanda still suffers from scarcity of resources and lacks the necessary basis for lasting economic development.

The political leadership is determined to lead the country out of its socio-economic precariousness. In this regard, many actions have been undertaken, including economic good governance, opening to the outside world by taking a calculated risk to join regional and continental organizations, but also moving towards a style of cooperation and partnership that obviously signify the importance of freedom in decision-making and promotion of the spirit of initiative. In that respect, Rwanda, within its 2020 vision, adopted a point of reference in terms of middle term strategic planning through EDPRS¹ in 2008 for a period that ends with 2012. Poverty reduction and accessibility to health care are among the important pillars of that vision. A coherent socio-economic development strategy comes with a cost of good health for the citizens.

Health context in general

Since the last century, Rwanda has known a period of intense transformation in health practices in the manner consistent with that of other countries mainly in Africa. From traditional medicine based on the use of plants accompanied by invocation/sorcery, Rwanda gradually adhered to modern medicine

¹ Economic Development and Poverty Reduction Strategy

practices without breaking completely from the old ways that remain un-codified. The two approaches actually coexist although no dialogue between the practitioners of both types of knowledge takes place.

Modern medicine that was greatly centralized is today in the dynamic of decentralization. This decentralization is based on the philosophy of primary health care advocated by the World Health Organization which guarantees popular participation. This approach that seeks to give people access to care is connected to the national decentralization policy, strongly backed by the government. For each administrative entity at various levels, there is a corresponding health service.

The introduction of health insurance, and especially the 'Mutuelle' health insurance, has revolutionized access to health care for all. With the aim of ensuring coherence in services provided to the population, the ministry of health today defines the minimum package that a health center or a district hospital must coordinate and provide to the citizens that they serve. This minimum package of activities takes into account the needs of a citizen in terms of care, and the obligation of accountability becomes a preoccupation for health teams at various levels.

To motivate the personnel so that they fulfill their duties related to the minimum package of activities and access to care for all responsibly, a Performance Based Financing (PBF) system based on a contractual approach has been set up and is operational. Performance indicators were defined and allow equity vis-à-vis the contract related to health care services to the population.

Community health workers are expected to play a key role in helping patients with mental disorders to access health facilities services and facilitate the process of their social reintegration.

So what is the place of mental health in this system? To what extent is this dimension taken into account, a dynamic that works and seeks to meet the Millennium challenges as explained in the 2020 Vision, with a middle term strategic plan driven by EDPRS?

We are aware that the Millennium goals have the attention of the whole world when visualizing the development of communities. Since 2003 health and education are at the center of the preoccupation of the MDGs² because it is unimaginable to attain human development without the foundation of good health for the population, and coherent and innovative education. Obviously, no health is possible without mental health.

Mental Health Context

The national mental health policy was introduced in 1995 and has allowed political decision-makers and other actors in society to identify anchor points to initiate a mental health practice adapted to the context and that is close to the community. As the sectoral policy of mental health advocates the decentralization of health care, the national mental health policy allowed for initiating a dynamic of decentralization with the creation of referral services both in hospitals and as mobile care services. Today, that policy needs to be revised to meet the evolution of the context and adequately respond to the challenges of mental health within the Rwandan community. The mental health program is ensured today by the Mental Health Division on behalf of the health ministry. Its priority mission is to

²MillenniumDevelopment Goals (MDG'S)

coordinate initiatives in that sector, ensuring the implementation of national policy in mental health as adopted by appropriate authority. Within the limits of its resources, this program ensures the quality of mental health care, responds to the needs of citizens as close to them as possible, and promotes community mental health.

Today there are two referral services on the national level namely Ndera neuropsychiatric hospital, and the Psycho-social consultations service.

Six operational centers are shared out among all regions of the country and they benefit from support by touchstone services. One notices the integration of mental health on the ground, though it needs consolidating, within the complementary package of activities in district hospitals. Mental health practice within health centers remains to be introduced and developed.

During the post-genocide period, new challenges related to mental trauma problems and their complexity emerged within communities. A nationwide study conducted in 2009³ revealed PTSD prevalence within 28.54% of adult population. In the same study, a comorbidity dominated mainly by depression was noted within 53.93% of the population suffering from PTSD. A study that was conducted by Bolton 2002 and limited to Bugesera region testifies to the serious existence of depression within the local population by 15.5%. Mental health strategy will guide decision-makers in mental health.

Dependence on drugs and other psycho-active substances pose a new challenge and there is no strategy today to supervise treatment of that phenomenon that generates mental suffering and destabilizes the social fabric.

Another challenge, and not at all the least, is related to the problem of epilepsy that implies diverse cultural interpretations, presents difficulties in diagnosis and care, and whose cost of treatment is a real challenge.

Mental health development has known different periods:

- The period of traditional practice: This pre-colonial period had the merit of involving the entire community and alleviating the individual burden vis-à-vis mental suffering. Indeed if a member of the community presented signs of being psychologically disturbed, they were not held responsible but were taken to the spiritual mediators vis-à-vis its shortcomings in terms of diverse values. The community, which is hence responsible, sets out to structure a solution. This practice certainly had a few weaknesses mainly that of excluding the subject with a price to pay when the community failed to deal with it.
- The colonial period: This period demonized the traditional knowledge without providing any adequate alternative in psychological care. Charlatanism set in and the mental patient was

Munyandamutsa N & Mahoro-Nkubamugisha P.(2009) ; Prévalence de l'Etat de Stress Post-Traumatique dans la population rwandaise : Diversités de figures cliniques, abus de drogues et autres co-morbidités

forced into isolation. That is when mentally ill people were thrown to the street or into prisons not to mention the degrading methods to keep them under control like chains.

