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### Borderlands of mental health: Explorations in medical anthropology, psychiatric epidemiology and health systems research in Afghanistan and Burundi

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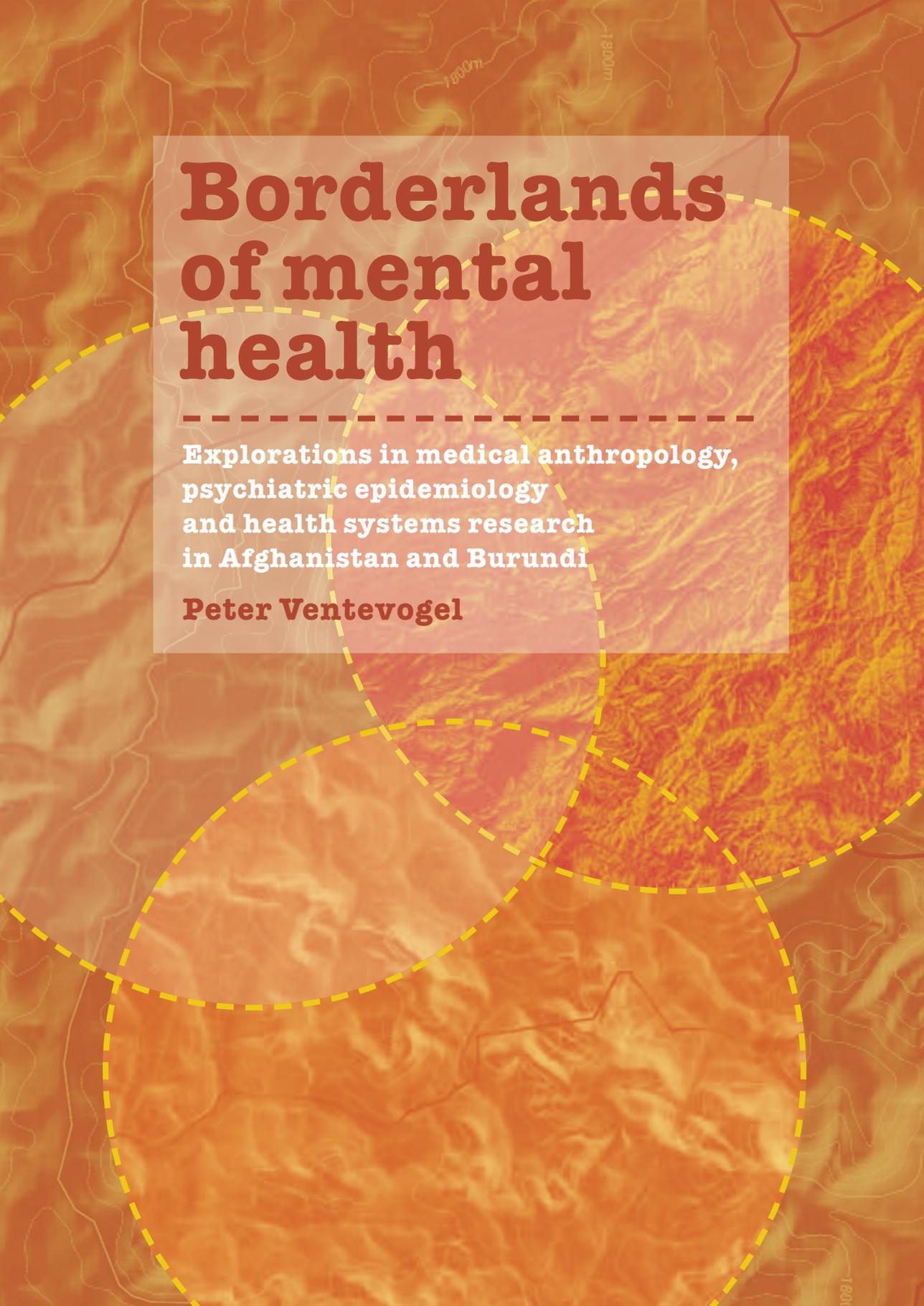
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# **Borderlands of mental health**

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**Explorations in medical anthropology,  
psychiatric epidemiology  
and health systems research  
in Afghanistan and Burundi**

**Peter Ventevogel**

## **About this book**

Many areas of the globe today face continuous armed conflict, with more and more populations caught in the crossfire. This has been true in both Afghanistan and Burundi where populations have to cope with the psychological and social effects of ongoing collective violence. While living and working in these countries, the author conducted research on the impact of these complex humanitarian emergencies on mental health and psychosocial wellbeing, and on ways to mitigate these impacts. His findings as published in this PhD thesis are based on the following questions:

- 1** How do people living in complex humanitarian emergencies conceptualise problems of mental health and wellbeing, and seek help for these issues?
- 2** How can mental health problems within complex humanitarian emergencies be adequately measured?
- 3** How can functional systems able to address mental health and psychosocial problems within complex humanitarian emergencies be developed?

Answering these central questions requires the use of a wide range of research techniques and draws from various academic disciplines, such as cultural anthropology, mental health epidemiology and health systems research. The twelve chapters of this book all delve into specific aspects related to these central questions. Taken together, this kaleidoscopic range of topics and perspectives provide the reader with invaluable insights into the emerging field of global mental health within complex humanitarian emergencies.

A grayscale topographic map showing contour lines of varying elevations. The map features several peaks and valleys. A prominent contour line is labeled '1800m' in multiple locations. In the lower-left quadrant, a higher elevation is marked '2000m'. A white line, possibly a road or path, winds across the upper portion of the map. The text 'Borderlands of mental health' is centered on the map in a white, sans-serif font.

**Borderlands of mental health**



1800m

1800m

1800m

1820m

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2000m

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1800m

Borderlands of mental health:

Explorations in medical anthropology, psychiatric epidemiology and health systems  
research in Afghanistan and Burundi

ACADEMISCH PROEFSCHRIFT

ter verkrijging van de graad van doctor

aan de Universiteit van Amsterdam

op gezag van de Rector Magnificus

Prof. dr. ir. K.I.J. Maex

ten overstaan van een door het College voor Promoties ingestelde commissie,

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Faculteit der Maatschappij- en Gedragwetenschappen

# Borderlands of mental health

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psychiatric epidemiology  
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**Peter Ventevogel**

## Colofon

*Borderlands of mental health – Explorations in medical anthropology, psychiatric epidemiology and health systems research in Afghanistan and Burundi*

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## List of acronyms

AIHRC	Afghan Independent Human Rights Commission
ASCL	Afghan Symptom Checklist
AUC	Area Under the Curve
BHC	Basic Health Centre
BPHS	Basic Package of Health Services (Afghanistan)
CDC	Centers for Disease Control
CDF	Centre du Développement Familial (Burundi)
CHC	Comprehensive Health Centre
CHW	Community Health Worker
CI	Confidence Interval
CIDI	Composite International Diagnostic Interview
CMD	Common Mental Disorder
CPDS	Child Psychosocial Distress Screener
CPSS	Child PTSD Symptom Scale
DAC	Development Assistance Committee
DRC	Democratic Republic of Congo
DSM-IV	Diagnostic and Statistical Manual, 4 <sup>th</sup> edition
DSM-5	Diagnostic and Statistical Manual, 5 <sup>th</sup> edition
DSRS	Depression Self-Rating Scale
EC	European Commission
EPHS	Essential Package of Hospital Services (Afghanistan)
FG	Focus Group
FGD	Focus Group Discussion
HMIS	Health Management and Information System
HSCL-25	Hopkins Symptom Checklist, 25 item version
HSS	Health Systems Strengthening
HTQ	Harvard Trauma Questionnaire
IAM	International Assistance Mission
IASC	Inter-agency Standing Committee
ICD-10	International Classification of Diseases (10 <sup>th</sup> Edition)
K-SADS-PL	Schedule for Affective Disorders and Schizophrenia for School-Age Children, Present and Lifetime version
KII	Key Informant Interview
LMIC	Low and Middle Income Country
mhGAP	Mental Health Gap Action Programme
MHPSS	Mental Health and Psychosocial Support
MNS	Mental, Neurological and Substance Use
MOPH	Ministry of Public Health
MOWA	Ministry of Women's Affairs (Afghanistan)
MSF	Médecins sans Frontières
NGO	Nongovernmental Organization
OECD	Organisation for Economic Co-operation and Development
OR	Odds Ratio

<b>PAS</b>	Psychiatric Assessment Schedule
<b>PHC</b>	Primary Health Care
<b>PBF</b>	Performance Based Financing
<b>PSE</b>	Present State Examination
<b>PTSD</b>	Posttraumatic Stress Disorder
<b>RCT</b>	Randomised Controlled Trial
<b>ROC</b>	Receiver Operating Characteristic
<b>SCARED-41</b>	Screen for Child Anxiety Related Emotional Disorders, 41 items version
<b>SCID</b>	Structured Clinical Interview for DSM Disorders
<b>SDG</b>	Sustainable Development Goals
<b>SMD</b>	Severe Mental Disorders
<b>SRQ-20</b>	Self-Reporting Questionnaire, 20 item version
<b>TPO</b>	Transcultural Psychosocial Organisation
<b>UK</b>	United Kingdom
<b>UN</b>	United Nations
<b>UNHCR</b>	United Nations High Commissioner for Refugees
<b>UNICEF</b>	United Nations Children's Fund
<b>USA</b>	United States of America
<b>USAID</b>	United States Agency for International Development
<b>USD</b>	United States Dollar
<b>UXO</b>	Unexploded Ordnance
<b>WHO</b>	World Health Organization
<b>WMHS</b>	World Mental Health Surveys

# Preface

This thesis represents a culmination of what has been both a personal and a professional journey, intricately intertwined. Further, my professional journey has run parallel to the history of the development of the field of mental health and psychosocial support within complex humanitarian emergencies over the past 12 years.

The research described in this thesis did not have one over-arching research agenda or a predefined narrow focus. Rather, it was a journey into the unknown that challenged many of my pre-conceived convictions: about the epistemology of psychiatric classification, about the utility of epidemiological research, and about the kind of assistance that should be provided to improve the mental health of people in war affected areas. The further I travelled on the road towards completing this thesis, the less sure I became of many of those pre-conceived convictions. One conviction did remain however, and if anything, the extensive explorations *have* strengthened my absolute conviction of the urgency to alleviate the mental suffering of people within complex humanitarian emergencies.

## **Diverging and converging identities**

I am both a psychiatrist, a *medical doctor* specialised in the identification and management of mental disorders, and a medical anthropologist, a *social scientist* trained in exploring multiple perspectives and providing space for alternative discourse. It has not always been easy to reconcile these two distinct professional identities, and I have felt torn on a regular basis between my interest in the perspectives of the direct stakeholders, attempting to understand what was really ‘at stake’ for them, and my professional urge to ‘get things done’ and provide people with essential psychiatric services without delay. As such, over the years in the search to resolve this dichotomy, I became increasingly involved in the development of policies, guidelines and training materials around public mental health in low resource settings. So now, as well as being a clinician and an anthropologist, I have developed, albeit hesitantly, a third professional identity, that of *policy maker*.

The chapters in this thesis reflect the tension inherent between these multiple professional identities. They also bear witness to my quest for coherent and comprehensive ways to conceptualise mental health and to set up contextually relevant mental health care within complex humanitarian emergencies. Because interwoven into these pages is what continues to drive me personally, an indignation stemming from the ongoing neglect and abuse of people suffering from mental disorders worldwide and particularly in contexts of collective violence and complex humanitarian emergencies.

Most of the case material is drawn from research conducted in Afghanistan and Bur-

undi, two countries that I grew to know and to continue to feel emotionally connected and bonded to.

### **In Afghanistan (2002-2005)**

It never was my intention to go to Afghanistan, but when Willem van de Put, director of HealthNet International, offered me a six months assignment in 2002, I did not hesitate for long. I was not sure I would like Afghanistan, the country that had just shaken off the yoke of the Taliban and that prompted images of poverty, eternal dust and drought, and radicalism. How different the real country was for me. I did not just like it. I loved it, with its rugged mountains, harsh climate and its hospitable, proud people with their profound sense of history.

The country has given me lot, professionally as well as personally. I stayed in Jalalabad for three years and travelled extensively throughout the country, both for work and, sometimes, for pleasure.

HealthNet International had recruited me to set up a project that aimed to introduce a mental health component into the existing primary health care system in Nangarhar province. This followed a needs assessment by psychiatrist Frank Kortmann (Kortmann, 2002), who maintained a mentoring role over the following years. The first Afghan I worked with was Hafizullah Faiz, a medical doctor, freshly graduated from the Nangarhar medical faculty. Initially he was my interpreter, but it soon became clear he was more than merely a translator and became my colleague and close collaborator. Later, he took up the role of team leader in the newly established mental health team.

Sadly, the time available to conduct research was limited in Afghanistan, but there were a few opportunities. Most notably the work around psychiatric epidemiology that is described in this thesis, and for which I worked with Pim Scholte from the University of Amsterdam.

### **In Burundi (2005-2008)**

In 2005 HealthNet International merged with the Transcultural Psychosocial Organisation, founded by Joop de Jong and became HealthNet TPO. I had known Joop since I was a medical student. In 1993, he was appointed professor at the VU University, where I studied medicine. I was the first to do an internship of six weeks in the mental health centre for migrants where Joop worked part-time. Since then, we have never lost contact with each other and it was a logical step that I would one day work with him and his organisation. In 2005, Joop needed a new mental health advisor for the programme that had been running in Burundi for four years. For me, it was time to move on. Burundi, the small mysterious country in the heart of Africa was quite a change from the Afghan rock deserts. It is lush, full of evergreen trees, tenderly sloping hills with swirling roads between the fields of maize, beans and plantain, and stunning vistas of Lake Tanganyika. It looked perfectly peaceful, but if you looked just a bit further you could easily find the *lieux de memoires*, the places where unimaginable atrocities had happened in the recent civil war.

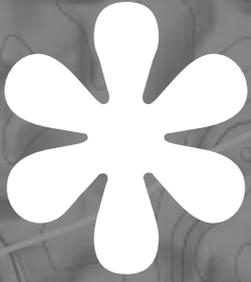
The main goal of my stay of almost three years was to assist the programme in making a transition from direct service delivery to integration in existing services. I worked closely with Norbert Munyentwari and other colleagues. In Burundi, I also became involved in the research work of Joop de Jong, Ivan Komproe, Mark Jordans, and Wietse Tol, who were setting up a multi country psychosocial programme for children in conflict affected areas. When my post became that of regional mental health advisor, I was able to travel to the other countries in the region where Health-Net TPO had programmes, such as the Democratic Republic of Congo, South Sudan, and Rwanda.

Afghanistan and Burundi could not be more different, culturally, linguistically, geographically and economically. However, there were striking similarities too. In both countries I have seen the tremendous suffering of people in the aftermath of war and upheaval. Yet, I have also seen the tenacity of the people of both Afghanistan and Burundi to go on, despite the misery and despite the lack of potential for structural change. Both countries taught me the shortcomings of a narrow biomedical perspective on mental wellbeing and the need for interventionists to be modest and patient.

Ultimately, this thesis can be seen to be the result of a professional and personal journey into the world of mental health and psychosocial support within the conflict affected settings in which I have had the privilege to work and live. It is an honour to share this journey with you.

*Peter Ventevogel*

*Geneva, April 25th 2016*





# Chapter one

## Introduction

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INTRODUCTION

Global mental health can be defined as the ‘area of study, research and practice that places a priority on improving mental health and achieving equity in mental health for all people worldwide’ (Patel & Prince, 2010, p. 1976).

## **Global mental health: development of a new field**

This thesis is developed in tandem with the emergence of the field of ‘global mental health’, albeit focused within a specific niche in that field: mental health within complex humanitarian emergencies and their aftermath. The term ‘global mental health’ is rather new and became widely used in the last decade (Whitley, 2015). It is a subsidiary of ‘global health’, a field that used to be called ‘international health’ or ‘tropical medicine’ (Koplan et al., 2009). The focus on equity fosters a strong policy orientation that aims to facilitate concrete changes in people’s lives by improving access to mental health care and by reducing inequalities in mental health outcomes (Patel, 2012). Importantly, global mental health is not limited to the mental health of people in low income countries, but also takes the interdependence of health among populations in both high and low incomes countries into account. Consequently, global mental health explores how ‘global networks of influence and exchange’, and structural factors related to globalisation contribute to health inequities (Kirmayer & Pedersen, 2014). It is, therefore, a multidisciplinary field that integrates insights traditional medical sciences with those from social sciences, including medical anthropology.

Global mental health has both similarities and differences to ‘transcultural psychiatry’ or ‘cultural psychiatry’, which are terms to denote the branch of psychiatry studying the influence of cultural factors on mental health. Cultural psychiatry, however, has quite a different lineage from ‘global mental health’, and tends to focus on localised phenomena, keeping a critical distance from ‘mainstream psychiatry’ (de Jong, 2014). The origins of cultural psychiatry can be traced to the colonial psychiatry of more than a century ago, when the German psychiatrist Kraepelin, based on research in the Buitenzorg mental hospital on the island of Java, published his observations on ‘comparative psychiatry’ (Kraepelin, 2000 [1904]).<sup>1</sup>

### **Improving mental health for all people worldwide**

While the term ‘global mental health’ may be relatively new, its aim to improve mental health for all people globally is not new. Forty years ago the World Health Organization (WHO) made a series of recommendations to make mental health services available for people in developing countries, which included the decentralisation of centralised, asylum based psychiatric services, the integration of mental health services into the general health care system, and linking these to social support systems not directly concerned with health matters (World Health Organization, 1975). In many countries this remained an unimplemented aim, but there have been signifi-

cant efforts over the past decades to implement these recommendations (de Jong, 1987; Sartorius & Harding, 1983; Schulsinger & Jablensky, 1991). Despite positive results in well selected study areas, with strong leaders, national recognition and external support, the work was not so easy to generalise. For example, when external support ceased (such as when international NGOs would withdraw after the initial crises has passed), the newly developed community care models that seemed so promising, often withered away, an experience reported in many countries over the years (Sartorius, 2014). Until now, the delivery of basic mental health services in low income country settings still ‘lags unacceptably and unjustly far behind that of other services’ (Raviola et al., 2011). This lack of service provision is, unsurprisingly, connected with a lack of global attention for mental health in policy making (Lund et al., 2013; Mackenzie, 2014; Saxena, van Ommeren, et al., 2006; Shatkin & Belfer, 2004), budget allocation (Chisholm & Knapp, 2011; Dixon et al., 2006; Gilbert, 2015; Saxena et al., 2003), human resources development (Baingana, 2011; Kakuma et al., 2011; Morris et al., 2013; Ndeti & Gatonga, 2014; Srinivasa Murthy, 2011b; World Health Organization, 2011b), and/or research prioritisation (Baingana et al., 2015; Mari et al., 2010; Patel, 2007; Saxena, Paraje, et al., 2006; Sumathipala, 2015; Yasamy et al., 2011). Nevertheless, the field of global mental health has taken major steps forward in recent years, thanks to various interrelated developments.

### **Burden of mental disorders**

First, the insight that mental disorders are widespread and cause a high burden was finally widely accepted relatively recently, compared to other fields of health. In 2001, the World Health Report was dedicated to mental health care (World Health Organization, 2001). The WHO, since then, has reinvigorated its call to integrate mental health into primary health care, and was now able to back this up with impressive statistics: worldwide around 450 million people have mental disorders and their treatment needs are largely unmet (The WHO World Mental Health Survey Consortium, 2004).

Two important global studies, the *Global Burden of Disease Studies* and the *World Mental Health Surveys*, have been instrumental in documenting the importance of mental disorders in terms of prevalence and disability. The landmark Global Burden of Diseases studies (Murray & Lopez, 1996), using new measures, such as the DALY’s<sup>2</sup>, estimated the relative importance of disease conditions in a way that captures disease specific mortality as well as non fatal health outcomes, or disability. Neuropsychiatric conditions, (including dementia, epilepsy and other neurological disorders), accounted for 10.5% of the global burden of disease in 1990 (Murray & Lopez, 1997) and 10.4% in 2010 (Whiteford et al., 2015). The burden of mental, neurological and substance use (MNS) disorders increased significantly (41%) between 1990 and 2010, and currently accounts for one in every ten lost years of health globally (Patel et al.; Vos et al., 2012).

The percentage of mental and substance use disorders alone on the total burden of disease (expressed in DALYs) increased from 5.4% in 1990 to 7.4% in 2010 (Whiteford et al., 2013), which, according to some experts still is a serious underestimation.

For example, Vigo et al. (2016) made recalculations of the existing data and put the figure at 13.0%.

The World Mental Health Surveys, by the World Health Organization and Harvard University, provided data on prevalence and burden of mental disorders worldwide. Data were collected through population based epidemiological surveys, using a structured lay administered psychiatric interview, the Comprehensive International Diagnostic Interview (CIDI) (Kessler & Ustun, 2008) with data available from 122,000 respondents in representative population samples in 24 countries, of which 12 were low and middle income countries (Alonso et al., 2014; Kessler et al., 2013). The 12-month prevalence of mental disorders was almost as high in low income countries (14.8%) as in high income countries (16.7%) (Wang et al., 2011). Having a mental disorder seriously decreases someone's ability to earn an income both in high income countries (29% reduction) as well as in low income countries (31% reduction) (Levinson et al., 2013). Moreover, mental disorders reduce the proportion of people who marry and increase the proportion of people who divorce (Breslau, Miller, et al., 2013). When mental disorders have an onset early in life they negatively affect the educational level (Breslau, Lee, et al., 2013) and increase the risk of developing chronic, non communicable physical health conditions such as arthritis, asthma, headache and heart disease later in life (Scott et al., 2013). Mental disorders should now be considered the largest contributor to years lived with disability (Lozano, 2012). Such data has helped making mental health credible as a global health priority, also to those outside the traditional sectors of psychiatry and psychology (Patel et al., 2016; Patel, Flisher, et al., 2006; Prince, 2011).

### **Global mental health research has improved**

Second, and related to the first point, research into mental health in low income countries has increased considerably, both in quantity and in quality, leading to a relatively cohesive body of academic scholarship (Tomlinson & Lund, 2012). Within that, there was a watershed moment in the 2007 publication by one of the foremost medical journals, *The Lancet*, of a series on global mental health consisting of commissioned papers by leading experts. This not only summarised the state of the art, but also positioned global mental health as a mainstream branch of the burgeoning field of global health. The series contained a strong advocacy purpose, with the aim of bringing global mental health into the spotlight, as exemplified by the title of the opening paper 'No health without mental health' (Prince et al., 2007). The papers in the *Lancet* series explicitly called for increased efforts in research, policy development and advocacy (Patel, Araya, et al., 2007; Saraceno et al., 2007; Saxena et al., 2007). In 2011, the *Lancet* published a follow up series, reinforcing these messages (Eaton et al., 2011; Kakuma et al., 2011; Kieling et al., 2011; Patel, Boyce, et al., 2011; Tol, Barbui, et al., 2011).

In 2009, *PLoS Medicine*, another major medical journal, published a series on 'Packages of care on global mental health conditions' (Benegal et al., 2009; Mari et al., 2009; Mbuba & Newton, 2009; Patel & Thornicroft, 2009). This series had a sub-text that there is, by now, sufficient evidence to scale up the implementation of con-

textually relevant mental health care in low and middle income countries, and that the world cannot afford to wait any longer. PLoS Medicine subsequently published other series on global mental health practice (Patel, Jenkins, et al., 2012) and on the integration of mental health into other health care platforms (Patel, Belkin, et al., 2013). Moreover, major advocacy papers were published in various other prestigious scientific journals (Becker & Kleinman, 2013; Collins et al., 2011; Patel & Prince, 2010). The strong partnerships between researchers, policy developers and practitioners, that characterises the development of global mental health, continues to be fruitful, at least as measured by the number of publications. For example, in the years between 1990 and 2010, books on mental health in low and middle income countries were relatively rare (e.g. Cohen et al., 2002; de Jong, 2002b; Desjarlais et al., 1995; Miller & Rasco, 2004), while in the last few years we have been almost flooded by voluminous tomes on a variety of aspects concerning global mental health (Akyeampong et al., 2015; Allden & Murakami, 2015; Kirmayer et al., 2015; Kohrt & Mendenhall, 2015; Okpaku, 2014; Patel, Minas, et al., 2013; Sorel, 2012; Thornicroft & Patel, 2014b; Trivedi & Tripathi, 2015; Winter et al., 2016). Also, now on a regular basis, mainstream psychiatric journals dedicate special issues to the myriad aspects of global mental health (Becker & Kleinman, 2012; Joshi, 2015; Lund et al., 2016) and various niche journals for global mental health have been established, such as the ‘International Journal of Mental Health Systems’, ‘Intervention: Journal for Mental Health and Psychosocial Support in Conflict Affected Areas’ and ‘Global Mental Health’. We can safely say that global mental health research has not only made a tremendous leap forward as an academic field, but has been firmly established.

### **Policy initiatives**

A third major development in global mental health was the launch of coordinated policy initiatives. Of particular importance is the ‘mental health Gap Action Programme’ (mhGAP) of the World Health Organization (2008) and its major tool, the ‘mhGAP Intervention Guide for management of Mental, Neurological and Substance Use Disorders in Non-specialized Health Settings’ (World Health Organization, 2010). The mhGAP Intervention Guide is rooted in an unprecedented review of existing evidence on mental health interventions with attention for their applicability in low resources settings and ‘non western’ contexts (Barbui et al., 2010; Dua et al., 2011; Tol, Barbui, et al., 2013). The mhGAP has many similarities with earlier initiatives of the World Health Organization to promote mental health. One of the weaknesses of the precursors of mhGAP was that good intentions were not accompanied by detailed, budgeted and concrete actions to which decision makers had committed.

The launch of the mhGAP as a technical set of interventions was followed by a major diplomatic initiative that eventually led to the adoption of the ‘Global Mental Health Action Plan 2013-2020’ by the World Health Assembly (World Health Organization, 2013b), which was hailed as a major breakthrough (Saxena, Funk, et al., 2013). Related to this are many attempts to explicitly link mental health to larger development goals (De Silva & Roland, 2014). Recently, in the run-up to the formula-

tion of the new Sustainable Development Goals (SDG) for the Post 2015 agenda, one of the key arguments that prominently figures in pleas for inclusion of mental health in SDG is that the integration of mental health into existing development programmes to promote social and economic development will prevent the development of or exacerbation of mental health problems (De Silva, 2015; Eaton et al., 2014; Gureje & Thornicroft, 2015; Thornicroft & Patel, 2014a; Tsai & Tomlinson, 2015). Such initiatives are starting to gain traction: In April 2016, the World Bank, an organisation that till recently largely overlooked mental health, co hosted a high level international meeting on global mental health, focusing on scaling up service provision for depression and anxiety in primary care and community settings (Chisholm, Sweeney, et al., 2016). The interest from economic actors, such as the World Bank, is prompted by alarming data on the huge economic cost of mental disorders for local communities and to societies as a whole. This is largely due to lost opportunities for production and consumption on the one hand, and increased expenditure on medical and social care on the other. For example, in 2010, worldwide, a staggering 2.5-8.5 trillion US dollars lost in output could be attributed to mental, neurological and substance use disorders, with this amount expected to have doubled by 2030 if no global action is taken (Bloom et al., 2011).

### **Suffering of people with mental disorders**

All these developments may lead to the concrete development that in the next decades, mental health will finally take the place within the ranks of global health it deserves. The arguments are convincing. However, what is not yet mentioned is my driving force, and that for many others: an indignation about the ongoing neglect and abuse of people suffering from mental disorders worldwide (Drew et al., 2011; Patel, Kleinman, et al., 2012; Patel, Saraceno, et al., 2006). Worldwide, also in low and middle income countries, people with serious mental health problems risk to be abandoned by their family, rejected by their communities, become destitute or end up chained in hospitals, prisons, or in private homes (De-Graft Aitkins, 2015; Dudley et al., 2012; Mall et al., 2016; Read et al., 2009).

This 'failure of humanity' (Kleinman, 2009) is perhaps nowhere as painful as within contexts of collective violence and complex emergencies, where people with severe mental illnesses suffer tremendously and services and support are seriously affected (Human Rights Watch, 2015; Jones, 2011; Jones, forthcoming; Jones et al., 2009; Silove et al., 2000).

## **Mental health in complex humanitarian emergencies**

### **Why the term complex humanitarian emergencies?**

Within the general field of 'global mental health', this thesis is situated within a specific niche characterised by the settings from which my data is drawn: low income settings affected by long periods of armed conflict, and compounded by ecological

and sociopolitical fragility. There are various terms to describe such settings, such as ‘fragile states’, ‘post conflict settings’ and ‘complex humanitarian emergencies’, which need to be understood and explored to give context to the discussion.

The term ‘fragile states’ is used for countries whose government lacks the capacity and/or the will, to manage public resources and to deliver core state functions, such as security, protection of property, basic public services and essential infrastructure, for the majority of its people (Leader & Colenso, 2005). This is the definition used by the Development Assistance Committee of the Organisation for Economic Co-operation and Development (OECD). The list of fragile states contains 51 countries (Organisation for Economic Co-operation and Development, 2015). Afghanistan and Burundi figure among them, together with countries such as Bangladesh, Madagascar and Malawi that are very poor and have dysfunctional government systems, but do not have a recent history of collective violence and mass displacements. While both Afghanistan and Burundi are defined as fragile states, the term fragile state is not specific enough for the purpose of this thesis.

The term ‘post conflict settings’ is used for countries ‘where active conflict ceases and where there is a political transformation process towards a recognised and functional post conflict government’ (Canavan et al., 2008, p. 2). However, often the transition to post conflict situations of peace and development is not linear: some countries experience continuous low grade armed violence, and are at great risk of returning to conditions of full conflict (Collier, 2008). In these cases, episodes of collective violence are usually embedded into a complex web of historical antecedents, political dynamics, availability of natural resources, population pressure, ethnic fragmentation and erosion of trust in the state, and as long as these constellations of predisposing factors are not fundamentally addressed, tensions may build up to the eruption of new mass conflict (de Jong, 2010b; Sambanis, 2005). Both Afghanistan and Burundi are examples where the peace in the ‘post conflict period’ has proved to be very fragile indeed.

Therefore the term ‘complex humanitarian emergencies’ is my preference, because it integrates the notion of fragility of governance with the social and economic effects of disaster and armed conflict. Based on definitions from the literature (Goodhand, 1999; Leaning et al., 1999; Zwi & Ugalde, 1991), I define complex humanitarian emergencies as situations characterised by: 1) complex political antecedents, often relating to competition for power and resources; 2) a protracted emergency situation with massive population displacement and destruction of social networks and ecosystems; 3) insecurity, often based on armed conflict, affecting civilians and others not engaged in fighting; and 4) the emergence of ‘predatory social formations’ with high levels of social insecurity threatening the ability of the population to sustain livelihood and life. Also, naming a situation an ‘emergency’ implies, as per definition, that the response capacity of the affected community and state is overwhelmed and that disruption and disintegration of the social fabric prohibits affected populations to function normally, maintaining and aggravating a dysfunctional political system (Gunn, 2003; Perez-Sales, 2004).

Traditionally, emergencies are categorised as either ‘natural’ (such as earthquakes or floods) or ‘man-made’ (such as technological disasters, environmental

disasters, terrorist acts, armed conflicts or refugee crises). However, this historical dichotomy is losing its utility as the distinctions become blurred. The impact of ‘natural’ disasters is often compounded when occurring in already fragile ecological or political contexts, while armed conflicts and massive displacements are, in turn, fuelled by ecological factors such as population pressure, and struggles for control over scarce natural resources, such as fertile land and water (cf de Jong, 2010b). For all of these reasons, the term ‘complex humanitarian emergency’ is more appropriate within the context of this thesis.

### **From ‘relief, rehabilitation and development’ to consensus frameworks**

The conventional classification for the sequence of humanitarian assistance levels to emergencies uses three phases: relief, rehabilitation and development. Activities in the relief phase attempt to provide essential services to those whose survival is threatened. This phase is followed by rehabilitation, in which basic services such as schools, health care, and water supply are supposed to be restored, and damaged infrastructure is to be rebuilt. Finally, the concept is that assistance in a subsequent phase can then focus on broader development goals, such as economic growth, improving living standards and creation of wealth and social capital (Ryscavage, 2003). While this relief – rehabilitation – development continuum is meant to organise the emergency response in a logical way, it has fundamental flaws when applied to complex humanitarian emergencies because these often do not follow a linear pattern from emergency and crisis to peace and stability, but rather a cyclical pattern often accompanied by cycles of collective violence or destruction, and requiring the need to begin again. It is important, therefore, to avoid a rigid application of a linear relief – rehabilitation – development continuum, and instead explicitly attempt to address structural needs in emergency or recovery situations by designing short-term interventions within a long-term perspective. In practice, the implication is to use participatory approaches in which emergency-affected people are actively involved in building long-term self-sustaining institutions (Mosel & Levine, 2014).

Consensus frameworks to guide humanitarian responses after disasters, while emphasising community based approaches and intersectoral collaboration (IASC, 2007; The Sphere Project, 2011) limit their scope to the most essential responses occurring in the midst of an emergency, i.e. the relief phase (van Ommeren & Wessells, 2008). The idea was that within one to two years after an emergency, rehabilitation will be well under way, with essential services restored. However, as described above, complex humanitarian emergencies require a different approach, with thorough and sustained attention to capacity building of national staff and public institutions (Salama et al., 2004; Spiegel et al., 2010). Another major problem in complex humanitarian emergencies is that, due to the absence of regulatory bodies, a magnitude of NGOs may emerge that provide often poorly coordinated services (Fritsche, 2001). NGOs, acting in parallel with what remains of the state systems and failing to support local capacity, increase the risk of little being left behind when humanitarian agencies withdraw (Farmer, 2011; Toole et al., 2006). Moreover, there is an inherent risk that such newly established services drain health workers from the existing

health care system and undermine, instead of strengthen, the public sector and perpetuate the problem of weak governance (Ganesan, 2011; Wickramage, 2006). Moreover, a divide between NGOs (working from a idealistic human rights or humanitarian perspective) and the government (with a bureaucratic ‘civil service’ way of working), may result in reticence to cooperate or to integrate NGO services into the local government systems (de Jong, 2014).<sup>3</sup>

### **Discussion: the arrival of ‘Mental Health and Psychosocial Support’**

Attention to mental health in complex humanitarian emergencies is relatively new, and dates from the 1980s. The field has been characterised by fierce, and often polarised, debates about what kind of mental health care and psychosocial support needs to be organised (Ager et al., 2006; Galappatti, 2003; van Ommeren et al., 2006; Williamson & Robinson, 2006). Major points of controversy have been: 1) the importance of individual approaches versus approaches to foster community cohesion; 2) the influence of traumatic events versus current contextual stressors in the development of psychopathology and; 3) the contribution of medical approaches versus social approaches (Betancourt & Williams, 2008; Budosan & Aziz, 2009; de Jong, 2005; de Vries 1998; McKay & Wessells, 2004; Pupavac, 2004, 2005; Summerfield, 1999; van Ommeren et al., 2006; van Ommeren et al., 2005b).

These widely diverging views among mental health and psychosocial practitioners working in complex humanitarian emergencies contributed heavily to poor coordination, resulting in fragmented services and a lack of comprehensive support. A breakthrough in the hitherto strongly divided field, was the publication of the ‘IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings’ (IASC, 2007). The IASC stands for the Inter-Agency Standing Committee, a high level body established by the United Nations General Assembly to improve humanitarian assistance in emergencies and consensus of all major actors. The fact that so many organisations and groups, all with competing interests and contrasting views, were able to agree on a common framework was a significant political achievement (Ager, 2008; Wessells & van Ommeren, 2008). The guidelines have proved to be a major step towards coordination of practice around MHPSS (Horn & Strang, 2008a, 2008b; IASC Reference Group for Mental Health and Psychosocial Support, 2015; Ventevogel, 2008).<sup>4</sup>

In an attempt to halt the unproductive bickering around the ‘right approach’, that was paralysing concerted action in the field, the guidelines introduced the composite term ‘Mental Health and Psychosocial Support’ (MHPSS) to indicate ‘any type of local or outside support that aims to protect or promote psychosocial wellbeing and/or prevent or treat mental disorder’ (IASC, 2007, p. 1). What is important is that included in this broad definition is that MHPSS may include support interventions in the health sector, as well as in other sectors such as education or social development (van Ommeren & Wessells, 2007).<sup>5</sup> The guidelines also state that good MHPSS services and supports are, per definition, multi layered and do not merely consist of interventions by specialists, but also include interventions by non specialists, as well as by families and communities themselves. As such, MHPSS interventions are not only



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focused on person to person support, but also include capacity building of people within affected communities in order to support them to ‘help themselves’ (Ager et al., 2005; Eisenbruch et al., 2004; Wessells, 2009; Wessells, 2012). Therefore, one important component in mental health programmes in complex humanitarian emergencies is training of general health workers and community volunteers (Baron, 2002; Boniface et al., 2009; Budosan, 2011; Jones et al., 2007; O’Hanlon & Budosan, 2015; Quosh, 2011; Rose et al., 2011; Salem-Pickartz, 2007; van de Put & van der Veer, 2005; Weissbecker & Jones, 2014). There is also a strong consensus that mental health services should, to the extent possible, be integrated within existing health services (Epping-Jordan et al., 2015; van Ommeren et al., 2015; van Ommeren et al., 2005b; Ventevogel et al., 2015; Weiss et al., 2003). To support this, the World Health Organisation and the United Nations High Commissioner for Refugees (UNHCR) have recently launched an new version of the ‘mhGAP Intervention Guide’, focused specifically on integrating clinical mental health care within general health care settings in humanitarian emergencies (Clark, 2015; World Health Organization & United Nations High Commissioner for Refugees, 2015).

Even though there is now a nominal consensus among humanitarian agencies about what should be done, and perhaps more importantly what not, there still is no solid evidence base to guide MHPSS interventions within complex humanitarian emergencies, consequently too often intervention strategies are employed where effectiveness is not clear (Ager et al., 2014; Blanchet et al., 2015; Jordans, Pigott & Tol, 2016; Jordans, Tol, et al., 2009; Mollica et al., 2004; Pedersen et al., 2015; Tol, Barbui, et al., 2011; Tol, Patel, et al., 2011; Wessells & van Ommeren, 2008). One of the areas where limited information is available is how interventions for mental health and psychosocial support within complex humanitarian emergencies may contribute to lasting mental health reforms in the post conflict phases. The information on this subject is still rather anecdotal and based on case studies (El Chammay & Ammar, 2014; Pérez-Sales et al., 2011; Ventevogel, DeMarinis, et al., 2013; World Health Organization, 2013a). Within the context of complex emergencies, the need for unconventional approaches and new leadership may arise. This can call into question the status quo of ‘how things were always done’, and may lead to rethinking and redefining of public service delivery. The influx of local and foreign qualified professionals, and the provision of aid funds, can provide additional factors, which can create essential opportunities for change, especially if opportunities are seized at the right moment. This requires the use of long term perspectives that go far beyond immediate services delivery, and aim to restore and restructure the systems that provide these services (de Jong, 2002a).

## **Settings**

The research presented in his thesis focuses on Afghanistan and Burundi, two conflict-ridden countries that are very different in terms of geography, climate, economy, cultural heritage, religious affiliations and socio-political history. But they have important similarities as well. For example, both score high on the instrument that for-

mer World Bank economist Collier developed in his ground breaking analysis of why some countries remain poor and others not (Collier, 2008). Countries have a high risk to remain poor and unstable when two or more of the following factors are present in a country: 1) a history of armed struggle; 2) being rich in natural resources, leading to conflict about these resources among the ruling elites; 3) being landlocked with poor neighbours, 4) being a small country with bad governance. Afghanistan and Burundi score high, with three out of four factors present, giving them poor prospects of a turn to prosperity any time soon. Both countries are caught in what Collier calls ‘the poverty trap’.

## Afghanistan

### Afghanistan: a history of violence

Afghanistan is the size of France, with approximately 30 million inhabitants. It is strategically situated between the Middle East, the Indian subcontinent and the central Asian plains and has been a battleground for regional and global powers throughout its history (Tanner, 2009). The seeds for the modern Afghan state were planted in 1747, when Ahmad Shah Durrani united the Pashtun tribes and became the first king of the Durrani dynasty, replaced in the 19<sup>th</sup> century by the Barakzai dynasty. Afghan rulers have always had great difficulty exerting central control on various parts of the country. To the enduring pride of many Afghans, the country has never been colonised despite three wars with British Indian colonial forces. In the late 19<sup>th</sup> century, a peace agreement between Afghanistan and (the then) British India, established the eastern borders of the country, dividing the Pashtun tribes between Afghanistan and what later was to become Pakistan (Dupree, 1973 [1980]). The monarchy has been relatively stable since then, with the exception of 1929, when the modernist king Amanullah was deposed by disgruntled tribal leaders from Nangarhar province. These tribal leaders revolted against him due to the imposition of what they regarded as non-Islamic and non-Afghan measures, including schools for girls and banning of the veil for women (Marsden, 2009). The monarchy ended in 1973 when king Zahir was deposed by Prime Minister Mohammed Daud, his own cousin, whose government in turn was overthrown in 1978 by the Afghan communist party. Since 1979, when the Soviet Union invaded the country to support the communist regime, Afghanistan has almost constantly been embedded in armed conflict. The secular politics of the Afghan government had made it increasingly unpopular with the majority of the rural population, and the invasion prompted widespread armed resistance, initially not religiously motivated, but quickly dominated by a strong Islamist ideology (Edwards, 2002; Marsden, 2009; Rubin, 2002 [1995]). With support from Pakistan, Saudi Arabia and the United States, various groups with religious nationalist ideology, referring to themselves as *mujahedeen* (literally: ‘the ones who wage *jihād*’) stepped up the military fight against the Soviet backed regime. After the Soviet withdrawal in 1989, the various *mujahedeen* groups, which had fortified ethno-religious divisions, fought a cruel war for the rule of Kabul. This

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led to the destruction of large parts of the city and an outpouring of refugees, mainly in the direction of Jalalabad in the east, where large refugee camps were established, and further into the tribal areas of Pakistan, near Peshawar. The country had lost central power and was mostly ruled by feuding and corrupted former *mujahedeen* (Rubin, 2002 [1995]). Within this climate, a new radical Islamic fundamentalist movement, the Taliban, or ‘the students’, emerged from the southern regions of Afghanistan. With considerable popular support from within their ethnic Pashtun communities, the Taliban quickly gained control over most parts of the country and in 1996 they proclaimed the Islamic Emirate of Afghanistan that governed most of country until December 2001 (Marsden, 2001). The Taliban ideology was rooted within a strain of purist Islam, but was, in practice, blended with traditionalist Pashtun customs. In 2001, (a few months after the 9/11 attacks), a military coalition led by the United States invaded the country helping the remaining *mujahedeen*, which were united in the Northern Alliance, to oust the Taliban and to establish a new, democratically elected government. Initially, the Taliban seemed to have almost disappeared, but since 2003 they slowly regained momentum and have come to the fore once again. They were aided by popular discontent over government institutions that are perceived as corrupted and ineffective, ongoing foreign military presence and continuing support for predatory local warlords (Laub, 2014). Since 2015 even more radical groups have pledged allegiance to the Islamic State in the Levant (ISIL), and various districts in Nangarhar fell under their control, some where I worked with HealthNet TPO and that form the setting for some of the research presented in this thesis (Gambhir, 2015).

### **Ethnicity and politics in Afghanistan**

Afghanistan is a multi ethnic country with as most numerous groups the Pashtun (around 40%) followed by Tajik (around 25%), Hazara (10%), Uzbek (8%), and others such as Turkmen and Pashai (Glatzer, 1998b; Simonsen, 2004). Dari, a form of Persian, functions as the lingua franca for most ethnic groups, and Pashto is the second language (Dupree, 1973 [1980]). While religion and Islamic values play a very important role in Afghanistan, it is also, and perhaps primarily, a tribal society (Dessart, 2001).

The various ethnic groups have their own traditions, which are particularly strong among the Pashtun, the vast majority of the population in Nangarhar province, where I lived and worked for three years. The Pashtun perception of Islam is deeply embedded in their social code of conduct, the *pashtunwali* that attributes great importance to social values such as *melmastia* (hospitality and sharing materials goods), *ghayrat* (self honour or dignity), *namus* (chastity, honour of women), *nang* (safeguarding the honour of the family and protecting the weak), shared decision making by elders through *jirgas* (councils), and, despite a clear social hierarchy also an ideal for equality among all Pashtun (*barabari*, equality and *musawat*, equality among brothers) (Abbas, 2014, pp. 17-19; Shams-ur-Rehman, 2015).

In most of Afghan history the term ‘Afghan’ was a label for Pashtun ethnicity. Only later, in the first part of the twentieth century, did it start to denote the national iden-

tity of a multi ethnic country (Green, 2015). This is significant because much of the recent history of the country can be read as oscillation between Pashtun tribal domination versus control of the central state. Afghanistan has seen a surge in ethnic consciousness over the last decades. The organisation of sociopolitical identities along ethnic lines has been fuelled by ongoing insecurity and the lack of central state institutions (Monsutti, 2013).

### **The effects of collective violence in Afghanistan**

Decades of war and violence have had a significant impact on the wellbeing of the Afghan population, and have led to many psychosocial and mental health problems (Cardozo et al., 2004; Cardozo et al., 2005). For example, the consequences of violence impact almost all domains of life: poverty, insecurity, strained family relations, limited educational opportunities for children, and poor health. The daily suffering of many Afghans often led to feelings of helplessness and powerlessness among many (Miller et al., 2008). Particularly the situation of women and girls remained precarious. While on paper there was a significant improvement in the rights of women, which were badly affected by the harsh measures of the Taliban to eradicate the role of women in public life, the situation on the ground did not necessarily improve after the fall of the Taliban. Many of the *mujahedeen* groups espoused fundamentalist interpretations of Islam that were hardly any more 'liberal' than those of the Taliban and while the refugee camps in Iran offered opportunities for a more female friendly society, the refugee camps in Pakistan strengthened a restrictive environment towards Afghan women (Mann, 2005). While the extended family is an important and often the sole source for survival, it also caused suffering due to violence and tensions. This will be described more in depth in chapter five of this thesis. But the protection of the family is not always there, even in Afghanistan: a sign of the deterioration of family bonds is the appearance of female *burqa* clad beggars in Kabul, which would have been unimaginable in pre-conflict Afghanistan (Dupree, 2004a, p. 186).

### **Reconstruction of health care in Afghanistan**

The health care system in Afghanistan had always been inefficient and badly organised, but at the fall of the Taliban it was totally deficient, and the health status of the people was dismal (Ahmad, 2001). In 2001, less than 10% of the Afghan population had access to health services, defined as living within one hour walking of a basic health facility (Newbrander et al., 2014). A national survey of health facilities in the county showed that 80% of service delivery was provided by NGOs, and that there were major gaps in critical services, as well as strong regional inequities in the distribution of those services (Ministry of Health, 2002).

The health care system in Afghanistan has ineffectively had hospitals stocked with large numbers of doctors in the major urban centres and a near total absence of formal health care in the rural areas (Strong et al., 2005). Since 2002, with massive foreign aid, the new government set out to restore basic services, including health care,

with a clear priority on primary health care services in rural areas (Loevinsohn & Sayed, 2008). By a decade later many health indicators had greatly improved and access to health services increased (Dalil et al., 2014). Eighty five percent of all Afghans now have access to some form of healthcare, compared to 9% in 2002 (International Crisis Group, 2011). The results of the focus on women's health care have been spectacular: 80% of facilities currently have female health staff. The number of midwives has dramatically increased through training of a new cadre, the community midwife, which has not only positively affected reproductive health, but also played role in women's empowerment (Currie et al., 2007; Speakman et al., 2014; Turkmani et al., 2013).

Two elements were critically important in the relatively successful scaling up of health services in Afghanistan. First, the decision more or less imposed to government by donors such as USAID and the World Bank, to contract NGOs to provide health care, with the role of the government restricted to policy making and control. Second, the development of well defined packages of minimum services for the various levels of the health care system: the Basic Package of Health Services (BPHS) and the Essential Package of Hospital Services (EPHS).

From the beginning, mental health was flagged by many as one of the priority health problems in the country (Ahmad, 2004; Sharp et al., 2002; van de Put, 2002). It is absolutely key that mental health was included in the basic package of health services. This was the result of effective lobbying by some key players in the field (mainly the WHO mental health advisor and NGO representatives) and the clear interest of the Ministry of Public Health (MOPH). Many senior officials declared that the mental health status of the Afghan people has suffered greatly due to decades of violence and upheaval. However, mental health was initially relegated to the 'second tier', which effectively meant that it would not be routinely financed. In practice, mental health care development was done by NGOs funded by donors with sympathy for mental health care. In the next version of the BPHS (2005) mental health was included in the minimum package and in the meantime, thanks to experiences of NGOs who had demonstrated that mental health could be integrated in primary care, mental health interventions could be more precisely described. The inclusion of mental health in the first tier of the BPHS has greatly helped to encourage donors to support mental health interventions in primary care. In fact, it has now become an obligation to do so. Chapters nine and twelve, discuss the (re) construction of mental health care in Afghanistan in more depth.

### **HealthNet TPO in Afghanistan**

HealthNet TPO, an international non-governmental organisation runs health care programmes in Afghanistan for more than two decades, initially under the name HealthNet International. The activities started in 1993, in the aftermath of the major population displacements to Jalalabad, capital of the eastern province of Nangarhar. The province has around 1.3 million people, mostly Pashtun. Over the years, HealthNet TPO has played a major role in supporting policy development and building implementation capacity of the Ministry of Public Health. Aspects of the mental health

programme have been described in various publications (van Mierlo, 2012; Ventevogel, Faiz, et al., 2011; Ventevogel & Kortmann, 2004; Ventevogel & Kortmann, 2006; Ventevogel, Sarwari, et al., 2013).

## Burundi

### History of collective violence in Burundi

The small central African country of Burundi is roughly the size of Belgium, and has around nine million inhabitants. Its history, culture and ethnic composition has many similarities with Rwanda, its northern neighbour. Burundi has had several major eruptions of collective violence in its history. In 1965, three years after independence, an attempted coup by Hutu officers was thwarted by Tutsi officers, which was quickly followed by the subsequent execution of hundreds of Hutus who held high positions in the army or politics (Lemarchand, 1996). Seven years later, in 1972, an estimated 200,000 people, comprised of mainly educated Hutus, were killed within a few months as revenge for a violent attack of armed Hutu rebel movements from Tanzania (Lemarchand, 2008; Meisler, 1990 [1976]).

This Burundian genocide of 1972 is not widely known outside the Great Lake Area, but has strongly influenced the history of the region as it became an emotional turning point, accelerating the formation of an 'ethnised' political consciousness, and the crystallization of the society along ethnic lines (Chrétien, 2008; Daley, 2008; Lemarchand, 2009). Moreover, it fostered fears of the presumed desire of the 'other' to dominate at any price. Despite attempts by the Tutsi dominated military governments in the 1970s and 1980s to suppress the memories of the 1972 massacres it 'dug deep rifts between the different ethnic groups in Burundi' (Bugbawari, 2014). In 1988, albeit on a smaller scale, a similar scenario occurred with Hutu led military killings of Tutsi, resulting in bloody repression. In 1993, for the first time in the history of the country, free elections were held. The newly elected Hutu president, Melchior Ndadaye, was assassinated by disgruntled officers of the Tutsi-dominated army after only a few months in office. Immediately after, violence erupted on a massive scale with Tutsi's killed by partisans of the assassinated president, followed by widespread revenge killings of Hutu peasants by the army (Ngakuru & Nkurunziza, 2005). Within weeks, 150,000 people lost their lives (Wolpe, 2011) and the country was immersed in a full-blown civil war, which lasted till 2002, and resulted in estimated 200,000 - 500,000 deaths with at least 1.2 million displaced persons (Floribert & Nkurunziza, 2000; Hatungimana, 2011; Lemarchand, 2009). Around half of the Burundian population has fled their homes at least once since the start of the civil war in 1993 (Uvin, 2009, p. 29). A lengthy negotiation process has led to a comprehensive Peace and Reconciliation Agreement in 2000, which aimed to institutionalise a democratic system of power sharing between Burundi's Hutu and Tutsi political parties. After a transitional period with a grand coalition government, a new president was elected through free elections in 2005 (Falch & Becker, 2007).

In the years after the signing of the peace agreements the political climate



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favoured de-escalation and compromise, and former rebels were integrated in high numbers into the army (Uvin, 2010). Burundi seemed to have become an example of successful transition towards a pluralistic peaceful society.

In the past few years, however, the ruling party has become increasingly authoritarian, and meaningful dialogue with the opposition has ended. In 2010, Nkurunziza was re-elected as president of Burundi in an election that was boycotted by all opposition candidates; they had complained of fraud in earlier communal elections. Political violence, albeit on a relatively small scale, restarted and has led to the regrouping of dissenting (Hutu) factions (Human Rights Watch, 2010; International Crisis Group, 2012). Political tensions and violence flared up after the re-election of Nkurunziza for a third term in 2015, that was considered anti-constitutional by the international community and many Burundians (Elgot, 2015). Mounting violence, and fear of more to come, prompted almost a quarter million Burundians to flee their country in 2015 (United Nations High Commissioner for Refugees, 2015). The current crisis in Burundi is essentially political, with opponents and supporters of the government among both Hutu and Tutsi, but there are concerns it could spark a new cycle of large scale ethnic violence.

### **Ethnicity and politics in Burundi**

In the mass media the history of collective violence in Burundi – and in neighbouring Rwanda – is often depicted as the continuation of ancient ethnic rivalry between the Tutsi minority and the Hutu majority. The reality is much more complex. The hierarchical order in Burundi goes well beyond a simple Hutu/Tutsi dichotomy, it also involves elements of social class and regional background, for example many Burundians, Hutu and Tutsi alike, mention, with pride their *colline natale* or the hill where they were born.

Moreover, in the years before independence, the affiliation to one of the princely *Ganwa* factions around the king that identified themselves neither as Tutsi nor as Hutu, was more important than one's ethnicity (Lemarchand, 1996; Wolpe, 2011). On the *collines* of the country, people were involved in intricate networks of clientelism between cattle owners (often Tutsi) and agriculturalists who did not possess cattle (often Hutu) (Botte et al., 1969). The history of the developments of Hutu and Tutsi ethnicity in the African interlacustrine area is politically highly charged (Chrétien, 2003, pp. 70-83; Lemarchand, 2009, pp. 49-68; Mamdani, 2001, pp. 41-103; Uvin, 1999), with some radical Hutu groups embracing the theory that the arrival of the Hutu, seen as a true Bantu people, predates by several centuries the arrival of Tutsi, depicted as Nilotic invaders from the north (Malkki, 1995, pp. 19-31, 56-65).<sup>6</sup> On the other side of the spectrum, some maintain that, in pre-colonial times, ethnic identities did not play a role at all and that the Hutu-Tutsi divide was entirely the product of colonialism (Lemarchand, 1996, p. 31; Ntahombaye & Nduwayo, 2007).<sup>7</sup> Regardless of how ethnic identities developed before colonisation, it is clear that Hutu and Tutsi identities in the interlacustrine area of Africa are not a 'given fact' but are malleable and situation-bound (Vansina, 1994, pp. 134-139; Waters, 1995).<sup>8</sup>

Differences between Hutu and Tutsi were 'rigidified' (cf Newbury, 1998) during

colonial times and after independence have been instrumentalised by those vying for power, particularly in times of crisis. Ironically, the fear of ethnic violence has inspired high levels of fear that, by themselves, catalysed ethnic violence and mass murder. As Uvin (1999, p. 263) observed: ‘people in both ethnic groups are deeply afraid of being attacked and attack first, in ‘defensive attack’, to avoid the fate they think is awaiting them.’ Such processes are not unique for Burundi and Rwanda, but have been described in depth for other ethno-political conflicts.<sup>9</sup>

However, ethnicity certainly does not explain everything. In Burundian politics, regional factors played a significant role as well, with the post independence governments from 1965 to 2000 dominated by the Hima, a Tutsi subgroup with traditionally a rather low standing, from the Southern Bururi province. The Hima dominance in politics led to economic funds being channelled to the south. Since 2005, when the current president of Burundi arrived with a powerbase in the northern and central provinces of Ngozi and Gitega, a similar process of regional dominance is going on.

### **The effects of collective violence in Burundi**

Conflict has had profound effects on all aspects of life in Burundi. Gross Domestic Product fell 30% and per capita income dropped from US\$ 214 (in the years before the crisis) to US\$ 83 in 2004 (Government of Burundi, 2006). The percentage of people living below the poverty line grew from approximately one third in 1990 to more than two thirds in 2004 (United Nations Development Programme, 2011). The adverse effect of the war on economic welfare seem to have had a disproportionate burden on people who were already poor before the war, with the consequence that further exposure to violence traps such households into chronic poverty (Mercier et al., 2015).

Life expectancy at birth fell from 51.8 in 1993 to 46.1 years of age in 2004 (Government of Burundi, 2006). Maternal mortality is currently around 800 deaths per 100,000 live births, infant mortality rate is 67 per 1000 live births and the under-five mortality rate is 104 per 1000 live births, which are among the world’s poorest figures (UNICEF, 2013). Moreover, people who were strongly affected by the conflict had higher risk of physical illness and poor mental health status (Mullen, 2008). For children, an association has been found between the amount and duration of exposure to conflict and a lower height for age (Bundervoet et al., 2009).

The massive displacements and huge death toll during the war tore apart families and heavily affected community life, with a general decline of mutual help and solidarity (Uvin, 2009). Return of refugees and other displaced populations to their former homes led to increased land disputes (van Leeuwen, 2010). Loss of human resources and the degrading of the educational system made the human resources indicators for health care staff in Burundi among the worst in the continent with three physicians and 13 qualified nurses per 100,000 people (International Monetary Fund, 2011). Most of the doctors were, moreover, settled in the capital, leaving entire provinces devoid of doctors. The violence and upheaval have affected the social fabric of society and have affected the traditional systems for dealing with conflicts and problems (Ingelaere & Kohlhagen, 2012).

## **HealthNet TPO in Burundi**

After 2002 the country was relatively stable and international donors invested significantly in the rebuilding of the countries institutions. Many NGOs settled in the country to assist with the reconstruction of all sectors, including health care and social development. One of these organisations was the Transcultural Psychosocial Organization (TPO). The organisation started in 2000, as a pilot project that grew out of an initiative by local Burundians who had heard about the TPO psychosocial programme in Uganda and went to Uganda and asked for help. The programme followed the model for comprehensive community based psychosocial programming as had been developed by TPO in other conflict affected settings (Baron, 2002; de Jong, 2002a; Somasundaram & Jamunanantha, 2002; van de Put & Eisenbruch, 2002). The programme will be described extensively in part three of this thesis (chapter ten).

There are a few further points that need to be mentioned already. First, in contrast to the programme in Afghanistan, this programme was initially a community based psychosocial programme, with some clinical psychiatric elements. Burundi had only a rudimentary mental health care system, comprised of basically one psychiatric hospital in the capital, led by a Catholic congregation (Stockman, 1994).

Second, apart from the generic MHPSS programme described in this thesis (Chapter ten) additional specialised projects were added, such as mental health and psychosocial care for Congolese and Rwandan refugees to Burundi (Ventevogel, Ntiranyibagira, et al., 2011), returning Burundian refugees from Tanzania (Nyamukeba & Ndayisaba, 2008), and former child soldiers (Jordans, Komproe, Tol, et al., 2012). Moreover, Burundi was one the sites of a multicountry programme to develop and test school based psychosocial interventions for conflict affected children. This has generated several academic publications about Burundi (Jordans, Komproe, Tol, et al., 2012; Jordans, Komproe, et al., 2011; Jordans et al., 2008; Jordans, Tol, Ndayisaba, et al., 2013; Song & de Jong, 2015; Song et al., 2015; Song et al., 2014; Tol, Komproe, et al., 2010; Tol et al., 2014). One of the components of the school based psychosocial programme in Burundi was the development and validation of research tools (Jordans, Komproe, et al., 2009; Jordans et al., 2008). Chapter eight in this thesis is based on work that was done in this context.

Third, the merger of TPO with HealthNet International in 2005 led to the addition of a health systems strengthening programme, using performance based financing (Falisse et al., 2015) that was, at least initially, not linked to the mental health and psychosocial programming in Burundi. The merger led to contacts with health systems strengthening programmes of HealthNet TPO in other African settings, such as in the Democratic Republic of Congo and South Sudan, where health programmes were developed without an MHPSS component. In order to inform integrated mental health programming within these general health care programmes a qualitative assessment was done, of which some results were published and are included in chapter three of this thesis.

## Structure of this dissertation

### Research questions

The research presented in this thesis focuses on three central questions:

- 1 What are local perspectives on mental health and healing by people in complex humanitarian emergencies?
- 2 How to measure mental health problems in complex humanitarian emergencies?
- 3 How to develop functional systems to address mental health and psychosocial problems in complex humanitarian emergencies?

Each of the central questions was studied with methods derived from one particular discipline, respectively: medical anthropology, psychiatric epidemiology, and health systems research. In the remainder of this introduction, per section, the research question will be contextualised, the core discipline characterised and its relevance for this thesis will be discussed, as well as introducing the corresponding chapters.

## Section one: local perspectives on mental health and healing

### Introduction to section one

If one wishes to provide mental health assistance within complex humanitarian emergencies, one critical issue is how the people concerned see their problems and how they cope with them. Context and culture influence how people delineate between ‘normal’ and ‘abnormal’ and, moreover, when abnormality become a mental illness (Helman, 2007). Definitions of mental disorders are embedded in how people view the world and conceptualise personhood. This in turn influences the way phenomena, such as dysphoric affect, hearing voices, or social withdrawal are labelled and interpreted (Kleinman & Good, 1985).

This leads to important variations in how people express that they are unhappy and distressed, for example by using ‘cultural idioms of distress’ (common modes of expressing distress within a culture or community), as well as how they explain and make sense of their symptoms or illness. In particular, how they view its causes, course and possible outcome, including how their condition affects them and their social environment, and what they believe is appropriate treatment (Kirmayer & Bhugra, 2009). Obviously, culture and context also matter in terms of the forms of healing that are available, particularly indigenous or ‘traditional’ healing practices that are often tied to religious systems. The content and relevance of indigenous healing systems is changing in tandem with changes occurring in the wider society (Luedke & West, 2006). Therefore, it is not only erroneous, but unhelpful to view ‘traditional’ medicine as a static and unchangeable set of practices, indicating that the ways local healing systems function should be explored within each setting and time.

In this thesis, the issue of local views on mental health and healing are explored,



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mainly for Burundi, with my insights and research methods drawn from the social sciences, particularly medical anthropology.

### **Core discipline: Medical anthropology**

As a sub discipline of cultural anthropology, medical anthropology is best defined as the study of cultural and social aspects of health, illness and medicine (Lambert, 2002). Medical anthropologists study ‘how people in different cultural and social groups explain the causes of ill health, the types of treatment they use, and to whom they turn if they get ill’ (Helman, 2007, p. 1). It is a relatively new branch of anthropology that has been thoroughly influenced by pioneers, of who beyond doubt, in my opinion, the most important is anthropologist and psychiatrist Arthur Kleinman. In his ground-breaking work on ‘explanatory models’ he focused on how people make meaning though ‘schemata for understanding illness held by individual sufferers and families as well as clinicians and healers’ (Kleinman, 1978; Kleinman, 1980, pp. 104-118).<sup>10</sup> Moreover, scientific psychiatric knowledge is also culturally produced and not free of values (Kleinman, 1988). The way symptoms are organised into syndromes and the way symptoms are experienced is also rooted in culturally based systems of meaning (Kirmayer, 2005). Ethnographic research has made it clear that experiences of psychopathology are embedded into local social worlds (Kirmayer & Ryder, 2016). Mental disorders are thus ‘intrinsically social’, shaped by social and cultural contexts and experiences, while, in turn, mental disorders shape context and experience of people (Bebbington, 2010; Reininghaus & Morgan, 2014).

Medical anthropology is not only defined by its subject, but also by its methodology. Typical medical anthropological research consists of lengthy fieldwork within a specific social setting, where the researcher may use a variety of formal ‘qualitative’ techniques, such as in-depth interviews and focus group discussions, but also, and most important of all, participatory observation. This implies that the researcher immerses him or herself in the lives of the people in order to find out what is at stake for them, and to develop an understanding of how they interpret their world and their lives (Eriksen, 2010). As a consequence, the role of the researcher is a critical element in ‘the production of anthropological knowledge’. I was familiar with classical anthropological fieldwork when I studied traditional healers in the Brong Ahafo region of Ghana in the early nineteen nineties (Ventevogel, 1996). That experience convinced me that ‘social knowledge is shaped by the observer’s point of view’. This epistemological premise makes anthropological knowledge sometimes difficult to swallow for policy makers and health researchers who may dismiss anthropological research as subjective and anecdotal (Parker & Harper, 2006), or chastise it for not producing results that can practically influence medical practice (Hemmings, 2005).

Sadly, it was not possible for me to conduct more in-depth anthropological research in Afghanistan and Burundi, as my position was not that of a researcher, but an NGO worker developing programmes and training health staff. As a result, I was limited to more modest forms of medical anthropological research done within the

context of ongoing NGO programming. This could be called ‘applied medical anthropology’, using a more restrictive methodology consisting of individual interviews, focus group discussion and field visits.

### **Chapters in section one**

Chapter two (‘Local perceptions of mental health and psychosocial problems in Burundi’) presents the results of a rapid ethnographic study using focus group discussions among war affected Burundian adults, asking what they themselves identified as the main difficulties and problems as a result of the war, and more specifically, what they saw as the main mental health psychosocial problems in their community.

Chapter three (‘Madness or sadness? Local concepts of mental illness in four conflict affected African communities’) describes and analyses how people in four settings in Burundi, South Sudan and the Democratic Republic of the Congo – where HealthNet TPO had programmes – view mental illness. The chapter discusses the boundaries between normality and mental illness in the view of the participants, and describes the presumed aetiology and preferred treatment options as well as to what extent these vary from one cultural context to another.

Chapter four (‘Change and continuity in Burundian divinatory healing’) focuses on diviner-healers in Burundi. Using data from in-depth interviews and participant observation with seven Burundian healers and focus groups discussion with community members, the traditional healing practices of diviners in post-war Burundi are described. Further, to what extent these practices have changed in comparison to what has been described in older literature on healing in the African Great Lake Area is explored. Finally, findings with ethnographic literature on traditional healing and divination in other parts of Africa are connected.

Chapter five (‘Child mental health, psychosocial well-being and resilience in Afghanistan’) provides a synthesis of child focused research and intervention literature (published as well as ‘grey’ literature) from various disciplines pertinent to mental health and psychosocial wellbeing in Afghanistan. It does this through an anthropological lens, even though it does not contain primary ethnographic data. This chapter provides a summary of epidemiological surveys into child mental health in Afghanistan, creating a bridge between Sections one and two, and ends with recommendations foreshadowing issues that will be discussed more in depth in Section three.

## **Section two: Measuring mental health**

### **Introduction to section two**

In the second part of this thesis another perspective is utilised to explore mental health issues within complex humanitarian emergencies. Whereas the chapters in the first Section focused on mental health problems from the view of the affected



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people themselves, the second Section explores mental health problems from the perspective of professional psychiatric classification systems. The relation between part one and part two of this thesis is akin to the ‘emic-etic’ distinction often used in cross cultural research (de Jong & van Ommeren, 2002; Jahoda, 1977; Weiss & Somma, 2007), contrasting local perspectives (the ‘emic’) with ‘external’ scientific perspectives (the ‘etic’). The central question explored in this Section is how, taking the professional psychiatric classification system for granted, to reliably measure the prevalence of mental disorders within complex humanitarian emergencies.

Prevalence research is often done with the use of instruments that assess the presence or absence of typical symptoms of mental disorders. Ideally, this should be done through a structured psychiatric interview by a mental health professional – the ‘gold standard’ – but this is not feasible for large-scale studies, and certainly not in low income countries that have very limited numbers of trained mental health professionals. Instead, in this case, research is done by either simplified structured clinical interviews conducted by trained lay people or by asking the research participants to fill in the questionnaire themselves through self-report symptom scales. Before such an instrument can be used in a new population, however, its properties should be assessed to measure what it is intended to measure. Validation research is one of the aspects of psychiatric epidemiology, a field that has seen a tremendous expansion in the last few decades.

### **Core discipline: Psychiatric epidemiology**

Psychiatric epidemiology is the systematic study of patterns of mental disorders with the aim of establishing estimates of prevalence and incidence, and link these to etiological factors and those influencing outcome (Lewis et al., 2011). The field traditionally lagged behind other branches of epidemiology because of the afore mentioned challenges with conceptualising and measuring mental disorders (Kessler, 2000). However, the field got a major boost in the 1970s when there was a rise in consensus around the classification of psychiatric disorders, which made it possible to measure mental disorders in a reliable way, with internationally agreed operationalisations of the symptoms of mental disorders (Susser et al., 2006). Since then, it became clear that also among people in low and middle income countries sizable rates of symptoms for depression and anxiety could be detected (Giel & van Luijk, 1969; Harding et al., 1980; Orley & Wing, 1979; Sethi et al., 1973).<sup>11</sup>

Initially, psychiatric epidemiology was mainly descriptive, focusing on the estimation of disorder prevalence (Prince et al., 2003). Most research in psychiatric epidemiology was done in high income countries, but with support of the World Health Organization, cross national studies (the World Mental Health Surveys that were mentioned above) were set up on a global scale (WHO International Consortium in Psychiatric Epidemiology, 2000).

International psychiatric epidemiology was a major force in demonstrating the enormous magnitude of mental health problems worldwide (Kessler et al., 2014; Whiteford et al., 2013). The days that a person affected by a mental disorders such as depression or anxiety disorders was ‘out of role’ was significant, and comparable to

cardiovascular disorders of diabetes mellitus. (Alonso et al., 2011). Analytical approaches to measure the societal consequences of psychiatric disorders become increasingly sophisticated. Apart from the Disability Adjusted Life Years (DALYs), as used in the Global Burden of Disease, another measure, Population Attributable Risk Proportion (PARP), was introduced in the World Mental Health Surveys to capture the effects of mental disorder on society as whole, meaning that the effect of preventative and treatment measures could be modelled (Kessler et al., 2013).

The underlying prevalence figures in global estimates of the burden of mental disorders have been criticised, particularly for some areas of the world, such as in Sub Saharan Africa and South Asia, as they are often derived by extrapolation of the results from few countries (Baxter et al., 2013). The study of mental disorders in areas affected by violent conflict was the last to be added to the mix. Methodologically strong studies, using structured diagnostic interviews, only started in the 2000s (de Jong et al., 2003; de Jong et al., 2001) and remain rare. Most psychiatric epidemiological research in conflict settings focuses on stress related disorder, particularly posttraumatic stress disorder (PSTD) and depression (Steel et al., 2009) that can be expected to increase after exposure to violence conflict. There is also mounting evidence that the prevalence of other mental health problems also increases significantly after collective violence, such as psychosis (Llosa et al., 2014; Soosay et al., 2012; Steel et al., 2009) and alcohol and substance use disorders (Ezard, 2012; Lai, 2014; Weaver & Roberts, 2010), but the research into these problems is far less prominent and the evidence base is consequently still modest. Within the global burden of disease in children, the leading causes related to mental health are emotional disorders, developmental disabilities, and disruptive behaviour disorders (Patel, Kieling, et al., 2013). Epidemiological research on mental health problems of children in humanitarian settings is focused disproportionately on children with ‘internalising’ emotional problems, such as stress related disorders and depression, while in fact, in complex humanitarian settings and their aftermath, externalising behavioural difficulties may be a more significant problem for children than internalising emotional problems (Grove et al., 2010; Jones, 2008). For children with intellectual disabilities within complex humanitarian emergencies, the scantiness of data is so big that these children are almost invisible in the research literature, despite the fact that they are extremely vulnerable to abuse and neglect (Rohwerder, 2013).

The adaptation of psychiatric research instruments for use with conflict-affected populations is fraught with methodological difficulties, particularly those related to issues of validity (van Ommeren, 2003; van Ommeren et al., 1999). There are two major issues that compromise the validity of research instruments in such settings.

First, the instruments are often developed in other settings, usually in high income countries, which can result in a bias in favour of culturally salient symptoms presentations in western countries, while not adequately capturing those in others (Kortmann, 1990; Patel & Mann, 1997). Therefore new scales have been developed in order to reach a high cultural and contextual relevance (Betancourt, Bass, et al., 2009; Jordans, Komproe, et al., 2009; Miller et al., 2006; Patel, Simunyu, et al., 1997; Tol, Komproe, et al., 2011), but this makes it more difficult to compare the outcomes

with those from other settings with other instruments (Rasmussen et al., 2014). Ideally, in any new context an instrument needs to be tested for its psychometric properties, but this is not often done.

The second issue that bedevils the literature on psychiatric epidemiological research instruments in disaster settings and within complex humanitarian emergencies is to what extent the measured mental distress represents true psychopathological states and to what extent are responses transient reactions to major stress factors (Horwitz, 2007). Here, we stumble on a very fundamental and essential question: when does suffering become a medical problem? The very large variance in prevalence rates of PTSD in conflict affected populations, ranging from 0-99% (Steel et al., 2009) is to a certain extent dependent on the quality of the research instruments, in particular whether the measured symptoms are clinically weighted, and whether additional elements such as loss of function have been taken into account. In general, more comprehensive instruments, particularly clinician based instruments, such as the Structured Clinical Interview for DSM disorders (SCID), and comprehensive lay administered instruments, such as the Composite International Diagnostic Interview that was used in the World Mental Health Surveys of the World Health Organization, give lower estimates of psychopathology in emergency affected populations, probably precisely because they are able to eliminate a considerable amount of the 'non disordered distress' (Rodin & van Ommeren, 2009).

## **Chapters in section two**

Chapter six ('Mental health problems following war and repression in eastern Afghanistan') is the report of a cross-sectional multicenter sample survey in the eastern province of Nangarhar among 1011 randomly selected adults. The survey was conducted 15 months after the fall of the Taliban. One of the main features of the study is the estimation of prevalence rates of symptoms of common mental disorders in this early post conflict setting. High symptom rates were reported for depression (38.5%), anxiety, (51.8%) and PTSD (20.4%).

Chapter seven ('Properties of the Hopkins Symptom Checklist-25 (HSCL-25) and the Self-Reporting Questionnaire (SRQ-20) as screening instruments used in primary care in Afghanistan') examines the validity of the Hopkins Symptom Checklist-25, one of the instruments that were used in the study of chapter six. The study was prompted by concerns over the use of such instruments within the context of complex emergencies in general, and in Afghanistan in particular (Bolton & Betancourt, 2004). The instruments tested in this study were the HSCL-25 and the Self-Reporting Questionnaire-20, another widely used brief self report scale for mental disorders. These two self-report scales were compared against a 'gold standard' semi structured psychiatric interview, the Psychiatric Assessment Schedule (PAS). The results were sobering: both short screening instruments had modest properties to correctly identify mental disorders, meaning that earlier studies in Afghanistan using these instruments probably overestimated the prevalence of mental disorders among women and underestimated the prevalence in men.

Chapter eight ('Validation of the Kirundi versions of brief self-rating scales for

common mental disorders among children in Burundi’) is another study to explore the psychometric properties of self report scales for mental disorders, this time with children in Burundi. This research was done within the context of a multi layered MH-PSS programme for war affected children in Burundi (Jordans, Tol, Susanty, et al., 2013). It explores the psychometric properties of the Depression Self-Rating Scale (DSRS), the Child PTSD Symptom Scale (CPSS) and the Screen for Child Anxiety Related Emotional Disorders (SCARED-41), in a sample of 65 primary school children in Burundi. The external ‘gold standard’ criterion was a comprehensive semi structured, clinical psychiatric interview for children according the DSM-IV criteria (the Schedule for Affective Disorders and Schizophrenia for School-Age Children – K-SADS-PL). Two of the three scales had acceptable properties for detecting depressive disorder and PTSD respectively, but cut-off points had to be adjusted.

## **Section three: Making systems work**

### **Introduction to section three**

The third section focuses on how to deliver mental health care within complex humanitarian emergencies in ways that make sense to the involved populations themselves (the topic of section one of this thesis), are informed by sound data on prevalence of mental health problems and their determinants (the topic of section two of this thesis), and how to sustainably incorporate mental health care into general health care systems.

The last decade has witnessed a surge in articles about treatments for mental health problems that are effective and feasible in low resource settings. Moreover, it has become clear that not all of these treatments have to be provided by specialists, but that many can be performed by non specialists, provided they are well trained and supervised (Padmanathan & De Silva, 2013). However, in order to make a real and concrete difference, such evidence based interventions need to be functionally integrated within larger sustainable systems of care outside of small scale research settings and demonstration projects. Some of the main challenges to achieve this roll out are related to the way health care systems in low income settings are organised. Health systems in these countries are unprepared for the epidemiological transition towards non communicable and chronic disorders, including mental disorders. Such problems require different approaches by health workers relating to behaviour modification and long term management of people with chronic disorders (Koehlmoos et al., 2011). A landmark publication in ‘Nature’ on the ‘Grand Challenges in Global Mental Health’ recognises that ‘health-system-wide changes’ are crucial, together with attention to social exclusion and discrimination (Collins et al., 2011).

Health systems changes that favour mental health care development are still rare and the process goes painstakingly slow (Tomlinson & Lund, 2012). Many low and middle income countries still do not have appropriate mental health policies and/or legislation to guide their mental health programmes and services, and consequently

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allocate little financial resources to develop human resources and infrastructure for mental health (Jacob et al., 2007; Saxena, Saraceno, et al., 2013). A major impediment to the progress of mental health care development is that mental health is not often included in health sector reforms. Usually, the mental health sector does not have the sources of political support and financial investment that other health sectors are able to mobilise (Jenkins et al., 2014).

