

The effects of war: local views and priorities concerning psychosocial and mental health problems as a result of collective violence in Burundi

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This paper explores how people in Burundi view the impact of the past civil war on their lives and wellbeing. The methodology consisted of focus group discussions (n = 104), including participatory ranking techniques, and key informant interviews with traditional healers (n = 8). Respondents saw economic decline (poverty, loss of livelihoods), worsened health and nutritional status as major issues, but also mentioned social aspects (erosion of mechanisms for social support and conflict resolution), and psychological aspects (sadness, grief). When invited to elaborate on the mental health and psychosocial consequences of war, the respondents mentioned a range of issues related to depressive states, fear/anxiety, grief, madness, and substance abuse. These findings lend support to the notion that mental health and psychosocial wellbeing need to be given due attention in the reconstruction of Burundian society. The findings corroborate the conceptualising of programmes for mental health and psychosocial support as multi-layered approaches with varying goals: to promote social cohesion, to strengthen family support, to help people deal with issues related to loss, grief and sadness, and to support individuals with severe mental disorders. The design of such interventions should take into account what people themselves find important in their lives and social settings.

Keywords: Burundi, local concepts, mental health and psychosocial support, participatory ranking, prioritisation

Key implications for practice:

- Views of local people provide essential information for mental health and psychosocial programming
- Mental health and psychosocial problems were spontaneously mentioned by people in post war Burundi
- Focus group discussions with participatory ranking methodology are a quick method to gain an overview of what is important to local residents

Introduction

For the development of programmes for mental health and psychosocial support in post conflict settings it is important to know what people who live in these settings see as their most pressing problems, and where problems related to mental health and psychosocial wellbeing sit amidst all of the problems that people are facing.

Assessments to explore local views on issues often use methods derived from qualitative social sciences, such as focus group discussions, key informant interviews and participatory observation (Bolton & Tang, 2004; WHO & UNHCR, 2012). These methods are based on what people report

themselves, more or less *spontaneously*, thus providing useful measures of the saliency of particular concepts. In order to get more reliable indicators of the relative significance of ideas are mentioned, one needs to order them. This can be done in various ways, for example by analysing data through the coding of results with the aid of qualitative research software (see Tol, Reis, Susanty, & de Jong, 2010).

Apart from such rigorous and time consuming analysis, a quick overview can be achieved by asking research participants themselves to rank concepts in order of perceived importance (Stark, Ager, Wessells, & Boothby, 2009). This *participatory ranking methodology* is considerably simpler and moreover, generates direct results, which the researchers can use in their immediate engagements with participants and their communities. Participatory ranking methodology is often used within contexts of rapid assessments by non governmental organisations during intervention planning (Bolton, 2001; Karki, Kohrt, & Jordans, 2009; Stark et al., 2009). The strength of this methodology – quick results – also has several downsides, some of which will be discussed in the limitations section of this paper.

This paper describes a brief, community based assessment with a participatory ranking exercise in Burundi.

Background

Burundi, in central Africa, has faced several periods of severe collective violence between the Tutsi minority and the Hutu majority. The 1993 assassination of the first democratically elected president, a Hutu, ignited a civil war. Within weeks, 150,000 people lost their lives (Wolpe, 2011) and the country was immersed in a full-blown civil war which lasted until 2002 and resulted in an estimated 200,000 – 500,000 deaths, with at least 1.2 million displaced persons (Floribert & Nkurunziza, 2000; Hatungimana, 2011; Lemarchand, 2009). Fifty-two percent of all

Burundians have fled their homes, at least once, since the start of the civil war in 1993 (Uvin, 2009, p. 29). Most of the warring parties signed a peace accord in August 2000. In the year that followed, hostilities decreased, with a formal ending of the war in 2005 when democratic elections led to a government dominated by former rebel groups. Considerable international aid flocked to the country, with the aim of rebuilding institutions and working towards peaceful development. Much attention was given to basic services, such as education, health care and integration of former rebels into the society, while almost no specific attention was given to mental health and psychosocial wellbeing (Government of Burundi, 2006).

The relative importance of interventions to improve psychological wellbeing of conflict affected populations has been the subject of fierce and often strongly ideologically charged academic debate that, however, hardly ever included the voices of the concerned populations themselves (Ager, Strang, & Wessells, 2006; Almedom & Summerfield, 2004; De Vries, 1998; Van Ommeren, Morris, & Saxena, 2006; Van Ommeren, Morris, & Saxena, 2008; Williamson & Robinson, 2006).

This paper, therefore, aims to explore what conflict affected people in Burundi think themselves about the effects of war on their own wellbeing, and to what extent they identify psychological problems as a priority. The research questions for the study reported in this paper were: 1) What are the main difficulties that people living in this area face as a result of the war? 2) What are the mental/psychosocial problems people identify in the community, and how have they been influenced by the war?

The paper places the local views of participants within the context of findings from other studies and assessments in Burundi, and explores the implications for good mental health and psychosocial programming in post conflict settings.