- The period of asylum psychiatry was developed in 1968 and mainly in 1974 when Ndera hospital became operational. There was almost no responsibility by the government, or any mental health policy whatsoever existed until 1995. The Brothers of Charity community was the only active body in this field. Genocide crippled even the little efforts there had been and plunged this sector into chaos like everything else.
- The contemporary period: This period has known the setting up of a mental health national policy in 1995 and a significant commitment by political actors in this field. There are also a number of actors that contribute to the development of the mental health system today.

Today the mental health sector is confronted by a number of major challenges including:

- An urgent need to have access to quality mental health, integrated within all health structures all the way to the grassroots, with well-trained human resources, efficient state financial assistance and the promotion of research;
- Involving the community and the necessity to have quality mental health care to prepare citizens to become efficient actors in the development process;
- An imperative to set up a legal framework governing mental health practice;
- The need to adopt specific strategies in regard to epilepsy, addiction to psycho-active substances and the problem of psycho-trauma;
- The establishment of a model in appropriate care for children and teenagers as well as other vulnerable groups (children heads of households, children born out of rape, women victims of rape, etc)

The revision of the National Mental Health Policy has the following objectives:

General objective

Promote quality mental health care that aims at reducing morbidity in mental health, appropriate to the context and is accessible to the community.

Specific objectives

- Integrate mental health care in all health structures of the national health system to the grassroots level;
- Promote multi-sectoral collaboration;
- Promote community care in mental health;
- Legislate in clear terms the mental health practice in chapter 5, Title II concerning specific health measures in the law governing medical practice in Rwanda;

- Provide quality health care by availing well-trained human resources, raising enough public and private funds and by emphasizing the importance of research;
- Initiate a specific strategy of intervention against psycho-active substance abuse;
- Adopt an intervention policy and care for issues related to psycho-trauma;
- Initiate a specific strategy of intervention and care specific to epilepsy;
- Create a system of care and prevention in regard to psychosocial problems in children and teenagers.

A number of fields of intervention are highlighted in the present policy paper and strategies of intervention are laid out with a strategic plan that ends in 2015, for better practices in mental health.

Fields of intervention

Field of intervention 1: Mental health care

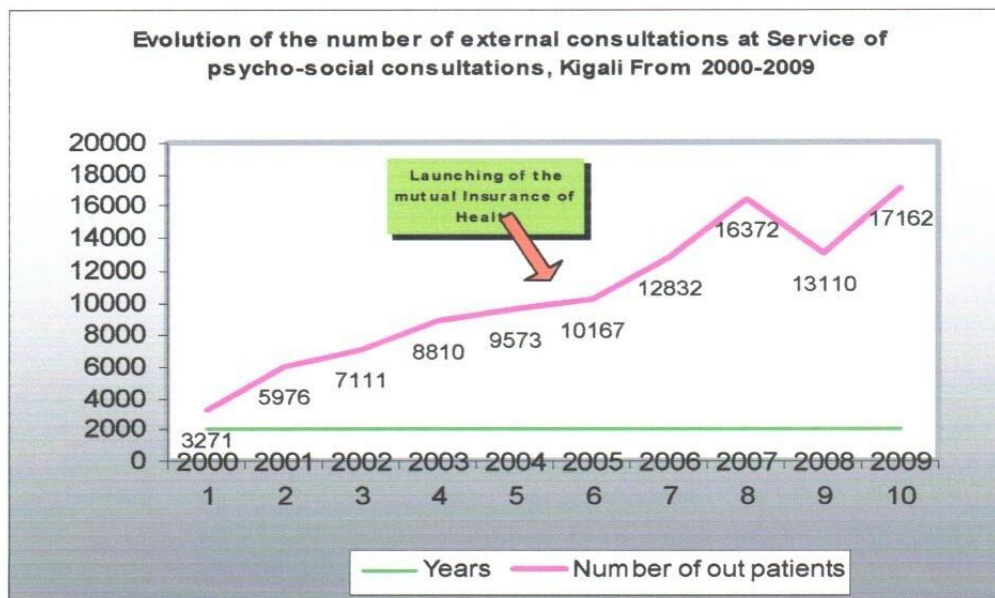
1. Context

The evolution of mental health practice through different periods, as highlighted above, saw an increased interest in the post-genocide period and allowed bringing mental suffering to the attention of the public. There are enormous challenges in providing quality health care to the population, and this requires operational strategies to reach the objectives set.

Since 2005 the sectoral policy acknowledges that mental health is a public health issue and that its practice must be integrated at all levels including the grassroots. Since 1995 the ministry of health adopted a mental health policy to tackle the challenges of mental suffering. The number of people that seek consultation is increasing.

This graph is an indication of the dynamic within reference structures.

