

Mental health problems among Rwandan youth

– patterns and causes as described by adults working with Rwandan adolescents

Master thesis in Medicine

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Abstract/Summary

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Mental health problems among Rwandan youth – patterns and causes as described by adults working with Rwandan adolescents, Marcus Johnsson, 2014, Sahlgrenska Academy, Gothenburg, Sweden

Background: Rwanda is an African low-income country. A rapid population growth together with a tragic modern history with the genocide 1994 has shaped a very young population exposed to several potential risk factors for mental illness such as the widespread poverty and the not clarified role of the traumatic experiences of their parents. That combination can be devastating in the future since mental illness in young age makes a risk for similar problems later in life as well as an elevated risk of somatic disorders. Mental illnesses are among the most costly diseases measured in economic terms as well as in human suffering.

Aim: Explore patterns and causes of mental illness among the generation born in Rwanda after the genocide 1994.

Methods: Asking for their experience-based understanding on the topic, 21 semi structured interviews with adult professionals working with children and adolescents in Rwanda were carried out. Among the informants were teachers, social workers and different professionals trained in either psychology or psychiatry. 18 of the interviews were later analyzed using inductive content analysis.

Results: Four main categories were identified and explored; *Symptoms, Possible causes to impaired mental health among Rwandans born after 1994, How Rwanda deals with impaired mental health among youth, Gender aspects*. Symptoms mentioned were mainly abnormal behavior and signs on affective disorders. The main causes were poverty, the genocide, family

issues and drugs. The general opinion was that the country has improved its work with these issues lately but that the public knowledge is still too low.

Discussion/Conclusions: Mental illness is an important health issue also in the Rwandan generation born after the genocide, partly due to factors within the Rwandan society. Mood and behavioral disorders can be caused by family problems such as conflicts and bad relationships, in many cases maybe originating from poverty or the events of genocide. Family planning, preventing violence, poverty reduction and educating staff as well as students on mental health issues in schools could benefit the future mental health status of Rwanda.

Key words: Mental health, Rwanda, Adolescents, Social medicine, Content analysis

Introduction/Background

Rwanda

Rwanda is a small country in the center of Sub-Saharan Africa neighboring Burundi, Tanzania, Uganda and the Democratic Republic of Congo. The area of the country is just 6% of Sweden's area and with a population of 12.3 million Rwanda has the highest population density among all the African countries (1).

The history of Rwanda is dramatic, not at least in modern years. 1962 the country won independence after Belgian colonial rule. The following decades were characterized by internal conflicts between the two major ethnicities, Hutu and Tutsi. After years of civil war Rwanda 1994 suffered from one of the most brutal genocides in the history of the world when around 1 million people, mainly Tutsis, lost their lives in about one month. Tutsi-led troops were able to overthrow the majority Hutu-regime. During these events approximately 2 million Rwandans fled to neighboring countries. Since then the country has stabilized and remained so politically but being forced to meet major societal challenges on behalf of its people (2).

Rwanda has a very young population which is growing with one of the highest rates in the world, the median age is 18.7 and 61% of the population is younger than 25 years old. The life expectancy is 59. About 80% of the whole population is still living in rural areas, problematic considering the small area and therefore availability to farmland.

The economic growth during the last years has been among the strongest in the world with annual figures of 7-8%, but starting from a very low level the country is still on 206th place when comparing GDP per capita between the worlds countries (1). In 2011 44.9% of the population was still living below the poverty line; however that is a decrease from 57% since 2006 (3).

Actions regarding the welfare have been taken during the post-genocide era and nowadays the school life expectancy is 10 years for boys and girls, making the literacy rate of today's 71,1% likely to rise. Rwanda is also top 20 in the world when it comes to the proportion of its GDP used for health care. But even if so, major challenges are still there to face. For example there are 6 physicians per 100 000 inhabitants, which can be compared with 380 per 100 000 in Sweden. The maternal as well as the infant mortality rates are among the 35 worst in the world, 11.7% out of the children under 5 are underweight to mention some major health issues (1). But with this in mind the young population can also make for great potential if the development can continue in a positive way.

Mental illness – definitions, epidemiology, causes and impact on the society

WHO defines mental health as “*a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community*”. Mental disorders on the other hand are a quite broad term and characterized by some combination of disturbed thoughts, emotions, behavior and relationships with others. This includes anxiety, depression, schizophrenia and substance abuse (4). The broad definition and difficulties with diagnosis makes it a bit difficult to estimate an exact prevalence, but it seems to be a major health issue worldwide and the lifetime prevalence of any DSM-V disorder has been estimated to be about 18%-36% globally, the lifetime prevalence of anxiety disorders and mood disorders being 10-17% and 8-18% respectively (5). When estimating the life time prevalence there are big differences between different countries and figures are ranging from 18-55%. The lowest rate in the survey is to be found in Nigeria, an African lower-middle-income country (6, 7). Low- and middle-income countries generally report lower figures, but it should be remembered that only 3-6% of the published research on mental health concerns these countries (8).

The psychiatric care as well as the health care is however very different between different countries. In Switzerland there are about 41 psychiatrists per 100 000 inhabitants (4), in Sweden 3.55 and in Rwanda 0.05 which makes it reasonable to believe that many patients, especially in low income countries don't get the right diagnosis (9, 10). Even though many mental disorders are treatable, the treatment gap is big all over the globe. It is however even more severe in low- and middle-income countries where it is estimated that as many as 76 to 85% of the people with mental disorders receive no treatment (11).

Worldwide mental and substance use disorders are the fifth biggest cause to disability-adjusted life-years (DALY's). Out of the DALY's lost from mental disorders depression (41%) and anxiety (14%) stands for the greater share. The burden of mental disorders has been increasing the last 20 years and is now recognized as an important threat towards human health (11, 12).

People suffering from mental disorders are expected to die 20 years younger than others, likely to be caused by bigger suicidal rate as well as large prevalence of chronic diseases. Mental disorders stands for 25.3% and 33.5%, respectively, of all years lived with a disability in low- and middle-income countries, and worldwide it is considered to be the leading non-fatal cause to the burden of disease (4, 11).

Figures of the total prevalence of mental disorders among adolescents vary in different studies but seem to be similar to the prevalence in the whole population (13). But when it comes to DALY's, the biggest proportion can be seen among people aged 10-29. This can be explained by the fact that half of all mental disorders start before the age of 14, suicide is the most common cause of death among adolescents and young adults and the lack of other common diseases in this age group (4, 12). Among the ten conditions causing the most DALY's in the age group of 15-19 years, five of the diagnoses directly categorized as mental disorders (unipolar depressive disorders, schizophrenia, bipolar disorder, alcohol use and

panic disorder) are to be seen. Also violence and self-inflicted injuries which are tightly connected to mental health are among the ten causes. When widening the age interval to 10-24 years the same diagnoses except for panic disorder can be found, unipolar depressive disorder being the major cause of DALY's (14).

It is also known that a mental disorder in early age makes a bigger risk for similar problems later in life. Juvenile depression is associated with adulthood depression while childhood conduct disorders are connected to substance abuse and antisocial personality disorders in adulthood (15, 16).