Table 1. Participants

Participants of the 14 focus groups (n = 104)

Gender	Male	58 participants
	Female	46 participants
Setting	Rural	65 (9 groups)
	Urban	39 (5 groups)
Age	Adolescent / youth	16 (2 groups)
	Adult	88 (12 groups)
Education	Educated primary finished	43 participants
	Primary school not finished	61 participants

Methodology

Study context

Data collection was conducted in 2005, just after the first free elections in 12 years, and were part of ongoing research activities to inform programming of a Dutch nongovernmental organisation (HealthNet TPO). They have been active in the country since 2000, with various programmes for general health care, and for mental health and psychosocial support. This study was done within the context of a larger study on traditional healers and mental health in Burundi.

Study location and participants

The study was done in five Burundian locations, four (Rumonge and Buta in Bururi province and Kinyovu and Rusaka in Mwaro province) are predominantly rural, while the fifth (Bujumbura Mairie) is the capital of the country. While Burundi is a very small country with a rather homogenous population, the sampling procedure limits the generalisability of the findings.

Fourteen focus group discussions (FGD) were held, with approximately 6–8 participants each. Since it can be difficult for young people, or those with limited education, to disagree publicly with someone who is older age or has higher education, separate focus groups were organised for rural and urban participants, men and women, young and old, literate and illiterate people. Participants were identified through purposive

sampling of categories, and within these categories using snowballing methods to identify a group of participants. In total, 104 persons participated in the focus groups. (See Table 1) In addition, eight key informants (traditional healers) were individually interviewed to collect additional data.

Procedure

The discussions lasted approximately two to three hours per session, and took place in the house of one of the participants, or in a secluded place in the open air. The data were collected from February to April 2005. Two Burundian research assistants guided each discussion, with one of them taking verbatim notes of the discussion. These notes were later typed and checked by both research assistants for accuracy. The Burundian research assistants (five women and three men) were all university graduates, with a bachelor level in psychology or social science. They had received four weeks training in ethnographic data collection and were supervised by a Burundian research coordinator.

The first part of the discussions centred on the question of what participants identified as the main difficulties for people living in the area as a result of war. Participants were invited to talk and discuss this topic freely. Subsequently, the focus group leader invited the groups to rank problems mentioned in a consensus seeking process. In a second part of the discussion, the participants were asked what they saw as the main problems relating

Table 2. Problems related to the war as mentioned by participants of focus groups

Rank	Problem
1	Poverty
2	Deaths due to fighting
3	Orphans and widows
4	Hatred and feelings of revenge
5	Increase of disease
6	Undermining of sexual morals
7	Increase in crime
8	Houses and goods destroyed
9	People not helping each other
10	People feeling sad and hopeless

to mental health and psychosocial support in their community, and how these problems had been influenced by the war. The research assistant chose the highest ranked 'mental health' items from the previous part of the discussion, and invited the groups to elaborate, and add more examples and similar problems. This was again followed by another participatory ranking exercise, in which each group prioritised their responses, with a maximum of 10 items per group.

All data were translated from Kirundi into English before being analysed, with key Burundian concepts being retained and clarified in the current text.

Results

The focus groups generated a list of many different problems that were either caused by the war, or had increased in importance due to the war. The top 10 general problems and the top five mental health problems will be presented, and contextualised, using findings from published literature and reports.

Problems caused by the war

The members of the FGD distinguished a wide array of negative consequences as a result of the war. Each topic will be discussed further below. (See Table 2).

1. Poverty

'People have become poor. All the goods have become very expensive these days.'
(FGD, women in Kinyovu, Mwaro)

In all focus groups, increased poverty was ranked as the main problem related to the war. People linked poverty to direct acts of war (destruction of crops and property) and to indirect effects, for example disruption of agriculture due to forced migration or insecurity, and the plummeting exchange rate of the Burundian franc. The socio-economic indicators of the country declined significantly during the war. Burundi was already poor at the start of the war and the fighting, complicated by an international embargo against the country during the war. These factors have prevented economic development and have made it one of the world's poorest and least developed nations. Since the crisis, the gross domestic product per capita has dropped from a level of US\$214 in early 1990s and 1980s, to US\$83 in 2004. The proportion of people living below the poverty line increased from 36% in 1992 to 68% in 2002 (Government of Burundi, 2006).

2. Loss of lives

The participants identified the direct loss of lives as a major effect of war.

'Many people have died in the war, especially young people. It gives a lot of sadness and loneliness. It is also bad for the future of the country. So many young people have died, and they should have been the ones to work for the future of our country.'

(FGD, young boys and girls in Rusaka, Mwaro)

'People who have lost their loved ones often remain very sad. For example, when adults who have lost some of their children are grieving, and that grief does not stop. They have lost all hope and have no interest in the things of life.'

(FGD, men in Kinyovu, Mwaro)

The experience of our participants is corroborated by statistics, the war left an estimated 200,000 dead and many more displaced (Wakabi, 2007). Life expectancy in Burundi had decreased from 54 years in 1992 to 41 years by 2001 (Government of Burundi, 2006).