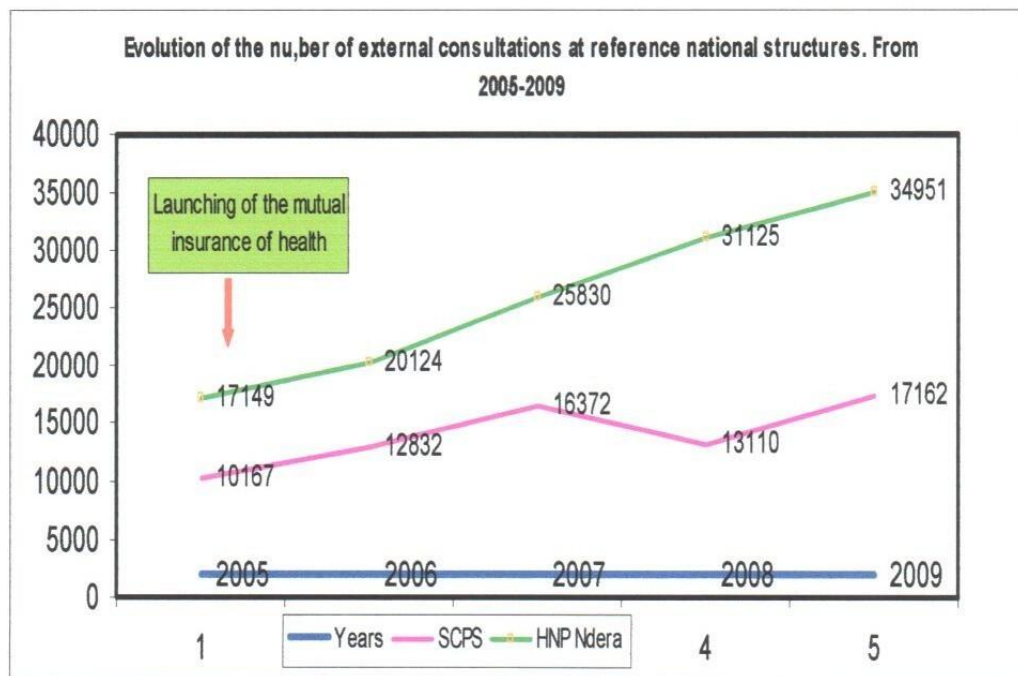
Problems of mental health in Rwanda: Demand care in progress



Reference: national programme of mental health report

The Psycho-social Consultations Service (SCPS) was created in 1999 to provide quality external consultations and be a reference in terms of ambulatory mental health care. The above graph gives an idea of consultations since 2000 to 2009. The existence of 'Mutuelle' health insurance has facilitated access to care in other health sectors.

Figure 2



References: National Programme of Mental Health report

Over the last five years, the psychiatric hospital and SCPS have significantly responded to the needs of the population. The decentralization policy and the establishment of operational centers facilitated accessibility to care as shown on the following graph.

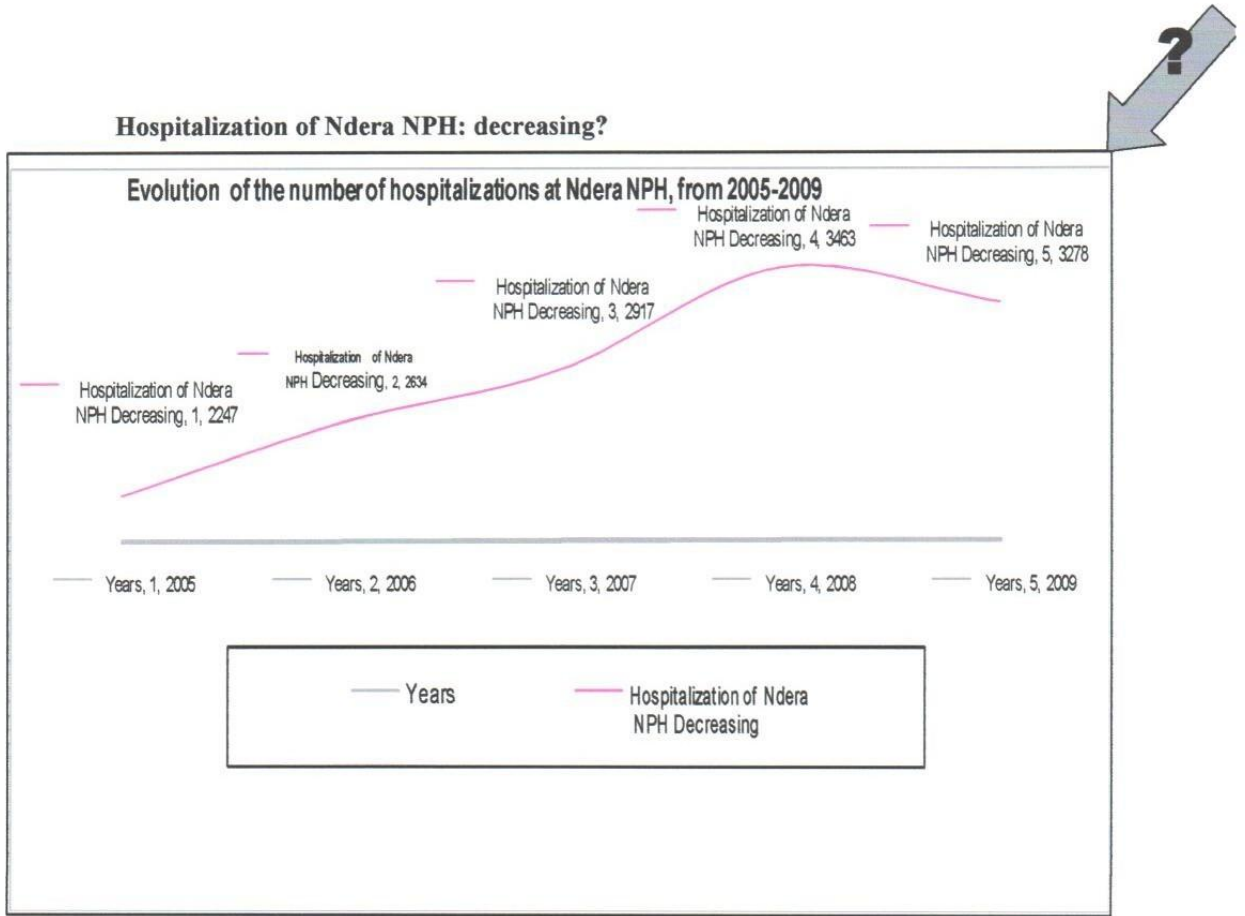
Figure 3

Activity of consultations and hospitalization on the level of the reference structures and decentralized services in 2009			
Activity	27 decentralized services to 32	Neuropsychiatric Hospital	Service of psychosocial consultations
Consultations	31520	34951	17162
Hospitalization	2240	3278	-
Referred cases	650 (2%)	-	-

One notes a good level of absorptive capacity in demand at the peripheral level. Only 650 cases equivalent to 2% were transferred. Over time, this dynamic of enhanced decentralization will influence the numbers of patients hospitalized at the national level.