All this tells us about the costs in human well-being and the limitations for the affected individual. But psychiatric disorders are also of great cost for a society in terms of health expenditures as well as loss of working hours. As been described above these conditions are affecting people still in their working years in larger extent than most other diseases. Approximately 80% of people suffering from depression in United States report functional impairment because of their depression. Apart from the direct health care costs and loss of production, this patient group are also overrepresented among several chronic diseases such as cardiovascular diseases, diabetes and stroke which of course also come with a cost (17). In some high-income countries mental disorders stands for about 40% of the social welfare benefits and disability pensions (4).

There are several risk factors which can affect the mental health among young people. Patel et al (2007) use three different categories; biological, psychological and social causes. Among the biological examples are infections, head trauma and exposure to toxins. The psychological factors are for example learning disorders and sexual, physical and emotional abuse or neglect. Finally the social causes are divided into three sub-categories; family, school and community, the last one mainly focusing on the lack of a safe and secure environment for the child (13).

WHO has highlighted the association between many risk factors for mental disorders and social inequalities and stated that larger inequalities predisposes for actual disease (18). This connection between socioeconomic factors and mental disorders is considered very strong also among children and adolescents, being extra strong among children 12 years and younger. Many studies show an inverse association between socioeconomic status of the family and a child's risk of developing a mental disorder. There seems to be no clear differences between the genders regarding this connection. Other factors affecting the mental well-being among children and adolescents could be family history of mental illness, poor parenting abilities and single parenthood (19). Growing up in a socioeconomically disadvantaged environment seems to come with a raised risk of not just developing some kind of mental disorder but also to stay in the same socioeconomically group as an adult and therefore having children that are given the same risk factors (20). Another study showing the impact of the socioeconomic situation within the family was made by Samaan et al (2000). The authors could also show that there were differences in the child's well-being depending on the family's cultural background. When living under the same economically conditions children of American minorities reported less mental health problems implying that there could be factors in different cultural contexts promoting mental health (21). This could of course suggest that the prevalence of mental disorders is not that underestimated in low- and middle-income countries despite their socioeconomic risk factors. To prevent mental illness more and more research focuses on positive factors promoting mental health. Many of these factors highlight the role of the community and the family, meaning that a secure, loving and including environment can compensate for the lack of money (8).

But even if the prevalence actually is lower in low- and middle-income countries it should still be seen as a major problem also there, not at least considering the size of the population in these countries combined with the small amount of people receiving proper treatment.

Mental illness in Rwanda

Most of the research regarding mental health in Rwanda is connected to the genocide and traumatic experiences. In refugee camps following the genocide the prevalence of mental health problems was estimated to 50% (22). Two different studies conducted shortly after the genocide showed that most of the children living in Rwanda during the genocide had some kind of traumatic experience such as witnessing a murder or sexual assault, hiding under corpses, losing a family member or threatening for their lives. 90% of the respondents in one of the articles had witnessed a killing and 54-79% of the Rwandan children met criteria for being likely to have PTSD (23, 24). Bolton et al found that the prevalence of depression in a rural area of Rwanda was about 15% five years after the genocide (25), significantly higher than the general prevalence worldwide of 1-10% (26). Fourteen years after the genocide Munyandamutsa et al (2012) estimated the prevalence of PTSD to 26%, still being a significant public health problem in Rwanda. Several risk factors stood out, some of them being female gender, low education, high age and loss of both parents. The patients showing signs of PTSD also turned out to have a higher prevalence of somatic symptoms as well as other mental disorders (27). Rieder et al (2013) showed similar figures and are especially pointing out physical illness as an important factor maintaining PTSD and vice versa. But their results showed that age, gender and economic status are not risk factors for the severity of symptoms (28). When comparing survivors and perpetrators Schaal et al (2012) found significantly higher prevalence of PTSD among the survivors. Although they showed that also the mental health of the perpetrators was clearly affected 15 years after the genocide and the numbers of depression were similar in both groups (29).

Clearly, it is known that the mental health among the Rwandans experiencing the genocide is still affected. However, not that much are known about the generation born after the genocide. Previous research on holocaust survivors, war veterans and their descendants has

shown that there might be a link between traumatic experiences among parents and the mental health of their children. The connection and its mechanism are not completely clarified, but at least it seems like children with parents having PTSD are more likely to develop mental or behavioral disorders themselves. There are different theories such as the parent's symptoms affecting the child or an epigenetically mechanism (30).

The little research that has been made about this possible connection in Rwanda is a bit divided. Roth et al (2014) were not able to find a connection between maternal PTSD and more impaired mental health among children, instead stating a link between children experiencing family violence and bad mental health. It was also implied that the maternal use of violence was caused by the mothers experiencing family violence in their childhood. (31). But another study is saying that children of parents with PTSD have shown higher levels of anxiety and depression also in Rwanda, even though the children born even shortly after the genocide show no signs of PTSD and lower symptom levels of anxiety and depression than the ones born before the genocide. Those born before also display higher levels of maltreatment by parents. Also it seems that the more violence a family has been exposed to, the more violence will occur within the family threatening the mental health of the descendants (28, 32). With this said it might be too early to rule out the theory of transgenerational trauma within Rwanda, but also that more interest is to take in family violence.

As described above Rwanda is still a very poor country why a bigger number of the children growing up there do so with additional risk factors developing mental illness than for example in Sweden. It should also be remembered that when the country is getting richer, the inequalities among people are likely to rise, and as mentioned inequalities makes a risk factor for mental health problems.

With the poverty it is not only coming an increased risk of develop the actual diseases, it is also more likely not to get the proper care. The country is not only lacking psychiatrists, also other important resources are under dimensioned. There are only 382 psychiatric beds all over the country compared to 3244 in Sweden, even though 3 million more inhabitants, and the expenditures on psychotherapeutic medicines only 2 895 dollars per 100 000 people and year compared to 3 700 000 dollars in Sweden (9, 10).

Considering the positive development of the country during the last years and the large proportion of people born after the genocide in the population, there is great potential in this young generation. But if there are certain groups that are held back because of their mental health it is of great interest to find out so considering the human suffering as well as the economical loss of the country.

Aim/specific objectives/research question

The aim is to explore patterns and causes of mental illness among the generation born in Rwanda after the genocide 1994 by describing the experience based understanding of professionals working with these Rwandan children and adolescents. The potential patterns the study focused on were which subgroups that may have these problems, in what way they are ill, why that is and how the society treats and helps them.

Material and Methods

Design

After having taken into account the small amount of published research on the topic a qualitative exploratory design using interviews as data collection was chosen (33).

Considering linguistic and ethical difficulties with interviewing children, the informants chosen were professionals working in one or another way with children and teenagers as informants.

Selection of participants and procedure

In order to get as many different perspectives as possible, three categories of professionals were chosen; teachers, social workers and professionals trained in psychology or psychiatry. 21 interviews were made, including 6 high school teachers, 6 social workers and 9 professionals in psychology or psychiatry. The informants were found through informal contacts with the help of the local supervisor. It was decided to not go officially to any kind of institution. All the teachers were invited through the same person who all but one worked at the same school. Informants were always asked after the interview if they knew someone else suitable for the interviews, and therefore also some of the informants knew each other. There was no relationship with the author and any of the informants on beforehand.