To some extent, post conflict settings provide opportunities that should not be ignored, nor underestimated. The ‘post-conflict’ period after complex humanitarian emergencies is of vital importance for the reconstruction of the health system after a period of social and political unrest (Bertone et al., 2014; Ter Veen & Commins, 2012). Paradoxically, the aftermath of complex humanitarian emergencies may provide a policy window in which mental health needs are so visible that in the restructuring of the health care system ‘the elephant in the room’ cannot be ignored (Lee et al., 2011). An important driver of health care reforms is the shared sense of urgency about mental health felt by many actors, and the availability of emergency funding (Epping-Jordan et al., 2015). It is important, therefore, that mental health interventions in complex humanitarian emergencies and post-conflict settings use these opportunities and strive to transform short term mental health interventions into positive long term processes that include human resources capacity building and institutional development (Baingana et al., 2005). Thus, the post emergency phase may actually provide important opportunities to rebuild the mental health care systems in ways that are better than before crisis (Epping-Jordan et al., 2015).

Public mental health programmes in such settings should fulfil various criteria: 1) using contextual approaches that integrate the social worlds of the beneficiaries into locally relevant frameworks for healing and treatment; 2) drawing from various, sometimes competing, academic perspectives in order to build relevant service delivery structures; 3) facilitating interventions that encompass multiple complex determinants of mental illness; 4) empower ‘natural’ local social support systems; 5) strengthen social cohesion and social capital; and 6) use capacity building techniques in order not to rely on specialists only (de Jong & Komproe, 2002).

Over the past few decades, major gains have been made in the struggle against global priority disorder such as HIV-Aids, malaria, tuberculosis, early childhood disorders and obstetric complications. However, the drawback has been that attention for disease specific interventions has been at the expense of the functioning of the health system in which these interventions should be embedded (Smith & Hanson, 2012). This is even more relevant in the wake of complex humanitarian emergencies, which are characterised by disrupted health systems. Disorder specific interventions, aiming to reduce narrowly defined priority problems through specialised programmes, can lead to unbalanced training of health care staff, fragmented service delivery and weakening of the overall health care system (Fujita et al., 2011). Therefore, over the past few years, attention has grown for systemic interventions in which the provision of a whole package of interventions is promoted, together with attention for health care financing and human resources management (Kruk et al., 2010; Newbrander et al., 2011). Health systems development within complex humanitarian emergencies is, more than in other settings, dependent on cooperation

with NGOs and other non state actors (Witter, 2012). Relevant elements for mental health include the integration of mental health in primary care systems and linking formal care systems with informal community support systems (Srinivasa Murthy, 2011b).

### **Core discipline: Health systems research**

The most important field from which this third Section is drawn is ‘health systems research’, a sub discipline of public health that studies the functioning of systems of health care delivery as well as access to health care. Over the years, it has become abundantly clear that achieving the goal of ‘health for all’, as enshrined in major documents such as the WHO constitution (World Health Organization, 1950) or the Alma Ata declaration of 1978 (World Health Organization, 1978), is only partially dependent on specific treatment methods or technical innovations. Equally important is that people have *access* to these services when they need them and can *afford* them. In the last decades the concept of ‘universal health coverage’ has gained prominence. Universal health coverage aims to ‘ensure that everyone, everywhere, can access quality health services without facing financial hardship as a result’ (World Health Organization, 2015). This requires that three interrelated objectives are met: 1) equitable access to health services for all who need them; 2) a quality of health services that is good enough to improve the health of those receiving services; and 3) organising the system in such a way that the cost of health care does not bring financial hardship to those with serious health problems. Universal health coverage in a population can only be reached with a well functioning ‘health system’: ‘the sum total of all the organizations, institutions, and resources whose primary purpose is to improve health’ (World Health Organization, not dated-a). In many countries, the health system is dysfunctional and should be strengthened. Health systems strengthening (HSS) is much more than simply investing in inputs. It includes reforming how the health system actually operates (Kutzin & Sparkes, 2016). Furthermore, a health system includes not only formal health care facilities, but also communities and households intended to benefit from the care. The World Health Organization distinguished six building blocks of a health system: 1) service delivery; 2) health workforce; 3) information; 4) medical products, vaccines, and technologies; 5) financing; and 6) leadership and governance (World Health Organization, 2007a). Health systems constitute thus of both ‘hardware’ (such as finance, medical products, and human resources), as well as the ‘software’ (governance), which includes the organisational structures and the policy environment (Sheikh et al., 2011).

The goals of ‘health systems strengthening’ are to improve access, quality, and utilisation of health services. Within humanitarian settings this must include specific efforts to strengthen national systems and governance in order to ensure sustainability (Alva et al., 2009). The reconstruction of the health sector within or after complex humanitarian emergencies is marred by low numbers of trained health professionals, damaged infrastructure, inadequate public financing, dysfunctional supply lines, deficient monitoring systems and limited management capacity (Newbrander,



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2007). Within this complex situation, the influx of NGOs may do a lot to alleviate immediate needs, but the focus on short term projects with services that are not easy to align within the national health system, has serious drawbacks as well as it may further undermine the national health care system (Deely, 2005). In general, there is consensus that health interventions in the aftermath of conflict need to consist of concerted efforts to urgently deliver essential health services, combined with planning for health system reforms and laying the foundations for a sustainable framework for service provision in the future (Cometto et al., 2010; Newbrander et al., 2011). It is essential to realize that improvements of the health status of population in complex humanitarian settings is only partially dependent on the health sector in narrow sense, and there is consensus that a truly multisectoral approach is essential to achieve health goals (Waldman & Kruk, 2011).

An important aspect for further study is how policies around public health are formulated and implemented within complex humanitarian emergencies. Legitimate and effective policy-making processes will not only strengthen delivery of health care services, but may also contribute to state building (Alliance for Health Policy and Systems Research, 2008; Eldon et al., 2008).

The methodology used in health systems strengthening research is often the analysis of secondary data, such as statistics from routine health information systems, policy documents, project evaluations etc.

### **Chapters in section three**

Chapter nine (Improving access to mental health care and psychosocial support within a fragile context: A case study from Afghanistan) is a description and critical analysis of the MHPSS programme by HealthNet TPO in Nangarhar province in Afghanistan. It presents statistics from mental health consultations within the primary health care system over a ten-year period (2002-2011). The number of patients with mental disorders that were treated within the general health services increased tremendously, but the drawback was that, inadvertently, the programme may have contributed to a process of medicalisation of social problems.

Chapter ten ('Psychosocial assistance and decentralised mental health care in post conflict Burundi 2000 – 2008') similarly describes and analyses the programme that HealthNet TPO has established in Burundi. Within a time frame over eight years, the context has changed from active war to a fragile post conflict setting. The chapter describes how in this transition period, the programme activities shifted from the delivery of direct services to capacity building activities aimed at embedding psychiatric services and psychosocial assistance within existing local health services and social systems, and the challenges faced during this process.

Chapter eleven ('Integration of mental health into primary healthcare in low-income countries: Avoiding medicalization') synthesises the literature around the integration of mental health into primary care in low and middle income countries. During my work in Afghanistan, Burundi, and later in various other complex humanitarian emergencies, I had become increasingly concerned over the tendency among policy makers in global mental health to see the integration of mental health

into non specialised (e.g. primary) healthcare as a ‘quick fix’, without realising the risk that it would contribute to the medicalisation of social and psychological problems if using a narrow focus on primary care without sufficient attention given to strengthening other levels of health care and community support.

## Closing chapter

The last chapter of this thesis discusses the major findings and reflects on three main issues that, in my opinion, are important to address in order to speed up progress in the field of mental health and psychosocial support within complex humanitarian emergencies.

### **1) Rethinking the role of culture and context in global mental health**

Part one of this thesis highlighted the role of cultural contexts for mental health and wellbeing. This is something that still does not get enough attention from researchers and practitioners of global mental health, and this neglect has given rise to some stinging critiques. These cultural critiques on the global mental health movement will be summarised and some ‘critique on the critique’ will be provided. Two points are discussed more in depth: the importance of local categories of mental illness and distress and the need to perceive culture and social context as dynamic concepts. This discussion ends with some suggestions on how medical anthropological insights can be better integrated into global mental health.

### **2) Making mental health epidemiology research more useful for public mental health programming**

The quandaries of measuring mental health of populations in complex humanitarian emergencies are discussed with personal reflections on research with brief symptom based questionnaires (the subject of Section two). In particular, the chapter describes why the survey in Afghanistan (chapter six) did not connect well with how Afghan men and women construct their emotional states. Moreover, the societal and political effects of that epidemiological survey are discussed. The discussion ends with suggestions of how psychiatric epidemiology can take local views more seriously in measurement instruments.

### **3) Integrating systems thinking in the development of mental health programmes.**

Using the examples of the mental health programmes in Afghanistan and Burundi that were described in chapters nine and ten, the health systems strengthening model of the World Health Organization is used to analyse mental health programmes in complex humanitarian emergencies. The chapter concludes with thoughts on how a broad systems approach is needed for global mental health programming.

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Taken together, the kaleidoscopic range of topics and perspectives in this thesis will hopefully provide the reader with valuable insights in the burgeoning and exciting field of global mental health within complex humanitarian emergencies

## Notes to chapter one

**1** For more elaborate descriptions of the historical development of ‘cultural psychiatry’ and ‘global mental health’ and its distinctions, see various other publications (Alarcón, 2013; de Jong, 2010a; Kirmayer, 2007; Littlewood & Dein, 2000; Lopez & Guarnaccia, 2000; Okpaku & Biswas, 2014; Prince et al., 1998).

**2** Disability Adjusted Life Years, composed of Years Lived with Disability (YLD) and Years of Life Lost (YLL).

**3** This is not to suggest that NGOs always undermine existing state-led services. See, for example, the case studies collected in a special issue of the journal ‘Intervention’ (Pérez-Sales et al., 2011; Ventevogel, Pérez-Sales, et al., 2011) and the description of the work of TPO in Nepal (Upadhaya et al., 2014) for examples of how NGOs contribute to systems building in complex humanitarian emergencies.

**4** There were some critical voices too, arguing that the guidelines were not evidence-based enough and particularly had not incorporated evidence from a trauma-informed perspective (Cardozo, 2008; Yule, 2008).

**5** The term MHPSS is used almost exclusively within the world of humanitarian assistance, which makes communication with people outside that sector sometimes difficult. Despite the introduction of the unifying term ‘MHPSS’, in daily practice of humanitarian emergencies a major divide remains between ‘mental health’ interventions that are usually done within health facilities, and ‘psychosocial support’ interventions, mainly done outside health facilities and by non health actors (Meyer & Morand, 2015). Tol et al. (2015) propose to abandon the term MHPSS altogether and use the term ‘public mental health’ instead. The multi layered intervention pyramid of the IASC guidelines would then be replaced with a framework consisting of levels of prevention: universal prevention, selective prevention and indicated prevention (Tol, 2015). The proposal to subsume all the work on MHPSS under the rubric ‘public mental health’, however, has received a rather cool reception by Wessells (2015) who feared that psychosocial workers would perceive it as disenfranchising because many of them use contextual approaches and are wary of individualistic and universalistic approaches of much work on mental health.

**6** In the last decades however, ethnic consciousness has increased and became strongly politicised. Burundian refugees in Tanzania, often supporters of ‘hard-line’ Hutu militant groups, developed their own narrative, a ‘mythico-history’ around a Hutu identity of purity and superiority (Malkki, 1995).

**7** For example Ntahombaye (2005: pp 51-52, cited in Ntahombaye & Nduwayo 2007: pp 246) claims that ‘nothing defines or justifies the existence of ethnicity in Burundi. The Baganwa, the Bahutu, the Batutsi and the Batwa are not casts, social classes, ethnic groups or tribes’.

**8** For example, the inhabitants of the Tanzanian districts of Kigoma, Kasulu and Ki-

bondo bordering Burundi and usually referred to as BuHa, are linguistically and culturally very similar to the people of Burundi and Rwanda. They also have a Hutu/Tutsi like divisions, but this has not led to ethno-political violence as in Rwanda and Burundi (Brain, 1973). Moreover, the Hutu/Tutsi divide among Kinyarwanda speaking people in the eastern DRC was only recently activated, largely as a result of the Rwandan genocide, the subsequent influx of Hutu militias and invasion of the Rwandan army (Lemarchand, 2009; Prunier, 2009).

**9** See for example the work of psychologist Staub (1989) who describes how genocide is facilitated through a process of increasing 'us-them' divisions in the public discourse, accompanied by systematic efforts to minimise meaningful social contact between groups and political efforts to devalue and 'de-humanise' the other group. See also the work of psychoanalyst (Volkan, 2001) who identifies 'chosen traumas' as rallying points to create a large group identity in opposition to an 'other' who may, from the outside, not seem so different at all.

**10** See Pool and Geissler (2005, pp. 35-36) for a concise overview of this 'meaning centred approach' in medical anthropology). For more in depth discussion of interpretive medical anthropology see Kleinman (1980) and Good (1993).

**11** Before these pioneering empirical studies, scientists assumed that depression was rare in Africa (Carothers, 1953, pp. 142-148) or studied it with descriptive methodology only (Field, 1960, pp. 149-200).

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**Local  
perspectives**



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

**P. Ventevogel**

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## Abstract

This paper explores how Burundians view the impact of the past civil war on their lives and wellbeing. The methodology consisted of focus group discussions (n = 104), including participatory ranking techniques, and key informant interviews with traditional healers (n = 7). Respondents saw economic decline (poverty, loss of livelihoods), worsened health and nutritional status as major issues, but also mentioned social aspects (erosion of mechanisms for social support and conflict resolution), and psychological aspects (sadness, grief). When invited to elaborate on the mental health and psychosocial consequences of war, the respondents mentioned a range of issues related to depressive states, fear/anxiety, grief, madness, and substance abuse. These findings lend support to the notion that mental health and psychosocial wellbeing need to be given due attention in the reconstruction of Burundian society. The findings corroborate the conceptualising of programmes for mental health and psychosocial support as multi-layered approaches with varying goals: to promote social cohesion, to strengthen family support, to help people deal with issues related to loss, grief and sadness, and to support individuals with severe mental disorders. The design of such interventions should take into account what people themselves find important in their lives and social settings.

## Introduction

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

Assessments to explore local views on issues often use methods derived from qualitative social sciences, such as focus group discussions, key informant interviews and participatory observation (Bolton & Tang, 2004; World Health Organization & United Nations High Commissioner for Refugees, 2012). These methods are based on what people report themselves, more or less 'spontaneously', thus providing useful measures of the saliency of particular concepts. In order to get more reliable indicators of the relative significance of the ideas that are mentioned, one needs to order them. This can be done in various ways, for example by analysing data through the coding of results with the aid of qualitative research software (see Tol, Reis, et al. (2010).

Apart from such rigorous and time consuming analysis, a quick overview can be achieved by asking research participants themselves to rank concepts in order of perceived importance (Stark et al., 2009). This 'participatory ranking methodology' is considerably simpler and moreover, generates direct results, which the researchers can use in their immediate engagements with participants and their com-

munities. Participatory ranking methodology is often used within contexts of rapid assessments by non governmental organisations during intervention planning (Bolton, 2001b; Karki et al., 2009; Stark et al., 2009). The strength of this methodology – quick results – also has several downsides, some of which will be discussed in the limitations section of this paper. This paper describes a brief, community based assessment with a participatory ranking exercise in Burundi.

## Background

Burundi, in central Africa, has faced several periods of severe collective violence between the Tutsi minority and the Hutu majority. The 1993 assassination of the first democratically elected president, a Hutu, ignited a civil war. Within weeks, 150,000 people lost their lives (Wolpe, 2011) and the country was immersed in a full-blown civil war which lasted till 2002 and resulted in an estimated 200,000 – 500,000 deaths, with at least 1.2 million displaced persons (Floribert & Nkurunziza, 2000; Hatungimana, 2011; Lemarchand, 2009). Fifty-two percent of all Burundians have fled their homes, at least once, since the start of the civil war in 1993 (Uvin, 2009, p. 29). Most of the warring parties signed a peace accord in August 2000. In the year that followed, hostilities decreased, with a formal ending of the war in 2005 when democratic elections led to a government dominated by former rebel groups. Considerable international aid flocked to the country, with the aim of rebuilding institutions and working towards peaceful development. Much attention was given to basic services, such as education, health care and integration of former rebels into the society, while almost no specific attention was given to mental health and psychosocial wellbeing (Government of Burundi, 2006).

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

This paper, therefore, aims to explore what conflict affected people in Burundi think themselves about the effects of war on their own wellbeing, and to what extent they identify psychological problems as a priority. The research questions for the study reported in this paper were:

- 1 What are the main difficulties that people living in this area face as a result of the war?
- 2 What are the mental/psychosocial problems people identify in the community, and how have they been influenced by the war?

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

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LOCAL PERSPECTIVES

## **Methodology**

### **Study context**

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

### **Study location and participants**

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

Fourteen focus group discussions (FGD) were held, with approximately 6-8 participants each. Since it can be difficult for young people, or those with limited education, to disagree publicly with someone who is older age or has higher education, separate focus groups were organised for rural and urban participants, men and women, young and old, literate and illiterate people. Participants were identified through purposive sampling of categories, and within these categories using snowballing methods to identify a group of participants. In total, 104 persons participated in the focus groups. (See Table 2.1) In addition, seven key informants (traditional healers) were individually interviewed to collect additional data.

### **Procedure**

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

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

**TABLE 2.1 Participants of the 14 focusgroups (n= 104)**

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

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

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

## Results

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

### Problems caused by the war

The members of the FGD distinguished a wide array of negative consequences as a result of the war. (See Table 2.2) Each topic will be discussed further below.

#### 1 POVERTY

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

In all focus groups, increased poverty was ranked as the main problem related to the war. People linked poverty to direct acts of war (destruction of crops and property) and to indirect effects, for example disruption of agriculture due to forced migration or insecurity, and the plummeting exchange rate of the Burundian franc. The socio-

**TABLE 2.2 Problems related to the war as mentioned by participants of focusgroups**

Rank	Problem
1	Poverty
2	Deaths due to fighting
3	Orphans and widows
4	Hatred and feelings of revenge
5	More diseases
6	Undermining of sexual morals
7	More crime
8	Destroyed houses and goods
9	People do not help each other
10	People feel sad and hopeless

economic indicators of the country declined significantly during the war. Burundi was already poor at the start of the war and the fighting, complicated by an international embargo against the country during the war. These factors have prevented economic development and have made it one of the world's poorest and least developed nations. Since the crisis, the 'gross domestic product per capita' has dropped from a level of US\$ 214 in early 1990s and 1980s, to US\$ 83 in 2004. The proportion of people living below the poverty line increased from 36% in 1992 to 68% in 2002 (Government of Burundi, 2006).

## 2 LOSS OF LIVES

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

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

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

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

## 3 MANY ORPHANS

**'So many children have no father anymore because he died in the war or due to disease. What will happen to all these children?'**

(FGD, women in Rusaka, Mwaro)

At the time of this research, the country had around 660,000 orphans (children from

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

#### 4 HATRED AND REVENGE

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

**'Nowadays, nobody trusts other people. A man keeps thinking that the other man will do him harm. A person who is the victim of injustice, or whose relatives have been killed, will seek ways to get revenge. Even now the war is over, the Hutu and Tutsi do not trust each other. One has to remain very careful. Killing a person has become normal. People do not care for the lives of others anymore. We used to have a lot of mixed marriages, but not anymore. The different ethnic groups do not pass evenings together. Since the war started, it even happens that someone from one ethnic group refuses to buy something from the other ethnic group.'**  
(FGD, male and female civil servants in Rusaka, Mwaro)

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

#### 5 INCREASE OF DISEASE

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

Participants mentioned an increased prevalence rate of HIV/AIDS, tuberculosis and malaria, and also related this to the war, through increased poverty, bad nutritional status and overcrowding in camps for refugees or internally displaced people. The

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health indicators of Burundi are among the world's poorest, with maternal mortality estimated at 800 deaths per 100,000 live births and an under five mortality rate of 104 per 1000 live births (UNICEF, 2013). The prevalence of HIV/AIDS has increased significantly during the years of conflict. The estimated adult prevalence of HIV/AIDS in the country was between 3.6% and 8.8% in 2005 (World Health Organization, 2005). There are no data to confirm an increase in malaria (O'Meara, 2010).

## 6 UNDERMINING OF SEXUAL MORALS

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

(FGD, school children in Bujumbura)

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

Sexual violence, often used during the active conflict as a weapon of war, continues to rage throughout the country. In 1997, more than a quarter of Burundian women in Tanzanian refugee camps had experienced sexual violence *after* they had become a refugee (Nduna & Goodyear, 1997). Credible statistics of prevalence of sexual violence over that period are not available, but NGOs in Burundi report massive levels of sexual violence. Furthermore, sexual violence is no longer mainly perpetrated by rebels and soldiers, but by family members, teachers and household domestic staff, reflecting 'a general breakdown in social norms' (Zicherman, 2007, p. 48). A mixed method study on sexual violence in Burundi found that, over the years, victims of sexual violence tend to be younger, with an increase in the number children (Dijkman et al., 2014). The participants in the latter study mentioned weakened solidarity in communities, poverty, lack of education, psychological problems and problematic integration of ex-combatants back into society as all factors contributing to high levels of sexual violence.

## 7 INCREASE IN CRIME

'If people get the chance, they steal from each other, even if they are family members. People do not care anymore.'

(FGD, unskilled houseboys and babysitters in Bujumbura).

Feelings of unsafety, related to increasing crime are widespread. Fights at *cabarets* (i.e. local bars) are numerous, and theft of food and property in rural and urban Burundi appears extremely common (Sommers, 2013). Governmental statistics, un-

reliable as they are, do show an increase in criminality, with increasing incidents of armed robbery by organised gangs and crimes related to land conflicts in particular areas, (Centre for International Governance Innovation, 2009). Additionally, trust in the justice system is very low among Burundians (Béduwé & Van Herp, 2008).

## 8 HOUSES AND GOODS DESTROYED

'So many houses were destroyed. We had to go to Congo and leave everything behind. All we had was lost and we had to start over again.'

(FGD, men in Rusaka, Mwaro)

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

## 9 PEOPLE NOT HELPING EACH OTHER

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

(FDG, men in Rusaka, Mwaro)

Various focus groups mentioned the erosion of traditional mechanisms for mutual support and conflict resolution as an important negative effect of the war. This point was particularly stressed in the groups in the city of Bujumbura. The lack of social support is, however, a major issue in the whole country and strongly related to the loss of trust, as mentioned above. Historically, social relations, with the mutual obligation to help each other in case of need, are based on the traditional institution of *ukuterera* in which food and beer are ceremonially shared (Ingelaere, 2009). The delicate social fabric of the traditional Burundian communities has been profoundly destroyed by years of violent conflict.

## 10 PEOPLE FEELING SAD AND HOPELESS

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

(FGD, men in Kinyovu, Mwaro)

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

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## Psychosocial and mental problems related to the war

In a second phase of the FGD, the participants were invited to talk about the *psychosocial and mental problems* as a result of the war, and participants again prioritised their responses. The tabulation of responses is shown in Table 2.3, and some responses are discussed in detail below.

### 1 AKABONGE ('DEPRESSION')

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

(FGD, boys and girls in Rusaka, Mwaro)

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

(FGD, women in Rusaka, Mwaro)

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

(FGD, men in Rusaka, Mwaro)

*Akabonge* literally means 'sorrow' or 'melancholy'. Other words that are used to indicate a state of sorrow in which a person is not able to function normally are *agahinda* or *kinemura akarunga*. In the descriptions of people with *akabonge* or *agahinda* several elements of the psychiatric concept of major depression can be found: low mood, loss of pleasure or interest, a tendency to isolate and retreat from all social activities, thinking a lot, loss of concentration and suicidal thoughts. Persons suffering from *akabonge* sing melancholic songs (*gucurintimba*), full of regret and sorrow,

TABLE 2.3 Psychosocial and mental health problems as mentioned by the focus groups

Rank	Kirundi term	Approximate English translation
1	<i>Akabonge (kuyinga)</i>	State of continuous sadness
2	<i>Guhahamuka</i>	Posttraumatic stress/having thoughts and fears related to events during the war
3	<i>Umubabaro udasanze/ikigandaro</i>	Grief/ endless mourning for the dead
4	<i>Ibisazi/abagwaye mu mutwe</i>	Mental disorders/madness
5	<i>Abanyawarumogi/fibiyayuramutwe</i>	Use of illegal drugs

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

## 2 UBWOBA BWINSHI (MUCH FEAR) AND GUHAMUKA

‘Some persons have no other thoughts than those related to the war. Whatever such a person says has to do with the war. He has no other kind of talk.’  
(FGD, male and female civil servants in Rusaka, Mwaro)

‘Some people are hit very hard by the war. Their houses were burnt, and people have died. They cannot forget.’  
(FGD, peasant men in Buta, Bururi)

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

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

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### 3 UMUBABARO UDASANZWE/IKIGANDARO (GRIEF/MOURNING)

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

'People mourn endless for their dead ones. Especially when one cannot find the remains of a dear relative in order to bury him. Then the mourning does not stop.'

(FGD, peasant men in Buta, Bururi)

In Burundi, mourning is a complicated process in which several stages can be traced, and that end in a ritual signifying the end of the mourning period and the re-beginning of life, as has been described for neighbouring Rwanda (Bagilishya, 2000). In Burundian culture, similar to other settings in Africa, proper burial of relatives is of high significance. When it is impossible to bury a person because his body is never found, or his whereabouts remain unknown, the mourning process can be disturbed. As everywhere in subSaharan Africa, deceased ancestors in Burundi are considered to continue to play an active role in the lives of the living offspring, and maintaining a good reciprocal relation is therefore important. The spirits of the dead who are not properly buried can cause all kinds of misfortune. These spirits (*imizimu* = ancestor spirits) wander around in nature and can attack anyone who passes by. Many different kinds of problems, such as a disturbed peace in the house, failed crops, madness and other illnesses may be attributed to them (Barancira, 2002).

### 4 ABAGWAYE MU MUTWE/IBISAZI

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

(FGD, men in Rusaka, Mwaro)

*Abagwaye mu mutwe* are people who 'suffer in their mind'. *Abasazi* indicates 'mad people'. The terms overlap, and are in daily use, often as synonyms, but they are not identical. *Abagwaye mu mutwe* is the term for 'mental disorders', and as such are people who suffer from a disease, mostly a chronic one. *Ibisazi* is a more general concept that is also applied for people who have temporary 'crazy behaviour', for example due to the use of alcohol or drugs. In the definition of *abagwaye mu mutwe/ibisazi*, the behavioural disturbances are in the foreground: 'talking without stopping', 'talking nonsense', 'being aggressive', 'having bad hygiene', 'wandering in the streets without any reason', 'destroying things', 'destroying clothes', and 'insulting others'. It is remarkable that some defining symptoms of psychosis, such as perceptual disturbances (hallucinations) are not mentioned. The predominance of behavioural symptoms in the local definitions of 'madness' is as is described for many other African societies (Ventevogel, Jordans, Reis, et al., 2013). Sometimes *ibisazi* is related in a very direct way to exposure to traumatic events:

'There are people whom the war has made so sad that it seems they are mad. People have many negative thoughts. They do not believe in the future anymore. They do not have happiness or hope about things in their life.' (FGD, women in Rusaka, Mwaro)

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

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

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

#### 5 ABANYAWARUMOGI/IBIYAYURAMUTWE (USE OF DRUGS AND ALCOHOL)

'Many men, but also women, spend the whole afternoon in bars where *igiti umudiringi ou umunanasi* (local alcoholic drinks) are being sold. They go home late in the night, drunk. Some even stay till the morning in the bar because they are not able to walk anymore. They do not eat well, because they drink so much. They lose the strength in their body.'

(FGD, teachers in Buta, Bururi)

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

(FGD, women in Rusaka, Mwaro)

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

(FGD, female petty traders in Bujumbura)

The use of alcohol is engrained in Burundian culture. In the old times, alcoholic sorghum beer or banana beer was brewed by the women of the house. While it has been described that its' use could easily lead to aggression and violence, within the family and between families (Albert, 1963), the use of bottled beer has increased the problem due to the low price and its use outside the family structure. There has been little research on alcohol consumption in Burundi (Adelekan, 2008). However, there have been reports that consumption is declining since the mid 1990s (World Health Organization, 2011a), but this finding is not corroborated by the lived experience of the Burundian respondents in our study who say use is on the rise, and that is related to the loss of social control. More recently, Sommers (2013) mentions that stories of boys drinking alcohol and smoking marijuana have become very common. A *colline* (commune) level government official told him that 'maybe 90 out of 100 ordin-

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ary male youth, including adolescent boys, drink banana beer. Many also smoke marijuana. Many girls drink banana beer, too, almost as many as boys' (Sommers (2013, p. 18). The use of illicit drugs consists mainly of cannabis (*chanvre*) that is grown in secrecy locally, and that according to anecdotal reports is increasing, particularly in urban areas (Barancira, 2002; Sommers, 2013).

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

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

First, within the spectrum of problems identified by the communities, mental health and psychosocial issues do play a role and are spontaneously mentioned by the population. The most prominent problems are *economic aspects* (such as poverty, loss of goods and houses), *health aspects* (increase in prevalence of diseases and malnutrition) but, without being probed, people also clearly indicate *social aspects* (weakening of mechanisms for social support and conflict resolution) and *psychological aspects* (sadness, grief). This discredits the notion, still prevailing in some circles, that issues related to psychological wellbeing would not be prioritised by people in Africa, or would represent externally imposed categories (Fernando, 2014b; Summerfield, 1999). Studies with populations elsewhere in the Great Lakes Region also found that mental and psychosocial issues are considered a real concern and are perceived as embedded within larger sociocultural phenomena, (Bolton, 2001b; Horn, 2009; Tankink et al., 2010). Major implications for post conflict recovery programmes, therefore, are that mental health and psychosocial aspects need to be addressed. Further, programmes need to be firmly embedded in, or linked to, other activities outside the mental health sector such as programmes for community development, livelihoods and peace building, in order to address the multiplicity of causal factors that impact psychosocial wellbeing (de Jong, 2007). This requires comprehensive public mental health approaches (de Jong, 2002b).

Second, when specifically asked about mental and psychosocial problems related to war, the respondents mention a wide range of concerns. They prioritise loss related problems, such as depression, trauma and grief, followed by severe mental disorder and then alcohol and drug use. A mental health programme should therefore target a wide range of mental health issues, and not merely one condition. This is highly relevant given the discussions around the significance of posttraumatic stress disorder in post war contexts, with some arguing that this is the key issue for war affected populations (Neuner, 2010; Neuner et al., 2014), and others opposing that view and emphasising the role of daily stressors and ongoing adversity as the major contributor to mental health problems (Miller & Rasmussen, 2010, 2014).

Third, mental and psychosocial concerns appear to be firmly embedded within wider sociocultural phenomena, as suggested by the interviewees' descriptions. For the Burundians in this study, the domain of psychosocial wellbeing is not viewed as 'separate', but as connected to their social and economic situation. Arguably, inter-

ventions should go beyond mere attempts to fix ‘an individual with a problem’, to assistance to solve problems between people (community focus) and to create sustained change within the institutions (systems orientation). Thus, MHPSS need to be conceptualised as multilayered approaches that target various levels (Fairbank et al., 2003; IASC, 2007). There are various ways to do this. The remainder of this paper will discuss how these local views could inform the selection of culturally and contextually relevant MHPSS interventions. Four broad areas of interventions that should be considered if wanting to take the views of the Burundian respondents into account are highlighted.

### **Interventions to promote social cohesion**

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

An evaluation of community based initiatives by international NGOs in Burundi found that, for example, the repair or replacement of water taps or training seminars for people from the same *collines* created such new meeting places, reflecting the preference of rural Burundians for informal daily interactions, rather than formal community associations or committees (Vervisch et al., 2013). Of course, this is not unique to Burundi. For example, a comparison of a psychosocial intervention in Afghanistan with a water-sanitation intervention (the construction of wells using a participatory process) showed much stronger beneficial effects on psychosocial wellbeing of the water-sanitation intervention (Loughry et al., 2005). In Rwanda, one of the effects of sociotherapy (a form of peer support groups) was the activation of social connections on a community level, and as such contributed to fostering participation of marginalised people in the community (Jansen et al., 2015; Richters et al., 2013; Scholte, Verduin, Kamperman, et al., 2011). Much in line with this, HealthNet TPO in Burundi has developed a community systems strengthening approach, such as has been

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described for other settings, for example Afghanistan (van Mierlo, 2012). A recent study in southern Burundi showed how also good community based health care can foster community cohesion and peaceful relations (Christensen & Edward 2015).

### **Interventions to strengthen family support**

The family in Burundi is the nucleus of social support and wellbeing. However, families are under strain and may have become dysfunctional. For example, adults who have experienced gruesome violence in their life bear the emotional tolls of this, which may in turn, lead to parenting styles that are prone to harsh corporal punishment, neglect and abuse and cause an intergenerational passing of distrust, aggression, and withdrawal from their children (Song et al., 2014). Testimony to this is the prioritisation by the respondents of problems related to orphans, and behavioural problems in children. Moreover, the lack of family support drives some children to the streets, particularly in the main towns, where they face physical and psychological violence and neglect. This can lead further to a deep mistrust and feelings of insecurity that can, to some extent, be modified by being in a safe environment (Crombach et al., 2014). As the participants in the focus groups remarked, children in post conflict Burundi have lost respect for elders and show ‘bad behaviour’. The problem behaviour may be related to changes in the dynamics between parents and children, and the changing roles of the family. Addressing these problems in an effective way may require a shift to include non clinical problems. HealthNet TPO has piloted a brief parenting, psycho-education intervention with the aim of ultimately improving children’s mental health. The intervention targets children indirectly, and works in the first place with the parents. An evaluation of the project showed that the intervention leads to a reduction in aggressive behaviour, particularly in boys, and to a lesser degree in depressive symptoms (Jordans, Tol, Ndayisaba, et al., 2013). Similarly, preliminary results of a randomised control trial in Burundi showed that adding a family based discussion group to a project for microfinancing led to large reductions in harsh methods of disciplining their children, both physical and verbal (Bundervoet et al., 2012).

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

Next to interventions that cover larger groups, it is also important to organise support for those who are so overwhelmed by sadness and anxiety that they do not sufficiently recover. Or, those whose emotional states prevent them from participating in social activities, thus aggravating the vicious circle of demoralisation, poverty and despair. While certainly not all people who are sad and anxious have a clinically relevant mental disorder, quantitative studies measuring affective and stress related disorders in Burundi (with standardised rating scales) indicate high levels of depression, anxiety disorder and PTSD (Jordans, Komproe, Tol, et al., 2012; Tol et al., 2014; Ventevogel et al., 2014; Yeomans et al., 2010).

Given the magnitude of the problem, and the lack of professional resources in a

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

### **Interventions for individuals with severe mental health problems**

For those individuals who have developed serious mental disorders, assistance should be made available within the general health care system. The few psychiatric services that are present tended to be centralised and therefore, not accessible to most people. In the aftermath of the war, a programme has been developed in Burundi for the integration of mental health care into the general health care system, by training and supervising nurses in the provincial hospitals of the country. This project has been described in depth elsewhere (Ventevogel, Ndayisaba, et al., 2011). People using these mental health services are mainly people with chronic psychosis, bipolar disorder, severe depression and epilepsy.

### **Limitations**

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

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to find consensus may have overlooked the complexities and contradiction inherent in peoples discourses, and moreover, may ignore differences between people in constructing one 'local view' (Cornwall & Fleming, 1995; Pool & Geissler, 2005).

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

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

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

## **Conclusions**

Mental health and psychosocial problems have their own place amidst the priorities as defined by Burundians themselves. The design of MHPSS interventions should link to what local people find important and what is at stake in their lives and social settings. In order to create synergies, MHPSS programmes should be conceptualised as multi layered services, be firmly embedded into other systems of care and be explicitly linked within broader, socio-economic recovery programmes after violent conflict.

## **Acknowledgments**

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## **Madness or sadness? Local concepts of mental illness in four conflict-affected African communities**

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## **Abstract**

**Background:** Concepts of ‘what constitutes mental illness’, the presumed aetiology and preferred treatment options, vary considerably from one cultural context to another. Knowledge and understanding of these local conceptualisations is essential to inform public mental health programming and policy.

**Methods:** Participants from four locations in Burundi, South Sudan and the Democratic Republic of the Congo, were invited to describe ‘problems they knew of that related to thinking, feeling and behaviour?’ Data were collected over 31 focus groups discussions (251 participants) and key informant interviews with traditional healers and health workers.

**Results:** While remarkable similarities occurred across all settings, there were also striking differences. In all areas, participants were able to describe localized syndromes characterized by severe behavioural and cognitive disturbances with considerable resemblance to psychotic disorders. Additionally, respondents throughout all settings described local syndromes that included sadness and social withdrawal as core features. These syndromes had some similarities with nonpsychotic mental disorders, such as major depression or anxiety disorders, but also differed significantly. Aetiological concepts varied a great deal within each setting, and attributed causes varied from supernatural to psychosocial and natural. Local syndromes resembling psychotic disorders were seen as an abnormality in need of treatment, although people did not really know where to go. Local syndromes resembling nonpsychotic mental disorders were not regarded as a ‘medical’ disorder, and were therefore also not seen as a condition for which help should be sought within the biomedical health-care system. Rather, such conditions were expected to improve through social and emotional support from relatives, traditional healers and community members.

**Conclusions:** Local conceptualizations have significant implications for the planning of mental-health interventions in resource-poor settings recovering from conflict. Treatment options for people suffering from severe mental disorders should be made available to people, preferably within general health care facilities. For people suffering from local syndromes characterized by loss or sadness, the primary aim for public mental health interventions would be to empower existing social support systems already in place at local levels, and to strengthen social cohesion and self-help within communities.

## **Background**

Understanding local concepts of mental illness, and the related health care-seeking behaviour, is essential for the development of effective public mental health interventions after conflicts (de Jong, 2002b). Elucidating popular nosologies of mental disorders not only can help health workers to better understand their patients, it can

also prevent the imposition of categories that are meaningless to the patient and his social environment. This is important when health planners wish to address mental problems in non-Western cultural settings, such as in Sub-Saharan Africa, where formalized mental-health care is often limited to hospital-based services in major urban areas and where existing resources are insufficient, both in terms of human resources as well as in terms of coverage (World Health Organization, 2011b). Conflict-ridden areas, in particular, are often devoid of mental-health professionals, while the mental health needs are huge (Silove, 2012; Tol, Barbui, et al., 2011). Therefore, before starting an intervention programme to address mental health problems within a postconflict context, it is essential to know what local people think and which local concepts of mental distress they use. Such data may help to plan services that ‘make sense’ to potential users, including the way the services are organized and which problems they primarily should address.

Several challenges arise when studying ‘local concepts’ of ‘mental illnesses’. Firstly, what is a ‘local concept’? Local knowledge is continually reproduced and evolving (Pottier, 2003) and is often somewhat idiosyncratic, and context dependent (Kokanovic et al., 2008). It may also vary due to historical changes, as well as shifting geographical boundaries. Past attempts to discover ‘folk illnesses’, described as ‘syndromes from which members of a particular group claim to suffer and for which their culture provides aetiology, diagnosis, preventative measures and regiments of healing’ (Rubel, 1977, p. 120), or ‘culturally bound syndromes’, described as the ‘clinical manifestation found in particular societies or cultural areas’ (Simons & Hughes, 1985), have been criticized for their tendency to force local knowledge into a rigid system. Local medical knowledge may not be bounded by such a ‘system’, and local concepts may be ambiguous. What makes the study of local concepts particularly difficult is that they are, given the changing nature of our social world (including beliefs and culture) and the efforts of individuals to adapt to these changes, best viewed as an ongoing process or ‘work in progress’ (Nichter, 2010).

A second challenge is how to define ‘mental illness’? The boundaries of what constitutes mental illness are influenced by cultural and other contextual factors and change over time (Sadler, 2005). Indigenous African categories of misfortune may not consider mental illness a separate, or distinct, category from other ‘nonmedical’ forms of misfortune, such as marital problems, failure to prosper or poor performance at school (Whyte, 1997). One classic challenge of crosscultural, psychiatric research is the need to avoid being blinkered by a rigid set of professional definitions of mental disorder that may have limited validity in different populations. This is known as the ‘category fallacy’ that was popularized by Kleinman (1977). Another challenge is to collect data that may have more than only local meaning and go beyond the specific boundaries of geographic location and historical context, and thereby may be useful for meaningful comparisons. This dilemma, often presented as an emic/etic dichotomy, manifests itself from the very beginning of the research: how do we define the subject, mental disorders, under investigation? Do we take the professional classifications as our starting point and check their ‘fit’ within each context? Or do we start with the local definitions, using ethnographic methods to elabo-



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rate local conceptualizations, while at the same time acknowledging the inherent implication that the boundaries of ‘mental illness’ may be fluid?

This paper presents the results of a rapid ethnographic assessment to explore local concepts of mental disorders in four settings in Africa. As a working definition for ‘mental disorder’, the authors used the description by the World Health Organization, referring to ‘disorders or problems characterized by symptoms expressed in abnormal thoughts, emotions, behaviour and relationships with others’ (World Health Organization, not dated-b). The boundaries of a mental disorder were not further specified, in order to give respondents the opportunity to describe the local concepts and local syndromes they found useful and appropriate. We define a local syndrome as ‘a widely recognized prototypical ailment that encompasses a fuzzy set of associations coalescing around one or more core cultural symbols’ (Nichter, 2010, p. 407).

The assessment aimed to generate data to assist HealthNet TPO (an international nongovernmental organization involved in health care development in postconflict settings) to integrate mental health activities into existing public health programmes in South Sudan, the Democratic Republic of the Congo (DRC) and Burundi. Information on local names for mental problems was gathered. Additionally, what respondents saw as defining features and causes related to these conditions and what they commonly did to address these problems were also discussed.

## Methods

### Study settings

The study was conducted in four African settings, where HealthNet TPO implements programmes to construct or reconstruct health care systems. The fieldwork was done between March and October of 2007.

#### SETTING 1: KWAJENA PAYAM (SOUTH SUDAN)

Kwajena Payam is an administrative district in Western Bahr el Ghazal State. The main ethnic group are the Jo-Luo, one of the smaller ethnic groups in South Sudan. They speak a form of the Nilotic language Luo (*Dho-luo*) and are culturally and linguistically related to other Luo-speaking people, such as the Shilluk in Sudan and the Acholi in Uganda. During the second Sudanese civil war (1991–2005) Kwajena Payam, one of the main settlements of the Jo-Luo, saw a temporary influx of other ethnic groups, mostly Dinka (LeRiche & Arnold, 2012). Most people live in *tukuls* (round huts) constructed with mud, branches and thatched roofs, although some reside in tents provided by aid organizations. The land is fertile, bushy forest. The population of Jo-Luo are agriculturalists, mainly growing beans and sorghum, but many of them, following their Dinka neighbours, have also become cattle keepers. In Kwajena Payam, there are few health facilities and no formal mental health services. The closest town is the state capital Wau, around 100 km from the district (three hours’ drive in the dry season). Hospitals in Wau do not have facilities to treat people with mental disorders.

### SETTING 2: YEI (SOUTH SUDAN)

Yei River County is one of the most southern administrative units of South Sudan. It has direct road connections to the DRC and Uganda. The county is culturally dominated by the Kakwa, who live in the borderlands between Uganda, the DRC and South Sudan. The Kakwa survive on a mix of agriculture, pastoralism and increasingly from trade with neighbouring countries. They speak Kakwa, one of the Nilotic Bari-languages of South Sudan. During the second Sudanese civil war it was a stronghold of the Southern Sudanese rebel movement. The people are relatively well educated, with many returning refugees having received basic education in Uganda. At the time of this research, there were no formal mental health services in Yei River County. The county is approximately 100 km from the capital of South Sudan, Juba, which has a neuropsychiatry unit at the teaching hospital (but no psychiatrist and no qualified psychiatric nurse). The few patients in Yei River County who could afford transportation and treatment costs are often sent to treatment facilities in northern Uganda.

### SETTING 3: BUTEMBO (DRC)

Butembo is situated in the northern part of the North Kivu Province in the DRC. This area has experienced decades of political and ethnic violence as a result of two wars (1996–1997) and 1998–2003) and the influx of refugees from Rwanda (Chrétien, 2003). The area around Butembo is the homeland of the Wanande, numbering about one million people. They speak Kinande, a Bantu language. Economically, the region around Butembo is dependent on subsistence agriculture and trade. The only psychiatric institution in the area is a small facility in Butembo town, headed by a psychiatric nurse who trained in the 1980s. The closest psychiatric hospital is in Goma, the capital of North Kivu; however this facility is too far away to be of any use to the residents of Butembo.

### SETTING 4: KIBUYE (BURUNDI)

Kibuye is a district in central Burundi, a country that has experienced cyclic outbreaks of ethnic violence, notably in the 1970s and 1990s (Lemarchand, 1996). Fighting between the Tutsi-dominated national army and rebel groups from the Hutu majority killed 300,000 people and displaced over one million between 1993 and 2003 (Uvin, 2009). The conflict caused the destruction of socioeconomic infrastructure countrywide. There are no formal mental health services in the district, but in the provincial capital Gitega, approximately 50 km away, a monthly mobile mental health clinic is run by the provincial hospital (Ventevogel, Ndayisaba, et al., 2011).

### Procedure

The authors used the methods of rapid ethnographic assessment and qualitative research techniques to collect data within a short period for programme development (Bentley et al., 1988). In each area, two or three research assistants were selected. Their educational background varied from secondary school leavers (Sudan) to BSc

psychologists (DRC and Burundi). They were fluent in the local language of the participants, and in English or French. The first author trained the research assistants in each setting, during a three-day training that consisted of preparing and using the instruments and methods. The study protocol was reviewed and approved by the Research and Development Department of the concerned NGO (HealthNet TPO). This included a review of procedures and ethics. The research plan was also discussed in all four settings with the local health authorities who gave approval. The objectives of the study were read out to all participants and verbal consent was obtained before the interviews and focus group discussions.

### **Focus groups discussions (FGDs)**

FGDs were held in a public venue such as a school, a local health care centre or a church. Discussions followed a topic guide around one question: ‘We would like to talk with you about problems and illnesses that manifest through problems in thinking, feeling or behaving.’ The participants were asked to describe how such problems or illnesses manifested, what causes were related to them and how such problems or illness were usually managed. The duration of each FGD was between one and a half and three and a half hours.

The first FGDs were conducted with the first author as co-facilitator and were passed over to the research assistants when they were able to do the FGDs without supervision. Participants for the FGDs were purposely selected, by the research assistants and community leaders, on the basis of gender and age. The aim, as explained to the community leaders, was to have a broad representation of people in the community. First-degree family members of each other were not allowed to participate in the same group.

Separate groups were held with men and with women, with older persons and with youngsters (aged 16–25, the defining criterion being ‘unmarried’). In total, 31 FGDs (with a total of 251 participants, about half of whom were female) were organized. See Table 3.1 for demographic details of the participants. A minimum of six focus groups per location was planned. However, in two locations (Butembo and Kwajena Payam), no data saturation was reached after six focus groups; therefore, additional focus groups were conducted.

### **Key informant interviews (KII)**

During meetings with the community leaders and during focus groups, a broad category of people identified as ‘experts on mental problems’ were approached for semistructured interviews. The first author and research staff conducted the interviews with key informants, such as traditional and religious healers, and health-care staff. In each setting, two or three traditional healers were interviewed and between three to seven other key informants (general health workers, policy-makers). In total, twenty-six key informants were interviewed. They were asked the same questions as the participants of the focus groups, but in addition were asked more in detail about their own work.

**TABLE 3.1 Demographic characteristic of participants in focus group discussions**

	<b>Butembo (DRC)</b>	<b>Kwajena (South Sudan)</b>	<b>Yei (South Sudan)</b>	<b>Kibuye (Burundi)</b>	<b>Total</b>
Number of groups	9	10	6	6	31
Rural	4	10	5	6	25
Urban	5	0	1	0	6
Gender of participants					
Male (% of total)	32 (43%)	40 (48%)	27 (60%)	24 (50%)	
Female (% of total)	42 (57%)	44 (52%)	18 (40%)	24 (50%)	
Mean age (years) of participants in subgroups					
Youngsters	18.7 (16-20)	20.4 (15-27)	25.5 (22-29)	20.0 (17-23)	
Men	37.3 (24-52)	46.2 (32-51)	48 (30-61)	45.2 (31-60)	
Women	40.8 (32-39)	37.5 (31-51)	38.3 (27-60)	36.0 (23-46)	
Elder men	49.0 (44-67)	50.1 (30-70)	46.4 (40-62)	54.8 (39-70)	
Elder women	55.8 (42-76)	43 (37-50)	– –	44.3 30-63	
Education					
Mean number of years in school (spread)	4.9 (0-13)	1.6 (0-10)	4.5 (0-12)	3.7 (0-9)	
Languages used	Kinande	Kakwa	Luo	Kirundi	

### **Data analysis**

The discussions, including the questions asked by the facilitator, were noted by one of the research assistants in the local language and later translated into English. During this translation process, the two research assistants checked the work of the other and, when required, assisted each other in modifying the translations. The information collected from the focus groups was reviewed by the authors using content analysis, with an iterative coding procedure (Strauss & Corbin, 1990). Only items that were mentioned in two or more focus groups in one setting were included in the analysis. For each local category, responses were ordered according to ‘symptoms’, ‘causes’ and ‘treatment options’ (Hardon et al., 1995; van Duijl et al., 2005). These

data were analyzed by the first author, and emerging themes and categories of illness were discussed with the research assistants. The resultant adaptations were made on a consensus basis.

## Results

A brief overview of the local syndromes found in each setting is presented first. Also, for the purposes of this paper, syndromes that referred to epilepsy-like syndromes, mental retardation and drug and alcohol conditions were excluded, although they were mentioned in all settings. These will be discussed in separate papers.

### Local syndromes in Kwajena (South Sudan)

#### MOUL

Respondents describe people with *moul* as aggressive ('fighting with people, throwing spears or setting houses on fire') with bizarre behaviour, such as: 'walking around naked, eating faeces or collecting rubbish'.

'They say things that make no sense. They talk about one thing and in the next sentence they talk about something completely different. So a normal person cannot understand them.'

(Man in FGD, 12 April 2007)

#### WEHIE ARENJO/WEHIE ARIR

*Wehie arenjo* ('destroyed mind') or *wehie arir* ('disturbed mind') refer to those who used to be normal, but suddenly behave abnormally. Features mentioned by the respondents include: 'becoming very sad', suicidal thoughts and displaying strange behaviours, such as 'talking or laughing when no one is around'. People with this condition are thought to be easily angered and aggressive. It is also thought to be a temporary, reversible, condition.

'He behaves like someone drunk. The next morning he realises what he has done and then regrets his behaviour. *Wehie arenjo* is less severe than *moul*, because *wehie arenjo* can return to normal.'

(Man in FGD, 10 April 2007)

#### NGER YEC

People with *nger yec* ('cramped stomach') are believed to always be sad. They have little appetite, are inactive and do not work. Many have suicidal thoughts. They cannot quieten their minds and often sleep only a few hours a day. A person with *nger yec* feels weak and tired and often believes that his or her situation is hopeless. Frequently, this is accompanied by diarrhoea, which is often green in colour and can sometimes cause collapse due to weakness. They are forgetful and tend to isolate themselves.

'If you tell him something, he will forget it. When people talk to him, he does not listen, be-

cause his mind is somewhere else. They do not walk to their neighbours, but hide in their houses and will not come to a meeting like the one we are having now.'

(Woman in FGD, 10 April 10 2007)

### **Local syndromes in Yei (South Sudan)**

#### **MAMALI**

The main feature of *mamali* ('disturbed mind') is aggressive behaviour, such as 'throwing stones at people'. Other characteristics are: 'talking when no one is present', bizarre behaviour including eating dirty or inedible things, 'walking naked', bad hygiene and self-neglect, social isolation and speaking in an unintelligible manner.

#### **NGENGERE**

A specific type of *mamali* is called *ngengerere*. This is an acute condition characterized by: aggressive behaviour (fighting, throwing stones and shouting), disturbed speech (singing songs all the time), emotional instability ('they change in a moment from laughing to crying') and running away, into the bush.

#### **YEYEESI**

*Yeyeesi* ('many thoughts') is used to indicate people 'whose mind is always busy with thoughts'. People with *yeyeesi* often isolate themselves, lack appetite, feel sad and often cry. Usually they cannot sleep properly and sometimes have suicidal thoughts.

'Such a person thinks everything in the world is very bad. When something good happens, for example when he gets a present, he will only be happy for a short time and then be sad again.'

(Man in FGD, 30 March 2007)

Other characteristics mentioned included: absent-mindedness, frequent headaches, self-neglect and poor hygiene, and irritability.

### **Local syndromes in Butembo (DRC)**

#### **ERISIRE**

A *musire* (a person with *erisire*) is typically thought to be verbally and physically aggressive (throwing stones and beating people). The behaviour of *musire* is uncoordinated, 'without order in their actions', as indicated by taking their clothes off, walking naked, eating inedible things (like leaves from the street), walking aimlessly and sitting down in dirty places. People with *erisire* talk about things that are not relevant or are unable to logically follow the course of a discussion:

'One can understand the words they are saying, but these are only things that are not relevant. They say whatever comes into their mind and they say it whenever they like.'

(Man in FGD, 8 March 2007)

Other symptoms include: 'singing songs all the time', 'laughing or crying at inap-

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propriate moments', 'talking to people when no one is there', 'stealing things' and 'not realizing they are mentally ill'. A specific type is *erisire ry'emumu* (silent *erisire*), which was described in two focus groups and is characterized by social isolation, not speaking, absence of movement and a profound sadness. In two urban groups, another type of *erisire* was described, characterized by too much activity, talking, dancing and singing excessively and an inappropriate, exalted mood.

#### **AMUTWE ALLUHIRE**

*Amutwe alluhire* ('tired head') is used to indicate someone who is sad, irritable or nervous, and often cries without reason. A person with *alluhire* is 'confused.' They are easily angered or irritated, and feel neglected by family and friends. They are often forgetful and socially withdrawn. These problems become visible during social contact with others:

'He has difficulties in contact with other people. He does not recognize people, because he is occupied with his thoughts. His mind is somewhere else.'

(Elderly woman in FGD, 7 March 2007)

#### **Local syndromes in Kibuye (Burundi)**

##### **IBISAZI**

According to all respondents in Kibuye, the key features of people with *ibisazi* are aggression and lack of respect for others. They may have a mad or bewildered look in their eyes and exhibit bizarre behaviour, such as: going naked, collecting useless things and neglecting personal hygiene. Some talk all of the time, while others hardly speak at all.

##### **IBONGE OR AKABONGE**

People with *ibonge* are either always talking and dwelling on what they have lost or are very withdrawn and hardly speak. Other features are social isolation, always feeling sad, not allowing anything to cheer them, sleep problems and suicidal thoughts. They exhibit no interest in anything. Other words that are used to indicate a state of sorrow, in which a person is not able to function normally, are *agahinda*, *kinemura* or *akarunga*. People suffering from *ibonge* often sing *gucurintimba* (melancholic songs), full of regret and sorrow, about the mistakes they have made and how everything was lost. The syndrome of *ibonge* can also include symptoms such as 'having a deranged mind' and 'talking to oneself'. The neglect of social obligations is an element that was also stressed. Sometimes *ibonge* is distinguished from *kuyinga*, a more dangerous condition in which a person becomes a 'quiet fool'. This condition is characterized by disorganized behaviour, such as gathering plants and rubbish, but also by a lack of aggression.

##### **IHAHAMUKA**

People with *ihahamuka* are highly fearful and startled by loud noises. They are always 'on alert', easily distracted by things within the environment and often silent.

They may also sleep badly and have no appetite. *Ihamamuka* is always a reaction to traumatic events, for example: witnessing massacres during the war, rape or a bad car accident:

‘They are always alert, as if there is always danger, but this danger is not real. At night, while they are sleeping, they often awake suddenly. Then they cannot fall asleep again. They are also afraid to go anywhere.’

(Woman in FGD, 12 July 2007)

## Comparing syndromes

### Symptoms

There are several similarities within the four settings. The local syndromes of *moul* (Kwajena, South Sudan), *mamali* (Yei, South Sudan), *erisire* (Butembo, DRC) and *ibisazi* (Burundi) would all have to be literally translated as ‘madness’ and are all ‘conditions related to severe behavioural disturbance’. Among the defining features are interpersonal violence, chaotic behaviour (walking aimlessly or naked, collecting rubbish, etc.) and ‘talking nonsense’. Other elements, such as talking when alone, talking too much, eating dirt and bad hygiene, were mentioned in three of the four locations as characteristic symptoms. This is visualized in Figure 3.1, in which each circle represents a local concept from one of the four research settings. Thus, symptoms that were mentioned as defining characteristics for all four conditions are situated in the centre of the picture, enclosed by all four circles. A symptom that was mentioned as a symptom for three of the four conditions is enclosed by three circles.

The local syndromes of *nger yec* (Kwajena), *yeyeesi* (Yei), *alluhire* (Butembo) and *ibonge* (Kibuye) share some features such as feeling overwhelmingly sad and social withdrawal, but there are significant differences as well. The unique symptoms include ‘green diarrhoea’ (*nger yec*), ‘headache’ (*yeyeesi*), ‘confusion’ and ‘irritability’ (*alluhire*), as well as self-remorse and dwelling on the past (*ibonge*). This is visualized in Figure 2, in which each circle represents a local concept from one of the four research settings. Thus, symptoms that were mentioned as defining characteristics for all four conditions are situated in the centre of the picture, enclosed by all four circles. A symptom that was mentioned as a symptom for three of the four conditions is enclosed by three circles. These local concepts are referred to as ‘conditions related to sadness and social withdrawal’.

### Aetiology

In all four research settings, the locally described conditions are thought to be related to a wide range of potential aetiological factors. These are summarized in Table 3.2 and include supernatural, natural and psychosocial causes.

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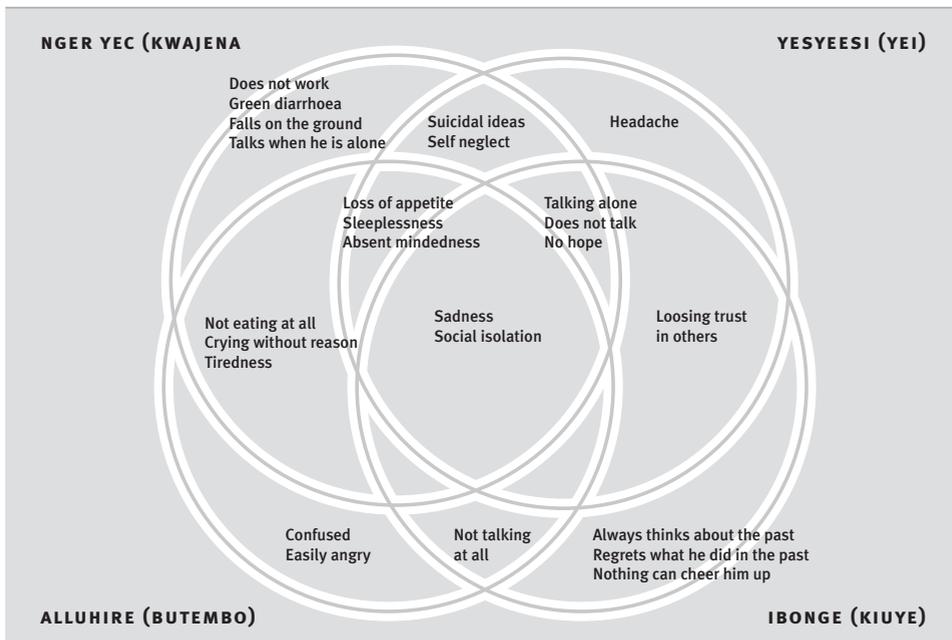
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**FIGURE 3.1** Local syndromes with behavioural disturbances and violence as common features in four African settings



**FIGURE 3.2** Local syndromes with sadness and social isolation as a common feature in four African settings



**TABLE 3.2 Perceived aetiology of locally defined conditions in four African settings**

	Supernatural	Natural	Psychosocial
<b>Kwajena (South Sudan)</b>			
<i>Moul</i>	Spirits of dead people ( <i>cien</i> )	Malaria	Thinking too much
	Malevolent spirits ( <i>djok, arop</i> )	Meningitis	Loss of properties and loved due to the war
	Violating a taboo		
<i>Wehie Arir</i>	Being cursed		
	'Perhaps somebody is behind your misfortune' (indicating sorcery or witchcraft)		Having lost children or property
<i>Nger yec</i>			Recent loss (of a person or property)
<b>Yei (South Sudan)</b>			
<i>Mamali</i>	Being bewitched	Cannabis	<i>Yeyeesi</i> ('thinking too much')
	Attack by spirits from water or forest (a <i>bionga</i> or <i>dulako</i> )	Alcohol	'Too many problems'
		Brain damage	Family disputes
		Typhoid fever	Born this way
<i>Ngengere</i>	Being bewitched	Drugs	
		Alcohol	
<i>Yeyeesi</i>			Loss of beloved person
			Loss of property
			State of poverty
			Family disputes
<b>Butembo (DRC)</b>			
<i>Erisire</i>	Bad spirits ( <i>virumu</i> )	Cerebral malaria	Death of a loved one
	Scorcery (by a <i>mukumu</i> , traditional healer)	Epilepsy	Being rejected in love
	Bad spell ( <i>lirengo</i> )	Drugs	
<i>Alluhire</i>		Alcohol	
			Worrying about problems
			Poverty
			Family problems
			Death of loved ones
		Rape	
<b>Kibuye (Burundi)</b>			
<i>Ibisazi</i>	Sorcery	Malaria	<i>Ibonge</i> (see below)
	Angry ancestor spirits	Fall on head in	Having lost belongings
	Bad spirits	accident	Seen too many bad things in the war
		Change in blood	
		Drugs	
	Alcohol		

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LOCAL PERSPECTIVES

<i>Ibonge</i>			Death of a loved one
			Loss of property
			Loss of livelihood
			Having witnessed
			atrocities during the war
			Worrying about bad health
<i>Ihahamuka</i>			Having witnessed terrible
			things in war
			Having been raped
			Car accident

### SUPERNATURAL FORCES

In all four areas, respondents described supernatural forces as a causal factor for conditions related to severe behavioural disturbance. Local cosmologies within the four settings were not identical, however, with different ways of conceptualizing the supernatural realm. For example, it can be related to ‘bad spirits’ (from rivers, lakes or rocks), disturbed ancestral spirits, violating a taboo or being cursed or bewitched (although this is usually through the mediation of a sorcerer or a ‘bad’ traditional healer).

‘A person can get *mamali* when the person has stolen something from another who seeks spiritual revenge, or is attacked by spirits from the mountain, the waters or from the thick forests.’  
(Man in FGD, Yei, South Sudan, 30 March 2007)

‘An *arop* (a malevolent spirit) can come into the house with, for example, a goat or a cow that you have bought, and bring the spirit with him. If you are not aware this spirit is in the house, it can start killing people or cause moul. You have to do something, like slaughtering an animal, so the *arop* knows that you respect him.’  
(Woman in FGD, Kwajena, South Sudan, 12 April 2007)

Spiritual causes were never mentioned for conditions that have sadness and social withdrawal as common features.

### NATURAL DISEASES

In all four settings, infectious diseases (e.g. malaria) were mentioned as potential causes of the conditions related to severe behavioural disturbance. Apart from in Kwajena (South Sudan), the use of alcohol and drugs were also mentioned as a cause, in all settings. For ‘conditions related to sadness and social withdrawal’, natural diseases were not mentioned as a potential cause.

### LOSS AND WORRY

All groups mentioned loss as main cause of ‘conditions related to sadness and social withdrawal’. This could have been the loss of livelihood and properties, but often in-

volves the death of a loved one, particularly children. It could also be induced by living in miserable conditions, such as extreme poverty, being physically ill for a long time, by family problems such as divorce or too many responsibilities.

**'When you lose someone you loved very much, or when you lost a lot of money or when your house is burnt, this can cause illness. You can get really sick from it, but when you go to the health centre, the doctors cannot find any disease. [...] When a father dies and he has three sons, all will cry. But one son cries too much. That one has *nger yec*. He feels it in his stomach. Sometimes a person can even tie his belly with a rope to stop the cramp.'**  
(FGD, Kwajena, South Sudan, 10 April 2007)

**'*Akabonge* is seen especially with adult people who have lost their children and goods. They continue to mourn and despair completely. People with *akabonge* remain silent, as if they are dumb. They are absent-minded and are not interested in life.'**  
(FGD, Kibuye, Burundi, 13 July 2007)

The cause of *ihahamuka* (Kibuye, Burundi) is related to having witnessed gruesome events, for example massacres during the war, or surviving extreme events, such as rape or a bad car accident.

In all four settings, people also made a link between situations of severe loss and conditions related to severe behavioural distance and violence. In Butembo, for example, respondents mentioned that *erisire* may follow a major setback in life, such as the loss of a beloved family member or rejection by someone they love. Respondents, within different settings, used similar explanations.

**'*Mamali* can be caused through *yeyeesi*, for example when one has lost all his properties or dear ones.'** (KII with healer, Yei, South Sudan, 30 March 2007)

This is in contrast to the acute forms of severe behavioural disturbance and violence that were distinguished in Yei and in Kwajena. These were related to clearly identifiable factors. *Wehie arenjo*, the acute form of behavioural disturbance that was described in Kwajena (South Sudan), was overwhelmingly thought to be related to loss, which leads to *par keter* ('thinking too much'), which in turn could lead to *wehie arenjo*.

**'Those people think too much. For example, when many of your children have died, then a person can become very sad and think too much. They think in a negative way.'**  
(KII with healer, Kwajena, South Sudan, 30 April 2007)

Across all geographic locations, respondents reported that sadness and social withdrawal could contribute to conditions related to severe behavioural disturbances; in Burundi *ibonge* can, for example, lead to *ibisazi*. For example, someone who had lost all their belongings, or was haunted by memories of the war, would first develop *ibonge* or *ihahamuka*, but could eventually reach a stage of *ibisazi*.

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## Treatment

In all four settings, treatment decisions were strongly dependent on the perceived cause of the condition, which was not always apparent from the ‘symptoms’. What seemed to have similar effects could have very different causes. For example, if a condition was related to a natural cause, such as a disease with fever, health facilities were mentioned as a treatment option. Usually, however, the causes of conditions related to severe behavioural disturbance and violence were not immediately clear. Therefore, a first step in the help-seeking process would be to discover the cause, and in particular, to resolve it if supernatural factors were believed to be present. Perceived treatment options for locally defined conditions in four African settings are given in Table 3.3.

Participants, in all settings, were very pessimistic about treatment options for conditions related to severe behavioural disturbances.

‘It is difficult to help because the problem is inside the mind of the person. There are no medicines for this.’

(KII with community leader, Yei, South Sudan, 31 March 2007)

‘We bring a person with moul to a *ruodbedho* (spear master) who can chase bad spirits away, or can do away with sorcery done by another spear master. We also go to *ngadyeadh* (herbalist) who can give medicine, but often this does not help.’

(Elderly man in FGD in Kwajena, South Sudan, 9 April 2007)

If a spiritual cause is established, rituals can be done to banish harmful spiritual forces.

‘There is not a single treatment for *ibisazi*. In the case of *uburozi* (sorcery/poisoning), one should go to a traditional healer. In the case of bad spirits, one has to chase the spirit away by praying and rituals in the church, and in cases that do not have a clear supernatural cause, one should go to the hospital. If you do nothing, the patient will not improve and will finally die.’

(Elderly man in FGD, Kibuye, Burundi, 13 July 2007)

In one setting (Yei, South Sudan), traditional healers made the distinction between the chronic condition *mamali* (considered very difficult to treat) and the more acute condition *ngengere* (easy to treat). They believe that herbs for *ngengere* will calm the patient and, with use, the problem will disappear completely.

In Butembo (DRC), participants in all groups reported that patients with *erisire* can be treated in the mental health centre in the town. In the rural areas, people mentioned that the distance to the mental health centre was a problem. Butembo was the only place where people mentioned psychiatric treatment, and indeed was the only setting with such a facility available. People with *erisire* are thought to improve through treatment with Western medication, but not when sorcery or spirits caused the condition. In these cases, a visit to *mukumu* (traditional healers who work with spirits) is recommended.

**TABLE 3.3 Perceived treatment options for locally defined conditions in four African settings**

	Traditional healers	Health care facilities	Family and community interventions
<b>Kwajena (South Sudan)</b>			
<i>Moul</i>	Visit <i>ruedbedho</i> ('spear master') to chase spirits away	Health centre in case of malaria	
	<i>Ngadeyeadh</i> (herbalist) who can give herbs		
<i>Wehie Arir</i>	Visit <i>ruodbedho</i> ('spear master') to understand the cause	Health centre (medicine to calm patient down) Medicines if caused by malaria	Try to replace the things or persons he has lost Relatives or elders in community should talk to person Pray in the church together with the patient Prevent person from drinking alcohol and smoking cannabis
<i>Nger yec</i>			Relatives or elders in community should talk to person and give advice to overcome the sadness Compensate person for the losses he suffered Invite the person to come to your house
<b>Yei (South Sudan)</b>			
<i>Mamali</i>	Visit a <i>buni</i> (traditional soothsayer) to find out the cause and perform rituals to chase away the spiritual forces		Praying to calm down a patient
<i>Ngengere</i>	Some healers have herbs to calm person down		
<i>Yeyeesi</i>			Family or religious leader talk with the person and give him advice The family and neighbours should also help the patient not to be alone and to involve him in activities, in particular

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			those that can give him income
			Elders from the church can visit the person and pray together.
<b>Butembo (DRC)</b>			
<i>Erisire</i>	<i>Mukumu</i> (traditional healers who work with spirits), if there are super-natural causes	Visit a health facility to check if there is malaria or another physical cause	
	<i>Musaki</i> (herbal healers) for herbal medicine	Visit mental health centre in town	
	Christian pastors who can pray with the patient		
	In case of possession by ancestral spirits, one should construct a <i>vuhima</i> , a small house for the ancestors		
<i>Alluhire</i>			Provide him money, goods or work
			Visit the person
			Pray with the person
			Ensure that the person is not alone
			Involve him in communal work in the village
<b>Kibuye (Burundi)</b>			
<i>Ibisazi</i>	In case of sorcery: traditional healer	Provincial hospital	
	In case of bad spirits: praying and rituals in the church		
<i>Ibonge</i>			Family and try to comfort person
			Encourage person to talk about his problems
			Replace the loss
<i>Ihahamuka</i>			Family to listen to the person
			Family and friends should help the person to do the things he is afraid of

Respondents in all settings believed that ‘conditions related to sadness and social withdrawal’ were not diseases, but states caused by circumstances. Therefore, health centres and traditional healers were not thought to be effective in helping those with such conditions. For these conditions, in all four settings, the actions required were believed to be social and involved a combination of advice, comfort, practical support and breaking through social withdrawal.

‘The first thing to do to help a person with *nger yec* is to talk to him, and to give advice to overcome his sadness. Elders in the community, or relatives, can talk with him and tell him to be courageous, and about other people who have been in the same situation and survived.’  
(Man in FGD, Kwajena, South Sudan, 10 April 2007)

‘When a mother has lost many children and gets *ibonge*, a family member can replace the lost children by sending one of his own children to live with her, and to help her.’  
(Woman in FDG, Kibuye, Burundi, 12 July 2007)

A person suffering from *alluhire* can be helped by providing material assistance, work or a good house. It can also help to seek distraction, so he will not always think about the bad things, for example by visiting the person. The family of the person should be advised how they can help. Praying with the person can also help. With good assistance, a person with *alluhire* will become normal.’  
(Woman in FGD Butembo, DRC, 7 March 2007)

## Discussion

The group of local syndromes defined by severe behavioural disturbances have considerable similarities with ‘psychotic disorders’ (including manic states). Local syndromes that were characterized by sadness and social withdrawal have similarities to what used to be known collectively as ‘neurotic disorders’. However, in the current international psychiatric classifications such as DSM-5 and ICD-10, these would be characterized as mood disorders, complicated bereavement and/or anxiety disorders.

### Conditions related to severe behavioural disturbances

The concept of ‘psychosis’ in psychiatry encompasses five elements: confused thinking, delusions, hallucinations, changed emotions and disturbed behaviour. The local concepts identified in this research do not emphasize all these symptoms, but tend to focus on ‘behavioural problems’, particularly violent and chaotic behaviour, and ‘cognitive symptoms’ (‘speaking in a way that people cannot understand’ or ‘saying things that are not real’). Emotional expressions, such as crying and laughing without reason, were found, but these were not considered as typical for severe mental disorders. Hallucinations were not mentioned in any of the settings; however, in all four settings, examples were given of behaviour that could indicate auditory hallucinations, such as ‘speaking when there is no one around’.

Perhaps some elements of popular discourse around psychotic disorders in this study bear witness to prevailing norms and ideals within a particular society. For example, the Luo from Kwajena in South Sudan revere male strength, and see men primarily as warriors. Men are often armed with spears. In their descriptions of *moul* and *wehie arir*, they emphasized violent aspects, such as killing people and burning houses. The Burundians in Kibuye stressed the ‘disrespectful behaviour’ of those with mental disorders, which may reflect the importance of harmony and modest, respectful behaviour within their society (as conferred by the local concept of *indero*). Public displays of emotion are frowned on in Burundi.

Lay descriptions of psychotic disorders in Sub-Saharan Africa emphasize behavioural disturbance and disruption of social norms, yet do not often contain symptoms related to thought disturbance and perceptual symptoms (Alem et al., 1999; Gureje et al., 2005; Kabir et al., 2004; Patel, 1995; Teuton, Bentall, et al., 2007). The list of characteristics of people with ‘psychosis’, reported by respondents from four East African ethnic groups in a classical study by Edgerton (1966), included: walking naked, being violent, arson, and talking nonsense. The concepts of *moul*, *mamali*, *erisire* and *ibisazi* in our study are quite similar and significantly overlap with the psychiatric concept of psychosis. They are, however, less narrowly defined and include categories that in current psychiatric nosology are often separated from psychosis, such as manic episodes and delirium.

The Luo and the Kakwa respondents used separate names for acute, and potentially time limited, states of severe disturbance (*wehie arenjo* in Kwajena and *ngengere* in Butembo), with pathology centred on problems with interpersonal behaviour. Professional psychiatric classifications would refer to these acute syndromes as brief reactive psychosis, acute mania, non-affective acute remitting psychosis, *bouffée délirante* or early-stage schizophrenia. Similar distinctions between chronic states of psychosis, and between acute forms characterized by aggression and behavioural disturbance, have been described in other African societies (Edgerton, 1966; Niehaus et al., 2004; Patel, Musara, et al., 1995; Whyte, 1998).

#### **LOCAL AETIOLOGIES FOR CONDITIONS RELATED TO SEVERE BEHAVIOURAL DISTURBANCES**

The respondents in this study list a wide range of possible causes for disorders with severe behavioural disturbances, including spiritual, natural and psychosocial factors. In the literature on African causal theories for mental disorders, the role of spiritual aetiology is often emphasized. Indigenous healers in Uganda indicated that the cause of these disorders was not specific to the person, but could be due to any family member or members neglecting cultural practice (Teuton, Dowrick, et al., 2007). However, not all cases of psychotic disorders are attributed to supernatural forces. Edgerton (1966) found that psychosis is not always attributed to witchcraft, and it was often regarded as an illness occurring for no reason or as the ‘natural result of life stress’. In the literature on local etiological beliefs with regards to psychotic disorders in Africa, a wide range of factors have been described, such as substance misuse (Kortmann, 1987), nutritional factors (Fosu, 1981), diseases of the blood (Good, 1987), malaria (Patel, 1995) and ‘worms in the brain’ (Edgerton, 1966)

In this study, most of these factors were mentioned by the respondents, but there was variance between the settings. Among the Luo (arguably the setting that has been least influenced by monotheistic religions), spiritual causes were more prominent. The Kakwa also mentioned spiritual causes, but more frequently mentioned natural causes (cannabis and alcohol use) and psychosocial causes ('too much thinking').

### TREATMENT

In three of the four settings, respondents indicated that they thought severe mental disorders could not be effectively treated by either traditional healers or in biomedical health facilities. They generally do not seek help in modern health facilities because they are not aware that medications to treat psychotic symptoms may exist. This is quite understandable because, in three of the four locations, there were no health workers who were trained in the diagnosis or management of mental disorders and no psychotropic medication was available in the health facilities. The exception is Butembo, where treatment by Western medication is generally thought to be effective; this may be due to the long-term presence of an active, and highly respected, psychiatric nurse. Respondents were more optimistic about treatment options for acute psychotic conditions. This may be an indication that when psychiatric treatment options for severe mental disorder are made available, people will try them out and continue using them once they experience positive effects.

### Conditions related to sadness and social withdrawal

In various African populations, conditions can be found that are assigned to 'too much worrying' or 'too much thinking' (Betancourt, Speelman, et al., 2009; Fox, 2003; Okello & Ekblad, 2006; Patel, Simunyu, et al., 1995). To what extent are these local concepts identical to psychiatric concepts for affective disorder, such as depressive disorders? On first sight, the resemblance is striking. For example, the Luo description of *ngeryec* includes all symptoms of the DSM-IV definition of depression, with the exception of excessive or inappropriate guilt. However, the defining feature cited by the Luo respondents was not the emotional features, but the existence of typical somatic symptoms, in particular pressure on the stomach and diarrhoea.

*ibonge* in Burundi also resembles, but is not identical to, depression. *ibonge* signifies 'sadness resulting from a multiple sufferings' and *kurwara akabonge* is 'being sick of sadness' (Ntahombaye, 1983). In Rwanda, which shares many linguistic and sociocultural features with Burundi, similar local categories were identified. These included *agahinda gakabije* (with symptoms such as deep sadness, isolation, lack of self-care, loss of mind, not able to work, feeling life is meaningless, not pleased by anything and difficulty in interacting with others) (Bolton, 2001b). The features of *ibonge* and *agahinda* may seem quite similar to Western concepts of depression, but also reflect a transgression of what is considered 'good behaviour'. For example, the emphasis that Burundian culture places on harmony and not showing emotions to others.

The conditions identified in this research are not discrete diagnostic categories

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with a specific set of symptoms, but have fluid boundaries and are applied pragmatically. For example, while the Nande concept *alluhire* may be associated with features of major depression, it is also a rather idiomatic expression to communicate that a person does ‘not feel well’ and is overwhelmed by the tasks of life. *Alluhire* should thus not only be understood as a local syndrome, but also, and foremost, as an ‘idiom of distress’: a culturally prescribed way of communicating distress. An idiom of distress may be indicative of psychopathological states that undermine the well-being of a person, but may in other cases better be seen as adaptive reactions to a situation of distress, and thus be a way of coping with distress (Nichter, 1981, 2010).