Below is a graph on the requests for hospitalization today.

Figure 4



This graph suggests a decrease in hospitalization requests but one has to be careful at drawing conclusions related to reasons leading to this decrease given that it requires a longer period of observation of the trend.

The problem of psycho-trauma poses major challenges and adds to the suffering of our citizens in mental health. That burden is mainly due to the violence generated by the genocide in 1994 and the consequences that ensued. A nationwide study conducted in 2009 shows that 79.41% of the adult population has been exposed to traumatic events such as those defined in DSM-IV. Trauma prevalence within the adult population is estimated at 28.54%. This means that a problem of such magnitude requires as much attention and action by society.

Sustained efforts are still necessary to ensure quality practices in mental health. The present policy document emphasizes the following priority objectives:

2. Objectives

- Promote equitable and quality mental health care;
- Ensure access to integrated and accepted mental health practice to actors in the health sector;
- Find adequate responses to mental trauma related challenges;
- Promote mental health care that prepares citizens to embrace the human development dynamic towards the millennium goals (MDGs);

To meet those goals, it is important to have the following priority strategies that obviously imply a number of actions to undertake.

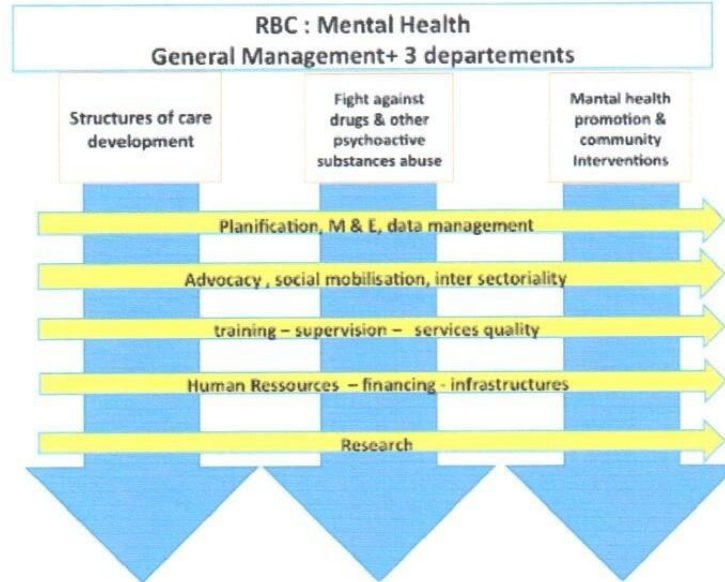
3. Strategies

Strategy 1: *Good coordination and planning as well as coherent activities at all levels of intervention. This coordination will have to include existing non-governmental initiatives.*

Such coordination calls for realistic actions which reflect the sectoral vision of the ministry of health.

Actions to undertake

- Mental Health Division to play an administrative role in the conception and planning of mental health interventions, as well as creating three departments that will play a technical role in each field of intervention as per the following structure:



- Create a consultative technical working group to provide critical analyses and advice to the mental health division. This will respect the criteria of competence, must be multidisciplinary and rational. Its role is just consultative and it is not a decision-making body.

Strategy 2: Optimize the level of reference service

Quality care has to rely on the existence of reference services capable of providing specialized care, model practice in a given field, ensure supervision of decentralized entities and be a hub for adequate and quality training. There will be two reference services in mental health:

1. Ndera Neuro-psychiatric Hospital (HNP) is expected to be a model in mental care and a training centre in mental health in a hospital setting. It also has a neurology service providing a place for diagnosis and quality care.
2. A mental health therapeutic intervention center (CITSM) that seeks to provide quality care and serve as a place of learning in ambulatory practice in mental health. It also serves as a model for short-term crisis intervention and out-patient hospital care.

Actions to undertake:

- Turn reference services into university types of training places and into mental health « think tank »;
- Define the collaboration of these services within the RBC as the agency within mental health division is;
- Define a strategic framework for accompanying operational centers (POSM) that works as follows:
 - ✓ A multidisciplinary team: a psychiatrist, psychologist, three mental health nurses;
 - ✓ POSMs will be integrated within provincial hospitals;

- ✓ Their role will be to provide liaison mental care;
- ✓ They will be model structures in their respective provinces;
- ✓ They will ensure training and supervision of mental health actors in their zone of activity.

Strategy 3: Provide mental health professionals with prevention tools and techniques in trauma and enable the community to be competent with regard to trauma;

Actions to undertake:

- Launch research to shed light on the issue of trauma;
- Avail diverse intervention protocols in the mental health sector;
- Sensitize political decision-makers on the challenges caused by mental trauma;
- Devise acoherent training plan based on research findings;
- Organize regional and international forums to update knowledge in psycho-trauma

4. Conclusion

Mental health care will only meet the required levels of quality when it is backed by good planning and coordination of actions that aim at reducing morbidity in mental health. Optimizing the services offered by reference structures in mental health will allow the provision of quality care that is adapted to scientific evolution in the field of mental health on one hand, and training focused on practice on the other hand. For the sake of global coherence vis-à-vis the services provided to citizens, multi-sectoral collaboration will be strengthened.

Field of intervention 2: Accessibility of mental health care in the community

1. Context

In 2005, a mental health care decentralization policy was launched and integrated in primary health care. Almost all district hospitals had a mental health service. Operation centers were created with the country's geographic zones in mind.