Data collection

The interviews were conducted during three weeks in September and October 2014 in Rwanda. All but two took place in Kigali. The setting for the interview was either the workplace of the informant or a local bar. The length of the interviews varied between 30 and 60 minutes. In three of the interviews more than one informant took part, this because of the planned informants limitations to express themselves in English only. The interviews

consisted of two equally long parts, one with questions asked by the author (medical student by profession) and one part with questions asked by a colleague to the author with a similar research topic but mainly focusing on the concept of transgenerational trauma. Content from both parts were used in the data analysis.

The interviews were semi-structured (34) and a document with open-ended questions written in advance was used. The questions requested the participants experience based understanding on different aspects of mental health issues among Rwandans born after 1994, such as likely causes, the public knowledge and perception, and available and missed treatment. The informants had not seen the questions before the start of the interview and had only received a short description of the main topic of the interviews. Before the interview the informants were briefed about their anonymity, the purpose of the study, the structure of the interview and their right to decline answering any question as well as ending the interview at any point.

Data analysis

Considering the study aiming to explore formerly not well-known phenomena, inductive content analysis was used. This means that the unit of analysis were coded and matched into categories formed by the process rather than into pre-assumed categories since no hypothesis was stated (35, 36). All the interviews were sound-recorded and were later transcribed by the author and his colleague. The participants did not receive the transcripts to comment upon. 2 of the interviews with social workers were excluded since they mainly had experience from children with physical handicap which made it difficult to interpret the information they gave in relation to aim of this study, and one of the interviews with a psychology professional was excluded due to linguistic problems. The interviews were read through carefully by the author while during the process marking parts considered to be of interest in relation to the scientific

issues. Meaning units were picked out of the text and put into a table. The meaning units were later condensed and labeled with codes (35). The codes were later organized into categories and sometimes subcategories. Four main themes, reflecting the scientific issues, were chosen based on the categories. The condensed meaning units as well as the original meaning units were kept through the whole analysis as a support to remember what the codes reflected.

Ethics

Some of the questions involved a very traumatic event in the Rwandan past, and several of the participants most likely have their own horrible experiences from that time. No questions were however asked about personal experiences. Neither did any children or adolescents participate in the study. All interviewees participated voluntarily and did not receive any payment. Since not required when writing a master thesis no ethical approval was applied for in either Sweden or Rwanda.

Results

Themes	<i>Signs and symptoms</i>	<i>Possible causes to impaired mental health among Rwandans born after 1994</i>	<i>How Rwanda deals with impaired mental health among youth</i>	<i>Gender aspects</i>
Categories <i>(without hierarchial relations)</i>	<i>Abnormal behavior</i>	<i>The poverty</i>	<i>The role of the school</i>	<i>Difference in character and vulnerability</i>
	<i>Impaired abilities of social interaction</i>	<i>The genocide</i>	<i>Public attitudes and awareness</i>	<i>Exposure</i>
	<i>Psychiatric disorders</i>	<i>Drugs</i>	<i>Resources</i>	<i>Consequences</i>
	<i>Somatic symptoms</i>	<i>Family issues</i>	<i>Actions</i>	

Table 1. The result consists of fifteen categories sorted into four different themes as summarized in the table.

Signs and symptoms

The symptoms and signs were described through different perspectives depending on the profession of the informant. The ones with medical or psychological training tended to focus more on actual diagnosis while the non-professionals usually described different behaviors they have noticed. Symptoms of psychotic conditions were hardly mentioned and have therefore been ruled out from the analysis. Four categories of signs and symptoms were found.

Abnormal behavior

Mainly described by the teachers and social workers different kinds of behavior avoiding from “normal” were mentioned. Examples can be not acting in a way proper for the child’s actual age or acting in a way disrupting lessons in school. One teacher exemplified with a student of his behaving like his or her fellow classmates but suddenly changing the behavior in an inappropriate way such as leaving the classroom without permission or impaired performance in school.

“You find that this has been a vibrant student in class but eventually you may find that this vibrant student you have been teaching for a while is the one sleeping in class. Or if that student has been so good, behaving in a proper way and the person is behaving in a way that is not accepted.”

High school teacher

Disobedience as a form of abnormal behavior was particularly mentioned by the teachers, while the professionals who meet the children at a later stage more often mentioned aggressiveness or a conflictive behavior as symptoms. Also performing poorly in school can be included in this category and was widely seen, this due to lack of interest, concentration or inability to learn.

Impaired abilities of social interaction

This category includes some of the most frequently mentioned symptoms. The professionals and the teachers described how children suffering from mental illness tend to withdraw from other

children and rather be on their own. Added to this behavior is often unwillingness or inability to speak, mutism. The social workers mainly described difficulties when conversing with the children since the children may avoid eye-contact or act uncomfortably in that situation.

Psychiatric disorders

The professionals trained in mental health or psychology often preferred to speak in actual diagnosis to describe what the children are suffering from. Mainly symptoms or diseases deriving from affective disorders, such as depression, anxiety and phobia, were the ones observed by the informants. PTSD was considered to be highly present also among the Rwandan children and teenagers of today. Suicidality exists but was not emphasized as a big issue. Social workers and professionals were the ones considering drug abuse as a sign of an underlying mental disorder.

Somatic symptoms

Mainly described by staff working in the psychiatric hospital was somatization. Children come to the clinic with loss of senses, convulsions, body pain or headache without any physical cause why a psychological or psychiatric is used as an explanation. Sleeping disturbance is another symptom, sometimes causing the child to use drugs to find sleep.

Possible causes to impaired mental health among Rwandans born after 1994

The three categories of informants gave in general rather similar answers and pointed, with few exceptions, on four main causes when including drugs (which also can be seen as a symptom or consequence).

*“So the issues in the family, the poverty and the consequences of the genocide
I think are the main causes of disorder mental”*

One of the social workers

The poverty

Growing up and living under very poor circumstances were mentioned by basically all the informants as a cause to develop mental illness. Especially the teachers described the relative poverty with students whose families can't afford the same amount of clothes and school equipment. A couple of the psychologists argued that it is harder to be poor in urban areas, where you can see rich people, than in rural where everyone is more or less poor and people are taking care of each other with more solidarity. But the kind of poverty mostly mentioned was the extreme or absolute one. Families which can't provide the children with the basic needs and are unable to pay for school fees, circumstances forcing the children to stay home or start working at an early age. Poverty was also seen as one of the main causes of family conflicts, described further on. In search of a better life kids from poor families sometimes leave home, ending up as street children and exposed to other risk factors for poor mental health such as drugs or prostitution.

“And we have also children who were affected by the poverty of their lives, and then they find themselves in the street. And then their street life is the cause of mental health”

Clinical psychologist

A few of the informants actually had the opinion that poverty is not a very important cause since most people in the country in fact are poor.

“But to be poor, especially in Rwanda, it is not a problem. We are starting to discover how it is a problem, but really before we were not taking it as a problem because love was full and the society was good.[...] The love and affection has decreased because if you are not loved you will not love others. Now the parents we have they have been affected during genocide at '94.”