#### **LOCAL AETIOLOGIES FOR CONDITION RELATED TO SADNESS AND SOCIAL WITHDRAWAL**

The local concepts related to sadness and social withdrawal in this assessment are thought to be the consequence of identifiable contextual factors, such as severe loss or adversity that, once removed, will result in improvement. Personality factors (such as being ‘weak’) play a role as well. As elsewhere in Africa, these conditions are less likely to be seen as a medical or mental disorder, but are more likely to be ascribed to social or spiritual problems with poverty, social issues, major life events and ‘thinking too much’ (Aidoo & Harpham, 2001; Alem et al., 1999; Muga & Jenkins, 2008; Patel, 1998).

#### **TREATMENT**

Despite diversity in the symptomatic descriptions, management of conditions related to sadness and social withdrawal is quite similar, especially as these conditions are not seen as medical disorders and therefore treatment is rarely sought in modern health care facilities. People believe the management should be entirely psychosocial and aimed at improving the economic situation, increasing social support and decreasing social isolation and loneliness.

#### **Psychotrauma**

Local African concepts of mental conditions related to ‘traumatic events’ vary considerably from the DSM concept of posttraumatic stress disorder, as demonstrated in Gambia (Fox, 2003), Rwanda (Bolton, 2001b) and among Darfuri refugees in Chad (Rasmussen et al., 2011). The latter group distinguished two differing local concepts. The first, *hozun*, had similarities with depression and some elements of posttraumatic stress disorder. The second, *majnun* (literally ‘madness’) also contains some posttraumatic stress symptoms similar to major depression, but in general the syndrome is defined by psychotic symptoms mentioned by the Darfuri respondents (such as ‘talking when you are alone’, ‘talking in a way others cannot understand’ and ‘doing things others consider foolish’). In fact, local categories of *hozun* and *majnun* would fit well in the dichotomy found in this study, between ‘conditions related to severe behavioural disturbance’ and ‘conditions related to sadness and social withdrawal’. In this assessment, only the Burundian respondents had a concept that referred to trauma related complaints. This syndrome, *ihahamuka*, is related to the

psychological aftermath of terrible events and is characterized by fear and hyperarousal. This is one of the features of posttraumatic stress disorder. Other features, such as traumatic recollections and avoidance or numbing, were not spontaneously mentioned. Yet, according to Hagengimana and Hinton (2009), *guhahamuka* in Rwanda resembles both posttraumatic stress disorder and panic attacks.

The absence of a local category of trauma-related mental disorders in three of the four settings does, of course, not imply that there is no effect of collective violence on the mental state of the population. As has been shown for Juba in South Sudan, violent and traumatic events may have pervasive effects on the general physical and mental health of conflict-affected populations (Roberts et al., 2010).

## Limitations

Data yielded by FGDs are often influenced by social dynamics within a group and frequently describe what people assume they *should* think and do, rather than what people *actually* think and do. Therefore, our data are limited, and cannot shed light on how the illness categories described here actually play out in people's lives. Moreover, asking nonaffected people about their observations of affected people may favour mentioning phenomena that are easily *observable* rather than internal cognitive or emotional states, which are less easily observed by outsiders. Another limitation of this study relates to the role of the researcher. By using local research assistants, who were familiar with the language of the participants, the authors tried to reduce the possibility of interviewer bias. However, the presence of an expatriate researcher in some of the FGDs may have still caused bias. The fact that a non-African representing an international organization providing health services shows interest in the phenomena of 'madness and sadness' is in itself a social act with some importance that may have induced social desirability in the responses. Alternatively, participants may also have been reluctant to be honest with someone local in the room.

Finally, there was a limitation with the approach used; through the elicitation of how local syndromes are commonly understood, there is a risk of an 'essentialising' approach. This sort of approach focuses on what Nichter (2010) calls the 'whatness' of particular cultural modes of expressing distress. The authors were aware that local syndromes often have no rigid boundaries, but are used flexibly to interpret illness and misfortune. Yet, this exploratory survey, which identified culturally salient idioms and syndromes, provides a starting point for further, in-depth exploration of how and why specific means of expressing distress, at specific points in time, are being used in concrete situations.

## Conclusions and implications for practice

While cultural categories may be closely aligned to mainstream psychiatric categories, it is important to realize they are not identical and to resist reifying them into professional psychiatric classifications. The local terms used by our respondents are

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heuristic concepts, used pragmatically to bring order to chaotic and disturbing experiences and to assist in the quests for meaning and solutions to end suffering. These concepts are localized and, therefore, show the influence of contextual factors in shaping illness experience.

This assessment has several implications for public mental health interventions. In the first instance, it clearly shows that the population is concerned about conditions characterized by behavioural disturbances. These conditions share many features with psychotic disorders, as identified by Western psychiatry. People see overwhelmingly the need for these conditions to be treated, but do not know how to do so effectively. Treatment by traditional, or religious, healers is primarily not seen as effective. Neither is treatment within the health care sector an option sought very often, as health facilities do not have staff trained in diagnosis and treatment of mental-health conditions and lack effective medicines for treating these conditions. The population is, however, likely to try any treatment option that seems viable once it is made available to them.

Our conclusions are similar to those of a recent study showing that rural Haitians in areas affected by an earthquake do not seek mental health treatment within the formal health sector as this option is not readily available, and not because they do not wish to try it (Khoury et al., 2012). Moreover, the evidence for the effectiveness of psychiatric interventions for the management of severe mental disorders, such as psychotic syndromes, is relatively strong (Dua et al., 2011). Therefore, we advocate that treatment of severe mental disorders should be made a priority for the health care system. Given the extreme shortage of mental health professionals in low-income countries (approximately one psychiatrist per two million people and one psychiatric nurse per 200,000 people), these interventions cannot be implemented simply by specialists (Kakuma et al., 2011). Evidence suggests, however, that mental health care can be delivered effectively within general health care facilities by non-specialist health providers, with brief training and appropriate supervision by mental health specialists (Eaton et al., 2011).

Secondly, each population has local categories for states in which a person is overwhelmed by loss or sadness. These conditions are not seen as medical problems or indeed as conditions requiring assistance from the health sector. The interventions considered viable in these instances, by the local population, most often occur within the family and the community. Therefore, the entry point to provide assistance for those who suffer from these conditions would ideally be within the families and the communities. A primary aim for public mental health interventions for these conditions would thus be to empower 'natural' social support systems already in place at local levels and to strengthen social cohesion and social capital within communities (de Jong & Komproe, 2002). However, our respondents also made it clear that the existing mechanisms for healing may fall short or be overwhelmed, particularly in postconflict areas. Local systems of support can be strengthened through capacity building for community-based psychosocial support and by installing services through trained paraprofessional counsellors or community workers (Murray, Dorsey, et al., 2011; Scholte, Verduin, Kamperman, et al., 2011). It is important that any approach includes various, overlapping levels of interventions in order to ad-

dress varying needs for support for problems that range from primarily psychosocial to psychiatric (Jordans, Tol, et al., 2010).

One major challenge to the development of such integrated, multilevelled care systems among populations that are overwhelmed by massive losses and breakdown of social-support structures is how to determine when mild and/or moderate depressive states become psychiatric conditions requiring medical attention (de Jong, 2011; Ventevogel et al., 2012). Addressing this problem needs continuous cooperation between health professionals and community resources. Within such a dialogue, it is essential to keep account of how people themselves define what is at stake for their own lives.

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## Change and continuity in Burundian divinatory healing

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## Abstract

Traditional healing practices in Burundi are rarely documented within ethnographic literature; further, it is unknown if or how practices described in older, mostly French, literature have changed in the last two decades. This paper provides and analyses data based on interviews and observations with seven Burundian *abapfumu* (diviner-healers), and 14 focus group discussions with community members (n=104). The results show that the position of traditional healers towards tradition is, in fact, ambivalent; giving less emphasis to the role of ancestor spirits causing and healing misfortune than in the past. Some of the interviewed healers belonged to the established cult of *kubandwa* that is found all over the African Great Lakes Region and that still thrives in Burundi. In this adorcistic cult, afflicted persons are assisted to enter into a peaceful and accepting relation with the possessing spirit. More recently a novel healing technique (*gucekeru*), has emerged, in which unknown spirits are aggressively driven out of the affected person. As elsewhere in Africa, the rise of exorcistic healing in Burundi may be a reaction to the breakdown of community structures resulting from the collective violence and mass displacements that occurred over the past decades. Further, the results show that Burundian healers have considerable flexibility in adapting to new circumstances and are attempting to create new 'niches' within a society that is profoundly changing due to modernization and the aftermath of violent conflict.

## Introduction

Understanding traditional healing methods and how the community perceives them is important for public health programming in Africa. This is particularly true in the field of mental health as people frequently seek help from traditional healers for mental health issues (Abbo et al., 2008; Campbell-Hall et al., 2010), yet the work of traditional healers is rarely understood by policy makers or clinicians. Therefore, in order to contribute to this scant pool of knowledge, this paper describes aspects of traditional healing and healers in Burundi, using data from seven practicing Burundian healers and focus group discussions (FGD) with community members. The research was carried out within the context of programme development for a nongovernmental organisation (NGO). Before presenting and analysing the ethnographic data, a brief overview of what is known from the literature on Burundian healers, the spiritual cosmology in the country, and notions of witchcraft and sorcery will be provided. Finally, these concepts will be connected to literature from within the wider context of Bantu speaking people, particularly those of the interlacustrine region in Africa, to which Burundi belongs.<sup>1</sup>

## Healers in Burundi: Diviners, herbalists and blurred distinctions

Traditional Bantu healers may often be categorised as either ‘diviners’ (who diagnose illness through spiritual means), or ‘herbalists’ (who exclusively use medicines based on herbs and substances of animal origin). This differentiation between diviners and herbalists is also to be found in literature on Burundian traditional healing.<sup>2</sup> In practice, however, the distinction between herbalists and diviners is often blurred, with boundaries becoming amorphous as diviners incorporate acquired knowledge into their practices, while conversely, herbalists claim to have derived their knowledge of plants from God or spirits, and use divinatory techniques (Erdsieck, 1997, pp. 7-8; Gessler et al., 1995; Gort, 1989; Willis, 1999, pp. 150-162). Tellingly, documents written by Burundian policy makers and development workers often focus on the prescription of herbs as the primary core of traditional healing (Gouvernement de la République du Burundi, 2002, 2014; Ndikubagenzi et al., 2006), ignoring or dismissing the work of healers who claim to work through contact with the spiritual world.

The Kirundi word for diviner, *abapfumu* (singular: *umupfumu*), is derived from the verb *gupfumura*, ‘to divine’ (Rodegem, 1971). The word *abapfumu* can be used to indicate diviners, healers, magicians, seers and advisors (Rodegem, 1970). In Burundi, as in other Bantu societies throughout Central and Southern Africa, this type of healer uses divinatory techniques to *diagnose* illness and other misfortunes (d’Hertefeld et al., 1962; Davis-Roberts, 1992; Janzen, 1992; Steinforth, 2009; Whyte, 1997).<sup>3</sup> After the cause of a problem has been identified, the healer may use varying techniques, including administration or use of herbs, to heal the affliction. Diviners are believed to be a medium between the visible and invisible worlds, and they derive their diagnostic capacities and healing power from supernatural forces (such as ancestral spirits) who have chosen to bestow powers onto the healer. Consequently, such divinatory healing power cannot be acquired through one’s own volition. It is believed that spirits often force acceptance of this vocation through the sending of a serious illness, which may only be cured if consent to undergo the necessary apprenticeship is given, making such a initiatory illness an important part of the transformation process from an individual to a member of the guild of healers (Reis, 2002).<sup>4</sup>

Older, ethnographic descriptions of Burundi did not identify a separate term for a pure ‘herbalist’. While more recently, Burundians frequently use the term *umuvuzi w’imiti kama* or *umuvuzi w’imitiy’i Kirundi* (literally: ‘healer who uses natural medicines’ or ‘healer who uses Burundian medicines’). Such healer may work with leaves, roots, bark and animal skins, but also small objects (such as amulets) or fumigation (the use of smoke to inhale plants) and ‘traditional vaccinations’ made by the healer.

The knowledge to prepare these medicines, and specific procedures that ‘make them work’, is often acquired from other healers as it is believed that a substance that may in itself be innate, can be ‘made to work’ through words and rituals. By invoking the spirits, a healer can infuse the medicine with power. This can be accomplished through singing incantations to the bark, plants and animal bones used while preparing the medicine, or by adding power that counteracts sorcery (called *kurogora*, to ‘de-witch’).

Some authors claim that to Burundian healers, it would not matter *which* herb was

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used, but that *they* made it into a medicine (Baerts & Lehmann, 1989), suggesting the power uniquely comes from the spirits through them. This is most likely a gross exaggeration, given ample evidence that elsewhere in Africa, traditional healers use medicines that are believed to contain potency by themselves, also outside of ritual contexts (Green, 1994; Janzen & Green, 2003). However, the claim that medicines obtain ‘agentive power’ (Simmons, 2006, p. 71) through spoken intention illuminates at least two important aspects of Burundian healing practices. First, as found echoed elsewhere in Africa, there is a large degree of idiosyncrasy among Burundian healers: they are secretive about their methods and have not formalised their knowledge into a coherent ‘medical system’ that would contain a particular cure for a particular set of symptoms (Last, 1981). Secondly, it points to the power of the spoken word, both in healing practices as well as in sorcery. A proverb in Kinyarwanda/Kirundi says ‘*Ntihica uburozi, hica umutukiro*’: ‘It is not the poison that kills but malicious words’ (Rwangabo, 1993, p. 44).

### **Sorcery and witchcraft in Burundi**

In the literature, the ‘good’ *abapfumu* are often contrasted with the ‘bad’ *abarozi* (sorcerers and poisoners). *Abarozi* are thought to operate in secret, bringing misfortune, including infertility, poverty, failed crops, traffic accidents, illness and death (Feltz, 1993, p. 37; Hakizimana, 2002, pp. 123-125; Trouwborst, 1962, pp. 158-160; Zuure, 1926, p. 735). Sorcerers do this by using *uburozi*, which is a wilful act by one person to cause misery to another through non-natural means. *Uburuzi* has been translated as ‘poisoning’, ‘sorcery’, or ‘witchcraft’, but these terms do not wholly inform the concept.

The English ‘poisoning’ or the French ‘empoisonner’ are insufficient translations as *uburozi* is certainly not always literally ‘poisoning’ in the sense of eating or drinking something containing a poison. As in many other Bantu societies in the Great Lake area, and elsewhere in Africa, *uburozi* can be done distantly (sending magical substances through the air or putting magic objects on the path of a person), or within close proximity by shaking hands, as well as many other ways. Medical literature on Rwanda describes how patients and families attribute chronic illnesses, such as severe mental disorder, tuberculosis and HIV-AIDS to ‘poisoning’ (*uburozi*) (Ngang, Ntaganira, Kalk, Wolter, & Ecks, 2007) (De Keukelaere, 2005; Ngang et al., 2007; Thurman et al., 2008).

Translating *uburozi* with ‘sorcery’ is also problematic. Within anthropology, the term sorcery has a distinct meaning and is often juxtaposed to ‘witchcraft’. According to Evans-Pritchard, proposed in his classical study on the Azande in Southern Sudan that a sharp distinction between the two concepts should be made (Evans-Pritchard, 1937). Sorcery represents learned and consciously applied acts of a bad person (the ‘sorcerer’) to create trouble for others. While witchcraft is an evil force that resides within a person (the ‘witch’), and who may be unaware of the misfortunes he or she inflicts upon others, often through jealousy or greed. While the witchcraft/sorcery distinction may have validity for some societies in East Africa (Middleton & Winter, 1963), it does not in many of the Bantu societies in the inter-

lacustrine region of Africa, such as the Nyole and the Gisu in Eastern Uganda (La Fontaine, 1963; Whyte, 1997), the Nande in North Kivu (Sabuni, 2007), the Zinza at the Tanzanian lake shores of Lake Victoria (Bjerke, 1989) and indeed the societies of Burundi and Rwanda (Taylor, 1999). Several anthropologists have proposed abandoning the sorcery/witchcraft dyad (Devisch, 2005; Moore & Sanders, 2001) and instead follow local terms used within a specific context, which is what has been done in this paper.

### **Spirits in Burundi**

Burundian spiritual cosmology is extremely rich and difficult to grasp for outsiders, who grapple with the meaning of terms that seem to be loosely defined and can differ from informant to informant, and from context to context (Droz, 1994). As in Rwanda, there is also considerable geographical variation, with some terms more often used within particular areas of the country, or in specific contexts (Rwangabo, 1993; Taylor, 1992). Spirits can be classified into at least three different categories.

One group are spirits of those who have died. These are called *imizimu* (singular: *umuzimu*) (Trouwborst, 1962). When people have died in unnatural ways, or not buried properly, *imizimu* may wander as vagrant spirits, hiding in nature or in cemeteries (cf Barancira, 2002, pp. 206-211 for recent examples). They may be considered to be the cause of a variety of misfortunes, including failed crops, poverty or mental illness. Additionally, the word *intezi* indicates ancestral spirits from one's own lineage, therefore, they may also be seen as intervening, to bring someone back to the proper path (Barancira, 1990).

A second group consist of spirits who exist in nature (such as lakes and rivers) and were never human beings. The most well known are the *abaganza* spirits who usually are benign. When they possess a person, family members appease the spirit by obeying the demands made by the possessed person on behalf of the spirit (Barancira, 1990; Suguru, 1988). Affliction by *abaganza* spirits can drive the sufferer to the *kubandwa* cult (described below). This cult venerates the great ancestral spirit of Kiranga-Ryangombe who, once the sufferer agrees to become his devotee, will act as a protector against the nuisances cause by *abaganza* spirits (Fales, 2002, pp. 81-82). There are, however, also malevolent spirits from the waters, called *ibisigo*. One definition of affliction caused by these spirits is that a person caught by *ibisigo* can become mad, and consequently these spirits will have to be driven out. However, Burundian refugees in Tanzania used the term *ibisigo* slightly differently, as bad spirits that can incarnate in a living being, who brings harm to the living person they inhabit (Malkki, 1995, p. 316).

A third category consists of nameless wandering spirits, such as the *ibihume* who often live in thick forests and dark stagnated waters (as opposed to the flowing waters where the *abaganza* reside) and can attack, especially at night (Rodegem, 1971). *Ibihume* are usually evil and the haunted places where they live have to be avoided (Pettersson, 1967). New *ibihume* can be formed by the spirits of men who have died violently (Barancira, 1990), and in that regard they are similar to the aforementioned *imizimu*. Related to the *ibihume* are the *ibitega*, spirits of deceased peo-

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ple that can be obtained by a person, often outside the country, such as in Tanzania or the Democratic Republic of Congo. The one who has caught or obtained *ibitega* spirits can send them, often through the air, to his enemies in order to harm them by causing illness or other misfortune (Droz, 1994; Habimana & Tousignant, 2003).

Similarly, in Rwanda, terms denoting spirits, such as *ibitega* and *ibisigo*, may also indicate ‘being afflicted by such spirit’ and can be used as a diagnostic and aetiological category, for example for a mental disorder (Irakunda et al., Irakunda & Heatherington, 2016; Rwangabo, 1993, p. 35).

### **Project context**

The nongovernmental organization Transcultural Psychosocial Organisation, since 2005 ‘HealthNet TPO’, has been active in Burundi since 2000 with programmes for mental health and psychosocial support (Ventevogel, Ndayisaba, et al., 2011). Within this context, operational research was conducted around various issues pertinent to mental health and psychosocial wellbeing of conflict-affected Burundians (Jordans, Komproe, Smallegange, et al., 2012; Jordans, Komproe, et al., 2009; Jordans et al., 2008; Jordans, Tol, Susanty, et al., 2013; Tol et al., 2014; Ventevogel, Jordans, Reis, et al., 2013; Ventevogel et al., 2014). As part of these research activities, a qualitative study into Burundian traditional healing was set up. Data collected over 2005-2006 is presented below, in order to increase understanding of healing practices in Burundi and explore how these may have changed due to collective violence throughout the country.

## **Methods**

Data were collected in three rural provinces (Bururi, Mwaro, Gitega) and one urban site (Bujumbura Mairie). During field visits by the research team seven healers were identified who were known by the communities to be involved in healing mental disorders. These healers all used divinatory methods combined with herbal medicine. The healers were above 40 years old with one exception, a young man of 23 years old (see Table 4.1).

In 2006, seven Burundian research assistants (four women and three men, all university bachelor graduates in psychology), formerly having participated in a four-week training in ethnographic data collection, visited the healers regularly over a period of eight months to observe activities in the healer’s compound and follow healing sessions. Additionally, the first and second author visited the healers for additional data collection in 2006. In order to understand the views of the population on healers, 14 FGD were held with community members ( $n= 104$ ). Each focus group (FG) consisted of six to eight participants who were identified through a snowball method. Separate FG were organised for rural and urban participants, men and women, young and old. The participants were invited to describe the kind of healers they knew within their own area and how they perceived them. One of the research assistants guided the discussions, while the other took notes.

**TABLE 4.1** Characteristics of the healers

Name	Sex	Initiatory illness	Location	Province	Age	Religion
Bernadette	Female	yes	Urban	Bujumbura	50	Catholic
Laurent	Male	yes	Rural	Mwaro	23	Animist
Alain	Male	no	Urban	Bujumbura	44	Animist
Françoise	Female	yes	Rural	Gitega	63	Animist
Pierre	Male	yes	Rural	Mwaro	44	Catholic
Theo	Male	no	Urban/rural	Bururi	61	Anglican
Khamis	Male	yes	Urban/rural	Bururi	53	Muslim

**TABLE 4.2** Background variable of participants in focus group discussions

Variable	Label	Number (percentage)
Gender	Male	58 (56%)
	Female	46 (44%)
Setting	Rural	65 (9 groups)
	Urban	39 (5 groups)
Age	Adolescent / youth	16 (2 groups)
	Adult	88 (12 groups)
Education	Educated primary completed	43 (41%)
	Primary school not completed	61 (58%)
Total		104 participants
		14 groups

All relevant data (interviews, FG transcripts, field notes, etc.) were translated from Kirundi into English, with the research assistants each checking the work of the others and, when required, modifying the translations. The first and second author developed the specific themes that are described in this paper during an iterative process of comparing data from transcripts of interviews and field notes (Strauss & Corbin, 1990).

## Results

Our primary data are ordered around four salient themes. First we describe how healers are viewed by themselves and by community members, arguing that the label *abapfumu* has become a source of controversy. Second, data on the importance of witchcraft, sorcery and poisoning for our respondents is presented. Third, elements



of the healing process among the seven healers are described. Finally, the changing role of healing cults in Burundi, with a particular attention for the old *kubandwa* cult versus a new form of healing called *gucekera* is explored.

### **1. Abapfumu: Contested labels and controversial practices**

While the community members in the FG frequently used the word *umupfumu* to denote traditional healers, none of the healers in our study wanted to be called *umupfumu*. According to the typology they would qualify for the label as they practice divination, the hallmark of an *umupfumu*. Moreover, five of the seven had experienced an initiatory illness that was believed to be a calling of the spirits. The healers Bernadette and Laurent claim they cannot be *abapfumu* because they use Christian symbols, such as a rosary and the sign of the cross, and consider themselves Christians. Community participants in the FDG said it that it was often difficult to distinguish between a diviner (*umupfumu*) and a herbalist (*umuvuzi w imiti kama*), however after further discussion, participants mentioned the use of incantations to enrich the medicines, as this is an *umupfumu* practice, it consequently became the defining difference.

While the seven healers were widely respected within their community, and often played significant roles within community life, they were also feared as it is believed they can turn those powers against others. Adding to this fear is the fact that there is no way to know whether a diviner may also be involved in sorcery. This is expressed in the Burundian phrase ‘An *umupfumu* can do to you whatever he wants. He can heal or kill.’ People regularly suspect an *umupfumu* to be a sorcerer secretly. Healers may accuse other healers of being *abarozi*. This fear that healers might be using dark powers may also lead to conflicts with the community, and within families. Laurent, one of the healers, lives in permanent conflict with the parish priest, who forbids him to attend mass, as the priest believes the healer to be involved in black magic. On the other hand, Françoise, another healer, plays an important role in the community serving on the committee of ‘wise persons’ (*abashingantaha*) who function as community leaders, traditional judges and mediators. Three of her children have been initiated as healers. However, two other children have joined a Pentecostal movement and are vehemently opposed to their mother’s activities, which they reject as the ‘work of Satan’. This public rejection of traditional healers prompts people to go to visit them in secret.

‘If you are ill and go to see an *umupfumu* everybody will say you are mad, that you are someone who does not respect himself, and that a good Christian would not do that. This is why you go there secretly when you are sick.’

(FG with men and women, Kinama, 18 February 2005)

‘The relations of a healer with the community depend mainly on what he or she does. Some *abapfumu* hide themselves, and are not open to the outside. They have many secrets. Others are often together with members of the community, during festivities and funerals, and they do a lot of good for the community.’

(FG, men in Rusaka, 19 February 2005)

## 2. Uburozi and ibitega: Manipulating the spiritual realm

*Uburozi* (sorcery, poisoning) can be carried out in many ways. Most often it is thought to be accomplished through the air (called *ibitega* or *imiyaga*, ‘the winds’): by a sorcerer sending evil spirits through the air to attack someone. The afflicted person typically starts to talk in a strange voice and sometimes, the spirit possessing the person identifies himself/herself to any one witnessing the possession. When a person has fallen ill, due to *ibitega*, the application of modern medicine is thought to be dangerous and an injection of western medicine is believed to lead to death. Another form of sorcery is called *ihembe*.<sup>5</sup> It involves magically sending a small object in the form of an animal’s horn, accompanied by incantations (*gutongera uvuga amajambo*). Bewitched persons will suddenly feel a strong pain, as if a sharp object has struck their body.

Sorcery can also happen when someone inadvertently touches prefabricated objects that have been put on crossroads or doorsteps. A generally used Kirundi expression for this type of sorcery is *kwandika ibintu hasi*: ‘putting something on the ground’, however, FG participants also used the word *ubudago* for this practice. *Kwabura* is another form of sorcery accomplished by manipulating something that intimately belongs to a person, such as his clothes (especially his underwear), hair, nails, a footprint, handwriting, the dregs of an unfinished drink, or a plate that has been used by the intended target. For the most part, this falls into line with descriptions of sorcery elsewhere in Africa.

FG participants mentioned several times that when an illness is accompanied by unusual symptoms or circumstances, a spiritual cause becomes more likely. For this reason, when a person falls sick or dies in Burundi one often hears people say ‘*yararozwe*’ (he was bewitched) or *yahawe*’ (he was poisoned). Many diseases, as well as deaths, in Burundi are thought to be caused by poisoning. The first author, doing research among Burundian children, found that many of the children who had lost a family member, said that the person had died of ‘poisoning’. Death by *uburozi* can be the result of magical actions, but it may also be quite literal, by putting chemical substances in drink or food, making the targeted person sick immediately. According to our informants *uburozi* can result in typical symptoms, such as skin blisters that release water when scratched, or small holes or perforations of the body. The effect of ‘draining bloody fluid’ through *uburozi* is significant: healers in Rwanda state that poisons (*amarozi*) diminish the total volume of blood in the body, causing the body to dehydrate (Taylor, 1992). People believe that ‘things’ that have entered the body should be extracted and the poison removed through vomiting, purgatives, symbolic cutting of the infected part of the body, or by cleaning body parts with special liquids and medicines.

In the FGD, the importance of *ibitega* (or wind) spirits was also often mentioned, although participants claimed not to know much about it.

‘Sometimes a person is suffering, but he does not know why. Once he visits an *umupfumu*, he can be told he is suffering from *ibitega* that are sent from a distance through the air. The *umupfumu* will tell the sufferer where the *ibitega* come from and what they want. Ordinary

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people do not know much about all this.’  
(FG of secondary school teachers, Buta)

In Burundi, like in Rwanda, *ibitega* spirits are considered a major cause of ‘madness’ (serious mental disorder) (Habimana and Tousignant 2003). Our Burundian informants also described how wandering spirits could make a person crazy. Some people explained that fighters who lived in the bush during the war, were sometimes caught by such spirits (cf Igreja, 2003, for descriptions of similar phenomena in Mozambique). For example, one of the seven healers, Alain, explained.

‘Some people went crazy because of war. Some died, some others were possessed by *ibihume* in the bush. When they returned home, they had lost their senses.’  
(Notebook first author, August 14th 2006)

### **3. Healing: techniques and treatment**

The diagnostic processes of the *abapfumu* vary. Some ask questions, while others claim to ‘see’ the source of the evil of the problem that the client brings to him without asking any questions. Usually the diagnostic process is done in an open space. For example, Françoise, a 63-year-old woman who has a flourishing healing practice in Ryansoro in the south of Gitega province, starts her consultations by asking the helpseekers some biographical questions (name, parents’ names, number in the sibling row, birthplace, marital status, number of children including abortions, identity card). After having received all this information, she sings incantations to discover any bad spirits that might be affecting the helpseekers. This is all done in public, with often dozens of patients watching. In this diagnostic phase, she uses only divinatory methods through which she disposes any evil forces causing problems to the helpseeker and immediately proposes what that person must do to be healed. It is often a lively performance, as is shown in the following observation from a séance in the healing compound of Françoise.

‘The healer interrupts our conversation and says that now she will start her work. She stands up and starts to speak in a high-pitched staccato voice. Her voice gets louder and louder. All patients, around 50, mostly women, stop talking and look attentively to the chanting healer. The healer speaks faster and faster and louder and louder. She is asking the spirits to make themselves known. The crowd is silent. After a few minutes some women in the crowd start to shake and shiver, soon to be followed by others. It soon becomes a cacophony of voices and screams. The patients shriek in high voices and utter unintelligible sounds such as ‘iek, iek, iek’ and ‘he he he he’. Soon around seven patients are in this state of frenzy. The patients scream louder and louder and then one also starts to speak in a strange, falsetto like voice. Now the spirit that speaks through her utters who he is and where he came from. Then the attention shifts to another patient, a middle aged man who is dressed in an old suit and is accompanied by his intellectually disabled daughter. The healer sits in front of him and actively addresses the spirit. The healer herself is not in trance. While she continues to address the spirits that haunt the man, she sits comfortably, laughs at what the man in trance is saying and con-

verses with the audience, making jokes etc. The man continues to speak in the strange high voice, accusing persons in his family, among whom his own mother, that they are *abarozi* who poisoned him and his children, causing all kinds of illness and misfortune.’  
(Notebook first author, September 22nd 2006)

Healers can help with all kinds of problems (participants used the words *kuraguza*, becoming ‘unlucky, or *imikoshi*, misfortunes) including protection against sorcery, bringing back stolen goods, infertility, broken relations and joblessness.

‘Apart from diseases, there are other problems that people bring to *abapfumu*, such as when a couple has a problem getting a child, or when many children in one family die and he thinks it may be caused by witchcraft. Or somebody who has a problem with his neighbours and suspects them of doing things against him. Girls who are not yet married, despite an advanced age, also go to healers to solve the problem. They can also help persons to find a piece of land or a job.’

(FG, school children from Kinama)

Healers often specialise in certain kinds of problems, and can be renowned for his or her ability to deal with certain cases.

A diviner uses different techniques for healing such as: rituals, fumigation, incantations, behavioural advice (in the form of prohibitions and instructions) and substances to be swallowed, or drunk. The healers in our study talk and sing to their medicine and tell it to obey them. The healer orders where the medicine has to go and what it should do. Another technique is ‘traditional vaccinations’ (*gutsirika*) in which a substance (usually from plants) is burnt and the ash is put in ritual incisions made on the body. Often, these methods are combined, as one of the healers, Theo, explained.

‘For people with *ibisazi* (madness), I prepare the medicine on a fire and give the person a blanket to cover himself with. Then the vapours of the medicine enter the body, and the person loses control. I also drop some fluid into the nostril. With the combination of the smoke and drops, bad spirits go out and fly. Then I incise him and the person falls asleep. It can take a whole day before he wakes up. He seems to come from somewhere else and begins to talk slowly, with a soft voice. He is calm then. When he becomes talkative again, you repeat the same operation and after two or three days he starts to recover slowly.’

(Notebook, research assistant)

Treatment by *abapfumu* often consists of a ritual, as demanded by the spirits. Some patients have to stay in the healer’s compound, others can return home. Often the patient has to get *imfundikano* (certain things desired by the spirits). This can vary from objects to shoes or clothes (in a certain colour). Some use techniques in which they enter into a trance state, as was described above for the healer Françoise, who calls this *nyamukina*. In such a state she can become very aggressive and agitated. She shouts at people and beats people she suspects of being sorcerers. During this state of frenzy, that can last a few hours, she exposes the bad habits of patients and

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people who have poison (*ibihoko*), during this state she uses obscene language and sometimes insults or even beats her patients, in a mockery, or reversal, of established cultural norms.

*Abapfumu* may also use rituals such as *guterekera*, in which the ancestral spirits are appeased, in order to involve them in the important moments of family life (birth, marriage, etc.) and to prevent them from directing anger at their living offspring. In case other spirits afflict them, for example aquatic spirits (*abaganza*), people may seek recourse through a healing cult.

#### 4. Healing cults

##### KUBANDWA

The *kubandwa* possession cult has been described throughout the African Great Lake area (Arnoldussen, 2015; Beattie, 1967; Berger, 1981; d’Hertefeld et al., 1962; De Heusch, 1964; Hoelsing, 2006; Pennacini, 2009; Rodegem, 1971; Schoenbrun, 2006; Vidal, 1974; Whyte, 1991). It is an example of an ‘adorcistic’ cult in which the afflicted person enters into a peaceful and accepting relation with the possessing spirit, as opposed to an ‘exorcistic’ cult that aims to drive the spirit out (Boddy, 1994, pp. 409, following De Heusch, 1962). The members of the *kubandwa* cult used to hold gatherings, usually at waterfalls or lakes, where they indulged in elaborate rituals in which cult members were possessed by spirits from the mythological past, such as the hero Kiranga-Ryangombe’s spirit (Ntabona, 1986).<sup>6</sup> The Burundian psychiatrist Barancira (1990) who studied the phenomenon of *kubandwa*, documents how the cult can be considered a place of recourse for women affected by *abaganza* spirits. Initiation into the cult enables a person to control the *abaganza* spirit within a ritualised form of possession that is often described as ‘marrying’ Kiranga-Ryangombe (Hoelsing, 2006). The rituals of *kubandwa* are described as ‘sacred theatre’ (Barancira, 1990) or ‘mimetical forms of expression’, in which stories from the collective past are acted out or enacted through the body (Pennacini, 2009). The ritualised possession of *kubandwa* enables the afflicted person to live with his/her spirit, even if he or she, occasionally exhibits behaviour that would otherwise be unacceptable. Another important aspect of initiation into *kubandwa* is that it transforms the social status of the affected person from ‘deviant’ and ‘ill’ to that of a respected cult member (cf Beattie, 1967; de Jong & Reis, 2010; de Jong & Reis, 2013; Janzen, 1992; Turner, 1968). Three of the seven healers in our sample were connected to the *kubandwa* cult, including Bernadette.

‘Twenty-five years ago Bernadette became a healer after a long initiatory illness. This illness prevented her from eating. She lost weight. She was often mute and sometimes even paralysed. She recalls that she heard voices speaking to her and preventing her from speaking and eating. She spent whole nights without sleeping. She felt more and more hopeless and often cried. Her health deteriorated. Finally, she got help from an old female *umupfumu* from Bukeye, who revealed that it was angry *abaganza* spirits that caused her problem. Bernadette was initiated into the *kubandwa* cult by this old healer, and started her own healing practice.’ (Notebook research assistant, August 5th 2005)

The rituals of the *kubandwa* cult have become increasingly difficult to organise and some of the FG participants told us that the cult had ceased:

‘In the past, there was the *kubandwa* ritual. But nowadays, when someone is attacked by *abaganza* spirits, we resort to prayer in the Protestant churches, or visit a Catholic priest. *Kubandwa* had been abandoned when Christianity spread in Burundi. But it also disappeared due to the war. People had to flee constantly, and we were not together. The old people who knew about *kubandwa* have died. So how can we now think about Kiranga? But when peace returns, the rituals of *kubandwa* may come back. It really was very effective for people who were affected by *abaganza* spirits.’

(Woman in FG in Mwaro, November 2006)

### **GUCEKERA, A NEW FORM OF HEALING**

*Gucekera* is a type of healing that is neither mentioned in descriptions of the colonial anthropology of Burundi and Rwanda (d’Hertefeld et al., 1962; Rodegem, 1971), nor more recent works on healing in Burundi or Rwanda (Barancira, 1990; Suguru, 1978; Taylor, 1992), having emerged in more recent decades.

The word *gucekera* is derived from the verb *guceka* (to shake). Similar to shaking an object to remove some of the content, *gucekera* means to shake someone in order to encourage the illness to leave. The response of the patient to this shaking is called *kubambura* (from the verb *kubamba*, to crucify or to refuse to communicate). *Kubambura* means to reach a person who was prevented from communicating. It consists of a trance in which words and cries are uttered. The power of the suggestion by the healer is very strong. The second author observed how, after a healer suggested in his incantations ‘*turira mu maguru*’ (burn your legs), the patient actually felt a burning sensation in his legs. *Gucekera* is used against *ibisigo* and *intezi* spirits, as well as against sorcery from a distance, but it can also function as a welcoming rite for benevolent spirits:

‘A young girl is seen by Bernadette. The healer tells her she is possessed by *ibihume*. When she has been administered the medication in her nose she starts to speak and reveals the origin of the spirits that haunt her. When this happens, the healer starts to use a technique called *ugucekera*. She sings special songs to the spirits and asks the spirits who are possessing the girl to tell what they want, and who are their ‘patrons’. The healer with help of her assistant, a young *Twa* man<sup>7</sup>, asks the spirits to leave the patient. When the healer orders the spirits to leave an assistant brings a pot with smouldering charcoal and medicaments to the nose of the patient. At the moment the smoke reaches the nose of the patient she falls, but bystanders grab her before she falls to the ground. The body of the patients becomes stiff and she starts to scream.’

(Notebook research assistant, Feb 3rd 2005)

### **Social embeddedness of healing**

During rituals the healer often gathers the family of a patient, not only to participate in the rituals, but also to inform them how they should behave towards the patient to

improve the situation. The whole family has to be involved, because according to the Kirundi proverb '*lyo umuntu yikuye kumuryango aba ahevye umuryango ujana kumuryango*' ('If someone abandons a family member, he closes the door to his family'). In case of problems in the family, the healer actively offers his/her opinion about what each family member should do to help the patient. In many cases, such family gatherings take place over several consecutive days. In the first sessions the healer explains the state of the patient. In later stages, a healer can become more direct and confrontational. Sometimes a healer may publicly reproach the bad behaviour of a patient and order him to change and not to fall back into his old habits.

Healing is often a long process that is aimed at a balance between exorcistic and adoristic techniques through chasing bad spirits away and appeasing good ones. Sometimes the spirits demand that the patient himself becomes a healer. During a final ceremony, the families of the patient and the healer come together for festivities. During this event, the healer hands over the objects the spirits have demanded to the patient and his family. They eat and drink together and establish ties of friendship.

#### Case of a man who was possessed by *abaganza* spirits

'Jean-Claude is a young man of 26 years. He is married with two children. He is the second in a family of 11 children. As a child he was often sick and looked thin. He reports that he has been the victim of many poisonings. His disease broke out in May 2004. He felt tired and without any joy. He preferred to sit all day. In July 2004 his state deteriorated and did not even speak, but became agitated. His family said he looked drunk and became agitated and he had tried to run away. His family would tie him up at times. His father consulted a diviner who revealed that Jean-Claude was bewitched and possessed by *abaganza* spirits. The healer would stop the sorcery. The patient started to speak again and stopped running away. After four months, he once again became mute and started to run away. This time, he said he was possessed by spirits. He was brought to Laurent, who performed the *gucchera* ritual to drive out evil spirits (*ibisigo*) and to allow good spirits (*abavyeyi*) to reveal to the patient what to do. The good spirits told him he should be initiated himself. He had to acquire many objects (such as clothing, an umbrella, etc.) and these should be handed over to the patient during a ceremony, in which the healing powers are invested in the person. All of this time he stayed with the healer and improved significantly.' (Notebook second author, June 2005)

#### Case of a woman with *ibisazi*

'Jeanine is a 22-year old mother of four children, who was interviewed at the compound of Françoise, the healer. Two years ago her disease started. She felt something strange in her head and stopped talking. She felt very tired. After a while it was better, but sometimes the spirits came back, very violently. In those periods, she talked about things that were not there. She was singing all the time, even in the night, and was talking to each and everyone. She tells, ashamed, that she even defaecated in public because she did not care what people thought, and said sexually inappropriate things to men. She did not sleep at all because she felt she did not need any sleep. She heard voices and saw strange men that no one else could see. Nine months ago, during one of these periods, she was brought to the compound of Françoise, and she now lives here, together with her four children and her mother. Her husband has abandoned her. Her situation has slowly improved. But, as she tells me shyly, three

months ago she had again a period of the same problems, but now less severe. She wanted to buy all kinds of things, but because she was here with Françoise she could not because she was kept at the compound. Françoise has told her she has been possessed by *ibisigo*, and has chased them away, but sometimes they come back. She lives permanently at the healer's compound and helps with routine activities and works with her mother on the land.' (Notebook first author, 22 Sept 2006)

Both cases demonstrate that healing often is a long term and intensive process, in which the client and the healer develop a strongly personalised relationship that may continue long after the illness or problem has been solved. In the compounds of the healers, there are often dozens of current or former patients who live there or frequently visit. Patients describe they feel at ease with each other, because they all have experienced similar problems.

## Discussion

The ethnographic material present in this study provides a brief sketch of traditional healing in early 21<sup>st</sup> century Burundi. To some extent, this picture confirms what we know from the French language literature on traditional healing in Burundi before the war. Some of our findings, however, are markedly different from what was recorded in the past. Two elements stand out: the predominance of exorcistic techniques such as *gucekera*, and the changing role of 'tradition' as exemplified by an ambivalence of the healers themselves towards tradition and the emergence of syncretistic forms of healing.

### Exorcistic healing as adaptation to social disintegration

*Gucekera*, an exorcistic ritual, provides the means to drive out unknown aggressive spirits, and send them back to where they supposedly came from. This is very different to the way spirits are dealt with in the traditional *kubandwa* cult, that is essentially an adoristic movement whose initiates do not drive their spirits out, but appease and venerate them. Taylor (1992) describes how, in Rwanda in the 1980s, changes in the political economy from 'personal domination' (as it was in precolonial and colonial Rwanda) to 'abstracted domination' (by depersonalised and institutionalised political forces that have no face) led to changes in the notions of misfortune. Likewise, ideas on the causes of misfortune tended to move in the direction of abstraction, although such ideas change gradually. This process could explain how 'misfortune-causing agents' are more and more seen as beings that are unknown to the person and his family. Ancestors who enforce respect for lineage and community morality are no longer the main form of possession in Rwanda. Instead, increasingly people are afflicted by spirits that appear to have no familial origin and 'no morality at all'. These spirits strike haphazardly, and those who employ them seek primarily to cause their victims material loss. It is likely that similar processes are happening in Burundi: the traditional family system with ancestor spirits (*imizimu*) as custodians

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has fallen apart, which has led to less emphasis on ancestral *imizimu* spirits, and consequently less emphasis on the traditional ritual of *guterekera*. There seems to be less cultural space for the *kubandwa* cult as well. *Kubandwa* started out as what Lewis termed a 'peripheral cult' (Lewis, 2003), that is it was an outlet for people with marginal societal status, primarily women, who in their ritual language expressed some resistance to vested order and whose possession provided them with respect and safety. The structure of the *kubandwa* cult, with elaborate communal rituals in which various cult members gather at places near rivers or waterfalls, are also more difficult to perform in present day Burundi because the necessary secrecy and community cohesion is difficult to achieve.

The presumed rise of cases of 'poisoning' (done by others for personal gain) and attacks by aggressive, anonymous spirits may be the consequence of various factors, such as the breakdown of the safety net of the family, the diminished role of the ancestral spirits, and the loss of social cohesion related to mass displacement.<sup>8</sup> The healing through *gucekerera* involves 'embodied spirituality' through singing, dancing, exorcism and purification rituals, in a collective gathering. Such ceremonies may facilitate an individual's capacity to contain and integrate adverse life events, promote restorative self-awareness, and engage community support. As such, the emerging rituals in Burundi may, in the end, contribute to healing the social fabric of this wounded society, as has been described for other post conflict settings. Igreja et al. (2010) described a similar process in Mozambique, and de Jong and Reis (2013) interpreted the use of dissociation as a way to process post war traumatic stress in Guinea Bissau as 'collective trauma processing'. Particularly for people with mental disorders, such rituals may be beneficial in providing a common understanding about the behavioural problems of the affected person and foster reintegration into community life.

### **Adaptive healers**

All over Africa, healing traditions have changed significantly and healers have had to adapt their methods to new, often quickly changing circumstances (Sundal, 2012; Teuton, Dowrick, et al., 2007; van der Geest, 1997; West, 2006). New modes of healing have emerged and existing forms of healing have been incorporating or appropriating 'modern' elements, leading to syncretic forms of healing and the redefinition of boundaries between different categories of healers (Gort, 1989; Janzen, 1992; Luedke & West, 2006; McMillen, 2004; Oppong, 1989; Reis, 2000; Rekdal, 1999).

However, processes of adaptation and change had not yet been described for traditional healers in Burundi, where the most important literature predates the recent war (Barancira, 1990; Suguru, 1988) and tends to present traditional healing as a rather static and fixed system that is essentially a relic from the past. The breakdown of community structures due to collective violence and mass displacements have accelerated this process of change and erosion of traditional institutions, as has been described for the Burundian *bashingantahe*, the local community judges and mediators (Ingelaere & Kohlhagen, 2012; Uvin, 2009). Also previously described, as for a new generation of healers in Ghana, the healers in 21<sup>st</sup> century

Burundi follow an eclectic approach to healing, with a strategic self-positioning across healing traditions (Hampshire & Owusu, 2013). In this way, healers construct and re-invent traditions, as can be witnessed by the adoption of religious symbols from Christianity (such as rosaries) and by their ambivalence at being labelled *umupfumu*, which they associate with a tradition that is not theirs anymore.

Burundian healers are not stoic followers of tradition, but instead demonstrate a remarkable capacity to ‘broker and apply powers derived from other times and places’ (West, 2006) and their practices include elements that were not handed down from generation to generation, but are created by the healers themselves. Successful healers have an entrepreneurial spirit and are keen to position themselves as *different* from ‘mainstream’ traditional healers, showing off with that which makes them distinct and special (Edgerton, 1971). As in Uganda, the new generation of healers both stress the African origins of their healing methods and at the same time, feely use paraphernalia and concepts of biomedical healing (Obbo, 1996). In doing so they are transcending the traditional–modern dichotomy and resisting the label of pure traditionality and position themselves as neither modern, nor traditional (Marsland, 2007) while safeguarding essentially supernaturalistic modes of explanations.

## Limitations

This paper has several limitations. First, it is based on a selection of seven healers from four of the 17 provinces and it cannot, therefore, provide a ‘representative’ overview of traditional healing in Burundi. Second, the focus of this paper was on *abapfumu*, and by doing so did not study independent African churches. In the blossoming African syncretic churches, idiosyncratic Pentecostal ideas (in which salvation through Jesus Christ or the Holy Spirit) are articulated can both be seen as a rejection of, but also as transformation of, African traditional views of spirits, sorcery and witchcraft. The increasing role of such churches as healing institutions provide methods to cope with affliction and disease, as has been described within many African settings (Devisch, 1996; Dilger, 2007; Jonker, 2000; Luedke, 2007; Núñez, 2015; Pfeifer, 2006; Tankink, 2007) but, to our knowledge, this phenomenon has not been described for the Burundian context. Lastly, this paper is based on ethnographic data that were collected almost a decade ago. Since 2006 much has happened in Burundi, initially in the direction of stabilisation and economic development, but in the wake of the controversial re-election of Pierre Nkurunziza as president in 2015 the country may now be on the brink of new and severe episodes of collective violence.

## Conclusion

The forms and expressions of traditional healing in Burundi have changed considerably over the last decades and have been affected by modernisation and the collective violence and displacement of the last decades. Processes of change in African traditional healing are not exceptional, and various historical ethnographic studies

argue convincingly that African healing practices have always been dynamic, incorporating new beliefs and practices. However, they maintain certain core beliefs and principles that are grounded in a specific epistemology which renders the ‘western’ body-mind dichotomy irrelevant and which sees the human being as vulnerable with permeable boundaries, in constant danger of being attacked by evil that can only be countered with the help of inspired healing (Reis, 2002). Old forms of spiritual healing related to spirits of deceased family members are being replaced by healing forms dealing with more distant and capricious spirits. The centuries old interlacustrine adoristic *kubandwa* cult is still alive, but new healing forms with stronger exorcistic elements are emerging. Burundian healers skilfully find ways to position their healing praxis within the new realities of their rapidly changing country.

## Acknowledgements

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## Notes to chapter four

**1** See Janzen (1992: 181-208) and Schoenbrun (2006) for comparative analysis of the Bantu speaking people in the ‘interlacustrine’ area of Africa (the region bounded by Lakes Victoria, Kyoga, Albert, Edward, and Tanganyika).

**2** The question whether it is correct to use words such as ‘African traditional healers’ or ‘African medical systems’ has been debated extensively in anthropological literature (Janzen & Green, 2003). The tendency to conveniently ‘narrow down’ African conceptions of illness and misfortune, and bring them into line with more acceptable naturalistic conceptualisation of disease and healing, may amount to a misrepresentation of African modes of healing (Pool, 1994). Some argue that even the term ‘healing system’ may be too restrictive as the practice of diviners in Africa goes well beyond that of ‘healing’ and includes political and other social transitions. For example, the transgeographical practice of *ngoma* in central and southern Africa, which Janzen famously describes as a therapeutic practice in which a sufferer is transformed through a healing ritual, may well have to be defined within a broader context as a transformative discourse that involves an authority who claims to have a specific association with the spiritual world (Van Dijk, Reis & Spierenburg, 2000). Given the subject of this thesis and the context in which this research took place, the focus in this article will be on healing in a more restrictive sense.

**3** Bantu languages have many similarities for words that are related to religion and healing, which points to a common cultural ancestry (see Janzen, 1992). For the interlacustrine Bantu, who live in the areas between the Great African Lakes, this can be illustrated by the words for healer diviners, for which the Ha in Tanzania, like the people from Rwanda and Burundi use the word *abapfumu* (Scherer, 1962: 215). Near-

ly similar terms are used by the Nyole in Eastern Uganda (*abafumu*, see Whyte, 1997: 60) and the Zinza on the Tanzanian shores of Lake Victoria (*mufumu*, see Bjerke, 1989). See Schoenbrun (1997, pp. 203-204, for more examples).

**4** Initiatory sicknesses that transform a sufferer of a mysterious affliction into a healer have been described all over Africa (cf. Good, 1987; Janzen, 1992; Reis, 2000; Swantz, 1990; Turner, 1967; van Duijl et al., 2014). See also the description by the Dutch anthropologist Van Binsbergen of his experience in becoming a diviner healer, which started, appropriately, with a mysterious illness that turned out to be an ancestral calling (van Binsbergen, 1991: 315, 340).

**5** Cf Taylor (1991) who describes *kuraguza amahembe* ('to divine by horns') in southern Rwanda.

**6** According to de Heusch (1964, 1993), the cults around the mythical leaders Kiranga and Ryangome find their origin in historic event in the Great Lake Area when the indigenous Chewzi people were massacred by invaders from the North. Myths in the interlacustrine region address the story of how the survivors fled with their king to the south while others threw themselves into the lakes and volcanoes, and since that day, visit the initiated of the Chewi and Kubandwa cults (Stroeken, 2006: 787-788).

**7** It is significant that the assistant is a Twa. This small minority in Burundi are the descendants of the original inhabitants of the Great Lake region. In the social hierarchy of the ethnic groups, the Twa are the most marginalised and lowest in status, and associated with the raw forces of nature. They are traditionally neither cattlekeepers (Tutsi), nor agriculturalists (Hutu), but hunter-gatherers and potters. The clay healing pots that are used in the rituals of the *abapfumu* are usually made by Twa (see Celis & Nzikobanyanka 1984 for a description of ritual pottery and Taylor (2005) for a description of the role of the Twa in the symbolic ethnic hierarchy in Rwanda). Divinatory healing, including *kubandwa* rituals, continue to play an important role among the Twa in Burundi (Janssen, 2015).

**8** This is not specific to Burundi. Similar processes have been described elsewhere in Africa. Luig (1999) documents describe how, among the Tonga in Southern Zambia, possession by ancestral spirits from the lineage (*mizimu*) and by natural spirits related to rocks and rivers from the neighborhood (*basangu*) are being replaced with possession by individualistic, idiosyncratic spirits (*masabe*) leading to new healing cults. See also De Jong & Reis (2013). Among the Tabwa, on the shores of Lakes Tanganyika opposite Burundi, the arrival of new types of foreign spirits who take possession of people has been dated to the 1930s (Davis-Roberts, 1992: 387). E. Turner (1992: 184) notes that 'We can trace over the continent of Africa how varied – in a kind of patchwork style – are the cults of affliction that are concerned with spirit manifestation. Yet many have characteristics in common. The variations continue to ramify: healers are becoming *more individualistic*, not less, and their numbers have been increasing.' (emphasis added).

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## **Child mental health, psychosocial wellbeing, and resilience in Afghanistan: a review and future directions**

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This is a slightly abridged version of the chapter published in: Handbook of Resilience in Children of War (edited by C. Fernando & M. Ferrari), 2013, 51-79

## **Abstract**

The study of psychosocial distress in children and adolescents in Afghanistan needs to consider the critical importance of ‘everyday’ adversity rooted in poverty and domestic violence, and not merely focus on the direct effects of military violence. The bedrock of resilience is hope, underpinned by cultural values, which provide a moral framework to cope with life adversity; however, the pursuit of these cultural values may foster a sense of entrapment. Family is the most important context for child wellbeing, distress, and resilience. Children in especially difficult circumstances confront early marriage, forced labour, curtailed education, domestic or sexual violence, disabilities, self-injury, and illicit drugs. To build upon concrete but still-fragmented efforts to improve child mental health in Afghanistan, interventions need to address the structural drivers of psychosocial distress, address the impact of family-level violence as well as military conflict, assist families and communities to cope with psychosocial problems, and integrate specialized mental health interventions within general health care, social, and educational service provision.

## **Introduction**

The impact of war on child and adolescent mental health is an issue that sits high on the global public health agenda, especially where it concerns young people living in low-income countries (Patel, Flisher, et al., 2007) and conflict zones (Morris et al., 2007). One key debate in the literature on ‘conflict and child health’ focuses on the relative importance of exposure to different kinds of violence (Panter-Brick et al., 2011): are mental health outcomes primarily driven by war-related trauma, family-level violence, and/or structural barriers taking the form of institutional, social, and economic stressors? Of course, a protracted war exacerbates poverty, weakens social institutions, drives poor health, and often increases social and economic inequalities. But such a macro-level view of the consequences of war does not necessarily help to understand the everyday experiences, emotional lives, and social realities of children in conflict zones. It is essential for research to carefully assess the main drivers of child and adolescent mental health, in order to understand which cluster of childhood adversities have the greatest impact, to reach specific insights that have both local and global significance, and to underscore which interventions might be most effective.

Another key debate in the public health and child development literature centres on the conceptual understandings of ‘risk’ and ‘resilience’. Both risk and resilience matter to child wellbeing: it is necessary to assess both the vulnerabilities and the strengths of children, families, and communities living with protracted conflict. However, research on mental health in humanitarian settings is still dominated by a paradigm narrowly focused on individual responses to potentially traumatic events: a broader understanding of resilience is only nascent (Panter-Brick, 2010). As argued by

Layne et al. (2007), the fields of developmental psychopathology and traumatic stress research have been dominated by studies investigating a ‘shopping list’ of risk and protective factors, with little understanding of the intervening variables that mediate or moderate pathways of influence. By contrast, resilience research is attentive to social contexts and developmental processes, beyond the study of individual attributes shaping worse-than- or better-than-expected health outcomes. Thus a key emphasis of resilience research is to contextualize developmental and social trajectories, identifying what critical changes need to be made in social, educational and material environments to turn individual trajectories towards more favourable health outcomes (Panter-Brick et al. 2011). Contexts and resource provision are of central importance to turning points fostering trajectories of resilience. This conceptual framework is particularly useful to bridge major gaps between scientific evidence and policy-making pertaining to war-affected children. For a state-of-the-art review of findings on ecological resilience relevant to children and adolescents exposed to political violence in low- and middle-income countries see Tol, Jordans, et al. (2013).

This chapter reviews the literature on child mental health and psychosocial wellbeing in present-day Afghanistan. Use of these terms needs some clarification. ‘Mental health problems’ and ‘mental disorders’ are terms in the vocabulary of psychiatrists, psychologists, epidemiologists, and policy-makers. However, many social scientists and humanitarian workers prefer to focus attention on ‘psychosocial wellbeing’ – referring to a ‘dynamic relationship that exists between psychological and social processes, each continually influencing the other’ (Williamson & Robinson, 2006, p. 24). Thus psychosocial wellbeing refers not only to the subjective nature of one’s experiences but also to the social nature of life stressors, behavioural responses, and contributions made to the community (Strang & Ager, 2003). We follow here the consensus established in the humanitarian sector (IASC, 2007): the composite term ‘mental health and psychosocial support’ describes ‘any type of local or outside support that aims to protect or promote psychosocial wellbeing and/or prevent or treat mental disorder’ (Wessells & van Ommeren, 2008). This approach entails a wide lens on child mental health that includes epidemiological and clinical data on ‘problems’ and ‘disorders’ as well as contextual data on economic, cultural and social structures that impact vulnerability and resilience in everyday lives.

This chapter thus provides a synthesis of child-focused research and intervention literature related to mental health and psychosocial wellbeing in Afghanistan. Our intent is to inform the research agenda and service provision strategies for Afghan children and adolescents. We also discuss a framework for developing initiatives to promote mental health and psychosocial wellbeing within this group, and make recommendations for future directions.

## **Afghan childhood in social context**

We begin this section with a brief historical background of the country, and then highlight contextual aspects of childhood in Afghanistan pertaining to socialization, education, and health.

## Childhood in Afghanistan

Afghan society is patriarchal (elder men are decision-makers), patrilineal (a child belongs to his father's family) and patrilocal (the girl moves to her husband's household at marriage). The core social and economic unit is the extended family, although its influence has to some extent been eroded by social changes linked to forced displacement and urbanisation. The home and family are private domains. Surrounding walls shield family life from public view, and walls of silence habitually shield family problems from outsiders. While family life is recognized as a nexus of care and protection, desperate poverty, poor family dynamics and loss of key family members can turn families into harsh and unloving environments for children (De Berry et al., 2003).

Afghan children usually have no 'adolescence' as conceptualized in the western world; that is, no transitional life stage situated within peer groups before social adulthood. Traditionally, Afghan boys from the age of 10-12 years of age, or even younger, move directly into an adult world (Dupree, 1973 [1980]), while girls are given in marriage around puberty. In contemporary Afghanistan, individuals older than fourteen are considered adults rather than children (Loughry et al., 2005), and this is also the legal age of employment. Particularly in non-urban areas, children assume social responsibilities early and have limited time for play. Social life is rigorously gendered, and often includes systematic exposure to violence. Some thirty years ago, Afghan street games were described as rough but including war games only rarely (Dupree, 1973 [1980]; van Oudenhoven, 1979); nowadays, according to personal communications from Afghan colleagues, street games include violent re-enactments of the war, and children's drawings readily show disturbing images of armed conflict, death, and injury (De Berry et al., 2003; Save the Children USA, 2002).

A central concept in the socialization of Afghan children is *tarbia*, a word found in both Arabic and Persian, commonly translated as 'training' or 'education' while also implying 'upbringing' or 'civility.' It includes both *adab* (politeness and good manners) as well as *akhlaq* (morality) (Karlsson & Mansory, 2007). One qualitative study involving both children and adults in Kabul concluded that *tarbia* was a term used to refer to children's manners and the quality of their relationships with others. Good *tarbia* entailed good manners and proper language, respect for elders, bodily cleanliness, and hospitality. The concept is gender-specific: a girl must display modesty (lowering her gaze outside the home, not looking around or making eye contact with boys, keeping her head covered), but this is not expected of boys (De Berry et al., 2003). Among the main qualities Afghan girls are expected to acquire in the process of becoming a woman are 'acceptance, suffering and patience' (Billaud, 2012).

## EDUCATION

At the end of the Taliban era, around 80% of the schools had been destroyed. In 2002, the Afghan government launched a 'Back to School' campaign, which resulted in huge expansion in school attendance throughout the country from about 900,000 to nearly 6.4 million in 2008. The percentage of girl's primary school attendance has grown from almost 0% in 2001 to over 37% in 2007 (UNESCO, 2010a). The gender gap in education is narrowing, but girls still lag far behind boys in school enrolment,

especially at the secondary level. In general, the education of girls is increasingly accepted; many Afghans now see it as a religious obligation within Islam (*farz*), though often on the condition that older girls are taught by female teachers (Karlsson & Mansory, 2007). The adult literacy rate is pegged at 28%, with a strong gender inequality (43% males, 13% women). There are still many challenges for programmes of state-sponsored education, related to both economic and political insecurity. In particular areas of the country, schools are increasingly regarded as justifiable targets by insurgents (UNESCO, 2010b).

#### HEALTH CARE

After the fall of the Taliban, Afghanistan had some of the worst health indicators in the world but progress has been made over the past years, especially with respect to access to health care. The primary health care system offers a ‘basic package of health services’ (BPHS), developed to address the basic needs of the Afghan population (Waldman et al., 2006). There has been a significant improvement in coverage of health care services. The relatively quick recovery of health care structures is largely attributed to the close collaboration between government, donors, and implementing NGOs (Arur et al., 2010; Sabri et al., 2007). A nationwide survey also found that the government BPHS had partially reached its goal of targeting the most vulnerable, including disabled people and members of female-headed and poorer households; these groups were indeed visiting health centres relatively more often than others. However, the study also showed that such vulnerable groups still face considerable difficulties in using health facilities, and that their out-of-pocket expenditures were higher than those of other population groups (Trani et al., 2010).

### Child and adolescent mental health, distress, and resilience

In this section, we review the existing literature on child and adolescent mental health (age ≤ 18 years) in Afghanistan. From May 2011 to August 2012, we conducted a comprehensive review of this literature, using online databases, PubMed and PsycINFO, with the following search terms: (‘Afghan\*’) and (‘child\*’ or ‘adolescent’) and (‘mental’ or ‘psychosocial’), in abstracts, titles or keywords, and without a limit on date of publication. In addition, we searched available databases on Afghanistan, including published reports and unpublished studies presenting primary research data. We excluded literature un-related to mental health or psychosocial support, and media reports or scientific publications focused solely on adults and/or Afghan refugees in high-income countries. We included, however, reports on child refugees in neighbouring countries such as Pakistan and Iran, given their cultural and socio-economic similarity to Afghanistan. We found a total of 43 publications suitable for full text review, and subsequently excluded 23 for not meeting the inclusion criteria or for reporting on datasets already included, and retained 20 for full discussion (Table 5.1). After presenting their main findings, we contextualize these studies by drawing upon a much larger body of scientific publications, reports by the Afghan government, international agencies and non-governmental organizations, and media reports.

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**TABLE 5.1** A review of literature on child and adolescent mental health and psychosocial well being in Afghanistan

Authors	Study design	Objective	Setting	Study population	Main findings and conclusion
Catani et al. 2008	Cross-sectional survey	Establish the extent of cumulative traumatic and stressful experiences related to war and family violence in school children in Kabul	Urban district in Kabul affected by war and violence in the past	287 children (age 7-15) from two schools in Kabul, 2005	In addition to multiple exposure to war or disaster-related traumatic events children also indicated high levels of exposure to family violence.
Catani et al. 2009	As above, see Catani et al. 2008	See Catani et al. 2008	See Catani et al. 2008	See Catani et al. 2008	Boys reported higher overall amounts of traumatic events, specifically domestic of violence. Boys have higher rate of PTSD (26.1%) compared to girls (14.1%). Average of 4.3 different types of violent incidents at home. Child labour was common phenomenon and associated with an increased likelihood of experiencing family violence for girls.
De Berry 2003	Explorative study using ethnographic methods (key informant interviews, focus group discussions)	Identify wellbeing goals for children, threats to psychosocial wellbeing and existing coping resources	Kabul	321 children (age 7-13) 116 children (age 13-18) 215 parents	Afghan families considered their children's emotional and social development important, and highlighted the central importance of tarbia – obedience, manners, and correct conduct – in their upbringing. Child wellbeing was dependent on the availability of opportunities for personal and social development, their personal characteristics, and the immediate situation around them. Kabuli children drew on many resources to cope with challenges; some coping mechanisms were found to be comforting in the present, but to have potentially negative long-term consequences.

Authors	Study design	Objective	Setting	Study population	Main findings and conclusion
Eggerman & Panter-Brick 2010	Thematic analysis of responses to open-ended questions from children and caregivers in a stratified randomized sample of schools (see Panter-Brick et al. 2009)	Analyse how constructs of hope and suffering frame the life experiences of schoolchildren and their caregivers in light of reported stressors and professed solutions.	See Panter-Brick et al. 2009	See Panter-Brick et al. 2009	Adults were primarily concerned with overcoming economic difficulties, while children prioritised problems in their learning environments as well. Education was perceived as the key to social and economic improvement of the family. Respondents derived hope from a sense of moral and social order embodied in the expression of key cultural values: faith, family unity, service, effort, morals, and honour. These values form the bedrock of resilience, drive social aspirations, and underpin self-respect and dignity. However, respondents also reported strong feelings of entrapment caused by a combination of economic impediments, social expectations and cultural dictates which frustrated the realization of personal and social aspirations.
Gupta 1997	Cross sectional survey with self-report questionnaires	Identify psychopathology in children	Kabul during Taliban rule in 1996	Community sample (n= 310) of children aged 8-18 years	72 % had experienced the death of a family member between 1992 and 1996. 41% had lost one or more parents because of the conflict. Nearly half had seen many people killed in rocket and artillery attacks. Over 80% of the children indicated that they were often so sad that they felt they could not cope with events and felt that life was not worth living.
HealthNet TPO 2008b	399 structured questionnaires; 22 focus group discussions, 40 key informant	Assessment of mental health and psychosocial wellbeing; coping and barriers to service provision	Four districts (Baghlan, Kapisa, Kunduz, Parwan)	School-age children, parents, teachers, community elders, traditional healers, and healthcare staff	Moderate but omnipresent psychosocial problems, with 25% of children indicated for some form of psychosocial support. Current stressors (poverty, social injustice, child marriages) reportedly cause



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Authors	Study design	Objective	Setting	Study population	Main findings and conclusion
	interviews; 12 case studies				most frequently reported problems (aggression, substance abuse, distress, disturbed peer relations, suicide attacks, family violence). Boys report more complaints than girls.
(HealthNet TPO, 2008a)	Exploratory participatory assessment; individual interviews (n=19) and 5 group discussions (n= 49)	Rapid assessment of perceived MHPS problems and local resources in the context of NGP program design	Uruzgan Province in Southern Afghanistan	Local key informants (governmental leaders, formal and informal mental health care and psychosocial service providers)	Psychosocial concerns that were prioritized by participants included (a) domestic and family violence, (b) drug abuse (c) general psychological symptoms, (d) poverty, (e) tribal conflicts, and (e) malpractices in marriage customs. As child-specific problems respondents mentioned fear and anxiety, concentration problems, development problems and epilepsy.
Hoodfar 2008	Ethnographic research using participant observation, focus group discussions and key informant interviews	Map experiences, concerns, self-perceptions and coping strategies of Afghan youth in Iran	Urban areas in Iran (Mashhad, Tehran, Qom)	a. 100 Afghan refugees (age 12-18) in Iran (2001) b. 51 Afghan refugees (age 12-18) in Iran (2002-3)	Afghan girls and boys are not passive victims of circumstances but actively adopt strategies to deal with unwanted family dynamics (marriage, discrimination). Young Afghans seek to introduce fundamental changes into their families and communities often using the legitimate force of religion.
Izutsu et al. 2005	Cross-sectional study	Describe physical and mental health status of Afghan refugee children	Refugee camps in Pakistan in the early post-Taliban period	100 Afghan children aged 6-14	The majority of children showed signs of hopelessness, suicidal feelings, and other mental health difficulties.
Kassam & Nanji 2006	Brief exploratory study using focus group discussions and key informant interviews	Explore mental health situation of Afghan refugees in Karachi	Afghan refugee camp in Karachi, Pakistan (1999)	61 participants (including adolescents)	Distress was communicated on a collective level. Mental illness was often equated with severe psychotropic illness. Somatic symptoms were a common way of expressing distress. Social and community-based approaches that drew on natural

Authors	Study design	Objective	Setting	Study population	Main findings and conclusion
					<p>coping strategies were recommended to improve mental health.</p>
Loughry et al. 2005	Quasi-experimental design	<ol style="list-style-type: none"> <li>1. Develop instruments for child psychosocial wellbeing</li> <li>2. Compare psychosocial with non-psychosocial intervention</li> </ol>	7 villages in Northern Afghanistan	267 children (8-14 years), 145 adults	Developed a culturally-grounded, quantitative scale for assessing Afghan child psychosocial wellbeing. Quantitative data showed the non-psychosocial intervention had better outcomes for child wellbeing than the psychosocial intervention.
Omidian & Papadopoulos 2003	Questionnaires, interviews with teachers, students, and parents, classroom observations	Compare impact in the classroom environment, for teachers who received psychosocial training vs. those who did not	4 schools for Afghan refugees in Peshawar, Pakistan, November 2002	4 schools. Sample size of people interviewed is not mentioned	The attitudes of teachers who received the psychosocial training had changed substantially. By helping teachers to better understand their own emotions and that of their students, they became better teachers. Their way of teaching was more relaxed, they exhibited patience, were more friendly and helpful and felt able to find out about the students' problems and to help resolve many of them.
Panter-Brick et al. 2009	Stratified random sample; interviews with children, caregivers, and teachers	Evaluate mental health, suffering and trauma exposure among Afghan schoolchildren and their caregivers; assess multiple outcomes, and triangulation across child, parent, and teacher reports.	24 schools in three provinces (Kabul, Bamyán, Mazar-e-Sharif), 2006-07	1011 male/female 11-16 year old schoolchildren, 1011 caregivers, 358 classroom teachers	Children's most distressing lifetime trauma included accidents, painful medical treatment, and domestic and community-level violence, not just war-related events. Mental health outcomes were strongly associated with number of lifetime traumatic events and with caregivers' mental health status. Emotional problems were more prevalent than behavioral disorders. The research highlights the value of school-based initiatives to raise awareness of mental health, and to address wider issues of everyday suffering and resilience.



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Authors	Study design	Objective	Setting	Study population	Main findings and conclusion
Panter-Brick et al. 2011	Longitudinal study; gender-balanced, stratified random sample, with follow-up one year after baseline, after Panter-Brick et al. 2009; interviews with children and caregivers	Examine 1-year mental health trajectories for multiple outcomes; assess the relative impact of risk and protective factors using individual, family, and area-level variables	9 schools (Kabul)	234 male/female 11-16 year-old schoolchildren (64% of baseline sample) and their caregivers	With the exception of post-traumatic stress (PTS) symptoms, mental health outcomes improved in the absence of a targeted intervention. Family-level events such as traumatic beatings, stressful conflict, and violence worsened mental health outcomes; improvements in family life and relationships had protective effects. PTS symptoms remained dependent on lifetime trauma exposure; by contrast, other mental health problems associated with intervening-year family-level violence rather than war-related violence.
Raj 2011	Open-ended interviews (N = 102)	Identify Afghan perspectives on the causes of and potential solutions to child and forced marriage	Religious leaders, police, teachers, Afghan staff of non-governmental organizations and government officials	Three major towns (Kabul, Jalalabad, and Mazar-e-Sharif)	Informants reported recognition of the poor social and health consequences of child and forced marriage for mothers and infants. Recommended solutions centered on child marriage prevention; most informants felt little could be done for married girls.
Sellick 1998	Semi-structured interviews with convenience samples of children supplemented by focus group discussions with parents and adults working with children	Needs assessment and situation analysis for child protection agencies on the effects of conflict on children in Afghanistan	Urban and rural locations in five provinces (Kabul, Herat, Mazar-e-Sharif, Jalalabad, Kandahar)	500 children (age 6-18) in five provinces	Security and safety-related problems were the most important threats to Afghan child wellbeing. Support to families and caregivers is required to provide an adequate livelihood for children. Agency assistance needs to be guided by local vulnerability analyses, with special attention to disability and gender.
Slugget 2003	Key informant	Situation analysis	Afghanistan	Senior staff in UN,	Cases of child sexual abuse cases

Authors	Study design	Objective	Setting	Study population	Main findings and conclusion
	interviews with senior staff	related to child sexual abuse in Afghanistan	(Kabul)	NGOs	are not made public, especially in the case of girls due to the high value placed on their virginity. There is strong social stigma directed at abused children, and such abuse brings shame upon their families.
Smith 2008	319 semi-structured interviews, 56 focus group discussions	Identify and understand stress factors and individual and societal attitudes regarding violence on children within the family	Urban and rural sites in four provinces, (Kabul, Jalalabad, Bamyan and Herat), 2006-07	More than 200 adult men and women from 61 different families	To some extent, domestic violence against children is an accepted way of disciplining children, although there is social disapproval regarding the use of violence; child abuse is seen as a problem, and mainly attributed to the inability of adults to control their anger.
Trani & Bakhshi 2006	Nationwide population-based survey with probability proportional to size sampling	Evaluate the prevalence of disability and access to public services for persons with disability	175 clusters in all 34 provinces	People of all ages in 5250 selected households	2.7% of all Afghans fulfilled the (strict) criteria for disability; among those aged 0-9 years the figure was 1.4%, rising to 2.4% for the 10-19 age group. Over 20% of Afghans share a household with a person who has a disability. Prevalence of severe learning disability was 0.26% and of epilepsy/ seizures 0.51%. People with disabilities had higher levels of mental distress.
Wessells & Kostelny 2002	Semi-structured interviews and focus group discussions	Identify key risks and issues of child protection/ well-being; identify vulnerable groups	Northern Afghanistan in early post-Taliban period	200 children and 120 adults	Key issues affecting child wellbeing were: landmines, protection and support for the most vulnerable, disarmament, de-mobilisation, and reintegration (DDR), informal education, gender discrimination and drug abuse. Vulnerable groups included ex-child soldiers, children who had been internally-displaced, orphaned, or separated from their families, children with disabilities, working children, and victims of sexual exploitation.



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### **Psychosocial distress**

Decades of war and conflict have had a significant impact on health and wellbeing across almost all domains of children's lives, due to exposure to violence, pervasive poverty, ongoing insecurity, strained family relations, disrupted networks of social support, curtailed education, and poor health. A 1998 needs assessment and situation analysis for child protection agencies in five provinces found that security and safety-related problems were the most important threats to child wellbeing, and that support for families and caregivers was required to provide an adequate livelihood for their children (Sellick, 1998). In 2003, UNICEF and Save the Children published a qualitative study on the wellbeing of children in Kabul two years after the fall of the Taliban: 'The Children of Kabul, Discussions with Afghan Families' (De Berry et al., 2003). While children reported many disturbing past experiences, they were most worried by and preoccupied with ongoing, day-to-day threats and pressing concerns, such as the risk of becoming disabled due to landmines, unexploded ordnance (UXO) and traffic accidents, economic hardship and poverty, and problems and tensions in the family. Participants stated that poverty was a major source of the latter: parents worried about feeding, clothing and providing care for children, which took its toll on relationships within the family and also put extra pressure on children themselves. The study also highlighted children's difficulties stemming from the loss of and/or separation from family members, due to both deaths and disappearances during years of conflict, and as a result of protracted illnesses or traffic accidents.

'My father died, and then I lived with my uncle and he died also, and then I lived with another uncle but he also died, and then I lost all my protectors.' Focus group discussion with boys (De Berry et al., 2003).

'The main impact of war on children has been that they grew very afraid, also during the war no one could give good *tarbia* to their children.' Focus group discussion with mothers (De Berry et al., 2003).

Such findings are echoed in an unpublished survey in four districts in northern Afghanistan which assessed the psychosocial and mental health problems of 399 school-age children, and the perceptions of parents, teachers and other community stakeholders regarding them (HealthNet TPO, 2008b). Gender discrimination and social injustice, unmet basic needs and poverty, continued insecurity and violence, and marriage-related issues were reported as causing children's psychosocial and mental health problems. While war and conflict-related traumatic events were commonly mentioned as a cause of psychosocial and mental health difficulties, structural socio-economic problems and recurrent stressors (maltreatment of children by adults, domestic violence and traffic accidents) were also seen as contributing to much of the perceived distress of children.

More recently, a systematic survey of mental health, lifetime trauma exposures, daily stressors, and social resilience was conducted with a random sample of 1,011 children and 1,011 caregivers in three areas of the country (Kabul, Mazar-i-Sharif,

and Bamyan; Panter-Brick et al. 2009). The qualitative component of the study featured a content analysis of responses elicited, in face-to-face interviews conducted in Dari and Pashto, regarding the main problems faced in daily life and the solutions envisaged. For both male and female caregivers, economic stressors were identified as the most significant day-to-day problem, while for 11-16 year old boys and girls, stressors pertaining to education were the most significant. Afghan adults and children alike underscored the overriding importance of economic insecurity as ‘the root of all a man’s misery,’ using the Dari expression *iqtsad kharab* (‘broken economy’) to label a state of socioeconomic ‘entrapment’ (Eggerman & Panter-Brick, 2010).

