Psychosocial assistance and decentralised mental health care in post conflict Burundi 2000 – 2008

Peter Ventevogel, Herman Ndayisaba & Willem van de Put

In 2000 the nongovernmental organisation (NGO) HealthNet TPO started mental health and psychosocial support services in Burundi, a country that has been severely affectedby civil war. Within a time frame of eight years, a wide range of mental health and psychosocial services were established, covering large parts of the country. During the programme period the NGO activities shifted from the delivery of direct services to capacity building activities aimed at embedding psychiatric services and psychosocial assistance withinexisting local health services and social systems. Among the strategies used were 1) training and supervision in mental health for government nurses and doctors in provincial hospitals, 2) trainingin psychosocial assistance and supervision of governmental social workers, and 3) building the capacity of psychosocial volunteers and local community based organisations. The handover of mental health and psychosocial services presented formidable challenges arising from difficulties for the state in sustaining mental health and psychosocial services within their systems, and from difficulties for users in contributing financially to the provision of services. Major lessons are that installing basic mental health within general care should be firmly rooted in a general health-system-strengthening approach and also that healing the social wounds of war should be embedded within an approach to strengthening 'community systems'.

Keywords: Burundi, community based psychosocial support, decentralisation of mental health care, post conflict settings, sustainability

Introduction

Burundi is a small and densely populated country situated in the Great Lakes region in the heart of Africa, which has experienced cyclic outbreaks of violence since its independence in 1962. The major ethnic groups are *Tutsi* (an estimated 14%) who were historically economically and politically dominant, and the majority *Hutu* (an estimated 85%). Burundi is one of the world's most densely populated countries, with 206 persons per sq km (Bureau Intégré des Nations Unies au Burundi (BINUB), 2006) and one of the poorest countries, consistently appearing among the five least developed countries according to the Human Development Index (UNDP, 2011).

Several violent episodes led to considerable political and social upheaval, causing massive population movements and the destruction of social fabric throughout the country. In 1972, the Tutsi led government systematically killed approximately 150,000 better-educated Hutus after rebel attacks from neighbouring countries. In 1993, the assassination of the country's first democratically-elected president, a Hutu, was followed by massacres of unarmed Tutsis who were attacked by Hutu militias. This was followed by assaults on Hutu peasants by the Tutsi

led army. As many as 150,000 people died in the weeks immediately following the assassination (Wolpe, 2011). A protracted civil war erupted. The peace agreement in Arusha in 2001 diminished the violence and in 2005 democratic elections were held, but some rebel groups still remain active at the time of writing (2011).

An estimated 400,000 Burundians have been killed in the last few decades. Some 800,000 were forced to flee to neighbouring countries, and hundreds of thousands were internally displaced (Wolpe, 2011, BINUB, 2006). Development indicators show further deterioration during the period of war (1993–2002). The proportion of the population living below the poverty line (US$2.15 a day) rose from 58% in 1993 to 89% in 2002, and the gross domestic product per capita fell from 524 USD in 1990 to 368 USD in 2005 (UNDP, 2011).

Mental disorders and psychosocial problems in Burundi

There are no published prevalence figures for mental disorders and psychosocial problems in Burundi. Based on rough estimates by the WHO we can assume that, as typical of other humanitarian emergencies, around 3–4% of the population will have severe mental disorders such as psychosis, bipolar disorder or severe depression, and around 10–20% will develop mild forms of mental disorders including mild to moderate depression, anxiety disorders, substance-use disorders and post-traumatic syndromes (van Ommeren, Saxena, & Saraceno, 2005). The prevalence of epilepsy is thought to be high in Burundi due to the abundant presence of risk: etiological factors include head trauma, obstetric complications and infectious diseases with neurological sequelae, such as cerebral malaria and parasitic worm infections (Nsengiyumva et al., 2003; Yemadje et al., 2011). People in Burundi tend to associate epilepsy and severe mental disorders with supernatural causes and often seek help outside the health care sector (Nsengiyumva et al., 2006). An unpublished study by the authors to identify local idioms of distress shows that Burundians distinguish between several types of '*mental problems*.' The word *ibisazi* indicates a state of chronic confusion and is often used to indicate severe mental disorders. An important state of mind is *akabonge*, which 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 *kinemuraakarunga*. In the descriptions of these states, several elements of the psychiatric concept of depression can be found: a subdued mood, loss of pleasure or lack of interest, loss of concentration and suicidal thoughts. The neglect of social obligations is an element that is stressed: the person is not interested in anything in the surroundings and is not able to play a useful part in life. Another expression is *ubwobabwinshi* which indicates fear, and especially fear that is related to traumatic events during war. People also use a specific word for epileptic seizures, *intandara*.

