CAMH – RWANDA

WORKSHOP IN KIGALI

POLITICAL ECONOMY ANALYSIS ON CHILDREN AND ADOLESCENTS' MENTAL WELLBEING IN RWANDA

PRELIMINARY FINDINGS

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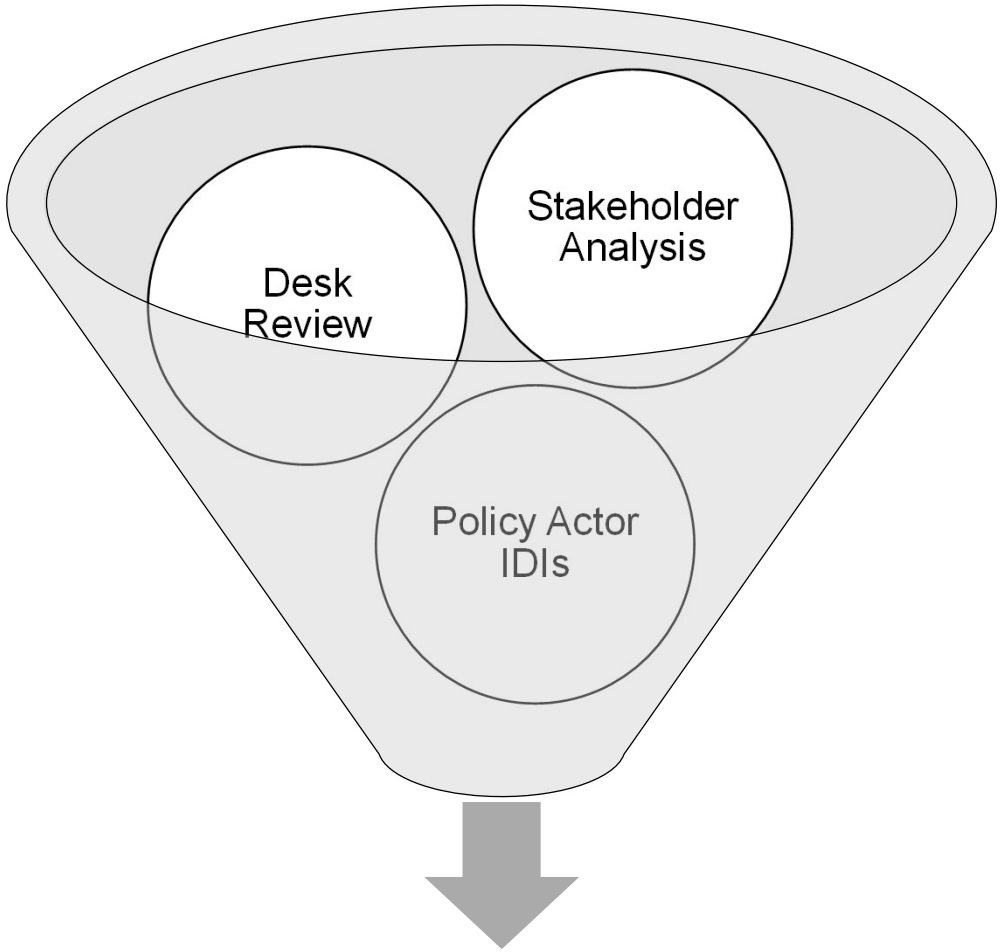
WP 1-1 Situation Analysis



Describe policy contexts, priorities, and key stakeholders for CA mental wellbeing

WP1 Progress to date

- PEA/SA Protocol approved
- CAMH Rwanda Research Team recruitement – Done
- Team trained in April 23
- School selected: GS Rwasa (Intervention); CYASA (Feasability); Rugarama (Control).
- Stakeholders analysis – done
- Desk review: documents identified, draft report under review
- Stakeholders interviews: planned to start next week

1. Desk Review

Policy contexts, policy priorities and key stakeholders, structured using PEA framework

a) **Structure/context**: overall features of social, political, economic and sectoral contexts, social and cultural aspects of the family

b) **Incentives and ideas**: how agents interact in multiple open, complex, overlapping ('laminated') systems

c) **Bargaining**: whose voices are heard? Who are the main policy actors? How do they operate?

d) **Stakeholders**: who have vested interests; what are their relative levels of power and interest?