Poverty led to overcrowding in the home, strained social relationships, and domestic conflict. Economically-frustrated men become ‘ill-natured’ (*bad khalqi*), an expression denoting difficult, abusive, or morally reprehensible behaviour. Violent behaviour at home was often attributed to *takleef asabi* (‘a mental problem’). For example, one young girl expressed the linkages between economic frustrations, poor mental health, and domestic violence as follows:

‘My father’s salary is not enough for us, he has *takleef asabi* and he beats us. If he finds a decent job then maybe he will calm down.’ (Interview with a 16-year-old girl, Eggerman & Panter-Brick, 2010)

### Coping and resilience

For Afghan families, resilience to adversity is the cornerstone of survival and well-being, signifying emotional, social, and economic fortitude in the face of war, displacement, social conflict, severe illness, and crippling debt. As De Berry and colleagues (2003) showed, the emotional and social development of children is a paramount social and cultural issue. Among the most important prerequisites for child wellbeing were morality, respect, faith, positive feelings, good relationships, and correct behaviour, as well as physical health – all values which would help one to cope with challenging life circumstances. Children saw that families adopted coping strategies that were effective in the short-term but problematic in the long-term: hiding the truth, over-protection, use of physical punishment, violence, and taking revenge (De Berry et al., 2003). Building on a similar understanding of emic representations of emotional and social priorities, Loughry et al. (2005) constructed a quantitative measure of children’s wellbeing, consisting of several sub-scales to assess feelings, social relations, and coping strategies, for use in NGO project evaluations of psychosocial interventions.

Six cultural values fundamental to upbringing, psychosocial wellbeing, and fortitude were identified in Eggerman & Panter-Brick’s larger-scale interdisciplinary study (2010).

- 1 Faith in Islam (*iman*) plays a fundamental role in framing life experiences in Afghanistan; it is a source of strength, perseverance and hope in the face of hardship and uncertainty, at both the individual and family level. Faith helps individuals make sense of what happens to them; this can be articulated in expressions of resigna-

tion – an acceptance that all life proceeds from the will of God, and is ultimately beyond the control of the individual.

- 2 Family unity and harmony (*wahdat* and *ittifaq*). Afghan households and families attribute great importance to peaceful resolution of disputes within the primary reference group, and adherence of all members to consensus decisions.
- 3 Service (*khidmat*). A critical value in the Afghan cultural system is the ability to make useful contributions to the wellbeing of others, to ‘serve’ parents, family, community and country. Failure to ‘serve’ can be a source of shame, and viewed as a sign of weakness in character.
- 4 Perseverance and effort (*koshesh*). In order to achieve a goal one needs to be persistent. Children often stated that they could improve their lives through hard work and *koshesh*.
- 5 Morals (*akhlaq*). This refers to cultural codes governing appropriate and morally correct behaviour, deference to parents and community elders, modesty in dress and comportment, and good manners in day-to-day relationships.
- 6 Social prominence, respectability, and honour (*izzat*). By fulfilling their parent’s ambitions for them, by working hard, demonstrating good morals, and serving others, children hope to achieve respect and social recognition.

These six cultural values underpin the sense of resilience in Afghan culture. They provide a moral framework to order experiences of suffering, as well as hope and the promise of a better life (Panter-Brick & Eggerman, 2010). Hope and resilience were closely connected.

**‘The only way to make life better is to be hopeful... If a person has hope, then he or she can work and acquire knowledge to make their life better’**  
(Interview with an Afghan mother, Eggerman & Panter-Brick, 2010, p.76).

This sense of hope centred on accessing the resources needed to create social and economic opportunities for one’s family. Children went to school in the hope of advancing the economic situation of their household – and also bore the burden of such expectations. In this context, ‘hope’ was the bedrock of resilience as well as the crux of social suffering (Panter-Brick & Eggerman, 2010).

Indeed, there can be no simplistic understanding of promoting ‘culture’ as resilience, or using ‘hope’ as a simple index of wellbeing. Efforts to adhere to cultural values often contributed to feelings of entrapment, for instance when men married several wives to demonstrate their social standing, or when school attendance was interrupted so that boys could ‘serve’ the household economy, or to allow girls to be married off into another family. While faith is clearly central to resilience in Afghanistan (Kanji et al., 2007), religious beliefs can themselves be a source of suffering, and may encourage inactivity or even paralysis in dealing with adversity (Wessells & Strang, 2006). Feelings of entrapment led to considerable personal distress and social tensions, potentially reaching the point of violence and attempted suicide. Eggerman and Panter-Brick (2010) identified three forms of entrapment.

- 1 Poverty, overcrowding, and other harsh socioeconomic realities prevent people from

demonstrating cultural values and meeting social obligations, individually or collectively.

- 2 Individual ambitions clash with expectations inherent in the values of morality, ‘service,’ and ‘family unity.’
- 3 Cultural dictates, particularly those surrounding marriage decisions and the social position of women in family and society, are themselves a cause of direct suffering.

### **Mental health disorders in children**

Rigorous data on the prevalence of child and adolescent mental health disorders in Afghanistan are scarce. The first large-scale epidemiological survey of common mental health problems was published in 2009: as mentioned above, this was a multi-stage random sample of 1,011 school-based children to assess adversity, experiences of trauma and life stressors, and resilience. Importantly, it included a multi-informant assessment (child, caregiver, and teacher) of emotional/behavioural psychiatric difficulties and prosocial strengths, based upon *both* symptoms and impact on social life (across four domains of home, classroom, leisure, and peer activities). It also included assessment of depression and post-traumatic symptoms, based on international instruments, and featured a combination of international and locally-constructed scales (Miller et al., 2006) to assess caregivers’ mental health (Panter-Brick et al., 2009). The instruments were validated, with Dari and Pashto translations copyrighted ([www.sdqinfo.org](http://www.sdqinfo.org)). The survey showed that one out of five schoolchildren (22.2%) met the criteria for probable psychiatric disorder, with girls two-and-a-half times more likely to have disorders than boys. Children who had suffered five or more traumatic events were two-and-a-half times more likely to have a psychiatric disorder, as well as three times more likely to report symptoms of post-traumatic stress, than those who had experienced four or less. The study showed that caregiver mental health was correlated with the wellbeing of the children under their care: there was a 10% increase in the likelihood of child psychiatric disorder for each and every symptom of psychological distress reported by caregivers.

A follow-up survey was undertaken in Kabul – but not in other areas of the country, due to logistical and security problems. This represents the first longitudinal survey of family-level mental health in Afghanistan, with follow-up data on 115 boys, 119 girls, and 234 caregivers. The research aimed to test the extent to which individual-level, family-level, and community-level exposures to adversity predicted a one-year change in mental health outcomes such as psychiatric difficulties, depression, and post-traumatic stress. It examined which aspects of violence and poverty were the most critical predictors of changes in child and adult mental health status, and conversely, which aspects of the family and community environment were the best predictors of mental health recovery (Panter-Brick et al., 2011).

The weight of the evidence indicates that even in a context of militarized violence, cumulative ‘everyday’ socio-economic stressors are critical determinants of mental health and wellbeing: these daily stressors impose a major burden on family relationships, triggering domestic violence, and were identified in this research as the



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main predictor of one-year changes in mental health burden. Yet over the one-year follow-up period, child and adult mental health outcomes improved for the cohort as a whole, for all measures except posttraumatic stress symptoms. This improvement occurred in the absence of a dedicated mental health intervention, or even better political and economic security. The follow-up pertained to Afghan families who had kept their near-adolescent children in school: in the context of Afghanistan, this was a significant expression of hope for socio-economic advancement and resilience to social and economic challenges – and continued school attendance was demonstrably associated with unexpected mental health improvements, for both children and caregivers in the study cohort.

Previous studies have generated a great deal of valuable contextual data on the extent of war-related deaths affecting children during the early years of Taliban control (Gupta, 1997), emotional despair and suicidal feelings in refugee camps (Izutsu et al., 2005), and the burden and war-related and domestic violence. However, these studies did not triangulate data from multiple informants, used non-validated questionnaires, and specifically looked for links between direct exposure to war-related violence and psychopathology. In a context where studies in conflict zones are increasingly common, several authors have warned that prevalence rates derived from trauma-focused psychiatric epidemiology are of limited value to community-based organisations working to promote mental health and psychosocial wellbeing (Bolton & Betancourt, 2004; Miller et al., 2006; Rodin & van Ommeren, 2009). Furthermore, recent evidence from conflict zones, including Afghanistan, has shown that in the genesis of mental health problems and psychosocial distress, war-related trauma does not necessarily outweigh the ‘structural’ daily stressors associated with the struggle to make a living. Even traumatic experiences, from the perspectives of children, are not solely contingent on war-related violence, but are related to family-level and community-level violence – such as punitive beatings, disputes between relatives or neighbours, criminal acts, including robberies and stabbings, or physical harassment by local hooligans and/or police (Panter-Brick et al., 2009). Social stressors in the family-level environment are also demonstrably associated with biomarkers of stress such as immune competence and blood pressure, over and above other social and political factors reported as ‘top stressors’ in Kabul (Panter-Brick et al., 2008).

### **Self-inflicted injury and suicide**

Women and girls in Afghanistan have limited ways to ‘protest’ when they disagree with decisions made about them, particularly in choosing a marriage partner, or in controlling use of their time and labour. They may present with health problems at local clinics or hospitals simply because visits to health centres are often one of the few acceptable ways to leave the house, and because being ill draws attention to the seriousness of their malaise. In addition, Afghan teenage girls may seek resolve in self-injury, such as beating themselves severely when they are highly stressed (Omidian & Miller, 2006).

A gruesome expression of the severe distress some Afghan women face can be

found in high rates of self immolation as an ultimate and very public display of dissatisfaction (Aziz, 2011). A study carried out by the international NGO Medica Mondiale documented cases based on medical records at central hospitals in Kabul, Wardak, and Herat provinces; this study found that girls as young as 12 years old had committed self-immolation, while girls aged 16 to 19 were particularly at risk. Forced child marriage and abuse from in-laws were among the most frequent reasons given to explain self-immolation, which often occurred after girls spoke out against the violence to which they were subjected, or sought help in alleviating the violence (Medica Mondiale, 2007; Raj et al., 2008). The high number of suicidal attempts among young Afghan women may be indicative of the difficulties they face in attempting to reconcile a ‘modern’ feminine identity with ‘traditional’ Afghan roles (Billaud, 2012). The United Nations news network IRIN quotes an 18-year-old girl receiving treatment for her burn injuries in a hospital in the capital, Kabul, four months after she was married against her will.

**‘I did not know how to end the misery of torture and daily beatings I got from my cruel husband. So I poured petrol on myself and set myself ablaze. I did not like him [the husband] even at the beginning... but there was no solution because I was married by my father.’**  
(IRIN, 2006)

There are no comprehensive statistics on the number of suicides in Afghanistan. However, anecdotal reports suggest the problem is significant (Tang, 2006), and there has been a concerted effort by the Afghanistan Independent Human Rights Commission (AIHRC) and other advocacy groups to address the problem (Afghan Independent Human Rights Commission, 2006).

### **Drug use**

Afghanistan is the world’s largest producer of opium and heroin, and the origin of more than 90% of the heroin consumed in Europe and other countries. According to surveys by the United Nations Office on Drugs and Crime, Afghanistan is home to nearly one million problem drug users, roughly 8% of the population between 15 and 64 years old (United Nations Office on Drug Control, 2009) An estimated 60,000 children are heroin users – approximately 0.7% of the total Afghan child population (United Nations Office on Drugs and Crime, 2005) Around 50% of drug users in the north and south of the country are reported as giving opiates to their children (United Nations Office on Drugs and Crime, 2009). Afghan folk traditions include the use of raw opium to alleviate common physical complaints, e.g. to suppress children’s coughs and allow them to sleep.

It is likely that the abundance of psychological stressors in overcrowded urban settings and among displaced populations with limited resources and social support networks, fuels opiate use among those who previously only considered opiate use for medicinal or social purposes. These processes may disproportionately affect youth in urban settings (Todd et al., 2012). In the Western town of Herat alone there are some 2,000 drug-addicted children. One of them, 17-year-old Mohammad Zarif,

told how he became addicted to opium while cutting poppy plants in nearby Farah province.

'I am not happy that I am an addict. But I can't stop – there is no treatment for me. There is no real employment, either, and I do anything I have to in order to get food and drugs.'

(Behnam & Afzali, 2006)

## **Vulnerable sub-populations**

### **GENDER-SPECIFIC RISK FACTORS**

The system of *pardah* separates the male domain from the closely regulated female domain. It is an important part of men's honour to protect a woman from outside influences. This protection results in a narrowly-defined code of conduct and far-reaching restrictions on female movements. Many men consider seclusion of women the only way to protect them. During Taliban rule the extreme isolation of women, in particular those in the cities who were confined to small apartments that they could hardly leave, led to considerable mental distress (Dupree, 2004b; Rasekh et al., 1998). However, this '*pardah*-related depressive state' is not only related to Taliban rule but engrained in Afghan society (de Jong, 1999). The position of women and girls is subject to rapid and sometimes dramatic change. Many women and girls who have lived in refugee camps in Iran or Pakistan have seen the relatively higher degree of participation of women in society, and have often had the opportunity to pursue an education (Hoodfar, 2008). The work of many NGOs and the new government to bolster the rights of women and girls has had a clear impact, but is also cause of considerable tension within families and communities. Attempts to explicitly link the position of women and issues such as domestic violence to mental health and the promotion of women's rights may in fact exacerbate the problem of domestic violence, since many men will often simply not accept *pardah*-related stress as a possible source of female problems (van de Put, 2002).

Interestingly, in the above-mentioned study of children in four northern provinces of Afghanistan (HealthNet TPO, 2008b) boys reported higher levels of problems on most indicators (functional impairment, resources & coping, psychological difficulties, conduct problems, hyperactivity and peer problems). No significant differences were found for posttraumatic stress and depressive symptoms. The counter-intuitive finding that boys report more problems than girls may be explained by a greater exposure of boys to contextual stressors – they enjoy more freedom of action, are more mobile, and are more likely to be employed in work environments that may expose them to abuse. It may also be that they are more willing to express complaints in a research context. We should in any case be careful not to underestimate the problems that boys face, particularly in rural areas.

### **GIRLS IN EARLY OR FORCED MARRIAGES**

By custom, marriage occurs at a young age, although among educated people the wedding is often postponed until the completion of school. The legal minimum age for marriage is 16 years; however, the Afghan Ministry of Women's Affairs reports

that an estimated 57% of girls are married before the age of sixteen, with a mean age of marriage of 17.8 years for women and 25.3 years for men (Ministry of Women's Affairs, 2008). Several thousand girls in Afghanistan are married as early as 10 years of age. Forced marriage was estimated to be the norm rather than the exception, reportedly accounting for between 60-80% of marriages (Afghanistan Human Development Report, 2007). Afghan NGO workers, government officials, religious leaders, police officer, and teachers acknowledged the detrimental social and health outcomes of these practices for mothers and infants, and advocated for child marriage prevention; however, the consensus was that little could be done to assist girls who were already married (Raj et al., 2008).

In a study carried out in Kabul, many young girls raised serious concerns about early marriage, saying that they were not prepared for pregnancy (Slugget, 2003). An 18-year-old mother of four, who was married at age 13 to a 59-year-old man as his third wife stated.

**'My husband is too old; he cannot work and cannot bring anything like brush or anything for us. My husband's first wife died last year in child birth, the other wife is not well. So now, at 18, I take care of all these children, four of mine and five of theirs.'**

(Feinstein International Famine Center, 2004)

After marriage a girl will usually move to the husband's family. An important and often conflict-ridden relationship is that of the newly-married woman and her mother-in-law. Sometimes two families exchange girls, with each marrying a son from the other family, in order to avoid dowry costs or the division of inheritable property, particularly land holdings. The decision to exchange girls between two families is often made when the children are still young, sometimes even immediately after birth; thus, in most cases, the girl has no influence on the arrangement. Such *badal* marriages may strengthen the ties between families, and in this respect they provide support and protection. However, they also increase the vulnerability of the women involved; for instance, if a husband mistreats his wife, her relatives may take revenge on his sister, who was married into the other family and lives in their household.

In Pashtun custom, violent crimes (such as murder) can at times be settled peacefully through a decision by the tribal *jirga* (council) that a girl from the perpetrator's family or clan be given in marriage to someone from the victims' family (Medica Mondiale, 2007). The girls who are involved in these practices (known as *baad*) often suffer maltreatment and abuse, which they have no means to resist. The prevalence of these exchanges has not been quantified, nor are they permitted under Afghan state law. Nevertheless, a recent report on 'traditional' justice mechanisms acknowledged the continued existence of the practice, while characterising it as 'an exception – not a norm,' and pointing out that its acceptance as a vehicle for the settlement of disputes varied between areas of the country, being altogether prohibited by some groups (Afghanistan Human Development Report, 2007).

## **CHILD LABOUR**

The Law on Labour in Afghanistan stipulates 14 years as the minimum legal age at which children can be employed; employment of children aged 13 as apprentices is also permitted. About half of the children aged 5-18 are employed, or required to work by their families, often for long hours, and at the expense of attaining an education (Afghan Independent Human Rights Commission, 2007b).

Child labour is often linked to family poverty. For children who do not attend school, child labour is likely to be more prevalent, particularly in rural, farming areas, where children are often called upon to participate in farm labour, or in larger cities, where children may work on the streets to contribute to family income (UNICEF, 2005). Forms of child labour amounting to indentured slavery can be found in carpet weaving workshops, brick factories and car repair establishments (Dupree, 2004b).

## **CHILD SOLDIERS**

A rapid assessment by UNICEF in 2003 found an estimated total of 8000 combatants under the age of 18 in Afghanistan. A programme for Disarmament, Demobilisation, and Reintegration (DDR) was set up for child soldiers, and in 2007 more than 5000 former child soldiers participated (Coalition to Stop the Use of Child Soldiers, 2008). The programme worked with NGO partners who developed community programmes to provide education, life skills and vocational training, and psychosocial support (Wessells, 2006). In some areas, demobilized child soldiers have returned home, but have faced problems reintegrating in the absence of vocational training and psychosocial support (HRW, 2004).

## **CHILDREN WITH DISABILITIES**

*Children with physical disabilities* The high level of malnutrition, birth complications, accidents and untreated medical conditions in Afghanistan gives rise to high numbers of disabled children. According to the most recent, carefully-conducted survey by Handicap International (2005), there are an estimated 196,000 school-aged children with disabilities in Afghanistan; less than one in four of them attend school. Children with disabilities have traditionally been seen as less worthy of social investment, which leads to exclusion of disabled children from services (Turmusani, 2004). Disabled children and adults also show more signs of mental distress than others (Bakhshi et al., 2006) Increasing access to education in Afghanistan over the last decade has not significantly reduced the marginalisation of children with disabilities (Trani et al., 2012).

According to the United Nations Mine Action Centre for Afghanistan (UNMACA), Afghanistan has one of the highest landmine casualty figures in the world. About 70,000 Afghans have either been killed or disabled by landmines in the past two decades. Children are especially vulnerable to injury from these weapons, often in the course of performing everyday chores such as gathering wood, tending livestock and collecting water for their families. While overall annual figures for new mine victims are decreasing, the number of victims under 18 years is increasing (ICBL, 2007). In addition, unexploded ordnance (UXO) is easily mistaken by children for a toy or an

interesting object to investigate. In a study in Kabul in 1995, roughly 85% of all UXO victims were children (Save the Children USA, 2003). There is no systematic research on the mental or psychosocial consequences of injuries due to landmines or UXO on children in Afghanistan. The effects are assumed to be profound as illustrated in this quote from a report by Save the Children on the subject.

'I feel miserable. I can't play football with my friends anymore or help my mother bring up water from the well. Why has this happened to me? I am so disappointed with my life. I don't understand why this has happened.'

(10-year old Ali; he lost one leg while the other was severely injured.)

***Children with intellectual disabilities*** A nationwide epidemiological survey on disability found a point prevalence of 0.11% for learning disabilities (Trani & Bakhshi, 2006). The case identification was through self-report by family members, who were asked if there was a member in the household who had delayed/slower speaking ability or delayed walking/mobility development compared to other members of the family, or who demonstrated behaviour that did not correspond to their given age. In neighbouring Pakistan the prevalence of mental retardation was found to be considerably higher than in industrialized countries: nearly one in 50 children had severe mental retardation, and one in 15 mild mental retardation (Durkin et al., 1998). Many of the risk factors for mental retardation in the Pakistan study are present in Afghanistan: perinatal difficulties, consanguineous marriages, high rates of neonatal infections, postnatal brain infections (cerebral malaria), malnourishment of pregnant women and young children, and head trauma. The difficult living conditions faced by many Afghan families, including poor nutrition, hygiene and health care, leads to many developmental problems in children. Excessive numbers of infants are born with congenital abnormalities, which are probably the result of maternal malnutrition during early foetal development. Developmental milestones are significantly delayed for many Afghan children (Miller et al., 1994; Prasad, 2006).

#### **VIOLENCE AGAINST CHILDREN**

***Domestic violence against children*** In Afghanistan violence in families is widespread, and beating children is, in general, not considered immoral when it is not excessive. The Afghan Independent Human Rights Commission (AIHRC) has drawn attention to the high level of domestic violence reported by children in both rural and urban areas. In one study, over half of the children interviewed by AIHRC reported experiencing physical violence at home; the report authors also point out that as many children were worried about answering the question, rates of domestic violence are likely to be underreported (Afghan Independent Human Rights Commission, 2007a). In her study of children in two schools in poor neighbourhoods in Kabul, Catani et al. (2008) found that while 39% of respondents had directly experienced war-related events, 10% reported having suffered at least one injury due to maltreatment at home. Children had experienced an average of 4.3 different types of domestic violence, with most children reporting three or more event types. Predictors of domestic violence included a history of experiencing war trauma, family size, engagement in child labour and poverty.

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Smith (2008) interviewed Afghan adults about their views on and experience of violence against children in the home, and found that they identified two distinct categories: violence used as a means of disciplining children, and violence resulting from adult anger, stress or frustration. In the communities where the research was carried out, violence toward children by family members is accepted and widely practised. Much violence directed at children relates to how the adult is feeling, with adults under stress venting their anger on their children. Many people would be keen to adopt nonviolent means for disciplining their children, but do not know how.

**'Beating children also is not good. When I had my first daughter I beat her a lot when she was very small but now I know that we should not beat children because they do not understand. So parents should not beat their children. But when my husband fights with me and I'm angry I beat my children. And when I'm tired from doing housework I beat my children very hard if they do not listen to me. Once I had washed the clothes and it was three thirty and I was very tired. My husband had been doing construction work at home. When I finished the clothes and without giving me any break to drink tea, he asked me to cook food for dinner. I said ok after having some tea I will cook. But he didn't listen to me and asked me to cook food now. I became angry and did not say anything to him. At the same time my son came to me and I asked him to wash his face, I told him to take water and wash his face but he didn't listen to me and asked me to do it. I was angry with my husband, but I couldn't say anything to him so I took a big stone and I threw it at my son and shouted to him, do what I am telling. I am not your servant. Unfortunately, the stone broke one of his teeth and his mouth was bleeding.'**

(Mother of a six year old son; Smith 2008: 51)

Women in the large-scale study by Eggerman & Panter-Brick (2010) recounted similar experiences of becoming violent due to frustration with their circumstances.

**'My husband is a driver, but he doesn't own the car he drives, so he has to give a large part of what he earns to the owner. We have to share a house with four other families, we live in the separate rooms of the house and it's difficult. My mind gets weaker and weaker, and I get upset and beat the kids. Yesterday I beat my daughter, then I felt bad about it and slapped myself on the face.'**

(Woman, aged 28; Eggerman & Panter-Brick 2010:75)

Prospective data, from a baseline and follow-up study, have most clearly shown the impact of domestic violence on child mental health: while cross-sectional data only point to associations between variables, longitudinal data can assess the relative causal impact of different types of violence and socio-economic stressors. In their follow-up study, Panter-Brick and colleagues concluded that violence inside the family was the most critical predictor of mental health trajectories, even in the context of exposure to extraordinary levels of collective violence (Panter-Brick & Eggerman, 2012; Panter-Brick et al., 2011). The quality of past-year family relationships was key to changes in psychiatric difficulties and depression: domestic violence (reported as stressful), severe beatings (reported as trauma), and family conflict predicted worse outcomes, while family 'harmony and unity' (Dari: *ittifaq* and *wahdat*) – a

sense of family cohesion and connectedness – predicted better outcomes. By contrast, exposure to militarized violence had no discernable impact on mental health changes over the period of study. Thus family environments may outweigh collective violence in predicting psychiatric and depressive burden (but not posttraumatic stress, for which lifetime trauma exposure trumped all other risk and protective factors). Family relationships are also central to developmental resilience, as evidenced by better-than-expected prospective mental health outcomes.

**Sexual violence against children** In Afghanistan it is very difficult to find information on sexual abuse of children. Most information is from press reports or anecdotal accounts as no official statistics are available (IRIN, 2007, 2008). Sexual abuse against a child is considered an offence against the honour of the family, and not specifically a crime against the child itself (Slugget, 2003). Among Afghans, child abuse is thought to affect boys more frequently than girls, as the latter are supposed to be protected within the safety of their homes; abuse of girls is therefore a particularly ‘taboo’ subject, and hidden within the family.

Medical reports in Afghanistan suggest that reproductive health problems of young women constitute a health burden, with case reports of girls as young as twelve years presenting with vaginal and anal bleeding resulting from early consummation of marriage (Women’s Commission for Refugee Women and Children, 2002).

In Afghanistan, the unavailability of female sexual partners for men outside of marriage seems to provoke the use of young boys as sexual partners. In a cross sectional sample of 4750 men (age 18-35) in the recruitment process for the Afghan national army, 18.3% reported having had sexual relations with boys. Very few of them (2.6%) reported ever using condoms in such contacts (Todd, 2012). Traditionally, the ‘keeping’ of handsome boys is a marker of status and prestige for men. The practice visibly continues today, with militia commanders and other important leaders accompanied by teenage ‘tea-boys,’ and truck drivers by a young assistant referred to as a ‘wife.’ Khan (2009) reports the story of a boy whose father died when he was five years old, and whose mother remarried and sent him to live with his grandmother; the latter asked him to collect wood to sell in order to contribute to her household income:

**‘Some people were giving me money and started to sexually use me. I was happy with that because it was the easiest way to have money for my grandmother. Now it is my business, even if it is shameful. If there is another alternative, I will stop it.’**

(Schoolboy in Kabul. Cited in Khan, 2009)

Severe sexual violations against boys are thought to be most common in South and Southeast of the country (Feinstein International Famine Center, 2004), but are also well-known in the North. There is also evidence of young male adolescents being systematically exploited and sexually abused by tribal leaders, militia commanders, or other powerful men, as part of a practice known as *bache-bazi* (lit. ‘playing with boys’). Often poor and orphaned, these boys are bought by older men to dance at parties, and are sexually abused by them afterwards; such gatherings also serve as

marketplaces, with good-looking boys being traded by their 'owners' for money. In 2008 the US Department of State Bureau of Democracy, Human Rights, and Labor concluded that 'child abuse was endemic throughout the country, ranging from general neglect, physical abuse, abandonment, and confinement to work in order to pay off family debts,' and that 'sexual abuse of children remained pervasive' (State Department, 2008).

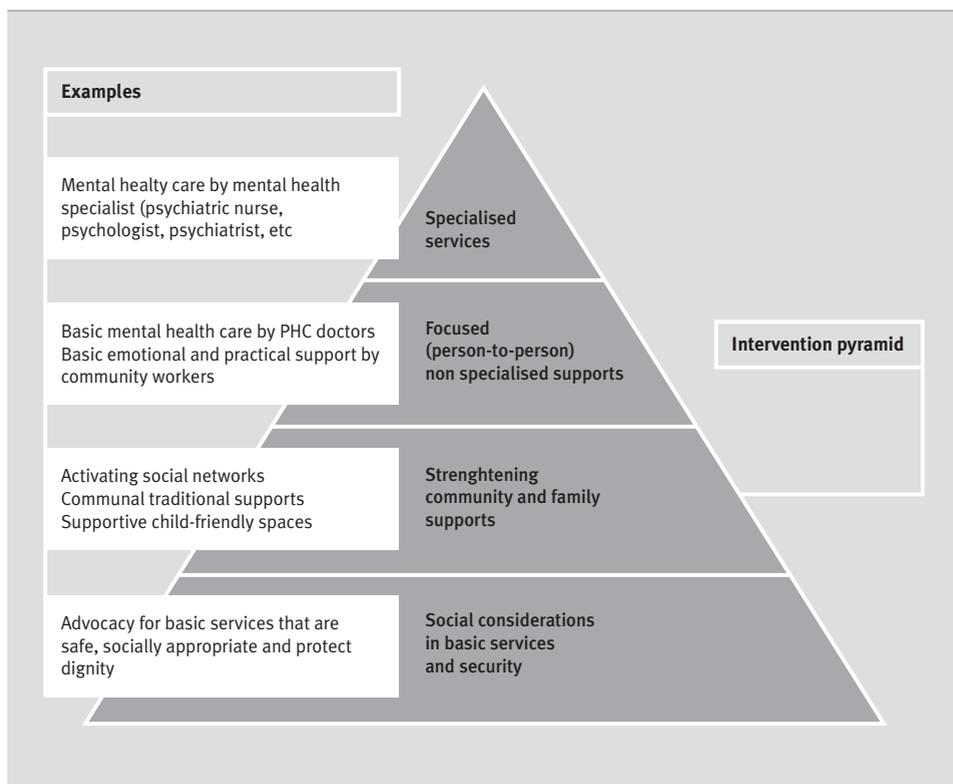
## **Services to assist Afghan children and youth**

Psychosocial well being of children can be affected by traumatic events and by daily stressors. Traumatic stressors may include war-related events, but also family conflict and community-level violence not directly related to war (Panter-Brick et al., 2009). Daily stressors consist of social and economic hardships in everyday life, related to physical ill-health, malnutrition, crowding, unemployment, low wages, illiteracy and gender-based discrimination including domestic violence, social isolation and barriers to equitable access to health, educational and vocational resources (Arntson, 2001; De Berry et al., 2003; Miller et al., 2008; Omidian & Miller, 2006). Thus, the call from public health advocates for a population-based, youth-focused model, which explicitly integrates mental health with other health and welfare initiatives in low and middle-income countries (Patel, Flisher, et al., 2007) is highly relevant for Afghanistan.

Successful mental health and psychosocial support programming in Afghanistan has to take into account the complex political, socioeconomic and cultural situation of the country. It is hard to build sustainable systems of care, and in Afghanistan this requires taking community variation into account in the design, implementation and evaluation of programme initiatives. It requires collaboration with organisations and groups at community and district level, and with formal structures such as ministries and programmes at national and provincial level. Interventions have to address huge gaps between national-level policies and local priorities in the lives of ordinary people. Community relations with the outside world and regional political elites are often mediated through personal relationships with powerful decision-making 'key figures' at the national level. Until these higher-level elites are willing to allow transformation of existing power relations, it will be difficult to change social systems where change is required to meet the goals of quality and equity in access to basic services, and the effectiveness ability of programmes will be limited. Given this situation, a step-by-step approach and a willingness to work with existing community-based and governmental structures is required. Effort must be put into the creation of networks, and the nurturing of collective action to improve the lives of Afghan children and their families.

Several organisations provide services for Afghan children; however, existing initiatives are fragmented, and many existing programmes are in the embryonic stage at best. Such efforts are often initiated and run by international non-governmental organizations and reach relatively small numbers of targeted groups; they may not be firmly rooted in Afghan social structures, and may not prove to be

**FIGURE 5.1** Intervention pyramid for mental health and psychosocial support (IASC Reference Group, 2010)



sustainable. International consensus documents such as the IASC-guidelines on mental health and psychosocial support in emergency settings (IASC, 2007) recommend that services must be connected within a multi-layered support system, in order to cater for a range of people affected in different ways who may require different kinds of mental health and psychosocial support (Figure 5.1). We will provide an overview of existing initiatives in terms of this framework of interrelated services.

A small percentage of people experience intolerable suffering and have significant difficulties in daily function; they would need access to clinical, psychological, psychiatric, or other highly specialized supports. A majority of people manage to cope with difficulties and distress through access to local, non-formal support systems bolstered by the reestablishment of adequate security, governance and services that meet basic survival needs. In between these extremes are people affected by disruptions in key family and community support networks, who will benefit from efforts such as tracking down missing family members and effecting a reunification, communal healing ceremonies, formal and non-formal education, livelihood activities, and the strengthening of hope and social capital (Jordans, Tol, et al., 2010; Wessells & van Ommeren, 2008).

## **Layer 1: Basic services and security**

The most important interventions to improve mental health and psychosocial well-being for Afghan children and youth have apparently nothing to do with psychosocial support and mental health care. The best guarantee for improved mental health status is the normalization of living circumstances and the alleviation of severe problems resulting from poverty and insecure livelihoods. Programmes to promote income generation and reduce children's workloads will have direct beneficial effects on children and their families. The development of infrastructure, health and educational services are important elements of the reconstruction of Afghanistan, as well as initiatives that bring together youth, local communities and stakeholders to increase general child safety, as exemplified by demining and road safety campaigns (De Berry, 2008). An important impediment to healthy psychosocial development is ongoing violence and political instability. The continued violence between anti-government insurgents and pro-government forces, including foreign military troops, prevents a normalization of life for many Afghans. In particular, attacks by Taliban on schools catering for girls and other public services for women increase the sense of insecurity among the population.

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### *Example: Building water wells improves psychosocial wellbeing*

Loughry et al. (2005) present a salient illustration of the importance of providing basic needs to improve psychosocial wellbeing. Using a quasi-experimental design, the project compared the effects after 9-14 months of a 'psychosocial' intervention, consisting of Child Centered Spaces and activities facilitated by Child Well-Being Committees (described below in layer 2) with an intervention to improve basic services: a water-sanitation programme consisting of the construction of wells using a participatory process. A questionnaire-based measure indicated that the water intervention had greater impact on children's well-being than the psychosocial intervention (Loughry et al., 2005).

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## **Layer 2: Community and family-level support**

The second layer represents services to enable people to maintain good mental health and psychosocial wellbeing by accessing key community and family support (van Mierlo, 2012). In the Afghan context, appropriate activities for children and youth might consist of promoting alternative disciplining techniques and providing child-rearing support. Examples include awareness-raising workshops for parents, teachers or local religious leaders, involving adolescents in meaningful activities to prevent substance abuse, training community members to better provide psychosocial support, and discouraging child abuse and maltreatment, social exclusion, gender discrimination and domestic violence. Further options include the activation of social networks through youth clubs or the development of recreational spaces to provide opportunities for sharing experiences and mutual learning. A similar approach is the promotion of 'Child Centred Spaces,' places where children who have often lived with

war all their lives can re-socialize through play and education in the norms and values of peaceful Afghan society (Snider, 2003). We give two examples of interventions of offering community-level and family support undertaken in Afghanistan.

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*Example: Child Well Being Committees, giving children a voice in decision-making*

Since 2002, three major international NGOs (Child Fund Afghanistan, Save The Children USA and International Rescue Committee) formed the Consortium for the Psychosocial Care and Protection of Children, with the objective to ‘improve, in a sustainable manner, the psychosocial wellbeing and development opportunities of Afghan children, enabling primary and secondary stakeholders to cope better with the effects of a poverty-stricken, protracted conflict environment through participatory, community-based programming.’ (USAID/DCOF, 2007). The backbone of this approach is the establishment of Child Well-Being Committees, consisting of a mixed group of children, adolescents and adults that aim to mobilize, monitor and guide child protection efforts. The committees address a variety of issues relevant to children such as health and hygiene, child protection, parenting skills, and monitoring the protection of vulnerable children in the community. During evaluations in 2005, children felt safer, went to school more often, made friends with children from other ethnic groups, and – according to their parents – exhibited better behaviour (Loughry et al., 2005). A 2006 follow-up revealed significant changes in children’s self-reported behaviours: negative behaviours such as fighting with and hitting other children declined. In remote Faryab province, girls reported a dramatic increase in their ability to speak up in a group. This finding was corroborated by reports from community members, one of whom described the children as follows: ‘They are aware of their rights. They know things in the right ways. They are able to prepare songs and poems and [know] how to gather information about the problems in the community. The change is positive. Children share information with other children and attempt to have the other children involved in the activities. Children will know what to do when they are adults, how to resolve problems and to allow children to participate.’ Women’s Community Committee Member (USAID/DCOF, 2007).

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*Example: Promotion of physical education and play in schools and communities*

The NGO ‘War Child’ implements psychosocial activities in schools and in communities throughout Herat and Kabul. A component of this programme is getting non-school-attending working children back to school. Communities are encouraged to develop children’s clubs as a means through which issues affecting children can be identified, explored, and addressed through subsequent advocacy campaigns. The programme uses community-relevant indicators related to social change, such as an increased opportunities to meet peers and escape from isolating and monotonous home-based activities, improved balance between work-related responsibilities and leisure activities, less violent games (which often trigger memories of conflict), more positive interactions between children, the understanding and acceptance by adults of children’s right to play, and the importance of play for child development and wellbeing. A 2006 evaluation of the school and community-based work found that there has been an increase in parent’s support for children’s play and learning. Girls in particular had received



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increased support from adults to play and attend school; many girls had not been permitted to play before. The attendance of girls and working children in learning activities was seen as a clear expression of increased support, as some of these required a small fee from parents for participation. As one mother stated:

'I have five daughters and they are all involved in the NGO activities. They are in different courses and they are learning things like tailoring and English. We have an activity now. We did not have any when we were in Iran, because they looked down on us because we are Afghans. Now I am happy that my daughters can learn things that I could not. We want to open first aid and beauty classes. We are also learning table tennis.'

(Woman in Herat Province – report by War Child Holland, 2007)

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### **Layer 3: Focused non-specialized supports**

The third layer consists of focused support for people who require individual, family or group interventions by trained and supervised workers who are not necessarily specialists in mental health and psychosocial support. Interventions within this layer can include a system of caseworkers who provide psychosocial support to families and individuals. In Afghanistan, HealthNet TPO has developed community-based psychosocial work using para-professional psychosocial workers as the backbone of the service (HealthNet TPO, 2008c). Structured psychosocial group interventions for children and youth with symptoms of moderate distress have not been documented for Afghanistan, but there is some evidence for its effectiveness in other settings (Bolton et al., 2007; Tol et al., 2008). Organizing such services requires a long-term commitment by skilled helpers to ensure appropriate follow-up support, ongoing training, and supervision. Omidian and Lawrence (2007) describe how they use 'focusing' self-therapy – a therapeutic technique of 'bringing attention to the body in a gently, accepting way and becoming aware of felt sensations, leading to insight, physical release and positive life change' – which connects well with the rich Afghan heritage of Islamic Sufi philosophy and Farsi poetry.

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#### *Example: Helping school teachers to provide psychosocial support*

In Afghanistan many teachers have no notion of teaching beyond academic instruction and lack the necessary skills to promote the social and emotional development of children. Organizations such as Save the Children US and UNICEF have made an effort to integrate training on psychosocial support into the primary school teacher curriculum. With approval of the Afghan Ministry of Education, a training module was developed on how teachers could offer psychosocial support and take measures to protect children. The module aimed to help teachers integrate traditional Afghan coping strategies for promoting emotional wellbeing into their work. The Ministry of Education prepared and distributed the training package to all primary school teachers in Afghanistan (De Berry, 2004). Similar approaches have been taken to train teacher in psychosocial wellness models and to enable them to provide improved psychosocial support to children in the classroom (Omidian & Papadopoulos, 2003; Omidian, 2012).

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#### Layer 4: Specialized services

The pyramid's top layer represents specialized interventions required for a small percentage of people with severe psychological complaints or mental disorders. Appropriate interventions include services to treat substance abuse in adolescents, and the identification and treatment of severely depressed children. Afghanistan does not have specialized services for child psychiatry or child psychology (Ventevogel et al., 2006). Institutional mental health services hardly exist, with just one national mental health hospital, and four psychiatric wards in general hospitals. The proportion of child and adolescent users of these mental health services is low (World Health Organization, 2006). Given the extreme scarcity of Afghan mental health professionals and limited financial resources, the establishment of specialized mental health services for children in the country still has a long way to go.

The World Health Organization advocates the inclusion of mental health services within existing primary health care services (World Health Organization, 2008). This entails training health care workers to identify mental, neurological and substance use disorders, installing a system of clinical supervision and regular medication supply, and promoting awareness-raising activities in communities. In Afghanistan this approach has been developed by non-governmental organisations such as Health-Net TPO in eastern Afghanistan and the International Assistance Mission (IAM) in the western provinces around Herat (Ventevogel, Faiz, et al., 2011; Ventevogel & Kortmann, 2004; Ventevogel et al., 2012).

Afghan NGOs such as Windows for Life (WFL), Humanitarian Organization Supporting Afghans (HOSA), and Medica Mondiale provide psychosocial services through psychosocial counsellors who have had intensive training in a variety of counselling techniques and are extensively supervised. These services are not specifically geared towards children and adolescents. A recent randomized control trial among Afghan women ( $n = 61$ ), diagnosed with poor mental health symptoms by local physicians, compared the impact of routine medical treatment (treatment as usual) with psychosocial counselling (for 5–8 sessions) following a purposively-developed protocol. At 3-month follow-up, the patients who had received psychosocial counselling showed a drastic decrease in symptoms of depression and anxiety and an enhancement of coping strategies, while no such improvements were seen in the control group (Ayoughi et al., 2012). We may conclude that adding psychosocial services into the basic health care services of Afghanistan has proven to be both feasible and effective. Yet there is still a long road ahead, despite the impressive progress made to-date with regards to the provision of mental health services in Afghanistan. One specific priority is tailoring mental health and social services to the needs of children and adolescents.

## Conclusions

This chapter has provided a focused study of research and intervention efforts related to child mental health and wellbeing in Afghanistan. We reviewed the structural adversities that challenge Afghan children and adolescents, in terms of war, dis-

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placement, poverty, widening inequalities, social expectations, and restricted opportunities for education and healthcare. We reviewed the evidence base for psychosocial distress and mental health disorders, emphasizing the importance of family dynamics and the capacity for resilience. A fundamental take-home lesson from Afghanistan is that the family is a central institution shaping child health and well-being – in terms of both everyday distress and everyday resilience. Six fundamental cultural values – faith (*iman*), family unity and harmony (*wahdat* and *ittifaq*), service (*khidmat*), perseverance and effort (*koshesh*), morals (*akhlaq*), and respectability and honour (*izzat*) – underpin the sense of resilience in Afghan culture. These key values provide a moral framework to make sense of suffering, regulate social behaviour, maintain a sense of hope and human dignity, and give a sense of coherence to past experiences and future aspirations.

A second key point is that family relationships and cultural values are themselves a driver of poor mental health, where war, poverty, and discrimination steal away the wherewithal to realize economic and social milestones. Family relationships become marred by conflict, while ambitions to adhere to cultural values are frustrated by dire poverty or powerlessness – this drives ordinary people into a sense of entrapment, especially with regards to cultural dictates governing reproductive and economic decisions. Such drivers of psychological distress and social entrapment are especially relevant for children who are forcibly married, children in forced labour, children with physical or intellectual disabilities, children who face domestic or sexual violence, and children using illicit drugs or resorting to self-injury. ‘Everyday stressors,’ rooted in poverty and violence, generate lasting psychological distress in children and adolescents, over and above the more dramatic forms of trauma associated with the brutality of war.

The implication of such research findings is that structural injustices in Afghanistan (including gender and ethnic discrimination, lack of stable employment opportunities, and exposure to violence) need to be addressed through a multi-level system of interventions that cuts across sectors of health, education, employment, and social work. Indeed, with respect to child mental health, policy makers, researchers and practitioners have begun to move well beyond a primary consideration of the acute negative impacts of war-related violence. Efforts to design integrated, effective and equitable access to basic health, social, and economic services are still fragmented, but there is a sense that real progress has been made to-date, and that formal evaluation of concrete initiatives will provide an important next step towards the consolidation of basic service provision. Because education is often perceived as the gateway to social and economic success, and because Afghans often express hope in the future in terms of social prominence and economic milestones, initiatives to improve the quality of education are crucially important. Other interventions have focused on livelihoods and community governance, such as building wells and establishing child-centred spaces. Yet other programmes have been concerned with fostering community-based psychosocial support, including training psychosocial workers or group interventions based on therapeutic techniques such as focusing. This is a rich tapestry of interventions, but one that needs better integration in existing systems in such a way that sources of resiliency are strengthened rather than undermined.

The best way forward is to answer to the simple logic of a pyramid structure with interconnected layers of interventions: the bottom layer of the pyramid encompasses initiatives for equitable access to broad-based services such as health care, education, and shelter. The middle layers of the pyramid focuses on activities aimed to strengthen coping and resilience in families and local communities, and initiatives that enable community-based health workers and teachers to assist children who present psychosocial problems that cannot be handled with simple family or community support. Specialized *clinical* interventions, constituting the very top of the pyramid, target children and adolescents with severely disabling mental disorders and substance use disorders, who cannot be adequately supported within other layers of the service system.

We believe it is essential to view services provision within such a broad perspective to ensure that culturally-relevant interventions to improve mental health and psychosocial wellbeing encompass efforts to build resilience, rather than just focus on at-risk groups of children. Building resilience in Afghanistan entails strengthening families and communities, addressing the main factors which weaken helpful social ties: poor governance, economic and political insecurity, severe overcrowding, recurrent domestic violence, unequal opportunities for education and advancement. We therefore call for broad community-oriented approaches to address issues of mental health and psychosocial wellbeing, giving specific attention to the physical needs and social aspirations of children and adolescents. To be successful, such initiatives are best embedded in a multi-sectoral approach that addresses larger issues pertaining to poverty reduction, environmental safety, quality health and education, family dynamics, and stability of governance, livelihoods, and social structures – a matter of securing a stable future and dignity at the most crucial social level, that of the family.

## Acknowledgements

We wish to thank Hafizullah Faiz, M.D., and the staff members of HealthNet TPO's mental health programme in Afghanistan; Ivan Komproe, Ph.D., from HealthNet TPO; Julian Smith, Eshaq Zakhizada, and Najeeb Nuristani, from War Child Holland; and Michael Wessells, Ph.D., from Columbia University.

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A grayscale topographic map of a mountainous region, featuring numerous contour lines and elevation markers such as 1800m, 1900m, and 2000m. A prominent white number '2' is positioned in the upper left quadrant, and a horizontal dashed white line spans across the middle of the page.

# 2

## Measuring mental health



## Mental health symptoms following war and repression in eastern Afghanistan

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*JAMA* (2004), 292, 585-593

## Abstract

**Context:** Decades of armed conflict, suppression, and displacement resulted in a high prevalence of mental health symptoms throughout Afghanistan. Its Eastern province of Nangarhar is part of the region that originated the Taliban movement. This may have had a distinct impact on the living circumstances and mental health condition of the province's population.

**Objectives:** To determine the rate of exposure to traumatic events; estimate prevalence rates of symptoms of posttraumatic stress disorder (PTSD), depression, and anxiety; identify resources used for emotional support and risk factors for mental health symptoms; and assess the present coverage of basic needs in Nangarhar province, Afghanistan.

**Design, Setting and Participants:** A cross-sectional multicenter sample survey of 1011 respondents aged 15 years or older, conducted in Nangarhar province during January and March 2003; 362 households were represented with a mean of 2.8 respondents per household (72% participation rate).

**Main outcome measures:** Posttraumatic stress disorder symptoms and traumatic events using the Harvard Trauma Questionnaire; depression and general anxiety symptoms using the Hopkins Symptom Checklist; and resources for emotional support through a locally informed questionnaire.

**Results:** During the past 10 years, 432 respondents (43.7%) experienced between 8 and 10 traumatic events; 141 respondents (14.1%) experienced 11 or more. High rates of symptoms of depression were reported by 391 respondents (38.5%); anxiety, 524 (51.8%); and PTSD, 207 (20.4%). Symptoms were more prevalent in women than in men (depression: odds ratio [OR], 7.3 [95% confidence interval (CI), 5.4-9.8]; anxiety: OR, 12.8 [95% CI, 9.0-18.1]; PTSD: OR, 5.8 [95% CI, 3.8-8.9]). Higher rates of symptoms were associated with higher numbers of traumas experienced. The main resources for emotional support were religion and family. Medical care was reported to be insufficient by 228 respondents (22.6%).

**Conclusions:** In this survey of inhabitants of Nangarhar province, Afghanistan, prevalence rates of having experienced multiple traumatic events and having symptoms of anxiety, depression, and PTSD were high. These findings suggest that mental health symptoms in this region should be addressed at the population and primary health care level.

## Introduction

Nangarhar province is part of the Pashtun belt that covers southern and eastern Afghanistan and Pakistan's North West Frontier province. The Taliban movement is rooted in Pashtun tribal culture and in the ideology of the radical Deobandi-sect of Sunni Islam, blending both into a rigid social and religious system with strict seclusion of women from public life and harsh punishment of any violation of social rules

(Rashid, 2001).<sup>1</sup> The Taliban took the Pashtunwali (the Pashtun code of conduct) far beyond the tribal norm and was uncompromising in its aim to return society to the ‘purity’ of an idealized seventh century (Hilton, 2001).

In the 1980s, the Nangarhar province was the scene of heavy fighting between the former Soviet Union army and the *mujahedeen* forces. The cave complexes of Tora Bora, situated in Nangarhar’s district Pachir wa Agam, used to be a center of *mujahedeen* forces, where prisoners were interrogated and many were killed. Later it was used by Al Qaeda. The bombing raids launched by the United States on Afghanistan from October to December 2001 had a large impact on the region and triggered an exodus from Jalalabad city to neighbouring districts and Pakistan.

The fall of the Taliban regime ended the extreme conservatism, but did not lead to an overall liberalisation in Nangarhar province. Individuals doubt the stability of the new government, and fear that current liberal behaviour could be punished in the future. Other potential stressors in the actual situation are unemployment, general poverty, and an ongoing lack of security in the region.

Given the country’s past and present sociopolitical and economic situation and its recent history of violence and persecution, the prevalence of mental health disorders is expected to be high. In a survey conducted during the Taliban regime in 1998 among a community sample of women living in Kabul or in refugee camps in Pakistan, 97% reported symptoms of major depression and 86% reported significant anxiety symptoms (Rasekh et al., 1998). Of 310 children and adolescents aged 8 to 18 years interviewed during a community survey in Kabul, 80% said they were sad, frightened, and unable to cope with life; 40% had lost a parent; and 67% had seen dead bodies or part of bodies on the street (UNICEF, 1997). A qualitative study in the Herat province reported a general increase in psychosomatic problems, anxiety, depression, and domestic violence (de Jong, 1999). In a study using the General Health Questionnaire among a community sample of Afghan refugees in southern Iran, 34.5% of respondents reported mental health symptoms (Kalafi et al., 2002).

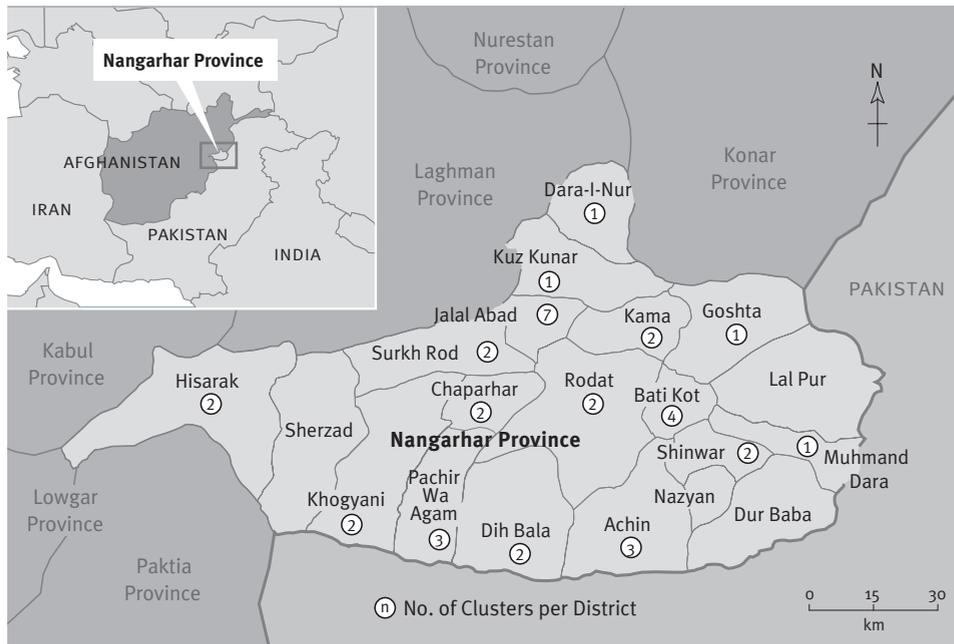
We conducted a survey among the general population of Nangarhar province to determine the rate of exposure to traumatic events; estimate prevalence rates of symptoms of posttraumatic stress disorder (PTSD), depression, and anxiety; identify resources used for emotional support and risk factors for mental health symptoms; and assess the present coverage of basic needs.

## Methods

### Survey design

From January 27 to March 18, 2003, we conducted a 2-stage, 40-cluster sample survey. The study population included all individuals aged 15 years or older, who were residing within the recognized borders of Nangarhar province (Figure 6.1). Because no accurate list of villages and their population sizes existed, a new list was assembled from district information obtained through the United Nations Children’s Fund (UNICEF) Expanded Programme on Immunization. Our estimation of total population

**FIGURE 6.1** Geographic distribution of 37 clusters in Nangarhar Province, Afghanistan, included in survey sample

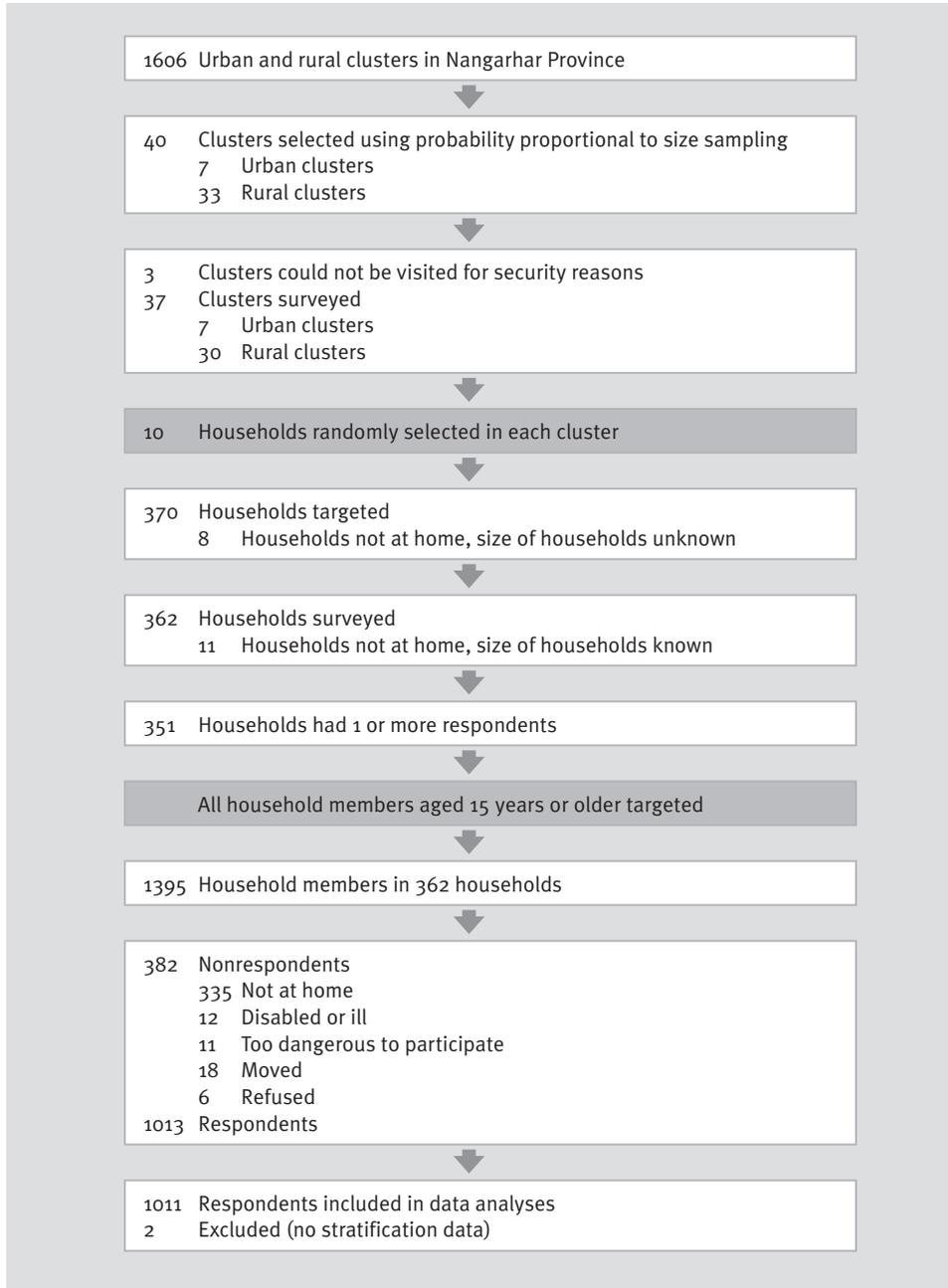


size was based on the number of children aged 5 years or younger, vaccinated in the Oral Polio Vaccination Program, and assuming that these children formed 20% of the population. District coordinators for UNICEF were asked to list all villages and their population size. If population figures were unavailable for specific villages, we asked for an indication of the relative size (large, medium, or small) of the settlement. Water and sanitation records of the Danish Committee for Aid to Afghan Refugees were used to complete district lists. Our final list consisted of 1606 villages and settlements. This list included UNICEF's division of the city of Jalalabad into four segments. Using the primary sampling frame, we estimated the total population of Nangarhar province to be slightly more than 1.6 million individuals, which corresponds with UNICEF's estimations (UNICEF, 2002).

To determine the sample size for our study, we assumed a prevalence rate of 50% of mental health-related problems. We estimated that a minimum of 770 participants would be required for a 95% confidence interval (CI) to detect a prevalence rate between 45% and 55%. The required minimum was increased to 1100 because we anticipated nonresponse to be 30%. Based on available information on household size and age distribution, we further assumed an average of four adults per household. Therefore, a minimum of 275 households would need to be included. However, we planned to include a larger sample: 400 households, a trade-off between the desired numbers of clusters and of households. With probability proportional to population size, we selected 40 clusters in the first sampling stage: 33 in rural areas and seven in the city of Jalalabad (Figure 6.1 and Figure 6.2).

In the second stage of sampling, ten households were selected within each cluster. Identification of cluster samples differed for urban areas and rural villages. No maps of the selected villages were available. In small settlements, we first asked the village leader to list all families and then selected ten households using a random

**FIGURE 6.2** Sampling stages of survey



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MEASURING MENTAL HEALTH

number table. In larger communities, we asked a village leader to list all mosques, and then selected 1 mosque using a random number table; next, we asked the *mullah* to list all families and we randomly selected ten. Maps were available for the city of Jalalabad and Nangarhar province. By blindly throwing a pen onto a map, a spot was selected as a starting point for the survey. The first house on the left was selected for the first interviews. The next house was selected to be the closest house to the left when leaving the house just surveyed. This procedure was repeated until ten households within the cluster had been surveyed. All members of the selected households aged 15 years or older were requested to participate.

We selected nine male and six female interviewers who were fluent in the Pashto language and were able to read and write. They were trained over a five-day period, which included a field test. Supervision occurred on a day-to-day basis throughout the survey. To ensure privacy, we encouraged interviewers and participants to complete the questionnaires in private places. Participants were paired up with same-sex interviewers. If household members were not at home, interviewers and household members agreed on a day to complete the interview. If potential participants were still absent or unwilling to respond at the second visit, background information and reasons of nonresponse were noted.

Formal review and approval of this survey has been given by the medical ethical committee of the University of Amsterdam, Amsterdam, the Netherlands. Because of the high illiteracy of the Afghan population (UN 1999 estimation: 64%) (United Nations, 2002), informed consent was obtained from each respondent by reading aloud an explanatory text and then asking for participation.

## **Instruments**

All instruments in this study were designed as self-reported questionnaires. Due to the high illiteracy rate, we used the questionnaires as a structured interview in which questions were read aloud to each participant. We collected demographic information on sex, age, marital status, education level, religion, and ethnicity. Ethnicity was defined by respondents who chose from a preselected list. All questionnaires were translated into Pashto with the help of a bilingual mental health expert and back-translated by another who was blinded to the first translation.

To assess mental health symptoms, we used the Harvard Trauma Questionnaire (HTQ) and the Hopkins Symptom Checklist (HSCL-25). In addition, we asked questions about physical, social, and mental well-being. We chose these instruments to obtain information on common, nonspecific psychiatric problems and to gather information on symptoms of specific disorders such as PTSD, anxiety, and depression, and related life events.

The HTQ combines the measurement of PTSD symptoms over the past four weeks and traumatic events experienced over the past 10 years (Mollica et al., 1992). Trauma event questions were adapted for specific events among the Afghan population in a similar way as was done in a national mental health survey in Afghanistan in 2002 (Cardozo et al., 2004). Because rape appeared to be a delicate issue to address, the interviewers often asked participants if they had ever ‘heard of’ or ‘knew’

someone who had been raped—this being the only wording sufficiently acceptable to elicit a response. Consequently, this question about ‘witnessing’ rape may also have covered ‘experiencing’ it. The PTSD items are derived from the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV)* (American Psychiatric Association, 1994). We determined if an individual met symptom criteria for the occurrence of PTSD according to a scoring algorithm proposed by the Harvard Refugee Trauma Group on the basis of *DSM-IV* diagnostic criteria (Mollica et al., 1993). This definition of PTSD requires a score of three or four on at least one of four re-experiencing symptoms, at least three of seven avoidance and numbing symptoms, and at least two of five arousal symptoms.

The HSCL-25 is a widely used screening instrument measuring symptoms of anxiety and depression among individuals during the past 30 days (Derogatis et al., 1974). Symptoms are scored on a four-point Likert scale. The HSCL-25 comprises two subscales for anxiety and depression (score range, 1-4). It has been consistently shown in several populations that the total score is correlated with severe emotional distress of unspecified diagnosis, and the depression score is correlated with major depression as defined by the *DSM-IV* (Kleijn et al., 2001; Shrestha et al., 1998). Both instruments have been validated in various countries and cultures (Kleijn et al., 2001; Mollica et al., 1987), although at the time not yet in Afghanistan, and were previously used in post conflict settings (Mollica et al., 2001).

To assess resources used for emotional support, we used the following procedure based on the outcomes of focus group interviews and field tests: we asked respondents to think about a situation or event that once made them sad, worried, or tense. We made it clear that they did not need to reveal that situation. We then asked with whom they had talked for emotional support in that specific situation. Respondents could choose from 11 listed options (which also included places): direct family, family in law, friends, neighbours, *mullah*, shrine or other holy place, Allah, village health volunteer/traditional birth attendant, physician, herbalist, or other. To assess the present sufficiency of basic needs, we asked respondents if shelter, food, drinking water, and medical care were sufficiently, reasonably, or not sufficiently available.

### Data Analysis

Statistical analyses were performed using SUDAAN statistical software (Research Triangle Institute, Research Triangle Park, NC), which accounts for complex sampling designs. All presented data were adjusted for clustering and assigned a population-based weighting factor, based on the population size of each cluster in our final listing of all 1606 villages and settlements. Data were not weighted for nonresponse. Multivariate linear regression models were used to assess the effects of demographic variables and exposure variables on continuous variables (anxiety and depression). To analyze dichotomous outcomes, such as PTSD symptoms, we used multivariate logistic regression models. The results obtained from the regression models were based on partial, not sequential analyses. All *P* values were derived from adjusted Wald F tests based on these regression models, except for those derived from

**TABLE 6.1 Characteristics of respondents**

	Total (n=1011)		Male (n=469)		Female (n=542)	
	n*	%	n*	%	n*	%
<b>Age group</b>						
15-24	302	(30.0)	152	(32.5)	150	(27.9)
25-34	265	(26.3)	98	(20.9)	167	(31.0)
35-44	202	(20.1)	77	(16.5)	125	(23.2)
45+	237	(23.6)	141	(30.1)	96	(17.8)
<b>Marital status</b>						
Single	206	(20.7)	117	(24.9)	89	(16.9)
Married	770	(77.4)	350	(74.6)	420	(79.8)
Widowed	19	(1.9)	2	(.4)	17	(3.2)
<b>Ethnicity</b>						
Pashtun	933	(92.4)	430	(91.9)	503	(92.8)
Tajik	33	(3.3)	19	(4.1)	14	(2.6)
Pashayi	43	(4.3)	19	(4.1)	24	(4.4)
<b>Education</b>						
None	680	(67.7)	205	(44.0)	475	(88.1)
Primary	60	(6.0)	53	(11.4)	7	(1.3)
Religious school	86	(8.6)	76	(16.3)	10	(1.9)
Middle	80	(8.0)	75	(16.1)	5	(.9)
High	43	(4.3)	42	(9.0)	1	(.2)
More than high	56	(5.6)	15	(3.2)	41	(7.6)
<b>Location</b>						
Urban	199	(19.7)	104	(22.2)	95	(17.5)
Rural	812	(80.3)	365	(77.8)	447	(82.5)
<b>Job</b>						
Yes	410	(41.0)	404	(87.1)	6	(1.1)
No	60	(6.0)	60	(12.9)	–	–
Housewife	531	(53.0)	–	–	531	(98.9)
<b>Physical health state+</b>						
Poor	185	(18.3)	18	(3.8)	167	(30.8)
Good	826	(81.7)	451	(96.2)	375	(69.2)
<b>Prev. mental illness+</b>						
Yes	187	(19.0)	76	(16.3)	111	(21.5)
No	795	(81.0)	390	(83.7)	405	(78.5)

\*) Excluded are missing data or unknown responses

+) As reported by the respondent himself/herself.

the analysis of resources used for emotional support, which were based on adjusted Wald  $\chi^2$  tests. When a characteristic had a natural ordering (eg, age, number of traumatic events), a test for linear trend was performed. For the analysis of the effect of exposure variables on mental health outcomes, *P* values were based on the comparison between those having experienced the event and those who had not.  $P < .05$  was considered statistically significant. Bonferroni corrections for multiple comparisons were applied when comparing traumatic events ( $P < .002$ ), the number of traumatic events ( $P < .01$ ), and resources for emotional support ( $P < .005$ ).

## Results

### Sample characteristics

A total of 351 households were surveyed. From these, 1013 individuals aged 15 years or older were interviewed. In the households surveyed, there were 382 (27%) non-responders, mostly because of practical reasons such as the respondent being absent; 6 persons refused to be interviewed. Due to the loss of stratification data of two respondents, the data of 1011 respondents could eventually be used for analysis (representing a 72% participation rate). Three clusters that could not be visited for security reasons were not replaced by newly selected clusters because at the time the imminent attack on Iraq called for evacuation preparedness.

Demographic sample characteristics are summarized in Table 6.1. Nearly all respondents belong to the Pashtun ethnic group (their national proportion is 44%) and most live in rural areas. Fifty-five percent were women. Most were married. Eighty-eight percent of female participants and 44% of male participants had not received any education. A majority of men (87%) reported having jobs, most of them being a farmer or stockbreeder; practically all women were housewives. Ninety-six percent of the men and 69% of the women reported being in good physical health. Twenty-two percent of female respondents and 16% of male respondents indicated they had ever been told by a physician, (mental) health professional, or healer that they had a mental illness.

### Basic needs

At the time of the survey, 228 (22.6%) respondents indicated that access to medical care was not sufficient. Food was available for 98.0% of individuals; drinking water, 92.9%; and shelter, 94.0%.

### Exposure

A modification of the list of potential trauma events as recited in the HTQ is shown in Table 6.2. High percentages of the participants reported having experienced multiple traumatic events over the past 10 years. Fourteen percent reported experiencing 11 or more traumatic events. Seventy-one percent experienced a lack of access to

**TABLE 6.2 Traumatic events experienced during the past 10 years**

	Male (N=469)		Female (N=542)		Total (N=1011)	
	N	%	N	%	N	%
No. of traumatic events						
0-3	103	(20.8)	51	(8.8)	154	(14.4)
4-7	143	(30.4)	141	(25.6)	284	(27.8)
8-10	133	(29.4)	299	(56.4)	432	(43.7)
≥11	90	(19.4)	51	(9.3)	141	(14.1)
Lack of food or water	264	(57)	430	(79)	694	(69)
No access to medical care	253	(55)	458	(85)	711	(71)
Lack of shelter	215	(47)	348	(64)	563	(56)
Imprisonment	129	(28)	8	(1)	137	(14)
Injury due to knife, gunshot or fighting	93	(2)	21	(1)	114	(11)
Injury due to landmine	22	(4)	13	(2)	35	(3)
Separation of family	32	(7)	8	(2)	40	(4)
Rape* yes	2	(0)	3	(1)	5	(1)
witnessed	41	(9)	82	(15)	123	(12)
Murder of family or friend	105	(24)	60	(11)	165	(17)
Murder of someone known	118	(27)	58	(11)	176	(18)
Death family/friend due illness/lack of food	225	(48)	209	(39)	434	(43)
Missing family	39	(8)	28	(5)	67	(7)
Torture	101	(22)	49	(9)	150	(15)
Interrogation or harassments	135	(29)	67	(12)	202	(20)
Beatings	110	(24)	59	(11)	169	(17)
Recent bombardments	237	(52)	377	(71)	614	(62)
Shelling/rocket attacks	216	(47)	390	(73)	606	(61)
Having to flee	237	(52)	365	(69)	602	(61)
Loss of property	155	(35)	233	(45)	388	(40)
Refugee camp	187	(39)	325	(59)	512	(50)
Kidnapping	10	(2)	9	(2)	19	(2)
Being close to death	290	(63)	376	(71)	666	(67)

Percentages are corrected for sample design; the number of respondents is not.

\*) On the HTQ item Rape the number of male respondents was 447 instead of 469, the number of female respondents was 530 instead of 542, indicating a possible response bias for this item. The interviewers thought it would be more acceptable to ask whether one had ever witnessed a rape than asking if one had experienced it.

medical care and 69% experienced a lack of food or water. Sixty-seven percent indicated that they have been close to death during the previous 10 years. Sixty-two percent experienced or witnessed the coalition-led bombardments in 2001 and 61% experienced other shelling or rocket attacks from *mujahedeen* or former Soviet Union forces. Sixty-one percent of all participants had to suddenly flee at some point and 50% had lived in a refugee camp.

**TABLE 6.3 Mental health outcomes among respondents\***

Mental health outcome	Total	Male	Female	Unadjusted OR(95%CI)†
<b>Hopkins Symptom Checklist-25</b>				
Total symptom score (n = 1010)				
Mean (SE)	1.79 (0.03)	1.44 (0.02)	2.10 (0.03)	
Median (SE)	1.68 (0.04)	1.30 (0.03)	1.97 (0.03)	
Intraquartile range	1.28-2.10	1.14-1.60	1.67-2.51	
Depression symptoms (n = 1010)				7.31 (5.4-9.8)
No.(%) of respondents [95% CI]				
with scale score ≥ 1.75	391 (38.5) [35.1-42.0]	77 (16.1) [12.8-19.4]	314 (58.4) [54.2-62.6]	
Mean(SE)	1.71 (0.03)	1.42 (0.02)	1.97 (0.03)	
Median(SE)	1.59 (0.03)	1.27 (0.04)	1.86(0.03)	
Intraquartile range	1.24-1.95	1.11-1.59	1.57-2.29	
Anxiety symptoms (n = 1010)				12.79 (9.02-18.14)
No. (%) of respondents [95% CI]				
with scale score ≥ 1.75	524 (51.8) [48.0-56.6]	102 (21.9) [18.0-25.9]	422 (78.2) [74.0-82.5]	
Mean(SE)	1.91 (0.03)	1.47 (0.03)	2.29 (0.04)	
Median(SE)	1.74 (0.05)	1.29 (0.02)	2.15 (0.06)	
Intraquartile range	1.27-2.36	1.06-1.67	1.75-2.79	
<b>Harvard Trauma Questionnaire</b>				
PTSD symptoms(n = 1009)				5.78 (3.75-8.90)
No.(%) of respondents [95% CI]				
meeting Harvard Refugee Trauma				
Group scoring algorithm	207 (20.4) [18.1-22.8]	36 (7.5) [5.6-9.4]	171 (31.9) [27.9-35.9]	
Mean(SE)	1.92 (0.02)	1.66 (0.02)	2.15 (0.03)	
Median(SE)	1.87 (0.03)	1.55 (0.03)	2.08 (0.04)	
Intraquartile range	1.49-2.23	1.34-1.87	1.77-2.42	

Abbreviations:CI, confidence interval; OR, Odds ratio; PTSD, posttraumatic stress disorder.

\* Percentages are weighted and adjusted for sample design. There was one male with missing data for the HSCL-25 and 2 males for the PTSD assessment. † Unadjusted OR for sex for comparison of mean values.

**TABLE 6.4 Effects of selected variables on mental health outcome measures\***

	Depression Symptoms		Anxiety Symptoms		PTSD Symptoms	
	Adjusted Mean (SE)	P Value	Adjusted Mean (SE)	P Value	Adjusted OR (95% CI)	P Value
<b>Sex</b>						
Male	1.51 (0.03)	<.001	1.58 (0.03)	<.001	1.00	.001
Female	1.84 (0.03)		2.13 (0.03)		3.90 (2.30-6.62)	
<b>Age group</b>						
15-24	1.57 (0.03)	.006†	1.76 (0.04)	.01†	1.00	.01†
25-34	1.75 (0.03)		1.96 (0.04)		2.90 (1.31 - 6.14)	
35-44	1.71 (0.04)		1.91 (0.04)		1.84 (0.79 - 4.25)	
≥ 45	1.71 (0.03)		1.86 (0.04)		3.69 (1.57 - 8.68)	
<b>Marital status</b>						
Married	1.67 (0.02)	.94	1.87 (0.02)	0.67	1.00	0.03
Single	1.69 (0.04)		1.85 (0.05)		2.42 (1.08 - 5.44)	
Widowed	1.68 (0.11)		1.77 (0.12)		0.39 (0.12 - 1.31)	
<b>Ethnicity</b>						
Pashtun	1.67 (0.02)	0.11	1.86 (0.02)	0.16	1.00	0.02
Tajik	1.85 (0.08)		2.05 (0.10)		4.15 (1.57 - 11.0)	
Pashayi	1.69 (0.05)		1.83 (0.07)		1.46 (0.84 - 2.53)	
<b>Education</b>						
None	1.70 (0.02)	.002†	1.90 (0.03)	.04†	1.00	.32†
Primary	1.74 (0.06)		1.95 (0.07)		0.65 (0.23 - 1.84)	
Rel. school	1.60 (0.05)		1.71 (0.05)		0.44 (0.17 - 1.16)	
Middle	1.65 (0.04)		1.81 (0.05)		0.82 (0.40 - 1.66)	
High	1.56 (0.04)		1.76 (0.04)		0.42 (0.13 - 1.29)	
> High	1.56 (0.05)		1.78 (0.07)		0.44 (0.08 - 2.33)	
<b>Location</b>						
Urban	1.68 (0.03)	0.83	1.87 (0.03)	0.80	1.00	0.42
Rural	1.67 (0.02)		1.86 (0.02)		0.85 (0.57 - 1.28)	
<b>Physical health state</b>						
Good	1.60 (0.02)	<.001	1.77 (0.02)	<.001	1.00	0.003
Poor	2.05 (0.06)		2.34 (0.05)		2.31 (1.35 - 3.97)	
<b>Previous mental illness</b>						
No	1.64 (0.02)	<.001	1.80 (0.03)	<.001	1.00	0.002
Yes	1.81 (0.04)		2.12 (0.03)		2.09 (1.34 - 3.35)	

Abbreviation: PTSD, posttraumatic stress disorder.

\*Each demographic characteristic has been adjusted for all other characteristics listed in the table.

†Indicates linear P value.

## Mental health

Table 6.3 shows estimated mean scores on the HSCL-25 and the HTQ, along with 95% CIs. For the HSCL-25, the estimated mean total score is 1.79 (1.44 for men and 2.10 for women). Mean scores for the HSCL-25 subscales show high levels of symptoms of depression and anxiety, especially among women. When using a standard cut-off score of 1.75 (Mollica et al., 1987) the depression symptom scale scores yield estimated prevalence rates of 38.5% (16.1% in men and 58.4% in women). On the anxiety symptom scale, estimated prevalence rates were 51.8% (21.9% in men and 78.2% in women). The HTQ yielded an estimated total prevalence of 20.4% for PTSD symptoms (7.5% in men and 31.9% in women).

## Sociodemographic factors and mental health outcomes

We performed multivariate analyses of the effect of selected demographic factors to mental health outcomes. Table 6.4 shows mean scores of the HSCL-25 scales for symptoms of anxiety and depression and estimated prevalence rates of participants who met PTSD symptom criteria in relation to separate demographic variables and adjusted for all other listed demographic variables. For all mental health outcomes, higher symptom scores were associated with being female, experiencing poor physical health, and reporting previous mental illness. Higher scores of depression were associated with being older and having received less education. Education was also associated with high scores of anxiety. Symptoms of PTSD were associated with marital status and ethnicity, that is, being single and belonging to the Tajik ethnic minority group.

## Exposure to traumatic events and mental health outcomes

We also performed multivariate analyses of the effect of war-related traumatic events to mental health outcomes. Table 6.5 shows mean scores of the HSCL-25 scales for symptoms of anxiety and depression and ORs (95% CIs) for participants who met PTSD symptom criteria in relation to the number of traumatic events experienced, as well as to separate traumatic events. All demographic variables listed in Table 6.4 were controlled for in the analysis. There was a significant linear increase in all selected mental health outcomes with increasing numbers of traumatic events. All trauma exposure variables were significant at the  $P < .002$  level for anxiety and depression scores, except having been injured by a landmine, separated from the family, rape, missing family, recent bombardments, or being kidnapped. Trauma events that were associated with high PTSD symptom scores were having experienced a lack of food or water, or a lack of shelter, having been tortured, having had to flee suddenly, having loss of property, having been kidnapped, and having been close to death.

