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# DETERMINANTS OF MENTAL HEALTH: IMPROVING RWANDA'S MENTAL HEALTH SYSTEM

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## ABSTRACT

Rwanda, being a post-conflict setting has been inconclusive in the assessment of its Mental health system from several studies. Not much work has been done in any country of such setting in relation to assessing the entire mental health system after a major armed conflict of genocidal proportion. Therefore, in this review, the use of an academic model- the Dahlgren and Whitehead framework to identify determinants of Mental health in the region.Determinants of Mental Health in Rwanda are the 1994 genocide, COVID-19, resentment/bitterness/unforgiveness, HIV burden directly and indirectly, substance abuse, high sexual activity of the young population, tobacco smoking, social isolation, post-traumatic stress disorder, intimate partner violence, socio-economic hardship and development gaps in infrastructures and institutions.Recommendations of research, more infrastructural developments, the integration of traditional medicine, capacity building and more community participation are given to consolidate on the impressive attempts made by the government for the improvement of mental health in Rwanda. These recommendations, together with what the government has done can serve as a blueprint for systems with similar post-disaster or conflict context.



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# INTRODUCTION

According to World Health Organization, determinants of health are those factors that can enhance or threaten an individual's or a community's health status and Mental health is described as a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community (World Health Organization, 2004).Mental health is an integral part of health and well-being, as reflected in the definition of health in the Constitution of the World Health Organization: 'Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity' (World Health Organization, 2022). Dahlgren and Whitehead's determinants of health framework (Dahlgren & Whitehead, 2021) provides an enabling platform that improves health, through categorizing determinants of health (Rice & Sara, 2019). The effectiveness of Rwanda's Mental Health System as evaluated from the international literature is highly debatable. Objectively speaking, we could say that it is still inconclusive as we cannot ascertain how effective some of its policies, interventions or strategies have been (Betancourt *et al*., 2013; Ng & Harerimana, 2016; Rugema *et al*., 2015; Sabey, 2019; Saraceno et al., 2007; Yarlagadda, 2022). Therefore, a holistic approach through the Dahlgren and Whitehead's model is adopted to identify the factors of mental health in Rwanda, and then the interventions carried out to improve mental health in the country will be matched with these factors to have a good grasp of how effective these efforts have been in improving these determinants. Recommendations will be given if gaps are identified.

# METHODOLOGY

Ten key phrases were used to search the literature and Table 1 below summarizes the number of articles these key phrases were able to find, and the ones finally included, for this study after screening the initial ones found.Putting into consideration databases that have significant collections of articles with mental health themes, thirteen databases were selected for this study. Each of these ten key phrases, in Table 1 were searched through each of the thirteen selected databases which are: Academia.edu, African Journal Online (AJOL), biomed central, frontier in, Google Scholar, ingentaconnect, Psychotrauma net, Pub Med, Public Library of Science (PLOS ONE), Researchgate, Science direct, Springer and Taylor & Francis Online. Table 2 summarizes how articles were searched and finally included

after screening through these databases. During this search, 279 full-text articles were identified from academic databases while 80 were retrieved from Google Scholar. After identifying the total of 359 articles, 131 duplicates were found and eliminated to leave 228 articles for the screening phase of our search. During screening, 61 articles were further excluded because they were published before the year 1980, which means they are not recent publications. This leaves 167 articles for the eligibility phase of our search. To meet the eligibility for this study, the Abstracts, introductions, and conclusions of the remaining 167 articles were carefully assessed and 77 more articles were excluded due to unrelated contents. The final number of articles included for this study was 90. The inclusion and exclusion criteria for the final inclusion of the 90 articles are summarized in Table 3.

**Table 1. Articles Included after Screening from the 12 Key Phrases**

| Key Phrases | Articles Found | Articles Included |
|---|---|---|
| Actors in Rwanda mental health | 56 | 7 |
| Causes of mental health in Rwanda | 66 | 23 |
| Challenges of mental health in Rwanda | 29 | 4 |
| Equity and mental health in Rwanda | 11 | 3 |
| Gaps in mental health, Rwanda | 8 | 6 |
| Gender and mental health, Rwanda | 3 | 2 |
| Lifestyle causes of mental health in Rwanda | 13 | 4 |
| Mental health in Rwanda | 71 | 14 |
| Mental health interventions in Rwanda | 33 | 8 |
| Mental Health System in post-disaster and conflict countries | 69 | 19 |
| Total | 304 | 90 |