1. Desk Review

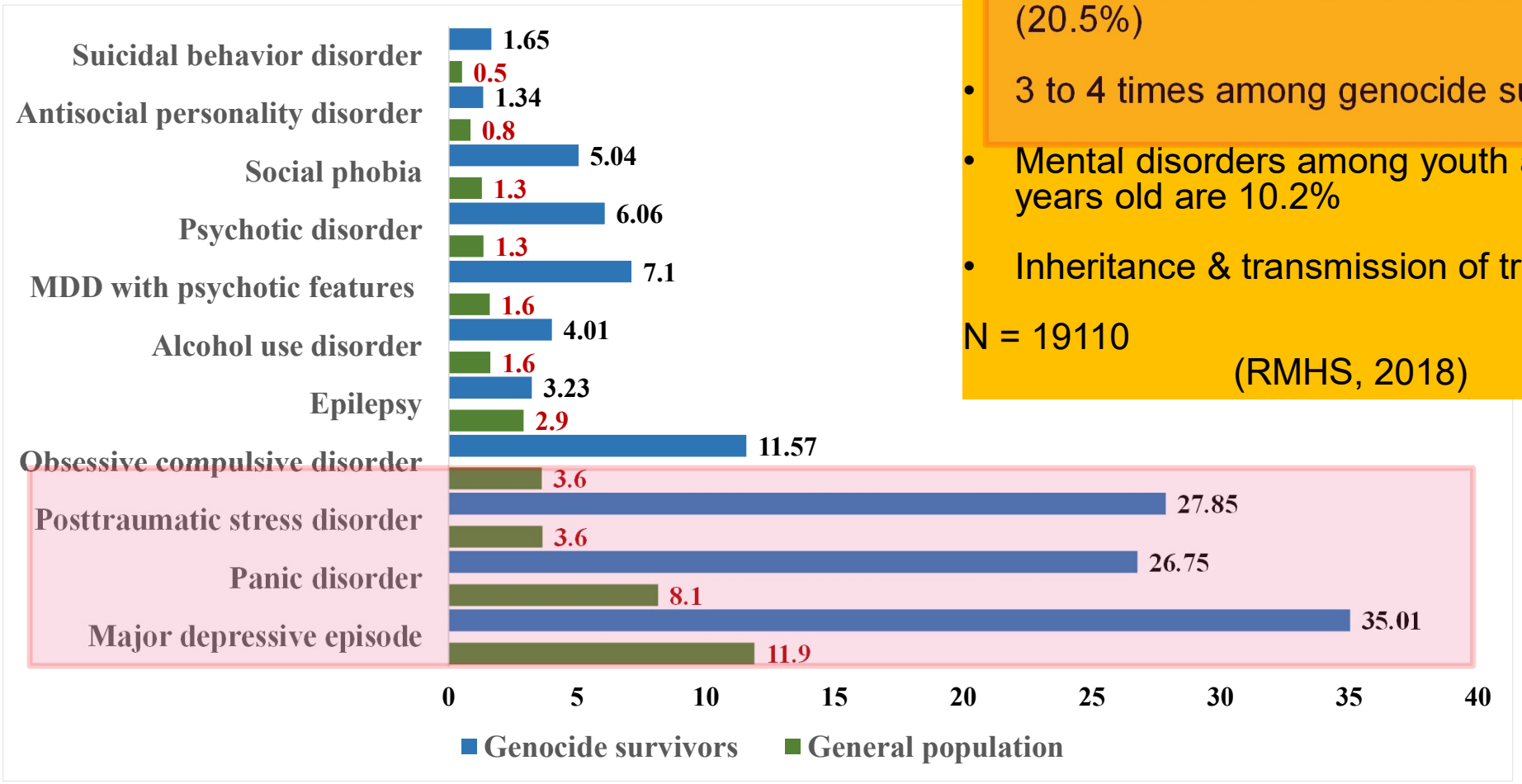
PEA element	Section	Description
	1. Introduction	Purpose is to describe political, economic, and social contexts for CA wellbeing.
Structural and contextual	2. Social context 3. Economic context 4. Sectoral overview 5. Study setting	What are the structures that agents operate within? What are the main social and economic features of these systems? What is it about the economic contexts that is particularly relevant for CA wellbeing? How are the family and children seen in society including e.g., violence, lived realities of children, patriarchy, child-rearing norms, religion?
Bargaining	6. Political and economic power holders	Whose voices are heard? Who are the main policy actors? What are their roles how do they operate?
Incentives and ideas	7. Interactions	Interaction of economic / political / social. Two main layers: global inequalities and domestic (multiple, overlapping, interacting open systems)
Stakeholders	8. Stakeholder analysis	Who are the key 'winners and losers' in CA mental wellbeing in Rwanda, Ethiopia and across SSA? What are their relative levels of power and interest in CA mental wellbeing?
	9. Resources	10 key resources
	10. References	