Despite such progress, resistance persists in terms of integration of mental health services within hospitals and health centers. This resistance is mainly due to lack of enough mechanisms that would oblige heads of health structures to be accountable to the ministry of health and to citizens with regard to their actions in mental health. This is also due to insufficiency of information and training, as well as follow-up tools and protocols in terms of mental care.

It is therefore appropriate to have realistic strategies and concrete actions to address the challenge.

2. Objectives

To facilitate accessibility to mental health care within the community, it will be necessary to aim for the following objectives:

- Integrate mental health care into health care in general
- Bring mental health care close to the community by facilitating accessibility

To reach these objectives, the following strategies are considered to be efficient:

3. Strategies

Strategy 1: *Make effective the integration of mental health care in the minimum package of activities in district hospitals and in health centers.*

The actions that are undertaken must be efficient and testify to the responsibility of the institution.

Actions to undertake:

- Match performance indicators to the reality of care provided at each level to enhance the integration of mental health actors in the Performance Based Paying (PBF) system.
- Assist mental health professionals in structuring their actions for SIS reporting.
- Train district hospital medical doctors and heads of health centers in community supervision in regard to mental health and support the action of psychiatric nurses by strengthening their skills.

Strategy 2: *Continue supporting 'mutuelle' health insurance*

The policy that set up the 'mutuelle' health insurance has significantly revolutionized access to care and will have an impact beyond health. The following actions must be undertaken:

Actions to undertake:

- Sensitize patients with mental disorders to join the ‘mutuelle’ health insurance for those that have not yet done so;
- Ensure that indigent patients have access to the ‘mutuelle’ health insurance based on the usual classification;

Strategy 3: *Involve the community more*

Primary health care and especially mental health care will only be effective if the mechanisms to involve the population are operational.

Actions to undertake:

- Increase the number of psychosocial actors in the community and reinforce their role in health centers
- Initiate mental health discussion groups within communities under the supervision of psychosocial organizers (APS) health workers (AS)
- Define dialogue mechanisms with traditional-practitioners to establish contact with the aim of ensuring complementarity and to mitigate charlatanism.

Field of intervention 3: Human resource development

1. Context

One of the challenges in the field of mental health is insufficiency of qualified human resources. Since the end of the genocide the Rwandan government made every effort to deal with this reality. A psychology department was created at Rwanda national university (UNR), a mental health department started at Kigali health institute (KHI), short training sessions were conducted throughout various associations and NGOs involved in mental health; a few general physicians were sent abroad to pursue specialization in psychiatry.

However there are still needs in that sector. It is important to plan for training that is adapted to specific issues resulting from suffering in the Rwandan context. The personnel trained is not always prepared for the issues on the ground because the training is not practice-oriented enough due to insufficiency of venues for training favorable to that effect.

2. Objectives:

- To have quality personnel in the mental health field;
- To have the quantity of personnel that corresponds to the needs in the mental health.

It will be necessary to resort to operational strategies to meet those objectives and thus meet the population’s expectations with regard to mental suffering.

3. Strategies:

Strategy 1: *Aim at training of mental health personnel focusing on practice.*

This mental health policy document proposes the following actions to meet the challenges related to inadequate training and specific needs:

- Refocus the training approach in clinical psychology, the mental health department at KHI and the training of psychiatrists. That reorientation must focus on practice and should be structured around continuing education for those appointed in various services;
- Set up a generic job descriptions for the mental health personnel within all existing structures that will be used as point of reference by the different entities in need to recruit;
- Have venues for care and training. The two reference centers will be structured and organized as university institutions.

Strategy 2: *Plan for middle and long-term training based on the needs identified before-hand.*

This strategy proposes to ensure that training needs are adequate but also that the available resources are utilized in a judicious manner. A certain number of actions are thus necessary.

Actions to undertake

- Initiate a study on the human resources needs at all levels of the mental health services system;
- Plan for training as required.

4. Conclusion

The improvement of services rendered to a community intimately depends on the availability of a skilled personnel working at all levels. Both academic and continuing education must be inspired by the societal problems that need to be resolved.

Efficient utilization of available resources is another important pillar for the quality, level and type of care that must be attained.

Field of intervention 4: Information, Education and communication (IEC)

1. Context

In all societies mental health has always been a sector that is feared and stigmatized. A patient with mental disorder is often considered as an irreversible case. One efficient way of fighting that stigmatization is to make sure that the community becomes responsible through information dissemination, ties between places of treatment and the community but also through direct communication with the community.

2. Objectives

- Eradicate the marginalization of patients with mental disorders;
- Collect organized information that facilitates decision-making in the mental health sector;
- Obtain a significant place for mental health in the media.

It will be necessary to use strategies that involve the community, the media and decision-makers.

3. Strategies

Strategy 1: *Using computers and information technology and its network where each health service provider has access;*

Actions to undertake:

- Provide mental health services with computers and connect them on a network to the overall health service sector;
- Ensure consistency in diagnosis criteria based on international classification (DSM, CIM);
- Establish the collaboration between various partner ministries with the ministry of health;

Strategy 2: *Ensure that the media world-wide is an indispensable partner*

Actions to undertake:

- Ensure that every mental health service at all levels frequently provides the media with information;
- Ensure that radio and television programs on mental health are aired on a regular basis;
- On an annual basis, identify a list of themes that will be addressed in those broadcasts;

4. Conclusion

It takes time to change mentalities. You can only change a culture when you master its channels of communication and when you know how to manage information. In addition, involving the community, families, media, or just citizens in general, is the best way to fight against marginalization with an efficient use of IEC tools.