**Table 2. Articles Included After Finding and Screening from 11 Databases**

| Databases | Articles Found | Articles Included |
|---|---|---|
| Academia.edu | 34 | 5 |
| African Journal Online (AJOL) | 18 | 7 |
| Biomed central | 66 | 11 |
| Frontiers in | 11 | 2 |
| Google Scholar | 80 | 17 |
| Ingentaconnect | 10 | 3 |
| Psychotrauma net | 12 | 2 |
| Pub Med | 33 | 11 |
| Public Library of Science (PLOS ONE) | 8 | 3 |
| Researchgate | 28 | 9 |
| Science direct | 22 | 7 |
| Springer | 22 | 6 |
| Taylor & Francis Online | 15 | 7 |
| Total | 359 | 90 |

**Table 3. Inclusion and Exclusion Criteria of Study**

| Inclusion Criteria | Exclusion Criteria |
|---|---|
| 1. related titles<br>2. English-only publications<br>3. Full-texted articles<br>4. easy access articles (downloadable)<br>5. related Abstract + Introduction + Conclusion<br>6. Research articles, Meta-analyses, systematic reviews and publications of events strongly associated to the topic of study | 1. unrelated titles<br>2. duplicates<br>3. any of these components, not related to the topic of study: Abstract, Introduction or Conclusion<br>4. monetized articles<br>5. non-downloadable articles<br>6. non-English publications<br>7. review articles, letters to editors, personal opinions or "perspective" articles |

# DISCUSSION

### *Determinants*

| *Layers* | *Definitions* |
|---|---|
| Core | Fixed determinants such as Age, sex and constitutional factors |
| First | Individual lifestyle factors |
| Second | Social and community networks such as family, friends and local communities |
| Third | Larger networks surrounding living and working conditions such as Agriculture and food production, education, work environment, employment status, water and sanitation, health care services, housing etc. |
| Fourth | General socioeconomic, cultural and environmental conditions such as government policies, economic recessions/boom, unfavourable laws etc. |

**Figure 1. Different Layers of the Dahlgren and Whitehead Framework and their definitions**

Figure 1 summarizes the layers defined by the Dahlgren and Whitehead Model which will be used to analyse the mental health status of Rwandans. A person's mental health can be affected by the four layers of this framework through the number of factors each layer is defined by. These determinants range from social, economic and physical factors in an environment which a person lives (Allen et al., 2014). This discussion will not follow the determinants in any particular order so as not to be distracted by the model itself, but rather, concentrate fully on the actual factors causing mental health disorders in Rwanda.

### *The Rwandan Genocide and COVID-19: Layer 4*

The 1994 genocide and civil war between the two ethnic groups of the Tutsi and Hutu had largely been a major determinant of mental health disorder in Rwanda. Though it is a level 4 determinant, it has had a massive spillover effect that cuts across all determinants. Approximately one million people lost their lives during the genocide and 250,000 women were raped, as millions were displaced (Pham et al., 2004). This genocide affected the population at all stages. For example, the pregnant mothers at that time were not able to access antenatal care because the health system collapsed. This is a spill over to layer-3 of the model. This not only impacted on the mental health of the pregnant women, it also affected the quality of the mental health of their children. The effects of the war continued to expose the children born after the genocide with stressors that have, till date, continued to cause mental health disorders, a layer-2 determinant at play here. The genocide, characterized by violent attacks of murder, rape, destruction of property and looting rendered the communities powerless and exposed to poor living conditions, hence exacerbating the layer-3 determinant. This translates to increased levels of poverty as most properties were destroyed, looted and more importantly, it made the environment hostile to the victims to engage in productive economic activities. The rape victims who were largely of the female population are most likely going to suffer mental disorders since there is an established fact that shows the correlation between the two (Campbell, 2008; Kilpatrick, 2003; Koss & Harvey, 1991; SILVERMAN, 2012). The genocide continues to pose huge trauma and depression among the survivors of the war. This trauma has impacted on mental illnesses within the communities that witnessed the horrific events during the civil war (Palmer & Firmin, 2011). COVID 19, which has nothing to do with the genocide is another determinant of mental health illness in Rwanda under this layer. It has been recently reported to have caused mental health disorders among

the general population and the frontline health workers. During the pandemic, countries locked down the population, putting restrictions on movements on the people, and Rwanda was no exception. The restrictions on movement made it very difficult for patients to access health care services, escalating mental health disorders in Rwanda (Nshimyiryo et al., 2021). Rwanda, being the first country in the Sub-Saharan region of Africa to impose lockdowns, social gathering limitations, closure of educational facilities and the wearing of masks, the people suffered psychological stresses such as anxiety disorders, continued fear and panic attacks (Kalisa *et al.,* 2020).