Structural and contextual: social and economical context

Structural and contextual: social and economical context

- ✓Poor mental health resulting from Genocide consequences (Majority of Rwandans are suffering from PTSD mostly genocide survivors)
- ✓Studies also showed that children of parents who experienced Genocide are also suffering from PTSD and other mental disorders (Possible transgenerational transfer: Stefan et al. (2020).
- ✓The rate of child abuse and neglect among descendants was 10% in the study conducted in Muhanga district(Rieder & Elbert, 2013)
- ✓Sexual violence had been inflicted on approximately 12% females & 5% of males aged 13-17years which is likely to expose them to mental health problems (MOH,2019)

1. High burden of mental health issues due to the 1994 Genocide against the Tutsi

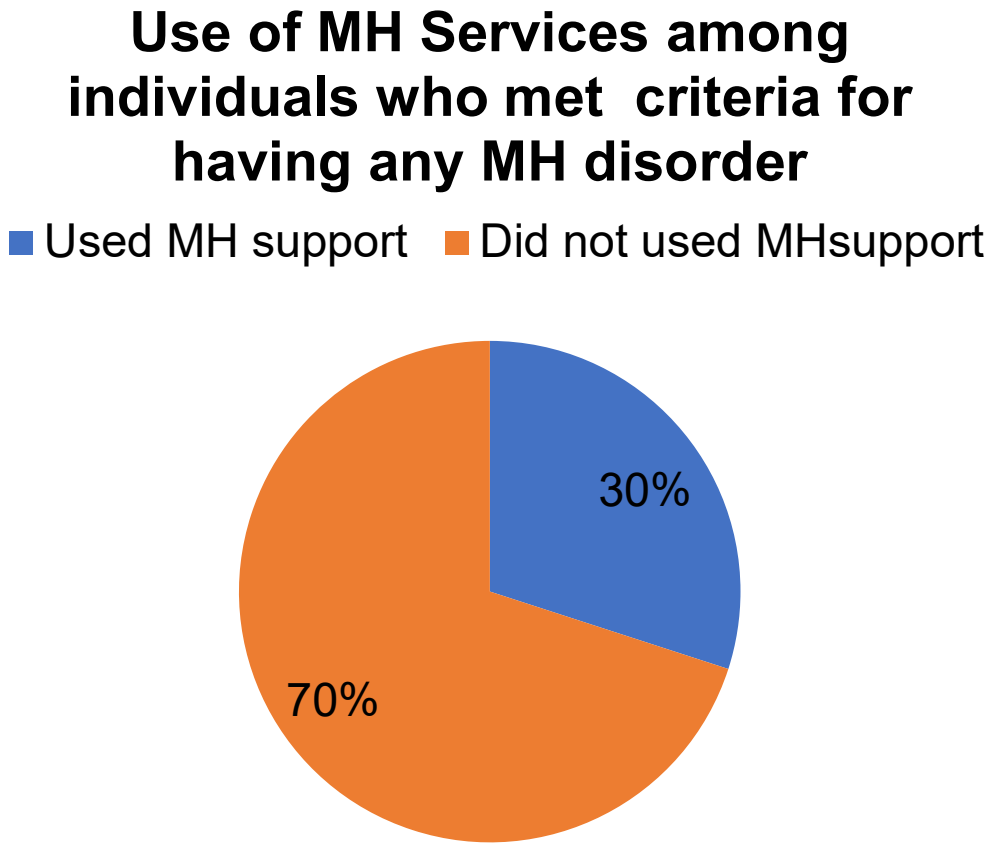


- 1 in 5 has one or more mental disorders (20.5%)
- 3 to 4 times among genocide survivors
- Mental disorders among youth aged 14 -18 years old are 10.2%
- Inheritance & transmission of trauma?

N = 19110

(RMHS, 2018)

2. Barriers - Rwanda Mental Health Survey (MoH, 2018)



Only 30% of individuals who met criteria for having any mental disorders reported having utilized mental health support

Structural and contextual: social and economical context 2

Low MH Services utilization:

- ✓Mental health awareness stands at 62% however utilization rate is still low at 5.3%
- ✓76.2% of genocide survivors are aware of available services however only 14% use them
- ✓Those who do utilize health facilities they face barriers like: inability to access services, fear of stigma, financial constraints, lack of awareness about their conditions.

Cultural context

Research suggest that:

- A high number of those who are suffering from mental health problems tend to seek help from traditional healers or religious leaders.
- coexistence between traditional medicine and modern approaches to mental health care
- but with very little collaboration and dialogue

(study conducted by Schierenbeck, Johansson, Andersson, Krantz & Ntaganira[25]; Kayiteshonga et al.)

2011- National Mental Health Policy revised (10priorities)

1. Improve the financial accessibility to health services- CBHI;
2. Expand geographical accessibility to health services (HCs);
3. Expanding Community Mental health
4. Mental health care for vulnerable groups (children, PLWH,)

HMIS & Data

Substance use services expanded

School-based MH, ECD, family

Technology-based services (telephone, e-MH)