## Resources for emotional support

Ninety-eight percent (989) of the respondents mention 'Allah' as the main resource for emotional support when feeling sad, worried, or tense. The second preferred

**TABLE 6.5 Exposure to traumatic events affecting mental health outcomes**

	Adjusted Mean (SE)*		OR (95% CI)	
	Anxiety Symptoms	Depression Symptoms	PTSD Symptoms Unadjusted	Adjusted*
No. of Traumatic Events				
0-3	1.56 (0.03)†	1.41 (0.02)†	1.00†	1.00†
4-7	1.71 (0.03)	1.56 (0.02)	2.38 (0.89-6.34)	1.99 (0.66-5.98)
8-10	1.98 (0.02)	1.76 (0.03)	10.82 (4.73-24.77)	7.10 (3.03-16.73)
≥ 11	2.12 (0.05)	1.91 (0.04)	8.19 (3.22-20.83)	8.45 (3.29-23.24)
Lack of food or water	1.95 (0.02)‡	1.75 (0.02)‡	6.18 (2.64-14.48)‡	4.58 (1.99-10.72)‡
No access to medical care	1.94 (0.02)‡	1.74 (0.02)‡	4.73 (2.05-10.93)‡	2.63 (1.25-5.60)
Lack of shelter	1.97 (0.02)‡	1.77 (0.02)‡	4.23 (2.24-7.96)‡	3.45 (1.70-6.99)‡
Imprisonment	2.05 (0.06)‡	1.85 (0.04)‡	0.72 (0.45-1.14)	2.69 (1.31-5.53)
Injury due to knife, gunshot, or fighting	1.98 (0.04)‡	1.77 (0.04)‡	0.49 (0.29-0.85)	0.78 (0.36-1.69)
Injury due to landmine	1.98 (0.11)	1.82 (0.10)	0.82 (0.04-1.78)	1.03 (0.40-2.67)
Separation of family	2.00 (0.10)	1.86 (0.08)	1.04 (0.53-2.04)	1.82 (0.66-5.03)
Witnessing or experiencing rape	1.57 (0.14)	1.50 (0.12)	1.02 (0.10-10.47)	1.01 (0.05-18.56)
Murder of family or friend	1.98 (0.04)‡	1.78 (0.04)‡	1.38 (0.79-2.42)	1.80 (1.03-3.14)
Murder of someone known	2.00 (0.04)‡	1.83 (0.04)‡	1.36 (0.75-2.47)	2.20 (1.10-4.42)
Death of family or friends due to illness/lack of food	1.92 (0.03)‡	1.74 (0.03)‡	1.34 (0.86-2.09)	0.99 (0.59-1.68)
Missing family	2.04 (0.08)	1.80 (0.08)	2.01 (0.97-4.14)	2.45 (0.92-6.53)
Torture	2.05 (0.05)‡	1.85 (0.04)‡	1.90 (1.33-2.71)‡	3.89 (2.49-6.09)‡
Interrogation or harassments	1.98 (0.04)‡	1.79 (0.04)‡	1.32 (0.88-1.98)	2.00 (1.18-3.37)
Beatings by armed groups	2.00 (0.05)‡	1.81 (0.04)‡	1.49 (0.99-2.24)	2.29 (1.28-4.10)
Recent bombardments by Coalition forces	1.86 (0.02)‡	1.66 (0.02)	2.12 (0.82-5.43)	1.62 (0.63-4.15)
Shelling or rocket attacks <sup>1</sup>	1.93 (0.02)‡	1.72 (0.02)‡	3.55 (1.69-7.47)‡	1.87 (0.81-4.28)
Having to flee	1.99 (0.03)‡	1.78 (0.02)‡	5.70 (3.14-10.34)‡	4.85 (2.59-9.07)‡
Loss of property	2.08 (0.03)‡	1.85 (0.03)‡	4.45 (2.88-6.88)‡	3.89 (2.29-6.60)‡
Lived in refugee camp	1.97 (0.02)‡	1.77 (0.02)‡	2.39 (1.42-4.02)‡	2.02 (1.24-3.30)
Being kidnapped	2.25 (0.17)	2.20 (0.16)	3.68 (1.30-10.48)	6.32 (2.14-18.63)‡
Being close to death	1.98 (0.02)‡	1.76 (0.02)‡	4.41 (2.85-6.81)‡	3.12 (2.00-4.87)‡

Abbreviation: PTSD, posttraumatic stress disorder.

\*Each variable has been adjusted for sex, age, marital status, ethnicity, education, location, physical health state, and self-reported previous mental illness. †Linear effect, statistically significant at  $P < .01$  level (adjusted for multiple comparisons using Bonferroni correction). ‡Statistically significantly different at  $P < .002$  level (Bonferroni correction for multiple comparisons applied). <sup>1</sup> From mujahideen or former Soviet Union forces.

resource was direct family members (812; 81.0%). Family-in-law was mentioned more by women (348; 34.9% compared with 21.1% [206 men]); married women generally live with the husband's direct family. Males scoring high on symptoms of depression and anxiety (scale score  $\geq 1.75$ ) reported seeking support from village health volunteers or traditional health attendants more often than those men with lower symptom scores ( $P < .001$ ). Females with high depression symptom scores reported seeking less support from their direct family ( $P < .001$ ), family-in-law ( $P = .009$ ), friends ( $P < .001$ ), and neighbours ( $P < .001$ ) than did females with lower scores.

## Comment

This survey, conducted in early 2003 among the population of Nangarhar province, Afghanistan, shows a high prevalence of symptoms of anxiety, depression, and PTSD. Anxiety and depression symptom scores were even higher than usually found in postwar situations (Cardozo et al., 2000; de Jong et al., 2003), but not PTSD symptoms (de Jong et al., 2001). However, studies of community samples of Afghan refugees living in the Netherlands and Iran, respectively, reported similar findings (Gernaat et al., 2002; Kalafi et al., 2002). This may be related to the country's tragic recent history. During the past 25 years, individuals in Afghanistan have continuously experienced war and civil unrest. The Soviet occupation was followed by violence subsequently from the *mujahedeen* forces, the Taliban regime, and a Coalition-led military campaign. In addition, a four-year regional drought forced many Afghans to leave their homes in search of food and water (Ford & Davis, 2001; United States Office for Development Aid, 2002).

Our study had a number of limitations. First, we did not ask respondents when during the previous ten years they had experienced traumatic events and what were the period of onset and the course of their symptoms. As a consequence, we cannot draw conclusions about the chronicity of mental health symptoms and their relation to traumas experienced. The existence of a relationship is plausible because there is a linear increase of symptom prevalence rates with growing numbers of traumas experienced. Another limitation to this study is the fact that our main measurement instruments have not yet been validated in Afghanistan. Validity has been proven, however, in various languages and cultures. In addition, these instruments only provide outcomes on symptom levels, not diagnoses.

While women generally show higher levels of mental health symptoms than men do, scores in female participants of this survey were extremely high. Previous studies have provided insight in the mental health consequences of the subordination of women in social life in Afghanistan, particularly under the Taliban regime but also before and after (Amowitz et al., 2003; de Jong, 1999; Rasekh et al., 1998). The differences in outcomes also may reflect differences in coping patterns as preferred by, or available to, women compared with men.

The overall prevalence rates of mental health symptoms found in this survey are lower than those reported from a national survey conducted in Afghanistan in 2002 (Cardozo et al., 2004). Slight differences between methods applied during the na-

tional and this survey may have contributed to this. For example, in this survey we attempted to include all adult household members. The national survey included one nondisabled member and one disabled member (if any) from each household.

The variance in outcomes between this and the national survey may also be explained by cultural and geographic differences of the participants. First, during the Taliban regime repression and restrictions were much harsher in the country's central and northern part with its non-Pashtun population than in Nangarhar, which is a conservative Pashtun area. Second, there has been less continuous fighting in this province than in other regions. The city of Jalalabad suffered heavily in the 1980s during the Russian occupation, but was more or less spared since. Kabul, in contrast, was targeted for years by various factions. The front between Taliban and the Northern Alliance has been shifting alternately to the North and to the South for a long time, bringing violence to the country's central and northern regions. Third, this survey sample contains a larger urban proportion than the national survey. Jalalabad's population may have been protected by a greater social connectedness and infrastructure. This may be more relevant in light of the relatively intact state of the city of Jalalabad compared with Kabul. Finally, the population of Jalalabad may have experienced less insecurity because the city is located close to the Pakistan border, therefore providing an easier fleeing route than from Kabul.

These hypotheses are not entirely in concurrence with the experienced numbers of traumatic events as reported. Although it is suggested that circumstances have generally been less harsh in Nangarhar than elsewhere, most traumatic events were reported more frequently than in the national survey. Some of these, however, such as lack of shelter, food, water, and medical care, and death of family members or friends due to illness or lack of food, may be associated with economic and social decline rather than to repression or war. Others, like shelling or rocket attacks, having had to flee, living in refugee camps, and the coalition-led bombings, may relate to armed violence that took place outside the period of Taliban regime; belonging to the Pashtun belt then did not provide protection, and many temporarily fled to Pakistan. Events like beatings, interrogations, and harassments probably have taken place under the Taliban regime, and these are reported more often in the national survey.

In this study, religion and the family were reported as the main resources for emotional support; women do not or cannot frequently make use of any other resources. There is an indication that women with mental health symptoms withdrew from social resources. Both men and women in distress did not report seeking support from physicians. This may relate to a general access problem; although our findings suggest that the present coverage of basic needs is reasonably sufficient, a quarter of the population report this is not the case for medical care.

## **Conclusion**

Among the population of Nangarhar province, Afghanistan, many have experienced traumatic events during a long history of armed conflict, repression, and insufficiency of needs. Mental health symptoms are highly prevalent, especially in those who

experienced multiple traumas and in women. The capacity of primary health care workers to raise awareness of basic options for support or treatment and to address mental health needs should be strengthened.

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## **Properties of the Hopkins Symptom Checklist-25 (HSCL-25) and the Self Reporting Questionnaire (SRQ-20) as screening instruments used in primary care in Afghanistan**

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## Abstract

**Background:** Recent epidemiological studies in Afghanistan using mental health questionnaires yielded high prevalence rates for anxiety and depression.

**Objectives:** To explore the validity in the Afghan cultural context of two mental health questionnaires, the Hopkins Symptom Checklist-25 (HSCL-25) and the Self Reporting Questionnaire-20 (SRQ-20).

**Methods:** The two mental health questionnaires were compared against a 'gold standard' semi-structured psychiatric interview, the Psychiatric Assessment Schedule (PAS). All instruments were administered to a sample of 116 Pashto-speaking patients (53 men, 63 women) attending primary health care facilities in Eastern Afghanistan.

**Results:** Both HSCL-25 and SRQ-20 had modest properties to correctly identify mental disorders, with an AUC (area under the curve) of 0.73 and 0.72 respectively. The optimal cut-off points for this population are different from those often used in transcultural research. For women the optimal cut-off points are higher than usual (2.25 for the HSCL-25 and 17 for the SRQ-20). For men the cut off point for the HSCL-25 is lower than usual (1.50) and for the SRQ-20 it was 10).

**Conclusions:** This study underlines the necessity of validating instruments along with cultural context and gender. Earlier studies in Afghanistan may have over-estimated the prevalence of mental disorders among women and under-estimated the prevalence in men.

## Introduction

Several recent studies in Afghanistan have demonstrated very high levels of depressive and anxiety symptoms among the general population, especially in women (Amowitz et al., 2003; Cardozo et al., 2004; Scholte et al., 2004). These studies, as do many others in the aftermath of humanitarian emergencies in low income countries, used brief questionnaires administered by lay persons, to obtain a quick impression of the mental health status of the population. The authors were involved in one of these studies, a cross sectional survey in which the Hopkins Symptom Checklist-25 (HSCL-25) was used (Scholte et al., 2004). The decision to use this instrument was pragmatic – people who are not trained mental health professionals can be easily instructed, and little time is lost to administration. These instruments were, however, not originally designed to distinguish between mental disorders and normal reactions to severe environmental stress, and have not been validated for use in Afghanistan. It remains unclear to what extent they can be used to estimate the prevalence of mental disorders in this context (Bolton & Betancourt, 2004). Therefore we felt the need to conduct this additional research. In this study, which should ideally have been done before the mentioned cross-sectional survey, we assessed the psychometric properties of the Hopkins Symptom Checklist 25 (HSCL-25) and of

another frequently used brief, lay-administered mental health questionnaire, the Self Reporting Questionnaire 20 (SRQ-20), to detect persons with psychiatric disorders in a primary care setting in Eastern Afghanistan. As a gold standard we used a structured psychiatric interview conducted by a trained clinician from the same culture as the respondents, which is a procedure widely used in instrument validation in Western and non-Western populations (Aydin et al., 2004; Bressan et al., 1998; Eberhard-Gran et al., 2001; Hinton et al., 1994; Kaaya et al., 2002; Leung et al., 1998; Mollica et al., 1987; Pollock et al., 2006; Rait et al., 1999; Smith Fawzi et al., 1997).

## Methods

### The study site and population

Nangarhar province in Eastern Afghanistan is ethnically dominated by the Pashtun, the largest and most conservative of Afghanistan's ethnic groups. The province is relatively well off economically due to its strategic location, near the Khyber Pass that connects Afghanistan with Pakistan. During the time of the Russian occupation of Afghanistan (1979 – 1987) the province was the scene of heavy resistance by *mujahedeen* forces. After the fall of the Soviet backed communist government, a prolonged fight for power broke out between several *mujahedeen* factions. During this period hundred of thousands of residents fled the ongoing destruction in the capital Kabul and were given temporary shelter in huge camps in Nangarhar. The period of Taliban government (1996 – 2001) was relatively peaceful but was characterized by considerable human rights violations and severe restrictions on the rights of women. During the US led attack on the Taliban in the fall of 2001, some parts of the province where training camps of Al Qaida were suspected (such as in the mountain region of Tora Bora) suffered from heavy bombardments. After the installation of the new government, attacks by insurgents on government, aid-organizations and women's organizations continued.

### Study design

In June 2004 we assessed five rural basic health centers in Nangarhar Province run by HealthNet TPO, a non governmental organization specialized in health care and psychosocial assistance in post conflict areas. In each health facility a sample of persons older than 15 years was drawn from the registration book in which each patient's data has to be entered before being seen by the health care staff. Sampling ratios at the health centers differed due to variations in the number of people attending (average sampling ratio was 1:3). The purpose of the study was explained to each potential participant by the local study coordinator (NSR). The literacy rate of the Afghan population is very low: 28.1% for ages 15 and older in 2004 (United Nations Development Programme, 2006). Therefore informed consent was obtained from each respondent by reading aloud an explanatory text and then asking for participation. Using verbal instead of written consent is often a necessity when conducting

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research in low income countries with high rates of illiteracy and a high level of distrust toward signing documents.

The SRQ-20 and HSCL-25 were administered by trained lay interviewers of the same sex as the participant. Subsequently a mental health professional held a clinical interview with each participant, on the site. The interviewer used a semi-structured clinical psychiatric interview, which contained no information about the scores on the HSCL-25 and SRQ-20. The mental health professionals were all male and therefore accompanied by a female *chaperone* for those female participants who did not want to talk to a male in a one-to-one situation. This survey formed part of a larger research project for which formal review and approval has been given by the medical ethical committee of the University of Amsterdam, Amsterdam, the Netherlands. Local programme directors, their boards, and local authorities approved the research procedures, which were consistent with the Declaration of Helsinki (World Medical Association, 2001).

## **Instruments**

### **HOPKINS SYMPTOM CHECKLIST 25 (HSCL-25)**

The Hopkins Symptom Checklist-25, derived from the 90-item Symptom Checklist (SCL-90) (Derogatis et al., 1974), is a screening tool designed to detect symptoms of anxiety and depression. It is composed of a 10-item subscale for anxiety and a 15-item subscale for depression, with each item scored on a Likert scale from 1 ('not at all') to 4 ('extremely'). The period of reference is the past month. Originally developed as a self-report symptom inventory it is often used as an interviewer administered scale in settings with non-literate populations. A cut-off point of 1.75 was found to be optimal in the UK (Winokur et al., 1984). In a clinic sample of Indochinese refugees in the USA this finding was replicated and this cut-off point became widely accepted in refugee settings and in cross-cultural research (Mollica et al., 2004; Mollica et al., 1987). Few validation studies of the HSCL-25 with non-western populations have been done. For Vietnamese refugees in the USA sensitivity and specificity for detection of DSM-III major depression were estimated as 88% and 73%, based on a cut-off score of 1.75 for 'caseness' (Hinton et al., 1994). In a population of human immuno-deficiency virus (HIV) positive pregnant women in Tanzania a significantly lower value (1.06 with sensitivity 89% and specificity 80%) was found to be the optimum cut-off point (Kaaya et al., 2002). In Nepal, Thapa and Hauff (2005) calculated a sensitivity of 87% and specificity of 60% against DSM-IV mild depression diagnosed using the Composite International Diagnostic Interview (CIDI; Area under the curve of 0.79).

### **SELF REPORTING QUESTIONNAIRE 20 (SRQ-20)**

The Self-Reporting Questionnaire 20 items (SRQ-20) was developed by the World Health Organization (WHO) as a screening tool for common mental disorders in primary health care settings, especially in developing countries (Harding et al., 1980). When patients are literate it can be self-administered; but in developing countries it is usually administered by lay interviewers. The instrument consists of 20 yes/no questions about common mental health symptoms such as anxiety, depressive

symptoms, and psychosomatic complaints. The SRQ-20 has been used in numerous settings (World Health Organization, 1994). Cut-off points vary considerably depending on setting (community, primary care, hospital) and culture. A cut-off point of 8 is widely used (Harpham et al., 2003). Among primary care attenders in India the most appropriate cut-off score was found to be 12 (World Health Organization, 1994). In a community sample in the Punjab province of Pakistan, a validation study led to a cut-off score of 9 (Saeed, Mubbashar, et al., 2001). As far as we know, no validation study for Afghanistan has been performed. The SRQ was administered among Afghan refugees in Pakistan using a cut-off point of 13; however, this value was not empirically validated among the study population (Rahman & Hafeez, 2003).

### **PSYCHIATRIC ASSESSMENT SCHEDULE (PAS)**

A semi structured psychiatric interview was conducted using the Psychiatric Assessment Schedule (PAS). This instrument uses selected questions from the Present State Examination (PSE) (Wing et al., 1974). As screening items, subsequently followed by the appropriate ICD-10 research diagnostic criteria. The PAS assesses systematically depressive disorders, anxiety disorders (obsessive-compulsive disorder, panic disorder, agoraphobia, social phobia, specific phobia, generalized anxiety disorder) and somatisation disorder. The instrument has never been used in Afghanistan but is well known in the region through its use in various areas in neighbouring Pakistan (Husain et al., 2007; Mumford et al., 2000; Mumford et al., 1996; Mumford et al., 1997; Saeed et al., 2000). The original English version was expanded with a section for posttraumatic stress disorder (PTSD). This was done within the format of the original instrument, during a workshop of the Afghan research team and the team from Rawalpindi Psychiatric Institute that had earlier developed Urdu and Chitrali PAS versions for Pakistan.

### **Instrument translation**

All instruments were translated into Pashto as spoken in Nangarhar province. The HSCL-25 was translated in 2002, in preparation of the epidemiological survey (Scholte et al., 2004), following the principles described by van Ommeren et al. (1999) which include translation to Pashto and back translation to English by separate groups of bilingual clinicians. Discrepancies between the various translations were subjected to a panel discussion with the involved clinicians and translators. Each item was then examined to ensure face validity and a transfer of conceptual meaning. Final changes to the Pashto versions were made after field-testing that included focus group discussions. The SRQ-20 was translated according to the same thorough guidelines in 2003, and was subsequently used in training activities for primary health care staff.

### **Training of study staff**

A team of two male and two female interviewers who had no background in mental health care administered the HSCL-25 and SRQ-20. Two of the interviewers had also

participated in the earlier epidemiological study (Scholte et al., 2004). They received a three-day training in Jalalabad in administering the instrument (elements of the training: ‘explanation and discussion of each item’, ‘learning how to interview with role playing and real patients’, and a ‘one day field test’). The psychiatric interviews were carried out by five mental health professionals (subsequently referred to as ‘MHPs’) who were all native Pashto speakers. Three were Afghan medical doctors (NRS, HF and RN) with extensive experience as mental health supervisors in the primary mental health care project of HealthNet TPO in Nangarhar; two were psychiatrists from Peshawar, Pakistan. A four-day training in the use of the PAS was organized in the Institute of Psychiatry in Rawalpindi, Pakistan by two senior Pakistani psychiatrists and a Dutch psychiatrist (PV). The training consisted of detailed discussions of the different items of the instrument, (using the conceptual definitions of symptoms in the glossary of the PSE as a reference point), role-playing, and group interviewing of typical patients. Subsequently the inter-rater reliability among the mental health professionals was assessed through 52 independent interviews using 12 different Pashto speaking patients from Lady Reading Hospital Postgraduate Medical Institute in Peshawar, Pakistan. The level of agreement among raters was high: 96% for the main diagnosis, and 78% for second diagnoses. Cohen’s kappa’s for diagnoses were calculated for different combinations of raters, and ranged from 0.76 to 1.00.

### **Statistical analysis**

Factor analyses were performed to check the cross-cultural measurement equivalence of the HSCL-25 and the SRQ-20. Measurement equivalence is based on the concept of construct or theoretical validity, which is defined as the correlation of an observed variable with some theoretical construct (latent variable) of interest (Irvine & Carroll, 1980). Measurement equivalence refers to the equivalence of theoretical validities across populations. Evidence for measurement equivalence is a psychometric prerequisite for the comparison of prevalence rates or mean scores of (sub)scales (de Jong et al., 2005).

Factor analyses with principal axing factoring extraction were performed to uncover the covariances between items (eg latent constructs). To facilitate interpretation of the factor structures varimax rotations were performed on the initial factor solutions. The revealed factor structures were visually inspected.

We used independent t-tests to compare the continuous instrument scores between men and women. For the comparison of the number of psychiatric diagnoses between men and women, the Pearson Chi square statistic was used. The Pearson’s correlation coefficient was calculated to examine the relationship between the HSCL-25 and SRQ-20 scales.

Receiver operating characteristic (ROC) curves were used to explore the optimal cut-off scores for the HSCL-25 and the SRQ-20 in the current sample with the psychiatric diagnoses as established with the PAS as the gold standard. ROC curves plot the sensitivity (on the y-axis) against 1 – specificity (on the x-axis) of each possible cut-off point. Each ROC curve is characterized by an area under the curve (AUC) indi-

cating the overall accuracy of the questionnaire over the whole range of possible cut-off points to distinguish correctly between a case and a non-case. The AUC can range from 0.0-1.0. An AUC of 1.0 indicates a perfect prediction, and 0.5 indicates that the ability of a questionnaire to correctly identify a case is equal to chance prediction. The AUC is used to compare the validity of the two screeners over the total range of scores. Calculations are based on the empirically derived values and not on interpolations from the binormal distribution. In addition, sensitivity, specificity, and AUC were calculated for the HSCL-25 scale and its subscales for depressive disorders and anxiety disorder, and the SRQ-20 scale.

Differences were considered statistically significant when the two-sided p-value <0.05. To test whether the criterion value of the instrument at hand exceeded chance level (AUC>0.5), a one-side p-value was used.

## Results

### Socio demographic data

The sample was composed of 116 patients (53 men; 63 women) visiting a health centre. The male respondents ranged in age from 18 and 80 years old with a mean of 33 years (SD=14.8). Women respondents ranged in age between 17 and 57 years with a mean of 29 years (SD=9.3). The sample differed in several aspects from the cross-sectional population sample of the epidemiological study (Scholte et al., 2004). The current sample consisted of health care users in the eastern part of the province where HealthNet TPO supports the governmental health services. Our sample is ethnically more homogeneous (100% Pashtun compared to 92% in the epidemiological survey), more rural, less well educated, and more often unemployed. Unsurprisingly, male and female respondents differed on some background variables such as educational level and occupation. On all other variables no statistically significant differences were found (see Table 7.1).

### Outcomes on HSCL-25, SRQ-20 and PAS

Factor analysis of the HSCL-25 items (principal axis factoring extraction and varimax rotation) revealed a two-factor model (factors 'depression' and 'anxiety') that explained 48% of the items variances. A factor analysis of the SRQ-20 items revealed a two-factor model (factors 'common disorders' and 'social disability') that explained 39% of the items variances. The factor structure of the items of both instruments agreed with the factor structures reported in the literature. Thus we found support for the measurement equivalence of the HSCL-25 and the SRQ-20.

Table 7.2 presents results of the SRQ-20 and HSCL-25 including relevant subscales. We used independent t-tests to compare the continuous instrument scores between men and women. For the comparison of the number of psychiatric diagnoses between men and women, the Pearson Chi square statistic was used. Mean scores on the HSCL-25 were 2.07 (SD=0.62) for the total scale with significant

**TABLE 7.1 Sociodemographic characteristics of the study sample (N=116)**

		No. (%) of Respondents					
		Male (N=53)		Female (N=63)		Total (N=116)	
		N	%	N	%	N	%
Age	17 - 24	18	(34)	12	(19)	30	(26)
	25 - 34	14	(27)	15	(24)	29	(25)
	35 - 44	10	(19)	12	(19)	22	(19)
	45 - 80	11	(21)	24	(38)	35	(30)
Marital status	Single	6	(11)	6	(10)	12	(10)
	Married	47	(89)	51	(81)	98	(85)
	Widowed	0	(0)	6	(10)	6	(5)
Education	None	29	(55)	55	(89)	84	(73)
	Primary (0-6 years)	11	(21)	0	(0)	11	(10)
	Middle (6-9 years)	7	(13)	0	(0)	7	(6)
	High (>9 years)	3	(6)	0	(0)	3	(3)
	Religious school	3	(6)	7	(11)	10	(9)
Job	Yes	40	(76)	1	(2)	41	(36)
	No	10	(19)	0	(0)	10	(9)
	Student	3	(6)	0	(0)	3	(3)
	Housewife	0	(0)	61	(98)	61	(53)
Previous mental illness	Yes	11	(21)	22	(34.9)	33	(28)
	No	42	(79)	41	(65.1)	83	(72)

gender differences (men: mean=1.59; women: mean=2.47;  $p < .001$ ). For the SRQ-20 the mean for endorsed items was 16 (out of 20) for women and 9 for men. The correlation between the two screening instruments was 0.82, indicating a high overlap between them. Table 7.3 gives an overview of the diagnosis with the PAS. Many men (24/53=43%) and many women (38/63=60%) had a common mental disorder, mainly depressive and anxiety disorders.

### **HSCL-25 and SRQ-20 as screener for psychopathology**

The primary analysis focused on the ability of the HSCL-25 and SRQ-20 to detect any psychiatric disorder. Both HSCL-25 and SRQ-20 performed moderately; the area under the curve measured 0.73 for the HSCL-25 and 0.72 for the SRQ-20 (see Table 7.4, figure 7.1 and figure 7.2). When analyzed separately for men and women the HSCL-25 showed a tendency to perform better in men (AUC 0.78) than in women

**TABLE 7.2 Outcomes on screening instruments HSCL-25, SRQ-20 for both males and females**

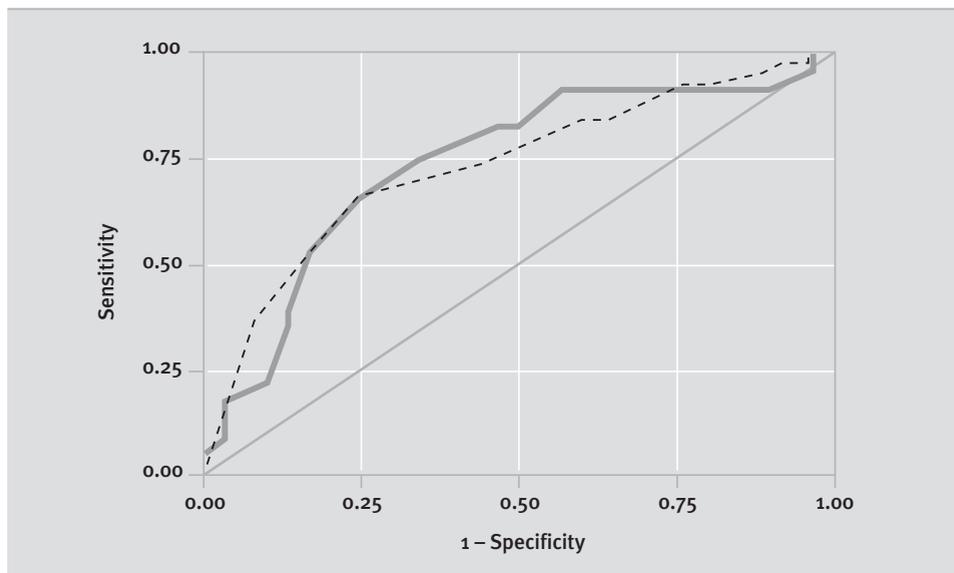
	Male		Female		Total		Differences between men and women	
	Mean	SD	Mean	SD	Mean	SD	T	p-value
HSCL total	1.59	(0.40)	2.47	(0.46)	2.07	(0.62)	10.95	<.001
HSCL general anxiety	1.65	(0.45)	2.66	(0.54)	2.19	(0.71)	10.76	<.001
HSCL depression	1.55	(0.40)	2.35	(0.48)	1.99	(0.60)	9.54	<.001
SRQ_20	9.25	(4.71)	16.38	(3.42)	13.12	(5.39)	9.43	<.001

**TABLE 7.3 Clinical psychiatric diagnoses with PAS for both males and females**

	Male		Female		Total		Differences between men and women	
	N	%	N	%	N	%	Chi sqr	p-value
Depressive disorder	15	28.3	33	52.4	48	41.4	6.880	.009
Anxiety disorder (incl. PTSD)	15	28.3	13	20.6	28	24.1	0.924	.336
Posttraumatic stress disorder	1	1.9	3	4.8	4	3.4	0.715	.398
Somatization disorder	2	3.8	0	0.0	2	1.7	2.419	.120
Any disorder	23	43.4	38	60.3	61	52.6	3.306	.069

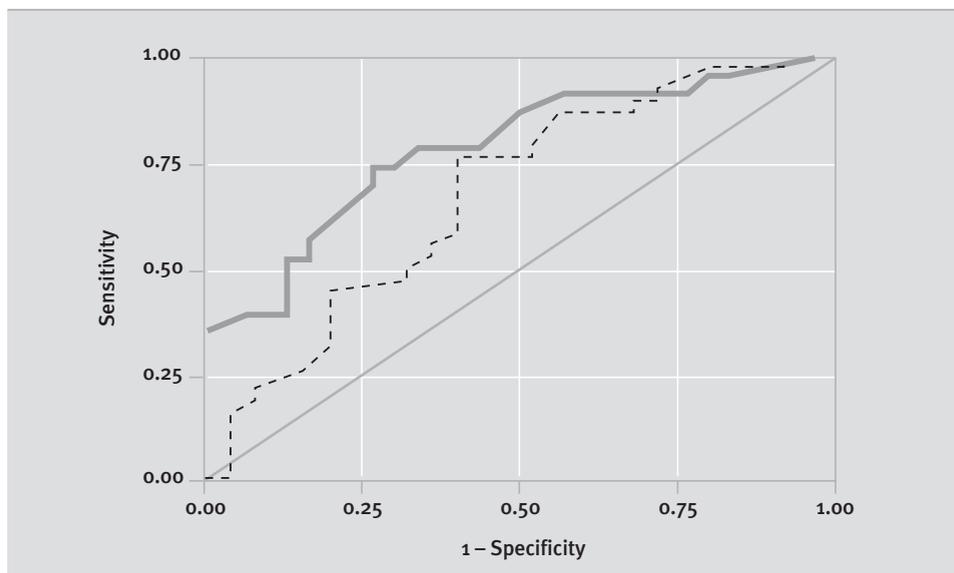
(AUC 0.67). Additional separate analyses were also made for the HSCL-25 depression subscale to detect any depressive disorder, and HSCL-25 anxiety subscale to detect any anxiety disorder. For men, as the SRQ-20 scale performed moderately (AUC 0.74), while the HSCL-25 depression and anxiety scales did reasonably well (respectively AUC 0.79, AUC 0.81). For women the AUC's for the HSCL-25 subscales are low (both AUC 0.65). For all analyses, except for that of the HSCL-25 anxiety scale ( $p=.05$ ), the scales still differ significantly from chance level (AUC 0.5). Table 7.5 gives the sensitivity, specificity, positive and negative predictive values, kappa's, and percent agreement of the scales with different cut-off points. In evaluating the HSCL-25 and SRQ-20 as potential screeners for psychopathology the most appropriate cut-off points is a trade-off between a high sensitivity with an acceptable specificity. Depending on the purpose of the instrument (here used as a screening instrument) the optimal cut-off point is the one with a high rate of sensitivity and good specificity. For the HSCL-25 this optimal cut-off was 2.00 (sensitivity 0.69, specificity 0.67). However, when men and women were analyzed separately the cut-off point for men had to be lowered to 1.50; that for women had to be elevated to 2.25. The optimum cut-off point for the SRQ-20 was 10 for men and 17 for women.

**FIGURE 7.1** ROC curve of the classification of any disorder for the SRQ-20



The solid line displays the curve found for male subjects, the dashed line displays the curve found for female subjects.

**FIGURE 7.2** ROC curve of the classification of any disorder for the HSCL-25



The solid line displays the curve found for male subjects, the dashed line displays the curve found for female subjects.

**TABLE 7.4** Properties of HSCL-25 and SRQ-20 to detect psychopathology as measured by clinical interview with PAS

Sex	Instrument/ Scale	AUC	LL	UL	Z-value	p-value
Male	HSCL-25 Total Scale	.78	.62	.88	4.35	<.01
	HSCL-25 Depression Scale	.79	.60	.90	4.02	<.01
	HSCL-25 Anxiety Scale	.81	.65	.90	4.92	<.01
	SRQ-20	.74	.56	.85	3.31	<.01
Female	HSCL-25 Total Scale	.67	.51	.79	2.40	.01
	HSCL-25 Depression Scale	.65	.49	.77	2.09	.02
	HSCL-25 Anxiety Scale	.65	.48	.78	1.97	.02
	SRQ-20	.73	.58	.83	3.62	<.01
Total	HSCL-25 Total Scale	.73	.62	.81	4.78	<.01
	HSCL-25 Depression Scale	.74	.64	.82	0.52	<.01
	HSCL-25 Anxiety Scale	.61	.49	.71	2.03	.02
	SRQ-20	.72	.62	.80	4.79	<.01

AUC: Area Under Curve; LL: 95% Confidence Interval lower limit; UL: 95% Confidence Interval upper limit; Z-value: The Z-value compares the AUC to 0.5, since the AUC of a 'useless' criterium equals 0.5; p-value: one-sided probability value expressing whether the criterion is better than chance level

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**TABLE 7.5 Properties of HSCL and SRQ-20 with different cut-off points**

Sex	Scale	Cut-off	Sens.	Spec.	PPV	NPV	Kappa	% Agree	Case
Male	HSCL-25	1.50*	.78	.67	.64	.80	.44	71.7	18/23
	Total Scale	1.75	.39	.87	.69	.65	.27	66.1	9/23
	HSCL-25	1.25	.93	.24	.33	.90	.13	45.3	14/15
	Depression Scale	1.50*	.80	.70	.52	.90	.44	73.5	14/15
		1.75	.53	.89	.67	.83	.46	79.3	7/15
	HSCL-25	1.50	.93	.50	.42	.95	.32	62.2	15/15
	Anxiety Scale	1.75*	.67	.76	.53	.85	.40	73.6	15/15
		2.00	.47	.92	.70	.81	.43	79.2	10/15
	SRQ-20	9	.83	.53	.58	.80	.34	66.0	19/23
		10*	.74	.67	.63	.77	.40	69.8	17/23
	11	.65	.77	.68	.74	.42	71.7	15/23	
Female	HSCL-25	1.75	.97	.16	.64	.80	.11	63.5	37/38
	Total Scale	2.00	.92	.28	.66	.70	.22	66.7	35/38
		2.25*	.79	.48	.70	.60	.28	66.6	30/38
	HSCL-25	1.75	.97	.13	.55	.80	.11	57.1	32/33
	Depression Scale	2.00*	.91	.37	.61	.79	.28	65.1	30/33
		2.25	.64	.57	.62	.59	.20	60.3	30/33
	HSCL-25	1.75	1.00	.10	.21	1.00	.01	26.9	12/13
	Anxiety Scale	2.50	.92	.30	.24	.94	.08	41.3	12/13
		2.75*	.58	.60	.26	.86	.10	58.7	12/13
	SRQ-20	16	.84	.40	.67	.63	.08	61.9	36/38
	17*	.74	.56	.72	.58	.30	66.6	28/38	
	18	.66	.76	.81	.59	.30	66.6	28/38	
Total	HSCL-25	1.75	.75	.55	.65	.67	.30	65.6	46/61
	Total Scale	2.00*	.69	.67	.70	.66	.36	68.1	42/61
		2.25	.54	.76	.72	.60	.30	64.6	33/61
	HSCL-25	1.50	.93	.31	.49	.86	.30	62.0	44/48
	Depression Scale	1.75*	.84	.48	.53	.80	.37	67.3	40/48
		2.00	.70	.65	.59	.75	.41	70.7	35/48
	HSCL-25	1.75	.86	.30	.28	.88	.11	48.3	22/28
	Anxiety Scale	2.00*	.75	.43	.29	.85	.13	54.3	19/28
		2.25	.60	.57	.30	.82	.16	58.6	19/28
	SRQ-20	10	.89	.40	.62	.76	.29	65.6	54/61
	11*	.84	.47	.64	.72	.31	66.4	51/61	
	12	.79	.51	.64	.68	.31	66.4	51/61	

\*) Optimal threshold for use as a screening instrument Sens: Sensitivity is the probability of a positive test result given the condition is present; Spec: Specificity is the probability of a negative test result given the condition is absent. PPV: Positive Predictive Value is the probability that the condition is present given the test is positive; NPV: Negative Predictive Value is the probability that the condition is absent given the test is negative; % Agree: Proportion Agreement in percentages.

## Discussion

The aim of the study was to assess whether frequently used, easy to administer questionnaires were able to detect clinical cases of anxiety and depression. It proved difficult to identify an optimal cut-off point for the HSCL-25 or SRQ-20 with both a reasonable positive predictive value and a satisfactory degree of sensitivity. Our study corroborates the conclusions of a study with the HSCL-25 with Afghan refugees in Japan where the use of the usual cut-off point of the HSCL 25 would have led to overestimation of the rate of depression among the respondents and the authors conclude that the usual cut-off points would not even have been acceptable for screening purposes (Ichikawa et al., 2006). The implication of our findings is that inferences made from checklist research with the HSCL-25 or SRQ-20 in Afghanistan need to be interpreted with caution. This again highlights the need to calibrate and evaluate screening instruments in cross-cultural epidemiological research.

Some might argue that the use of an ICD-10 derived diagnosis in itself lacks cultural validity. International and presumably 'universal' diagnostic categories such as the ICD-10 and DSM-IV are to a large extent embedded in the culturally bound Euro-American psychiatric conceptualization of mental disorders and thus might not capture culturally unique patterns of distress (Draguns & Tanaka-Matsumi, 2003). Our goal was to assess the accuracy of screening questionnaires to detect mental disorders as defined by the ICD-10. We have not assessed the cross-cultural validity of the ICD-10 classification itself. Such an undertaking would have required a different type of research based on in-depth ethnographic fieldwork, which was not feasible in the context of the current research. However, we feel that a diagnosis made by well-trained clinicians, being ethnic Pashtuns themselves and familiar with the cultural ways of expressing distress among Pashtun, guarantees a minimal level of cultural competency in the clinical assessment procedure.

An interesting finding is that women and men differ with regard to the predictive value of scores on the questionnaires. The HSCL-25 and its subscales showed a tendency to perform worse for women than for men, while this could not be observed for the SRQ-20. A possible explanation is that the HSCL-25 compared to the SRQ-20 has fewer questions about somatic equivalents of mental distress (such as 'Is your appetite poor?' or 'Do you have uncomfortable feelings in your stomach') and questions about social dysfunctioning (such as 'is your daily work suffering'). Socially or somatically oriented questions are, among the Pashtun, less sensitive to gender-specific interpretations than 'psychologically oriented' questions about 'feeling sad' or 'crying much'. Indeed, a questionnaire for depression and anxiety that was constructed within neighbouring Pakistan included more somatic items and items about social functioning (Mumford et al., 2005). Similarly, in a sample of Mongolian women in the reproductive age, the SRQ-20 performed better than the Edinburgh Postnatal Depression Scale (EPDS), which does not contain somatic items (Pollock et al., 2006). Optimizing the cut-off points for men and women separately had opposite effects: for men the cut-off point had to be lowered while for women it had to be elevated. This may be related to the strong differences within traditional Pashtun culture between male and female modes of expression, differences so strong indeed that

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some speak of a 'schism between men's and women's emotional worlds' (Grima, 1993). We concur with Miller et al. (2006) who suggest that the use of self-reporting questionnaires as read aloud by interviewers might lead to underreporting of mental distress in Afghan men who have the tendency to downplay the frequency of certain expressions of distress (e.g., crying) in order to save face in the eyes of the surveyors. This suggests that earlier epidemiological studies about common mental disorders among Pashtun in Afghanistan (Amowitz et al., 2003; Cardozo et al., 2004; Scholte et al., 2004) might have overestimated the prevalence in women and underestimated the prevalence in men.

Several factors might have contributed to the rather limited discriminative ability of the HSCL-25 and SRQ-20 in this setting. Firstly, the self reported symptoms might not represent psychopathology but rather general psychological distress, as was suggested by Bolton and Betancourt (2004). Secondly, respondents might have aggravated the severity of symptoms on the questionnaires, hoping to get attention for their suffering and possibly hoping to get better treatment. Respondents may have answered affirmative if they perceived an advantage in being seen as ill. This has been suggested in studies with the SRQ-20 in Guinea Bissau (de Jong, 1987). In Ethiopia, an analysis of the affirmative responses on SRQ-20 items showed a large percentage of the affirmative answers to be invalid due to linguistic problems, a lack of conceptual clarity or deliberately affirmative answers in order to gain something from it (Kortmann & ten Horn, 1988). Thirdly, it may be that the psychiatric diagnoses derived by the mental health professionals were biased because of the lack of female professional clinician interviewers. It is possible that women who endorsed certain symptoms to a same sex lay interviewer showed constraint in doing so in the presence of a male clinician. Without a doubt the use of mental health professionals of the same sex as the participant would have improved the quality of the data. However, Pashto speaking female mental health professionals are extremely rare; therefore this was not feasible.

Another striking feature of our sample of primary care attendees was the high percentage of people who had a mental disorder as assessed by a mental health professional. High prevalence rates for mental disorders among primary care patients have been found in many cultural settings, but had not been established before in Afghanistan. The particularly high figures in our sample can probably, at least partly, be explained by the fact that the ICD-10 diagnostic criteria used do not require a significant social or occupational disability. Unfortunately, no data on associated social disability in this sample are available to put these figures in context.

## **Conclusion**

The results of this study point to a rather limited usefulness of the HSCL-25 and SRQ-20 as screening tools for common mental disorders in the Afghan population. Earlier studies in Afghanistan using the HSCL-25 with the standard cut-off points might have overestimated the prevalence of mental disorder among women and underestimated the prevalence in men. The high prevalence of mental disorders in primary

care patients in Nangarhar magnifies this problem since the properties of a screening instrument need to be extremely robust to be useful for diseases with high prevalence among the screening population. If the HCSL-25 and SRQ-20 would nevertheless be used as screening instruments, different cut-off points for men and women have to be used. Rather than advocating the use of screeners to dichotomize the primary care attendees in ‘probably mentally ill’ and ‘probably not mentally ill’, we believe that overall attempts need to be made to increase the ability of primary health care staff in Afghanistan to identify depression and anxiety in their clinical encounters with patients. This involves training and supervision of Afghan doctors and nurses in primary mental health care skills, something that the Afghan government has high on its list of health care priorities (Baingana et al., 2005; Ministry of Public Health, 2005; Ventevogel et al., 2006).

### **Acknowledgements**

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## **Validation of the Kirundi versions of brief self-rating scales for common mental disorders among children in Burundi**

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## Abstract

**Background:** In Sub Saharan Africa, there has been limited research on instruments to identify specific mental disorders in children in conflict-affected settings. This study evaluates the psychometric properties of three self-report scales for child mental disorder in order to inform an emerging child mental health programme in post-conflict Burundi.

**Methods:** Trained lay interviewers administered local language versions of three self-report scales, the Depression Self-Rating Scale (DSRS), the Child PTSD Symptom Scale (CPSS) and the Screen for Child Anxiety Related Emotional Disorders (SCARED-41), to a sample of 65 primary school children in Burundi. The test scores were compared with an external 'gold standard' criterion: the outcomes of a comprehensive semistructured clinical psychiatric interview for children according the DSM-IV criteria (the Schedule for Affective Disorders and Schizophrenia for School-Age Children – K-SADS-PL).

**Results:** The DSRS has an area under the curve (AUC) of 0.85 with a confidence interval (c.i.) of 0.73–0.97. With a cut-off point of 19, the sensitivity was 0.64, and the specificity was 0.88. For the CPSS, with a cut-off point of 26, the AUC was 0.78 (c.i.: 0.62–0.95) with a sensitivity of 0.71 and a specificity of 0.83. The AUC for the SCARED-41, with a cut-off point of 44, was 0.69 (c.i.: 0.54–0.84) with a sensitivity of 0.55 and a specificity of 0.90.

**Conclusions:** The DSRS and CPSS showed good utility in detecting depressive disorder and posttraumatic stress disorder in Burundian children, but cut-off points had to be put considerably higher than in western norm populations. The psychometric properties of the SCARED-41 to identify anxiety disorders were less strong. The DSRS and CPSS have acceptable properties, and they could be used in clinical practice as part of a two-stage screening procedure in public mental health programmes in Burundi and in similar cultural and linguistic settings in the African Great Lakes region.

## Background

Global mental health researchers often use brief self-rating questionnaires to screen for DSM-IV disorders (Mollica et al., 2004). These instruments require minimal time and limited or no clinical expertise and training. They are, therefore, often recommended to be used in school, community and research settings to screen for symptoms of mental disorders (Chipimo & Fylkesnes, 2010). In low-resource settings with extremely limited numbers of mental health professionals, a simple means to identify people with probable mental health problems may constitute an important component to develop a public mental health programme.

We have reported earlier on the development of the Child Psychosocial Distress Screener (CPDS), a screening instrument to identify children with high levels of psy-

chosocial distress in order to guide the triage of psychosocially affected children in situations of massive organized violence (Jordans, Komproe, et al., 2009; Jordans et al., 2008). Children who scored above threshold on the CPDS were offered group-based psychosocial interventions (Jordans, Tol, et al., 2010). However, the instrument does not differentiate between ‘nondisordered distress’ and ‘disordered distress’. In order to identify the children in need of more specialized interventions, instruments are required to screen for specific disorders such as depression, anxiety disorders or posttraumatic stress disorder (PTSD).

Screening questionnaires to detect child mental disorders are usually developed and validated in populations in high-income countries, and norm scores are commonly derived from research with western populations (Ehnholt & Yule, 2006). In a new context, instruments may have different psychometric properties (Goldberg et al., 1998; Silove et al., 2007). Contexts vary in the extent to which symptoms are experienced and expressed. Uncritical use of self-report scales may lead to figures that skew prevalence rates of disorder and conflate mental disorder with subthreshold disorders or normal (‘nondisordered’) stress reactions in the face of loss and adversity (Jones & Kafetsios, 2005; Rodin & van Ommeren, 2009). Moreover they may measure grief reactions rather than specific mental disorder (Schaal et al., 2009b).

Ideally, validation of disorder-specific self-report questionnaires is recommended in new contexts (Joint Committee on Standards for Educational, 1999). This is certainly important in complex humanitarian emergencies with populations suffering from high levels of contextual distress in which uncritical use of self-report questionnaires may lead to inflated estimations of mental health disorders (Narrow et al., 2002; Rodin & van Ommeren, 2009; Ventevogel, 2005). However, clinical validation in postconflict settings is not commonly done (Tol, Patel, et al., 2011; Tol, Rees, et al., 2013). In Sub Saharan Africa, several validation studies with self-report questionnaires on mental problems have been carried out, mostly in adult populations (Attanayake et al., 2009; Bolton, 2001a; Bolton et al., 2004; Kaaya et al., 2002; Kortmann, 1987; Odenwald et al., 2007; Scholte, Verduin, van Lammeren, et al., 2011). Only a few African validation studies have been carried out with adolescents and youths (Betancourt et al., 2012; Ertl et al., 2010; Mels et al., 2010) and children (Betancourt, Bass, et al., 2009; Frank-Schultz et al., 2012; Murray, Bass, et al., 2011).

Many questionnaires focus on a particular category of mental disorders, for example depressive disorders or PTSD. Such questionnaires can be used to screen for mental disorders that are seen as priority in a given context. There is however debate in the literature about the usefulness of distinguishing between the various depressive and anxiety disorders on a population level or the level of primary health care. Some argue that, in unspecialized settings, designating cases as a ‘pure’ depressive episode or a ‘pure’ anxiety disorder may not be necessary because symptoms of both anxiety and depression are present in many cases, even if they are insufficient to support a full diagnosis in one of the categories (Das-Munshi et al., 2008; Horwitz & Wakefield, 2012). Goldberg introduced the term ‘common mental disorder’ to denote any depressive or anxiety disorder (including PTSD) (Goldberg, 1972; Goldberg & Huxley, 1992). In Africa, the term ‘common mental disorder’ has been used, for example in adult populations in Zimbabwe (Patel, Gwanzura, et al., 1995; Patel,

Todd, et al., 1997) and Ethiopia (Medhin et al., 2010). For children in Africa, the concept of ‘common mental disorder’ has not been widely used, and there has been no research into a single questionnaire to identify children with mental disorder in need of assistance.

Our study took place in Burundi, a country that, since its independence in 1962, has experienced recurrent cycles of severe interethnic violence (Chrétien, 2003). In 1993, after the assassination of the first democratically elected president, a civil war broke out that caused the death of an estimated 300,000 people and the displacement of many more (Wakabi, 2007). Since peace agreements were signed in 2003, violence has significantly decreased, except in the three northwestern provinces (Bujumbura Rural, Bujumbura Mairie and Bubanza) where rebel groups remained active. In these three provinces, the nongovernmental organization (NGO) HealthNet TPO implements a community- and school-based psychosocial and mental health programme for children.

In the current paper, we explore the psychometric properties of three well-known self-report questionnaires for child psychiatric disorders in a sample of Burundian schoolchildren: the Depression Self-Rating Scale (DSRS) for depressive disorders (Birlleson, 1981), the Child PTSD Symptom Scale (CPSS) for PTSD (Foa et al., 2001) and the Screen for Child Anxiety-Related Emotional Disorders (SCARED) for anxiety disorders (Birmaher et al., 1997). These questionnaires were translated in Kirundi, the local language of Burundi. The paper focuses on assessment of criterion validity by comparing the scores on the questionnaires with a ‘gold standard’, the presence of mental disorder as established through a semistructured clinical interview for child psychiatric disorder according to DSM-IV criteria. We also explored how well the three self-report questionnaires would be able to identify ‘any common mental disorder’ in children.

## **Methods**

### **Design and participants**

The sample consisted of children from three schools in the three provinces where HealthNet TPO implemented its school-based mental health programme. The schools were randomly chosen, using a random number generator, from a list with all schools provided by the Ministry of Education. In each school, the research assistant made a list of all children in the 4th or 5th grade and a random sample was drawn, again using a random number generator. In this way, 49 children aged from 10 to 15 years were randomly selected and invited to participate. We deliberately chose students from higher classes in school because these were the children targeted in the intervention programme. In order to gain a larger sample of probable cases of mental disorder, the sample was complemented with a random sample of 16 children from these same schools who had been identified in the psychosocial care programme and who received individual psychosocial care. Data were collected between January and May 2006. The demographic characteristics of the sample are described in Table 8.1.

**TABLE 8.1** Descriptive statistics of the sample (n=65)

Sex	Male	55%
	Female	45%
Class	4th class	83%
	5th class	17%
Mean age		12.8 (SD 1.3)
Father has died		26%
Mother has died		14%
Number of siblings that are alive		4.2 (SD 1.9)
Number of siblings that have died		1.8 (SD 2.2)
Children with at least one deceased sibling		60%
Having witnessed relatives been killed		32%
Having witnessed unknown people been killed		46%
Family situation	Lives with both parents	51%
	Lives with one parent	40%
	Does not live with parents	9%
Has been displaced		92%
House has been burnt		69%

The assessment for each child was done in two steps that were both carried out on the same day. The first step consisted of administering three self-report questionnaires. A Burundian research assistant read each question and asked the child to respond following the available response format (30–45 minutes). These research assistants had a Bachelors degree in social science and had been trained in quantitative data collection during a five-week period.

The second step was a psychiatric assessment by an expatriate research psychiatrist (PV) and a Burundian psychologist, who were both blinded to the results of the three self-report questionnaires; further, for the 16 children who received individual counselling, they did not know the type of problems that the child had, nor did they study the case files. This psychiatric assessment took place in an empty classroom, after school time with no other persons present apart from the child and the two clinician-researchers. At the time of the study, the research psychiatrist had lived and worked in Burundi for around two years, spoke fluent French, had some basic understanding of local Kirundi concepts and was involved in clinical work, supervision and training of Burundian mental health professionals. The second member of the assessment team was one of two Burundian psychologists who took turns. They had

worked with the psychosocial project for children of HealthNet TPO since 2005 and were trained in psychosocial assessments with children. The Burundian psychologist took the lead in asking questions and acted as a translator for the research psychiatrist. The psychiatric assessment team (psychiatrist and psychologist) had been trained for seven days in the use of the Schedule for Affective Disorders and Schizophrenia for School-Age Children (K-SADS-PL) by an Italian child psychiatrist (PF) and his Burundian research assistants who had extensive experience with the instrument.

The clinical assessment started with a general section that took between 15 and 45 minutes, in which the two interviewers built rapport with the child and obtained information about biographical events (including death or sicknesses of siblings or parents), the migration history and the current life situation of the child. In the Burundian context, children are not used to speak about their emotional life and are often quite reticent at first contact. Therefore, an introduction phase was of importance to make the child feel comfortable in front of two unknown adults.

Subsequently, a semistructured interview was held with the help of the K-SADS-PL that had been translated into Kirundi. The psychiatric assessment took on average 105 minutes (between 45 and 200 minutes). When the responses of the child were not sufficiently clear after the interview with the child, additional information about the functioning of the child was obtained from the teacher. Both the psychiatrist and psychologist independently rated the scores on the K-SADS-PL and made additional notes during the interview. The scores and notes were reviewed after the interview; in case of different ratings on an item, the assessors discussed this to come to a consensus agreement; here, they took into account the cultural relevance of presented symptoms and their severity, using cultural information regarding the Burundian setting and contextual knowledge about the child's family background and daily life. For example, the K-SADS probing questions for separation anxiety disorder contain questions about 'fears of harm befalling an attachment figure' such as 'Has there ever been a time when you worried about something bad happening to your parents? Like what? Were you afraid of them being in an accident or getting killed? Were you afraid that they would leave you and not come back? How much did you worry about this?' In evaluating whether the child's responses were pathological, it proved essential to include a general knowledge of the violence in the area and the particular life history of the child. Other examples include the evaluation of sleeping with the mother in the same bed, or children who reported to be afraid in the dark. In such instances information about prevailing cultural norms in Burundi are important and the discussions between the Burundian and expatriate mental health experts proved to be very helpful.

The study was part of a multisite study on how secondary-school-based interventions affect the psychosocial wellbeing of violence-affected children in Burundi, Indonesia, Nepal, South Sudan and Sri Lanka (Jordans, Tol, Susanty, et al., 2013; Tol et al., 2008). The research proposal, including the elements reported in this study, was reviewed and approved by the Medical Ethics Committee of the VU University Medical Centre in Amsterdam, the Netherlands. A written approval was obtained on 28 March 2006.

Before starting research activities, meetings were organized in schools, with parents, teachers and principals, to explain the research purposes, including the selection method, and to obtain informed consent. The objectives of the study were read out to each participant, individual informed written consent from children and their caregivers was obtained before starting the interview, and confidentiality was assured by explaining to participants about procedures of data storage and anonymity. Data collection procedures were consistent with the Declaration of Helsinki (48th World Medical Assembly, 1997).

### **Instruments**

We translated all instruments from English into Kirundi, using a five-step procedure for cross-cultural translation (van Ommeren et al., 1999): (1) translation from English into Kirundi, and lexical back-translation; (2) review by a bilingual mental health professional; (3) evaluation of items in focus group discussions of Burundian children from the study area; (4) blind back-translation from Kirundi into English by a bilingual Burundian psychologist who was unfamiliar with the original version, and comparison of the back-translation with the original; (5) pilot testing in a Burundian school.

### **DSRS**

The DSRS is an 18-item questionnaire designed to identify symptoms of depression among children and adolescents (Birleson, 1981). The items refer to the frequency of self-reported symptoms in the past week utilizing a three-point scale response format including ‘never’, ‘sometimes’ and ‘most of the time’. The major advantages of the DSRS are its very simple language, brevity and ease of use and scoring (Myers & Winters, 2002). Internal consistency was good in samples of British children ( $\alpha = 0.86$ ) (Birleson, 1981) and Swedish children ( $\alpha = 0.88$ ) (Ivarsson & Gillberg, 1997). However, in the United Kingdom, the DSRS showed only moderate discrimination between depressed and nondepressed children in the diagnosis of depression in 93 children (aged 8-16 years) attending a university child psychiatry department, with around of 25% of the children misclassified (Fundudis et al., 1991).

The scale has been used among children affected by natural disaster or armed conflict in several low- and middle-income countries (LMICs) (Durakovi -Belko et al., 2002; Ehntholt et al., 2005; Fan et al., 2011; Goenjian et al., 1995; Jordans, Komproe, Smallegange, et al., 2012; Jordans, Komproe, et al., 2010; Jordans, Komproe, et al., 2013; Jordans, Tol, Ndayisaba, et al., 2013; Kolltveit et al., 2012; Papageorgiou et al., 2000; Smith et al., 2002; Thabet et al., 2011; Thienkrua et al., 2006; Tol et al., 2012; Tol et al., 2008; Zvizdic & Butollo, 2001) and among refugee children who migrated to high-income countries (Ellis et al., 2006; Sanchez-Cao et al., 2012). To our knowledge, it has never been validated for children in Africa. It was designed to be a written test, but in nonwestern populations it is often used orally (Ellis et al., 2006). In western populations, a cut-off score between 13 (Asarnow & Carlson, 1985) and 15 (Birleson et al., 1987) was optimal to discriminate depressed from nondepressed children. In Indonesia, the optimal cut-off point (19.5) was higher than in western

\*

1

2

3

\*

populations, with an area under the curve (AUC) of 0.76 (Tol et al., 2008). In Nepal, the optimal cut-off point was 14 and the AUC was 0.82 (Kohrt et al., 2011).

### **CPSS**

The CPSS is a 17-item questionnaire to detect symptoms of PTSD in children (Foa et al., 2001). It measures symptoms in the three clusters of DSM-IV category of PTSD (re-experiencing, avoidance and arousal) and thus provides a PTSD symptom severity score. Symptom items are rated on a four-point frequency scale (0 = 'not at all' to 3 = 'five or more times a week').

The scale has been used in various LMICs among children and adolescents exposed to collective violence (Jordans, Komproe, et al., 2010; Kohrt et al., 2008; Staples et al., 2011; Tol et al., 2008). In samples of trauma-exposed children in the US and war-affected children in Nepal, the internal consistency was high ( $\alpha$  between 0.81 and 0.89) (Brown & Goodman, 2005; Foa et al., 2001; Jaycox et al., 2002; Jordans, Komproe, et al., 2010). The standard cut-off point is 11, with American children having a sensitivity of 95% and a specificity of 96% (Foa et al., 2001). In a conflict-ridden area of Indonesia, the psychometric properties were different, with a considerable higher optimal cut-off point of 17 (AUC = 0.71), while in Nepal the optimum cut-off score was 20 (AUC = 0.77) (Kohrt et al., 2011).

### **SCARED-41**

The SCARED is a self-report instrument designed as a screening tool for anxiety disorders in children and adolescents according to the DSM IV-TR classification (Birmaher et al., 1997). The severity of symptoms is rated using a three-point response format, ranging from 0 ('not true') to 2 ('often true'). The questionnaire has five subscales: panic disorder; generalized anxiety disorder; separation anxiety disorder; social anxiety disorder; and school anxiety. Due to difficulties of the scale in discriminating between social anxiety and other anxiety disorders, its developers have adapted its original 38-item version into a 41-item version, the SCARED-41, which was used in our study (Birmaher et al., 1999). Factor analysis with the SCARED-41 in clinical samples of American and Dutch children showed a five-factor solution confirming the five subscales, with each factor showing good internal consistency ( $\alpha$  ranging between 0.78 and 0.87) (Birmaher et al., 1999; Hale et al., 2005). The five-factor structure was more or less also found in nonclinical populations of South African children (Muris et al., 2006); however, in a multiethnic primary-care population, the factor structure was less robust across ethnic and gender subgroups (Wren et al., 2004). A recent meta-analysis of 25 studies on the SCARED, with only three done in LMICs (two in South Africa (Muris et al., 2006; Muris et al., 2002) and one in China (Su et al., 2008)), showed good psychometric properties and suggested that the scale could be used in various cultural settings to screen for DSM-IV anxiety disorders (Hale et al., 2011). Since then, the psychometric properties of the SCARED-41 have been studied in Brazil (Isolan et al., 2011) and Iran (Dehghani et al., 2013), confirming the five-factor structure and demonstrating good convergent validity and discriminate validity. Apart from the validation studies by the developers of the SCARED (Birmaher et al., 1999; Birmaher et al., 1997; Monga et al., 2000), only two studies assessed concurrent validity

using a structured clinical psychiatric interview as gold standard. In Brazil, the total score of the SCARED-41 in a community sample of students aged 9–18 had an optimum cut-off point of 22 (AUC 0.73, sensitivity 52%, specificity 82%) (Desousa et al., 2013). In a sample of children and adolescents attending a psychiatric clinic in Lebanon, the cut-off score that maximized both sensitivity and specificity was 26 (AUC 0.63, sensitivity 66% and a specificity of 56%) (Hariz et al., 2013).

### K-SADS-PL

Psychiatric diagnosis was established using the K-SADS-PL, a comprehensive semi-structured clinical interview designed to identify Axis I mental disorders in children according to DSM-IV criteria (Kaufman et al., 1997). It uses probing questions to establish the presence or absence of a DSM-IV symptom (present/subthreshold/absent). Its application procedure mirrors closely the clinical diagnostic process that is employed by trained clinicians. Symptoms are rated in a format that allows for rephrasing and asking additional clarifying questions, an aspect that allows flexibility when the instrument is used in a cultural context that differs from its source. The instrument has been used widely in clinical research and practice in western settings but, to the best of our knowledge, this is the first translation to an African context. The translation was done by a group of Italian, Dutch and Burundian researchers and followed the same translation procedure as described for the DSRS, CPSS and SCARED-41 (Feo et al., 2006). The Kirundi version of the K-SADS-PL assists clinicians in the diagnosis of depressive disorders, anxiety disorders including PTSD, alcohol use and addiction, ADHD, *enuresis nocturna* and oppositional defiant disorder. It does not include the section on psychotic disorders, but in each interview, basic questions on delusions and hallucinations were asked, together with careful observation of the child during the whole interview, to exclude the presence of psychosis. The section on eating disorders in the K-SADS-PL was not included because of the limited relevance in the Burundian setting (with high rates of malnutrition). The screening questionnaire of this version of the K-SADS-PL has a total of 49 items to be scored. When one or more items in the screening questionnaire scores positively, a corresponding supplement is to be administered.

Interrater reliability between the multicultural assessment team of this research (a Dutch psychiatrist [PV] with a Burundian psychologist) and the team that trained them (an Italian child psychiatrist [PF] with extensive experience with the K-SADS-PL in Italy and Burundi, and his Burundian research assistant) in a convenience sample of 11 patients in Burundi was good: in 10 cases, the two raters came to exactly the same DSM-IV classification, while in one case the diagnosis differed slightly: a depression not otherwise specified versus a mild depression. On item level, kappa values were substantial to good (0.75–1.00).

### Statistical analysis

Internal consistency of the three questionnaires was measured by Cronbach's alpha. The scores on the screening questionnaires in relation to 'psychiatric caseness' (the clinical psychiatric diagnosis with the K-SADS-PL) were evaluated using Receiver

Operating Characteristic (ROC) analysis. ROC analysis plots the diagnostic sensitivity against '1 minus specificity' of each value of a dimensional screening scale. For each ROC curve, the AUC was calculated, indicating the accuracy in detection of caseness. Positive predictive value (PPV) and negative predictive value (NPV) for the screening questionnaires were calculated at various cut-off points. We analyzed the discriminative diagnostic capacity of the scales by means of ROC analysis of the different scores on the three questionnaires against the appropriate clinical diagnosis as derived from the psychiatric interview through the K-SADS-PL and against 'any common mental disorder'. As a means to measure overall diagnostic effectiveness of a test using a specific cut-off point, we also calculated Youden's index (J): the sum of sensitivity + specificity minus 1 (where sensitivity and specificity are calculated as proportions). This index ranges between 0 and 1, with values close to 1 indicating that the effectiveness of the test is relatively large (Schisterman et al., 2005).

## Results

Many of the children in the sample had experienced violence and death (see Table 1): 92% had been displaced, 69% had their house burnt. 60% had at least one sibling who had died. 17 children (26%) had lost their father, in 13 cases often due to war violence, and nine children (14%) had lost their mother (five due to war violence).

The psychiatric assessments with K-SADS-PL in our sample ( $n = 65$ ) identified 28 children (43%) with a common mental disorder such as depressive disorder, PTSD and/or another anxiety disorder. See Table 7.2 for a breakdown of diagnoses.

### Internal consistency

In our sample the total scores of three scales had a high internal consistency (DSRS:  $\alpha = 0.85$ ; CPSS:  $\alpha = 0.90$ ; SCARED-41:  $\alpha = 0.92$ ). For the subscale scores of the CPSS, internal consistency was good (re-experiencing subscale = 0.84; avoidance/numbing subscale, = 0.79; and hyperarousal subscale,  $\alpha = 0.77$ ). Internal consistency was high in four of the five subscale scores of the SCARED-41 (panic/somatic subscale, = 0.86; social phobia subscale,  $\alpha = 0.76$ ; generalized anxiety subscale,  $\alpha = 0.71$ ; separation anxiety disorder subscale,  $\alpha = 0.70$ ). Only the scores for the SCARED-41 subscale for school phobia did not show sufficient internal consistency ( $\alpha = 0.49$ ).

### Receiver Operating Characteristic curve analysis: sensitivity and specificity

For the scores on each of the three self-rating scales, we created an ROC curve by plotting the fraction of true positives out of the positives against the fraction of false positives out of the negatives, at various cut-off points (see Figures 8.1, 8.2, 8.3). Performances of the CPSS (measuring posttraumatic stress [AUC 0.78]) and of the DSRS (measuring depressive disorders [AUC 0.85]) were good, while the SCARED-41, measuring anxiety disorders including PTSD, performed less well (AUC 0.69).

**TABLE 8.2 Psychiatric diagnosis according to K-SADS-PL**

Diagnosis	n = 65	%
Depressive disorders	12	18
Depression	10	15
Adjustment Disorder with depressive symptoms	2	3
Posttraumatic stress syndromes	15	23
PTSD	7	11
PTSD subsyndromal cases	8	12
Other anxiety disorders <sup>1</sup>	15	23
Separation Anxiety Disorder	5	8
Panic Disorder	2	3
Obsessive Compulsive Disorder	1	2
Anxiety NOS	12	18
Any common mental disorder <sup>2</sup>	28	43
No diagnosis	37	57

K-SADS-PL, Schedule for Affective Disorders and Schizophrenia for School-Age Children; NOS, not otherwise specified; PTSD, posttraumatic stress disorder

<sup>1</sup> Numbers of the specific anxiety disorders do not add up because some children had more than one anxiety disorder.

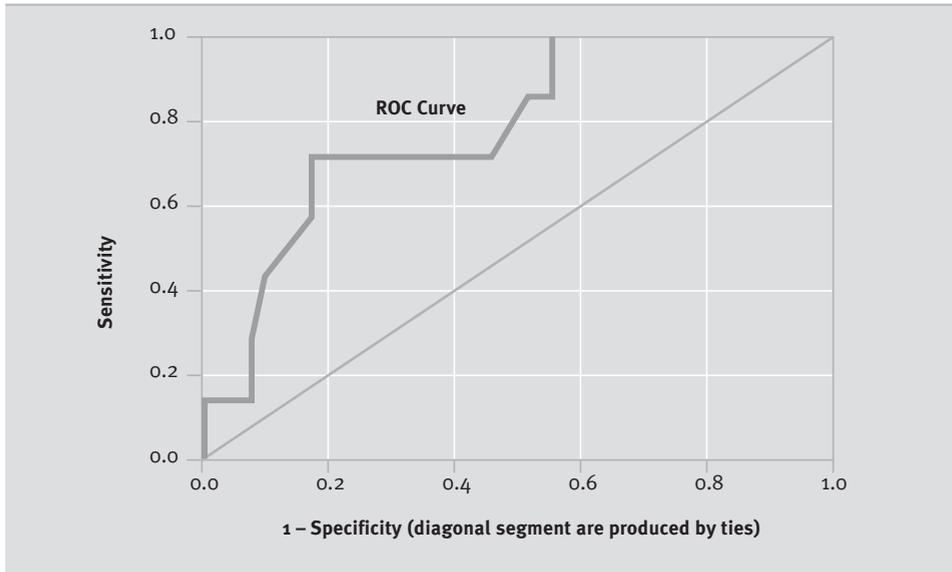
<sup>2</sup> Numbers of 'depressive disorders', 'posttraumatic stress syndromes' and 'other anxiety disorders' do not add up because some children had more than one disorder.

### Performance of the instruments at various cut-off points

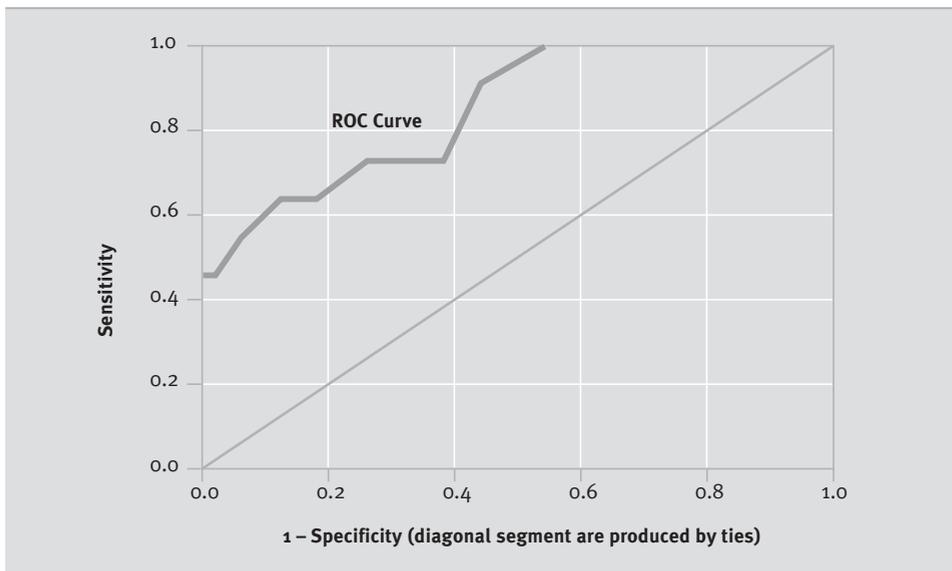
Tables 8.3, 8.4 and 8.5 present the performance at various cut-off points of the CPSS, DSRS and SCARED-41 to detect PTSD, depression and anxiety disorders, respectively. For each cut-off point, we calculated the overall diagnostic effectiveness (J), i.e. the sum of sensitivity and specificity minus 1. For the CPSS, measuring posttraumatic stress, the highest J was reached at a cut-off score of 26. For this cut-off point, sensitivity was 71% and specificity 83%. The PPV was 0.36 and the NPV was 0.96. If, instead, the standard cut-off point of 11 that has been found in western research had been used, the test parameters in this population would have worsened drastically: PPV 0.15 and NPV 1.00. For the DSRS, measuring depressive disorders, the cut-off point with the highest J was 19 (sensitivity 64%, specificity 88%, PPV 0.54, NPV 0.92). For the SCARED-41, measuring anxiety disorders including PTSD, the highest J was reached at a cut-off point of 44 (sensitivity 55%, specificity 90%, PPV 0.80, NPV 0.74).

We also tested the capability of the three questionnaires to detect any 'common mental disorder' (which we define as any depressive disorder and/or any anxiety disorder, including PTSD). Here, all questionnaires performed moderately (CPSS: AUC = 0.71; DRSR: AUC = 0.73; SCARED-41: AUC = 0.75) (see Table 8.6).

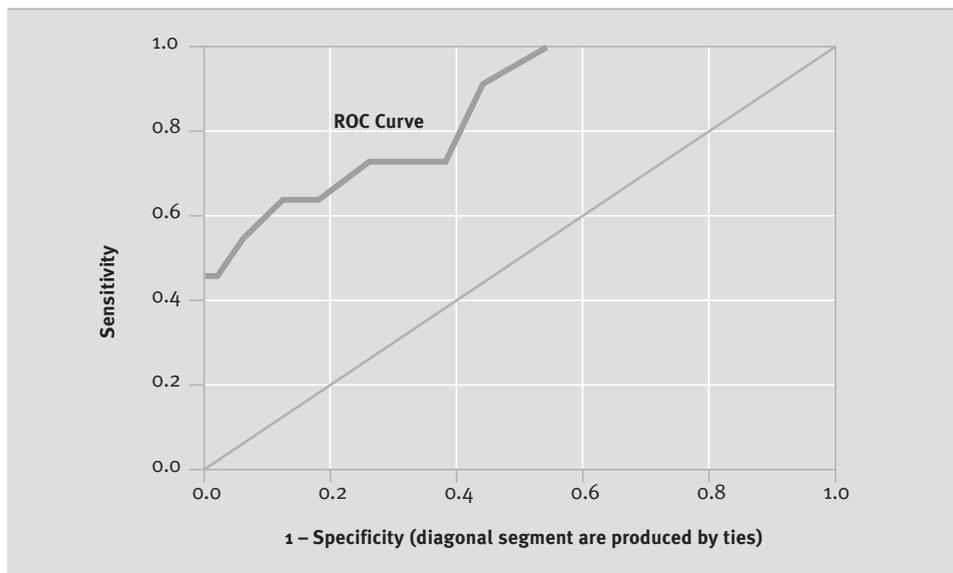
**FIGURE 8.1** ROC curve of the CPSS (PTSD)



**FIGURE 8.2** ROC curve of the DRSR (depressive disorders)



**FIGURE 8.3** ROC curve of the SCARED-41 (anxiety disorders including PTSD)



**TABLE 8.3** Properties of the Kirundi version of the CPSS to detect children with PTSD

AUC (95% c.i.)	Cut-off score	Sensitivity (%)	Specificity (%)	PPV	NPV	J
	11	100	22	0.15	1	0.21
	14	100	35	0.17	1	0.35
0.78 (0.62–0.95) *	17	86	44	0.17	0.96	0.30
	21	71	60	0.19	0.94	0.30
	24	71	79	0.31	0.95	0.52
	26	71	83	0.36	0.96	0.54
	28	57	83	0.31	0.93	0.40

AUC, area under curve; CPSS, Child PTSD Symptom Scale; J, Youden’s index; NPV, negative predictive value; PPV, positive predictive value, PTSD, posttraumatic stress disorder; \* =  $p < 0.05$

**TABLE 8.4 Properties of the Kirundi version of the DSRS to detect children with depression**

AUC (95% c.i.)	Cut-off score	Sensitivity (%)	Specificity (%)	PPV	NPV	J
0.85 (0.73–0.97)**	13	91	56	0.31	0.97	0.47
	15	73	66	0.32	0.92	0.39
	17	64	82	0.44	0.91	0.46
	19	64	88	0.54	0.92	0.52
	21	46	98	0.84	0.89	0.44

AUC, area under curve; DSRS, Depression Self-Rating Scale; J, Youden's index; NPV, negative predictive value; PPV, positive predictive value; \*\*  $p < 0.01$

## Discussion

Concurrent validation of the test scores on the DSRS and the CPSS against a clinical gold standard showed reasonably good psychometric properties, while the properties of the SCARED-41 were not satisfactory. The relatively weak performance of the SCARED-41 may be related to the fact that this instrument, in contrast to the DSRS and the CPSS, targets not a single diagnostic category but various categories of anxiety disorder. Screening instruments that mirror closely the diagnostic criteria of a specific disorder against which they are validated will perform better in singling out that disorder, while instruments that are meant to identify a broad range of disorders will be less able to discriminate between disorders. Moreover, the combination of anxiety disorders covered by the SCARED-41 has a poor fit with local concepts of and idioms for anxiety in Burundi, and therefore that tool does not capture the construction and elaboration of anxiety in the local cultural setting (Ventevogel, Jordans, Reis, et al., 2013).

The properties of the Kirundi versions of the DSRS and CPSS to detect depression and PTSD are good. However, to improve utility, the cut-off points of all self-report questionnaires had to be raised (see Tables 8.3 and 8.4) to reach acceptable psychometric properties. If we had used the standard cut-off score of 15 for the DSRS as established for British children, the utility of the scale would have deteriorated considerably (PPV 0.54 and NPV 0.92 for optimum cut-off point in this research and PPV 0.32 and NPV 0.93 for the standard cut-off point) (Birlleson, 1981). Similarly, for the CPSS and for the SCARED-41, using the standard cut-off points as established in American children would have given significant overestimations of children with mental disorder.