One of the social workers

The genocide

Even though not completely clear how, there was consensus about the genocide as a cause to mental illness also among the Rwandans born after the genocide took place. Some informants described how the parents are still suffering from their experiences and how that affects their abilities as parents. It was also argued that the whole society is overshadowed by the country's past and growing up there with stories from the genocide being told and the knowledge of what your family and their friends have been through will affect the mental status of the ones growing up.

"...for example when you talk about genocide in schools you have to be very careful so that you don't bring back the memories of what maybe happened to this child's parents or what. So that one it affects them seriously"

High school history teacher

"Yeah, you see, the ones who were born after 1994, when they got aware of that history of Rwanda sometimes the interpretation of that it is not very simple. When you take to an adolescent that the husband has killed his wife or a wife has killed his husband and so on. In some village they have killed their neighbors, for children, adolescents and even for adults it is not very easy to understand."

Clinical psychologist

This is especially actualized in April during the commemoration period when children actually can show signs of PTSD due to the movies and TV-programs of the events that are shown then. Also lacking relatives was mentioned as a cause, seeing how classmates have grandparents or uncles, but due to genocide miss parts of one's own family. Poverty due to genocide was described as one issue. The experiences from genocide were, just like the poverty, described as one potential cause to family conflicts, causing arguments about who suffered the most and so on.

“There is also kids borne after genocide and have both parents together but they have lost a lot of things. They have lost their grandparents and the kid asks then “Where is my grandmother?”, things like that. “Uncles? Aunts?”. Maybe they have lost all the things they had: house, cows and other different issues. And they are now live in poverty compared before genocide. All of these issues will affect a child.”

Clinical psychologist

Family issues

The family of the child was seen as extremely important when it comes to the development of mental health illness. Several informants considered family problems as the main cause. Four subcategories were identified; *Family conflicts, Parenthood, Family relationships and Lack of parents.*

Family conflicts including verbally and physical violence was described as a major cause. Parents fighting each other due to financial or marital problems are common and can cause the child to suffer or to leave the home, as earlier mentioned as a risk factor on its own. The husband beating the wife is far more common than the opposite, but also verbal abuse appears. Also the children can be beaten, although it is in line with Rwandan upbringing, mainly the severe cases where the ones considered adding to mental health problems.

“There may be a discussion which is not good in the family, maybe the mother and the father doesn’t have the same understanding about things. So when they beat each other for example it affects the children.”

High school teacher

Family relationships were also taken into account. Separation or divorce between the parents can be something affecting the mental health of the child.

“Another thing is when parents aren’t staying with each other, maybe they have been divorced. For sure, we know many people divorcing. But if parents are not united, it will not be easy for children to adjust to that.”

Social worker

Examples were also given of stepmothers who don’t treat the children in an appropriate way and also conflicts between stepchildren. Polygamy was considered to be a cause of conflicts and a bad family environment for the child.

When you are asking different kids they say “for me I came to be a street child because I didn’t have someone to take care of me, I was living with my stepmother and she used to treat me bad so that I decided to come in the streets”.

Clinical psychologist

Widely discussed was how the parents and their behaviour can be a cause to mental illness among their descendants. The informants emphasized that children get education from their parents and copy their behaviour, saying that a bad or inappropriate parental behaviour can cause harm to the children. Examples can be parents abusing drugs or parents forcing children to do heavy work not suitable for their age.

“If the parent is abuse alcohol or drugs she is likely to fail as a parent. The parent will be angry and can’t control the anger and end up beating the child. They end up even failing to take care of their need, material needs.”

Family therapist

Also lack of care, love and affection from the parents were considered causing impairment in the mental health.

“If the child lack care of their parents it is automatically lack of education from home. Because in Rwanda we’ve had an education whereby a child

learn different good behaviours. And if you have aware parents you will grow well. If you have bad parents it is not easy to be and grow well of course.”

High school teacher

Among the theories why the parents act like this was having been raised badly themselves or suffering from depression or some kind of mental illness, sometimes as a consequence of the genocide. Another cause to maltreatment could be the poverty and insufficient means to provide the child food, or not time to give the proper care while struggling to earn to the basic needs. Also more financially stable parents were considered not spending enough time with their children when busy working and making more money. One more aspect was family planning and too many children in the families resulting in insufficient attention to one and each child. When teenagers lack parental care they are more likely to end up in bad company, a step towards drug abuse.

“Even parent must care to their children. So they look after what they do, where they go or the peer they meet, their friends so that they don’t consume drugs.”

Social worker

A final aspect of family issues that came up was the lack of parents, children having just one parent or none at all. In Rwanda the husband has a strong position in the family and when he is not around, kids sometimes have to take disproportionately big responsibility considering their age. Also orphans growing up in orphanages or in their own houses are considered more vulnerable since they lack the parental education and can have a feeling of missing something in life.

Drugs

The issue of drugs kept coming up during the interviews and was seen as a major problem among Rwandan youth of today. Drugs mentioned as common were alcohol, marijuana and glue. It was many times considered as a symptom or a consequence of mental illness, but can also be a cause by damaging the brain or through development of addiction. Most of the informants meant that the ones using drugs are already troubled mentally, and the drugs are used as an escape or an opportunity to forget the reality and their background. Also peer pressure or plain curiosity can be a gateway to drug abuse according to the informants. Some were blaming foreign influences for the recent year's acceleration of the problem. Street children are the ones suffering more, being more eager to forget their past and being more accessible for the trade.

“According to how they say it, they say that if they take it they go in good mood. In case they have problems, if they take drugs those problems goes away”

Social worker

How Rwanda deals with impaired mental health among youth

To describe how the country deals with these issues four categories have been created from the input of the informants; *The role of the school, Public attitudes and awareness, Resources and Actions*. The categories deal with the formal and informal structures available and desirable from the informant's perspectives that affect the outcome of mentally ill children and adolescents.

The role of the school

This category is mainly based on the answers coming from the group of teachers, but also other informants emphasized the importance of the school as an instance meeting most of the

children, and by doing so having the opportunity to find mental disorders on an early basis. The teachers seemed to play the role of a counselor for their students. They told that they have some skills and knowledge about mental health issues and some of them have had external experts coming to the school to give more education. A few considered their knowledge and the resources in school enough, but most of them felt that they don't have enough competence to deal with these issues and that more professionals in mental health are needed in the schools.

“We don't have specialists for knowing the level of disease they are having. That's why I say we need some specialists, because I can say they don't get the help. Because people, including me, don't know how to help them.”

High school teacher

A good relationship and cooperation between the teachers and the parents were considered as crucial. Many parents just rely on the teachers to help the children while the teachers need more input from the parents regarding how they act outside of school, something they don't do to enough extension. The teachers meant that if they have enough knowledge they can be the ones noticing when a child is ill and advice the parents of where to go for proper care. It was also mentioned that the teachers have about 120 children in class per day and it is hard to find time to also act as a counselor to the students.

“And another barrier it is the fact that we are not always with those children. We are with the children when they are at school, when they are at home it is another case. It requires the relationship with the teachers and the parents so that we can help one and other.”