Protocol & Guidelines

Private practice

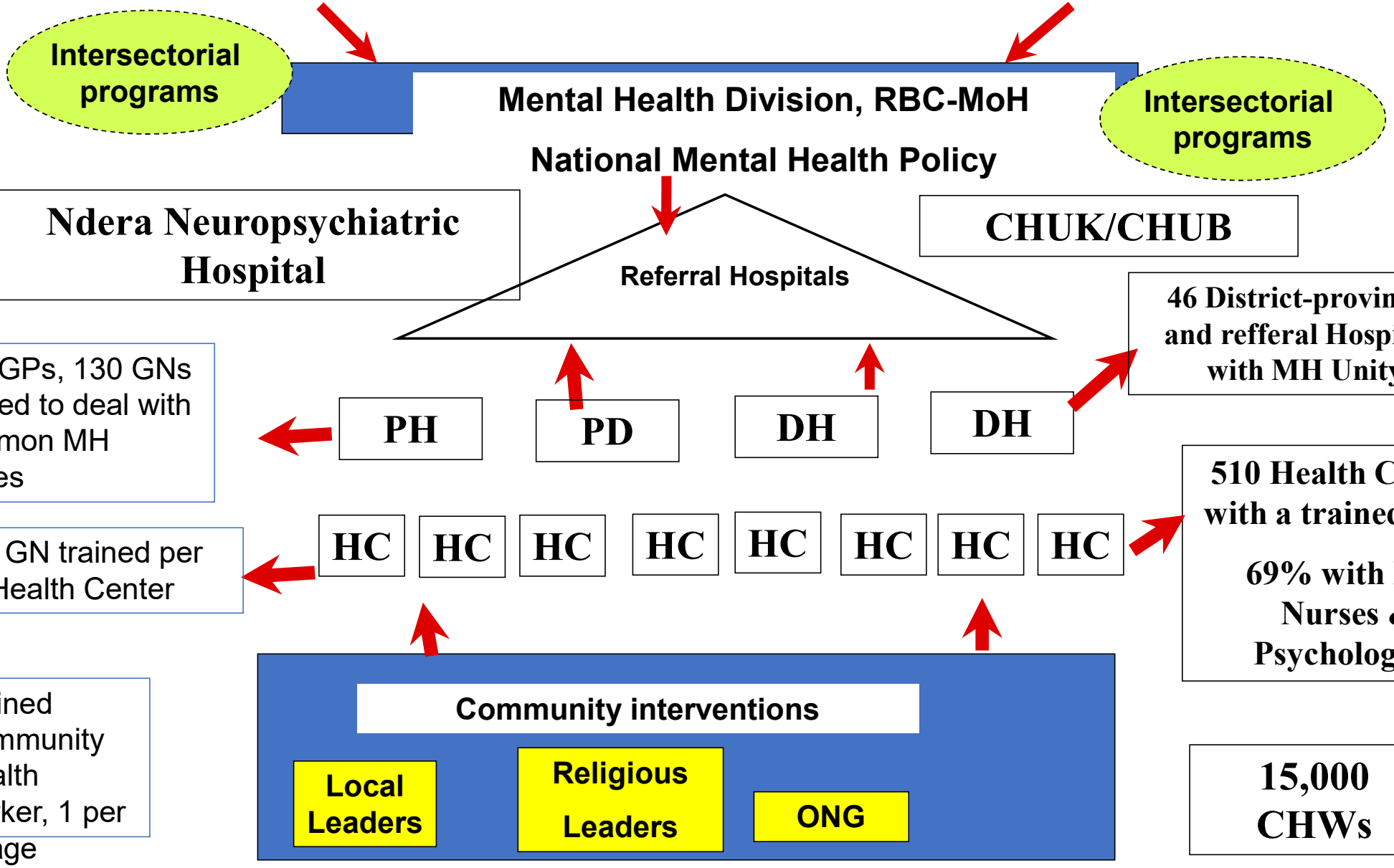
National rehabilitation service

correctional facilities

1994 2011 2019

Policy revised

Rwanda MH Strategic Plan 2020-2024


Intersectorial programs
Mental Health Division, RBC-MoH
National Mental Health Policy
Intersectorial programs
Ndera Neuropsychiatric Hospital
Referral Hospitals
CHUK/CHUB
46 District-provincial and refferal Hospitals with MH Unity
158 GPs, 130 GNs trained to deal with common MH issues
PH
PD
DH
DH
510 Health Centers with a trained nurse
69% with MH Nurses & Psychologists
1GN trained per Health Center
HC
HC
HC
HC
HC
HC
HC
HC
Community interventions
Local Leaders
Religious Leaders
ONG
Trained Community Health worker, 1 per village
15,000 CHWs

Structural and contextual: social and economical context 3

Strategies:

- MOH made efforts to improve access to mental health services
- Increase the number of skilled psychologists and social workers at the district level (664 mental health nurses per 2030 to reach the norm of one per health center, 2 per district Hospital, 4 per provincial hospital, 4 per referral hospital and 4 per teaching hospital:
- Capacitate UMU (Umugoroba w'Umuryango and IZU (Inshuti z'Umuryango: Families's friends)
- Set up an adolescent mental health promotion/prevention model at the community level (Abajyanama b'urungano)