3. Many orphans

'So many children have no father anymore because he died in the war or due to disease. What will happen to all these children?'
(FGD, women in Rusaka, Mwaro)

At the time of this research, the country had around 660,000 orphans (children from 0 to 17 years) of whom around 200,000 are orphaned due to HIV related death of the parents and around 250,000 due to the war (UNICEF, 2006). In the early years after the war, around 1/5 of Burundian children grew up in the absence of one or both parents (Guarcello, Lyon, & Rosati, 2004). Widows constitute a significant percentage of the population. For example two-thirds of households of internally displaced persons were headed by women and children (Jooma, 2005).

4. Hatred and revenge

The strain on interpersonal relations was expressed as increased sentiments of mistrust and feelings of revenge, which was sometimes specifically linked to ethnic aspects of the war.

'Nowadays, nobody trusts other people. A man keeps thinking that the other man will do him harm. A person who is the victim of injustice, or whose relatives have been killed, will seek ways to get revenge. Even now the war is over, the Hutu and Tutsi do not trust each other. One has to remain very careful. Killing a person has become normal. People do not care for the lives of others anymore. We used to have a lot of mixed marriages, but not anymore.'

'The different ethnic groups do not pass evenings together. Since the war started, it even happens that someone from one ethnic group refuses to buy something from the other ethnic group.'

(FGD, male and female civil servants in Rusaka, Mwaro)

Burundian respondents describe the past as a time when ethnicity was not such a dominant factor in social life, and people would trust each other more, particularly those living in the same community. Historical and ethnographic accounts confirm, to some extent, that the ethnic cleavage between Hutu and Tutsi became much more pronounced during the crisis of 1993–1995, and the years that followed (Campagne, 1995). For many Burundians, a wide gap exists between Hutus and Tutsis (with limited intermarriages) although, since the peace agreements, the ethnic polarisation is lessening, and political affiliation and the province of origin become more pronounced as denominators of group identity. An ethnographic study of poor urban youth in Bujumbura found that the relevance of ethnicity, as a defining social category was disappearing among them, but that this was not accompanied by an increase in stable and trusting social relations (Berckmoes, 2014).

5. Increase of disease

'Many people have been infected by AIDS, because the men, when they travel, they may sleep with other women, come home with the disease and pass it to their wives who stayed in the rural areas. Often these wives die first, because they do not eat well and have to work too hard. This causes problems, because people start to talk about sorcery and look for someone who has caused the disease.'

(FGD, men in Rusaka Mwaro)

Participants mentioned an increased prevalence rate of HIV/AIDS, tuberculosis and

malaria, and also related this to the war, through increased poverty, bad nutritional status and overcrowding in camps for refugees or internally displaced people. The health indicators of Burundi are among the world's poorest, with maternal mortality estimated at 800 deaths per 100,000 live births and an under five mortality rate of 104 per 1,000 live births (UNICEF, 2013). The prevalence of HIV/AIDS has increased significantly during the years of conflict. The estimated adult prevalence of HIV/AIDS in the country was between 3.6 and 8.8% in 2005 (World Health Organization, 2005). There are no data to confirm an increase in malaria (O'Meara, Mangeni, Steketee & Greenwood, 2010).

6. Undermining of sexual morals

'Burundians have lost their culture ('abarundi barataye akaranga'). Nowadays there are adult men who have sexual intercourse with children. Men rape women and young girls. Too many different people live in one house. So many, that sometimes the people have to take turns to find a place to sleep.'
(FGD, school children in Bujumbura)

The erosion of sexual morals, particularly among youth, was an oft heard complaint among Burundians, including intellectuals and policy makers (Rwantabagu, 2006). It is difficult to corroborate this with statistics, but in the post war years, there are signs of a clear increase in the number of unmarried adolescent mothers, having a profoundly negative impact on the adolescent mothers and their families, due to the strong social stigma and increased vulnerability of both the girls and their children, as mentioned in a qualitative study among youth in Burundi (Sommers, 2013).

Sexual violence, often used during the active conflict as a weapon of war, continues to rage throughout the country. In 1997, more than a quarter of Burundian women in Tanzanian refugee camps had experienced sexual violence *after* they had become a refugee

(Nduna & Goodyear, 1997). Credible statistics of prevalence of sexual violence over that period are not available, but NGOs in Burundi report massive levels of sexual violence. Furthermore, sexual violence is no longer mainly perpetrated by rebels and soldiers, but by family members, teachers and household domestic staff, reflecting '*a general breakdown in social norms*' (Zicherman, 2007, p. 48). A mixed method study on sexual violence in Burundi found that, over the years, victims of sexual violence tend to be younger, with an increase in the number of children (Dijkman, Bijleveld, & Verwimp, 2014). The participants in the latter study mentioned weakened solidarity in communities, poverty, lack of education, psychological problems and problematic integration of ex-combatants back into society as all factors contributing to high levels of sexual violence.