Warfare and conflict also lead to social problems, including sexual violence and the erosion of traditional mechanisms for social support and conflict resolution. As described in neighbouring Rwanda (Richters et al., 2008), traditional forms of mutual self-help were undermined because the social fabric of society was damaged. People in the same neighbourhoods did not trust each other any more and had lost their faith in institutions (Sliep, 2004). Generally, Burundians have developed a profound cynicism and distrust toward the state (Uvin, 2009). In

Burundi when talking to people one can hear complaints such as:

> *People do not help each other any more. They do not help each other if their neighbours have problems. They do not like to give advice to each other (as is our custom). People have become selfish.* (Focus group of unskilled houseboys and babysitters in Bujumbura Mairie).

Overview of the development of the programme

In this context of poverty, lack of basic needs, damaged social fabric and neglect of mental health issues, the international nongovernmental organisation (NGO) TPO (Transcultural Psychosocial Organisation, after 2005: HealthNet TPO) successfully applied in 2000 for funds from The Netherlands government to begin a programme which would provide psychosocial and mental health services to the war-affected population. Formal services in mental health and psychosocial support were hitherto almost non-existent. In 2000, Burundi had one psychiatrist (trained abroad) and no psychiatric nurses or psychiatric social workers. The country had (and still has) only one psychiatric hospital, with around 60 beds and no psychiatrist. The Faculty of Education at the University of Burundi started to train clinical psychologists in the late 1990s, but at the time there were no organisations in which these workers could be employed. The country has no school for psychiatric nursing or psychiatric social work. In 2000, the Ministry of Public Health had no section for mental health and no written policy or strategy documents in regard to mental health.

The psychosocial and mental health activities of HealthNet TPO started in 2000 as a pilot project in the capital, Bujumbura, and its surrounding provinces, and were based on a protocol, developed by De Jong and Komproe, which had been implemented in Uganda (Baron, 2002) and Cambodia (Somasundaram et al., 1999). The basic premise of the programme is that delivery of psychosocial and mental health services is of great importance for the empowerment and reintegration of vulnerable war survivors in post-conflict societies where, due to the destruction caused by war and displacement of population, the normal *'healing systems'* have been damaged and the health care system has become dysfunctional (De Jong, 2002).

The programme in Burundi can be divided into three phases.

1. The first phase of the programme (2000–2004): initiating services

The programme set out to build a network of psychosocial and mental health services in communities in the city of Bujumbura and seven provinces in the country. In Burundi a province is usually small, with around 200–400.000 inhabitants. People with prior experience as social workers, teachers, nurses, or community development workers were installed as *psychosocial workers*[1] in the communities from which they originated. The ethnic composition of the team was balanced between the ethnic groups. Their training included six weeks of classroom training, followed by two weeks of field training, and then subsequent supervision and additional training courses. For more details about this training for psychosocial workers see Baron's report (2002: 181-183) which describes similar training in Uganda. The psychosocial workers are employed by the NGO and form the backbone of the community based psychosocial programme, providing a broad package of services to

individual clients, their families and the communities.
They were engaged in:

1) Advocacy and awareness-raising among the general population and in specific target groups, such as internally-displaced persons, local leaders, government authorities, health workers and school teachers;
2) Supportive and problem-solving counselling of clients who presented themselves with psychosocial problems, mental problems or epilepsy. These consultations take place either in the '*counselling centre*' (a small brick house with one or two rooms) or at the clients' homes;
3) Client referrals, as appropriate., to the relevant service institutions: health centres, the psychiatric hospital, the consultant psychiatrist (in the capital), social services, legal advice, local administration, and other NGOs (e.g. for assistance with income-generating activities or material assistance);
4) Developing and conducting group interventions and self-help groups for specific client groups, such as people with alcohol problems, relatives of epileptics, women vulnerable to domestic violence, people living with HIV/AIDS;
5) Facilitating sports, cultural- and recreational activities (mainly for youth), while at the same time providing opportunities to access psychosocial education and counselling;
6) Crisis interventions at the community level, e.g. in cases of domestic violence or neighbour disputes;
7) Supervision of community based volunteers who assist the psychosocial workers in mobilising communities and other tasks;
8) Networking and coordinating activities with other relevant stakeholders in the area: local administration, health and social action authorities, other NGOs, health service providers.