High school teacher

Public attitudes and awareness

The informants meant that people in Rwanda still have quite little knowledge about mental health issues, especially non-educated people and people in rural areas. Before the genocide in 1994 it was more or less unknown, but with lot of people suffering from these kinds of problems after the genocide in combination with measures taken by the government, such as investing in facilities and advertising in media, the general awareness has been elevated. But according to the informants there is still a stigmatization in some communities where the families may deny the problems of their children and other people in the community can reject the ones that have been treated in mental health facilities. Nowadays there is a policy saying that everyone should take care of every child and even if it wasn't clear how well this works, some informants meant that this kind of collective responsibility can be helpful.

“Let me say that today the progress is reducing how public take care of those who have problem and different to the past. But this is a result of as I told you of those policies of Rwanda, like education for all. It means that many people have become wise about those people, knowing that someone who is taking drugs or having mental problem can become a gentle one. And as those policies I said, “take child as yours”, every parent with family know that they have to care every child if you meet him or her and you find that he suffer, you see the symptoms or character which show that he or she has mental problem you try to help and you advise administrative on sector level. The public right now I can say how they care these problems is balancing not bad, not good.”

Social worker

Also the lack of knowledge in the families can cause patients delay; the parents can mistake a mental disorder for misbehavior and instead punish the child. When it came to the attitude

showed by classmates and friends the informants were a bit divided. Some meant that there is no bullying and that they rather approach the affected children and in that sentence can be a help, but some meant that ill children are badly treated and considered useless by their peers. One social worker pointed out the fact that also the children lack knowledge about these diseases and the causes behind, but when aware they can be a good support.

“When the child maybe ask the parents “I feel sad” or whatever, sometimes what is very, very difficult now is to convince the parents that mental problems exist in children, because it is difficult to understand for parents to understand how a child can be angry, feel anger, how a child can feel sadness. They take it as misbehaving. They punish them. The reason why we see them later, because they consider it as misbehavior and punish. And if they fail to control those emotions they go in praying. Maybe it is the demons. And if the praying fails maybe they go into the hospital.”

Mental health nurse

Something the informants kept coming back to was the importance of Rwandan culture as a barrier to mental health care. It was said that Rwandans don't like to express their feelings and prefer to keep their problems to themselves, something that can stop a child from getting treatment in an early stage.

“In our country we don't know how to express our emotions. It is very difficult after the commemoration to ask someone ‘How are you’, he tell you ‘Everything is okay’. ‘You can tell me about it’, ‘No it is okay’. Because in our society: Expressing traumatically problems and mental problems is considered as a weakness. So everybody try to show that everything is okay.”

Medical doctor

Further on it was mentioned that it is not compatible with the culture to see a counselor. Instead one rather talks to friends and relatives who may lack the professional view. It was also told that the knowledge about the role of psychologists and therapists are limited. In some communities it is still believed that mental illness are caused by devils and spirits why the families prefer to pray or consult a priest or traditional healer to get help. This was also considered causing a patient's delay.

"...even if our government have their force to understand those who have mental illness, our population they don't understand mental illness like something which is normal. They consider it like devils. If you are like that they consider it like you have some devils. Some start to pray for you, some reject you and they say that your ancestors have come to get you."

Clinical psychologist

Resources

Also when it came to the available resources in the country the response was a bit mixed. Regarding the availability it was mentioned that there are counselors and medical professionals to see and different centers taking care of mentally ill children.

"In general we have some hospitals, there are psychotherapists. Also there is hospitalization for them. There are also psychosocial and psychologists. There are many kinds."

Clinical psychologist

But some meant that there is not enough, mainly because of budget limitations. Money and professionals were the two most missed things. About the accessibility the poverty of the families was taken into account and it was said that some families can't afford the care for the

children. A few informants also wished institutions closer to for example the schools so that people don't have to travel to get their care.

“As we were speaking previously there is the lack of capacity, I mean financially.[...] In the secondary it is the expert of psychologists which have enough knowledge about mental. So because I can say for example we have one youth center in the district that may be a big challenge because if we have one center for ten sectors it can be long distance to reach for those in the sectors surrounding.”

Social worker

Actions

The informants were in general quite satisfied with the government's way of handling the issue of mental health in Rwanda. They thought that right priorities have been taken and things will be better if the country continues along the same path. Policies on education and family planning and the general promotion of mental health issues were uplifted as good examples. Also policies on poverty reduction were seen as something that can improve the mental health. Elevating the public knowledge and awareness about these issues was mentioned as an important action to reduce the burden of mental disorders.

“And local community, local leaders can be able also to handle it. So then the help will be close, nobody will escape it. But it is a good strategy of government for that by empowering community and local leaders also to help in that way. But they are not well-educated about it, that is one barrier”

Social worker

Other suggestions on important actions to take were programs for reintegrating children that have been treated in mental health facilities and involving the local community in that process

to prevent the isolation and stigmatization of those children. The importance of the family for a child's mental well-being was once again emphasized and one of the psychologists expressed the vision of finding a family and promoted adoption. It was also desired to have mental health professionals working in different sectors of the society involving a lot of people, for example in the schools, to be better able to catch cases in an early stage. Some mentioned that there are many people being educated in the subject of mental health, and for example doctors are going to European countries as a part of their specialty training, also considered as signs of how Rwanda takes these issues seriously.

“I think we are trying to build something, the government has...like us, doing our specialization. The professionals are being trained. There are some psychiatrists that are being trained in Switzerland, Belgium, so there are some structures that are being put in place to try to help. In the community community workers are being trained. There are some training organized each year so that the stigma about the mental problems are being fought by many means: media, radio, televisions. They are trying to do something to help.”

Medical doctors

The criticism that came up was the fact that there are many educated clinical psychologists who cannot get a job, partly since the financial resources are missing.

Gender aspects

Even if disagreeing a bit whether boys or girls are suffering the most, the informants described some differences in the way Rwandan boys and girls express their symptoms and cope with their situation. The ones working at the mental hospital considered it equally common with mental disorders among boys and girls, while the other informants believed it to

be more common among girls. It was also clear that the informants believed that boys and girls are different by nature regarding their opportunities to face problems in life.

Difference in character and vulnerability

Girls were considered as weaker and more emotional by nature. It was said that a troubled situation will affect a girl more than a boy in general. Also their behavior was described as different from each others with girls being more quiet and weak. One of the teachers meant that it is easier to see when a boy has problems since he will act more aggressively while the girls won't show that much symptoms. Some meant that girls show more somatoform symptoms and more traumatism and fear, but some meant that the differences are not that big.

“For me I see that girls are suffering from different kind of issues that boys didn't. For example girls may have experienced violence based on sex, which is not maybe for boys. And how we created girls somehow, I mean emotional, things like that, I mean maybe that's why they most of the time are suffering from mental problems than boys.”

Clinical psychologist

Exposure

Boys tend to be the ones to take more responsibility in the family if the father is missing, which can affect their mental health in a bad way. Girls were considered more exposed to violence, and especially sexual violence. It was also told that girls traditionally have been discriminated regarding education and that some of these structures have remained, for example will a girl more often be the one who cannot continue in school if the family has to choose.

“Our culture which discriminates women and give big role to men. In the past traditionally when the schools started in Rwanda girls didn't go to

school, only boys. That mindset is still here. That is one of the causes to the violence we are facing.”