7. Increase in crime

'If people get the chance, they steal from each other, even if they are family members. People do not care anymore.'
(FGD, unskilled houseboys and babysitters in Bujumbura).

Feelings of insecurity, related to increasing crime are widespread. Fights at '*cabarets*' (i.e. local bars) are numerous, and theft of food and property in rural and urban Burundi appears extremely common (Sommers, 2013). Governmental statistics, unreliable as they are, do show an increase in criminality, with increasing incidents of armed robbery by organised gangs and crimes related to land conflicts in particular areas (The Centre for International Governance Innovation (CIGI), 2009). Additionally, trust in the justice system is very low among Burundians (Bédoué & Van Herp, 2008).

8. Houses and goods destroyed

'So many houses were destroyed. We had to go to Congo and leave everything behind. All we had

was lost and we had to start over again?
(FGD, men in Rusaka, Mwaro)

The effects of the fighting on the infrastructure of Burundi has been devastating, with hundreds of schools, thousands of houses being destroyed within a few years time (Jackson, 2000; Longman, 1998). A major issue is the ownership of lands: in the densely populated country many economic disputes centre around land possession, particularly between people who owned the land but went as refugees to neighbouring countries and find their land occupied by neighbours or relatives when they return (Van Leeuwen, 2010).

9. People not helping each other

'In the past when a child became an orphan, the neighbours would take care of them and give milk for the small children, but nowadays they do not do that and one has to buy milk.'
(FDG, men in Rusaka, Mwaro)

Various focus groups mentioned the erosion of traditional mechanisms for mutual support and conflict resolution as an important negative effect of the war. This point was particularly stressed in the groups in the city of Bujumbura. The lack of social support is, however, a major issue in the whole country and strongly related to the loss of trust, as mentioned above. Historically, social relations, with the mutual obligation to help

each other in case of need, are based on the traditional institution of *ukuterera* in which food and beer are ceremonially shared (Ingelaere, 2009). The delicate social fabric of the traditional Burundian communities has been profoundly destroyed by years of violent conflict.

10. People feeling sad and hopeless

'People who have lost their loved ones often remain very sad. For example, when adults who have lost some of their children are grieving, and that grief does not stop. They have lost all hope and have no interest in the things of life.'

(FGD, men in Kinyovu, Mwaro)

Psychological aspects, such as people who feel depressed and hopeless, were mentioned spontaneously in the groups when asked about problems related to the war. In the next section, these will be discussed in detail.

Psychosocial and mental problems related to the war

In a second phase of the FGD, the participants were invited to talk about the *psychosocial and mental problems* as a result of the war, and participants again prioritised their responses. The responses are shown in Table 3, and some responses are discussed in detail below.

Table 3 Psychosocial problems as mentioned by the focus groups

Rank	Kurundi word	English translation
1	<i>Akabonge (kuyinga)</i>	'State of depression'
2	<i>Guhahamuka</i>	Traumatism/having thoughts related to what happened during the war
3	<i>Umubabaro udasanzwe / ikigandaro</i>	Grief/ endless mourning for the dead (not finding body)
4	<i>Ibisazi/ abagwaye mu mutwe</i>	Mental disorders/madness
5	<i>Abanyawarumogi / ibiyayuramutwe</i>	Use of illegal drugs

1. Akabonge ('depression')

'People with 'akabonge' do not have pleasure in anything in life. They do not work properly, they cannot be helpful to other people. Sometimes they harm themselves, they might even kill themselves.'

(FGD, boys and girls in Rusaka, Mwaro)

'A person with 'akabonge' is deranged in his mind ('ugupayuka'). He is constantly murmuring to himself and is not aware of what is happening around him. He is not interested in anything in life. He sometimes speaks to himself, and when he is drunk he talks about anything that he worries about.'

(FGD, women in Rusaka, Mwaro)

'When 'akabonge' becomes very deep it can become 'kuyinga'. In that case the person isolates himself, and does not speak a word. He likes to sit alone in the house and when he goes out he does not speak a word. He does not like to be with others. Such people often think about killing themselves, and sometimes they even do it.'

(FGD, men in Rusaka, Mwaro)

Akabonge literally means 'sorrow' or 'melancholy'. Other words that are used to indicate a state of sorrow in which a person is not able to function normally are *agahinda* or *kinemura akarunga*. In the descriptions of people with *akabonge* or *agahinda* several elements of the psychiatric concept of major depression can be found: low mood, loss of pleasure or interest, a tendency to isolate and retreat from all social activities, thinking a lot, loss of concentration and suicidal thoughts. Persons suffering from *akabonge* sing melancholic songs (*gucurintimba'*), full of regret and sorrow, about how one has made mistakes in life and lost everything and how the good life is now over. The term *akabonge* can also include phenomena such as 'having a deranged mind' and 'talking to oneself'. These could