At the end of this phase, in 2004, 20 psychosocial workers were deployed (two or three per province, each given a target population of around 50,000 to 100,000 persons). All psychosocial workers could make use of a motorbike and a monthly fuel allowance which enabled them to cover two or three municipalities. Every two weeks the psychosocial workers of each area met with each other and their supervisors in a group to discuss new or difficult cases, thereby enabling them to learn about how to improve interventions by sharing their experiences. From the start through to 2008, additional training courses were organised according to specific themes including sexual- and gender based violence, and the use of specific intervention techniques such as narrative theatre (Meyer-Weitz and Sliep, 2005), as well as how to work with specific target groups. During the course of the programme several smaller separately-funded projects were added. They included projects for former child soldiers, for orphans and other vulnerable children, for survivors of sexual violence, for prisoners and for returning refugees (Nyamukeba and Ndayisaba, 2008). These sub- programmes functioned under the umbrella of the large programme that is described in this article. During the course of the programme research was done into traditional healing systems, and informal contacts were made between psychosocial workers and traditional healers. We chose to not formalise these relationships, with formal referral lines, but rather to maintain good relations on

an individual basis and to respect the choice of the client if they chose to get treatment from traditional healers.

In addition, a child focused psychosocial programme was set up in the provinces close to the capital Bujumbura since 2004. This latter programme was separately funded. It will not be discussed here as it has been described in depth elsewhere (Jordans et al., 2010).

Psychiatric services were provided through monthly mental health clinics that were held in provincial hospitals run by a team consisting of an (expatriate) psychiatrist and Burundian nurses employed by the NGO. They would see patients that were referred by the psychosocial workers, or (increasingly) that were self-referred. Given the absence of qualified psychiatric nurses in Burundi the NGO paid for the three year psychiatric nursing training of two Burundian nurses in Rwanda. Towards the end of 2004 mental health clinics by NGO nurses were organised in four provincial hospitals. These included on-the-job training of governmental nurses in these hospitals.

Reflections on this phase

The project started with the aim of providing services in a situation that was extremely fragile. Funding came from a single donor, under their budget earmarked for humanitarian emergencies. However, it must be remembered, that most people; within the government, the NGOs, and the general population, were unfamiliar with the concepts of community mental health care and psychosocial assistance. Much attention was given to developing *internal resource capacity* and ensuring *access to care* for those who were most in need. There was not much attention given to the embedding of our work in formalised systems. The project introduced NGO-based decentralised psychiatric services and created a discipline that was new to Burundi, the psychosocial worker, salaried by the project, and with some basic skills to deal with a wide range of problems.

2. Second phase of the programme (2005 - march 2007): searching for sustainability

The next phase of the programme was funded by the donor on the condition that it would outline a proper exit strategy and provide a plan to ensure sustainability of the activities.

During this phase HealthNet TPO employed three approaches to achieve sustainability of the psychosocial services and also developed plans with the Ministry of Public Health to anchor the psychiatric services within the government-run health care structures.

Community based psychosocial support

1. *Training psychosocial volunteers.* The initial approach of HealthNet TPO to the work of the psychosocial workers was, as in phase one, to train *community volunteers* who could take over a part of the psychosocial work. These volunteers would get regular supervision from experienced psychosocial workers. They were not paid, but would get some remuneration in the form of a bicycle and transport reimbursements for meetings. In 2005, the NGO's input to psychosocial assistance was reduced in the three western provinces where the programme had started. The number of psychosocial workers was reduced from three to one per province.
2. *Training social workers of the government.* In two new provinces in the north of Burundi, HealthNet TPO started an intensive cooperation with the Ministry of National Solidarity[2]. In some provinces this ministry ran Centres for

Family Development (Centres de DévelopementFamiliale CDF) staffed by social workers who were not trained in psychosocial assistance and were mainly occupied with reporting problem families and providing material assistance. A training programme for these workers was set up. Psychosocial assistance was integrated into the services of the CDF. During the first year the NGO provided 50% of the salaries, transferred equipment such as motorbikes and computers and gave intensive supervision. At the end of the period the psychosocial care in these two provinces was handed over in full to the ministry.