Clinical psychologist

Consequences

It was said that boys use drugs much more than girls, by some informants suggested as being one aspect of the theory that boys try to solve their problems on their own. Girls, as it was said, are more unable to handle their own situation and may turn to men for help. In a way to improve their life they can go into prostitution, which can cause them even more mental problems as a consequence of the living conditions, HIV or an unwanted pregnancy. Girls without parents and girls violated by their parents were considered more likely to prostitute themselves.

“The girls when they meet a problem they search for men that somehow can help them in that problem... That is different from the boys. Boys, I don’t know if this is natural, but when they meet a problem they search for solving themselves and when they are unable to get jobs they take drugs and alcohol.”

Social worker

Discussion

Requesting the experience-based understanding of professionals working with Rwandans born after 1994 this study has aimed to explore different patterns and causes of mental illness among these young Rwandans. The findings comprise four different themes; symptoms, causes, how Rwanda deals with the issue, and gender aspects. Considering the method it is hard to make any definite conclusions from the results. That was however not the purpose

when designing the study, but instead a try to create a picture of a formerly not very well-known matter and rather raise questions for future research.

The symptoms described were a bit hard to interpret. Widely mentioned was a behavior not considered normal. If that in any way is pathologic by definition is very difficult for third part to understand. In some cases they may be, and in some cases they may not. It can be a sign of something not being as it should in the child's life, and later lead to an actual psychiatric disorder. But just as well it can just be a phase in the child's development, not completely understood by the adults observing it. Other things mentioned were mostly affective disorders such as depression and anxiety, things that can be connected to one's life situation in a way for example psychotic disorders usually are not. Most notable was the mentioning of PTSD as a common problem. According to Rieder et al (2013) there are no significant levels of PTSD in the Rwandans borne a couple of years after the genocide (32). So how come that the informants state the opposite? One possibility is plain and simple that they think of the ones that were teenagers a couple of years ago and then showing the symptoms. Another is that PTSD mainly is found among the street children, the ones that have already experienced traumatic events and that the participants in the Rieder et al (2013) study were all parent and child-pairs still living together where the children may not yet have gone through any traumatic event. The street children were often mentioned as a big issue and are definitely a group that should be taken into account when conducting a new quantitative study on the topic.

When it comes to the causes, the results were more substantial. Poverty, the genocide and family issues came out as the main findings with the usage of drugs as a cause as well as a consequence of mental illness. Different kinds of family issues were considered as the most important and often created from poverty or the experiences from the genocide. As stated in the background poverty is by no means an unexpected finding. Many looked positively on the

future with poverty reduction as an important action, but there is a risk of widening income gaps when a country finds itself in a period of fast economic growth (37, 38). The development is mainly seen in Kigali where most of the interviews were conducted. Therefore it has to be remembered that inequalities also makes a risk factor of mental illness in a population (18, 19), something also mentioned in the study where it was suggested that poor people in urban areas also in Rwanda suffer even more from bad mental health than the poor in rural areas.

The family turned out as a very important factor that in different ways can affect the mental health of a child. Family conflicts and violence within the family, between the parents or towards the child, were main issues. It has been shown before that experiencing domestic violence can lead to trauma symptoms, mood disorders or an abnormal behavior (39, 40), more or less the main findings among the symptoms in this study. Family violence has proven to be a key finding among causes to mental illness among the adult victims (41) as well as among children and adolescents also in former research in Rwanda (31, 32). Domestic violence seems to be a major problem in Rwanda and definitely something to put resources into prevent.

Another issue in the family was parenthood. Bad parenthood is of course a bit difficult to define but the results implied things like maltreatment and lack of care, love and affection. Those are also causes well-known from the literature (13), more interesting is then what is causing the bad parenting in Rwanda. Among the results several theories were found. For example things typical for a low-income country such as poverty and bad family planning which causes too less time for the parents with every child together with a stressful life situation where they every day are struggling to provide the basic needs. It is reasonable to believe that poverty reduction and especially family planning programs will benefit also the mental health status in Rwanda, just like some of the informants thought. It must however be

remembered that also children in richer families were considered to be at risk since their parents maybe work too much and don't prioritize spending time with the family. The poverty is likely to play a role, but it may also be switched for another risk factor when reduced.

Parental diseases, and especially depression or correspondent, were also seen as something that can affect the parental abilities. It has been shown before that parental depression comes with an elevated risk for the offspring to develop mood disorders or behavioral problems (42, 43), making also this finding valid due to former research. But what make this extra interesting in Rwanda is the history of the country and a generation of parents carrying a trauma after the genocide.

Neither Rieder et al or Roth et al have been able to find proof for transgenerational transmission of trauma in Rwanda (28, 31), and it is not the main purpose of this study to do so either. But with this said one cannot avoid notice how the participants in this study stressed the importance of the genocide as a factor causing mental problems also among the Rwandan children of today. Research in the past imply a connection between parental PTSD and elevated mental health problems in the offspring, something that can have an explanation of genetic or epigenetic nature or by the fact that PTSD affect the parenting abilities (44, 45). A higher risk of developing PTSD as a child of someone with PTSD has been seen among adult descendants to holocaust survivors (46) and in Cambodia, a country that also has suffered from genocide, it has been shown that traumatized parents and their inappropriate parenting can cause mental illness in their descendants (47, 48). Linking up previous research with the findings of this study suggests that the transgenerational trauma theory shouldn't be ruled out in Rwanda either. It might be the case that the offspring of parents with PTSD will not develop symptoms until later in life, in the study on holocaust survivors the offspring were in their forties. Therefore it could be of interest to conduct a similar study on the Rwandan teenagers of today in maybe twenty years from now.

Transgenerational trauma or not, there are still other ways in how the young Rwandans of today can be affected by the genocide. For example is the lack of relatives something that can cause identity problems. The commemoration period every April is of course a way to prevent something similar to happen again, but it also seems to be something that goes quite hard on the people, and not at least the children. Even if it obviously is of great importance to enlighten the next generation of the past of the country, one from the outside cannot help questioning the way it is done in. Several informants told how sad everyone gets, and simply how children are not feeling well during that time. A study just focusing on what the commemoration period and how it takes place affects the mood and health of the young Rwandans would be of great interest.

To summarize it seems like the main causes found in this study interact and enhance each other. Family issues appears to be the most important cause but is connected to the other ones. Figure 1 suggests how the different causes interact and how the genocide may be a source to mental illness among the youth of today.

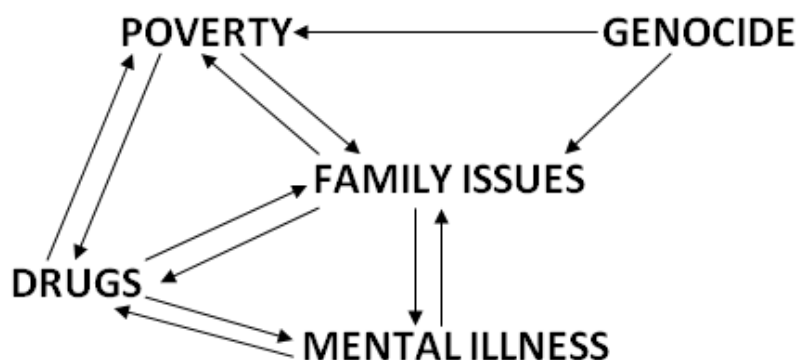


Figure 1. A suggestion of how the different causes interact. A pathway straight from genocide to mental illness cannot be ruled out but is yet to describe.