perhaps reflect a psychotic depression, though in many African cultures hearing voices has been described within various non-psychotic syndromes, including dissociative states (De Jong, 1987; Kortmann, 1990; Van Duijl, Nijenhuis, Komproe, Gernaat, & De Jong, 2010). The neglect of social obligations and lack of care for social appearances are stressed: the person is not interested in anything in the surrounding world and is not able to play a useful role in the community. In one FGD, the concept *akabonge* was distinguished from *kuyinga*, which is a more dangerous variant in which a person is more prone to suicide. The results have significant similarities with the Rwandan concept of *agahinda* as found in a rapid ethnographic appraisal, where *agahinda gakabije* was identified as the local illness most similar to depression. Symptoms include: deep sadness, isolation, lack of self care, loss of mind, not able to work, feeling life is meaningless, not being pleased by anything, and difficulty in interacting with others (poor relationships) (Bolton, 2001). The Burundian concept of *akabonge* is not identical to depression, and may also refer to grief and other non-pathological forms of sadness. The local terminology for mental problems in Burundi is more elaborately described elsewhere (Familiar et al., 2013; Ventevogel, Jordans, Reis, & De Jong, 2013).

2. Ubwoba bwinshi (much fear) and guhahamuka (traumatism)

'Some persons have no other thoughts than those related to the war. Whatever such a person says has to do with the war. He has no other kind of talk.'

(FGD, male and female civil servants in Rusaka, Mwaro)

'Some people are hit very hard by the war. Their houses were burnt, and people have died. They cannot forget.'

(FGD, peasant men in Buta, Bururi)

'They are always alert, as if there is always danger, but this danger is not real. In the night, while they are sleeping they suddenly wake many times. Then they cannot fall asleep again. They are also afraid to go to places where they want to go, out of fear.' (FGD, men in Rusaka, Mwaro)

In several groups, the problem of excessive fear due to war related events was mentioned. In two groups, both with respondents who had completed secondary school, the French word 'traumatism' was used. In other groups, Kirundi words were used, such as: *gusimbuka* (literally 'a reaction of emotional fear when one remembers a terrible event'); *gutabagara* (loss of control when a person is hurt); or *guhahamuka* or *ihahamuka* (Familiar et al., 2013). The concept of *guhahamuka* has recently entered the Burundian discourse. Informants claimed it came from Rwanda, where it became widely used after the genocide of 1994. A qualitative study in Rwanda describes *guhahamuka* as reactions after shocking events (Bolton, 2001). In Rwanda, it also has similarities to panic attack and other anxiety symptoms (Hagengimana & Hinton, 2009).

3. Umubabaro udasanzwe / ikigandaro (grief/mourning)

Many people died in the last decade, and conditions related to conflict and displacement complicate the mourning process.

'People mourn endless for their dead ones. Especially when one cannot find the remains of a dear relative in order to bury him. Then the mourning does not stop.' (FGD, peasant men in Buta, Bururi)

In Burundi, mourning is a complicated process in which several stages can be traced, and that end in a ritual signifying the end of the mourning period and the re-beginning of life, as has been described for neighbouring Rwanda (Bagilishya, 2000). In Burundian culture, similar to other settings in Africa, proper burial of relatives is of high

significance. When it is impossible to bury a person because his body is never found, or his whereabouts remain unknown, the mourning process can be disturbed. As everywhere in subSaharan Africa, deceased ancestors in Burundi are considered to continue to play an active role in the lives of the living offspring, and maintaining a good reciprocal relation is therefore important. The spirits of the dead who are not properly buried can cause all kinds of misfortune. These spirits (*imizimu* = *ancestor spirits*) wander around in nature and can attack anyone who passes by. Many different kinds of problems, such as a disturbed peace in the house, failed crops, madness and other illnesses may be attributed to them (Barancira, 2002).

4. Abagwaye mu mutwe/ibisazi (mental disorders/madness)

'Abasazi are talking nonsense, take off their clothes, insult others and wander around the streets. They behave crazily. They run around and laugh while they are on their own.'

(FGD, men in Rusaka, Mwaro)

Abagwaye mu mutwe are people who 'suffer in their mind'. *Abasazi* indicates 'mad people'. The terms overlap, and are in daily use, often as synonyms, but they are not identical. *Abagwaye mu mutwe* is the term for 'mental disorders', and as such are people who suffer from a disease, mostly a chronic one. *Ibisazi* is a more general concept that is also applied for people who have temporary 'crazy behaviour', for example due to the use of alcohol or drugs. In the definition of *abagwaye mu mutwe/ibisazi*, the behavioral disturbances are in the foreground: 'talking without stopping', 'talking nonsense', 'being aggressive', 'having bad hygiene', 'wandering in the streets without any reason', 'destroying things', 'destroying clothes', and 'insulting others'. It is remarkable that some defining symptoms of psychosis, such as perceptual disturbances (hallucinations) are not mentioned. The predominance of behavioural symptoms in the local definitions of 'madness'

is as is described for many other African societies (Ventevogel et al., 2013). Sometimes *ibisazi* is related to exposure to traumatic events.

‘There are people whom the war has made so sad that it seems they are mad. People have many negative thoughts. They do not believe in the future anymore. They do not have happiness or hope about things in their life.’