***Core-Layer Determinants:*** The 'political apology' of the perpetrators of the genocide means that restitution is not satisfactorily achieved. The victims and their descendants have every right to still feel resentment towards the perpetrators of the genocide and, hence, not to forgive them (Jeffery, 2011; Vollhardt&Bilewicz, 2013; Wilson &Bleiker, 2013). But Brandon J. Griffin and Colleagues (Griffin et al., 2015) concluded in their study that forgiveness is an effective way to promote better mental health among the victims and perpetrators of harm. The issue of forgiveness is not only important to the victims of the genocide and their families but also to those who perpetrated harm. Ann Macaskill (Macaskill, 2012) demonstrated the positive link between dispositional self-forgiveness with mental health and life satisfaction, strongly suggesting the need for the perpetrators of the genocide to forgive themselves and doing otherwise puts them at a high risk of anxiety, shame and anger. More studies strongly link the feeling of unforgiveness for past transgressions to depressive symptoms of later life, be it the forgiveness of others on oneself or one's forgiveness of others. Symptoms of unforgiveness are, but not limited to bitterness, the emotions of resentment, hostility, hatred, residual anger and fear. They all eventually lead to poor mental health outcomes, usually depressive disorders in later years of life (Ingersoll-Dayton et al., 2010; Toussaint & Webb, 2005; Tuck & Anderson, 2014). And Ashley Ermer and Christine Proulx (Ermer & Proulx, 2016) showed that men more easily forgive then women.

Also, post-traumatic stress disorder, depression, anxiety and suicidal attempts are prevalent in Rwanda. Despite the women slightly less exposed than the men during the genocide, their rates of the afore-mentioned disorders are twice as much when compared to the men. And this has been strongly associated with the physical and sexual abuse that they faced (Rugema et al., 2015). During the Covid-19 pandemic, lockdowns prompted the younger population to misuse the internet as a coping mechanism for isolation and loneliness. This led to the massive exposure to pornography and violent movies, resulting to 'maniac syndromes' and an increased likelihood for violent crimes (Ngamije, 2021). Finally on this layer, young people in Rwanda are sexually active, leading to one of the major causes of the high prevalence of HIV among the young population. The burden of disease and especially the antiretroviral adherence significantly affects their mental health negatively (Smith et al., 2016), indicating the age determinant of mental health in Rwanda.

***Lifestyle- 1st Layer:*** Drug abuse and other psycho-active substances are determinants of mental health in Rwanda. The country lacks a strategy that supervises treatment of such phenomenon that degenerate to mental suffering and destabilizes the social fabric. More than half of the youth had used substance/drug (52.4%), among them 7.46 % are dependent on alcohol, 4.88 % on tobacco and 2.54 on Cannabis. The age of onset is as low as 11 years (Mohand &Kayiteshonga, 2015). The sexual activity of the young population, leading to HIV and its associated mental health outcomes can also be categorized under lifestyle determinant and therefore can be a 1st layer determinant of Mental Health in Rwanda as well. Tobacco smokers, people with high blood pressure, people that are physically inactive and those with an abdominal obesity have poor mental health, health-related quality of life (HRQOL) in Rwanda (Biraguma et al., 2018). Also, behavioural and biological risk factors to non-communicable diseases such as Type-2 Diabetes Mellitus, Hypertension and Malignancies are significantly associated with poor mental health, health-related quality of Life (HRQOL) in Rwanda (Biraguma et al., 2018).