Field of intervention 5: Legislation

1. Context

Legislation in a given field seeks to define limits, protect rights and establish standards in a particular profession. Regarding legislation, this policy paper intends to suggest the setting up of legal tools that will define the sector, its scope of work, its main fields of intervention, as well as the different implications in the practice. The chapter will describe the role of each and everyone in the overall system of mental health policy in Rwanda. Roles and tasks are defined by the national mental health division through reference services, hospitals and health centers. It will also clarify the rights of the mentally handicapped with regard to care and supervision.

2. Objectives

- To have a legal framework in mental health practice that clarifies patients' rights, caregivers' rights and responsibilities, those of families and various structures;
- To define a legal framework that mitigates abuses in mental health practice by clarifying limits in each intervention.

3. Strategy: *Raise the public opinion's awareness about mental health and influence political decision-making on the specificity of the mental health sector.*

Actions to undertake:

- Initiate professional associations;
- To organize a consultation meetings with the expert in mental health to discuss about a chapter relating to the mental health within the governing new health law in Rwanda;
- To develop the contents of the chapter relating to the practice of the mental health and to integrate it in new law on the practice of health in Rwanda

4. Conclusion

Acknowledging the citizens' rights and establishing limits to some freedoms requires regulation of practices. The same applies to the mental health sector where absence of legislation could lead to abuse of practices that do not ensure limits to responsibilities and rights. This policy paper seeks to consolidate efforts towards the adoption of legislation in mental health practice.

Field of intervention 6: Research

1. Context

One cannot pretend to promote the mental health sector without encouraging research therein. It is through research that theoretical and intervention models are developed and tested. The tools that take the cultural context into account are developed based on research conducted by experts. Therefore, when you think about promoting mental health, you first and foremost think about promoting its research.

2. Objectives

- Reach a step where practice is based on research findings (« evidence based »)
- Adopt a culture of policy-making and decision-making in mental health based on what research has produced.

3. Strategies

Strategy 1: *To have a functional research supervision system;*

Actions to undertake:

- Create a research unit as part and parcel of the mental health division cutting across of the areas in mental health and clearly define its mission;
- Identify research themes and organize them into a hierarchy;
- Start mental health reviews and journals;

Strategy 2: *Avail sufficient human and financial resources;*

Actions to undertake:

- Define a specific budget line specific to research within the mental health budget;
- Raise partners' awareness on the importance of mental health;
- Train practitioners in research;
- Establish a functional partnership with other research institutions;
- Create a documentation center.

4. Conclusion

The culture of excellence in this practice, and the development of intervention models in mental health will definitely be strengthened by research. This relation between practice and research will naturally open a dialogue window to the scientific world. Investing in research then becomes a prerequisite to quality interventions for the benefit of the community.

Field of intervention 7: Psychopharmacological treatment

1. Context

Treating psychiatric patients implies psychopharmacological approach control of side effects and the management of orders and use of psychoactive drugs. Challenges in that dimension of treatment are related to competence in prescription, to the integration of psychoactive drugs in general orders

of products, but also to the frequency of orders, which sometimes cause stock shortage. The mental health policy proposes strategies and actions that need to be undertaken to attain the objectives set with the purpose of ensuring coherent and efficient prescriptions.

2. Objective

Reach a point where treatment to mental illnesses is provided at different levels of mental health services with a minimum of side effects.

3. Strategy

Identify efficient channels for the supply of psychoactive medications at a reasonable price.

Actions to undertake:

- Review the list of essential medications at each level of care on a regular basis;
- Ensure that MPPD is aware of stock shortage related problems;
- Train actors, medical doctors and psychiatric nurses in mastering the prescription of psychoactive drugs and in managing side effects;
- Develop a treatment guide;
- Make an annual plan of needs and medical orders;
- Supply all mental health services with psychoactive drugs.

4. Conclusion

Psychopharmacologic approach is an indispensable pillar in administering mental care to patients. This is a useful act but one that can be dangerous when you do not master the art of prescription in that field. Efficiency depends on know-how, good coordination of the order chain, but also on the quality and frequency of supervision sessions in form of training.

Field of intervention 8: Epilepsy treatment

1. Context

Epilepsy cases occur frequently around the world. It affects 50 million people worldwide including 85% living in developing countries. This high prevalence in poor countries is due to cerebral and chronic infections, malnutrition and cranial trauma resulting from accidents and war that are frequent in those countries.

Mental health reference services' records show a significant number of epileptic patients. As an indication, the Psycho-social Consultation Service has received and registered epileptic patients with a rate of 52.7% of all consultations from June 2010 to June 2011, while Ndera neuro-psychiatric hospital recorded a rate of 32.7% the same year. A study commissioned by the ministry of health proved that epilepsy prevalence was 5% of the whole population (MoH, 2005).

These statistics are alarming for the country, which explains why the mental health policy puts a special emphasis on this disorder.

Within the community, epilepsy is perceived more through a number of mystical representations compared to other illnesses. A person suffering from the disorder is therefore marginalized. The community needs to understand but also to be involved in care and prevention. Treating epilepsy requires appropriate and realistic technical means.

2. Objective

To have an efficient treatment and prevention system that integrates epileptic patients into their community;

3. Strategies:

Strategy 1: *Make the community a partner in care and prevention of epilepsy;*

Actions to undertake:

- Launch a sensitization campaign to explain the medical nature and the socio-economic implications of epilepsy;
- Train health workers and psycho-social mobilizers (APS) in prevention, reference and information in the community.
- Initiate dialogue with traditional-practitioners to facilitate coherent and coordinated treatment of epilepsy
- Start a Rwandan league against epilepsy

Strategy 2: Set up a reference structure in epileptology and provide it with technical skills;

Actions to undertake:

- Define human and financial resource needs;
- Define job descriptions for this service and its functional relation to other care structures;
- Create the service and make it operational
- Train specialists in epileptology
- Plan for the transmission of knowledge that can deal with needs within the health care structures.