(FGD, women in Rusaka, Mwaro)

‘Some people became ibisazi because of war. Men and boys who went to war have been manipulated by politicians. Some died, others were obsessed by bad spirits in the bush. When they return home, they have lost their senses. The war also made people lose money and things. They keep thinking about them, and the end result is to lose your senses. Problems in the family are also the source of ibisazi. Another cause is the fact that people no longer respect ancestors’ rites. There are some who were sleeping in the bush or on graveyards. Consequently, they get bad spirits from the bush or the grave. The last cause I know is overwork for students when they are taking exams. The combination of work at school, while you are also thinking of the war can make one crazy.’

(N.C. 40 years) (Traditional healer)

The direct link between experiencing traumatic events and the development of psychotic reactions has long been neglected and has only more recently (re)gained scientific interest (Braakman, 2013). In Burundi, cases of psychotic reactions attributed to war violence have been described by others (Simbananiye, 2014) but this has not been systematically researched.

5. Abanyawarumogi / ibiyayuramutwe (use of drugs and alcohol)

‘Many men, but also women, spend the whole afternoon in bars, igiti umudiringi ou umunansi (local alcoholic drinks) are being sold. They go home late in the night, drunk. Some

even stay till the morning in the bar because they are not able to walk anymore. They do not eat well, because they drink so much. They lose the strength in their body.’

(FGD, teachers in Buta, Bururi)

‘Even young children start to drink beer now. It was not like that before. Drinking was for in the family.’

(FGD, women in Rusaka, Mwaro)

‘There are many ‘abanywarumogi’ drug users these days. This is often because of the poverty. When one is poor, one wants to use drugs to forget his problems. They do many things that are wrong, like fighting and stealing and raping women.’

(FGD, female petty traders in Bujumbura)

The use of alcohol is engrained in Burundian culture. In the old times, alcoholic sorghum beer or banana beer was brewed by the women of the house. While it has been described that its use could easily lead to aggression and violence, within the family and between families (Albert, 1963), the use of bottled beer has increased the problem due to the low price and its use outside the family structure. There has been little research on alcohol consumption in Burundi (Adelekan, Razvodovsky, & Liyanage, 2008) However, there have been reports that consumption is declining since the mid 1990s (WHO, 2011), but this finding is not corroborated by the lived experience of the Burundan respondents in our study who say use is on the rise, and that is related to the loss of social control. More recently, Sommers (2013) mentions that stories of boys drinking alcohol and smoking marijuana have become very common. A colline (commune) level government official told him that *‘maybe 90 out of 100 ordinary male youth [including adolescent boys] drink banana beer. Many also smoke marijuana. Many girls drink banana beer, too, almost as many as boys’* (Sommers (2013, p. 18). The use of illicit drugs consists mainly of cannabis (*chanvre*) that is grown in secrecy locally, and that according

to anecdotal reports is increasing, particularly in urban areas (Barancira, 2002; Sommers, 2013).

Discussion: implications for the development of contextually relevant mental health and psychosocial support interventions

What can we conclude from this small explorative study about community perceptions of post war problems in Burundi?

First, within the spectrum of problems identified by the communities, mental health and psychosocial issues do play a role and are spontaneously mentioned by the population. The most prominent problems are *economic aspects* (such as poverty, loss of goods and houses), *health aspects* (increase in prevalence of diseases and malnutrition) but, without being probed, people also clearly indicate *social aspects* (weakening of mechanisms for social support and conflict resolution) and *psychological aspects* (sadness, grief). This discredits the notion, still prevailing in some circles, that issues related to psychological wellbeing would not be prioritised by people in Africa, or would represent externally imposed categories (Fernando, 2014; Summerfield, 1999). Studies with populations elsewhere in the Great Lakes Region also found that mental and psychosocial issues are considered a real concern and are perceived as embedded within larger socio-cultural phenomena (Bolton, 2001; Horn, 2009; Tankink, Ventevogel, Ntiranyibagira, Ndayisaba & Ndayisaba, 2010). Major implications for post conflict recovery programmes, therefore, are that mental health and psychosocial aspects need to be addressed. Further, programmes need to be firmly embedded in, or linked to, other activities outside the mental health sector such as programmes for community development, livelihoods and peace building, in order to address the multiplicity of causal factors that impact psychosocial wellbeing (DeJong, 2007). This requires comprehensive

public mental health approaches (De Jong, 2002).