3. *Training community based organisations*
In other provinces, the NGO interventions focussed less on direct service delivery and more on building capacity in local community based organisations such as women's groups, religious associations or youth associations. This entailed a dramatic reorientation of the role of the psychosocial worker, away from *'assisting people in difficulties' towards 'enabling people to become more effective psychosocial helpers'*. In this new approach, psychosocial workers devoted much time to mobilising and training members of volunteer organisations, involving them in psychosocial activities, and assisting them in taking over direct psychosocial service delivery. Staff of these community based organisations would refer only the most difficult cases to the (more-experienced) NGO staff.

Services for people with mental disorders and epilepsy

The approach of the mental health component of the programme had three elements:

1. *Increasing the acceptance of treatment for mental health problems and epilepsy in the community*
Community mental health interventions included community-awareness workshops on mental disorders and the treatment possibilities, individual and family counselling and – when necessary – the referral of clients with mental problems by psychosocial workers and volunteers.
2. *Capacity building of governmental nurses and doctors*
HealthNet TPO was the lead-agency in the development of training materials for '*Mental Health into Primary Health Care*' drafted by a Technical Commission of the Ministry of Public Health (MSP, 2007). Agreements between the national ministry of health, the hospital directors and the NGO were signed. The provincial hospitals each appointed four general nurses to be trained in mental health, enabling them to dedicate part of their time to running the psychiatric service, and providing consultation rooms on the hospital premises. The NGO provided essential psychotropic drugs and equipment as well as training and supervision. The initial mental health training for nurses lasted 10 days, and was followed by a second training of 10 days, and a 5-day clinical apprenticeship in the psychiatric hospital. Courses were conducted by a Burundian psychiatric nurse and an expatriate psychiatrist. The trained nurses participated in the psychiatric services in their hospital under supervision of a psychiatric nurse from the NGO for at least 12 months, during which time they had group supervision meetings every two months in the capital. Each hospital only had one to three doctors. These doctors also received basic training in mental health (10 days)

so that they would be able to support the trained nurses.

3. *Engaging the national policy makers in the ministry of public health*

   In this second phase, the NGO increased its efforts to engage national and local health authorities. HealthNet TPO and the Ministry of Public Health organised two regional conferences in Bujumbura to discuss the integration of mental health within general health care. Governmental and non-governmental representatives from Rwanda, Uganda, South Sudan, Tanzania and the Democratic Republic of Congo presented and shared their experiences around this theme. The World Health Organisation asked HealthNet TPO to carry out an evaluation of the mental health care situation in the country (WHO, 2007). This report has been the basis of a mental health strategy prepared by the government in November 2007. Several workshops were held with the ministry to develop their plan to decentralise the mental health services.

Reflections on this phase

In this phase, the NGO was aware of the need to install sustainable services while, at the same time, acknowledging that the country was recovering from a long civil war. During the period, elections took place and a consensus government came into office. Public institutions were rebuilt, but the reach of governmental services remained very weak and the level of public services was low. It quickly became apparent that creating sustainable psychosocial services through volunteers would be difficult. Although volunteers can play important roles in their communities, organisational strength at the community level is required. Incentives that keep volunteers productive need to be developed and maintained by community-based organisations. Therefore working with community based organisations has greater potential because the intrinsic motivation of these groups is to support others. Such groups existed before the NGO intervention started and are likely to remain functional when the NGO ends its support. However, it remains doubtful whether problems of sustainability will be completely resolved by leaving community-based organisations with responsibility for the continuation of the activities.

The strategy of integrating psychosocial services work within governmental structures seemed promising at the start, and a fruitful collaboration with the Ministry of National Solidarity developed. However, in the longer term this ministry had a position that was too marginal within the government and demonstrated insufficient leverage to be able to sustain psychosocial services. An intensive cooperation with the Ministry of Public Health was developed in regard to psychiatric services. The provincial health authorities were very supportive and facilitated the installation of outpatient psychiatric services in their hospitals. At the national level, HealthNet TPO attempted to build interest by initiating conferences, working groups and developing materials with the government. However, the attitude of the government remained predominantly reactive.