4. Conclusion

Epilepsy prevalence in the Rwandan population is 5% according to a study conducted in 2005. It goes without saying that prevention measures and adequate treatment are indispensable. Efforts made by the population and by specialized care providers will need to demystify epilepsy and ensure quality care.

Field of intervention 9: Fight against drugs and others psychoactive substances abuse

1. Context

The problem of toxic-dependence affects the youth around the world and Rwanda is obviously no exception. We do not have convincing epidemiological data on Rwanda to-date. What we know however is that genocide related violence resulted into enormous challenges of post-genocide psychological suffering, psycho-trauma being the most important of them. A nationwide study commissioned by the ministry of health in 2009 shows that among the people suffering from mental trauma, 8.21% also suffer from addiction to alcohol while 1.23% abuse other drugs. According to another study conducted by MYICT and KHI in 2012, 52.5% of the youth with age between 14 and 35 years old had consumed one or more substances at least once in their life time. Due to regular substance/drug use, One young man or woman out of thirteen (7.46 %) is alcohol dependent, one young man or woman out of twenty (4.88%) suffered from nicotine dependence and one young man or woman out of forty (2.54%) was cannabis dependent (KHI&MYICT 2012). There is no specific structure that treats toxic-dependence related problems in Rwanda yet. There is therefore a need to invest in that field.

2. Objectives

- Reduce morbidity and mortality from dependence related illnesses;
- Contribute to the security of the patient in the community in general

3. Strategies:

Strategy 1: *To have competent structures in prevention, treatment and rehabilitation of persons suffering from addiction;*

- Define human and financial resources needs;
- Define job descriptions for the structures in question;
- Set up the structures and make them operational;

Strategy 2: *To have a functional communication system with other institutions of care;*

Actions to undertake:

- Create a consultation committee between the police and health actors for prevention and treatment;
- Set up a fast communication system between diverse actors working to fight drug related problems.

Strategy 3: *Involve the community in the prevention and treatment process as well as in the rehabilitation of addictive problems.*

Actions to undertake:

- Encourage initiatives to fight addiction (AA);
- Launch a campaign to sensitize the community to problems related to psycho-active substance dependence;
- Initiate the training of health workers and APS in addictive problems.

4. Conclusion

Dependence to drugs and psycho-active substances poses problems in health in general and especially in mental health. The citizens' security is also affected to a certain extent by this problem of dependence on drugs and alcohol. Therefore there is a need for a policy for prevention and adapted care which involves all that are concerned.

Field of intervention 10: Mental care for children and teenagers

1. Context

Mental treatment for adults has its own principles and goals; treatment deals with challenges caused by the specific suffering of an adult patient. For a child on the other hand whose mental structure is not yet fully developed; dependence on the environment is such that the treatment requires specialized know-how. The teenager's mode of expression of his suffering relates to specific needs with the transition from childhood to adulthood that comes with a relationship with others that can present misunderstandings, as well as issues related to authority.

Therefore child psychiatry and psychotherapeutic care for children and teenagers is a specialized field in mental health. Rwanda has no skills in specific treatment for children and teenagers yet.

1. Objectives

- Promote quality mental health care for children and teenagers;
- Prepare the child to become a reliable and active actor in the socio-economic development of the country.

2. Strategies

To attain these objectives one needs to count on a number of strategies adapted to the prevailing context:

Strategy 1: Promote skills in prevention mental care for children and teenagers

Actions to undertake:

- Training of psychiatrists and psychologists specialized in mental care for children and teenagers;
- Introduce a module specific to child psychiatry in the medical department of educational institutions;
- Introduce a specific and consolidated module on child and teenager psychotherapy in the psychology department at the Rwanda national university and private universities and in the mental health department at Kigali Health Institute.

Strategy 2: Integrate the practice of mental treatment for children and teenagers in existing mental care structures

Actions to undertake:

- Define care models that are specific to children and teenagers within mental health care structures;
- Introduce the use of and validate diverse projective and neuropsychological tests in the daily evaluation practice;
- Develop a systemic approach for family and couples therapy;
- Create a treatment unit for children and teenagers within mental health structures.

Strategy 3: Involve all actors beginning with families who have the responsibility of the children and teenagers

Action to undertake:

- Adopt a strategy of multidisciplinary care;
- Create discussion groups within the community to talk about problems facing children and teenagers, under the supervision of APS and AS.

4. Conclusion

Childhood and adolescence periods are of great importance to a society that is committed to preparing a citizen to become a key actor in its development dynamics. Indeed, mental problems that are not handled cause a risk of making the patient incompetent, becoming a burden to the family that should otherwise be focused on building their social and economic well being. It is also known that mental suffering in a child is often the consequence of dysfunctional families and societies' failure to take its responsibilities. The promotion of mental health care for children and teenagers is a good investment in a society's future.