Second, when specifically asked about mental and psychosocial problems related to war, the respondents mention a wide range of concerns. They prioritise loss related problems, such as depression, trauma and grief, followed by severe mental disorder and then alcohol and drug use. A mental health programme should therefore target a wide range of mental health issues, and not merely one condition. This is highly relevant given the discussions around the significance of post-traumatic stress disorder in post war contexts, with some arguing that this is the key issue for war affected populations (Neuner, 2010; Neuner, Schauer, & Elbert, 2014), and others opposing that view and emphasising the role of daily stressors and ongoing adversity as the major contributor to mental health problems (Miller & Rasmussen, 2010, 2014). Third, mental and psychosocial concerns appear to be firmly embedded within wider sociocultural phenomena, as suggested by the interviewees' descriptions. For the Burundians in this study, the domain of psychosocial wellbeing is not viewed as *separate*, but as connected to their social and economic situation (see Bragin, Onta, Janepher, Nzeyimana, & Eibs, 2014). Arguably, interventions should go beyond mere attempts to fix *'an individual with a problem'*, to assistance to solve problems between people (community focus) and to create sustained change within the institutions (systems orientation). Thus, MHPSS need to be conceptualised as multilayered approaches that target various levels (Fairbank, Friedman, De Jong, Green & Solomon, 2003; IASC, 2007). There are various ways to do this. The remainder of this paper will discuss how these local views could inform the selection of culturally and contextually relevant mental health and psychosocial support (MHPSS) interventions. Four broad areas of interventions are highlighted that should be considered if wanting to take into account the views of the Burundian respondents.

Interventions to promote social cohesion

A major problem mentioned by the respondents in the focus groups is that within the post conflict context of Burundi, the mechanisms of solidarity and support have become dysfunctional. People do not trust each other anymore. The Burundian psychologists Simbananiye and Nkwirikiye (2003) argue that to promote individual mental health it is necessary to work on healing the broken social fabric in Burundi, and to work towards reestablishing mutual trust. Uvin (2009) found that rural Burundians defined peace on a community level, as a situation with strong social ties to the community and neighbours living together in harmony. Such social peace can be fostered through tangible interventions that may have seemingly little to do with issues that are usually associated with peace (such as democracy or human rights), but all the more with possibilities of how to *'live together as neighbours'* and have peaceful relations with each other. These can be fostered by increasing the space for informal social contact, and provide concrete places and opportunities for people to meet fellow community members (Ingelaere, 2009). This resonates well with what Burundian women defined as essential aspects of psychosocial wellbeing, for which they used the word *kumererwa-neza* (*'being well in the heart'*) and that is defined by aspects such as *'harmony in the family'*, *'being able to access resources'* *'having a voice in home and in the community'*, being able to maintain friendships and being educated (Bragin, Onta, Janepher, Nzeyimana, & Eibs, 2014).

An evaluation of community based initiatives by international NGOs in Burundi found that, for example, the repair or replacement of water taps or training seminars for people from the same *'collines'* created such new meeting places, reflecting the preference of rural Burundians for informal daily interactions, rather than formal community associations or committees (Vervisch, Titeca, Vlassenroot, & Braeckman, 2013).

Of course, this is not unique to Burundi. For example, a comparison of a psychosocial intervention in Afghanistan with a water-sanitation intervention (the construction of wells using a participatory process) showed much stronger beneficial effects on psychosocial wellbeing than of the water-sanitation intervention (Loughry et al., 2005). In Rwanda, one of the effects of sociotherapy (a form of peer support groups) was the activation of social connections on a community level, and as such contributed to fostering participation of marginalised people in the community (Richters, Rutayisire & Slegh, 2013; Scholte et al., 2011). Much in line with this, HealthNet TPO in Burundi has developed a community systems strengthening approach, such as has been described for other settings, for example Afghanistan (Van Mierlo, 2012). A recent study in southern Burundi showed how also good community based health care can foster community cohesion and peaceful relations (Christensen & Edward 2015).

Interventions to strengthen family support

The family in Burundi is the nucleus of social support and wellbeing. However, families are under strain and may have become dysfunctional. For example, adults who have experienced gruesome violence in their life bear the emotional tolls of this, which may, in turn, lead to parenting styles that are prone to harsh corporal punishment, neglect and abuse and cause an intergenerational passing of distrust, aggression, and withdrawal from their children (Song, Tol, & deJong, 2014). Testimony to this is the prioritisation by the respondents of problems related to orphans, and behavioural problems in children. Moreover, the lack of family support drives some children to the streets, particularly in the main towns, where they face physical and psychological violence and neglect. This can lead further to a deep mistrust and feelings of insecurity that can, to some extent, be modified by being in a safe

environment (Crombach, Bambonye & Elbert, 2014). As the participants in the focus groups remarked, children in post conflict Burundi have lost respect for elders and show 'bad behaviour'. The problem behaviour may be related to changes in the dynamics between parents and children, and the changing roles of the family. Addressing these problems in an effective way may require a shift to include non clinical problems. HealthNet TPO has piloted a brief parenting, psychoeducation intervention with the aim of ultimately improving children's mental health. The intervention targets children indirectly, and works in the first place with the parents. An evaluation of the project showed that the intervention leads to a reduction in aggressive behaviour, particularly in boys, and to a lesser degree in depressive symptoms (Jordans, Tol, Ndayisaba & Komproe, 2012). Similarly, preliminary results of a randomised control trial in Burundi showed that adding a family based discussion group to a project for microfinancing led to large reductions in harsh methods of disciplining their children, both physical and verbal (Bundervoet, Annan & Armstrong, 2012).