***Community and Family determinants- 2nd Layer :*** Due to the historic violence and genocide, community life has been altered in Rwanda, hence, the predominance for social isolation. And because to this, the community is hardly ever used to promote healthy mental well-being through synergic approaches of collective strength and resources. The outcome of this issue is the medicalization of social problems and the use of 'the community' for the reduction of healthcare cost to increase economic efficiency. This has resulted to a huge treatment gap in the mental health system of Rwanda (Jansen et al., 2015). Also, the families of survivors, survivors themselves and the prisoners of the genocide and their families significantly suffer from post-traumatic stress disorder (PTSD) (Rieder & Elbert, 2013). HIV/AIDS is another factor of significance in this layer. Evidence has shown that HIV positive children and HIV-affected children, especially orphans who are catered for by HIV-positive caregivers or adopted/foster parents have demonstrated higher levels of depression, anxiety, conduct problems and have also manifested more conduct impairment when compared with HIV-unaffected children in Rwanda (Betancourt et al., 2013). Furthermore, intimate partner violence (IPV) is a common social problem in Rwanda communities, especially in the rural settings. Substantial evidence still shows a correlation between increased mental health disorders to victims of IPV in the Rwandan communities (Mukashema, 2014; Verduin et al., 2013). And finally, HIV-related factors such as: being unmarried, discrimination, lack of HIV disclosure and low CD4 count of less than 350 cell counts/$mm^3$ have been significantly associated with poor mental health and health-related quality of life (HRQOL) in Rwanda (Biraguma et al., 2018).

***3rd Layer:*** Both the young and old were largely deprived of their economic and social rights as majority of the Rwandans migrated to neighbouring countries of DR Congo and Burundi due to the genocide(Munyandamutsa et al., 2012). The socio-economic hardships during and after the genocide propelled mental health problems. The genocide destroyed all the infrastructure and institutions, and this explains why there was hardship in trying to access social services like education, medical care and employment. This created social clusters among the two ethnic groups of the Tutsi and Hutu communities causing more mental health disorders.Figure2 is a summary of the determinants of Mental Health in Rwanda according to these layers discussed.

| *Layers* | *Definitions* |
|---|---|
| Core | Victims of rape from the war, victims of IPV, the burden of HIV/AIDs in the young population and the tendency to not forgive and reconcile with perpetrators, as victim, or with oneself as an offender during the war. The watching of pornography and violent movies by the younger generation. |
| First | Substance abuse, cigarette smoking, poor eating habits, physical inactivity and other lifestyle habits predisposing one to Non-communicable diseases, |
| Second | Children with Mental health disorders directly affected by their mentally ill mothers; disrupted community life etc. |
| Third | Destruction of healthcare system, poor living conditions of poverty, destitution and a destroyed social system. |
| Fourth | The 1994 civil war and COVID-19 Pandemic |

**Figure 2. Different Determinants of Mental Health in Rwanda According to the Dahlgren and Whitehead Framework**

***Responses***

1. ***1995 National Mental Policy*:** Rwanda developed and launched the first National Mental Policy in 1995 to address mental health at all levels, in all structures. The major focus of this

policy was to mitigate and eliminate complex barriers for improved access and outcomes of the mental healthcare program and services in Rwanda (Mohand &Kayiteshonga, 2015). This Mental Health policy was surrounded by uncertainty at the time of development because it was created with limited data, and while its interventions needed support from research, they were not based on robust evidence, as few post-conflict countries have implemented mental health policies (Sabey, 2022). The policy highlighted a number of priorities among which included; Decentralization of mental health care, accessibility of health care in the communities, human resources development, information and education (Republic of Rwanda Ministry of Health, n.d.). Decentralization of mental health services in primary health care package at district level was put in place to ensure that mental health services were brought closer to the people who needed them. Each district in Rwanda was empowered with a referral hospital which was affiliated to eight to twenty primary health care centres. All the 43 district health hospitals had a mental health unit (Mohand &Kayiteshonga, 2015). This was able to address the issues of access and reconstructing the broken healthcare systems. Strategies such as decentralization and integration of mental health care into the primary health care system increased access to care and have the potential to be successful in implementing mental health reforms in post-conflict countries, especially those lacking personnel, resources and financing (Sabey, 2022). The decentralization of mental health care facilitated the establishment of an integration of mental health into the primary health care model using the community-based approach. This included the community-based health insurance that covers psychotropic medicines on the list of essential medicine in Rwanda. Primary health care enhanced promotion of community-based approaches for responding to mental health care. This followed the involvement of the community members in the fight against mental health disorders.