General conclusion

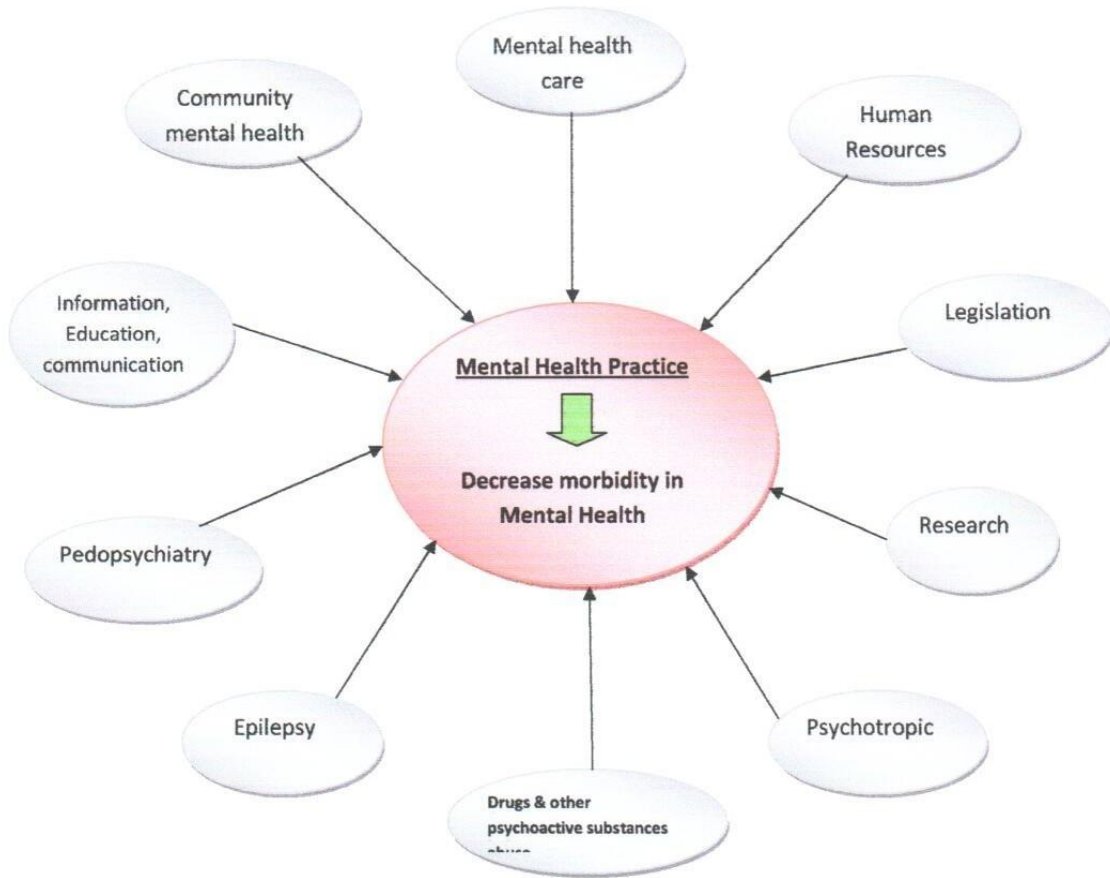
This policy proposes an intervention that revolves around ten areas to attain quality health care practice. These areas are highlighted in the figure below to illustrate the importance of integrated intervention logic where all areas are in a dynamic and permanent interaction.

There is a necessity to review the policy on a regular basis to adapt it to a changing context; hence, the strategic plan below will cover a period over five years.

The national mental health policy is an important basis for the health of a community in general. As J. Jaime Miranda and Vikram Patel say, "no health exists without mental health".

The following chart visibly shows the orientation of the present policy that advocates for a coherent convergence of coordinated actions in priority areas towards quality mental health that is accessible to beneficiaries.

National Mental Health Policy



As the above figure shows, optimizing mental health care requires concerted actions at different strategic levels with the aim to reduce morbidity in mental health.

References

- Ministry of health (2009). Performance-based funding on the community level; users' guide
- Health Sector Policy II (2008); Ministry of Health;
- Ministère de la santé: HealthSectorStrategic Plan (HSSP-II) 2009-2012
- Ministère de la Santé (2009) Financement Base sur la Performance au niveau Communautaire. Guide de l'utilisateur.
- Ministère de la Santé : Politique Nationale de santé mentale (1995).
- Ministère de la santé : Rwanda Biomedical Center Organigramme (2010).
- Munyandamutsa N&Mahoro P. (2009). Prévalence de l'Etat de Stress Post-Traumatique : Diversités des figures cliniques, abus de drogues et autres co-morbidités
- Sebera F (2006) ; Prévalence de l'épilepsie au Rwanda : connaissance, perception, vécu et attitudes de la population et des professionnels de la santé.
- Bolton P et Coll (2002), Prevalence of Depression in Rural Rwanda Based on Symptom and Functional Criteria in The journal of Nervous and Mental Disease n° 9
- DSM-IV (1994); Diagnostic and Statistical Manuel of Mental Disorders, 4e version
- Mental Health Policy and Service Guidance Package, WHO, 2007
- OMS: Projet politique de santé mentale: Guide des pratiques et des services ; 2001.
- Mental Health Policy plans and programmes (updated version 2), Geneva, WHO, 2005 (Mental health policy and service guidance package).
- Child and adolescent mental health policies and plans; Geneva, WHO, 2005 (Mental health policy and service guidance package)
- Promoting mental health. Concept emerging evidence-practice; a report of WHO, department of mental health and substance abuse in collaboration with the Victorian health of Melbourne. By Helen Herrman, ShekharSexana and Rob Moodie (2005).
- Checklist for evaluating a mental health policy; WHO.
- Achieving the Millennium Development Goals: Does Mental Health Play a Role? By Jaime Miranda, Vikram Patel; octobre 2005.
- Mental policies and programmes in the workplace. Geneva, WHO, 2005 (Mental Health policy and service guidance package).

- Improving access and use of psychotropic Medicines. Geneva, WHO, 2005 (Mental Health Policy and Service Guidance Package)
- Quality improvement for Mental Health. Geneva, WHO; 2003 (Mental Health Policy and Service Guidance Package).
- Mental Health GAP: Elargir l'accès aux soins pour lutter contre les troubles mentaux, neurologiques et liés à l'utilisation de substances psychoactives, 2008.