Interventions for people with common mental disorders related to loss, grief and sadness

Next to interventions that cover larger groups, it is also important to organise support for those who are so overwhelmed by sadness and anxiety that they do not sufficiently recover. Or, those whose emotional states prevent them from participating in social activities, thus aggravating the vicious circle of demoralisation, poverty and despair. While certainly not all people who are sad and anxious have a clinically relevant mental disorder, quantitative studies measuring affective and stress related disorders in Burundi (with standardised rating scales) indicate high levels of depression, anxiety disorder and PTSD (Jordans et al., 2012; Tol et al., 2014; Ventevogel,

Komproe, Jordans, Feo & De Jong, 2014; Yeomans, Forman, Herbert & Yuen, 2010). Given the magnitude of the problem, and the lack of professional resources in a country like Burundi (only one psychiatrist and a few psychiatric nurses), interventions need to be developed that can be provided by trained non specialists and that are culturally acceptable to the population. In recent years' such culturally relevant, brief, evidence based psychotherapies have been developed and tested in low resource settings in Africa (Bass et al., 2013; Bolton et al., 2007; Bolton et al., 2003; Patel, Araya & Bolton, 2004; Verdelli et al., 2008). It is important that psychological interventions are thoroughly adapted to, and linked into, the cultural context. For example, by avoiding medicalising or psychologising language that may alienate beneficiaries, but instead use local terms for mental and psychosocial suffering, such as *akabonge*, that that are well understood and to which people can easily relate (see Patel, 2014). Such psychological intervention programmes are ideally linked to the community focused activities mentioned above, as there are indications that interventions geared towards changing individual problems will, in turn, enhance the benefits that participants will gain from social and community activities (Hall, Tol, Jordans, Bass & de Jong, 2014), as well as create synergies between various layers of interventions.

Interventions for individuals with severe mental health problems

For those individuals who have developed serious mental disorders, assistance should be made available within the general health care system. The few psychiatric services that are present tended to be centralised and therefore, not accessible to most people. In the aftermath of the war, a programme has been developed in Burundi for the integration of mental health care into the general health care system, by training and supervising nurses in the provincial hospitals of the

country. This project has been described in depth elsewhere (Ventevogel, Ndayisaba & Van de Put, 2011). People using these mental health services are mainly people with chronic psychosis, bipolar disorder, severe depression and epilepsy.

Limitations

This paper presents and analyses the results of a rapid assessment using participatory ranking methodology. The research was done within the context of nongovernmental organisation programme planning with the purpose of obtaining a global overview of local perceptions of problems related to mental health and psychosocial problems. Within these parameter, several choices had to be made that may have compromised the quality of the data. First, with regards to the *data collection*; due to high levels of suspicion in early post conflict settings, it was decided not to tape record the discussions, but to make notes. While the research assistants were instructed to make verbatim notes, it is possible that some of the rich detail of the real discussion – with sometimes several people speaking at once, may have been lost. Moreover, despite a thorough training in qualitative research techniques, and explicit instructions to let participants express themselves freely, it is possible that the presence of research assistants from an organisation that was known for psychosocial programming, has influenced the response patterns of the participants. The use of rapid ethnographic techniques aimed to find ‘*consensus*’ may have overlooked the complexities and contradiction inherent in peoples discourses, and moreover, may ignore differences between people in constructing ‘*a local view*’ (Cornwall & Fleming, 1995; Pool & Geissler, 2005).

Second, with regards to the *data handling*; the notes of the research assistants were translated (by themselves) into English in the weeks immediately after data collection. The absence of an independent translator may have caused bias.

Third, the *data analysis*; took place in the months after the focus groups were held, and as a result have a post hoc character, while an iterative process with the possibility to go back to the focus group participants to validate the outcomes and ask for supplementary information would have been preferred. Additionally, the methodology described in this paper does not allow for a detailed comparison of differences between groups, for example, between men and women or older and younger people, who may at times have conflicting views. To explore the nuances of the views of participants and elicit various layers of meaning making in the discourse of the research, participants would require a different study set up with a researcher collecting data through an iterative process of discussions and reflections with informants over a longer period of time.

Lastly, the *reporting* took place several years after data were collected. While the data still provides important insights into how people in Burundi looked at the problems caused by war, their views will have changed over the years. Moreover, data were collected in only three of the 17 provinces of Burundi, which limits the generalisability of the data to some extent. However, Burundi is a small country with a rather homogeneous population in terms of ethnic and linguistic composition. Therefore, it is possible to be sufficiently confident that the findings are relevant for populations outside the study areas, and are similar to other qualitative research in Burundi done in only one or two locations (Christensen & Edward, 2015; Uvin, 2009).

Conclusions

Mental health and psychosocial problems have their own place amidst the priorities as defined by Burundians themselves. The design of MHPSS interventions should link to what local people find important and what is at stake in their lives and social settings. In order to create synergies, MHPSS

programmes should be conceptualised as multi layered services, be firmly embedded into other systems of care and be explicitly linked within broader, socio-economic recovery programmes after violent conflict.

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