3. Third phase of the project: April 2007 – December 2008: handing over

The last phase of the project focused on sustainability of the interventions through capacity-building, aiming to hand over services and integrate them within existing structures. In three provinces, the psychosocial assistance was integrated into the services of the Ministry of National

Solidarity. In the remaining provinces, the psychosocial workers worked with existing community structures. The role of the psychosocial worker was transformed into that of a trainer and supervisor who only assists in the more severe cases. Experienced psychosocial workers provided supportive supervision for a longer period before leaving the community volunteers and psychosocial workers of the ministry to deal with community awareness raising, promotion of support groups, and individual case-handling.

Psychiatric care was integrated into general health care services of the provincial hospitals through psychiatric outpatient services (two days a week) provided by trained governmental nurses. The NGO continued to provide technical assistance, supervision, psychotropic drugs and adaptation of the health information system. In each provincial hospital, four general nurses were put through a training programme. Each nurse received two basic training courses of 10 days each, a clinical internship of five days, and a *'refresher'* course of five days. The doctors of the provincial hospitals received an introductory training of five days with follow-up training. All training courses were part of a governmental plan to decentralise the mental health services and integrate them into general health care.

A national mental health strategy has been drafted and signed by the Minister of Public Health, and anational mental health policy was drafted in 2007 by a multidisciplinary team with representatives of the Ministry of Health, the World Health Organization and HealthNet TPO. Monitoring and reporting tools have been elaborated by the project, and as a result of lobby six psychiatric diagnoses have been incorporated into the governmental health information system (See Box 1).

Separate trainings were held for officers of the Health Information System to include mental health data. As a result of a continuous lobby from the NGO the National List of Essential Drugs has been revised and now includes all basic psychotropic and anti-epileptic drugs from the model List of Essential Drugs by WHO, with the exception of long-acting depot medication.

Reflections on this phase

The handover of mental health and psychosocial services presented formidable challenges. It proved to be difficult for the Burundian authorities to sustain their commitments to continuing mental health and psychosocial services. The government was faced with severe funding problems and internal political instability that paralysed their decision-making. For example, from 2005 to 2008 there were four different Ministers of Public Health with varying levels of commitment to mental health.

The handing over of responsibilities to community based organisations has been

Box 1: Mental, neurological and substance use disorders newly included in the health information system in Burundi in 2008.

- Psychotic disorders
- Depression (moderate and severe)
- Bipolar disorder
- Epilepsy and seizure disorders
- Disorders related to use of alcohol and drugs
- Psychotrauma

successful in the sense that they feel empowered and respected and are proud of their involvement in mediation and referral, support and advice. Whether these capacities will last or need further strengthening is not clear. In her evaluation of the programme, Kortmann (2009) remarks that although help structures such as churches, women groups or traditional healers can give basic support they cannot provide all the psychosocial assistance needed. The assistance one can reasonably expect from these help structures are mobilisation of social support, providing emotional support, and mediation. This needs to be accompanied by: (a) a more specialised level of psychosocial assistance to which the community structures can refer in case of complicated problems; (b) ongoing clinical supervision and refresher courses and (c) a functional system of monitoring and evaluation.

Coverage and kinds of clients assisted: some data

Since 2003 the project has maintained an electronic psychosocial database registering the data about people who requested assistance from NGO psychosocial workers. 17,713 clients were seen by the psychosocial workers. The users of the services appear broadly representative of the population, although we did not register ethnicity because this is extremely sensitive in a country with a history of ethnic violence. The clients requested assistance for (severe) mental disorders (21.5 %), epilepsy (35.1%) and for psychosocial problems that were not related to these conditions (43.4%) (see Table 1). Once the initial psycho-education for patient and family was complete, the patient was given regular follow-up through the mental health clinic, and the psychosocial worker would limit his or her involvement to treatment compliance-enhancing activities.

People with '*psychosocial problems*' who did not have a mental disorder or epilepsy generally required the more active involvement of the psychosocial workers. A psychosocial worker worked with approximately 20-28 people showing such psychosocial problems per month. Family disputes, sexual violence, depression/bereavement/suicidal behaviour and health related complaints were the most frequent problems while psycho trauma, human rights violations and socioeconomic problems have also been presented often (See Table 2). From a psychiatric care perspective it is perhaps remarkable that relatively few clients were treated for '*depression*'. This reflects the way that psychosocial workers work; i.e. they work with the problems which the client presents and tend to avoid using labels such as '*depressive disorder*' or '*anxiety disorder*'.