2. ***Community-based Approach*:** The Government took deliberate efforts to reconstruct the collapsed health systems that was almost destroyed by the genocide of 1994. The first Mental health policy deployed a community driven approach using the primary care nurses to manage mental health problems. This was achieved by an establishment of the Division of Mental Health within the Ministry of Health to oversee Mental Health Programmes (Smith et al., 2017a). This was also useful in responding to post trauma disorders through a community of practice training psychologists and counsellors that offered counselling services to the patients of mental health disorders.
3. ***Collaborations*:** The involvement of the external and non-governmental players and some civil society organizations to address the mental health challenges, provided more services. Some of the external international organizations like UNICEF established the trauma rehabilitation centre. targeting the children and youth. The establishment of specific hospital beds set aside was for those patients who were mentally ill and required admission in the 11 hospitals in Rwanda and this was carried out by interest groups of local communities (Ingabire et al., 2014; Ntigurirwa et al., 2017). The staffing was in such a way that at least each hospital has 2 psychiatric nurses and one psychologist who were all under the supervision of the physician-doctor trained in mental health care by the ministry of health and partners like 'Partners in Health' and 'International Health Care Organization'. The inpatient and outpatient mental health services were also available and served with the trained health workers in the districts (Chauvin et al., 1998; Dvregrov et al., 2000; Gupta, 1999). The Division of Mental Health created by the Ministry of Health integrated mental health services into the non-specialist primary care services. This response was critical for sustainability and the building capacity of the frontline health workers in managing mental health. This was from more specialized clinicians to less specialized primary care givers to address the challenges of workload by the highly specialized mental health clinicians. Rwandan authorities promoted collaborations to adequately address and respond to citizen needs and ensure quality mental health care for all to take a centre stage in mental health reform (Smith et al., 2017b). The Ministry of Health with support from partners, developed a basic mental health training package intended for building the capacity for lower facilities and primary care nurses to effectively recognize and manage mental health disorders even when it was still inadequate (Levers et al., 2006; Dvregrov et al., 2000).
4. ***Effective Monitoring and Evaluation and the Strict Protection of Mental Health Victims' Rights*:** The Division of Mental Health was mandated to oversee the mental health programme in Rwanda and to offer effective regulations and oversight to the district hospitals. Referral structures and systems were put in place from the national level to the community to create a chain of monitoring the victims of mental health in Rwanda. And to address stigma against mental health, there has been sensitization around mental health, and a law has been drafted to protect the victims of mental health but also to promote their human rights (Mohand &Kayiteshonga, 2015).

***Actors***

1. ***The Central Government of Rwanda*:** The 1994 Genocide destroyed the whole health sector in Rwanda but thanks to the post genocide leadership that has worked so tirelessly to restore the destroyed infrastructure and institutions in the young East African country. Rwanda has taken drastic reforms in health and incorporated mental health into the different sectors (Mohand &Kayiteshonga, 2015). The decentralization of mental health care services to all district hospitals has reduced the victims living in far distant areas from the major city referral hospitals. Patients can access mental health services within their districts.
2. ***Ministry of Health*:** The Ministry of Health has been at the forefront in guiding the reforms influencing the improved mental health status of the country. For instance, the adoption of a decentralized primary healthcare approach involved district leaders in Rwanda (Levers et al., 2006). This witnessed a drastic shift in providing training to the local people to conducting counselling sessions and creating awareness around mental health. There was also collaboration with the traditional healers who were very influential during the post genocide period because the community seemed to believe in them more due to their cultural beliefs.
3. ***Ministry of Education*:** The education sector was also a key player in addressing mental health disorders in Rwanda. The Ministry of Education of Rwanda recommended for each school, the establishment of a youth club where youth health issues like mental health and HIV/AIDS among others are addressed. The establishment of Kigali Health Institute was a milestone in providing health training to qualified health personnel to meet health needs through the initiation of a mental health department which currently oversees mental health programmes in Rwanda. The Education sector provided culturally accepted learning to support the development of the minds of the learners (Levers et al., 2006).
4. ***Local Collaborators*:** Traditional leaders have already been mentioned in the previous point. The Rwandan government through the Ministry of Health reviewed the Mental Health Policy in 2011 and a new version was published in 2012 to respond to the 'new challenges, new environment, and the new questions raised from the communities (Sabey, 2022). This witnessed a new branch of the Ministry of Health which is the 'Rwanda Biomedical Centre,' becoming the implementing body of the policy and led by its Mental Health Division. Policymakers consulted various stakeholders in contributing to the drafting of the revision, especially academics, and also some local associations, community health workers and traditional healers.
5. ***External Collaborators*:** The external players were very critical in supporting the government's efforts towards addressing mental health disorders through the establishment of trauma