In other settings affected by collective violence, higher cut-off points have been found for self-report questionnaires (Betancourt et al., 2012; Ventevogel et al., 2007). We postulate that this may be related to expressing overall high nonspecific distress in the research areas where the level of everyday violence was high, and

**TABLE 8.5 Properties of the Kirundi version of the SCARED-41 to detect children with anxiety disorders including PTSD**

AUC (95% c.i.)	Cut-off score	Sensitivity (%)	Specificity (%)	PPV	NPV	J
0.69 (0.54–0.84)*	22	91	19	0.44	0.75	0.10
	25	91	29	0.48	0.82	0.20
	29	82	36	0.47	0.73	0.17
	33	73	45	0.48	0.70	0.18
	36	59	52	0.46	0.64	0.11
	41	59	74	0.62	0.72	0.33
	44	55	90	0.80	0.74	0.45
	49	46	90	0.77	0.70	0.36

AUC, area under curve; J, Youden's index; NPV, negative predictive value; PPV, positive predicted value; PTSD, post-traumatic stress disorder; SCARED-41, Screen for Anxiety-Related Emotional Disorder, 41-item version. \* =  $p < 0.05$

**TABLE 8.6 Properties of self-report questionnaires to detect 'common mental disorders'**

Instrument	AUC (95% c.i.)	Cut-off score	Sensitivity (%)	Specificity (%)	PPV	NPV	J
CPSS	0.71 (0.58–0.84)**	11	89	26	0.52	0.73	0.15
		14	82	42	0.56	0.72	0.24
		16	79	55	0.61	0.74	0.33
		19	64	64	0.62	0.67	0.29
		21	57	68	0.61	0.64	0.25
		26	39	90	0.79	0.62	0.30
DSRS	0.73 (0.60–0.85)**	12	75	49	0.55	0.70	0.24
		15	57	73	0.64	0.67	0.30
		18	46	94	0.87	0.67	0.40
		21	18	97	0.84	0.58	0.15
SCARED-41	0.75 (0.61–0.88)**	36	62	56	0.57	0.60	0.17
		41	62	82	0.76	0.69	0.43
		43	55	96	0.93	0.68	0.51
		45	50	96	0.93	0.67	0.46

AUC, area under curve; CPSS, Child PTSD Symptom Scale; DSRS, Depression Self-Rating Scale; J, Youden's index; NPV, negative predictive value; PPV, positive predicted value; PTSD, posttraumatic stress disorder; SCARED-41, Screen for Anxiety-Related Emotional Disorder, 41-item version. \*\*  $p < 0.01$

many of the interviewed children lived in adverse circumstances. Another reason for high cut-off points may be related to the lack of validity of universal classificatory constructs in the local setting caused by symptoms that overlap with idioms of distress, as has been found elsewhere in Africa (Igreja et al., 2010; Neuner et al., 2012).

When used to identify any common mental disorder in children, all three questionnaires performed reasonably, with the SCARED-41 demonstrating the best properties.

### **Making screeners useful within low resource settings**

However, acceptable psychometric properties are by themselves not enough to justify a broad use in general health practice. While our results are promising, we are cautious about overt optimism that introducing mental health screening tools for use by nonspecialists or lay workers by themselves would make ‘a dramatic contribution to the health sector’s ability to identify those in need of mental health support’ (Chishinga et al., 2011, p.2). The utility of scales in actual practice may be decreased by practical and logistical factors, such as the time needed to administer the scale and the ease of interpretation of results, as well as by ethical concerns, related to the identification of children with mental disorders without the ability to provide them with adequate treatment (Kagee et al., 2013).

Therefore, we argue that screening questionnaires can best be used within a multileveled system of care. In Burundi, the project by HealthNet TPO uses a community mental health approach that has both curative and preventive components. In our child psychosocial programme, we used a generic psychological distress-screener as the first step to identify children who are in need of psychosocial support without differentiating between those with and without mental disorder. The instrument in this ‘universal’ screening, the CPDS, can be administered by trained community workers or classroom assistants, requiring less than 5 minutes per child. This is followed by a second step of ‘selective’ screening in which instruments to identify children with a probable mental disorder, such as the CPSS and DSRS can be administered by trained lay persons, taking around 20–30 minutes per child. Screening would routinely have to be followed by clinical assessment of all screen positives to reduce the proportion of false positives (Patel, Araya, et al., 2008). This will require targeted training of general health care workers about mental disorders in order to help them to identify people with mental disorders during the clinical encounter (Ventevogel, Ndayisaba, et al., 2011). The World Health Organization promotes this training approach, a component of task sharing, through its Mental Health Gap Action Programme, which includes an Intervention Guide for Mental, Neurological and Substance Use Disorders in Non-Specialized Health Settings (World Health Organization, 2010). Within public health programmes to build the capacity of primary-care providers to manage mental disorders in children and adolescents (Patel, Flisher, et al., 2008), screening instruments may also be useful to enhance the ability of care providers to identify mental disorders in children and adolescents once those instruments are validated and calibrated for the settings in which they are to be used.

## Strengths and limitations

The study has several strengths. The major strength of our method is the use of a structured clinician-administered child psychiatric interview. Our study is one of the few validation studies in Africa using a full clinical child psychiatric interview. Another strength of the study is that it was conducted in the context of an ongoing service delivery programme. All children were recruited from schools where HealthNet TPO implemented a school-based mental health programme, and 16 of them had already received individual psychosocial care. Some of the other children had participated potentially in resilience groups or other activities. Hence, all children were familiar with the activities of the NGO and had presumably gained trust in the persons associated with HealthNet TPO. This might be a contributing factor for the readiness of the children to disclose the presence of symptoms and other personal problems. Usually the Burundian culture highly values keeping personal problems private, avoiding potential conflicts or admission of weakness or illness.

This study also has several limitations. First, the gold standard that we used, a clinical psychiatric assessment using a semistructured interview, was not performed by a local Burundian psychiatrist. During the time of the research, there was no Burundian psychiatrist active in the country. In order to account for contextual and culture-specific factors that may influence psychiatric diagnosis, the psychiatric assessment was carried out by a bicultural team consisting of a Burundian psychologist and an expatriate psychiatrist.

Second, in this paper we focused on a form of criterion validity: we assessed the concurrent validity by comparing scores on three self-report questionnaires with a standardized clinical interview as the external criterion or gold standard. We did not explore other aspects of validity, such as convergent and discriminant validity. We also explored only one aspect of reliability (internal consistency), while we did not assess test–retest reliability. This study reports on the first step in a staged process of validation. For future use of the CPSS, DSRS and SCARED-41 tools, further studies on the convergent or discriminative validity are recommended.

Third, in hindsight, we regret that we have not used emic local categories of mental distress in our evaluation (Kohrt et al., 2014; Ventevogel, Jordans, Reis, et al., 2013). While many words and phrases could be successfully translated into Kirundi, there were special challenges to differentiate between expressions of feelings that are close to each other. As is noted for other Bantu languages (Sharp et al., 2011), Kirundi has relatively few words to differentiate directly between feelings that may particularly have affected the diagnostic accuracy of the SCARED-41, which contains various terms related to anxiety. Within a semistructured diagnostic interview, this problem is less obvious because the interviewer can use metaphors and descriptions to ensure the person understands the term (Bagilishya, 2000).

Fourth, the fact that this study was done in the context of ongoing service delivery in Burundi, is both a strength and a weakness: while this is, in general, a desirable approach in order to establish efficient and sustainable assistance, the fact that the children knew the activities of the NGO for a long time may have influenced the

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results, and this could theoretically compromise the generalizability of the results regarding the cut-off scores.

Finally, validating with a gold standard is time consuming and, considering the limited resources, we could therefore interview only a relatively small number of children for the clinical validation. Involving more cases would have improved the statistical power of the study. Only seven children had the diagnosis of PTSD, for example. Moreover, when three instruments are administered to 65 people, the chance that at least one instrument will register poorer-than-usual psychometric properties is relatively high. Therefore, future research with self-report questionnaires for children in Africa should be done with larger samples to corroborate our outcomes and explore whether the cut-off points need to be adapted.

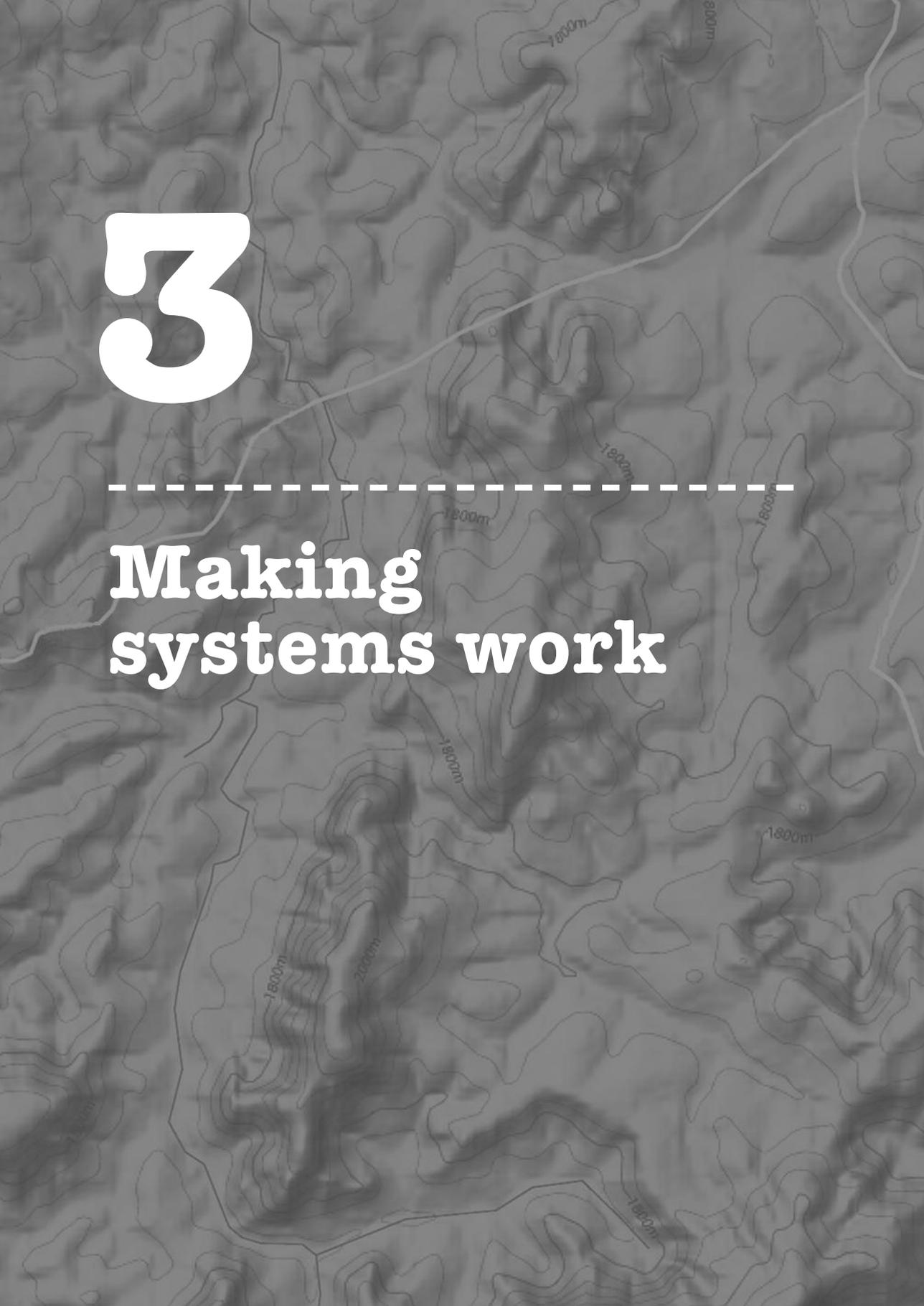
## **Conclusion**

Brief self-report questionnaires are often used in research to estimate the prevalence of psychiatric disorders in African children. Our findings underline the need for a clinical validation of brief self-report questionnaires before meaningful interpretation of scores can be done. We concur with Ertl et al. (2010) and de Jong and van Ommeren (2002) who caution against the application of ad hoc translated clinical instruments without validation and adjustment of cut-off scores across different populations. For research on depression and PTSD, the DSRS and CPSS have acceptable psychometric properties in war-affected Burundian children, but the optimal cut-off points are considerably higher than in western norm populations. All three questionnaires, including the SCARED-41, have acceptable properties for use as a generic screener to identify ‘any common mental disorder’.

In our opinion, self-report questionnaires to identify mental disorders can best be given *clinical utility* by incorporating them within a specific multitiered system of care that requires a two-stage screening procedure.

## **Acknowledgements**

The authors thank Wietse Tol, for his contributions to an earlier draft of this paper, and colleagues of the Burundian research team, particularly J  r  mie Niyonkuru, Alexis Ndereyimana, Aline Ndayisaba, S  raphine Hakizimana and Rosine Tuyishime.

A grayscale topographic map of a hilly region, featuring contour lines and elevation markers such as 1800m and 2000m. A white dashed horizontal line is positioned across the middle of the map.

# 3

## Making systems work



## Improving access to mental health care and psychosocial support within a fragile context: a case study from Afghanistan

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## Abstract

The rebuilding of the Afghan health care system, from scratch, provided opportunities to integrate mental health into the basic health services through the use of funds that became available during this complex humanitarian emergency. Practice-oriented mental health trainings for general health workers and ongoing clinical supervision in the basic health care system led to substantially increased demand for and access to basic mental health care services. Treatment of mental disorders within the health care system needs to be accompanied by a community-based approach that focuses on psychosocial problems. Addressing service delivery needs in a fragile state has to be accompanied by capacity building and policy development, in order to foster structural changes within the health care system.

## Background

By the fall of 2001, when an international military coalition intervened in Afghanistan to oust the Taliban from power, the Afghan people had already survived 23 years of armed conflict. The national health situation was disastrous, with high rates of morbidity and mortality for reproductive health conditions, childhood illnesses and infectious disorders (Ahmad, 2001). Within this context, epidemiological surveys in Afghanistan found high rates of self-reported symptoms of depression, anxiety and posttraumatic stress, particularly among women and girls (Cardozo et al., 2004; Panter-Brick et al., 2009; Scholte et al., 2004). Much of the psychological distress experienced by the Afghan people could be understood as the result of daily stress endured within the context of ongoing adversity and failing institutions (Bolton & Betancourt, 2004; Miller et al., 2008). As a result of these failures, the roles of local social structures, such as family and community were, and remain, of critical importance to preserve psychosocial wellbeing (Eggerman & Panter-Brick, 2010). Furthermore, there were no reliable data on the prevalence of severe mental disorder and epilepsy in Afghanistan, but it is estimated that the prevalence of severe mental disorder may rise with 50% after emergencies (van Ommeren et al., 2005a).

The health care system in Afghanistan had been completely shattered; there were severe shortages of health care staff, supplies and infrastructure. Furthermore, the *organisation* of the health care system itself was largely insufficient; plagued by weak coordination and management of service delivery, ineffective policy-making mechanisms and insufficient information for appropriate health policy planning. All of which meant that Afghanistan is an example of a 'fragile state', characterised by a government that lacks the capacity to provide core services and basic security to its population. Improving health care within fragile states needs to focus on quick and tangible improvement of services to the people, while also addressing long-term development and strengthening of the health care system (Newbrander et al., 2011).

In a situation of overwhelming needs and scarce resources, the mental health care system was disproportionately affected. Afghanistan's formal mental health services were limited to a few services in regional hospitals, as the country's only psychiatric hospital had been destroyed. In 2001, with an estimated population of over 25 million people, there were only two psychiatrists, and no (formally) qualified psychiatric nurses or clinical psychologists in the country. There was no department responsible for mental health care in the Ministry of Public Health (MoPH) (Ventevogel et al., 2006).

Within this context, it is important to enable the health care system to address at least some basic needs of people with mental disorders, and to strengthen the capacity of families and communities to address psychosocial distress (van de Put, 2002; Ventevogel et al., 2002). This paper reports the experiences of an international nongovernmental organisation (NGO), HealthNet TPO, in Nangarhar (one of Afghanistan's 34 provinces). The authors describe three interrelated key features of creating a sustainable system for mental health and psychosocial support within a fragile setting: 1) integration of services for some mental disorders within the general health care system; 2) community-based activities to strengthen self-help initiatives and social action; and 3) support for mental health policy development at the central, government level.

### **Integrating mental health care into basic health services**

After the fall of the Taliban in 2001, health service delivery was contracted out to NGOs by the government and international donors (Loevinsohn & Sayed, 2008). The aim was to rapidly scale-up health services, utilising well-described interventions, and replace fragmented and uncoordinated services with an acceptable level of basic services, countrywide. The Basic Package of Health Services (BPHS) describes minimum interventions, to be provided at various levels of the general health care system. Mental health care was initially included in the BPHS (2003), but these interventions were not well described. Donors doubted the feasibility of including them within the core package and any actors who wanted to integrate mental health care into the basic services had to develop their own methods and tools. Integrating mental health services into primary care is the most viable way of ensuring that people with mental disorders receive basic mental health care. However, there is no single best practice model that can be followed in all countries (WHO & Wonca, 2008). Moreover, longitudinal data from Pakistan demonstrated that integrating mental health into primary care services may strengthen the functionality of the primary health care system as a whole (Saeed, Gater, et al., 2001).

In the eastern province of Nangarhar (population 1.38 million (Central Statistics Office Afghanistan, 2011)) provision of health care services was contracted out to HealthNet TPO. The needs assessment included focus group discussions to explore local concepts of mental illness and health seeking behaviour. In consultation with provincial health authorities and local service providers, the programme prioritised common mental disorders (which included depressive and anxiety disorders), severe mental disorders (such as psychosis), and epilepsy. Health care staff were trained in

identification and management of priority conditions, using locally developed modules (Ventevogel & Kortmann, 2004).

### **HEALTH POSTS**

Community health workers (CHWs) have three months of training in health issues, offer limited curative care, and provide health education and referrals. The mental health care training aspect consisted of a three-day course focused on identification of people with possible mental health issues within the community, and follow-up of treatment adherence of patients with chronic, disabling mental disorders.

### **BASIC HEALTH CENTRES AND COMPREHENSIVE HEALTH CENTRES**

These are small health facilities covering a population of 15,000 to 30,000 people (basic health centre, BHC) to 30,000 to 60,000 people (comprehensive health centre, CHC), staffed by physicians, nurses and midwives. After two series of ten-day trainings, health workers learned to identify the priority disorders and formulate a treatment plan. Training strongly focused on improving clinical competence using demonstration videos, role plays and inviting patients to contribute to the training. Physicians received additional training in the appropriate prescription of psychotropic medication, whereas nurses and midwives received additional training in basic psychosocial interventions, such as psycho-education for patients and family members.

### **DISTRICT HOSPITALS**

Outpatient and inpatient services were made accessible for patients with mental health problems. Each hospital had a full time physician, trained in mental health care. The two-month training included an internship in a psychiatric department of an academic hospital in Pakistan. District hospitals also employed a psychosocial worker to provide psycho-education and organise support groups.

The first mental health trainings were given at the end of 2002, in six rural districts (the 'Shinwar cluster'), with an estimated 339,053 inhabitants. During this 'development phase' training materials and methodology were developed, tested and adapted. Medication supply occurred using existent supply lines and included all psychotropic drugs from the WHO Model List for Essential drugs, with the exception of lithium carbonate and methadone (World Health Organization, 2011c). In the 'scale up phase', from 2005-2008, the programme was rolled out over the entire province. An important element in this scaling-up was a two-months training for core staff to strengthen their clinical skills and enable them, in turn, to train and supervise general health care staff. Supervisors of the programme, general physicians and nurses trained in mental health, visited the trained health staff at least once a month. Gradually, mental health care has been integrated into the tasks of the general supervision system, through joint supervisions from a general health supervisor and a mental health supervisor. From 2009 onwards, there was no specific funding for mental health programmes, therefore all activities including training of new staff, supervision and provision of psychotropic drugs, have been integrated within the general health budgets ('maintenance phase').

## **Strengthening community care and resilience**

Community actors can play a critical role in achieving better outcomes in the field of mental health care and psychosocial wellbeing. For example, there is evidence from India that community mobilisation through participatory women's groups can reduce mild and moderate forms of depression, and provide a powerful addition to health-worker-led interventions (Tripathy et al., 2010). For these reasons, the programme developed activities to strengthen community resilience, and focused on women, due to the reports of high levels of mental distress (van Mierlo, 2012). Activities included: i) community psycho-education in health facilities, mosques and houses of community leaders, provided large numbers of people with information about psychosocial and mental health problems, as well as ways to cope, ii) workshops for village volunteers, or community health workers, about topics such as: grief, drug use, child rearing, domestic violence, and mental health issues, iii) support groups, in which people came together to tell their story, or discuss a problem, with the specific aim of receiving support and/or learning from other participants, and iv) individual case management through supportive counselling (Ventevogel, Faiz, et al., 2011).

### **Policy support**

In order to build a health care system within a fragile context, it is also important to invest in strengthening policy making (Bornemisza et al., 2010). HealthNet TPO has been an active partner of the MoPH. In 2003 and 2006, the NGO assisted the MoPH in organising national conferences on improving the mental health care system. In 2005, with financial and technical support of HealthNet TPO, a Mental Health Department was established in the MoPH. This enabled the ministry to take a leading role in policy development and service coordination.

## **Results**

### **Improved capacity of service providers**

Since the programme's initiation in 2002, 334 doctors, 275 nurses and midwives, and 931 community health workers have received basic mental health training in Nangarhar. The training covered all 592 health posts, all 39 BHCs, 17 CHCs and the three district hospitals.

### **Increased service utilisation**

From 2002, the number of consultations for mental, neurological and substance use disorders (MNS disorders) has increased. Figure 9.1 presents longitudinal data of diagnoses for common mental disorders (CMD), severe mental disorders (SMD), epilepsy, and other mental, neurological and substance use disorders (Other MNS)

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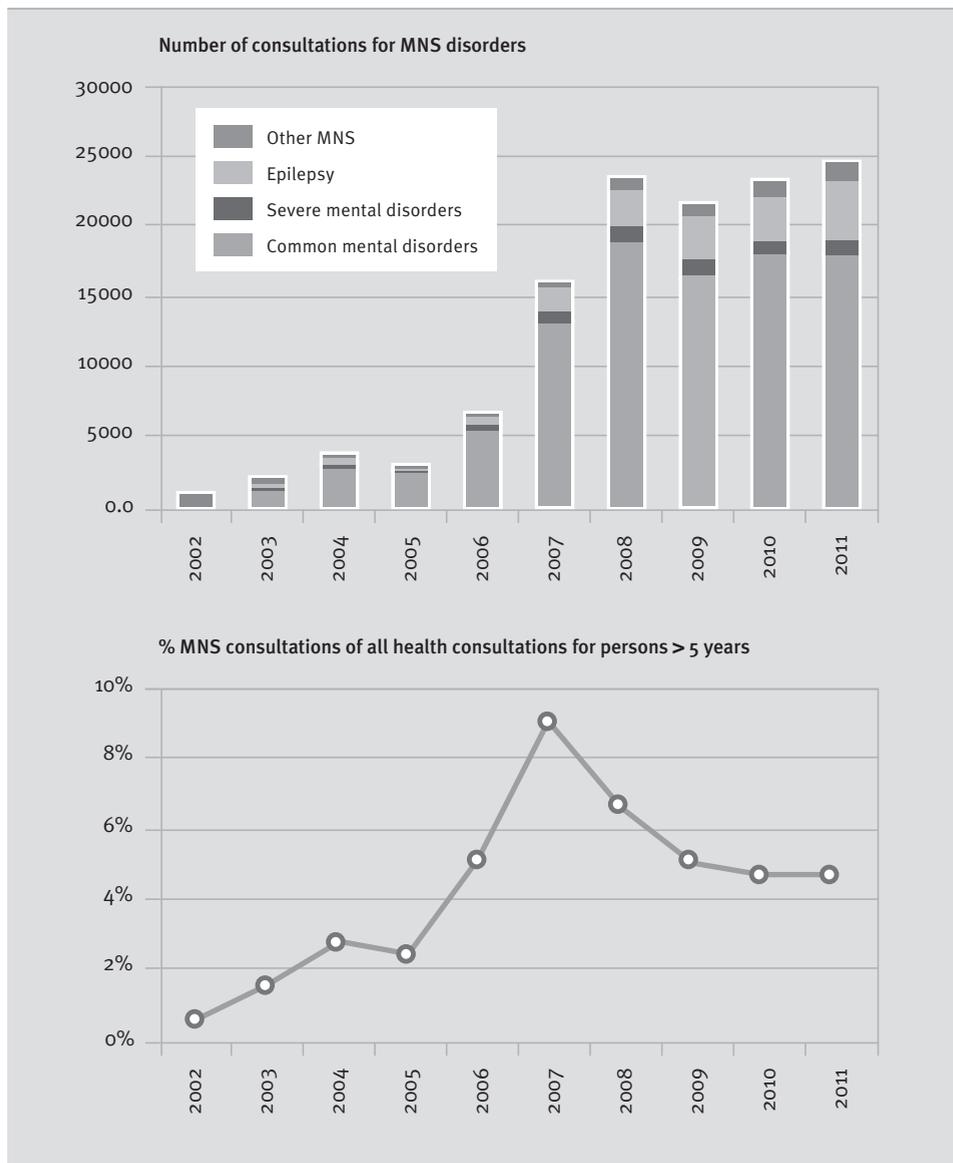
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**FIGURE 9.1 Annual consultations for CMD, SMD and Epilepsy and their percentage of all health consultations in the Shinwar cluster (2002-2011)**



in patients in the primary health care facilities of the Shinwar cluster. The absolute number of consultations for MNS disorders increased from 659 in 2002 (before the programme started) to well over 3000 per year by the end of the development phase (2004). During the scale-up phase, begun end of 2005, the numbers of consultations for MNS disorders increased significantly to over 20,000 per year. During the maintenance phase (from 2009 onwards) the number of consultations for MNS disorders remained stable, but the percentage of such consultations of all health con-

sultations decreased because of contextual changes in the overall health care system, such as concerted efforts to increase the utilisation of reproductive and child health services. From 2008 on, the basic health care system was strongly strengthened, leading to an increase in overall numbers of consultations. Among people newly diagnosed with a MNS disorder, most were diagnosed with CMD (83.2%), followed by epilepsy (8.9%) and SMD (2.7%). The category 'other MNS disorders' (including severe learning disabilities and opium addiction) constituted of 5.2% of the total new MNS disorders. Persons diagnosed with CMD had, on average, 2.0 annual visits, while those with chronic conditions had a higher number of annual visits: 3.9 and 3.3 for SMD and epilepsy, respectively. Of those patients diagnosed with CMD, 71.1% were female, for SMD the percentage of females was 43.3%, and for epilepsy, 51.8%.

### BOX 9.1 A depressed farmer

Rahimullah is a 31-year-old farmer in a mountainous district of Nangarhar province, about 100 kilometers from the provincial capital Jalalabad. He is responsible for supporting a wife and six children. He presented to a local, private physician with pains in his back, waist and arms, a burning sensations in his hands and shoulders, and 'heaviness' after eating. Additionally, he reported problems with weight loss, sleeping, chronic fatigue, loss of appetite, and a very low to absent libido. He felt overwhelmed with hopelessness, was unable to work, and rarely left home. As there had been no recent problems, nor a recent death in the family, Rahimullah could shed no light on the origin of his symptoms and was prescribed antimalarials.

However, the symptoms persisted, and over the course of a year, he travelled to a variety of physicians in Jalalabad and Peshawar (Pakistan), 200 km away. He submitted to repeated tests for blood, urine, and stool, as well as seven abdominal, kidney and pelvic ultrasonographic scans. All results were normal, with the exception of a moderately elevated alanine aminotransferase. He was prescribed a huge variety of pharmaceuticals, including antihelmintics, painkillers, antibiotics and sedatives. The tests and pharmaceutical treatments (in total) cost more than 30,000 Afghani (626 USD), or the equivalent of six months wages.

His symptoms did not decrease as a result of any of these treatments. One year after his symptoms had first manifested, Rahimullah was seen by a local community health worker (CHW) who was able to identify mental health disorders as a result of a three-day training. The CHW recommended the basic health centre (five km away), whose staff has also been trained in the diagnosis and treatment of mental health disorders. There, the physician diagnosed a depressive disorder and prescribed 75 mg amitriptylline per day. Additionally, during regular contact with the nurse, he was advised to begin with a few easy tasks each day, and to gradually return to work. After a few weeks, Rahimullah's sleep had improved dramatically, and both the sense of hopelessness and body pains had decreased. A few months later, he resumed work as a farmer.

*This example illustrates how the integration of mental health into primary health care can lead to services that are cheap, simple and tailored to local needs. It also illustrates the importance of an integrated team of trained health workers: the physician, nurse and community health worker each have a critical, but different role.*

## **Involving communities**

In Nangarhar, more than 500 community health workers and 300 teachers were trained in stress management and (domestic) violence related issues. Support groups were organised on a weekly basis to empower women towards an increased autonomy. People presenting with mental health problems received supportive counselling sessions, or were referred to the health care services. It was shown that community based activities can provide powerful ways to address mild forms of common mental disorders, as illustrated in Box 9.2.

### **Box 9.2 Support group on violence within the family**

Psychosocial workers from HealthNet TPO invited the women of Mohmandara, a village in the Nangarhar Province (close to the border with Pakistan), to participate in a support group in 2005. Almost all women from the village wanted to participate, specifically to discuss 'feelings of sadness' and 'worrying too much'. From the first group's first session it became clear that 'feelings of sadness' were often a local euphemism to express tension and violence within the family. Additionally, according to the participants, spouses were not the only violent perpetrators; mothers-in-law and sisters-in-law often encouraged the repression of their son's and brother's wives. These women were perceived, by the village women, as equally 'evil'. All members of the group agreed that it was unthinkable to involve the police, or other outsiders, in order to stop the violence. Therefore, other solutions had to be found. The village women shared their experiences and ideas, over several sessions, to find culturally appropriate solutions. Several concrete solutions were discussed, for example, involving a close relative who could act as a mediator. Improving 'communication skills' through role-play was another way to empower the group, as well as teaching the women effective ways to settle disputes. As all the participants of the group agreed that violence within a family was often the result of 'stress' due to unemployment and poverty, practical solutions were generated to improve their economic status. The facilitator of the support group, Farida, a local woman trained by HealthNet TPO, connected the group to a local NGO with income generating activities. The group raised some money to purchase a small flock of chickens. The eggs were then sold on the market, in order to supplement incomes.

*This example illustrates how a support group can evolve over time, can become a self-help group focusing on income generation, as well as providing improved psychosocial functioning.*

## **Mental health policy development**

Only with the insistence of the Afghan MoPH, and after NGO projects such as the one described in this paper had demonstrated its feasibility, did donors finally agree to fund mental health care interventions as part of the BPHS. In 2008, a technical working group of the Ministry, WHO and NGOs including HealthNet TPO, produced a full range of mental health training manuals for each type of health worker. In the 2010 revision of the BPHS, the mental health components became stronger, and in 2010, the MoPH endorsed a five year National Mental Health Strategy.

## Barriers to access

A challenge in the expansion of health care, within extremely under resourced settings, is that the rapid increase of service delivery is usually valued over long term integrated systems development. This carries the risk of creating a relative large coverage of services with low quality and limited sustainability (Palmer et al., 2006). In Afghanistan, while the number of patients per health facility has greatly increased, the time spent per health worker per patient did not. In fact, it has shown a decrease, with 80% of patients receiving less than 10 minutes per consultation (Edward, 2011). The pressure to see more patients makes it difficult for health workers to use psychosocial interventions that require time. Also, integrating mental health care into primary care carries the inherent danger of framing context-generated distress as a mental disorder (Miller et al., 2006). Medical staff has the tendency to use a 'medical' model when solving problems, and to focus on the prescription of drugs. Often, there is an expectation from both health worker and patient that drugs are to be prescribed during a consultation. When psychosocial aspects of treatment are given less emphasis, particularly with common mental disorders, there is a risk that treatment by medical staff concentrates on the biological (medication). Therefore, for people with CMD it is important that support in community settings is strengthened and that health providers are trained not to prescribe antidepressant medication for mild forms of depressive disorder (World Health Organization, 2010).

In general, rapidly expanding access to care for a mental disorder within the basic health care system mostly benefits those patients who do not need specialised or long term care. There is an obvious need to strengthen home-based care for people with chronic, disabling disorders, in order to improve the therapy compliance and to integrate mental health care into the secondary health care system, particularly the provincial hospitals. In order to respond to that need, HealthNet TPO assisted the Ministry of Public Health to open a 20 bed psychiatric, inpatient unit in the provincial hospital of Jalalabad.

## Looking to the future

The experience in Nangarhar shows that, even within a fragile and resource poor context, it is possible to develop integrated services for mental health and psychosocial support, to rapidly cover an area of more than a million people. It is important to use funds available during a humanitarian emergency to pursue lasting improvements in the health care system (Ventevogel, Pérez-Sales, et al., 2011). There is an urgent need to develop a system of routine outcome measuring tools that includes both symptom reduction and improvement of social functioning. It is challenging to develop context specific and low cost outcome measures, but recent evidence for child psychosocial programmes in post conflict areas demonstrates that it can be done (Jordans, Komproe, et al., 2011). People with a limited background in mental health care can deliver integrated services, once their tasks are integrated within a system of care that includes focused, competency-based trainings, regular super-

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vision and refresher training (Patel, Chowdhary, et al., 2011). It is important to strengthen the psychosocial elements of treatment within the health care system, and to ensure that the social context in which the symptoms occur and are maintained, are considered in the treatment plans of health care providers. The most recent version of the BPHS includes the addition of psychosocial counsellors at the district hospitals and comprehensive health centres. Preliminary evidence on the effectiveness of adding psychosocial counselling in primary health care settings in Afghanistan is encouraging (Ayoughi et al., 2012). Apart from health system based interventions, the authors have learned the importance of addressing psychosocial problems through activities outside the formal health care sector, to strengthen self-help and foster resilience.

## **Acknowledgements**

The authors are grateful to Mark Jordans, Saskia Nijhof, Shahagha Salehi, Sonali Sharma and Egbert Sondorp, and Martijn Vink for their comments on drafts of this manuscript.

### **PATIENT PRIVACY**

The persons described in the case examples in this manuscript ((box 9.1 and 9.2) have given informed consent (as outlined in the PLoS consent form) to publication of their case details.

## **Psychosocial assistance and decentralized mental health care in post-conflict Burundi 2000 – 2008**

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*Intervention* (2011), 9, 315-331

## Abstract

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

## Introduction

Burundi is a small and densely populated country situated in the Great Lakes region in the heart of Africa, which has experienced cyclic outbreaks of violence since its independence in 1962. The major ethnic groups are Tutsi (an estimated 14%) who were historically economically and politically dominant, and the majority Hutu (an estimated 85%). Burundi is one of the world's most densely populated countries, with 206 persons per sq. km (BINUB, not dated) and one of the poorest countries, consistently appearing among the five least-developed countries according to the Human Development Index (United Nations Development Programme, 2011).

Several violent episodes led to considerable political and social upheaval, causing massive population movements and the destruction of social fabric throughout the country. In 1972, the Tutsi-led government systematically killed approximately 150,000 better-educated Hutus after rebel attacks from neighbouring countries. In 1993, the assassination of the country's first democratically-elected president, a Hutu, was followed by massacres of unarmed Tutsis who were attacked by Hutu-militias. This was followed by assaults on Hutu peasants by the Tutsi-led army. As many as 150,000 people died in the weeks immediately following the assassination (Wolpe, 2011). A protracted civil war erupted. The peace agreement in Arusha in 2001 diminished the violence and in 2005 democratic elections were held, but some rebel groups still remain active at the time of writing (2011).

## Mental disorders and psychosocial problems in Burundi

There are no published prevalence figures for mental disorders and psychosocial problems in Burundi. Based on rough estimates by the WHO we can assume that, as typical of other humanitarian emergencies, around 3-4% of the population will have severe mental disorders such as psychosis, bipolar disorder or severe depression, and around 10-20% will develop mild forms of mental disorders including mild to moderate depression, anxiety disorders, substance-use disorders and post-traumatic syndromes (van Ommeren et al., 2005b). The prevalence of epilepsy is thought to be high in Burundi due to the abundant presence of risk: etiological factors include head trauma, obstetric complications and infectious diseases with neurological sequelae, such as cerebral malaria and parasitic worm infections (Nsengiyumva et al., 2003; Yemadje et al., 2011). People in Burundi tend to associate epilepsy and severe mental disorders with supernatural causes and often seek help outside the health care sector (Nsengiyumva et al., 2006). Another study by the authors to identify local idioms of distress shows that Burundians distinguish between several types of mental problems (Ventevogel, Jordans, Reis, et al., 2013). The word *ibisazi* indicates a state of chronic confusion and is often used to indicate severe mental disorders. An important state of mind is *akabonge*, which literally means ‘sorrow’ or ‘melancholy’. Other words that are used to indicate ‘a state of sorrow in which a person is not able to function normally’ are *agahinda* or *kinemura akarunga*. In the descriptions of these states, several elements of the psychiatric concept of depression can be found: a subdued mood, loss of pleasure or lack of interest, loss of concentration and suicidal thoughts. The neglect of social obligations is an element that is stressed: the person is not interested in anything in the surroundings and is not able to play a useful part in life. Another expression is *ubwoba bwinshi* which indicates fear, and especially fear that is related to traumatic events during war. People also use a specific word for epileptic seizures, *intandara*.

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

## Overview of the development of the programme

In this context of poverty, lack of basic needs, damaged social fabric and neglect of mental health issues, the international nongovernmental organization TPO (Trans-cultural Psychosocial Organisation, after 2005: HealthNet TPO) successfully applied in 2000 for funds from The Netherlands government to begin a programme which would provide psychosocial and mental health services to the war-affected population.

Formal services in mental health and psychosocial support were hitherto almost non-existent. In 2000, Burundi had one psychiatrist (trained abroad) and no psychiatric nurses or psychiatric social workers. The country had (and still has) only one psychiatric hospital, with around 60 beds and no psychiatrist. The Faculty of Education at the University of Burundi started to train clinical psychologists in the late 1990s, but at the time there were no organisations in which these workers could be employed. The country has no school for psychiatric nursing or psychiatric social work. In 2000, the Ministry of Public Health had no section for mental health and no written policy or strategy documents in regard to mental health.

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

The programme in Burundi can be divided into three phases.

### **1. The first phase of the programme (2000-2004): initiating services**

#### **PSYCHOSOCIAL WORKERS**

The programme set out to build a network of psychosocial and mental health services in communities in the city of Bujumbura and seven provinces in the country. In Burundi a province is usually small, with around 200-400,000 inhabitants. People with prior experience as social workers, teachers, nurses, or community development workers were installed as ‘psychosocial workers’ in the communities from which they originated. The ethnic composition of the team was balanced between the ethnic groups. Their training included six weeks of classroom training, followed by two weeks of field training, and then subsequent supervision and additional training courses. For more details about this training for psychosocial workers see Baron’s report (2002, pp. 181-183) which describes similar training in Uganda. The psychosocial workers are employed by the NGO and form the backbone of the community-based psychosocial programme, providing a broad package of services to individual clients, their families and the communities.

They were engaged in:

- Advocacy and awareness-raising among the general population and in specific target groups, such as internally-displaced persons, local leaders, government authorities, health workers and school teachers;
- Supportive and problem-solving counselling of clients who presented themselves with psychosocial problems, mental problems or epilepsy. These consultations take place either in the ‘counselling centre’ (a small brick house with one or two rooms) or at the clients’ homes;

- Client referrals, as appropriate, to the relevant service institutions: health centres, the psychiatric hospital, the consultant psychiatrist (in the capital), social services, legal advice, local administration, and other NGOs (e.g. for assistance with income-generating activities or material assistance);
- Developing and conducting group interventions and self-help groups for specific client groups, such as people with alcohol problems, relatives of epileptics, women vulnerable to domestic violence, people living with HIV/AIDS;
- Facilitating sports, cultural- and recreational activities (mainly for youth), while at the same time providing opportunities to access psychosocial education and counselling;
- Crisis interventions at the community level, e.g. in cases of domestic violence or neighbour disputes;
- Supervision of community-based volunteers who assist the psychosocial workers in mobilising communities and other tasks;
- Networking and coordinating activities with other relevant stakeholders in the area: local administration, health and social action authorities, other NGOs, health service providers.

At the end of this phase, in 2004, 20 psychosocial workers were deployed (two or three per province, each given a target population of around 50,000 to 100,000 persons). All psychosocial workers could make use of a motorbike and a monthly fuel allowance which enabled them to cover two or three municipalities. Every two weeks the psychosocial workers of each area met with each other and their supervisors in a group to discuss new or difficult cases, thereby enabling them to learn about how to improve interventions by sharing their experiences. From the start through to 2008 additional training courses were organized according to specific themes including sexual- and gender based violence, and the use of specific intervention techniques such as narrative theatre (Meyer-Weitz & Sliep, 2005; Sliep, 2009; Sliep & Gilbert, 2006; Sliep & Meyer-Weitz, 2003), as well as how to work with specific target groups. During the course of the programme several smaller separately-funded projects were added. They included projects for former child soldiers, for orphans and other vulnerable children, for survivors of sexual violence, for prisoners and for returning refugees (Nyamukeba & Ndayisaba, 2008). These sub- programmes functioned under the umbrella of the large programme that is described in this article. During the course of the programme research was done into traditional healing systems, and informal contacts were made between psychosocial workers and traditional healers. We chose to not formalize these relationships, with formal referral lines, but rather to maintain good relations on an individual basis and to respect the choice of the client if they chose to get treatment from traditional healers.

### PSYCHIATRIC SERVICES

Psychiatric services were provided through monthly mental health clinics that were held in provincial hospitals run by a team consisting of an (expatriate) psychiatrist and Burundian nurses employed by the NGO. They would see patients that were referred by the psychosocial workers, or (increasingly) that were self-referred. Given

the absence of qualified psychiatric nurses in Burundi the NGO paid for the three year psychiatric nursing training of two Burundian nurses in Rwanda. Towards the end of 2004 mental health clinics by NGO nurses were organized in four provincial hospitals. These included on-the-job training of governmental nurses in these hospitals.

#### **REFLECTIONS ON THIS PHASE**

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

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

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

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

#### **COMMUNITY-BASED PSYCHOSOCIAL SUPPORT**

***Training psychosocial volunteers*** The initial approach of HealthNet TPO to the work of the psychosocial workers was, as in phase one, to train *community volunteers* who could take over a part of the psychosocial work. These volunteers would get regular supervision from experienced psychosocial workers. They were not paid, but would get some remuneration in the form of a bicycle and transport reimbursements for meetings. In 2005 the NGO's input to psychosocial assistance was reduced in the three western provinces where the programme had started. The number of psychosocial workers was reduced from three to one per province.

***Training social workers of the government*** In two new provinces in the north of Burundi, HealthNet TPO started an intensive cooperation with the Ministry of National Solidarity: In some provinces this ministry ran Centres for Family Development (Centres de Développement Familial – CDF)<sup>2</sup> staffed by social workers who were not trained in psychosocial assistance and were mainly occupied with reporting problem families and providing material assistance. A training programme for these workers

was set up. Psychosocial assistance was integrated into the services of the CDF. During the first year the NGO provided 50% of the salaries, transferred equipment such as motorbikes and computers and gave intensive supervision. At the end of the period the psychosocial care in these two provinces was handed over in full to the ministry.

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

### SERVICES FOR PEOPLE WITH MENTAL DISORDERS AND EPILEPSY

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

**Increasing the acceptance of treatment for mental health problems and epilepsy in the community** Community mental health interventions included community-awareness workshops on mental disorders and the treatment possibilities, individual and family counselling and – when necessary – the referral of clients with mental problems by psychosocial workers and volunteers.

**Capacity building of governmental nurses and doctors** HealthNet TPO was the lead-agency in the development of training materials for 'Mental Health into Primary Health Care' drafted by a Technical Commission of the Ministry of Public Health (Ministère de la Santé Publique, 2007). Agreements between the national MOPH, the hospital directors and the NGO were signed. The provincial hospitals each appointed four general nurses to be trained in mental health, enabling them to dedicate part of their time to running the psychiatric service, and providing consultation rooms on the hospital premises. The NGO provided essential psychotropic drugs and equipment as well as training and supervision. The initial mental health training for nurses lasted ten days, and was followed by a second training of ten days, and a five-day clinical apprenticeship in the psychiatric hospital. Courses were conducted by a Burundian psychiatric nurse and an expatriate psychiatrist. The trained nurses participated in the psychiatric services in their hospital under supervision of a psychiatric nurse from the NGO for at least 12 months, during which time they had group supervision meetings every two months in the capital. Each hospital only had one to three doctors. These doctors also received basic training in mental health (ten days) so that they would be able to support the trained nurses.

**Engaging the national policy makers in the ministry of public health** In this second phase, the NGO increased its efforts to engage national and local health authorities. HealthNet TPO and the Ministry of Public Health organized two regional conferences in Bujumbura to discuss the integration of mental health within general health care.

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MAKING SYSTEMS WORK

Governmental and non-governmental representatives from Rwanda, Uganda, South Sudan, Tanzania and the Democratic Republic of Congo presented and shared their experiences around this theme. The World Health Organization asked HealthNet TPO to carry out an assessment of the mental health care situation in the country (World Health Organization, 2007b). This report has been the basis of a mental health strategy prepared by the government in November 2007. Several workshops were held with the ministry to develop their plan to decentralize the mental health services.

#### **REFLECTIONS ON THIS PHASE**

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

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

### **3. Third phase of the project: April 2007 - December 2008: handing over**

The last phase of the project focused on sustainability of the interventions through capacity-building, aiming to hand over services and integrate them within existing structures. In three provinces, the psychosocial assistance was integrated into the services of the Ministry of National Solidarity. In the remaining provinces, the psychosocial workers worked with existing community structures. The role of the psychosocial worker was transformed into that of a trainer and supervisor who only assists in the more severe cases. Experienced psychosocial workers provided

**Box 10.1 Mental, neurological and substance use disorders newly included in the Health Information System in Burundi in 2008**

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

supportive supervision for a longer period before leaving the community volunteers and psychosocial workers of the ministry to deal with community awareness raising, promotion of support groups, and individual case-handling.

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

A national mental health strategy has been drafted and signed by the Minister of Public Health, and a national mental health policy was drafted in 2007 by a multidisciplinary team with representatives of the Ministry, the World Health Organization and HealthNet TPO. Monitoring and reporting tools have been elaborated by the project, and as a result of lobby six psychiatric diagnoses have been incorporated into the governmental Health Information System. (See box 10.1)

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

**REFLECTIONS ON THIS PHASE**

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



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

### **Coverage and kinds of clients assisted: some data**

Since 2003 the project has maintained an electronic psychosocial database registering the data about people who requested assistance from NGO psychosocial workers. 17,713 clients were seen by the psychosocial workers. The users of the services appear broadly representative of the population, although we did not register ethnicity because this is extremely sensitive in a country with a history of ethnic violence. The clients requested assistance for (severe) mental disorders (21.5 %), epilepsy (35.1%) and for psychosocial problems that were not related to these conditions (43.4%) (see table 10.1). Once the initial psycho-education for patient and family was complete, the patient was given regular follow-up through the mental health clinic, and the psychosocial worker would limit his or her involvement to treatment compliance-enhancing activities.

People with 'psychosocial problems' who did not have a mental disorder or epilepsy generally required the more active involvement of the psychosocial workers. A psychosocial worker worked with approximately 20-28 people showing such psychosocial problems per month. Family disputes, sexual violence, depression/bereavement/suicidal behaviour and health related complaints were the most frequent problems while psychotrauma, human rights violations and socioeconomic problems have also been presented often (see table 10.2). From a psychiatric care perspective it is perhaps remarkable that relatively few clients were treated for 'depression'. This reflects the way that psychosocial workers work; i.e. they work with the problems which the client presents and tend to avoid using labels such as 'depressive disorder' or 'anxiety disorder'.

The psychosocial problems clearly cover a wide range of problems and are, in fact, not very specific to the post-conflict setting but can be found in many African societies. However, it is likely that these problems are aggravated by ongoing insecurity, the loss of loved ones, the return of refugees and internally-displaced persons, and the breakdown of social structures in the communities. A significant proportion of

**TABLE 10.1** Number of unique clients\* seen by psychosocial assistants (2000-2008)

Type of consultation	Number of clients	Percentage
Psychosocial problems	7695	43.4%
Mental disorder	3803	21.5%
Epilepsy	6215	35.1%
Total	17713	100%

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

**TABLE 10.2** Types of psychosocial problems\* seen by psychosocial assistants (January 2001- November 2008)

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

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

the problems presented to the psychosocial workers are not directly related to war or psychotrauma, but may be indirectly aggravated by the impact of war on the social structure and the reduced capacity of individuals and families to cope with their problems. The term ‘collective trauma’ (see Somasundaram, 2007) helps to better

**TABLE 10.3 Morbidity among users of mental health clinics set up by HealthNet TPO and Ministry of Public Health in provincial hospitals (2006-2008)**

	Number of patients	%	Number of consultations
Epilepsy and other neurological problems			
Generalized epilepsy	6,289	64%	43,074
Other epilepsies	58	<1%	281
Neurological problems	31	<1%	121
Subtotal	6,378	65%	43,476
Psychotic disorders			
Schizophrenia	632	6%	5,584
Other psychoses	1,725	18%	8,598
Bipolar disorder	104	1%	446
Subtotal	2,461	25%	14,628
Other mental disorders			
Depression	704	7%	2,750
Substance abuse	21	<1%	38
Behavioural problems	65	1%	253
Others e.g. stress, anxiety	188	2%	532
Subtotal	978	10%	3,573
Total	9,817	100%	61,677

understand how a chronic war situation can lead to fundamental social transformations and affect the psychosocial wellbeing and mental health of individuals.

A project-based computerized database for consultations at the mental health clinic started in 2006. From 2006 to 2008 the clinics registered almost 10,000 patients who received more than 60,000 consultations (see table 10.3). The majority (65%) are people with epilepsy. About one quarter were people with psychotic disorders and 10% were people with non-psychotic mental disorders such as depression and anxiety disorders. The severity of depressive and anxiety disorders was not estimated, but the clinical impression of the first author, who worked in the programme from 2005 to 2007, is that the people with depression who were seen in the mental health clinics often had severe and disabling forms of depression. People with milder forms of depression and anxiety (i.e. that do not lead to major functional impairment) tended not to present themselves at a psychiatric service.

## Discussion of achievements and challenges

It is rare that a long term intervention for mental health and psychosocial support in a resource-poor post-conflict setting is described. Eight years after the start of the project, mental health care services have improved. A mental health component was

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

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

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

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

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

ing capacity of the National Institute for Public Health to provide specialised training in mental health').

The general stock of essential psychiatric drugs in the governmental distribution system is still insufficient, although the Ministry of Public Health pledged its expansion at the International Mental Health Conference organized by the ministry and HealthNet TPO in January 2008. The difficulty in anchoring basic mental health care within official government policy reflects the low priority that the Burundian government gives to mental health, in common with many low-income countries (Jenkins et al., 2011). With hindsight, more time could have been invested in establishing the importance of mental health as an integrated part of health service provision. As an organization this should remind us of the importance of our investment in establishing policies which include mental health within general health-sector reforms.

While for mental health there is at least an approved strategic plan, there is no such thing for psychosocial interventions based outside the health sector. A working group which included government personnel and HealthNet TPO staff met several times, but its efforts did not result in a national policy document that could put psychosocial assistance more visibly on the national and international agenda or attract internal and external funding. The Ministry of Solidarity has a 'charitable profile' (e.g. paying for essential care of the very poor and vulnerable), but does not have well-developed strategies to empower communities to care for themselves. HealthNet TPO has invested considerably in building the capacity of the Centres for Family Development (CDF) of the Ministry through training, material-support, and 50% salary payment before finally handing over the projects. The dependency on external support renders the CDF structures vulnerable. Many of these centres are now almost dormant and psychosocial workers at community level receive minimal support. The government has apparently not been able to honour the agreements it signed with the NGO.

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

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

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

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

Providing mental health services at the level of the provincial hospital is an important step, but should be followed by integration of mental health service at the health-centre level. This would make mental health services accessible to all. The data shown in table 10.3 indicates that the psychiatric services in the provincial hospitals were mainly used by people with severe disorders such as epilepsy and psychotic disorders. The numbers of patients with common mental disorders such as depression and anxiety disorders were much lower than one would expect based on estimated prevalence. As has been described elsewhere in Eastern Africa (Muga & Jenkins, 2008; Nsereko et al., 2011), it is likely that many people with less severe mental disorders such as depression and anxiety do not self-identify as having a mental disorder and will not visit a specialized mental health centre, but rather present to the general health care system. Although the provinces in Burundi are small and the provincial hospitals can be reached within half a day on foot by almost all people, it is not realistic to expect chronic patients to seek treatment on a monthly basis if it is far from their homes.

## **Future**

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

### **Strengthening health-systems**

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

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## **Strengthening community-systems**

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

## **Conclusion**

We believe that integration of mental health at all levels of the health care, both secondary level as well as primary health care level, is necessary. It is the responsibility of the health care system to offer assistance to people with mental disorders, particularly those with severe and disabling mental disorders. However, health care services are not always best suited to assist people who have common mental disorders such as depression and anxiety disorders, whose aetiology is strongly related to social problems. We should therefore be wary of promoting psychiatric diagnostic categories as explanatory models for social suffering. For this reason we have learned to distinguish community-oriented social psychiatry from community-building social work. This leads logically to a two-pronged approach; health-system strengthening alongside community-system strengthening. In our view, the installation of basic psychiatric services within general health care should be accompanied by activities to heal the social wounds of war.

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## **Notes to chapter ten**

<sup>1</sup> Initially they were called *conseillers* (English: counsellors). However, the community-based psychosocial work they are involved in is much broader than what is usually

understood as ‘counselling’ and therefore the job title was changed into ‘psychosocial workers’, or in French *assistants psychosociaux* (the latter indicating the broader psychosocial assistance that they are giving).

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

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## **Integration of mental health into primary health care in low income countries: avoiding medicalization**

**P. Ventevogel**

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MAKING SYSTEMS WORK

International Review of Psychiatry (2014), 26, 669–679

## **Abstract**

Since 2008 the World Health Organization (WHO), through its mental health Gap Action Programme, has attempted to revitalize efforts to integrate mental health into non-specialized (e.g. primary) health care. While this has led to renewed interest in this potential method of mental health service delivery, it has also prompted criticism. Some concerns raised are that it would contribute to the medicalization of social and psychological problems, and narrowly focus on primary care without sufficient attention given to strengthening other levels of the health care system, notably community-based care and care on district levels. This paper discusses seven elements that may be critical to preventing inadvertently contributing to increasing a narrow biomedical approach to mental health care when integrating mental health into non-specialized health care: 1) using task shifting approaches within a system of stepped care; 2) ensuring primary mental health care also includes brief psychotherapeutic interventions; 3) promote community-based recovery oriented interventions for people with disabling chronic mental disorders; 4) conceptualizing training as a continuous process of strengthening clinical competencies through supervision; 5) engaging communities as partners in psychosocial interventions; 6) embedding shifts to primary mental health care within wider health policy reforms; and 7) promoting inter-sectoral approaches to address social determinants of mental health.

## **Introduction: why integrate mental health into primary care?**

Integrating core mental health services into routine primary health care was one of the top five ‘grand challenges’ in global mental health chosen through a recent prioritization exercise with a Delphi panel of hundreds of international mental health experts (Collins et al., 2011). This high level of priority is not surprising, given the high prevalence of mental disorders and the very low numbers of specialist mental health resources in low- and middle-income countries, compared to other medical specialties such as paediatrics and surgery (Saxena et al., 2007).

For example, many countries in sub-Saharan Africa have less than one psychiatrist per million inhabitants, with several countries having only one psychiatrist (e.g., Burundi, Chad, Liberia, Sierra Leone, Namibia) and others none at all (Eritrea, Central African Republic) (Ndyanabangi et al., 2004; World Health Organization, 2011b). While clearly the specialist mental health resource base needs strengthening, it is also evident that closing the mental health treatment gap cannot be realized by relying solely on psychiatrists, or other mental health specialists. Furthermore, the few mental health specialists in these regions are often concentrated in urban areas, catering for private patients (Saxena et al., 2007). Moreover, the specialist academic training of psychiatrists is likely to put them in an antagonistic position to most of their clients, who use various explanatory models for mental

health problems that are not easily compatible with those of academic psychiatry (Kleinman, 2012b).

Therefore, integration of mental health interventions within primary care systems has the advantage of being more accessible and also recognizes that people with mental disorders also often have significant acute and chronic physical health problems that may lead to worse health outcomes (Moussavi et al., 2007). Additionally, many people with (undetected) mental disorders will initially visit general health care providers as a gateway to care. As a result, integrating mental health care into non-specialized health care can optimize both mental health and physical health outcomes, and avoid fragmentation of health services (Patel, Belkin, et al., 2013). Another common concern, addressed by integrating care of mental health needs into the context of general care settings, is the stigmatization that may be associated with specialized settings for psychiatric care as general care settings are often more acceptable to patients and family members (Goldberg et al., 2013).

### **Task shifting and task dumping**

It should, therefore, be appealing to include non-specialist health professionals in general health care settings, with training to enable detection, diagnosis, treatment and monitoring of individuals with mental disorders, thus reducing caregiver burden (Kakuma et al., 2011). This is called task shifting: the transfer of tasks, normally performed by a specialist, to a health professional with a different or lower level of education and training, or to a person specifically trained to do a limited task only, without formal health training (Joshi et al., 2014). Potential benefits of task shifting include increased coverage, more efficient use of available health care staff and utilization of local staff who are familiar with locally used expressions and presentations of mental distress, with a reduction of stigma (Kagee et al., 2013; van Ginneken et al., 2013). There is now broad international consensus around the critical need to train non-specialist health workers, in low- and middle-income settings, in diagnosing and managing mental disorders (Isaac & Gureje, 2009; Patel, Maj, Flisher et al., 2010). Barriers to a task sharing approach include the significant rates of staff turn-over in many primary health care settings, the requirement of substantial training and supervision, and the risk of ‘task dumping’ (overloading primary health workers with tasks they cannot reasonably perform well) (Eaton et al., 2011; Iwu & Holzemer, 2014).

## **Methods**

This paper synthesizes the literature around the integration of mental health into primary care in low- and middle-income countries. English language literature was retrieved through searches in Medline and Google.Scholar using combined search terms such as ‘integration’, ‘primary health care’ ‘mental health’, ‘low- and middle-income countries’, ‘Asia’, Africa, ‘Middle East’, Latin ‘America’, and by scrutinizing the reference lists of retrieved articles and papers.

## Not a new idea

The idea of integrating mental health into primary care services of low resource settings is not new (Cohen, 2001). In fact, since the early 1970s calls have been made to start a process of decentralization of relatively expensive and malfunctioning psychiatric hospitals into basic psychiatric care integrated into general health services settings close to where people live (Carstairs, 1973; German, 1972). In 1976, almost 30 years ago, Giel and Harding aptly formulated what should be done:

**'Expansion of mental health services in developing countries is overdue. This will only take place if tasks of mental health care are undertaken by a wide range of non-specialist health workers, including those responsible for primary health care; and services are directed initially at a very limited range of priority conditions.'**

(Giel & Harding, 1976, p. 513)

The idea of inclusive primary health care services, in which psychological and social aspects of health are considered side-by-side with somatic aspects, has been enshrined in various landmark documents, such as the 1977 Declaration of Alma Ata on primary health care and publications of the World Health Organization (WHO & Wonca, 2008; World Health Organization, 1990, 2001). All of these initiatives emphasize that to improve coverage of mental health services, it is vital for primary care workers to be trained in recognition and management of mental disorders, comple-

### BOX 11.1 Modules in mhGAP Intervention Guide

• Moderate-Severe Depression
• Psychosis
• Bipolar Disorder
• Epilepsy / Seizures
• Developmental Disorders
• Behavioural Disorders
• Dementia
• Alcohol Use and Alcohol Use Disorders
• Drug Use and Drug Use Disorders
• Self-harm / Suicide
• Conditions Specifically Related to Stress
- Grief
- Acute Stress
- Posttraumatic stress disorder
• Other Significant Emotional and Medically Unexplained Complaints

Source: (World Health Organization, 2008, 2010; World Health Organization & United Nations High Commissioner for Refugees, 2013, 2015)

mented by a system of on-going supervision and support. Despite repeated calls to integrate mental health into primary care, the reality is that, in most regions of the world, regular primary health care services have disappointingly little – if anything – to offer most people with mental disorders (de Jong, 2014; Greenhalgh, 2008; Rohde et al., 2008; Wang et al., 2007). Most people with serious mental disorders in low-income countries still do not receive any treatment at all, at least not within the formal health care sector (The WHO World Mental Health Survey Consortium, 2004). There have been dozens of seemingly effective initiatives, within low income countries, to treat psychosis, depression, and other conditions within primary care, but almost none have been sustained or scaled-up to reach a larger coverage area (Kleinman, 2013). Programmes that started promisingly, and had impressive results, could not be sustained after external funding ended as national governments or local partners were unable or unwilling to continue (Schulsinger & Jablensky, 1991). In some of the few cases where sustainable programmes existed, newly erupting armed conflict disrupted services (de Jong, 1996). Against this backdrop, the WHO started a renewed initiative to close the treatment gap: the mental health Gap Action Programme (mhGAP) (World Health Organization, 2008). A major component of this programme is the integration of mental health services into primary care as ‘the most viable way of closing the treatment gap and ensuring that people get the mental health care they need’ (WHO & Wonca, 2008, p. 1).

### **mhGAP: revitalizing primary mental health care**

The Mental Health Global Action Programme (World Health Organization, 2008) aims to scale-up evidence-based services for mental, neurological and substance use disorders, in low- and middle-income countries, through medical care and psychosocial assistance. A key assumption of the programme is that mental disorders can be managed by non-specialist health-care providers with sufficient training, support and supervision. The central tool of mhGAP is its ‘Intervention Guide for Mental, Neurological and Substance Use Disorders in Non-specialized Health Settings’ (World Health Organization, 2010), a concise clinical manual based on systematic review of evidence of effectiveness of services. Reviews of evidence were conducted, with a focus on relevance to resource poor settings (Barbui et al., 2010; Dua et al., 2011; Tol, Barbui, et al., 2013) and with an extensive consultation. Each module (see Box 11.1) is brief, and contains flowcharts to facilitate clinical decision-making and additional intervention details.

The manual comes with supportive materials, such as a training package for a five-day basic training with an emphasis on case-identification, and a ten-day standard training with more details on clinical interventions. There are also (draft) versions of supervision manuals and training materials for community health workers, as well as materials for policy guidance and to support contextualization of the manual. In less than five years, the mhGAP approach has created great interest within low- and middle-income countries. Ministries of health and nongovernmental organizations alike

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have adopted and adapted the materials, and used them in over 50 countries (Abdulmalik et al., 2013; Abera et al., 2014; Ali et al., 2012; Almoshmosh, 2015; Bruni, 2014; Budosan, 2011; Budosan et al., 2014; Gavlak, 2016; Gumber et al.; Gureje et al., 2015; Hijazi et al., 2011; Hughes, 2015; Kigozi et al., 2016; Kokota, 2015; Luitel et al., 2015; Richards, 2016; Rose et al., 2011; Saxena, Saraceno, et al., 2013a; Siriwardhana et al., 2013; Siriwardhana et al. 2016).<sup>1</sup>

## **Medicalization: a potential drawback of mhGAP**

The integration of mental health into non-specialist health on a global scale is part of a process of the ‘coming of age of global mental health’ and its enshrinement in the global health agenda (Patel & Prince, 2010). The expectation of the WHO is that this will provide the groundwork for a major advance in access to evidence-based and contextually appropriate mental health services. However, the mhGAP programme has been criticized for its potential to contribute to a narrow medical approach to alleviation of psychological and social suffering, and may also be seen as a symptom of an on-going process of ‘medicalization’. This is a process whereby human problems are framed as medical problems, and are treated as such (Clark, 2014a, 2014b; de Jong, 2014). The potential for the mhGAP programme to contribute to medicalization may be related to (at least) three issues, discussed below.

First, the prevailing classification system used in mhGAP (based on the ICD) clusters severe disorders such as psychosis, dementia and bipolar disorder (for which a bio-genetic base is credible) with other more common problems, such as depression and anxiety for which less biological data exist to confirm distinct clinical entities and for which the distinction with non-pathological life problems is often difficult. For example, over the past few decades, dysphoric emotional states that are often tied to life circumstances and socio-economic factors have been progressively re-framed as mental disorders (Horwitz & Wakefield, 2007; Horwitz, 2007; Horwitz & Wakefield, 2012) and this has also been identified as a rising concern for low income countries (Watters 2010; White, 2013) Processes of medicalization of distress are additionally strongly reinforced by training primary care practitioners in ‘checklist psychiatry’ devoid of context (Summerfield, 2008, 2013).

Second, the approach of WHO’s mhGAP intervention programme is based on a presumed universality of mental disorders. Some argue that socio-cultural differences in symptomatology and culture are not sufficiently taken into consideration by global mental health initiatives such as the mhGAP programme (Bass et al., 2007; White & Sashidharan, 2014b), despite the fact that there are important variations in how mental distress presents and is experienced (Fernando, 2012; Kohrt et al., 2014; Patel, 1995; Ventevogel, Jordans, Reis, et al., 2013).

Third, the proposed interventions take an individualistic outlook and may in clinical practice promote the prescription of medication at the expense of psychosocial interventions (White & Sashidharan, 2014b). The mhGAP materials contain ample referral to psychosocial interventions, but in practice, these often prove to be unfeasible within general health care settings without additional human resources. An addi-

tional impact is the apparent preference of patients and health workers for a ‘quick fix’ through pharmacological substances. Whereas training of medical staff in diagnosis and drug prescriptions for priority disorders has proven to be doable, most general health workers do not have time to implement psychosocial interventions, even those of the most generic kind (Jain & Jadhav, 2009; Ventevogel et al., 2012). Also, adding tasks to the primary health care system may lead to an overburdening of already weak health care systems (Patel, Belkin, et al., 2013), further contributing to the trend towards quick fixes.

## **Primary mental health care in low-income settings: how to get it right?**

In the remainder of this paper, I will discuss seven elements that emerged from the literature as critical to preventing the expansion of a narrow biomedical approach to mental health care while integrating mental health into non-specialized health care. These are: 1) using task shifting approaches within a system of stepped care; 2) ensuring that primary mental health care includes brief psychotherapeutic interventions; 3) promote community-based recovery oriented interventions for people with severely disabling, chronic mental disorders; 4) conceptualizing and investing in training as a continuous process of strengthening clinical competencies through supervision; 5) engaging communities to be partners in psychosocial interventions; 6) embedding shifts to primary mental health within wider policy reforms for mental health care; and 7) ensuring a balance between curative interventions and preventative actions to address the social determinants of mental health problems.

### **1. Using task-shifting approaches within a system of stepped care**

Delivery of mental health care within primary health care systems requires a radical role transition of mental health professionals, from mainly service delivery to programme design, training, supervision, consultation-liaison for complex cases and, evaluation of programmes at the primary health care level and in the community (Patel, 2009; Srinivasa Murthy, 2011b; Thornicroft & Tansella, 2013). The role of psychiatrists and other mental health specialists in low- and middle-income contexts (LMIC) should, therefore, significantly widen from delivering services to the ‘(un)happy few’ to include new core tasks, such as training and supervision of other health workers and designing mental health care programmes that can be delivered by non-specialists. This requires a fundamental paradigm shift to a public health oriented approach, which would necessitate promoting psychiatrists to engage in public health and community work, and start addressing risk/protective factors at community levels (de Jong, 2011; Kigozi & Ssebunnya, 2009). Psychiatrists will have to leave their ivory towers of specialist medicine and engage with general health workers and communities in order to situate their position as one (essential) piece in the task shifting system. Task shifting is being used, in many low-income countries (de Jong, 1996; Srinivasa Murthy, 2011a), for example, in Ethiopia nurses were trained for a much

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wider range of extended roles in rural districts, from prescription of drugs to community mental health education (Araya et al., 2009). However, the outcomes of task shifting in mental health care have not been well established, and it is unclear how feasible it would be outside pilot projects (Padmanathan & De Silva, 2013). Non-specialized health workers, such as nurses, midwives and community health workers, may also be reluctant to engage in mental health activities when their roles and workloads historically did not include such activities. Apart from training and clinical supervision, additional measures, such as renewed job descriptions, revised appraisal systems and additional staff members, may be required to engage them in mental health work. Stepped care would also lead to a change in tasks for mental health specialists who would have to focus more on extensive training and supervision (Jordans, Luitel, et al., 2012; Murray, Tol, et al., 2014), than individual care. When done well, stepped care often requires additional human resources. At a minimum, focal health personnel dedicated to mental health or chronic diseases, for example at the level of district health facilities, are needed to improve the commitment to deliver mental health services in a sustainable way (Eaton et al., 2011). To provide a wide range of mental health services, the staffing in primary health care settings will also need to be increased (Petersen et al., 2012).

## **2. Brief psychotherapeutic interventions within primary and community care**

A major risk in training primary care providers in mental health is that it may amount to ‘biologising’ mental health problems, ignoring complex psychological and social problems. The power of biomedical explanations are such that even when psychosocial aspects are formally integrated in policies and trainings, the net effect may be that health workers prescribe more pills, thereby silencing alternative views (Jain & Jadhav, 2009). Despite unequivocal calls to brief psychological interventions within the management of common mental disorders, medical staff in primary care facilities often do not have the time or the inclination to provide such treatments (Petersen et al., 2011). An alternative to using health professionals (such as doctors and nurses) to provide psychotherapeutic interventions is to train community health workers for these tasks (Patel, Chowdhary, et al., 2011). Trials in various LMIC have shown positive results, for example interpersonal therapy (Bolton et al., 2003; Patel, Weiss, et al., 2010), cognitive behavioural therapy (Murray et al., 2013; Rahman, Malik, et al., 2008), narrative exposure therapy (Ertl et al., 2011; Neuner et al., 2008), cognitive processing therapy (Bass et al., 2013), and problem solving therapy (Ali et al., 2003; Chibanda et al., 2011). While the theoretical perspectives in these successful trials vary significantly, common features are; 1) contextualization through cultural and linguistic adaptations; 2) simplification of the often rather complex procedures of an original psychotherapy method; 3) training that is strongly competency-based, with minimal theory; and 4) intensive clinical supervision of trained workers (Murray, Dorsey, et al., 2011). One of the other problems that arises is the limited evidence for scalability of such interventions that show positive results within a relatively well-resourced and well-controlled research environment. While many RCTs focus on a

specific diagnostic group, within a clinical reality, a lay worker would need to be trained in general management of a much wider set of problems (Ventevogel, 2014). An important development is, therefore, the development of non-specific or transdiagnostic psychological treatment methods, with additional modules or skills sets that can be used by community workers when they are confronted by a client with a specific diagnostic category (Bolton et al., 2014; Murray, Dorsey, et al., 2014). This may amount to the training of paraprofessionals as general primary care psychosocial counselors, and who would then be enabled to deal with a wide range of psychological issues by combining elements of different evidence-based psychological treatments. Training of competent psychosocial counselors will usually take several months of intensive training, followed by intensive clinical, as shown by examples from Afghanistan (Ayoughi et al., 2012); Nepal (Jordans et al., 2007; Jordans et al., 2003), Syria (Quosh, 2011), Uganda (Baron, 2002), and elsewhere (van der Veer et al., 2004).

### **3. Dedicated attention for people with severely disabling chronic mental disorders**

Not all mental health conditions are equally ‘ripe’ for integration. Given their prevalence and evidence for effective task shifting, common mental disorders, such as depression, anxiety and alcohol use disorders are most suitable for treatment by non-specialists within health care settings (Patel, Belkin, et al., 2013). Rehabilitation of patients with chronic disabling psychiatric conditions, such as schizophrenia, bipolar disorder and dementia through primary care systems is not easy, and there are few examples of successful primary care programmes that included rehabilitation components. One of those, in South Africa, showed that general nurses, as part of their daily work, were able facilitate people with psychotic disorders to learn new skills, re-learn old skills that were lost due to illness and to utilize remaining abilities (Sokhela & Uys, 1998). Caretakers of people with psychosis may also be taught how to do this, so that they may eventually take-over the rehabilitation process, under the supervision of the health worker. However, in many settings, a supportive, clinical supervision environment and/or a supportive community environment may simply not be available. It is not easy to realize a significant reduction of symptoms and related disability through primary care facilities. An RCT in India, comparing facility-based care delivered by a mental health specialist (the control condition) with similar care plus home based-care delivered by community health workers (who had received a six-week training with regular supervision) could only demonstrate a modest added value for the community intervention (Chatterjee et al., 2014). The effect was, however, larger in resource poor settings where participants were recruited directly from the community, and where there was no access to specialized health care before the trial.

People with chronic disabling disorders, such as schizophrenia and dementia, will often need accompanying, non-medical (family-oriented) care that is focused on learning to live with disabilities and creating favorable social environments to live a dignified life (Saraceno & Dua, 2009). In this light, the adoption of the United Nations

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Convention for the Rights of Persons with Disabilities (United Nations, 2006) is highly important as this document explicitly defines disability not as the attribute of a person, but as a product of the interaction of people with functional impairments and environmental factors, including social support. There are several well-documented programmes in low resource settings that show contextually relevant and mental health care can be delivered to people who are disabled by chronic mental disorders (Cohen et al., 2011).

#### **4. Training as a continuous process of strengthening clinical competencies**

Primary care workers are often familiar with a diagnostic model with clear key symptoms, followed by straightforward interventions, and often prescription of medication or the provision of brief advice. It is important that building the mental health capacity of primary care workers is explicitly focused on psychosocial competencies that are directly related to interactions with patients and their families. This has implications for the way health workers should be trained. Training such skills should go beyond simply increasing knowledge. It is essential to provide trainees with skills they can use in daily practice, and that enhance their clinical competency and self-confidence (Henderson et al., 2008; Henderson et al., 2005). An RCT in Malawi found that, in comparison to a classic lecture-type brief training, a format using interactive short lectures, group discussions and role-play, emphasizing practical diagnostic algorithms, led to a significantly improved detection and management of patient's mental disorders by paramedical staff in health centers (Kauye et al., 2014). Often, on-off trainings are not useful, as only after several trainings with on-the-job supervision can one witness primary care workers begin to use their new skills (Jones et al., 2007; Ventevogel, Ndayisaba, et al., 2011). Another major barrier to integrating mental health care into primary care is lack of supportive supervision (Abera et al., 2014), as without a system of competency-based supervision, trainings will have limited impact. Supervision should be on-going and intensive. Additionally, integration initiatives will be further supported if locally tailored, clinical guidelines become integrated into the local curricula of training institutes for health professionals, as has been done in various countries in Africa (Jenkins, Kiima, et al., 2010).

#### **5. Engaging communities to be partners in psychosocial interventions**

Improving mental health care through primary care requires not stopping at merely making services available within health care facilities. Many health systems in low income countries make use of community health workers (CHWs), volunteers with a brief training of usually of 4 to 12 weeks who assist in case-finding, health education, follow-up, and assisting in vaccination campaigns. Various programmes have described how training community health workers in mental health has led to a significant increase in self-referrals to primary mental health services (Eaton & Agomoh, 2008; Ventevogel, Faiz, et al., 2011) and, as an added bonus, community stakeholders generally welcome such approaches (Mendenhall et al., 2014). However, far too

often mental health trainings for CHW focus on increasing the trainees' knowledge and attitude (referred to as 'mental health literacy') without any real life competency building to enable them to more effectively support people with mental distress (Armstrong et al., 2011). Additionally, CHW are often well positioned for broader and more empowering roles, such as mobilizing and organizing vulnerable members of their community (de Menil & Underhill, 2008). Community workers are not necessarily formally attached to a health care system, as are community health workers. Teachers, social workers and volunteers from community-based organizations can also play important roles in promoting mental health and raising awareness of mental illness (Jordans, Tol, et al., 2010). It is critically important to use a 'bottom-up approach' to ensure various actors within communities facilitate mental health initiatives. For example, in Northern Uganda, people in war-affected rural districts effectively lobbied for mental health services in their area, in response to high levels of alcohol abuse and suicidal behaviour (Ovuga et al., 2007).

It is important to train community workers to enable them to find practical solutions for people with psychosocial distress. Such an approach would not only be based on identification of potential mental disorders, but should remain truly community-based and empowering (Wright et al., 2014). Tangible and concrete support is often of critical importance in community mental health interventions. In India, for example, advice by community health workers about women's shelters and legal rights was found to be as essential an element of an intervention for severely depressed women as the use of antidepressants (Chatterjee et al., 2008). Community-based self-help groups can be a powerful tools to enable people with mental disorders, and their families, to become a stakeholder with clout and less dependent on formal service providers (Petersen et al., 2011). In Afghanistan, the training of health workers in basic psychiatry led to an increase in identification and management of psychiatric problems within primary care settings, but also threatened to lead to high levels of prescription of psychotropic drugs, particularly for those for common mental disorders (Ventevogel et al., 2012). Strengthening women's empowerment through basic social work methods was found to be a powerful antidote (van Mierlo, 2012). Such approaches address what is directly 'at stake' for disempowered women, and target causes of high levels of stress, such as conflicts with husbands and mother-in-laws, domestic violence and poverty (Kermode et al., 2007). Indeed, addressing livelihood skills, interpersonal skills and mobilizing community resources are all essential elements of such empowering approaches. While also an extremely under-researched area, examples from India and Rwanda show positive effects of support groups on the symptoms of common mental disorders (Richters et al., 2008; Scholte, Verduin, Kamperman, et al., 2011; Tripathy et al., 2010). Interestingly, these successful interventions did not use any medical language, such as 'depression', 'post-traumatic stress disorder' or other psychiatric jargon (Patel, 2014). This is an important distinction, as most people who could be diagnosed with a common mental disorder (e.g. depression, anxiety disorder, or harmful use of substances or alcohol), would not conceptualize their problem as a medical disease, but rather frame their problem in non-medical terms. This would occur, utilizing culturally relevant labels and causal explanations for their distress as being inextricably

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linked to life experiences or misfortune (Aggarwal et al., 2014; Patel, Simunyu, et al., 1995).