The psychosocial problems clearly cover a wide range of problems and are, in fact, not

Table 1. Number of unique clients* seen by psychosocial assistants (2000–2008)

Type of consultation	Number of clients	Percentage
Psychosocial problems	7,695	43.4
Mental disorder	3,803	21.5
Epilepsy	6,215	35.1
Total	17,713	100.0

Each client was seen multiple times over the period, in case of chronic problems up to eight years.

Table 2. Types of psychosocial problems* seen by psychosocial assistants (January 2001–November 2008)

Type of problems	Percentage of total contacts (n = 7695)
Family disputes	20.8
Suicidalbehaviour/ depression/bereavement	13.1
Child abuse and other related problems	5.9
Sexual violence/rape	7.2
Psycho-trauma	5.9
Socio-economic complaints	8.1
Domestic violence	4.3
Complaints related to general health	8.1
Stress and psychosomatic complaints	4.1
Human rights violations/legal problems	3.8
Sexual/reproductive problems	3.6
Psychosocial problems related to HIV/AIDS	3.2
Spirit possession	1.0
Alcohol/drug abuse	1.6
Mental retardation	2.2
Community relations	1.5
Otherproblems	5.6
Total	100.0

Clients with a severe mental disorder or epilepsy are not included here.

very specific to the post-conflict setting but can be found in many African societies. However, it is likely that these problems are aggravated by ongoing insecurity, the loss of loved ones, the return of refugees and internally-displaced persons, and the breakdown of social structures in the communities. A significant proportion of the problems presented to the psychosocial workers are not directly related to war or psychotrauma, but may be indirectly aggravated by the impact of war on the social structure and the reduced capacity of individuals and families to cope with their problems. The term '*collective trauma*' (Somasundaram, 2007) helps to better understand how a chronic war situation can lead to fundamental social transformations and affect the psychosocial wellbeing and mental health of individuals.

A project-based computerised database for consultations at the mental health clinic started in 2006. From 2006 to 2008 the clinics registered almost 10,000 patients who received more than 60,000 consultations (see Table 3). The majority (65%) are people with epilepsy. About one quarter were people with psychotic disorders and 10% were people with non-psychotic mental disorders such as depression and anxiety disorders. The severity of depressive and anxiety disorders was not estimated, but the clinical impression of the first author, who worked in the programme from 2005 to 2007, is that the people with depression who were seen in the mental health clinics

Table 3. Morbidity among users of mental health clinics set up by HealthNet TPO and Ministry of Public Health in provincial hospitals (2006-2008)

	Number of patients	Percentage	Number of consultations
Epilepsy and other neurological problems			
• Generalised epilepsy	6,289	64	43,074
• Other epilepsies	58	< 1	281
• Neurological problems	31	< 1	121
Subtotal	6,378	65	43,476
Psychotic disorders			
• Schizophrenia	632	6	5,584
• Other psychoses	1,725	18	8,598
• Bipolar disorder	104	1	446
Subtotal	2,461	25	14,628
Other mental disorders			
• Depression	704	7	2,750
• Substance abuse	21	< 1	38
• Behavioural problems	65	1	253
• Others e.g. stress, anxiety	188	2	532
Subtotal	978	10	
Total	9,817	100	61,677

often had severe and disabling forms of depression. People with milder forms of depression and anxiety (i.e. that do not lead to major functional impairment) tended not to present themselves at a psychiatric service.

Discussion of achievements and challenges

It is rare that a long term intervention for mental health and psychosocial support in a resource-poor post-conflict setting is described. Eight years after the start of the project, mental health care services have improved. A mental health component was added, within 11 provincial hospitals, governmental nurses and doctors were trained, and large numbers of people were seen for consultations. The essential drug list was updated with psychotropic medication and there was a more or less regular supply of psychotropic drugs to the hospitals. Initially the services were mainly used by people with epilepsy, but shortly thereafter more people with severe mental disorders (psychosis and bipolar disorder) presented themselves to the clinics, and gradually more people with severe depression sought psychiatric help. Community based psychosocial workers played a vital role as an intermediary between community and (mental) health services. They provided awareness-raising, psycho-education, referral and follow-up services, all of which are important elements of any effective programme for social psychiatry. The important ability to reach out into the community was, however, not subsequently continued by the formal health care system in Burundi.