programmes based on biomedical service delivery approach. Most international organizations working in the mental health domain offered training to paraprofessionals to provide effective mental health services for sustainability. This addressed the shortfall in the professionals trained in managing mental health care. A study conducted in Syria, proved the effectiveness of collaboration with non-professional personnel due to the shortage of formally trained mental healthcare professionals (Hamza & Hicks, 2021).

6. ***Health Promotion and other Schemes*:** Health promotion about mental health is ongoing through the empowerment of the communities to take charge of their mental health issues. There has been visible continuous professional development within the human resources and the integration of the mental health services within the community-based health insurance scheme where 10% of the savings of every registered individual has been dedicated to psychotropic medicines necessary for the treatment of mental health disorders (Schneider & Diop, 2004; Shimeles, 2010). Also, the establishment of mental health community mobile clinics in some of the hard-to-reach areas of Rwanda (Kayiteshonga et al., 2022) with support from partners like 'Intercept' has critically played a crucial role in supporting government efforts (Talbot et al., 2013). This clearly explains the importance of external non-state actors in addressing mental health gaps.
7. ***All-round effective Leadership*:** The intentional political transformation of the Rwandan society through state-initiated reconciliation activities (Amstutz, 2006; Clark, 2014), infrastructural developments, the changing of ideologies and new mindsets of the people, provision of social services, gradual development of the physical and social layout of the people and context-based public-oriented initiatives that have been effective from the transformations in state power and the development of capitalist relations have immensely contributed to the well-being of Rwandans. The leadership of Rwanda has shown a clear vision of physical and socioeconomic development of its people with proven outcomes of sustained economic growth and poverty reduction for decades (Gatsinzi& Donaldson, 2010; Goodfellow, 2015; Goodfellow, 2017; Lenz et al., 2017; Mann & Berry, 2016).

***Effectiveness:*** It is difficult to say if these policies and interventions in place have been effective in Rwanda. Nevertheless, the state-initiated reconciliation, for instance, has yielded observable positive social outcomes (Clark, 2010; Silva-Leander, 2008). Immaculee Mukashema and Elienne Mullet (Mukashema& Mullet, 2013) found in their study, a strong positive correlation between interpersonal reconciliation sentiments (trust and cooperation) and unconditional forgiveness. From this study, we can strongly suggest an improved mental state if true reconciliation was achieved from the government's reconciliation initiative. The primary care mental health implementation programme in rural Rwanda which incorporated mental health services into primary health care resulted to improved service use, improved mental health care delivery and a significant improvement in mental health clinical symptoms (Smith et al., 2020). With increasing infrastructural and socioeconomic developments in Rwanda, it is expected that the well-being of Rwandans in general and their mental health status, in particular, will improve as there is a correlation between infrastructural development (Ding et al., 2023; Saxena, 2007; Tzoulas et al., 2007), Socioeconomic development (Lund, 2014; Reiss et al., 2019; Wight et al., 2006) and improved mental health of the people. Psychological services among HIV-infected women and female victims of trauma and sexual violence have proven to be effective in improving their mental health outcomes. By organizing psychosocial support groups and supervising the participation of these women, positive outcomes such as: an improved relationship with men, significant improvement in mental health illnesses, anti-retroviral treatment adherence and HIV sero-status disclosure were observed. This psychological service has the potential to leverage on clinical outcomes and revive the well-being of affected women (Walstrom et al., 2013). A large-scale approach of psychosocial interventions in Rwanda also proved effective in improving mental health of the survivors of mass violence. An intervention still practiced till this day (Scholte et al., 2011). Nevertheless, the female sex, persecution and unreadiness to reconcile are still strong influencing factors to mental stress in Rwanda. These determinants have maintained the gap in quality service delivery to affected persons involved. The need for improved infrastructural development, more focus on women, and therapeutic interventions which should consider the readiness to reconcile from clients as a priority are important strategies required to improve the mental health status of Rwandans (Heim & Schaal, 2014). Therefore, we can see that the strategy of reconciliation is a very long process that will need government diligence, consistency and the people's patience.