## **6. Policy support**

Successful experiences with mental health integration highlight the role of supportive national health policies and the inclusion of mental health into minimum packages of care for primary care facilities (Kigozi & Ssebunnya, 2009; Mbatia & Jenkins, 2010). In many countries, the integration of mental health into primary care has been a policy objective, but remained window-dressing as long as no specific allocation of resources were made to implement it and while governments continue not to see mental health as a real priority. Within the emerging field of global health, the attention to mental health is growing, among financial donors, governments and researchers (Patel & Prince, 2010). A major reason for this rising focus, is the increasing domination of the global disease burden by chronic, non-communicable diseases, including mental neurological and substance use disorders (Beaglehole & Bonita, 2008). This has, however, not yet been translated into a proportional allocation of funds or other resources (Becker & Kleinman, 2013), although several countries (including Brazil, India, South Africa and China) have increased public resource allocation for mental health care, with a strong emphasis on integration into primary care delivery systems (Eaton et al., 2011).

In order to ensure a holistic mental health care at primary level, it is essential that the supportive structures on other levels of the health systems are also strengthened (Sartorius, 2009). For example, the appointment of dedicated focal points for mental health on district and provincial levels may help to coordinate mental health services, and contribute to the inclusion of mental health within district and provincial strategies, training plans and resource allocation (WHO & Wonca, 2008). On all policy levels, and across multiple sectors, mental health should be considered an integral element of any health system. On a national level, this requires inclusion of mental health into general health policies and strategies, and in training centers for health cadres.

## **7. Social determinants of mental health problems**

Poverty and common mental disorders are closely linked (Patel & Kleinman, 2003). Social inequalities increase the risk of disorders such as depression, alcohol and substance use, and stress related disorders. Social factors are paramount in the aetiology of many mental disorders ('social causation') and conversely these mental disorders have negative socio-economic consequences and may contribute to continuing impoverishment ('social drift') (Lund et al., 2011). Interventions to break the vicious cycle of poverty and ill mental health requires broad inter-sectoral action that will have to go beyond the health care sector and include various levels, from the local community to the society at large (World Health Organization & Calouste Gulbenkian Foundation, 2014). This additionally requires a broadening public mental health perspective mitigating vulnerability, resilience and risk factors (de Jong,

2002a; Panter-Brick & Eggerman, 2012; Tol, Jordans, et al., 2013). Comprehensive action across the life course is needed, particularly for children living in adversity, with the aim that every child has the best possible start, as this will generate societal and mental health benefits later in life (Kieling et al., 2011). To do this may necessitate the inclusion of mental health considerations in programmes that are not directly focused on mental health, but on improving maternal health, or the nutritional status of children (Morris et al., 2012; Rahman, Patel, et al., 2008). Actions to reduce risk of mental disorders at the community level, and at the country level, require the inclusion of mental health considerations within larger social schemes, such as poverty eradication plans and educational strategies. While this inclusion into social schemes may be important, it is rarely realized (Jenkins, Baingana, et al., 2010). Such broad interventions clearly go beyond and above the primary care level and require action and advocacy on higher policy level.

### **Towards an inclusive primary mental health care: the way forward**

This paper has argued that the integration of mental health into non-specialist health care, important as it may be, could also have negative effects that outweigh its benefits. In order to mitigate the risk of on-going medicalization of mental problems, various strategies need be taken into account. First, it is important to ensure that primary health workers are well trained and supervised in psychosocial approaches. Second, initiatives for primary health care staff needs to be embedded within a multi-layered system of care that both links to community-based initiatives, as well as to more specialized services. People with mental disorders and the communities they live in, need to genuinely be involved in shaping the responses to assist people with mental disorders. While obviously, there is a long way to go to achieve these goals, there are reasons for hope.

In 2013, the mhGAP programme was complemented by a major policy breakthrough, the adoption by the World Health Assembly (constituted of all Ministers of Health of United Nations member states), of the Mental Health Action Plan 2013-2020. This plan sets goals for mental health to be achieved by 2020, including provision of comprehensive, integrated and responsive mental health and social care services in community-based settings. One-hundred and fifty-three WHO member states have, so far, signed the Action Plan (Saxena, Funk, et al., 2013; World Health Organization, 2013b). Significantly, the action plan uses ‘community-based settings’ as the focus, instead of the more restrictive term ‘primary health care settings’. It is also of critical importance that the action plan explicitly favors social options, such as prevention and health promotion, for addressing the burden of mental health. While the integration of mental health into primary care is a key element of the action plan, it is clear that this is not a cheap or quick solution. In order to build holistic primary mental health care systems, policy makers and health workers need embrace a public mental health approach. Concerted efforts are needed to ensure community perspectives to mental distress are taken seriously, and for health professionals to take



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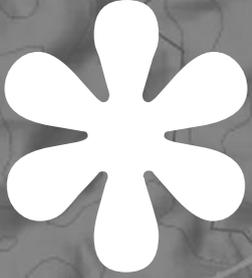
action to combat social marginalization and exclusion of people with mental disorders. Integration of mental health into primary care is a key element to reach this goal, but only if it will move beyond a technocratic approach and will be embedded into a multi-leveled approach that includes policy makers, mental health specialists, general health workers and community members

## **Acknowledgments**

The author would like to thank Joop de Jong, Mark Jordans, Gabriel Munene, Mindy Ran and Wietse Tol for their constructive comments on an earlier draft of this paper.

## **Note to chapter 11**

<sup>1</sup> This list has been update in July 2016.





# Chapter twelve

## **Concluding remarks: Findings, implications, and reflections**

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CONCLUDING REMARKS

While the journey that has led to this thesis did not have an over-arching research agenda or a predefined focus, my explorations have strengthened my conviction of the urgency to alleviate the mental suffering of people within complex humanitarian emergencies. To begin to understand how this might be accomplished, this thesis examined mental health within complex humanitarian emergencies from three angles: Part one: ethnographic research to explore local perspectives, Part two: epidemiological research aimed at capturing the magnitude of mental disorder, and Part three: health systems research to analyse how interventions can be integrated into systems that work.

In this context, this last chapter functions as a potential road map to the goal of alleviating mental suffering within complex humanitarian emergencies: through summarising major findings from research presented in preceding chapters; examining those findings within the broader context of global mental health in complex emergencies; formulating implications for further research and for practice; and reflections on issues that, in my opinion, need to be addressed in order to advance the field of mental health and psychosocial support in complex humanitarian emergencies.

## **Part one: Culture and context**

Part one focussed on local perspectives, using the question: ‘What are the perspectives on mental health and healing by people affected by complex humanitarian emergencies?’ The first three chapters of this section explored local perspectives on mental health and healing in Burundi. The last chapter examined mental health and psychosocial wellbeing of children in Afghanistan.

### **Summaries of major findings**

Chapter two (‘The effects of war: local views and priorities concerning psychosocial and mental health problems as a result of collective violence in Burundi’) examined what Burundians themselves see as the major consequences of the armed conflict that ravaged their country, and how they ranked these topics in order of importance. This exploratory research with qualitative methods showed that the most important consequences were perceived to be related to health, poverty and the breakdown of social institutions. Amidst these concerns, issues relating to mental health and psychosocial wellbeing were also mentioned, albeit only later in the discussions. This clearly showed that while mental health and psychosocial wellbeing are issues of grave concern to people in humanitarian emergencies. This has been doubted in the past, and still remains questioned by some critics of ‘global mental health’ who believe that such concerns are merely a reflection of the myopic views of western trained mental health professionals (Pupavac, 2005; Summerfield, 2005).

Chapter three ('Madness or sadness? Local concepts of mental illness in four conflict-affected African communities') presented a comparative analysis of ideas around mental illness in Burundi and three other conflict affected settings in east Africa. Participants in all four research settings described local syndromes (defined by severe behavioural disturbances) that corresponded remarkably with the grand category of 'psychotic disorders' (including manic states), both in professional psychiatry and recent WHO materials such as the 'mhGAP Intervention Guide' and 'mhGAP Humanitarian Intervention Guide' (World Health Organization, 2010; World Health Organization & United Nations High Commissioner for Refugees, 2015). However, no matter how aligned these idioms seemed to be to classic psychiatric definitions, in our research, ideas on aetiology and the meaning of symptoms differed considerably to professional ideas on psychosis. In addition, each of the four societies researched had local terms for conditions characterised by sadness, loss, and social withdrawal.

Here the link with psychiatric disorders is more complicated, despite similarities to the emotional disorders and grief conditions as they are defined in professional psychiatry. We concluded that the local categories for 'emotional states related to loss and sadness' identified are perhaps better not seen as 'cultural syndromes' with a relatively coherent set of symptoms and ideas of aetiology, but as 'idioms of distress': culturally prescribed ways of communicating that one feels bad and/or unhappy (Nichter, 1981, 2010). Such idioms of distress may be indicative of psychopathological states that undermine the wellbeing of a person, but in other cases may better be seen as adaptive reactions to a situation of distress, and may thus be a way of coping with distress.<sup>1</sup>

Chapter four ('Change and continuity in Burundian divinatory healing') described how traditional healing in Burundi is very much alive, but that its practitioners have adapted their healing methods to more contemporary circumstances. Therefore, these changes can, for a large part, be attributed to processes of modernisation and globalisation, as seen elsewhere in Africa. But, as I and my co-authors hypothesise, in Burundi the effects of war seem to have accelerated the ongoing decline of the old regional *kubandwa* cult and facilitated the emergence of a new type of healing, *gucekera*, in which spirits are aggressively driven out of afflicted people.

Part one concludes with Chapter five ('Child mental health, psychosocial wellbeing, and resilience in Afghanistan'), that was not based on primary ethnographic research, but consisted of a literature review on child and adolescent mental health and wellbeing in Afghanistan. This chapter contained references to both ethnographic and epidemiological literature, and thereby, forms a bridge to Part two of this thesis. The review made clear that mental health and psychosocial problems found in Afghan children and youth encompass a wide array of problems that go far further than strictly 'war related' pathology, but also, and perhaps foremost, include problems related to poverty, inequality and other forms of structural adversity. The chapter also showed the power of the sociocultural context in Afghanistan in both generating ill mental health, as well as providing resources for individuals and families to survive ongoing adversity. In this chapter, the work of my co-authors, anthropolo-

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gists Catherine Panter-Brick and Mark Eggerman, featured prominently. They demonstrated how important cultural concepts such as ‘honour’, ‘family unity’ and ‘hope’ play a significant role in building resilience to adversity (Eggerman & Panter-Brick, 2010; Panter-Brick & Eggerman, 2012; Panter-Brick et al., 2009; Panter-Brick et al., 2011). However, their work, as well as much of the other reviewed work, also demonstrates how such cultural values are not just an ‘asset’, but are generated within specific contexts. In other words, the very cultural values that may help people survive war and misery can also function as a straightjacket, thwarting individual peoples aspirations and freedom.

The papers in Part one are a stark reminder that ‘culture’ is not to be reified as a ‘something’, but requires unpacking. In fact, ‘culture’ can offer only a partial explanation of why people think and act as they do. Political and economic forces, social institutions, biological factors and psychological processes all have major roles to play within the whole and we, therefore, should remain wary of cultural determinism (cf Kuper, 1999).

### **Discussion**

Part one of this thesis raises essential issues that, in my opinion, deserve increased attention in the further development of global mental health as a field of both academic study and interdisciplinary practice. The surge of publications in global mental health is being followed by a small, but significant, number of publications critiquing ‘global mental health’ from a cultural perspective. For example, authors within these publications have criticised the global mental health ‘movement’ for:

- i) epistemological premises, thoroughly rooted in western ideas of the person and the self, that may be quite different to communities in the Global South (Fernando, 2012; Gilbert, 2008; Ingleby, 2014; Summerfield, 2008);
- ii) not taking seriously socio-culturally determined understandings, ways people express their distress and the practices they use to deal with mental illness, instead one-sidedly promote a concept of distress as symptomatic of ‘neuropsychiatric disorder’ and devalue what people do to heal themselves (Davar, 2014; Gilbert, 1999; Higginbotham & Marsella, 1988; Jakubec & Rankin, 2014; Mills & Fernando, 2014; Summerfield, 2012);
- iii) reinforce power inequalities in decision making, with priorities primarily formulated by mental health professionals and their institutional partners in wealthy countries, and so reflecting the interests of biological psychiatry and its consequent emphasis on psychopharmacological drugs (Applbaum, 2015), while at the same time giving insufficient attention to locally defined priorities, and as such being part of a neo-colonial movement – ‘medical imperialism’ (Summerfield (2013) – thus serving the interests of the pharmaceutical industry (Davar, 2014; Fernando, 2011; Thomas et al., 2005);
- iv) focusing on existing ‘evidence-based treatments’ while the evidence is often derived from high income settings (Fernando, 2012; White & Sashidharan, 2014a); and
- v) emphasising professional mental health interventions, often focused on individuals rather than families or communities, which may further marginalise indigenous

forms of helping, healing and social integration that can contribute to positive outcomes and recovery, as well as draw attention away from the need to create supportive social contexts that enable peoples' opportunities and agency to improve their own mental health and wellbeing (Campbell & Burgess, 2012; Cox & Webb, 2015; Fernando, 2014a; Sax, 2014).

It is clear there is much to be learned from cultural critiques on global mental health, and they deserve to be taken seriously. Some of the critique however, is beside the point, and seems to be rooted more in ideological rigidity than grounded in experience or based on a thorough review of the literature. For example, the critique that the evidence base in global mental health is primarily derived from 'western' evidence is increasingly belied by a rapidly growing body of literature on evidence based treatments that are developed and tested in low income settings (Fairburn & Patel, 2014; Jordans, Tol, et al., 2011; Kieling et al., 2009; Tol, Barbui, et al., 2011; Tomlinson et al., 2009). Equally misplaced is the accusation that global mental health advocates would only promote pharmacological therapies, and constitute a band of 'useful idiots' that are unwittingly deployed as the secret weapon of multi-national pharmaceutical companies in their zest to spread the consumption of their wares around the globe. An impressive amount of global mental health research is actually dedicated to brief psychological interventions that can be delivered by non specialists among disadvantaged populations affected by collective violence, forced displacement or structural adversity in low income countries in Africa (De Jong et al., 2014; Fairburn & Patel, 2014; Patel, Chowdhary et al., 2011; Shanks et al., 2013).<sup>2</sup>

My 'critique on the critique' is not meant to defuse the unpleasant truths that can be found within well-founded cultural critiques on global mental health. It is important for decision makers in global mental health to genuinely consider that their interventions may contribute to a 'homogenisation of psychiatry' (Higginbotham & Marsella, 1988) and may limit, rather than increase, the options that psychologically distressed people in low income countries have to feel better and solve their own ills. The critiques on global mental health should be explicitly fed into a more reflexive praxis of global mental health in which there is space for alterity, and for dialogue among stakeholders within specific socio-ecological contexts (Cooper, 2016; Kohrt & Griffith, 2015; Suffling et al., 2014). Such engagement with critical perspectives is necessary to avert the very real possibility that global mental health interventions can contribute to upholding or strengthening a status quo at the expense of any real liberation of disempowered people living with structural adversities (Kirmayer, 2016, p. 645). This requires us, as global mental health professionals, to move beyond the unproductive global/local dichotomy that situates 'local' dimensions of mental health experiences, forms of care and coping in an inevitable opposition to 'global' efforts to improve mental health through systematic production of evidence (Bemme & D'Souza, 2014). The global mental health agenda needs to embrace more 'pluralistic views of knowledge' and integrate models that have emerged from local practices (Kirmayer & Swartz, 2014).

While sadly in this thesis I can only briefly address these critical issues,<sup>3</sup> below are two key implications and reflections regarding the role of culture and context in shaping mental health, particularly within complex humanitarian emergencies.

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### 1) LOCAL CATEGORIES OF MENTAL ILLNESS AND DISTRESS MATTER AND ARE FLUID AND EMBEDDED WITHIN SPECIFIC CONTEXTS

The research in chapter three shows that people in four settings in East Africa had terms for something like psychosis. These findings held no surprise, because, as far as my understanding goes, all societies in the world have similar, often heavily stigmatised, terms that roughly correspond with psychotic states (cf Murphy, 1976, pp. 1019-1028, for a classical paper on this matter). Indeed, Robert Edgerton (1966) discovered half a century ago that symptoms of psychosis were recognised as a syndrome by the local population in East Africa. Moreover, he found that people did not always attribute it to witchcraft, they sometimes also saw it as an illness occurring for no reason, or as the ‘natural result of life stress’.

An often heard ‘charge’ against mainstream global mental health is the uncritical use of nosological constructs of western psychiatry (Ingleby, 2014; Summerfield, 2008). There is truth in that assertion and researchers and practitioners should be wary of reifying local idioms of distress into professional psychiatric classifications because these terms are used pragmatically and are embedded in local webs of signification as well as connected to contextually salient metaphors.<sup>4</sup> Concurring with other research into idioms of distress (cf den Hertog et al., 2015), the findings of Chapter four indicated that people who use expressions like *nger yec* (‘cramped stomach’, in Kwajena Payam in South Sudan) *yeyeesi* (‘many thoughts’, in Yei in South Sudan), *amutwe alluhire* (‘tired head’, in Butembo in the DRC) or *ibonge* in Burundi, may refer to a whole spectrum of emotional states, ranging from relatively brief, minor episodes of sadness and worrying to chronic and severe conditions of sadness and hopelessness.

Recently there has been a flurry of research on local idioms of distress and their relevance for mental health care (Kohrt et al., 2014). Widely found all over Africa, and elsewhere in the world, is the idiom of ‘thinking too much’ (Kaiser, Haroz, et al., 2015) that we also identified among the Bari speaking people in South Sudan, and that I also encountered in Afghanistan under the name *waswasi*. The idiom of ‘thinking too much’ as a key presentation of distress may relate to various psychopathological states such as depression, panic attacks and PTSD. Instead of pinning it to one DSM construct it may be more fruitful to view it as an indication of a causal network of psychopathology that is localized within a specific cultural context, as has been demonstrated for Cambodians (Hinton et al., 2016).

Such idioms of distress can play an important role in clinical encounters as they may provide useful clues to evaluating local psychological distress that, in turn, may assist in designing contextually sensitive treatments and interventions (Bolton et al., 2012; Hinton et al., 2015). They are, ultimately, important ways to express and experience distress (Nichter, 1981, 2010) and should not be reduced to merely an exotic variant of a psychiatric disease entity.

An example of the effects of ‘appropriation’ of a local idiom of distress (*open mole*) can be found in the work of medical anthropologist Sharon Abramowitz on post war Liberia. In Liberia, a local idiom of distress, ‘open mole’, was a loosely defined concept with a rich variety of symptoms (including bad dreams, sleeping problems, fast heartbeat, and fear of death) that could fit neatly within the descrip-

tion of PTSD. Other characteristics of *open mole* were, however, clearly very different from PTSD, such as: a soft spot in the centre of the head, back pain, neck pain, and heat through the body. In the wake of the Liberian war, the term *open mole* was used by NGO workers as a local variant of PTSD, and people presenting with it were treated for PTSD, through medication and trauma counselling (Abramowitz, 2010). A similar situation arose in Rwanda with *guhahamuka*, a local idiom that has some semblance to PTSD, but also to panic disorder (Hagengimana & Hinton, 2009; Hagengimana et al., 2003), and to mass psychogenic emotional crises provoked by the commemorations of the Rwandan genocide (Gishoma, 2014; Mohand et al., 2014). Moreover, as Guglielmo (2015) remarks, in the complex ethno-political reality of post genocide Rwanda, the syndrome of *guhahamuka* is an exclusive idiom of Tutsi survivors of the 1994 genocide.<sup>5</sup> These important connotations are lost when using *guhahamuka* as a synonym for PTSD.

It is, therefore, a major challenge for global mental health workers to take local cultural categories seriously and neither ignore nor appropriate them, or situate them in western diagnostic classifications. Instead, indigenous categories may be viewed as important for global mental health for at least three reasons (cf Kohrt et al., 2014). First, within *community outreach activities* they can be used as entry points for two-way communication in which community members are invited to describe idioms they use, what they do to get better and what the formal health care system could contribute. Second, in *clinical encounters* they can provide useful cues to start a meaningful dialogue between health worker and client that can open up local worlds of meaning making, and make it easier to reach a mutually agreed treatment goal.<sup>6</sup> Third, local categories may be integrated in *outcome measures* for research or clinical practice.

## 2) CULTURE AND SOCIAL CONTEXT SHOULD BE SEEN AS DYNAMIC CONCEPTS

As the cases of both Afghanistan and Burundi illustrate, massive violence and conflict related adversity have an impact on a wide variety of levels, including individual, familial and collective. Therefore, the individual focus of classical psychiatry and clinical psychology may obscure the effects of violence on a collective level: social relations are weakened, people in communities do not trust each other anymore, and pathways to help each other have become either redundant or dysfunctional. In his seminal writings, Sri Lankan psychiatrist Somasundaram, developed a comprehensive notion of ‘collective trauma’ as a powerful analytic concept relating the effects of war on a social level with individual suffering (Somasundaram, 2003, 2007, 2014a, 2014b; Somasundaram & Jamunanantha, 2002). The notions of multi-levelled effects need to be translated to multi-levelled and multi-modal MHPSS interventions, which were a hallmark of the programmes implemented by the Transcultural Psychosocial Organisation (de Jong, 2002a) and one of the key elements of the *IASC Guidelines for Mental Health and Psychosocial Support in Emergency Settings* (IASC, 2007).

Additionally, global mental health work may undermine, invalidate, or displace indigenous systems of mental health promotion and healing that are part of the essential social fabric and resilience of local communities (Kirmayer & Pedersen,



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2014). In understanding this, anthropologists have a major role to play in exploring and describing how processes of globalisation take place and how power relations play out within concrete contexts. The insidious nature and subtleties of the processes through which dominant ('global') forms of understanding become rooted in local practices are well illustrated by ethnographic research into mental health and psychosocial care practices. Jakubec and Campbell (2003) describe how the introduction of internationally standardised assessment instruments changed the way mental health nurses in Gambia interacted with their patients. The new tool provided such a powerful template to structure the interaction of the nurses with their patients that instead of listening carefully to their narratives, the nurses became more 'efficient' by interviewing people through standardised questions in order to receive specific answers that could be interpreted within predefined categories. Any actions patients had taken before coming to the clinic (such as performing rituals, visiting traditional healers) were now framed as 'delays in accessing appropriate care', i.e. the biomedical care offered by the health centre, usually medication provision.

In a totally different setting, Varma (2012) analyses how the biomedical discourse gets so engrained into psychosocial care in war torn Kashmir, that in spite of the fact that local counsellors employed by international organisations were trained specifically and only in non biomedical methods, in daily practice, they 'enacted' medical practices; attempting to look as 'medical' as they could, in order to satisfy their client's expectations and to increase their own self-confidence. The Kashmir psychosocial counsellors, similar to their clients, saw biomedical treatments as superior to talk therapy, and found medical expertise more credible than psychosocial competence. This ethnographic account turns the usual normative critique of humanitarianism – that it would not be locally grounded – upside down, and shows how subtle medical models of care can creep into local practice, whether intended or not.

Personally, these astute observations are rather painful to read. After all, during my work in Afghanistan and Burundi (described in Chapters nine and ten), I went to great lengths to ensure that trained health professionals understood and utilised evidence based guidance and materials. Yet, I can also see the veracity in Jakubec and Campbell's (2003) observations how skills-building with a decontextualised 'checklist psychiatry' may lead health workers to devalue their own existing helping skills, and turn them into 'experts' who have become disconnected from the local epistemological worlds of the people they are trying to assist.<sup>7</sup> I can also relate to Varma's (2012) description of psychosocial counsellors: in Afghanistan, the nurses and midwives we trained in psychosocial helping skills, continued to ask about medication therapy, even when they are not legally allowed to prescribe them. However, my experience training hundreds of nurses and doctors in Afghanistan and Burundi is also that it is very possible to train evidence based methods in ways that build on what people know and do already, and to further strengthen their skills to genuinely assist those that are suffering. This requires a dialogical approach to training, using experiential role play and group work, and a willingness to foster collaborative learning.

Moreover, in some critics zeal to redress the inequities that have developed from the globalisation of mental health, they may take a step too far and tend to contrast

the badness of global mental health with good local healing practices, presented as near perfect solutions, in wonderful harmony with the social context. For example, Suman Fernando, a British academic psychologist from Sri Lankan origin, speaks about the under development of indigenous healing and medical systems from the Global South since colonial times, and proclaims ‘the need to *protect* the Global South from potentially damaging systems being pushed on it by business interests and other forces that may be called (broadly speaking) neo-colonialism’ (Fernando, 2014b, p. 150: emphasis added by PV). Similarly, Mills (2014, p. 78), views Western medicine as ‘elbowing out’ the indigenous system of medicine in India and thereby ‘maintaining its hegemony’.<sup>8</sup> In Tribe’s view, western mental health is undermining ‘the rich cultural mental health traditions and systems, which may also be the preferred choice of the population’ (Tribe, 2014, p. 261).

Behind such charges, I believe, is a romantic naiveté that seems based on the assumption that new ideas and views are imposed on helpless people who are incapable of resisting evil forces that impose mental health care that these unsuspecting people would rather not have (cf Miller, 2014). The philosopher Kwame Appiah writes in this regard about a ‘conservationist ethic’ rooted in ‘an image of how the world used to be – an image that is both unrealistic and unappealing’ (Appiah, 2006, p. 111). It is important not to see indigenous knowledge as artefacts or ‘things’ that must be preserved at all costs, like a variety of animal species or minerals supposed to be naturally present (Briggs & Sharp, 2004).

Surely, indigenous healing can be both very powerful and effective. Over the course of decades of work I have spoken with many healers and am often impressed by their wisdom and ingenuity. However, it must also be remembered that traditional healing is like any other form of healing and does not always work. Sometimes, traditional healing may amount to harmful practices that violate the patient’s human rights and need to be stopped. The anthropologist Mhina (2009, p. 155) describes how she was shocked to see mentally ill men tied up outside the home of a traditional healer in Tanzania. The families of the men told her that it did not really help the patients, but made the life of the family somewhat easier. Similarly, Read et al. (2009) documented how local traditional and religious healers in Ghana chain and abuse people with severe mental illness. The authors argue that often this is not a matter of bad intentions, but because people feel there are no other options available to calm a severely disturbed person.

Over the last decade, I have personally witnessed human rights violations by traditional healers. In Afghanistan for example, in the healing shrine of Samar Khel, (30 km from Jalalabad), men with psychotic symptoms were tied to a tree in the burning sun and given limited amounts of bread mixed with pepper and water. After forty days, they would be released with the result that some of them would be so exhausted that the arousal and behavioural excesses would have disappeared.<sup>9</sup> Sometimes, perhaps, but certainly not always... Several patients who had survived the healing from the shrine later received treatment by doctors trained in mental health by HealthNet TPO. To me, this was a significant achievement of the programme.

Acknowledging the role of culture and context does not, therefore, imply the rejection of what comes from outside.

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'We need to accept that in attempting to achieve universal health care, particularly in low-resource settings, there will be a natural tension between approaches which are exquisitely sensitive to local contexts, and the demands of patients, policy makers, and practitioners for pragmatic solutions for health problems which can be implemented at scale in routine health care settings. In every setting, a balance between these poles will need to be struck based on contextual factors.'

(Becker & Kleinman, 2014, p. 88)

### **Reflections on enhancing medical anthropological knowledge in global mental health**

My work for this thesis has included qualitative research, and as a result, my thinking has been profoundly influenced by medical anthropological literature. Furthermore, it is my belief that medical anthropology has a major role to play within global mental health.

One important contribution to that role are 'thick ethnographic descriptions' that contextualise and analyse mental distress in low income countries, including within complex humanitarian emergencies.<sup>10</sup> However, medical anthropologists have sometimes been criticised for not offering practical solutions. Whitley (2014, p. 506) argues that medical anthropologists can and should become catalysts for change on the ground and he suggests practical methods for doing so, such as engaging with policymakers and programme designers, working with community based organisations to lobby for change, and improving and expanding services through developing, evaluating, enhancing and scaling-up of interventions. In doing so, anthropology can contribute to unpacking reified notions of culture and tradition, and explore the wider social forces and contexts that impinge on and transform the lives of people for whom services are designed to help. Social scientists, including anthropologists, have a role to play to facilitate a two-way exchange of information in global health research and practice (Nichter, 2008).

It is my belief that medical anthropologists should not shun away from more practical engagements. Describing and analysing social relationships and drivers for behaviour can help in designing better programmes, finding solutions for practical problems and developing critical self-reflection among practitioners and researchers in global health (Abramowitz et al, 2015; Abramowitz & Kleinman, 2008; Hanna & Kleinman, 2013). Understanding of local perspectives and different types of knowledge is essential to ensure that policies in global (mental) health become contextually grounded and locally relevant.

## **Part two: Measuring Mental Health**

The second part of this thesis looked at mental health within complex humanitarian emergencies from a different angle: 'how can mental health problems within complex humanitarian emergencies be measured?' The primary concern was how the results of standardised psychiatric research instruments should be interpreted.

## Summaries of major findings

Chapter six ('Mental health problems following war and repression in eastern Afghanistan') is the report of a cross-sectional, multi-cluster sample survey conducted in the eastern province of Nangarhar among 1011 randomly selected adults, 15 months after the fall of the Taliban.

Doing epidemiological research in the fragile setting of early post war Afghanistan proved to be extremely challenging. For example, how to take a representative sample of the adult population of an entire province in the country, without reliable statistics, and where most of the population had been displaced at some time – and to do that while the security situation remained precarious?

We solved these issues by using inventive methodologies for sampling and logistics. For me, however, the true challenge lied elsewhere: the main instruments, the Harvard Trauma Questionnaire (HTQ) and the Hopkins Symptom Checklist-25 (HSCL-25) had been carefully translated, back-translated and pilot tested, but *not* clinically validated for use in this particular setting. Our request to conduct a cultural validation of the instruments before research began was not accepted by the funder, who was striving for results as quickly as possible. Using non-validated cut off points, the study found high symptom rates for depression (36.5%), anxiety (51.8%), and PTSD (20.4%), with a marked gender difference: odds ratio's for women compared to men were 7.3, 12.8, and 5.8 respectively. The results were published in the JAMA, a high-impact medical journal, and accompanied by a rather critical editorial that questioned whether the rates of our, and another mental health study in Afghanistan using similar methodology (Cardozo et al., 2004), could be interpreted as proxy for prevalence rates of mental disorder.<sup>41</sup> It is worth quoting from this editorial at length.

'The data may not be so useful for determining rates of mental illness and informing clinical or focused interventions. The screening tools used by both studies – the HSCL and HTQ – were not originally designed to distinguish between mental disorder and normal reactions to severe environmental stress. For example, most of the symptoms assessed in the HSCL (loss of appetite, feeling sad, difficulty sleeping, loss of interest and energy) might reasonably be expected in someone who has no income, is experiencing a breakdown of normal environmental and social supports, and has extreme uncertainty about the future. Similarly, the symptoms assessed by the HTQ (such as nightmares, feeling detached, jumpiness, irritability, and avoidance behavior) could also be expected in someone who is still living in a highly stressful and dangerous environment. With its recent history, continuing instability and unrest, and a devastating drought, Afghanistan is clearly a highly stressful and dangerous environment. Thus, interpretations of the results of these 2 studies must include consideration of whether symptoms reported among the Afghan respondents represent actual psychopathology or a normal response to severely abnormal circumstances.'

(Bolton & Betancourt, 2004, p. 627)

This critique was fundamental but fair, and not unexpected. In fact, the authors of the other Afghan study already gave a veiled reference to this issue in their search for

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an explanation as to why their study did not find a significant association between trauma events and symptoms of PTSD.

**'Extreme poverty and concerns for day-to-day survival caused by economic hardship commonly causes stress. In Afghanistan, socioeconomic factors may have been more important risk factors than traumatic events for PTSD.'**

(Cardozo et al., 2004, p. 583)

The critique of Bolton and Betancourt resonated strongly with one of the main lessons Afghanistan taught me: 'Do not underestimate the suffering of the Afghans, and do not overestimate their psychopathology'. So, when the opportunity arose to do a clinical validation study, I grabbed it with both hands.

The results of that opportune study are presented in Chapter seven ('Properties of the Hopkins Symptom Checklist-25 (HSCL-25) and the Self Reporting Questionnaire (SRQ-20) as screening instruments used in primary care in Afghanistan'). We looked at the HSCL-25 and the SRQ-20 – an instrument that had been developed by the World Health Organization as a case finding instrument for detecting common mental disorders in research and clinical practice. Compared with the results of a structured psychiatric interview, both questionnaires had rather modest properties to correctly identify mental disorders (AUC of 0.73 and 0.72, respectively). The study results shed new light on the results of earlier studies in Afghanistan with the HSCL-25, and we concluded that these may have overestimated the prevalence of mental disorders among women and underestimated the prevalence in men.

The limited validity of the HSCL-25 among Afghans was later confirmed in research among Afghan refugees in Japan (Ichikawa et al., 2006). An important finding of our study was that the optimal cut-off points of the questionnaires were different for women than for men. A gender variance in using the SRQ-20 was later also found in a study that compared the SRQ-20 with a locally developed measure for psychological distress, the Afghan Symptom Checklist (ASCL): while the ASCL and SRQ-20 had substantial overlap in construct and external validity, the ASCL captured more variance for women, but not for men (Rasmussen et al., 2014).

Chapter eight ('Validation of the Kirundi versions of brief self-rating scales for common mental disorders among children in Burundi') is another study exploring the psychometric properties of self report scales for mental disorders, this time for children in Burundi. This research was done within the context of a multi-layered MHPSS programme for war affected children in the country (Jordans, Tol, Susanty, et al., 2013). We developed and validated a screening tool to identify 'children in distress' (Jordans et al., 2008). This brief instrument of seven items, the Child Psychosocial Distress Screener (CPDS), was meant to measure non specific child psychosocial distress, with the goal of detecting children with an indication for treatment. The screener seemed to pick the right children, because it accurately identified indication for treatment (AUC: 0.81). We also wanted to know whether it would be possible to detect children with specific mental disorders who may benefit from individual treat-

ment. For that goal, we conducted a validation exercise, by comparing three brief symptom based questionnaires for depression, anxiety and PTSD in children with the outcomes of a structured child psychiatric interview using the K-SADS-PL. We concluded that the Depression Self-Rating Scale (DSRS) and Child PTSD Symptom Scale (CPSS) had good utility in detecting depressive disorder and PTSD, respectively, in Burundian children. However, cut-off points were assigned considerably higher than in western norm populations. The results utilising SCARED-41 to identify anxiety disorders were less encouraging (AUC: 0.69). The relatively weak performance of the SCARED-41 could be caused by the fact that it covers various categories of anxiety disorders, with perhaps limited construct validity. We also hypothesised that screening instruments that mirror the diagnostic criteria of a specific disorder closely against which they are validated will perform better in singling out that disorder. While instruments that are meant to identify a broad range of disorders will be less able to discriminate between disorders and more often measure non disorder, specific distress. Another issue has to do with language. The Kirundi language has quite a complicated pattern for expressing being emotionally unwell, and particular words that may be distinguished in standard English (such as anxiety, fear and panic), are not easily differentiated in Kirundi (cf Bagilishya, 2000). Moreover, the SCARED-41 may have captured more ‘non specific distress’ that is not necessarily indicative of mental disorder. As also seen in Afghanistan, levels of such ‘non pathological’ distress are high in complex humanitarian emergencies, where everyday violence is rampant and people experience chronic adversity.

## Discussion

### EMOTIONAL WORLDS OF AFGHAN MEN AND WOMEN

In Afghanistan, as in many other settings in the world, expressions of psychological distress do not necessarily present themselves as a psychological idiom (Fish & Popal, 2003). For example, Bizouerne (2008) who did research among lactating women in Kabul in the early post Taliban years, found that ‘not having enough milk’ was often a way for mothers to express psychological distress in an acceptable way, and that it was often related to symptoms of maternal depression. Tankink and Vysma (2005) related the abundance of pseudo-seizures among women in Nangarhar that, while often (nominally) attributed to *djinn* (evil spirits, also called *perian* in Pashto), were generally associated with family violence – and as such were clear ‘idioms of distress’.

Afghan men and women vary greatly from each other in the way they express emotional wellbeing and distress. In order to understand this, we need to look deeper into the gendered social world of Afghanistan. The main qualities for Afghan women are ‘acceptance, suffering and patience’ (Billaud, 2015, p. 201). Values enshrined in Islam and tribal customs provide a context in which women, who otherwise have limited space or agency in the public sphere, can openly and relatively easily express their hardships and emotional pain. Ethnographic work among the Pashtun in Pakistans’ North-West Frontier Province showed that cultural norms encourage women to publicly express sorrow and grief through story telling and lamenting (*cham-khadi*)

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(Grima, 1993). Women gain status and recognition within their female peer group by expressing their suffering, which is regarded the predicament of women (Grima, 1991).<sup>12</sup>

Similarly, rural Pashtun women in Afghanistan have a culture of ‘storytelling centred around illness and suffering, of shrine visitations and dependence on *ta’wiz*,<sup>13</sup> and of alternative healing methods associated with religious beliefs’ (Grima, 2002, p. 39). Being publicly sad is not necessarily something shameful for an Afghan woman and may, in fact, be the only way to mobilise social support and gain access to outside resources.

For men, it is quite the opposite. They are expected to stay outwardly indifferent to their ills. For Pashtun men, a public display of emotions such as sadness, fear, jealousy or tenderness, is considered to be a sign of weakness and demonstrates a pitiable lack of self-control (Glatzer, 1998a; Lindholm, 1988, p. 233). This does, of course, not imply that Pashtun men do not feel such emotions, but simply that any outward expression would be restrained (Lindholm, 1982, pp. 191-192). Perhaps the values ascribed to holding emotions inside and denying their existence to outside world is in order to avoid humiliation and shame, and are best illustrated by the following lines of Kushal Khattak, the great 17<sup>th</sup> century Pashtun warrior-poet.

**‘If it is your hope never to be shamed before anyone.  
It is best to keep in your heart even the least affair...  
Let your heart bleed within itself, if bleed it must.  
But keep your secrets well concealed from enemy and friend.’  
Kushal Khattak, cited in Kleinman (2004)**

Apart from these gender-specific attitudes towards expressions of emotional distress, Afghans also have a rich vocabulary of cultural idioms to express that they feel unwell. The group around psychologist Ken Miller and anthropologist Patricia Omidian has done important work in this regard. Based on rapid ethnographic methodology, they identified various idioms among Afghans in Kabul, such as *jigar khun* (literally ‘bloody liver’, which occurs in the wake of strongly painful event in a person’s life, or after chronic stress), *asabi* (‘being nervous’) and *fishar*, an internal state of emotional pressure and/or agitation, or conversely, of very low energy and motivation (Miller et al., 2006; Omidian & Miller, 2006).<sup>14</sup>

These findings from Kabul, among Dari speakers, has some overlap with what I found in Nangarhar. In August and September 2002, my first months in the country, my Afghan colleague Dr. Hafizullah Faiz and I, explored local categories of mental illness among community members in villages around Jalalabad. We used rapid qualitative techniques such as ‘focus groups discussions’ and ‘card sorting’ (Bolton, 2001b; Bolton & Tang, 2004). The most salient idioms were: 1) *khapgan*, which literally means sadness or sorrow, but, particularly if preceded by an adjective such as ‘*seer*’ (very) then refers to a person who has ‘deep sadness’ and who always thinks about the bad in life, worries a lot, isolates him or herself, does not eat properly, and cannot sleep well,<sup>15</sup> somatic features as ‘constriction of the chest’, *jegar khonee* (bloody liver), ‘heaviness’ and stomach problems; 2) *Waswasi*, which is charac-

terised by constant worry, thinking a lot, social isolation and repetitive actions; 3) *Wahmi*, which is an unreasonable fear, easily being frightened and frightening dreams; and 4) the more elusive idiom of *peyran*<sup>16</sup> (“being possessed by spirits”) that is characterised by pseudo seizures and could be accompanied by a variety of different somatic complaints.

The presence of these idioms of distress does not imply that the symptoms of PTSD or depression was not found. On the contrary, Miller and Omidian found that symptoms of PTSD were as prevalent as in research from Nangarhar. They too found that having experienced traumatic events did not correlate any stronger with PTSD than with depression, anxiety or general distress, as measured by the Afghan Symptom Checklist, the locally constructed questionnaire that captured Afghan idioms of distress. More importantly, it was found that having PTSD symptoms did not impair social functioning, while having depressive symptoms clearly did so (Miller et al., 2008). The stressful conditions of everyday life in Kabul explained a great deal of the variance in the quality of mental health and psychosocial functioning. Miller et al (2009, p. 233) conclude, therefore, that PTSD had limited clinical utility in Afghanistan, while, in contrast, depression was a much more useful construct for the people of Kabul: ‘what is most salient for Afghans is the profound sadness resulting from experiences of violence, destruction and loss’. This corresponds quite closely with my experience in Nangarhar. During dozens of trainings of health workers and workshops for community members, I found it hard to explain what PTSD was: Afghans did not have a word for it and did not seem to recognise the symptoms of PTSD as belonging together. Depression, on the contrary, was easy to explain as people could relate to it and immediately had words and idioms that they could use, and knew people who suffered from it.

### THE SOCIAL LIVES OF AN EPIDEMIOLOGICAL SURVEY

The Afghan studies presented in section two leave me with a general feeling of discomfort related to the issue of how to distinguish ‘non-disordered distress’ from mental disorder. To be fair, the study of Scholte et al. carefully avoided talking about prevalence of mental disorder, but instead used terms such as ‘symptom scores’ and ‘rates of symptoms’. However, that sort of nuance was often lost: the findings of the papers published in the JAMA (Cardozo et al., 2004; Rasekh et al., 1998; Scholte et al., 2004) were frequently used in the media to make the point that the majority of the Afghan population suffered from mental disorders (Badkhen, 2012). This not only happened in the popular media,<sup>17</sup> but also in publications such as the Lancet and from the World Bank (Ahmad, 2004; Sayed, 2011). Similarly, policy makers, including various Afghan ministers of public health, have cited these and other studies while stating that the majority of the Afghan population suffers from a mental disorder.<sup>18</sup> The effects of declaring most Afghans mentally ill has certainly contributed to giving more attention to mental health among policy makers and has highlighted the urgent need for something to be done in order to strengthen mental health services. In December 2004, a few months after the JAMA studies were published, the new Afghan Minister of Public Health declared in his first policy announcement that mental health issues were his third highest priority to address in the next five years (Fatimie, 2004).

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Of course, it remains unclear whether the Afghan minister really needed these data to make mental health a priority. Whatever the case, the interest of financial donors to invest in Afghan mental health has increased over the years, as described in section three of this thesis.

### **Reflections on enhancing epidemiology in global mental health**

The discussion of the results of the epidemiological survey in Afghanistan and issues around validation in Afghanistan and Burundi raises two issues that I believe require further exploration for the future:

- 1 how to take local views more seriously in psychiatric epidemiology; and
- 2 how to differentiate distress from disorder.

#### **TAKING LOCAL VIEWS SERIOUSLY IN MEASUREMENT**

In many ways, our survey in Nangarhar was an example of ‘conventional psychiatric epidemiology’ within post conflict settings. This approach is characterised by estimating the prevalence of symptoms of mental disorders in such a way that is similar to how to measure the prevalence of infectious disorders: using standardised instruments to detect the presence or absence of the disease using a marker. In the case of malaria, the marker is the presence of infected cells in a blood sample. In the cases of depression and PTSD, it is an elevated score on a questionnaire, devoid of context and meaning. I have come to believe that this is a fundamentally flawed way of measuring mental illness as it ignores interaction symptoms within their social ecology. Instead, we need a transition from disorder oriented ‘psychiatric epidemiology’ to ‘mental health epidemiology’ (Tol, Rees, et al., 2013), which would bring an end to being mesmerised by identifying ‘cases’ who have a mental disorder, and help the field move on to a conceptualisation of common mental disorders as dimensional, not categorical, constructs. This implies that the focus of attention should move to identification of risk and protective factors that affect mental health rather than a simple assessment of the prevalence rates of disorders (Reed et al., 2012). It is, moreover, important to realise that people interact in a variety of ways to similar contextual variables, and consequently, may show varying discrete patterns of symptom trajectories (Betancourt et al., 2013; Hobfoll & de Jong, 2014).

Such considerations make the important point that research instruments to measure mental health conditions go beyond the symptoms of DSM-psychiatry and should include the following:

- *Locally salient idiomatic expressions of emotional distress.* In various complex humanitarian emergencies, as well as other settings of structural adversity, scales that include specific idioms of distress have been developed, such as the Acholi Psychosocial Assessment Instrument in Northern Uganda (Betancourt, Bass, et al., 2009), the Afghan Symptom Checklist in Afghanistan (Miller et al., 2006), the Aga Khan University Anxiety and Depression Scale in Pakistan (Ali et al., 1998), the Cambodian Somatic Symptom and Syndrome Inventory for Cambodian refugees (Hinton et al., 2013), the Kreyòl Distress Idioms screener in Haiti (Kaiser, Kohrt, et al., 2015; Weaver & Kaiser, 2015), the Shona Symptom Questionnaire in Zimbabwe (Patel,

Simunyu, et al., 1997), the Thinking A Lot Questionnaire for Cambodian refugees (Hinton et al., 2015), and the Zanmi Lasante Depression Symptom Inventory in Haiti (Rasmussen et al., 2015).

- *Measurements for life events and adversity in both past and present.* In order to correct the pre-occupation of researchers of attributing current distress to past adverse events, it will be important to include comprehensive measurements of actual stressors. One example of such a tool is the Humanitarian Emergency Settings Perceived Needs (HESPER) Scale (Semrau et al., 2012).
- *Measurements for social functioning.* A major shortcoming of our Afghan survey was that it did not include a scale for functional impairment, such as the WHO Disability Assessment Schedule, which has been used for cross-cultural comparison of psychiatric disability after extensive field trials and studies in dozens of countries (World Health Organization, 1988). It is important to differentiate distress from disorder. As such, measures need to be adapted for the context or newly constructed, as has been done for various complex humanitarian emergencies (Bolton et al., 2007; Bolton & Tang, 2002; Tol, Komproe, et al., 2011; Verduin, Scholte, et al., 2014).
- *Social connectedness and social inclusion.* Measuring the quality and quantity of social networks between people may be helpful in the search to answer why some people fare better in the face of adversity than others. Instruments to measure social capital have been used in this regard (Verduin, Smid, et al., 2014), as well as instruments to measure ‘social inclusion’ or ‘social/community integration’ (Baumgartner & Burns, 2014).<sup>19</sup>
- *Resilience.* The concept of ‘resilience’ has gained considerable attention over the last decade to explain why some people do reasonably well in the face of adversity, while others do not. (Betancourt & Khan, 2008). Ungar (2012) and Rutter (2012) emphasise that resilience is not a characteristic or trait that an individual possesses, but it is a *process* that the social environment (families, schools, and communities) can facilitate or undermine. Measuring resilience should involve measuring at least three capacities: i) the capacity of individuals to navigate their way to resources that sustain wellbeing; ii) the capacity of biosocial ecologies to provide these resources; and iii) the capacity of individuals, families and communities to arrange or negotiate contextually relevant ways for these resources to be shared (Ungar, 2008). Resilience, as a dynamic and contextual concept, has important heuristic value in the study of people affected by armed violence and structural adversity and should be studied more comprehensively (Hobfoll & de Jong, 2014; Panter-Brick & Leckman, 2013; Tol, Jordans, et al., 2013).

There are various protocols for local development of cultural and contextual adaptation (Bolton & Tang, 2004; Flaherty et al., 1988; Kaiser, 2013; van Ommeren et al., 1999). Common elements to these protocols are: i) rapid ethnographic methods to identify relevant local categories; ii) thorough linguistic checks to ensure that meaning of local concepts is well captured; and iii) systematic participatory field testing with opportunities for participants and interviewers to provide feedback. An obvious problem with locally developed instruments is, however, that the results are difficult to compare with results outside that setting, limiting the overall utility (Rasmussen et al., 2014).

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## **DISTINGUISHING DISTRESS FROM DISORDER**

Epidemiological studies in complex humanitarian emergencies using brief self report questionnaires, particularly if not contextually validated, yield highly inflated estimations of the prevalence of mental disorder. This is not only the case in Afghanistan. In other settings this has happened as well, for example, in early post war Sierra Leone a survey with the HTQ estimated that up to 99% of the population was suffering from PTSD (de Jong et al., 2000). Such inflated and incredible figures fuelled criticism and led to a vigorous and emotionally charged debate between proponents and critics of trauma focused programmes in humanitarian settings (de Vries 1998; Derluyn et al., 2004; McKay & Wessells, 2004; Summerfield, 1997; Summerfield, 2001). This debate has withered away somewhat, in part due to the newly found consensus in the field due to the IASC guidelines, as fragile as that consensus may be.

In general, surveys with more comprehensive instruments yield lower rates of mental disorder. Examples of such comprehensive instruments are the clinician administered Structured Clinical Interview for DSM disorders (SCID), or the K-SADS-PL that we used in our Burundi validation study. This also includes comprehensive lay administered instruments using diagnostic criteria, such as the Composite International Diagnostic Interview that was used in the World Mental Health Surveys (Kessler et al., 2013). Probably these comprehensive instruments arrive at lower prevalence rates for mental disorder, because they are able to eliminate a considerable amount of 'non disordered distress' (Rodin & van Ommeren, 2009; Steel et al., 2009). An essential feature of clinician rating scales, such as the K-SADS-PL that we used in Burundi in the research described in chapter eight, is that these require the user to evaluate the symptoms in their context, and only score a symptom when it is clinically relevant to the problem. Brief self-report measures usually score symptoms devoid of context, and may attribute symptoms to PTSD while actually measuring general psychological distress, coping style or illness behaviour. For example, the HSCL-25 and HTQ contain questions about problems with sleeping. In our research work in Afghanistan we regularly encountered women who answered affirmative on such questions, while some exploration revealed that the problems were, for example, related to a sick baby who had kept her awake, or very real worry about the financial situation of the family. The HSCL-25 ignores these contextual factors and scores the person as positive on the symptom of insomnia. This is, of course, not a new finding. Ethnographic research with scales such as the HSCL-25 and the HTQ have repeatedly revealed serious discrepancies between the outcomes of brief symptom rating scales and the lived experience of people (Jones & Kafetsios, 2002; Tankink, 2009).

When current life needs are also measured, a different picture emerges, for Afghanistan this was made clear by the work of Miller et al. (2008), who made scientifically credible what clinicians in Afghanistan already knew: that a substantial part of any current psychological distress should be attributed to stress related to the current life situation. In the academic literature around complex humanitarian emergencies this insight has relatively recently gained more interest (Miller & Rasmussen, 2016). Yet again, this insight is not new. Fifteen year ago de Jong et al. (2001) documented how, in complex humanitarian emergencies such as Algeria, Gaza and

Cambodia, current contextual factors such as poor living conditions, daily hassles, youth domestic stress, etc. contributed to PTSD symptoms. The moderating effect of current life stress on mental disorder has been found in various other complex humanitarian settings, including South Sudan (Ayazi et al., 2015) and refugee camps in Jordan (Jordans, Semrau, et al., 2012) and Bangladesh (Riley et al., in review).<sup>20</sup>

Some methodological problems related to the ‘naive application of unvalidated checklists’ (Summerfield, 1998, p. 1581) can be ‘fixed’ by using smarter checklists. A much more fundamental problem is less easily fixed: to what extent does a psychiatric diagnosis contribute to the medicalisation of distress? In a classic paper, Arthur and Joan Kleinman analyse, with some concern, how the mental health discourse may transform human suffering into mental disorders: ‘The professionalization of human problems as psychiatric disorders [...] causes sufferers and their communities to lose a world, the local context that organizes experiences through the moral re-sounding and reinforcing of popular cultural categories about what life means and what is at stake in living’ (Kleinman & Kleinman, 1991). A useful concept in this regard is ‘social suffering’, which attempts to capture personal distress as embedded in societal problems, and thus explicitly linking individual suffering and pain with larger processes of political, economic and institutional power (Kleinman et al., 1997). Social suffering therefore refers to *intersubjective* experiences, embedded in ‘interconnected adversities on the level of individual, family, community and society’ (Morgan & Kleinman, 2010, p. 61). The concept of social suffering has been embraced by medical anthropologists as a useful way to understand how suffering of individuals can be ‘caused and conditioned by society’ (Wilkinson & Kleinman, 2016, p. 14) but among general health professionals this concept is not well known. This is unfortunate because the transformation of social suffering into mental illness is engrained in the psychiatric enterprise and mental health professionals should more critically reflect on their own practices. ‘Stressful social arrangements’ (Horwitz 2002, p. 220) can have psychological consequences such as hopelessness, helplessness, disinterest, sleep problems, fatigue, etc. that correlate highly with symptoms of mental disorders. This constitutes a fundamental problem for the mental health professions. Vikram Patel, one of the most eminent and eloquent spokespersons of the global mental health movement, realised this problem when he, somewhat provocatively and in contrast with some of his other publications,<sup>21</sup> writes that the use of prevalence estimates as generated by epidemiological surveys are not a credible source of evidence to determine the ‘treatment gap’, because many of the professional categories as used by psychiatry do not correspond with the lived experience of people residing within diverse cultural settings in low and middle income countries: ‘Only a small fraction of the global population truly believes any of the astonishingly large figures that these surveys throw up. Those figures simply lack face validity because they conflate emotional distress with mental disorders that need specific biomedical interventions’ (Patel, 2014, p. 18). In a reaction, another global leader in mental health, Derrick Silove, remarks that we do not yet have the tools, either clinical nor scientific, to distinguish clearly between disorder and distress in mental health (Silove, 2015, pp. 107-108). Here we touch upon a fundamental challenge for global mental health, and I personally agree with Arthur Kleinman who marks the

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differentiation between social suffering and mental health problems (or psychiatric conditions) as one of the key issues to be explored by medical anthropologists in the period to come (Kleinman, 2012a).

### **Part three: making systems work**

#### **Summaries of major findings**

The central question in the third section was: ‘how to develop functional systems to address mental health and psychosocial problems within complex humanitarian emergencies?’ In order to do this, projects of HealthNet TPO in Afghanistan and Burundi were analysed and presented, followed by a literature review on the integration of mental health into general health care in low resource settings.

Chapter nine (‘Improving access to mental health care and psychosocial support within a fragile context: a case study from Afghanistan’) is a longitudinal overview of the mental health programme in Nangarhar province in Eastern Afghanistan. The programme aimed to introduce essential mental health aspects into the general health care system. Health care staff at all levels of the health system were trained in identification and management of priority mental health conditions. The chapter follows the developments in six rural districts (the ‘Shinwar cluster’) where the programme started and that form the heartland of the health system strengthening activities of HealthNet TPO in Afghanistan. Later, the programme expanded to cover the whole province (Ventevogel, Faiz, et al., 2011). In the early years of the Afghan reconstruction, the Nangarhar programme was unique because it was done in a rural area, in a time that few MHPSS programmes were set up in Kabul, but virtually nothing was being implemented to improve mental health in rural areas where most Afghans live. Later, many more organisations started mental health activities, particularly when mental health became a regular part of the Basic Package of Health Services.<sup>22</sup> However, this has been far from a straightforward path because of the constant deterioration of humanitarian space in the country due to increasing security risks.<sup>23</sup>

Chapter ten (‘Psychosocial assistance and decentralized mental health care in post-conflict Burundi 2000 – 2008’) described the development of mental health and psychosocial support services in a rapidly changing context, from active violent conflict to reconstruction. Over eight years, NGO activities shifted from direct service delivery to capacity building activities aimed at embedding psychiatric services and psychosocial assistance within existing local health services and social systems. In doing so, the NGO was entering untrodden domains as the country had never had any services for mental health or psychosocial support, with the exception of the psychiatric hospital in the capital Bujumbura.<sup>24</sup>

Chapter eleven (‘Integration of mental health into primary healthcare in low-income countries: Avoiding medicalization’) was a literature review around the integration of

mental health into non specialised (e.g. primary) health care. The paper was written with a critical view on the undesired side effect of such integration: namely the medicalisation of distress when using a narrow biomedical approach. The paper did not discuss a specific country, but many of the findings corroborated what we have seen in chapters nine and ten.

The project in Burundi was different from the project in Afghanistan. One reason was that this programme started as a community based psychosocial programme with limited links to the health care system, while the project in Afghanistan had started as a health care programme with limited links to community based work. Nevertheless some of the key issues learned were similar, particularly that installing basic mental health within general health care should be connected to community based activities, and be firmly rooted in a general health-system-strengthening approach.

## Discussion

The programmes in Afghanistan and in Burundi, described in chapters eight and nine, were both set up as comprehensive programmes, in which attention for service delivery was paired with capacity building of existing actors. These programmes were atypical for MHPSS programmes in humanitarian emergencies due to the long duration and because they were not classical, stand alone interventions with service delivery done by NGOs, in isolation of the government and other actors. A situation still true today.

However, global mental health is coming of age and this has increased attention to the development of a more systematic approach that includes mental health within health systems building (Minas, 2012; Semrau et al., 2015). This turn towards systems building in global mental health has only just begun and there is still a long road ahead. Too often mental health is left out of health policy development, and global mental health research focuses too narrowly on the efficacy of treatment modalities within a specific context, without looking how this can be brought to scale and implemented within real life health care systems (Betancourt & Chambers, 2016; Murray, Tol, et al., 2014; Ventevogel & Spiegel, 2015).

While many of these challenges will arise working in any low income country, health programming within a complex humanitarian emergency or fragile state faces additional, and severe challenges related to: i) an extreme lack of infrastructure for delivering health services because of destruction or neglect of the previously existing structures; ii) inadequate capacity building mechanisms and systems, including certified clinical training programmes; iii) insufficient coordination and monitoring of health services by the emerging health authorities; iv) a lack of equity in health service delivery, with some groups, such as those in remote areas, minority groups and the poor being totally deprived of services; v) a lack of policy mechanisms for developing and implementing national health policies; vi) non-operational health information systems; and vii) inadequate management capacity and systems (Bornemisza et al., 2010; Newbrander et al., 2011; Witter, 2012).

Afghanistan and Burundi are typical examples of situations where the initial humanitarian response, with a primary emphasis on service delivery, had to be trans-

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formed into an approach towards the development of nation wide sustainable services with a stewarding role for the government. Therefore, approaches to health systems strengthening should go hand in hand with in activities to provide quick and tangible results to the population. Health system strengthening can thus be seen as part of larger efforts for state building, aiming to reconstruct the legitimacy of the government and rebuild effectiveness of core services (Philips & Derderian, 2015).

This section will comment on the programmes described in chapter nine and ten, using the Health Systems Strengthening (HSS) framework (World Health Organization, 2007a). Based on the six pillars of the HSS framework, achievements and challenges encountered in Afghanistan and Burundi will be discussed and situated within the wider context of global mental health programming.

### **PILLAR 1. SERVICE DELIVERY**

**‘Good health services are those which deliver effective, safe, quality personal and non-personal health interventions to those that need them, when and where needed, with minimum waste of resources’.**

(World Health Organization, 2007a, p. 14)

#### ***Afghanistan***

Service utilisation for mental health increased significantly in the project area, from less than 0.5% of all consultation in the health care system to around 5% (which means that one in twenty consultations in primary health care was related to a mental health issue). Most of these consultations (83.2%) were for depression and anxiety complaints. The retention of people with common mental disorders was not high, with around, 2.0 annual visits, while those with severe mental disorders or epilepsy had 3.9 and 3.3 annual visits respectively. Once integrated mental health services were made available, they were well utilised by the population. This was not only the case for the ‘Shinwar cluster’ that was described in chapter nine, but also in other districts in Nangarhar province, and in six other provinces where the programme was rolled out (Le Roy, 2008).<sup>26</sup> Specificity to the Afghan context is that the delivery of health care services was contracted out to NGOs (Palmer et al., 2006), which meant that HealthNet TPO was managing the whole health care system in Nangarhar on the government’s behalf. This made the addition of mental health into the general health care system logistically much easier.

HealthNet TPO also established mental health units in the district hospitals (staffed by a doctor with a few months advanced training in Peshawar, Pakistan), and later established a psychiatric unit in the provincial hospital of Jalalabad that served as referral centre for short clinical inpatient hospitalisation and acute stabilisation. Prior to that time, the secondary mental health system in Afghanistan was limited to one 60-bed national mental hospital in Kabul and some psychiatric wards in provincial hospitals (World Health Organization, 2006). The development of community based psychosocial services was initially part of the mental health care programme, but was later separated and developed into a broader community systems strengthening, focusing not on ‘psychopathology’, but addressing social determinants of

(mental) health particularly related to gender and domestic violence (van Mierlo, 2012). The activities included participative mapping of local resources, promoting support networks between various local stakeholders, and assisting communities to develop joint activity plans to improve wellbeing. Moreover, such activities reinforced referral pathways between the community and the health facilities.

### **Burundi**

In Burundi service delivery started when the war was still raging in parts of the country and focused on psychiatric services delivery through mobile mental health clinics in the provincial hospitals. Over the years, these services were anchored in the provincial and district hospitals. The model was different from that in Afghanistan because there was reluctance from the government to integrate mental health in primary care. Once established, mainly people with severe mental disorders and epilepsy came forward for treatment by the psychiatric programme, while many others with mild mental disorders were seen by trained and supervised psychosocial workers outside of the health care system.

### **Discussion**

A major lesson learned was that the integration of mental health into primary care must be supported by a thorough involvement of the community and by support from the secondary level. It is important to see community health workers as part of a team and actively involve them in case finding (Jordans et al., 2015).

In both settings it proved difficult to foster smooth cooperation between different disciplines (doctors, nurses, psychosocial workers and community health workers). Teamwork, and the coordination of ‘who does what’ is a key challenge in the development of integrated mental health services in low resource settings. A recent systematic review identified the availability of a ‘case manager’<sup>27</sup> as the most crucial element in establishing collaborative, stepped care models in which trained non specialists perform mental health tasks (Shidhaye et al., 2015). In Afghanistan, there was no functionary with such a role. However, research in other parts of Afghanistan found that an added psychosocial counsellor was able to play that role (Ayoughi et al., 2012). This innovation was accepted into the Basic Package of Health Services (BPHS), and as far as I know, Afghanistan is now the only resource poor country where a psychosocial counsellor is formally included with a standardised function in the basic health centre. There are, however, still serious concerns about sustainability, which have been raised in various platforms (Mental Health in Fragile States, 2009; Sayed, 2011). In Burundi, the community based psychosocial worker fulfilled the role of case manager for a great part, being a mediator between the client and the services provision in the hospital and elsewhere. This staff could not be sustained when the services were transferred to the government.

Within global mental health ‘task-sharing’ has been hailed as an essential part of the solution, but the evidence base for task-sharing interventions for mental health in real life settings (outside small pilot projects) is still modest (Lund et al., 2015). In reality, it proves to be very hard to ensure that task-shifting approaches improve mental health service delivery for a wide variety of reasons, including: problems with



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staff retention, motivation, and difficulties in transforming newly acquired knowledge into clinical practice. Also, the results of classroom based trainings of primary care workers alone is often disappointing (Baingana & Onyango Mangen, 2011; Budosan & Bruno, 2011; Gureje et al., 2015; Siriwardhana et al., 2016). It becomes increasingly clear that this approach will fail if task-sharing is not accompanied by substantial on the job support and supervision for non specialists who have to do the work (Agyapong, Osei, Farren, et al., 2015; Agyapong, Osei, Mcloughlin, et al., 2015; Atif et al., 2016; Budosan & Jones, 2009; Legha et al., 2015; McLean et al., 2015; Mendenhall et al., 2014; Padmanathan & De Silva, 2013; Rose et al., 2011). Evidence becomes stronger when examining the best-established delivery model, which consists of a team approach in which a non specialist case manager coordinates care with primary care physicians and specialists (Patel & Chatterji, 2015).

Many of the issues described above are not specific to any one complex humanitarian emergency, it is simply that in such settings problems with services delivery are usually more pronounced and severe (van de Put & van der Veer, 2005). There is a tendency for humanitarian organisations to focus exclusively on responding rapidly to urgent health needs of the most vulnerable, while ignoring the longer term aspirations of improving existing health systems (Philips & Derderian, 2015; Sondorp et al., 2001). We also need to keep in mind that service delivery is only one of six pillars.

## **PILLAR 2. CAPACITY BUILDING AND WORKFORCE DEVELOPMENT**

**'A well-performing health workforce is one that works in ways that are responsive, fair and efficient to achieve the best health outcomes possible, given available resources and circumstances (i.e. there are sufficient staff, fairly distributed; they are competent, responsive and productive' (World Health Organization, 2007a, p. 16).**

### ***Afghanistan***

Mental health professionals working in Afghanistan were always extremely rare, and in the few cases they did exist, they were confined to large urban areas. In 2002, the country had precisely two qualified Afghan psychiatrists, one working with the World Health Organization and the other as Minister of Higher Education. About 60 doctors worked within various mental healthcare facilities, but their training varied from almost nothing to some in-service training, or short courses in institutes abroad (Ventevogel et al., 2002). In 1999, a three-month diploma course was held in northern Afghanistan to train 20 doctors in psychiatry (Mohit et al., 1999), but this initiative could not be followed up due to erupting violence. Afghanistan had (and has) no training for psychiatric nurses or social workers in mental health (World Health Organization, 2006). The choice to train existing health workers to enable them to identify and manage the most important mental health conditions was, therefore, a logical one in terms of human resources. However, when we started in 2002, the standardised clinical manuals of the WHO (World Health Organization, 2010; World Health Organization & United Nations High Commissioner for Refugees, 2015) had not yet been developed. There were various other materials available (World Health Organization, 2000; World Health Organization & United Nations High Commissioner for Refugees, 1996), but these were not specifically tailored to training physicians

and nurses within primary health care in low and middle income countries. So, we had to develop our own materials (Ventevogel & Kortmann, 2004). These were less comprehensive than the (later) WHO mhGAP materials, but contained similar priority conditions: common mental disorders (which included depressive and anxiety disorders), severe mental disorders (such as psychosis), and epilepsy. The Nangarhar materials were later accepted for standardised use by the Afghan Ministry of Public Health and the United States Agency for International Development (USAID) (Health-Net TPO and Ministry of Health, 2005) and remained in use till the MoPH developed their own new materials (Ministry of Public Health, 2009c).

The main element in capacity building in Afghanistan was the use of a key group of trainers proficient in mental health who could subsequently serve to transfer knowledge directly to basic health care providers and community health workers. It proved to be feasible with a very limited number of specialised mental health professionals providing basic training in mental health to hundreds of general health workers.<sup>28</sup> However, a major challenge remained in terms of the organisation of clinical, on the job supervision. The trainers were unable to visit the health centres frequently, due not only to travel time (up to six hours to the remote areas) and but increasingly, security issues.

### *Burundi*

In the Burundi programme, initially much attention was given to developing internal resource capacity without real attempts to integrate the workforce into formalised systems. Burundi had, and still has no training for psychiatric nurses or psychiatric social workers (Spitzer et al., 2014; World Health Organization, 2007b). Only in later phases of the programme did capacity building of existing health workers and social workers become a key element, with the NGO and government creating a formal training manual for health workers (Ministère de la Santé Publique, 2007). In eleven provincial hospitals the government appointed four general nurses to become focal persons for mental health care delivery. The backbone of the MHPSS programme in Burundi was, however, the community based psychosocial worker, salaried by the project and with a range of helping skills. It proved to be difficult to integrate this type of worker within existing formal (government) human resources systems, as was the case of the same NGO in other countries, such as Uganda (Baron, 2002). The approach to diminish the reliance on professional psychosocial workers by training individual volunteers proved to be unsustainable. However, using the approach of building capacity of existing community based organisations appears to be a more viable alternative.

### *Discussion*

It is obvious that countries like Afghanistan and Burundi will not, any time soon, have enough specialised mental health care workers to cater for the needs of the population. So, as yet, there is no alternative to task-sharing within a system of collaborative care, as described above. This will require a consistent and continuous investment in human resources development (Raja et al., 2014), something not easily accomplished. In low resource settings, the turn over of staff is high, and for that

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reason alone an ongoing series of trainings is required. However, this is often difficult to realise due to decreased prioritisation among policy makers who would like to see on-off trainings to ‘tick the box’ and then shift attention to new topics. Another thorny issue, not only in Afghanistan and Burundi, is clinical supervision. This should be seen as an essential part of a continuous process of training, but is often difficult to implement due to shortage of staff who can supervise and the multitudes of logistical systems (Legha et al., 2015). One potential solution is to have non specialists ‘supervise’ each other, which has been successfully tested in various settings, such as in Nigeria, where non specialist physicians and senior nurses were found to be able to adequately provide training and supervision in mental health to other health workers (Gureje et al., 2015), and in India and Pakistan where lay workers supervised other lay workers in mental health (Singla, Lazarus, et al., 2014). Our experience in Nangarhar clearly highlighted that method is not without risks, as essential information may be ‘watered down’ to simplified biomedical information about symptoms and corresponding medication. The global mental health field urgently needs to develop and test innovative methods such as tele-supervision (Jefee-Bahloul et al., 2015; Rebello et al, 2014; Wootton & Bonnardot, 2015), as well as ‘old’ methods, such as structured peer supervision.

### **PILLAR 3. HEALTH MANAGEMENT INFORMATION SYSTEMS**

‘A well-functioning health information system is one that ensures the production, analysis, dissemination and use of reliable and timely information on health determinants, health system performance and health status’.

(World Health Organization, 2007a, p. 18)

#### ***Afghanistan***

In Nangarhar province, the Health Information Management System (HMIS) was adapted to include the major mental health categories. HealthNet TPO has lobbied with the MoPH to improve the formal Health Information Management System. However, this process is slow and capacity and support for mental health is limited within the Ministry.

#### ***Burundi***

Monitoring and reporting tools have been elaborated by the project, and as a result of intensive lobby to the MoPH by HealthNet TPO and the *Centre Neuropsychiatrique de Kamenge*, six psychiatric diagnoses have been incorporated into the governmental health information system and being used. A major shortcoming, similar to the Afghan programme, was the absence of routine outcome measures and quality indicators, such as patient satisfaction and competence of staff and outcome.

#### ***Discussion***

Changing categories in official nationwide health management information systems is always a challenging and tedious task that takes time. One of the more complicated issues in working within existing state regulated systems is that they are quite resistant to change. National health information systems for primary care in many

low and middle income countries, contain none or only rudimentary mental health categories (Ryan et al., 2015). It essential for there to be successful integration of mental health into all levels of health care that the numbers of diagnoses are well registered. It is well worth it to advocate strongly for good indicators because they form the basis of accountability in the health system and can provide important comparative information useful for planning (De Silva et al., 2014; Jordans, Chisholm et al., 2016; Kane et al., 2014). Additionally, strengthening HMIS systems is one of the key areas for improvement in large multi-country programmes for the integration of mental health into primary care in low resource settings, such as EMERALD (Semrau et al., 2015) and PRIME (De Silva et al., 2016) . Particularly important is the addition of simple scales to measure changes in patient outcomes, such as social functioning. At this moment, this is not routinely done in low income countries, but various NGO are piloting this method regardless, including DRC and Ethiopia.<sup>29</sup>

#### **PILLAR 4. MEDICAL PRODUCTS, VACCINES AND TECHNOLOGY**

**'A well-functioning health system ensures equitable access to essential medical products, vaccines and technologies of assured quality, safety, efficacy and cost-effectiveness, and their scientifically sound and cost-effective use.'**

(World Health Organization, 2007a, p.20)

#### ***Afghanistan***

HealthNet TPO piloted the provision of psychotropic drugs within the BPHS. In the initial period, when the mental health integration was set up, there were separate budget lines in the mental health project for psychotropic drugs, but this responsibility has progressively been transferred to the general health system. The main issues with psychotropic medications were that prescribing patterns are dependent on the stock of drugs available. The beginning of the month, when new stock arrives, many drugs are prescribed. Which means, at the end of the cycle when the stocks are depleted, patients are unable to receive their medications. This problem is not specific to mental health, and is seen everywhere in Afghanistan. It is related to the fact that, by law, medication is free of charge and patients pressure health providers to provide as many different kinds of medication as possible. Another issue is that many drugs are sold outside the formal health care system, for example by physicians in private practice or by non authorised prescribers in pharmacies, in grocery stores and on markets (Harper & Strote, 2011; Paterson & Karimi, 2005).

#### ***Burundi***

Initially the NGO provided essential psychotropic drugs. Later, the national essential drug list was updated with psychotropic medication, which led initially to a more or less regular supply of psychotropic drugs, through the government channels, to the hospitals. However this has gone down in the last years, with the general deterioration of the health care system.<sup>30</sup> The private sector for pharmaceuticals in Burundi is much smaller than in Afghanistan, and much better regulated. Additionally, due to the extreme poverty and the isolated geography there is a more limited illicit trade in pharmaceuticals than in Afghanistan.

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### *Discussion*

Mental health care does not require much in the way of equipment or products, apart from medication. Now, with the availability of approximately ten psychotropic drugs from the WHO's 'Model List of Essential Medicines', a world can be won. Yet, drugs for mental disorders and other non-communicable disorders, cheap and effective as they may be, are not often routinely available in governmental health systems in low income countries (Barbui, 2015; Hogerzeil et al., 2013; Wagenaar et al., 2015). Apart from the difficulties in creating a reliable supply chain for medication, psychotropic medication has additional challenges, such as low prioritisation by planners, high acquisition costs, and strict regulations for some controlled substances (Barbui & Chatterjee, 2015; Padmanathan & Rai, 2016; Raja et al., 2015).

### **PILLAR 5. HEALTH FINANCING**

'A good health financing system raises adequate funds for health, in ways that ensure people can use needed services, and are protected from financial catastrophe or impoverishment associated with having to pay for them. It provides incentives for providers and users to be efficient.'

(World Health Organization, 2007a, p.21)

### *Afghanistan*

In Afghanistan much of the service delivery took place within existing health structures and by staff that was already employed within the health care system. Therefore, implementation costs were low considering the benefits for the population. An internal calculation of the cost for the integration of mental health into the Basic Package of Health Services (BPHS) in Nangarhar was estimated to be 0.27 euro per capita in the period 2005-2008. This includes all basic mental health training for all health staff (doctors, nurses, midwives, community health workers, and community leaders), drugs supply and psychosocial services related to the health care facilities. In the past, mental health was an element of the cost sharing system by HealthNet TPO in which service users paid a percentage of the medication costs and a nominal consultation fee. A decision of the Afghan parliament that health services and medications should be free ended that system, resulting in an increase in health service use and a perceived decrease in quality of services (Ministry of Public Health, 2008; Steinhardt et al., 2011). It also had a negative effect on the financial sustainability of the health programme and health services in Afghanistan, which remain highly dependent on international financial assistance. In the years 2004-2009, the total amount of budget allocation for mental health (including drug demand reduction) by international donors supporting the Afghan health sector was less than one percent (Belay, 2010, p. 43). On a national level, the financial investments in mental health were very modest compared to other sectors, such as maternal and child health and infectious diseases.

### *Burundi*

The programme in Burundi was largely dependent on one financial donor that remained the main funder throughout the programme cycle. It proved to be extremely

difficult, in the context of Burundi, to get the Ministry of Health to accept mental health as a regular part of the general health care services and, in fact, apart from paying the salaries for the staff of the mental health unit in the ministry, the MOPH has not invested in mental health care delivery at all. In the context of Burundi the joint pressure from WHO, various NGOs and the felt need of the population was lacking and therefore the pressure on donors to invest more in mental health care development never became substantial. Attempts to make the programme more sustainable by increasing of user fees and the installation of a revolving fund proved to have a mixed success. Indeed, poverty levels in Burundi are so extreme that even the seemingly modest fee of a dollar for a consultation and medication proved to be an insurmountable barrier for service users.

Another important point is that as of 2006 Burundi gradually introduced a Performance Based Financing (PBF) approach to the health system that consists of contracts with health facilities to deliver a minimum package of services. Based on externally verified 'performance indicators', a health facility could earn subsidies to be invested in the centre and staff allowances (Falisse et al., 2012). In contrast to Afghanistan, mental health never made it to the minimum package of activities. The PBF approach was gradually introduced in Burundi and in 2010 became a national policy. While it may have contributed to significant increases in mother and child care utilisation, the general results are inconclusive (Bonfrer et al., 2013; Falisse et al., 2015). In the years 2013-2015, HealthNet TPO integrated mental health into the PBF programme in one district, with a significant increase in mental health care provision in primary care (personal communication, Norbert Munyentwari, former mental health coordinator of HealthNet TPO Burundi, March 8<sup>th</sup> 2016).

### *Discussion*

The cost-effectiveness of investing in mental health in low resource countries is a contentious issue and little further is known to the answer of the question the senior World Bank official in charge of health for Afghanistan asked me in 2004: 'tell me how many dollars of health the Afghans will gain when we invest one dollar in mental health care.' The answer is that we still do not know. What we do know is that implementation of a standard package of basic, evidence based, mental health interventions in the general health care system is not expensive. The whole BPHS was estimated to cost around 4 USD per capita, per year, so spending a small percentage on mental health seems reasonable. Furthermore, the estimates of the Nangarhar project are not exceptional: the estimated cost to deliver a comparable care package at target coverage ranged from US\$0.21 to 0.56 per head of population in district level projects in Ethiopia, India, Nepal and Uganda (Chisholm, Burman-Roy, et al., 2016).

### **PILLAR 6. LEADERSHIP AND GOVERNANCE**

'Leadership and governance involves ensuring strategic policy frameworks exist and are combined with effective oversight, coalition building, regulation, attention to system-design and accountability.'