The psychosocial workers were, however, meant to be more than auxiliaries to the health care system. From a community development perspective, the psychosocial workers who were actively involved in awareness raising sessions with the communities on various psychosocial problems, helped communities to define problems in ways that could relate to local resources *beyond* the health system. The psychosocial workers who were trained in the programme have become competent social agents through years of experience. They initially provided direct psychosocial assistance to people with all kinds of problems, initiated support groups within their communities, initiated recreational groups for youth, learned to intervene in crisis situations, and referred people to appropriate services within and beyond the health care sector. Later, they trained and coached community based organisations, and governmental social workers whose capacity was developed to deliver services for psychosocial problems.

Despite the good results described in this article there are still major challenges ahead that have not been sufficiently addressed to date.

1. *Mental health and psychosocial support is insufficiently anchored in government policies and actions*

   The government has not been proactive with regard to mental health. A milestone in the development of mental healthcare in Burundi was the development and approval of a national mental health strategy, drafted in 2007. However, the document was only signed by the minister in 2010. Unfortunately the approval of the mental health strategy has not yet led to structurally increased government funding for mental health care. The budget for mental health services remains around USD 55,000 or 0.43% of the total health budget. More than 90% of this modest budget is allocated to the country's only psychiatric hospital and covers its staff salaries. In the new health policy, 2010–2015 mental health is explicitly mentioned (which is an important realisation in itself) but a careful look at the proposed and budgeted activities shows that mental health is only mentioned twice (namely *'the need to update the strategic documents on mental health'* and *'the need to reinforce the training capacity of the National Institute for Public Health to provide specialised training in mental health'*).

   The general stock of essential psychiatric drugs in the governmental distribution system is still insufficient, although the Ministry of Public Health pledged its expansion at the international Mental Health conference organised by the ministry and HealthNet TPO in January 2008. The difficulty in anchoring basic mental health care within official government policy reflects the low priority that the Burundian government gives to mental health, in common with many low-income countries (Jenkins et al., 2011). With hindsight, more time could have been invested in establishing the importance of mental health as an integrated part of health service provision. When the project started the plan to build-up the scope of the health system, in general, and in Burundi, in particular, was not as developed as it is now. As an organisation this should remind us of the importance of our investment in establishing policies which include mental health within general health-sector reforms.

   While for mental health there is at least an approved strategic plan, there is no

such thing for psychosocial interventions based outside the health sector. A working group which included government personnel and HealthNet TPO staff met several times, but its efforts did not result in a national policy document that could put psychosocial assistance more visibly on the national and international agenda or attract internal and external funding. The Ministry of Solidarity has a '*charitable profile*' (e.g. paying for essential care of the very poor and vulnerable), but does not have well developed strategies to empower communities to care for themselves. HealthNet TPO has invested considerably in building the capacity of the Centres for Family Development (CDF) of the Ministry through training, material-support, and 50% salary payment before finally handing over the projects. The dependency on external support renders the CDF structures vulnerable. Many of these centres are now almost dormant and psychosocial workers at community level receive minimal support. The government has apparently not been able to honour the agreements it signed with the NGO.

2. *Financial sustainability of mental health and psychosocial services remains problematic*

Patients in the clinics that were set up by HealthNet TPO were asked to pay 1000 Burundian Francs (around 0.6 euro in 2011) per consultation and then received free medication. This fee was kept in a '*revolving fund*' so as to establish a buffer against the day that the NGO input ceased. Quite a number of people with chronic mental disorders or epilepsy could not afford this fee and often dropped out, even though the mental health clinics were usually lenient and did not deny treatment. Very few patients in Burundi have access to appropriate health insurance for mental health care. Financial sustainability of the psychiatric services therefore remains problematic. At the time of the described project *results based financing* in Burundi was not yet implemented on a large scale. Including mental health services in such schemes may improve sustainability.

Achieving financial sustainability is even more problematic for psychosocial services. People in difficulties, who often have very limited cash and live at a substance level, will not easily be convinced into paying for an intervention that consists of '*just talking*'.