Structural and contextual: social and economical context 4

- Revisit and scale up the school-based mental health program (primary and secondary), by hiring one clinical psychologist at the district level
- Promote e-health and m-health interventions for mental health education and adolescent involvement in their own care
- Revisit the reporting system and include 10–14 years and 15–19 years as age categories in all health facilities (including HIRC) and youth centers in Rwanda
- Integrate mental health and ASRH in youth corners of YEGO centers
- Support anti-drug club competitions in schools as a strategy to prevent drug and substance abuse among in-school adolescents

Structural and contextual: social and economical context 5

- Provide special support for pregnant adolescents/adolescent mothers, focusing on education on self and childcare, empowerment to start up in life, and skilled-based education
- Conduct prenuptial counselling on social living, positive parenting, ASRH, and mental health
- Empower the rehabilitation process
- Strengthen ECD services in all villages
- Engage CHWs and traditional healers in mental health promotion, prevention, and referral at the community level
- Create safe spaces in community groups for adolescents to engage in dialogue about genocide

Bargaining: Political and Economical Power Holders

- ✓Most family are not financially stable to provide with their children the basic needs
- ✓Most of children are living in rural areas of Rwanda
- ✓Shortage of employment among youth that leads to delinquency, unwanted pregnancies, poverty, family conflicts, GBV, drug abuse, etc
- ✓45% of the total population are children aged 0-17 years (Total pop: 13, 246,394)

INTERACTIONS

Existing Multisectoral poverty reduction policies:

(Prime Minister office, MOH, MOE, MIGEPROFE, development partners)

- Education for all
- School feeding
- Job creation: 214,000 decent jobs annually totaling approximately 1,500,000 jobs in 7years

(NST1 (National Strategic Transformation 1): Generate over

- Girinka program (One cow per family)
- VUP Program
- Sugira Muryango (IZU)
- Etc…

INTERACTIONS

- Establishing early mental health intervention programs for children & their families

- Partnerships between the RBC, Early Childhood Development (ECD) facilities (now called NCDA),pre-schools, and other organizations

(Strategy 3.2.2 of the Rwanda Mental Health Strategic Plan)

➔School-based mental health program with skilled providers in pipeline

MH in Non-Health settings (Intersectorial programs

Intersectorial programs

Mental Health in Non-Health Settings (Prevention & rehabilitation)

Intersectorial programs

MNEDUC:

School-based MH program (starting)

MNINIJUST

MH Prisons (Psychologists under RCS)

CNLG

Isange (Police)

MIGEPROF

Psychologists under NCDA (30 psychologists & social workers)

Rwanda Demobilization Rehabilitation Commission
(Demobilized soldiers)

MINIYOUTH

- National Youth Council(wellbeing promotion)
- National Rehabilitation Services (Law-breaking, delinquency)
- Iwawa (18 Psychologists)

InterMinisterial committee to fight against Drugs under Prime Minister Office

Stakeholder Analysis

- Those with vested interested in a situation
- Affect or are affected by the situation
- Those who hold power (resources, policies, networks)
- Those who benefit or suffer from the situation
- Those who maintain the situation
- May or may not be visible in the situation

Stakeholder Analysis objectives

- To understand agents' positioning
- To assess feasibility of future policy
- To develop strategies to influence agents
- To facilitate implementation of projects

PRELIMINARY STAKEHOLDERS ANALYSIS 1

POWER OF ACTOR	High Interest	
	Enthusiastic (High Interest)	Compliant (Medium Interest)
High Power	**President's Office:** Constitution, National Child Development Agency (NCDA), Children's Summit, National Strategy for Transformation (NST1), Vision 2050, ratification of human and child rights,	**Prime Minister's Office/Social Securty Cluster** (MOH, MOE, MINALOC, MIGEPROFE, MINIJUST): Reduction of Proverty and malnutrition in Rwanda.
	Imbuto Foundation (1st Lady's Office): Child protection, girls education, MH and resilience projects in the community	**MINECOFIN**: GoR budget execution and planning; Rwanda Governance Board (managing all NGOs, FBO, CSO), RSSB (Social Security and Health Insurances covering MH services),
	MOH/RBC: Policies and strategic plans development and implementation via School Based MH Program	**MOE/REB:** Quarterly meetings with MOH on School Health Policy; Curriculum development and implementation including health sciences curriculum, implementation of performance based curricula.