(World Health Organization, 2007a, p. 23)

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### *Afghanistan*

A core activity in the mental health programme was to convince decision makers at the provincial level in Nangarhar, and on national level, to pay attention to mental health. HealthNet TPO has been a major partner with the Afghan MoPH in the advocacy for, and direct involvement in, development of mental health policy, organising national mental health conferences in 2003 and 2008, and actively participated in the national mental health taskforce, which was established in 2005. In the early years, the capacity in the national Ministry of Public Health to develop mental health policies was limited and depended largely on the input of NGOs. In 2005, the first national coordinator for mental health in primary health care was appointed in the MoPH, with support of HealthNet TPO. Later, with important support of the European Commission, a mental health unit with four staff was formed in the MoPH and the ministry started to take a steering role in developing a national mental health strategy (Ministry of Public Health, 2009b), the revision of the mental health elements in the Basic Package of Health Services (Ministry of Public Health, 2009a) and in the development of national mental health training materials (Ministry of Public Health, 2009c). The most recent five-year strategic plan by the Ministry of Public Health mentioned mental health among the key challenges for the ministry, as well as the need for training programmes for various categories of health workers, including psychosocial counsellors (Ministry of Public Health, 2011).

### *Burundi*

Engaging national policy makers was a major challenge in Burundi. HealthNet TPO and the Ministry of Public Health organised two international conferences in Bujumbura to discuss the integration of mental health within general health care, and in 2007 the government prepared a mental health strategy. However, the interest of key decision makers in the roll out of mental health services remained limited, and mental health was never made a priority. The strategy of integrating psychosocial services work within the structures of the Ministry of National Solidarity seemed fruitful, with a genuine and active collaboration from the government, but in the end the government could not sustain their commitment because it was heavily underfunded and unable to pay the salaries of the psychosocial workers.

### *Discussion*

Both in Afghanistan and Burundi considerable NGO staff time was spent in advocacy, lobbying and capacity building activities with the MoPH. This is inevitable as one of the characteristics of health care systems in fragile states or complex humanitarian emergencies is that the government lacks capacity for developing, establishing and implementing national health policies (Newbrander et al., 2011). Comparing outcomes in the two countries we can conclude that the efforts were much more effective in Afghanistan than in Burundi.

In Afghanistan, a major asset for mental health development has been the consistent support of the World Health Organization. Already in their first briefing to the financial donors (the Afghan Support Group) in 2001, the WHO delegation flagged mental health as priority in the reconstruction period (Bower, 2002, p. 24). Together

with one other major health donor (the EC), some NGOs and, most importantly, some key allies within the Ministry of Public Health appeared to have enough ‘clout’ to get things done. The results of the epidemiological mental health surveys that were discussed earlier were also used as an advocacy tool.

In Burundi, the number of actors who were active in advocacy work was much smaller and the interest of the national WHO office in mental health was minimal. The presence of a collaborative network of different stakeholders coalition, such as in Afghanistan, to consistently lobby on various policy levels was also conspicuously absent. In other post conflict settings, such as in Sierra Leone and Uganda, this has proven to be a key enabling factor to fight low prioritisation of mental health, sub-optimal political will and unwillingness to allocate government funding to mental health development (Bird et al., 2011; Hann et al., 2015).

### **Further reflections on ‘making systems work’**

In my opinion, there are two further aspects of the projects in Afghanistan and Burundi that deserve attention. First, the struggle for resources, and second the quest for getting the balance right between ‘facility based’ and ‘community based’ mental health and psychosocial support.

#### **THE STRUGGLE FOR RESOURCES**

What was not so clearly described in chapter nine was the constant struggle for resources to fund mental health and psychosocial activities. There was no disagreement on the abundance of mental health and psychosocial problems among the Afghan population, but there was a disagreement about what could be done about it. In 2012, after a major consultation round access priorities for (re)construction of Afghanistan’s health care system, two influential advisors to the donor community concluded that most mental health problems would probably be alleviated with community development activities, such as the opening of schools, the creation of income generating activities and increased security and stability. At the same time, they assumed it would be beyond the capacity of the basic health centres to diagnose and treat patients with mental disorders who would need medication (Waldman & Hanif, 2002, pp. 12-13). They were clearly hesitant to advise any investment in mental health.

**‘Although mental health problems were mentioned frequently at the National Health Sector Planning Workshop in March, it is not clear that there is a safe and effective set of interventions currently available to deal with the problem through a primary health care approach. NGOs currently engaged in psychosocial activities should make reports of their accomplishments public, and technical expertise should be sought for the design of mental health programmes that make sense in the Afghan context.’**

(Waldman & Hanif, 2002, p. 13)

Consequently, while the Basic Health Services Package (developed in 2002 and published in 2003) did contain a mental health component, it was deemed impossible to be implemented at the time (Strong et al., 2005, pp. 22-23). It was therefore neces-

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sary to demonstrate the feasibility and effectiveness of mental health care programmes in primary care before this could be funded. Major donors, such as USAID and the World Bank, refused to fund mental health activities, despite pleas from governmental officials and WHO and despite this being recommended by the World Bank's own Post Conflict Unit (Baingana et al., 2005). The programme in Nangarhar was initially primarily implemented through the existing general health care programmes, meaning some financial space for mental health had to be carved out of the budget, which initially created resistance within the NGO. More than two years after the start, the European Commission decided to fund a larger programme that would cover the whole province, and from 2005 the programme was scaled up and training activities intensified. This is clearly reflected in the statistics presented in chapter nine that show a clear increase in the number of consultations for mental health since that time.

Financing of decentralised mental health programmes remains problematic in low and middle income countries (Saraceno et al., 2011), and the reluctance of major financial donors in Afghanistan to invest in it, is, unfortunately not an exception. There are, despite this, reasons for optimism as more and more institutional donors are becoming willing to fund mental health initiatives. In fact, recent years have seen a substantial increase in global financial resources for mental health, although spending is still very low when compared to other areas of global health (Gilbert, 2015; Mackenzie & Kesner, 2016). In complex humanitarian emergencies, from where most materials for this thesis were drawn, the area of 'mental health and psychosocial support' has consolidated as an integral element of humanitarian assistance (IASC Reference Group for Mental Health and Psychosocial Support, 2015; United Nations High Commissioner for Refugees, 2013). In practice, however, problems as described in Burundi, such as limited buy-in of governmental policy makers and local health authorities, a tension between the wish of humanitarian organisation to prioritise direct service provision while ignoring integration into existing systems, and an absence of consistent support from funding agencies, are not unique. In other contexts too, they continue to slow down mental health care development in countries emerging from armed conflict (Baingana & Onyango Mangan, 2011; de Graaff, 2015; Good et al., 2015; Goodfriend et al., 2014; Shackman & Price, 2013).

#### **BALANCING BETWEEN FACILITY BASED AND COMMUNITY-BASED MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT**

Integrating mental health care into primary care carries the inherent danger of transforming distress into a mental disorder. Health staff has a professional tendency to translate the complaints they hear into a medical diagnosis, with the silent agreement from both health worker and patient that drugs or a medical procedure will solve the problem. In my opinion, the global mental health movement needs to take this criticism to heart: that promoting biological and psychological interventions for problems which also have social drivers could draw attention away from social grass-roots movement for people to help themselves (Campbell & Burgess, 2012). Even well intentioned initiatives to bring mental health services close to the people through community mental health models may get bogged down in bureaucratic

'checklist psychiatry' with little attention for local understanding of suffering (Jain, 2008), and amount to narrow approaches in which community work is approached as an 'extension' of the clinic and relegated to the subordinate role of providing information to the community and motivate people to seek treatment.<sup>31</sup> This means main tasks remain only case identification and referral to where the 'real treatment' is supposed to take place (Cohen et al., 2011; Monteiro, 2015).

I have come to believe that mental health care as part of the formal health care system must be accompanied by community based psychosocial work to provide an antidote to the medicalising tendencies of psychiatric practice. This will create a much needed synergy between mental health care, with broader programmes to tackle the socio-economic drivers of much of the social suffering of people with mental disorders (Lund, 2015; Satcher et al., 2013; World Health Organization & Calouste Gulbenkian Foundation, 2014). It is of critical importance to connect clinical approaches with what Jadhav et al. (2015) call 'local ecologies of suffering' and to link people with mental disorders effectively with available resources 'beyond the bio-medical' (Selamu et al., 2015). In order to do that, the first requirement for health professionals is to try to understand and respect 'other' healing epistemologies (Cooper, 2015).

Community based psychosocial interventions can take various forms, such as interventions for people with 'common mental disorders' such as depression and anxiety (Atif et al., 2016; van de Put & van der Veer, 2005; van der Veer, 2003), but psychosocial work in the community is equally important for people with *severe* mental disorders in order to help them regain control over their lives (Cohen et al., 2012; Underhill, 2015).

Despite growing calls for interventions to modify environmental stressors and strengthen protective resources, there is little high quality research on the effects of broad empowering approaches and resource strengthening approaches, perhaps due to the fact that such interventions cannot easily be translated into a research design (Miller & Jordans, 2016).

However, the field of global mental health may learn from the experience of mother and child health care programmes (Rosato et al., 2008). There is evidence from mother and child health programmes in low income countries that community based women's groups may generate positive changes, in which groups of women participated in a facilitated process to prioritise local issues affecting health, and designed and implemented solutions to the identified problems. These problems may be primarily related to health, but also to social issues, such as mutual support or assistance with child care. This approach is rooted in the assumption that many health problems, particularly for women, result from powerlessness and can be addressed through facilitated group learning involving a mix of peer support, dialogue and participatory problem solving (Darmstadt & Munar, 2013). A large cluster randomised controlled trial in rural districts in India with participatory women's groups, using participatory learning and joint action planning, showed beneficial effects such as a reduction in stillbirths and reduced neonatal mortality (Tripathy et al., 2016). The methodology of such groups is well suited for people with mental health problems, and is in fact quite similar to some community based psychosocial work

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that was done in Afghanistan and Burundi, but those projects were unfortunately not well researched or documented. The closest perhaps, was a well designed study in Burundi that looked at the effects of participatory family based discussion groups as an addition to income generating activities. Participation in the support groups led to reduced incidence of family problems, such as substance abuse and violence, and to improvements in mental health and psychosocial wellbeing of the children of the participants (Bundervoet et al., 2012). Another example comes from Rwanda, where the ‘community based sociotherapy’ programme that works with a 15 session model, in which participants share ‘togetherness’ through sitting together, talking, singing, role play, and non verbal communication. The groups constitute safe spaces for people who suffer from social isolation and psychological pain and offers opportunities to socially (re)connect, as well as addresses individual suffering through the ‘holding environment’ of the group (Richters, 2015). In this way, it contributes to repairing the shattered social world within a context that has been deeply affected by collective violence and structural adversity (Richters et al., 2010). Research on the effects of this profoundly *social* intervention found that, apart from increases in civic participation (increased social capital), also had positive effects on the *individual mental health* of those who participated (Scholte, Verduin, Kamperman, et al., 2011; Verduin, Smid et al., 2014).

Interestingly, and I believe quite telling, is that several other community based group interventions in LMIC that more explicitly target women with mild to moderate depression, do not use the word ‘depression’, but take as a starting point the problems as defined by the women themselves (Patel, 2014) and, as we have seen from Section one of this thesis, local conceptualisation differs significantly from professional constructs.

While global mental health research expands rapidly by organising clinical trials of psychological and psychiatric interventions, unfortunately, it still gives insufficient attention to the role of community based social interventions and to empowerment of volunteer helpers from the affected communities themselves.<sup>32</sup> Much more work is needed to document and research participatory psychosocial interventions that are not based on the ‘toolkit of the medical professions’ (Kirmayer & Pedersen, 2014), but rather build on mobilisation of existing resources in communities and aim to strengthen resilience and coping, and may ultimately contribute to social justice (Silove, 2013).

## **Finally: lesson learned and implications**

The papers in this thesis examined mental health issues within complex humanitarian emergencies from three angles: ethnographic research to explore local perspectives, epidemiological research trying to capture the magnitude of mental disorder, and health systems research to analyse how interventions can be integrated into systems that work.

The first primary implication is that culture and context must be taken seriously. The cases of Afghanistan and Burundi illustrate that collective violence and war related adversity have a huge impact on various levels. The individual focus of classical

psychiatry and clinical psychology may obscure the effects of violence on a collective level; social relations are weakened, people in communities do not trust each other anymore, and ways to help each other have become redundant or dysfunctional. For practitioners and policy makers alike, it is important to gain an understanding of local cultural categories of mental illness and distress. Such cultural categories, even if they may seem closely aligned to mainstream psychiatric categories, should not be seen as synonyms for professional psychiatric categories. Such local terms are pragmatically used, and grounded in particular contexts that are embedded into local webs of signification.

A second primary implication is that psychiatric epidemiology in complex humanitarian settings should move away from its gaze on collecting prevalence figures, and instead reconceptualise mental health and psychosocial wellbeing as states that are culturally embedded and influenced by social factors. A key challenge is to ensure that epidemiological research does not conflate social suffering with mental disorder.

A third primary implication is that mental health programming in complex humanitarian settings requires a systematic and sustained attempt to use systems approaches. The projects in Afghanistan and Burundi were quite different from each other, but some lessons learned were similar, particularly that installing basic mental health within general health care should be connected to community based activities, and be firmly rooted in a general health-system-strengthening approach. Integrating mental health care into primary care carries the inherent danger of promoting biological and psychological interventions for problems that also have major social drivers. I have come to believe that mental health care, as part of the formal health care system, must be accompanied by community based psychosocial interventions that do not emphasise the ‘toolkit of the medical professions’, but rather mobilise the available community resources and strengthen resilience and coping.

In the end, it is my firm belief that we must integrate various perspectives, even when we are not able to bring them into one single meta theory. I have had lots of doubts over the course of my research and intervention work. But, I have never doubted the necessity to search for ways to alleviate mental suffering of people within complex humanitarian emergencies. Furthermore, I believe it is our moral obligation to continue in that search for solutions.

## Notes to chapter twelve

1 Communicating suffering through ‘idioms of distress’ does not, in itself, always lead to appropriate solutions for ‘healing’ for the individual. For example, Reis (2013) doubts whether ‘being haunted by spirits of the dead’, idioms frequently used by Ugandan war affected children that prompt cultural responses such as cleansing rituals, actually lead to the most effective therapeutic pathways.

2 To give an impression: there is research on non pharmacological interventions in low income African countries such as Burundi (Crombach & Elbert, 2015; Jordans, Tol,

Ndayisaba, et al., 2013; Tol et al., 2014; Yeomans et al., 2010), Democratic Republic of Congo (Bass et al., 2013; Köbach et al., 2015; McMullen et al., 2013; O’Callaghan et al., 2015), Uganda (Bolton et al., 2007; Bolton et al., 2003; Neuner et al., 2012), Rwanda (Schaal et al., 2009a), Zambia (Murray et al., 2015), Zimbabwe (Chibanda et al., 2015), and in low income Asian countries: Afghanistan (Ayoughi et al., 2012), India (Chowdhary et al., 2016; Patel, Weiss, et al., 2010), Indonesia (Bass et al., 2012; Tol et al., 2008), Nepal (Jordans, Komproe, et al., 2010), Pakistan (Naeem et al., 2014; Rahman, Malik, et al., 2008; Sijbrandij et al., 2015). None of these trials were funded by pharmaceutical companies. Instead of slavishly following models from High Income Countries, these well researched interventions in low income settings could instead provide models for High Income Countries (Patel, 2016; cf Kieft et al., 2008; McKenzie et al., 2004).

**3** For more comprehensive discussions of the cultural critiques on global mental health see various review papers (Bemme & D’Souza, 2014; de Jong, 2005; de Jong, 2014; Kirmayer & Pedersen, 2014; Miller, 2014; Whitley, 2015)

**4** Hinton and Good (2016, pp. 88-96) describe a variety of errors in assessing ‘idioms of distress’, including ‘errors of decontextualisation’ (ignoring the way the people themselves experience complaints and give meaning to them), ‘medicalisation errors’ (interpreting an idiom of distress solely in terms of professional nosological categories and their putative biological origins), and ‘salience errors’ (disregarding the relative importance of a symptom within a particular cultural context).

**5** Guglielmo (2015, p. 156) describes how her respondents remark about *guhahamuka* (*ihahamuka*) that ‘a Hutu suffering from it would just make a fool of herself’ and be stigmatised as mentally ill. I did not note such similar ethnic specificity around *guhahamuka* in Burundi.

**6** An American psychiatrist who visited Haiti to do clinical work for 16 days, mentions how ‘some chief complaints of patients were vague or potentially misleading. For example, patients with depression complained of ‘headache’, ‘empty head’, ‘dizziness’, ‘tight heart’, or a combination of some or all of these complaints’ (Grelotti et al., 2015). Instead of suggesting that the way the patient present symptoms is ‘misleading’ because it would hide ‘the real thing’, I would argue that the standard toolkit of the mental health profession is insufficient and needs to be more sensitive to diversity (Hassan et al., 2015; Kirmayer, 1989).

**7** Indeed, a charge levelled at mhGAP-training and Psychological First Aid (PFA) workshops is that these may contribute to a ‘de-skilling’ of health workers in regards to the more intuitive, empathic ways of helping that they may have developed on their own.

**8** The notion that, due to the dominance of modern psychiatry, Indian healing traditions would have lost their niche in healing people with mental problems is contested by various recent ethnographic studies that found such healing traditions flourishing, albeit it for a large part outside the purview of the health authorities (Quack, 2012; Sax, 2014). A majority of Indians continue to utilise both Indian, as well as ‘western’ healing methods, for mental problems, often at the same time (Chadda & Deb, 2012; Pakaslahti, 2012).

**9** The *ziarat* (shrine) in Samar Khel has been built around the grave of Mia Ali Sahib, an 18th century Sufi saint and has been in use as a sanctuary for the mentally ill for a

long time and is well known throughout East Afghanistan (Sidky, 1990, p. 292; Dupree, 1973 [1980], p. 105). The caretakers of the shrine, who as in many shrines are supposed to be the descendants of the saint (cf Canfield, 2010), showed me remnants of buildings that were constructed on the order of king Amanullah who ruled from 1919 to 1929. The sanctuary has been the topic of sometimes rather sensationalist reports in international news media (AFP News Agency, 2011; Barker, 2008; Karokhel & Zawab, 2003; Malm, 2013; Nolan, 2013; Rasmussen, 2015).

**10** Examples of in depth ethnographic work during, or after, complex humanitarian emergencies that elicits how local understandings and experiences of distress are embedded into larger socio-political processes can be found in the work of anthropologists, such as Abramowitz (2014), Igreja (2003), and Zarowsky (2000).

**11** The study of Cardozo et al. (2004) found considerably higher symptom rates for depression (67.7%), anxiety (72.2%) and PTSD (42.1%) than our study. Rasekh et al. (1998), who had conducted an earlier study among women in Afghanistan under the Taliban, utilising the same research tools and also published in the JAMA, reported even that they found 'demonstrated evidence of major depression' in 97% of the women, and that 86% of the women had 'significant anxiety symptoms' with 42% 'with diagnostic criteria for posttraumatic stress disorder'. In 2000, when the Taliban were still in power in most parts of Afghanistan, a study among 724 women selected through systematic random sampling and cluster sampling in four areas, estimated the prevalence of depression among women in a Taliban controlled area to be 78%, while in a non Taliban controlled area and a refugee camp in Pakistan the prevalence was 28% and 73%, respectively. The presence of depression was established through a nine-item yes/no questionnaire, the PRIME MD, which according to the authors is a 'well-validated, highly sensitive instrument for identifying individuals with current and past depression' (Amowitz et al., 2003, p. 579). The praise for the instrument is based on research among American patients visiting primary care physicians in the east-coast of the United States (Brody et al., 1998).

**12** According to Grima (1986), suffering and pain constitute the main components of 'feminine honour' for the Pashtun. This is in contrast to masculine honour, which is centred around prowess and endurance of pain without showing it. A well known Pashto proverb says: *Khaza pa hay paida kigi, pa hay wadegi, pa hay mrha kegi*: 'A woman is born with sorrow, married with sorrow, and will die with sorrow' (Sanauddin, 2015).

**13** An amulet made of verses of the Quran written on a small piece of paper that is sewn inside little pouch of cloth or leather.

**14** The Dari concepts have some overlap with the Farsi idioms of distress used among Iranians, such as *nârâhati* ('being in distress') that may include sadness and grief (*gham o gosseh*), or excessive worry (*ziâdi fekr kardan*) and anxiety (*negarâni*). The word is associated with the heart (*nârâhati-e qalb*, characterised by pain in the chest and the sensation of the heart being squeezed) and with the nervous system (*nârâhati-e a'sâb*, 'distress of the nerves', accompanied by irritability weakness and tiredness) (Good et al., 1985; van Marrewijk, 1997).

**15** This is consistent with the thick description of the emotional suffering of an Afghan migrant to the United Kingdom by Khan (2013, p. 521). Her informant describes *khapgan* as 'feeling down', and as qualitatively different from *gham* (sadness) or

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*takleef* (being hurt, feeling pain). *Khappan* is more than sadness and connotes frustration and may be expressed through self-recrimination, blame, punishment and hostility.

**16** The concept of *peryan* or *peri* is more or less similar to that of *jinn* in the Arabic world (Sidky, 1990). Most vulnerable for *peryan* attacks are women and children. *Peryan* are attracted to chaos and disorderly behaviour and women who are possessed will often have an assortment of illnesses and difficulties fulfilling the women's role in the household. Possession by *peryan* may thereby, provide legitimacy for behaviour that would otherwise be unacceptable (Anderson, 1985; Tapper, 1991).

**17** See, for example, Hasrat-Nazimi (2012) who writes that 'mental illness is rampant in Afghanistan' or Rasmussen (2015) who saw an 'epidemic of mental disorder in Afghanistan'.

**18** For example, Dr Mohamed Amin Fatimie, Minister of Public Health declared in 2009: 'Recent surveys conducted by national and international organizations indicate that 66 percent of Afghans are suffering from stress disorders and mental problems' (IRIN, 2009). His successor as Minister, dr Sorya Dalil, said in 2010 that 'over 60 percent of Afghans suffer mental health problems' (AFP News Agency, 2010).

**19** Social integration should not be seen as a static attribute of a person or a system, but as a process over time, through which individuals increasingly develop and exercise their capacities for connectedness and citizenship' (Ware et al., 2007). Baumgartner and Burns (2014) recommend that instruments to measure social inclusion within global mental health projects should be comprised of at least four domains; 1) sense of belonging in the community and social acceptance; 2) level of participation in community and civic life; 3) sense of agency and capacity to choose whether to participate; and 4) opportunities to remove barriers to participation.

**20** The decisive influence of post migration factors in the development of psychopathology is also well documented for asylum seekers and refugees in high income countries (Gerritsen et al., 2006; Laban et al., 2005; Silove et al., 1997; Silove et al., 1998).

**21** In other publications (Patel et al., 2016; Patel, Kieling, et al., 2013; Patel, Koshorke, et al., 2011; Patel, Maj, Flisher et al., 2010), Patel has often, and largely uncritically, used the term 'treatment gap', the very concept that he now firmly criticizes.

**22** See various publications describing mental health and psychosocial interventions in Afghanistan (Ayoughi et al., 2012; Berdondini et al., 2014; De Berry, 2004; Hawkins, 2003; Manneschmidt & Griese, 2009; Missmahl et al., 2012; Omidian, 2012; Samadi, 2009; Ventevogel, 2006; Vogel et al., 2012).

**23** In 2002 and 2003, I conducted trainings and made field visits to almost all districts of Nangarhar. During my last visit in 2010, I was only able to visit places nearby. Afghanistan has once again become a very dangerous place with very real dangers. Two international colleagues working in mental health have been killed by armed insurgents: in 2004 a Belgian psychologist from *Médecins sans Frontières* (MSF) was killed in Badghis province and in 2014 a Finnish worker of the Community Mental Health Project of the International Assistance Mission (IAM) was killed in Herat.

**24** In the last decade a range of MHPSS activities has been developed, not only by

HealthNet TPO but also by others. A catholic congregation, the *Frères de la Charité*, has run a psychiatric hospital since 1981 (Stockman, 1994). In the last few years, as part of a decentralisation process, two new psychiatric centres were opened in the major towns of Gitega and Ngozi (Niyonkuru, 2014). A small local NGO, formed by nurses who had worked in mental health care, operates an eight bed clinic and out-patient department in Bujumbura (Besamusca-Ekelschot, 2014; Van Wolvelaer, 2015). Apart from these ‘psychiatric’ institutions there has been a range of psychosocial activities by various NGOs (see Watt, 2008, pp. 121-129).

**25** This is not unusually low. Analysis of routine health information systems for a Pashtun district in the north west of Pakistan, close to the Afghan border, found that that from the clients who visited the integrated, NGO led mental health services in a district hospital, hardly any patients showed up for a second consultation, except for those who had been admitted to the hospital and could be visited by the psychologist (Singla, Weobong, et al., 2014). Similar experiences were reported in a mental health programme for internally displaced Pashtun in North Waziristan, on the other side of the Spin Ghar Mountains that separate Nangarhar in Afghanistan from Waziristan in the Federally Administered Tribal Area of Pakistan (Humayun et al., 2016).

**26** The programme was implemented by HealthNet TPO and other NGO partners in the provinces of Kapisa, Laghman, Uruzgan, Khost, Kunar and Kandahar, with a total population of close to 3 million people. In these provinces, in the period from January 2005 to September 2008, a total number of 125,288 consultations related to mental health were registered with the following breakdown: 66.6% depression, 14.9% anxiety, 4.3% psychosis, 9.5% epilepsy, 1.2% learning disabilities, 0.7% substance abuse, 0.5% conversion and unexplained somatic complaints, 2.3% others (Le Roy, 2008).

**27** The tasks for a case manager (Shidhaye et al., 2015, p. 7) are defined as ‘screening; engaging; educating patients and family members; maintaining close follow-up; tracking adherence and clinical outcomes; and delivering targeted, evidence-based, psychological interventions, such as motivational interviewing, behavioral activation, problem-solving, or interpersonal therapy’.

**28** In the period of 2005-2008, the mental health programme provided 12-day trainings to a total of 350 medical doctors, 418 nurses and midwives and 151 community health supervisors, while 2539 community health workers followed basic trainings of three days, with 47 persons following the eight week track to become trainer/supervisors (Le Roy, 2008).

**29** Personal communication from J. le Roy on the mental health programme of HealthNet TPO in North Kivu, DRC, and I. Weissbecker on the programmes of the International Medical Corps IMC, Ethiopia and the Middle East.

**30** Personal communication NGO staff in Burundi, Dec 2015.

**31** This narrow role for community based activities has been called the ‘reach paradigm’ (Knibbe et al., 2016).

**32** For me personally, some of the most convincing descriptions of what MHPSS work can achieve, are the personal testimonies of people who were themselves affected by collective violence and who developed themselves to become effective and compassionate helpers of others. The journal ‘Intervention’ regularly publishes such ‘personal reflections’ and I recommend all readers of this academic thesis to

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CONCLUDING REMARKS

read the accounts of true heroes such as Feza Irene Penge from the Democratic Republic of Congo (Penge, 2012), Ibado Mahamoud Hilole from Somalia (Hilole, 2016), Kyaw Soe Win from Birma (Win, 2014), Laily Samadi from Afghanistan (Samadi, 2009), Lebona from Eritrea (Yohannes, 2012), Maha Ismael from Iraq (Ismael, 2013), Mohamed Abo Hilal from Syria (Abo-Hilal & Hoogstad, 2013), and Sabah Dhia Jaafar from Iraq (Jaafar, 2012). Their stories powerfully demonstrate how personal pain and suffering can be transformed into healing power.

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CONCLUDING REMARKS

## **Explanation of the relative contribution of the co-authors to the chapters**

### **Chapter two**

Ventevogel, P. (2015). The effects of war: local views and priorities concerning psychosocial and mental health problems as a result of collective violence in Burundi. *Intervention, 13*, 216-234.

PV designed the study, created the focus group questions, analyzed the data and wrote the manuscript.

### **Chapter three**

Ventevogel, P., Jordans, M., Reis, R. & de Jong, J. (2013). Madness or sadness? Local concepts of mental illness in four conflict-affected African communities. *Confl Health, 7*, 3.

PV designed the study, created the focus group questions, trained the interviewers, analyzed and coded the data, and wrote the first draft of the manuscript.

MJ, RR and JdJ contributed to the writing of the manuscript.

### **Chapter four**

Ventevogel, P., Niyonkuru, J., Ndayisaba, A., Reis, R. de Jong, J.T.V.M. (submitted). Change and continuity in divinatory healing in Burundi.

PV co-designed the study, trained interviewers for the focus groups, analyzed and coded the transcripts for prominent themes and wrote the first draft of the manuscript.

JN and AN trained the interviewers for the visits to the healers and contributed to the data analysis and to the writing of the manuscript.

RR contributed to the writing of the manuscript.

JdJ designed the study, contributed to the data analysis and to the writing of the manuscript.

### **Chapter five**

Ventevogel, P., Jordans, M., Eggerman, M., van Mierlo, M. & Panter-Brick, C. (2013). Child mental health, psychosocial wellbeing, and resilience in Afghanistan: a review and future directions In C. Fernando & M. Ferrari (Eds.), *Handbook on resilience in children of war*. (pp. 51-79). Amsterdam: Springer.

PV conceived and wrote the first draft of the manuscript and did the evidence retrieval.

MJ, ME, BvM and CPB contributed to the writing of the manuscript.

### **Chapter six**

Scholte, W. F., Olf, M., Ventevogel, P., de Vries, G. J., Jansveld, E., Cardozo, B. L. & Crawford, C. A. (2004). Mental health symptoms following war and repression in eastern Afghanistan. *JAMA, 292*, 585-593.

WS designed the study and wrote to the first draft of the manuscript.

MO contributed to the design of the study, supervised the data analysis and participated in the drafting of the manuscript.

PV contributed to the design of the study, trained the interviewers, supervised the data collection and contributed to the writing of the manuscript.

GdV did the statistical analysis of the data and contributed to the writing of the manuscript.

EJ trained the interviewers and supervised the data collection.

BC and CC contributed to the design of the study and participated in the drafting of the manuscript.

### **Chapter seven**

Ventevogel, P., De Vries, G., Scholte, W. F., Shinwari, N. R., Faiz, H., Nassery, R., van den Brink, W., Olf, M. (2007). Properties of the Hopkins Symptom Checklist-25 (HSCL-25) and the Self-Reporting Questionnaire (SRQ-20) as screening instruments used in primary care in Afghanistan. *Social Psychiatry and Psychiatric Epidemiology*, 42, 328-335.

PV designed the study, participated in the training of interviewers, supervised the data collection, participated in the statistical analysis and drafted the first version of the manuscript.

GdV did the statistical analysis and participated in the drafting of the manuscript.

WS participated in the design of study and in the drafting of the manuscript.

NS, HF and RN participated in the data collection and in the drafting of the manuscript.

WvdB participated in the drafting of the manuscript.

MO participated in the design of study and participated in the drafting of the manuscript.

### **Chapter eight**

Ventevogel, P., Komproe, I. H., Jordans, M. J., Feo, P. & De Jong, J. T. V. M. (2014). Validation of the Kirundi versions of brief self-rating scales for common mental disorders among children in Burundi. *BMC Psychiatry*, 14, 36.

PV designed the study, trained the interviewers, supervised the data collection, executed the statistical analysis, and drafted the first version of the manuscript.

IK participated in the design of study, supervised the statistical analysis and participated in the drafting of the manuscript.

MJ participated in the design of study and in the drafting of the manuscript.

PF participated in the data collection and in the drafting of the manuscript.

JdJ participated in the design of study and participated in the drafting of the manuscript.

### **Chapter nine**

Ventevogel, P., van de Put, W., Faiz, H., van Mierlo, B., Siddiqi, M. & Komproe, I. H. (2012). Improving access to mental health care and psychosocial support within a fragile context: a case study from Afghanistan. *PLoS Medicine*, 9, e1001225.

PV collected and analysed the data.

WvdP, HF, BvM, MS and IK contributed to the writing of the final manuscript.

#### **Chapter ten**

Ventevogel, P., Ndayisaba, H. & Van De Put, W. (2011). Psychosocial assistance and decentralized mental health care in post-conflict Burundi (2000 – 2008) *Intervention, 9*, 315-331.

PV collected and analysed the data.

HN and WvdP contributed to the writing of the manuscript.

#### **Chapter eleven**

Ventevogel, P. (2014). Integration of mental health into primary health care in low-income countries: avoiding medicalization. *International Review of Psychiatry, 26*, 669-679.

PV did the evidence retrieval and data analysis, and wrote the manuscript.

## English Summary

This thesis focuses on Afghanistan and Burundi, two countries that are facing ongoing, complex humanitarian emergencies and are characterised by ethno-political collective violence. I have worked in both of these countries, with the nongovernmental organisation HealthNet TPO, setting up mental health programmes, as well as conducting research when time allowed me.

The research presented in this thesis, specifically relating to mental health in Afghanistan and Burundi, was guided by three central research questions:

- 1 What are local perspectives on mental health and healing by people within complex humanitarian emergencies?
- 2 How can mental health problems within complex humanitarian emergencies be measured?
- 3 How can functional systems to address mental health and psychosocial problems within complex humanitarian emergencies be developed?

Answering these central questions required the use of a variety of research techniques, drawn from diverse academic fields.

The Introduction (Chapter one) introduces the reader to these various contexts, which framed and informed the research presented here. Thereby, the chapter aims to: 1) provide an overview of global mental health, and more specifically of mental health and psychosocial wellbeing within complex humanitarian emergencies; 2) describe the socio-political background of Afghanistan and Burundi; and 3) sketch the academic disciplines utilised in this thesis: i) ethnographic research to explore local perspectives; ii) epidemiological research with the aim of measuring mental disorder in populations; and iii) health systems research within global mental health, to analyse how mental health interventions can be made functional and sustainable.

### **Local perspectives on mental health and healing**

After introducing the complex contexts in the Introduction to frame and guide the reader, in the first part of the thesis I explore how people in Burundi and Afghanistan and conceptualise problems of mental health and wellbeing, and how they seek help for these issues.

Chapter two presents the results of a study using rapid appraisal methods, such as focus group discussions, among war affected Burundian adults. We asked Burundians, in four provinces of the country, what they saw as the main difficulties and problems resulting from the war. The respondents identified ill health, poverty and the breakdown of social fabric as major effects. Amidst these concerns, issues related to mental health and psychosocial wellbeing were also mentioned, including: depressive states, fear/anxiety, grief, madness, and substance abuse. This exercise makes it clear that mental health and psychosocial wellbeing are a serious concern to people in humanitarian emergencies. In the remainder of the chapter, I argue, therefore, that the design of mental health interventions should take into account

what is most important to the beneficiaries and relate to how they conceptualise their problems.

Chapter three delves deeper into ‘local views’, presenting a comparative analysis of ideas around mental illness in Burundi and three other conflict affected settings in east Africa. Participants of focus groups, in all four settings, described local syndromes that were defined by severe behavioural disturbances and that corresponded remarkably with the grand category of ‘psychotic disorders’ of professional psychiatry. However, ideas about aetiology and the meaning of symptoms differed considerably with professional ideas on psychosis. Additionally, those residing in each of the four communities had local terms for conditions characterised by sadness, loss and social withdrawal. Such concepts have some similarities with ‘mood disorders’, as defined in professional psychiatry, but it would be wrong and perhaps dangerous to reify them into ‘cultural syndromes’, complete with a coherent set of symptoms and aetiology. In practice, they function as *idioms of distress*; culturally prescribed ways of communicating that someone feels unwell and/or unhappy. Such idioms *could be* indicative of psychopathological states, but certainly should not be considered as *always* indicative.

Chapter four describes traditional healing in Burundi, through an analysis of the practices of seven diviner-healers (*abapfumu*). These practitioners use spiritual methods to diagnose spirit possession and to assist in dealing with someone’s affliction. The *adorcistic* healing methods of the *kubandwa* cult are meant to appease spirits and assist the possessed person in regaining a place within society. However, these have (to some extent) been replaced by an *exorcistic* technique called *gucekera*, in which spirits are aggressively driven out of afflicted people. My co-authors and I hypothesise that these changes are related to the effects of modernity, compounded by the effects of war that have deeply affected the social fabric. Additionally, we connect research findings to the ethnographic literature on traditional healing and divination found in other parts of Africa.

During the period I worked in Afghanistan I had, unfortunately, very limited opportunities to conduct ethnographic research on how people conceptualise mental disorders and how they seek help. Instead, in chapter five, I present a literature review that provides a synthesis of child-focused research and intervention literature from various disciplines pertinent to mental health and psychosocial wellbeing in Afghanistan. This review, containing references to both ethnographic and epidemiological literature, makes clear that the myriad of mental health and psychosocial problems found in the Afghan population encompass a wide array of problems that go far further than strictly ‘war related’ pathology, but also, and perhaps foremost, include problems related to poverty, inequality, and other forms of structural adversity. It was also clear that for Afghans, cultural concepts such as ‘honour’, ‘family unity’ and ‘hope’ play a significant role in building resilience to adversity. However, cultural values do not only function as an ‘asset’, but generated within specific contexts, they can also function as a straightjacket, thwarting individual aspirations and freedom.

## **Measuring mental health**

In the second part of this thesis I explore issues around the measurement of mental health issues. My main concern here was how the results of standardised, brief, self report instruments should be interpreted.

Chapter six is the report of a cross-sectional, multi-cluster sample survey among 1011 randomly selected adults in the eastern province of Nangarhar in Afghanistan. The survey was conducted a year after the fall of the Taliban. One of the main features of this study is the estimation of prevalence rates of symptoms of common mental disorders in this early post conflict setting. High symptom rates were reported for depression (38.5%), anxiety, (51.8%), and PTSD (20.4%), with a marked gender difference: odds ratios for women compared to men were 7.3, 12.8, and 5.8 respectively.

Chapter seven examines the validity of the Hopkins Symptom Checklist-25, one of the instruments utilised in the study described in chapter six. This work was prompted by concerns over the use of such instruments within the context of complex emergencies in general, and in Afghanistan in particular. Together with my co-authors, I tested the HSCL-25 and another often used brief self report scale for mental disorders, the Self-Reporting Questionnaire-20. These two self report scales were compared against a 'gold standard' semi structured psychiatric interview. The results were sobering; both short screening instruments had modest properties to correctly identify mental disorders (area under the curve was 0.73 and 0.72, respectively). Optimal cut off points of the scale differed for men and for women. The study results shed new light on the results of earlier studies in Afghanistan with the HSCL-25 as it is likely that these studies overestimated the prevalence of mental disorders among women, while at the same time, underestimated the prevalence in men.

Chapter eight also explores the psychometric properties of self report scales for mental disorders, but in this instance with a focus on children in Burundi. It explores the psychometric properties of the Depression Self-Rating Scale (DSRS), the Child PTSD Symptom Scale (CPSS) and the Screen for Child Anxiety Related Emotional Disorders (SCARED-41), in a sample of 65 primary school children in Burundi. The external 'gold standard' criterion was a comprehensive, semi structured, clinical psychiatric interview for children, according to the DSM-IV criteria (the Schedule for Affective Disorders and Schizophrenia for School-Age Children – K-SADS-PL). The DSRS and CPSS scales had acceptable properties for detecting depressive disorder and posttraumatic stress disorder (area under the curve was 0.85 and 0.78, respectively) if cut-off points were put considerably higher than in western, norm populations. The results, utilising the SCARED-41 to identify anxiety disorders, were less encouraging (AUC: 0.69). The relatively weak performance of the SCARED-41 could be attributed to the fact that it covers various categories of anxiety disorders, with perhaps limited cultural/construct validity.

## **Making systems work**

A third focus of this thesis is how to deliver mental health interventions in ways that 'make sense' within the context, and particularly how to make such interventions

sustainable. To some extent, almost paradoxically, post conflict settings provide policy opportunities for the development of better mental health care. This is due to a shared sense of urgency, by many stakeholders, on the need to address the consequent, painfully visible, mental health issues.

Chapter nine is a description and critical analysis of the programme for mental health and psychosocial support by HealthNet TPO in Afghanistan. The programme, which I helped to set up during my period of work in Afghanistan (2002-2005) aimed to include essential mental health aspects in the general health care system, through training of staff at all levels of the health system in identification and management of priority mental health conditions. The chapter follows the developments in six rural districts (the '*Shinwar cluster*') in Nangarhar over a ten-year period (2002-2011). The number of patients with mental disorders that were treated within the general health services increased tremendously, but the downside was that, inadvertently, the programme may have contributed to a process of medicalisation of social problems.

Chapter ten similarly describes and analyses a mental health and psychosocial support programme in Burundi. Within a time frame of eight years, the context had changed from active war to a fragile post conflict setting. During this period, the programme activities shifted from the delivery of direct services to capacity building activities aimed at embedding psychiatric services and psychosocial assistance within existing local health services and social systems. In the years 2005-2008, I lived in Burundi and was part of that transformation process, in which we faced formidable challenges and full sustainability of mental health and psychosocial activities was not realised.

Chapter eleven synthesises the literature around the integration of mental health into non-specialised (e.g. primary) health care. The paper was written with special attention to an undesired side effect of such integration: namely the medicalisation of distress when using a narrow biomedical approach. During my work in Afghanistan, Burundi and later in various other complex humanitarian emergencies, I became increasingly convinced that the integration of mental health into primary healthcare should be accompanied by strengthening other levels of health care and by fostering community support.

## **Reflections**

The last chapter of this thesis reflects on implications of my work for the development of global mental health research and practice within complex humanitarian emergencies.

A first implication is that culture and context must be taken seriously. The cases of Afghanistan and Burundi illustrate that collective violence and war related adversity have an impact on various levels. The individual focus of classical psychiatry and clinical psychology may obscure the effects of violence on a collective level; social relations are weakened, people in communities do not trust each other anymore, ways to help each other have become redundant or dysfunctional. For practitioners and policy makers alike it is important to gain an understanding of local cultural

categories of mental illness and distress. Such cultural categories, even if they may seem closely aligned to mainstream psychiatric categories, should not be seen as synonyms for professional psychiatric categories. Such local terms are pragmatically used, grounded in particular contexts that are embedded into local webs of signification.

A second implication is that psychiatric epidemiology in complex humanitarian settings should move away from its gaze on collecting prevalence figures, and instead reconceptualise mental health and psychosocial wellbeing as states that are culturally embedded and influenced by social factors. A key challenge is to ensure that epidemiological research does not conflate social suffering with mental disorder.

A third implication is that mental health programming in complex humanitarian settings requires a sustained attempt to use systems approaches. The projects in Afghanistan and Burundi were quite different from each other, but some lessons learned were similar, particularly that installing basic mental health within general care should be connected to community based activities, and be firmly rooted in a general health-system-strengthening approach. Integrating mental health care into primary care carries the inherent danger of promoting biological and psychological interventions for problems that also have major social drivers. I have come to believe that mental health care, as part of the formal health care system, must be accompanied by community based psychosocial interventions that do not emphasise the 'toolkit of the medical professions', but rather utilise the mobilisation of available community resources and the strengthening of resilience and coping.

## Résumé en Français

Cette thèse se concentre sur l'Afghanistan et le Burundi, deux pays régulièrement confrontés à des situations d'urgence humanitaire complexes et marqués par des violences collectives ethno-politiques. J'ai travaillé dans ces deux pays au sein de l'organisation non gouvernementale HealthNet TPO, afin de mettre en place des programmes de santé mentale et également, lorsque le temps me le permettait, de mener des recherches.

Les recherches présentées dans cette thèse, qui traite spécifiquement de la santé mentale en Afghanistan et au Burundi, se sont articulées autour de trois questions centrales:

- 1 Quelles sont les perceptions locales sur la santé mentale et la guérison parmi les populations vivant en situations d'urgence humanitaire complexes?
- 2 Comment mesurer les problèmes de santé mentale en situations d'urgence humanitaire complexes?
- 3 Comment développer des systèmes fonctionnels pour prendre en charge les problèmes de santé mentale et de bien-être psychosocial dans les situations d'urgence humanitaire complexes?

Pour répondre à ces questions centrales, il fallait employer des techniques variées de recherche, puisées dans divers domaines académiques.

L'*Introduction* (Chapitre un) introduit le lecteur dans les différents contextes qui ont servi de structure et d'éclairage à la recherche présentée ici. Ainsi, le chapitre vise à: 1) offrir une vue d'ensemble de la santé mentale dans le monde, et plus particulièrement de la santé mentale et du bien-être psychosocial dans les situations complexes d'urgence humanitaire; 2) décrire le contexte sociopolitique de l'Afghanistan et du Burundi; et 3) décrire les disciplines académiques utilisées dans cette thèse: i) la recherche ethnographique pour explorer les perceptions locales; ii) la recherche épidémiologique pour mesurer les troubles mentaux au sein des populations; iii) la recherche liée aux systèmes de santé dans le cadre de la santé mentale dans le monde (*global mental health*), afin d'analyser comment les interventions de santé mentale peuvent être rendues fonctionnelles et durables.

### **Perceptions locales sur la santé mentale et la guérison**

Après avoir, dans l'*Introduction*, présenté les contextes complexes et offert au lecteur des points de repère, j'examine dans la première partie de la thèse comment, au Burundi et en Afghanistan, les populations conceptualisent les problèmes de santé mentale et le bien-être, et comment ils cherchent de l'aide dans ces domaines.

Le chapitre deux présente les résultats d'une étude employant des méthodes d'évaluation ethnologique rapide – telles que les groupes de discussions thématiques (*focus group discussions*) – réalisée auprès d'adultes burundais affectés par la guerre.

Nous avons demandé à des Burundais, dans quatre provinces du pays, ce qu'ils considéreraient comme étant les difficultés et les problèmes majeurs résultant de la guerre. Les répondants ont désigné la mauvaise santé, la pauvreté et la détérioration du tissu social comme étant les effets majeurs. Parmi ces problèmes, des questions liées à la santé mentale et au bien-être psychosocial ont également été mentionnées, telles que: les états dépressifs, la peur et l'anxiété, le deuil, la folie et la toxicomanie. Cette étude met en évidence que la santé mentale et le bien-être psychosocial sont de graves préoccupations parmi les populations en situation d'urgence humanitaire complexe. C'est pourquoi, dans le reste de ce chapitre, je soutiens que la conception des interventions de santé mentale devrait tenir compte de ce que les bénéficiaires considèrent comme étant le plus important, et qu'elle devrait se rattacher à la façon dont ils conçoivent leurs problèmes.

Le chapitre trois examine plus en profondeur les 'points de vue locaux' en présentant une analyse comparative des idées concernant la santé mentale, au Burundi et dans trois autres zones de l'Afrique orientale touchées par des conflits. Les participants des groupes de discussion, dans chacune des quatre zones, ont décrit les syndromes locaux en termes de perturbations comportementales graves, correspondant remarquablement à la vaste catégorie des 'troubles psychotiques' de la psychiatrie professionnelle. Toutefois, les idées concernant l'étiologie et la signification des symptômes différaient considérablement des idées des professionnels en matière de psychoses. De plus, les résidents de chacune des quatre communautés avaient des termes locaux pour les états caractérisés par les termes de tristesse, de perte et d'isolement social. Ces concepts présentent des similitudes avec les 'troubles de l'humeur' tels qu'il sont définis par la psychiatrie professionnelle, mais il serait faux et peut-être dangereux de les réifier en termes de 'syndromes culturels', combinés à un ensemble de symptômes et d'étiologies. Dans la pratique, ils fonctionnent comme des idiomes exprimant la détresse (*idioms of distress*); comme des modes de communication culturellement prescrits pour exprimer qu'une personne se sent mal et/ou se sent malheureuse. De tels idiomes peuvent indiquer un état psychopathologique mais ne doivent absolument pas être considérés comme étant toujours indicatifs.

Le chapitre quatre décrit la guérison traditionnelle au Burundi à travers une analyse des pratiques de sept devins-guérisseurs (*abapfumu*). Ces praticiens emploient des méthodes spirituelles pour diagnostiquer la possession par les esprits et pour aider autrui à surmonter les affections. Les méthodes de guérison adorciatiques, employées dans le culte de *kubandwa*, visent à apaiser les esprits et à aider la personne possédée à retrouver une place dans la société. Celles-ci ont cependant été remplacées (à divers degrés) par une technique d'exorcisme appelée *gucékera*, par laquelle les esprits sont brutalement chassés des individus qui en sont affligés. Mes co-auteurs et moi-même émettons l'hypothèse que ces changements sont à relier aux effets de la modernité, décuplés par les effets des guerres qui ont profondément affecté le tissu social. De plus, nous relierons les résultats des recherches à la littérature ethnographique en matière de guérison traditionnelle et de divination présentes dans d'autres parties de l'Afrique.

Pendant la période où je travaillais en Afghanistan, je n'ai malheureusement eu que des possibilités réduites de mener une recherche ethnographique sur la façon dont les populations conçoivent les troubles mentaux, et sur leurs manières de chercher de l'aide. Au lieu de cela, je présente dans le chapitre cinq un article de revue offrant une synthèse des recherches consacrées aux enfants et de la littérature axée sur l'intervention, émanant de diverses disciplines afférentes à la santé mentale et au bien-être psychosocial en Afghanistan. Cet examen, qui contient des références aussi bien à la littérature ethnographique qu'épidémiologique, indique clairement que la multitude de problèmes de santé mentale et d'ordre psychosocial présents parmi la population afghane englobe un large éventail de problèmes qui dépassent les pathologies strictement 'liées à la guerre', mais également, et principalement peut-être, celles liées à la pauvreté, aux inégalités, ainsi qu'à d'autres formes d'adversité. Il est devenu clair également que pour les Afghans, des concepts culturels tels que 'honneur', 'unité familiale' et 'espoir' jouent un rôle significatif pour renforcer la résilience à l'adversité. Cependant, ces valeurs culturelles ne fonctionnent pas uniquement comme des 'atouts' mais peuvent, lorsqu'elles sont générées dans un contexte particulier, fonctionner aussi comme des carcans entravant les aspirations individuelles et la liberté.

### **Mesurer la santé mentale**

Dans la seconde partie de cette thèse, j'examine les questions concernant les mesures en matière de santé mentale. Ma préoccupation majeure dans ce domaine était de savoir comment interpréter les résultats d'auto-évaluations standardisées et succinctes.

Le chapitre six reprend le rapport concernant une étude transversale, basée sur un échantillonnage en grappes composé de 1011 adultes, sélectionnés au hasard dans la province orientale de Nangarhar, en Afghanistan. Cette étude a été menée un an après la chute des Talibans. L'une des principales caractéristiques de cette étude est l'estimation des taux de prévalence des symptômes de troubles mentaux courants dans cette zone, au début de la période d'après-conflit. Des taux élevés ont été rapportés pour les symptômes de dépression (38.5%), d'anxiété (51.8%) et de troubles de stress post-traumatique (PTSD) (20.4%), avec une différence marquée en fonction des genres: les taux de probabilité pour les femmes, comparativement aux hommes, étaient de respectivement de 7.3, 12.8 et de 5.8 pour ces derniers.

Le chapitre sept traite de la validité de la *Hopkins Symptom Checklist-25 (HSCL-25)*, l'un des instruments employés dans l'étude décrite au chapitre six. Ce travail était motivé par une préoccupation concernant l'emploi de tels instruments dans les contextes de situations d'urgence complexes en général, et dans celui de l'Afghanistan en particulier. Avec mes co-auteurs, j'ai testé le HSCL-25 ainsi qu'une autre échelle d'auto-évaluation succincte des troubles mentaux souvent employée, le *Self-Reporting Questionnaire-20*. Ces deux échelles d'auto-évaluation ont été comparées à un entretien psychiatrique semi-structuré, le *gold standard* (la norme d'or).

Les résultats ont été dérangeants. Les deux instruments de dépistage succinct avaient la modeste propriété d'identifier correctement les troubles mentaux (l'aire sous la courbe (*Area Under the Curve* – *AUC*) était respectivement de 0.73 et de 0.72). Les points de coupure optimaux de l'échelle différaient pour les hommes et pour les femmes. Les résultats de l'étude ont apporté un nouvel éclairage sur des études antérieures effectuées en Afghanistan avec le HSCL-25, et semblent indiquer que la prévalence des troubles mentaux chez les femmes a été surestimée tandis qu'elle était sous-estimée chez les hommes.

Le chapitre huit explore les propriétés psychométriques des échelles d'auto-évaluation des troubles mentaux, mais cette fois, en se concentrant sur les enfants au Burundi. Y sont explorées les propriétés psychométriques de la *Depression Self-Rating Scale* (DSRS) (Echelle d'auto-évaluation de la dépression – DSRS), de la *Child PTSD Symptom Scale* (CPSS) (Echelle d'évaluation des symptômes de l'état de stress post-traumatique chez l'enfant – CPSS), le *Screen for Child Anxiety Related Emotional Disorders* (SCARED-41) (Test de dépistage de l'anxiété liée au trouble émotionnel chez l'enfant – SCARED-41), sur la base d'un échantillonnage composé de 65 écoliers du primaire, au Burundi. Le critère externe du '*gold standard*' consistait en un examen diagnostique et semi-structuré avec les enfants, conformément aux critères du DSM-IV utilisant le *Schedule for Affective Disorders and Schizophrenia for School-Age Children (K-SADS-PL)*. Les échelles DSRS et CPSS étaient de qualité acceptable pour détecter les troubles dépressifs et le syndrome de stress post-traumatique (AUC respectivement de 0.85 et 0.78) si les points de coupure étaient nettement plus relevés que pour les populations occidentales servant de normes. Les résultats de l'emploi de SCARED-41 pour identifier les troubles de l'anxiété étaient moins encourageants (AUC: 0.69). Il serait possible d'attribuer cette performance assez faible de SCARED-41 au fait qu'il recouvre différentes catégories de troubles de l'anxiété, d'une validité culturelle et conceptuelle vraisemblablement restreinte.

### **Faire fonctionner le système**

Cette thèse met l'accent sur un troisième objectif, qui est de réaliser des interventions de santé mentale de façon à ce qu'elles aient 'du sens' dans le contexte donné, et en particulier, afin que de telles interventions aient un caractère durable. Dans une certaine mesure, et assez paradoxalement, les situations d'après conflit offrent des opportunités pour développer des politiques visant à offrir de meilleurs soins de santé mentale. Ceci est dû à un sentiment d'urgence, partagé par beaucoup de parties prenantes, quant à la nécessité de s'occuper des questions de santé mentale importantes et péniblement visibles.

Le chapitre neuf est une description et une analyse critique du programme de santé mentale et de soutien psychosocial réalisé par HealthNet TPO en Afghanistan. Ce programme, que j'ai contribué à mettre en place lorsque je travaillais en Afghanistan (2002-2005), visait à intégrer des aspects essentiels de la santé mentale dans le système de santé général, grâce à des formations pour les personnels de tous les ni-

veaux du système de santé, dans le domaine de l'identification et de la gestion des troubles mentaux prioritaires. Ce chapitre suit les développements dans six zones rurales du Nangarhar (le 'groupe Shinwar') sur une période de dix ans (2002-2011). Le nombre de patients souffrant de troubles mentaux ayant été traités au sein du service général de santé a considérablement augmenté, mais avec l'inconvénient que ce programme a peut-être contribué par inadvertance à un processus de médicalisation des problèmes sociaux.

Le chapitre dix décrit et analyse également un programme de santé mentale et de soutien psychosocial réalisé au Burundi. En l'espace de huit ans, l'on était passé d'une situation de guerre active à une fragile situation d'après conflit. Durant cette période, les activités du programme sont passées de la prestation directe de services à des activités de renforcement des capacités visant à incorporer les services psychiatriques et l'assistance psychosociale dans les services de santé existant au niveau local et dans les systèmes sociaux. Dans les années 2005-2008, j'ai vécu au Burundi et ai pris part à ce processus de transformation qui nous offrait d'énormes défis à relever, et la durabilité totale des activités de santé mentale et psychosociales n'a pas été atteinte.

Le chapitre onze synthétise la littérature consacrée à l'intégration de la santé mentale dans les soins de santé non spécialisés (c-à-d la santé primaire). Le document accorde une attention spéciale aux effets indésirables d'une telle intégration: en particulier, à la médicalisation de la détresse lorsqu'une approche biomédicale restrictive est employée. Lors de mon travail en Afghanistan, au Burundi, et plus tard dans diverses situations d'urgence humanitaire, j'ai été de plus en plus convaincu de ce que l'intégration des soins de santé mentale dans le système de santé primaire devrait s'accompagner d'un renforcement des autres niveaux des soins de santé et d'un encouragement au soutien communautaire.

## **Réflexions**

Le dernier chapitre de cette thèse est une réflexion sur les implications de mon travail pour le développement de la recherche en matière de santé mentale mondiale et pour la pratique en situation d'urgence humanitaire complexe.

Une première implication est que la culture et le contexte doivent être pris au sérieux. Les exemples de l'Afghanistan et du Burundi montrent que la violence collective et l'adversité liée à la guerre ont des effets à divers niveaux. La concentration sur l'individu, propre à la psychiatrie classique et à la psychologie clinique, pourrait occulter les effets de la violence au niveau collectif; les relations sociales sont fragilisées, les gens au sein des communautés ne se font plus confiance, l'entraide est devenue superflue ou dysfonctionnelle. Pour les praticiens aussi bien que pour les décideurs politiques, il est important de bien comprendre les catégories culturelles locales en matière de troubles mentaux et de détresse. Ces catégories culturelles, même si elles semblent parfois étroitement alignées sur les catégories psychia-

triques classiques, ne devraient pas être perçues comme des synonymes des catégories psychiatriques traditionnelles. Les termes locaux sont employés de manière pragmatique, ils sont ancrés dans des contextes particuliers qui sont incorporés dans des réseaux locaux de signification.

Une deuxième implication est que l'épidémiologie psychiatrique devrait, dans les contextes humanitaires complexes, se détourner de la collecte des chiffres de prévalence et, au contraire, repenser la santé mentale et le bien-être psychosocial comme des états qui sont culturellement enracinés et influencés par les facteurs sociaux. Un défi majeur consiste à garantir que la recherche épidémiologique n'assimile pas la souffrance sociale au trouble mental.

Une troisième implication est que la programmation en santé mentale, dans les contextes humanitaires complexes, requiert un effort profond pour utiliser des approches systémiques. Les projets en Afghanistan et au Burundi différaient largement, mais quelques-uns des enseignements qui en ont été tirés étaient similaires, en particulier celui qu'incorporer des soins de santé mentale de base dans un système général de soins devrait être associé à des activités communautaires et être fermement ancré dans une approche de renforcement du système de santé général (*health systems strengthening*). Intégrer les soins de santé mentale dans les soins de santé primaire comporte le danger intrinsèque de promouvoir des interventions biologiques et psychologiques pour des problèmes liés à des facteurs sociaux essentiels. J'en suis venu à penser que les soins de santé mentale, en tant que partie intégrante du système de soins de santé formels, doivent être associés à des interventions psychosociales communautaires qui ne mettent pas l'accent sur la 'boîte à outils des professions médicales', mais emploient plutôt la mobilisation des ressources présentes dans les communautés et le renforcement de la résilience et des facultés d'adaptation.

## Samenvatting in het Nederlands

Dit proefschrift gaat over Afghanistan en Burundi, twee landen die getroffen zijn door voortdurende complexe humanitaire noodsituaties en die worden gekenmerkt door een geschiedenis van etnisch-politiek collectief geweld. In beide landen heb ik een aantal jaren gewerkt, als medewerker van de niet-gouvernementele organisatie HealthNet TPO. Mijn hoofdtaak was het opzetten van programma's voor geestelijke gezondheid (GGZ), maar als de tijd me dat toestond probeerde ik ook, tussen de bedrijven door, onderzoek te doen. Dat heeft uiteindelijk tot dit proefschrift geleid. Hierin staan drie onderzoeksvragen centraal:

- 1 Welke opvattingen en perspectieven hebben mensen in de context van complexe humanitaire noodsituaties *zelf* over hun geestelijke gezondheid en manieren om die te verbeteren?
- 2 Hoe kunnen geestelijke gezondheidsproblemen in complexe humanitaire noodsituaties betrouwbaar worden vastgesteld?
- 3 Hoe kunnen functionele en duurzame systemen voor geestelijke gezondheid en psychosociale zorg worden opgezet in complexe humanitaire noodsituaties?

Voor het beantwoorden van deze centrale vragen is het nodig gebruik te maken van een scala van onderzoekstechnieken, afkomstig uit diverse wetenschapsgebieden.

De inleiding (hoofdstuk één) laat de lezer kennismaken met de verschillende contexten waarin het onderzoek plaatsvond. Daarbij gaat het om 1) het geven van een overzicht van het vakgebied 'wereldwijde geestelijke gezondheid' (*global mental health*), en meer in het bijzonder van 'geestelijke gezondheid en psychosociaal welzijn in complexe humanitaire noodsituaties' (*mental health and psychosocial support in complex humanitarian emergencies*); 2) het beschrijven van de sociaal-politieke achtergrond van Afghanistan en Burundi; en 3) het schetsen van de academische disciplines die gebruikt worden in dit proefschrift, te weten: a) etnografisch onderzoek om lokale perspectieven te exploreren; b) epidemiologisch onderzoek om psychische stoornissen op populaties niveau te meten; en c) onderzoek naar gezondheidssystemen om te analyseren hoe GGZ interventies binnen het kader van 'wereldwijde geestelijke gezondheid' optimaal functioneel en duurzaam kunnen worden gemaakt.

### Lokale perspectieven op geestelijke gezondheid en genezing

In het eerste deel van het proefschrift onderzoek ik hoe mensen in Burundi en Afghanistan en problemen rondom geestelijke gezondheid en psychosociaal welzijn conceptualiseren, en hoe ze hulp zoeken voor dit soort problemen.

Hoofdstuk twee presenteert de resultaten van een studie met behulp van snelle kwalitatieve evaluatie methoden, zoals focus discussie groepen. We vroegen aan Burundese mannen en vrouwen in vier provincies van het land wat zij zagen als de belangrijkste problemen en problemen als gevolg van de oorlog. De respondenten noemden toename van gezondheidsproblemen, meer armoede en de afbraak van het sociale weefsel als belangrijke effecten. Temidden van deze zorgen werden pro-

blemen rondom geestelijke gezondheid en psychosociaal welzijn ook genoemd, met name depressie, angst, verdriet, ‘gekke’ en drugsmisbruik. Dit hoofdstuk maakt duidelijk dat problemen rondom geestelijke gezondheid en psychosociaal welzijn wel degelijk een prioriteit zijn voor mensen in humanitaire noodsituaties. In dit hoofdstuk pleit ik er dan ook voor om bij het ontwikkelen van GGZ interventies in dat soort gebieden rekening te houden met hoe mensen zelf hun problemen conceptualiseren.

Hoofdstuk drie gaat dieper in op ‘lokale perspectieven’, door een vergelijkende analyse te presenteren van ideeën rondom geestesziekten in Burundi en drie andere conflict getroffen gebieden in Oost-Afrika. In alle vier locaties beschreven deelnemers aan de focus discussie groepen lokale syndromen die werden gekenmerkt door ernstige gedragsstoornissen. Deze beschrijvingen corresponderden opmerkelijk goed met de categorie van ‘psychotische stoornissen’ van de professionele psychiatrie. Echter, de ideeën over de ontstaanswijzen van de stoornissen en de betekenis van symptomen verschilden aanzienlijk van de professionele opvattingen over psychose. Daarnaast hadden de mensen in elk van de vier locaties ook lokale termen voor mildere aandoeningen die gekenmerkt werden door verdriet, verlies en sociale isolatie. Deze concepten hadden weliswaar overeenkomsten met ‘stemmingsstoornissen’ zoals gedefinieerd in de professionele psychiatrie, maar het zou onjuist en zelfs gevaarlijk kunnen zijn om ze daaraan zondermeer gelijk te stellen of om ze te beschouwen als welomschreven ‘culturele syndromen’, compleet met een samenhangend geheel van symptomen en een coherente etiologie. In de praktijk fungeren dit soort lokale termen namelijk als *idioms of distress*; cultureel voorgeschreven manieren om in taal en symptoom uit te drukken dat iemand zich onwel voelt of ongelukkig is. Dit soort *idioms of distress* kunnen wijzen op het bestaan van psychopathologie, maar dat is zeker niet altijd het geval.

Hoofdstuk vier beschrijft traditionele geneeswijzen in Burundi, door middel van een analyse van de praktijken van de zeven spirituele genezers (*abapfumu*). Deze genezers gebruiken bovennatuurlijke methoden om geestesbezetenheid te diagnosticeren en hun cliënten te helpen daarmee om te gaan. Sommige van de genezers gebruikten ‘adorcistische’ geneestechnieken van de *kubandwa* sekte die bedoeld zijn om geesten te kalmeren en de bezeten persoon te helpen bij het herwinnen van zijn of haar plaats in de samenleving. Deze manier van genezen is in de loop van de tijd (deels) verdrongen door een andere ‘exorcistische’ techniek (*gucquera*), waarbij geesten op agressieve wijze worden uitgedreven. Mijn co-auteurs en ik veronderstellen dat deze veranderingen verband houden met de effecten van modernisering die is versneld door de gevolgen van de oorlog die diep heeft ingesneden in het sociale weefsel van de Burundese samenleving. We verbinden de onderzoeksresultaten ook met de etnografische literatuur over de traditionele genezing en waarzeggerij in andere delen van Afrika.

In de tijd dat in Afghanistan werkte had ik helaas slechts beperkte mogelijkheden om etnografisch onderzoek te doen naar hoe mensen zelf psychische stoornissen conceptualiseren en hoe zij hulp zoeken. In plaats van primair onderzoek presenteer ik daarom in hoofdstuk vijf een literatuurstudie die een synthese geeft van door anderen gedaan onderzoek naar kinderen in Afghanistan. Ik doe dat vanuit verschillen-

de disciplines die relevant zijn voor de geestelijke gezondheid en psychosociaal welzijn, waaronder cultureel antropologische maar ook epidemiologische onderzoeken. Het hoofdstuk maakt duidelijk dat de problemen rondom geestelijke gezondheid en psychosociaal welzijn in de Afghaanse bevolking een breed scala vormen en dat de problemen veel verder gaan dan ‘oorlog gerelateerde’ pathologie in engere zin. Het gaat ook, en misschien zelfs wel *vooral*, om problemen die te maken hebben met armoede, ongelijkheid, en andere vormen van structurele tegenspoed. Het werd ook duidelijk dat voor de Afghanen culturele begrippen als ‘eer’, ‘eenheid van het gezin’ en ‘hoop’ een belangrijke rol spelen in hun veerkracht om aan tegenslagen het hoofd te bieden. Maar daarbij moeten we wel beseffen dat dit soort culturele waarden niet alleen functioneren als iets dat zondermeer ‘goed’ is, maar dat ze altijd gegeneerd worden in een specifieke context, en daarin ook kunnen functioneren als een keurslijf waarmee individuele ambities en vrijheden worden gedwarsboomd.

### **Het meten van de geestelijke gezondheid**

In het tweede deel van dit proefschrift verken ik problemen rondom het meten van geestelijke gezondheid, en vooral hoe de resultaten van onderzoek met korte gestandaardiseerde zelf- invul vragenlijsten geïnterpreteerd moeten worden.

Hoofdstuk zes doet verslag van een cross-sectionele, multi-cluster steekproef onder 1011 willekeurig geselecteerde volwassenen in de provincie Nangarhar in het oosten van Afghanistan. Het onderzoek werd uitgevoerd een jaar na de val van de Taliban. Een van de belangrijkste elementen van deze studie in een vroege post-conflict context is het schatten van de prevalentie van symptomen van psychische aandoeningen. We vonden hoge symptoom niveaus voor depressie (38,5%), angst (51,8%), en posttraumatische stress stoornis (PTSS, 20,4%), met duidelijke gender verschillen: *odds ratio's* voor vrouwen in vergelijking met mannen waren respectievelijk 7,3, 12,8 en 5,8.

Hoofdstuk zeven onderzoekt de validiteit van de *Hopkins Symptom Checklist-25*, één van de instrumenten die we in de studie van hoofdstuk zes studie gebruikten. Dit validatieonderzoek is ingegeven door onbehagen en bezorgdheid over het gebruik van dit soort korte zelfbeoordelvragenlijsten in de context van complexe humanitaire noodsituaties, zoals in Afghanistan. Samen met mijn co-auteurs, testte ik de HSCL-25 en een andere vaak gebruikte vragenlijst voor psychische aandoeningen, de *Self-Reporting Questionnaire-20*. De uitkomsten van deze twee kort zelfbeoordelvragenlijsten werden vergeleken met de uitkomsten van een ‘gouden standaard’ onderzoek: een semi-structureerd psychiatrisch interview door een professional. De resultaten waren nogal ontnuchterend; beide vragenlijsten hadden beperkte voorspellende waarde om psychische stoornissen zoals die in psychiatrisch onderzoek werden vastgesteld, correct te identificeren (De maat die hiervoor wordt gebruikt, de *Area Under the Curve* – *AUC* – was respectievelijk 0,73 en 0,72 hetgeen als ‘matig’ beschouwd kan worden). De optimale afkappunten van de schalen verschilden aanzienlijk voor mannen en voor vrouwen. Deze studieresultaten werpen nieuw licht op de uitkomsten van eerdere studies in Afghanistan met de HSCL-25 en het is aannemelijk dat de eerdere studies het vóórkomen van psychische

stoornissen bij vrouwen hebben overschat, terwijl ze de prevalentie bij mannen juist onderschat hebben

Ook hoofdstuk acht onderzoekt de psychometrische eigenschappen van zelfbeoordelingsvragenlijsten voor psychische stoornissen, ditmaal bij kinderen in Burundi. In een steekproef van 65 kinderen van basisschoolleeftijd in Burundi onderzochten we de psychometrische eigenschappen van de *Depression Self-Rating Scale* (DSRS), de *Child PTSD Symptom Scale* (CPSS) en de *Screen for Child Anxiety Related Emotional Disorders* (SCARED-41). De externe ‘gouden standaard’ was ditmaal een uitgebreid, semi-gestructureerd, klinisch psychiatrisch interview voor kinderen, volgens de DSM-IV criteria (de K-SADS-PL). De DSRS en CPSS bleken acceptabele eigenschappen te hebben voor het opsporen van depressieve stoornissen en post-traumatische stress-stoornissen (AUC was 0,85 en 0,78, respectievelijk), waarbij de afkappunten hoger werden gesteld dan gebruikelijk bij westerse norm populaties. De capaciteit van SCARED-41 om correct angststoornissen te identificeren, was veel minder goed (AUC: 0,69). De relatief zwakke prestaties van de SCARED-41 kunnen mogelijk worden toegeschreven aan het feit dat dit instrument verschillende categorieën van angststoornissen meet, die mogelijk beperkte culturele en construct validiteit hebben in de Burundese context.

### **Het functioneel maken van zorgsystemen**

Een derde doel van dit proefschrift is te exploreren hoe de GGZ interventies in complexe humanitaire noodsituaties kunnen worden opgezet op een manier die passend en logisch is de specifieke context, en hoe dit soort interventies ‘duurzaam’ kunnen worden gemaakt. Tot op zekere hoogte, en dat lijkt paradoxaal, bieden postconflict situaties, ondanks alle problemen en tekorten, vaak juist kansen om de geestelijke gezondheidszorg beter te maken. Dat komt onder andere doordat in dit soort contexten psychische problemen zo duidelijk zichtbaar worden dat ze niet meer genegeerd kunnen worden en er een algemeen gedeeld gevoel onder alle belanghebbenden ontstaat dat het nu echt urgent en noodzakelijk is om de massale psychische problemen aan te pakken.

Hoofdstuk negen beschrijft en analyseert het programma voor de geestelijke gezondheidszorg en psychosociale ondersteuning van HealthNet TPO in Afghanistan. Dit programma, dat ik hielp op te zetten toen ik in Afghanistan woonde (2002-2005), was er op gericht om kernaspecten van de geestelijke gezondheid in de algemene gezondheidszorg te integreren. Dat deden we door het personeel op alle niveaus van de gezondheidszorgsysteem te trainen in het herkennen en behandelen van de meest belangrijke psychische gezondheidsproblemen. Het hoofdstuk volgt de ontwikkelingen in zes plattelandsdistricten (het ‘Shinwar cluster’) in de provincie Nangarhar gedurende een tijdsbestek van tien jaar (2002-2011). Het aantal patiënten met psychische aandoeningen die binnen de algemene gezondheidszorg werden behandeld is in die periode enorm toegenomen. Dat is op zichzelf natuurlijk een winstpunt, maar een nadeel is dat het programma onbedoeld kan hebben bijgedragen aan een proces van ‘medicalisering’ waarbij primair sociale problemen worden omgevormd tot ‘medische aandoeningen’.

In dezelfde trant beschrijft en analyseert hoofdstuk tien een programma voor geestelijke gezondheidszorg en psychosociale ondersteuning in Burundi gedurende een tijdsbestek van acht jaar. In die periode veranderde de context in Burundi van een actieve oorlogssituatie tot wederopbouw in een fragiele post-conflict situatie. Gedurende deze acht jaar veranderden ook de programma-activiteiten: aanvankelijk ging het vooral om directe dienstverlening, maar later verschoof het accent naar capaciteitsopbouw en het integreren van psychiatrische en psychosociale hulp in bestaande lokale systemen voor gezondheidszorg en sociale steun. Ik woonde van 2005 tot 2008 in Burundi en maakte deel uit van dit transformatie proces. We werden geconfronteerd met enorme uitdagingen, en volledige duurzaamheid van de geestelijke gezondheidszorg en psychosociale activiteiten kon dan ook niet gerealiseerd worden.

Hoofdstuk elf geeft een synthese de wetenschappelijke literatuur rondom de integratie van de geestelijke gezondheidszorg in niet-gespecialiseerde gezondheidszorg met name eerstelijnsgezondheidszorg. Ik schreef dit hoofdstuk met speciale aandacht voor een ongewenste bijwerking van 'integratie': namelijk de medicalisering van geestelijk lijden door een beperkte 'biomedische' benadering. Tijdens mijn werk in Afghanistan en Burundi en later ook in diverse andere complexe humanitaire noodsituaties, raakte ik er steeds meer van overtuigd dat de integratie van de geestelijke gezondheidszorg in primaire gezondheidszorg alleen succesvol kan zijn als die wordt vergezeld door versterken van GGZ elementen op de andere niveaus van de gezondheidszorg en door het bevorderen van onderlinge sociale steun in gemeenschap.

## **Reflecties**

In het laatste hoofdstuk van dit proefschrift reflecteer ik op de consequenties die de bevindingen van de andere hoofdstukken zouden kunnen hebben voor de ontwikkeling van het vakgebied 'wereldwijde geestelijk gezondheid' en dan met name in complexe humanitaire noodsituaties.

Een eerste implicatie is dat cultuur en context serieus genomen moeten worden. De casus van Afghanistan en Burundi illustreren dat collectief geweld en oorlogsgelateerde tegenspoed een impact hebben op verschillende niveaus. De nadruk die de klassieke psychiatrie en klinische psychologie leggen op individueel intrapsychisch lijden verdoezelt de gevolgen van geweld op interpersoonlijk niveau: verzwakte sociale verbondenheid, mensen die elkaar niet meer vertrouwen en elkaar niet meer effectief kunnen steunen. Voor GGZ behandelaren en beleidsmakers is belangrijk om een goed zicht te krijgen op de lokale culturele categorieën voor geestelijk onwelbevinden. Dergelijke culturele categorieën, zelfs als zij in eerste instantie nogal lijken op professionele psychiatrische categorieën, moeten niet klakkeloos worden beschouwd als synoniemen daarvan. Lokale termen worden vaak pragmatisch gebruikt en zijn geworteld in een specifieke context en ingebed in semantische netwerken.

Een tweede implicatie is dat psychiatrische epidemiologie in complexe humanitaire noodsituaties zich niet meer zou moeten blindstaren op het verzamelen van pre-

valentiecijfers, maar in plaats daarvan zou moeten onderzoeken hoe psychische symptomen zijn ingebed in en worden beïnvloed door culturele, sociale, politieke en economische factoren. Een belangrijke uitdaging voor epidemiologisch onderzoek is om adequaat te leren differentiëren tussen 'sociaal lijden' en het hebben van een 'psychische stoornis'.

Een derde implicatie is dat het essentieel is om bij het ontwikkelen van programma's voor geestelijke gezondheidszorg in complexe humanitaire noodsituaties een brede 'systeem georiënteerde' benadering te gebruiken. Hoewel de projecten in Afghanistan en Burundi heel verschillend waren, zijn sommige lessen hetzelfde. Een belangrijke les is bijvoorbeeld dat het integreren van basispsychiatrie in de algemene gezondheidszorg hand in hand moet gaan met gemeenschaps-bevorderende activiteiten, en verankerd moet zijn in een algemene aanpak voor het versterking van gezondheidssystemen. Het integreren van geestelijke gezondheidszorg in de eerstelijns gezondheidszorg draagt het inherente gevaar in zich van een eenzijdig leunen op biologische en psychologische interventies voor problemen die vooral ook sociale oorzaken hebben. In de loop van de jaren dat ik over dit proefschrift na heb gedacht ben ik tot de overtuiging gekomen dat de geestelijke gezondheidszorg, als onderdeel van de formele gezondheidszorg, vergezeld moet gaan van *community-based* psychosociale interventies die niet zozeer van het medisch-therapeutische interventie arsenaal gebruik maken, maar van de kracht die te vinden is in de sociale netwerken van mensen en die in te zetten om de weerbaarheid en zelfredzaamheid van individuen te vergroten.

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Peter Ventevogel (born on 19 June 1967 in Vlissingen, the Netherlands), studied medicine (MD in 1994) and cultural anthropology (MA in 1992) at the VU University in Amsterdam. His anthropological fieldwork in Ghana, in 1991 to 1992, under the supervision of prof. dr. S. van der Geest, resulted in the publication of 'Whiteman's things, training and de-training healers in Ghana (Uitgeverij Het Spinhuis, Amsterdam, 1997).

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Over the years, he did various short-term consultancies for the World Health Organization and the United Nations High Commissioner for Refugees (UNHCR) in Egypt, Jordan, Libya, Pakistan, Sudan and Syria.

In October 2013 he moved to Geneva, Switzerland, to work full time with UNHCR as the Senior Mental Health Officer in the Public Health Section, where he is responsible for policy development and field support to refugee operations of UNHCR worldwide.

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#### **1992**

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Peter Ventevogel was born in Vlissingen, the Netherlands and holds academic degrees in medicine, psychiatry and cultural anthropology. From 2002-2005 he worked in Jalalabad, Afghanistan and from 2005-2008 in Bujumbura, Burundi, where he was involved in setting up mental health programmes with the Dutch nongovernmental organisation HealthNet TPO.

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