3. *Integration of mental health into primary care has not yet been realised*

Providing mental health services at the level of the provincial hospital is an important step, but should be followed by integration of mental health service at the health-centre level. This would make mental health services accessible to all. The data shown in Table 3 indicates that the psychiatric services in the provincial hospitals were mainly used by people with severe disorders such as epilepsy and psychotic disorders. The numbers of patients with common mental disorders such a depression and anxiety disorders were much lower than one would expect based on estimated prevalence. As has been described elsewhere in Eastern Africa (Muga and Jenkins, 2008; Nsereko et al., 2011), it is likely that many people with less severe mental disorders such as depression and anxiety do not self-identify as having a mental disorder and will not visit a specialised mental health centre, but rather present to the general health care system. Although the provinces in Burundi are small and the provincial hospitals can be reached within half a day on foot by almost all people, it

is not realistic to expect chronic patients to seek treatment on a monthly basis if it is far from their homes.

Future

Based on the experiences described in this article and similar experiences in other countries, HealthNet TPOs strategy for the next few years uses a *health system strengthening approach* together with a *community-system strengthening approach*. These should go hand in hand, but are not the same.

Strengthening health-systems

Burundi's health care system is undergoing major reforms in which decentralisation of the decision-making power (*autonomie de gestion*) is an important element and the introduction of Results Based Financing (RBF) another (MSP, 2011). It is important to ensure that mental health is included in these reforms. HealthNet TPO currently pilots the inclusion of mental health indicators in the healthcare programmes of the provinces of Gitega and Muramvya. As described above the sequence of interventions led us to work first on developing a set of skills that included elements of primary care as well as more sophisticated services (counselling, secondary care), and was then followed by attempts to embed these services in the system. An undesired effect of this approach is that mental health services were seen by the government as the responsibility of the NGO. An important lesson to be learned here is that the integration of mental health into the health system requires a systematic change in service delivery that should affect all units within the health system. A systematic approach to improving the conditions of work for health professionals, to financing models and to the governance aspects of organising services is needed.

Strengthening community systems

The initial strategy focused on training community based psychosocial counsellors to become a new professional group in a country where psychosocial assistance (at least as a professional intervention) did not exist. Learning from these lessons, the programme in Burundi changed its strategy towards strengtheningthe existing structures – public as well as more traditional and community based structures – not only in the interests of sustainability but also to reflect a cultural perspective and efficiency in terms of coverage: churches, women groups, healers, etc. Working with local resources for help and self-help requires a systematic approach to empowering local communities. This includes identifying existing (though sometimes dysfunctional) *'local resources'* and helping to strengthen these existing help- structures in the communities. The approach may contain elements of *sociotherapy* (an approach that has been successfully tested in Rwanda, see Scholte et al., 2011) and the *family support conference* (Tankink, 2011).

Conclusion

We believe that integration of mental health at all levels of the healthcare, both secondary level as well as primary health care level, is necessary. It is the responsibility of the health care system to offer assistance to people with mental disorders, particularly those with severe and disabling mental disorders. However, health care services are not always best suited to assist people who have common mental disorders such as depression and anxiety disorders, whose aetiology is strongly related to social problems. We should therefore be wary of promoting psychiatric diagnostic categories as explanatory models for social suffering. For this reason we have learned to distinguish

community-oriented social psychiatry from community-building social work. This leads logically to a two-pronged approach; health-system strengthening alongside community-system strengthening. In our view, the installation of basic psychiatric services within general health care should be accompanied by activities to heal the social wounds of war.

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[1] Initially they were called '*conseillers*' (English: counsellors). However, the community based psychosocial work they are involved in is much broader than what is usually understood as 'counselling' and therefore the job title was changed into 'psychosocial workers', or in French 'assistants psychosocials' (the latter indicating the broader psychosocial assistance that they are giving).

[2] Initially this ministry was called *Ministère de l'ActionSociale et du Genre* (Ministry of Social Action and Gender). In 2005, in a reshuffle of the ministerial portfolios most of this ministry merged into the new *Ministère de la Solidarité Nationale, des Droits de la PersonneHumaine et du Genre* (Ministry of National Solidarity, Human Rights and Gender). For simplicity, we use the term 'Ministry of National Solidarity' throughout this paper.

Peter Ventevogel is a psychiatrist and a medical anthropologist. He is technical advisor for Mental Health with HealthNet TPO. From 2005–2007 he was based in Bujumbura, Burundi. email: peter.ventevogel@hntpo.org.
Herman Ndayisaba is a clinical psychologist. He has been involved in the programme described here since 2000 in various functions. Since 2005 he has been the country representative for HealthNet TPO in Burundi.
Willem van de Put, medical anthropologist, is the general director of HealthNet TPO.