One cause hardly mentioned by the informants was HIV. Betancourt et al have shown that many HIV-positive children in rural Rwanda present themselves with typical affective symptoms as well as the changes in behavior such as isolation and interaction difficulties (49). It is still about 1% of the Rwandan adolescents that are infected (50) and therefore an issue worth mentioning even if the informants hardly did so. It could be that somatic diseases in general were overlooked because people in general associate to social misery when thinking of mental illness. No other somatic disorder was mentioned as a cause even though former research has shown a connection with for example manifestation of PTSD and physical pain (27). That is partly a question of same character as who came first of the hen and the egg, but it is at least worth noticing that somatic symptoms were considered as a consequence of a mental disorder but never the opposite by the participants in this study.

Another cause don't mentioned and denied by the participants on direct questions was bullying, something maybe thought of as an important issue affecting the mental health of children and adolescents in our part of the world and with evidence of doing so (51). Teachers are considered to be key players identifying and prevent bullying (52), but the ones in this study completely denied the existence of it in Rwanda. If that really is the case Rwanda seems to avoid one important cause to impaired mental health in the younger ages as well as later in life.

Considering past events of the country it has developed in an impressive way and invested in improvements of the healthcare. Today Rwanda has a desire of providing the best quality of health care in the region. The investments have also shown results in decreased rates of communicable diseases and next step would be to act on the communicable ones (mental disorders included), today more than 50% of the Rwandan burden of disease (53). When conducting this study it seemed like the government is aware of these issues and trying to

work with them. And even though the resources may not be enough, people seemed satisfied with the quality of the mental care and the actions taken by the government. The genocide left a big share of the population with mental wounds and created a public awareness of mental disorders and an acceptance of the ones suffering from it. But about half of today's population didn't experience the genocide but nevertheless are growing up in a community with several factors that can affect their mental health. It was very difficult to understand the magnitude of the problem in this group since the opinions of that were quite diverse. Despite the experiences from the genocide and the knowledge gained from it, it still seems that there is a large stigmatization regarding mental health issues in Rwanda today. Even though the knowledge and awareness of educated people are quite good, that is not the case everywhere in the society. It is still a bit shameful and in conflict with traditions and culture to talk about emotions or seek a psychologist. These attitudes reflect on children who don't get proper care in time. It seems like the country has good institutions and professionals to handle the ones actually coming for help when severely ill, but the result of this study imply a big number not getting medical attention at all. A problem that may cause an individual a much worse condition later on just because he or she didn't get the necessary help or attention in time, maybe because they or their parents lack knowledge of the condition or where to turn for help. Important steps with advertising and information campaigns have been taken already, but does it reach out to everyone? Other pathways may be cooperating with churches or traditional healers which some people start approaching nowadays. Another opportunity is to include it in the education. For example when the children learn about the genocide the mental health effects could be emphasized and spoken about in a way that can help to normalize these diseases in the general population. More research regarding actual prevalence and barriers to health would be of interest to penetrate these questions further.

This study has not been able to distinguish whether Rwandan boys or girls suffer the more of mental disorders. But it shows that there is a quite stereotypical view on the characters of boys and girls. The two genders seem to present themselves with different kind of symptoms, girls being more difficult to discover since mainly being more withdrawn and already considered to act more in that way. The societal expectations of boys and girls also seem to play a part in how young Rwandans react when having a mental disease, one not necessarily better than the other. Males, considered as a future head of the family and maybe expected to act more independently, are more likely to try finding solutions on their own and more often end up with substance abuse. Females, maybe raised into depend on males or in much larger extent exposed to sexual violence, turn into prostitution instead. Strengthening Rwandan girls, partly by acting harder on family violence as stated before, and in general equalize the relationship between males and females could maybe diminish the bad consequences of a difficult life situation or impaired mental health.

Methodological considerations

Regarding the collection of data there are some circumstances that may have affected the results. First of all it should be remembered that the author had no experience of qualitative research on beforehand. Also the usage of English in the interview which was neither the mother tongue of the author nor the informants may have caused misunderstandings or limited either parts in their respective questioning and responding or prevented the informants to tell something they would have like to include. Also not using professionals to transcribe the interviews and not going through the transcripts with the informants afterwards may have caused some errors and parts excluded from the interviews since not hearable or understandable. Because the limited time in field the interviews had to be conducted during a quite short period of time, therefore the interviews sometimes had to take place under not

optimal circumstances, for example the informants in a few cases didn't have enough time and some questions had to be left out. In three cases the informant's levels of English were limited and one additional person had to be in the room, translating and filling in. This can of course have caused the informants to withhold certain information and agreeing with each other. The setting was sometimes a public place like a bar with the risk of some parts being overheard, something that also may have caused the informant to be extra cautious. In most of the interviews the informant were not prepared, letting them see the questions in advance could have given them the opportunity to think things through and not miss out on potential perspectives.

Using three different target groups gave different perspectives, experiences and opinions, something strengthening the study. The topic was not very well described before and therefore it seemed wise to target different parts of the society where mental illnesses are to be seen. When analyzing the data it could be seen that this theory turned out correct since the three different groups gave rather different input but also confirmed, and therefore strengthened, some findings. The teachers also get to see the healthy children and could compare with them. However, their lack of professional knowledge on the questions asked may have led to difficulties with definitions. It was hard to understand if they described an actually mentally ill child or just someone a bit hyperactive for example. Their descriptions of symptoms may need more experience than the author possesses to interpret. Five of the six teachers worked in the same school and taught basically the same students, they were also males and in similar age (around 30). A strength since the answers could be compared and verified, but also a weakness since the desired diversity were lost. It was told that many of the mentally ill children don't reach as far as high school or have to go in private schools since lacking the needed marks, and therefore interviews with teachers in lower standards or in private schools could have been of interest for the study. Even the other groups of participants

were mostly found through informal contacts and suggestions from former informants (the “snowball effect”), maybe causing the answers to be a bit similar since coming from a friend or colleague with the same perspective. The informants were in general quite young, maybe a result of a young population, limited abilities in English in the older population and maybe as a consequence of the snowball effect. It sure could have been useful with a few more informants with more experience. All but two interviews were conducted in Kigali, by the informants described as much more developed than the rest of the country. To give a better picture of the whole country a wider geographical variation would have been of interest.

One consideration on beforehand were how the questions would be perceived by the participants. But no questions seemed to be uncomfortable and the informants responded to all questions with nothing but interest and openness, even if it of course cannot be ruled out that they may have withheld certain information. Regarding the questions about the genocide it was sometimes difficult to keep the interview to the ones born after 1994 and the informants sometimes also tended to let their own experiences from that time shape their opinion. Therefore the parts concerning the genocide are the most difficult to draw conclusions from.

Also when analyzing the data a method new to the author were used, possible to cause some beginner’s mistakes. Keeping the data in English have of course maintained the content, but may also have made it more difficult for the author to go further in abstraction level, struggling with finding proper words and expressions. The intention through the whole process has been to use inductive analysis, but since I had some pre-understanding on the topic this have of course influenced the questions during the interviews and most likely also the analysis since one might tend to see what one want or expect to see. With all this said the results of the study are to be received and interpreted with caution.