PRELIMINARY STAKEHOLDERS ANALYSIS 2

POWER OF ACTOR	High Interest	
	Enthusiastic (High Interest)	Compliant (Medium Interest)
Medium Power	**Members of Parliaments:** Community consultations, evaluations, and follow-up on audits about social policies in districts.	**Civil Society Organisations** (MH awareness, MH clubs in schools, safe space, child protection and reintegration in families, psychosocial support and life skils, GBV, training : SOS, Uyisenga n'Imanzi, GAERG, ARCT RUHUKA, CARE Intl, RWAMREC (positive masculinity)
	Development Partners of MOH and MOE; project fundings and policy and programs impact evaluations- UNICEF - ENABEL – USAID – UKAID – DFID –WHO – WB - etc…	**District and Sector officers in charge of social affairs:** community response to child adversity, Performance Based Contracts at local and family level (imihigo y'umuryango), PBC 4 teachers and public servants in charge of education
	Internatinal NGOs (positive parenting, education support, MH, child protection): World Vision, - Plan Intl- VSO - CARE Intl - AVSI	**Communities (CHWs, IZU, local leaders, local church leaders):** MH awareness, through umuganda, parental evening forums, cell assemblies, community mediation committees
	MIGEPROFE	**Parents and Teachers Associations:** school health interventions, CA protection and development.

PRELIMINARY STAKEHOLDERS ANALYSIS 3

POWER OF ACTOR	High Interest	
	Enthusiastic (High Interest)	Compliant (Medium Interest)
Low Power		**MICT:** ICT 4 Social Economic development in Rwanda: Technologies used in schools and health facilities, use of technologies for payments and governance
		MINIYOUTH: Youth Centers, Youth Health corners, Health services VCT, GBV, referral, youth mobilIzation

3. Policy Actor Interviews

- **Selection**: purposive to represent national level govt, development partners and INGOs in education and health and with interest in primary education and/or CAMH

- **N = thematic saturation:** where interviews are sufficiently diverse, identify relationships and degree of influence between features

3. Policy Actor Interviews

- **Process/content:**
  - Confidential semi-structured interviews under conditions of anonymity to uncover insights into practice,
  - Supplementing reliance on formal documents in public domain

- **Analysis**: expression of competing views while enabling a consensus to take shape

➔ **Topics**

a) **Policies**: what is in place? Extend of intersectoral working, challenges
b) **Situation/need**: CA health and wellbeing
c) **Policy support and recognition**: policies introduced why, by whom?
d) **Policy impact**: what has been achieved, how?
e) **Parents and children**: parental expectations and involvement in health and education of CA

CAMH Identified Political Actors for IDIs

HIGH POWER ACTORS

1. Presidential office
2. Prime Minister's office
3. Imbuto Foundation - 1st Lady's Office
4. MOH/RBC -MHD
5. MINECOFIN
6. MOE/REB – Curriculum Dpt

MEDIUM POWER ACTORS

7. Parliament
8. UNICEF
9. ENABEL
10. WHO
11. World Vision
12. Care International
13. Plan International
14. MIGEPROFE
15. Uyisenga n'Imanzi/GAERG
16. SOS
17. Burera District Vice Mayor in charge of Soc. Affaires
18. CHWs
19. IZU
20. Cty representative /church leaders
21. School Head (Schools: Cyapa & Rwasa)
22. PTA Representative

LOW POWER ACTORS

23. Youth Center coordinator- Burera District

THANK YOU!

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