Conclusions and Implications

The mental health among Rwandan adults has been investigated in several studies and considered impaired. Not much is known about the generation born after the genocide, today about 50% of the population, though. This explorative study has shown that the mental health is a big and important issue also among them. Changes in mood and behavior are being the most typical symptoms and signs and may in many cases be caused by the living conditions of many Rwandans. Poverty and the genocide are characteristics for Rwanda and can together with drugs cause conflicts or bad relations within the families. The family being safe, loving and well-functioning was considered vital to get every child a healthy upbringing. Different factors seem to interact when causing mental health issues, making it complex to point out single solutions to improve the mental health in the country. Partly due to consequences of the genocide and governmental efforts the attitudes towards people with mental disorders have improved, but there is still room for improvement. Children and adolescents today seeking professional health care are taken care of in a good way, but most likely there is a good number not getting any care at all due to lack of resources, unwillingness to show what is considered weakness, families being ashamed or traditional believes. On these issues better educated staffs in the schools and teaching about mental disorders in the schools are two ways to normalize the diseases and making this new big generation better informed about it. Elevating the public knowledge and reducing the causes by for example poverty reduction, family planning and campaigns against domestic violence may be the two most important steps to diminish the impact of mental illness in the future Rwanda, though more research on these measures are necessary to evaluate their efficiency. Mental illnesses stand for a big cost in terms of money and human suffering, therefore investing in mental health among children and adolescents makes a good investment for any country and not at least the ones with such a young population as Rwanda.

Populärvetenskaplig sammanfattning (svenska)

Psykisk ohälsa är en av de sjukdomsgrupper som åsamkar samhället störst kostnader samtidigt som det innebär stort personligt lidande. Psykisk ohälsa utgör en risk för att även drabbas av fysisk ohälsa, såsom t.ex. hjärt- och kärlsjukdomar.

I Rwanda, ett litet östafrikanskt låginkomstland, har frågan aktualiserats de senaste 20 åren pga. det fruktansvärda folkmord som tog plats under våren 1994 och slog landet i spillror. Att detta har satt sina spår i den psykiska ohälsan hos de som upplevde det har påvisats i flera studier, mer okänt är däremot hur de mår som fötts efter folkmordet och idag utgör närmare hälften av befolkningen. Genom att intervjua vuxna som på olika sätt arbetar med barn och ungdomare har den här studien försökt teckna en bild över den psykiska ohälsan hos barn och ungdomar i Rwanda. De aspekter som lyfts här gäller *Symptom, Orsaker, Hur frågan hanteras i Rwanda* samt *Genusaspekter*.

Summariskt kan man säga att psykisk ohälsa även i denna unga generation är en stor och viktig fråga som ofta utgörs av förändringar i stämningsläge eller beteende och kommer sig av en problematisk familjesituation med våld, dåligt föräldraskap, otrygga levnadsomständigheter eller avsaknad av föräldrar. Orsaken till detta kan i många fall komma från fattigdom eller påverkan av folkmordet. Droger är ett växande problem och något som framförallt pojkar tar till för att fly sina problem. Flickor förefaller snarare vända sig till prostitution. Det är svårt att peka ut enskilda orsaker till att någon utvecklar psykisk ohälsa, utan det förefaller snarare vara flera av orsakerna som samverkar på olika sätt och således gör det mer komplicerat att förhindra.

Den allmänna kunskapen och acceptansen för psykisk ohälsa har ökat sedan folkmordet och problemen det medförde. Det har gjorts satsningar på psykvården i landet och hjälp finns att få. Dock verkar det som att det finns ett stort mörkertal och att många barn och ungdomar får

hjälp för sent alternativt inte alls, delvis för att resurserna inte räcker till och delvis för att okunskapen och stigmatiseringen kring psykisk ohälsa på intet sätt är helt bekämpad.

Samhälleliga insatser kring familjeplanering, fattigdomsbekämpning och förebyggande av våld i nära relationer kan tillsammans med utbildning av både de som möter mycket barn, t.ex. lärare, och barnen själva ha positiva implikationer på såväl mängden som konsekvenserna av psykisk ohälsa och därmed den generella folkhälsan i Rwanda på sikt, ytterligare forskning beträffande sådana insatsers effektivitet är dock nödvändig för att kunna uttala sig säkrare.

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Appendix

Draft questions during the interviews

Part one

- What is your profession?
- How often do you make contact with youth aged 12-19 years? How many children do you approximately meet during a day?
- What is mental health illness according to you?

- What is the health status among the young Rwandans you meet according to you? The Rwandan youth in general?
- What kind of signs do you see that the young Rwandans you meet suffer from mental illness?
- How does the symptoms manifest?
 - Which groups suffer the most? (*Exemplify with socioeconomic situation, gender and age if needed*) Why do you think that is the case and describe what you build your opinion on?

- What do you think is the main underlying causes to mental illness among the young Rwandans you meet? The Rwandan youth in general?
 - Why is that?
- Describe the magnitude of the problem from your point of view! How big a problem is it considered to be in the country? Compare with physical illness and give your view on which is the bigger problem. Do you see any co-morbidity?
- What kind of options has Rwandan children to influence their situation? Develop!
 - Describe possible differences between different groups.
 - Which resources are available?
 - Describe formal or informal structures helping or stopping young Rwandans to influence their situation.

- If these children are affected of mental illness: How are they affected? Describe their level of function in a societal perspective? How do they perform in school and after elementary school? (*Do they move on to a higher education after Elementary School?, Can work normally? etc*)
- What about the use of alcohol, tobacco and drugs among the youths you meet? Can you describe differences among mentally ill youths and more healthy ones.
- What about violence from parents et.c.? How common is that? Connections with mental illness?
- What differences in prevalence and attitude towards mental illness after/before the genocide have you noticed? Describe your view on the problem with mental illness before the genocide. Describe changes and possible differences if there are any.

Part two

- Describe how and if children of genocide victims are affected of mental illness.
 - Are they suffering from violence in their homes?
 - How would you describe the underlying causes?
 - How would a possible connection manifest itself?
 - Is the parents and-/or the children themselves aware of this?
 - What can be done about this according to you?
- Is there a difference in how mental health problems in children of genocide perpetrators manifest compared to genocide victims?
- Are children of refugees (April-August 1994) who escaped the violence also represented? If yes, is there a different severity from the other groups?

Part three

- Is there a taboo about genocide? If yes, do you consider this as a barrier to health?
- What is the public attitude and opinion regarding mental health correlated to the genocide? How is it spoken about? (*Is it taboo?*)
 - Does it differ in how people speak to each other in families, among friends et.c. and in how the society treat the issue?
- How does this affect young people in their everyday lives?
- What kind of support is available for these young people? What is good in the way Rwanda handle these young people? In what way does it need improvement?
 - *Do you consider existing support as enough?*
 - *If yes → exemplify!*
 - *If no → what additional resources are needed?*
 - Describe how young Rwandans search help for problems with their mental health.
 - *Do they search, are they afraid (if so, why?), parents impact?, differences between groups, knowledge about their own condition.*

Completion

Were these questions understandable?

Do you have any concerns or questions to us?