***Gaps***

1. ***Poor Research*:** It is difficult to find adequate data to measure the effectiveness of some of the interventions implemented and policies enacted. Knowing the trend of mental health disorder whether it is getting better or getting worse is still an issue that is grossly inconclusive. Academics, researchers, research institutes, public health personnel, epidemiologists, mental health personnel and social scientists in and outside Rwanda need to collaborate to have not just a database of mental illnesses and associated conditions, but also have a research system that keeps improving on the information on the mental health status of Rwandans.
2. ***Inadequate Infrastructures*:** Despite efforts by the Rwanda government as it tries to address determinants of mental health care, the country still lacks a better diagnostic assessment for depression, post-traumatic stress disorders and alcohol related disorders (Lordos et al., 2021). This calls for huge investment, especially more important for a committed country like Rwanda which is recovering from the 1994 crisis- decades after the catastrophe had occurred (Ferguson & Williams, 2021; Logie et al., 2008).
3. ***Inadequate financing*:** Mental healthcare is still very much underfunded by both national governments and non-state actors and achieving the United Nations Sustainable Development Goals will require more actors in all sectors to support efforts of addressing mental health problems. Examples of theseActors include: the various communities, Ministry of Finance, collaborations with regional heavy weights such as South Africa, Kenya etc for health systems development, planning, financing and recovery etc. International bodies such as the IMF or World Bank may be needed to fully recover and rehabilitate the health system, especially in fighting against HIV/AIDs and Non-communicable diseases (Abbasi, 1991; Buckley & Baker, 2009; Rowden, 2009; World Bank, 2007).
4. ***Not enough Community involvement*:** The introduction of social therapy in the past two decades in Rwanda has helped to immensely close the treatment gap in the country. This social therapy is a 'community-support' scheme which mostly promotes mental health and the psychosocial well-being of the people (Jansen et al., 2015). The evidence of its effectiveness only means that the government should invest more on it and expand the scheme on a national level for all communities to benefit because community involvement is nowhere near enough (Verduin et al., 2014). Also, one of the major reasons domestic violence still has a high prevalence in Rwandan communities is due to the lack of community participation in fighting it. Lawrence Rugema and Colleagues (Rugema et al., 2015) have recommended community partnership as the best intervention in the early detection of gender-based violence.
5. ***Inadequate health workforce*:** More training on the Mental Health workforce is needed in the training of workers on appropriate counselling of Tobacco smokers and those with risky behaviours, and high-risk genetics to non-communicable diseases, and most importantly, to HIV patients (Biraguma et al., 2018). More nurses, doctors, caregivers and counsellors are needed to improve on access, coverage and quality of mental health services to Rwandans.

6. ***Traditional Medicine*:** Traditional medicine is still frowned at in the global south despite its significant contributions to rural settlements in places like Rwanda. Considerable evidence show that traditional medicine positively contributes to the treatment of mental health in Rwanda and the Eastern Cape Province of South Africa. And since this practice is more available, accessible and affordable, the health system should pay more attention, invest and collaborate with its practitioners to not only increase in its health workforce, but also in its service delivery for better access, coverage and effectiveness of the Mental Health care of Rwanda (Schierenbeck et al., 2018).
7. ***Law Enforcement*:** If the law enforcement agencies are further empowered through the enactment of policies and procedures of punishing the offenders of gender-based violence and any type of violence at all, such a crime should drastically reduce. Community leaders will be needed in these issues as well, to effectively orient the people of Rwanda against intimate partner violence.

# CONCLUSION

***Policy Relevance:*** Rwanda may not have blossomed in the outcome of its responses, but there is observable progress and initiatives implemented so far have been laudable. African countries with similar settings of civil war in their history may adopt some of the interventions implemented in Rwanda to strengthen their mental health systems. Some examples are, Somalia (Ibrahim et al., 2022), Ethiopia (Hailemichael et al., 2019; Mokona et al., 2020), Liberia (Sharma et al., 2023), Sierra Leone (Betancourt et al., 2020; Harris et al., 2020) and DR Congo (Familiar et al., 2021). Creating policies tailored towards mental health needs of the people, being thorough in the Monitoring and evaluation of the interventions implemented, collaborating with local and international actors and partnering with communities, especially for health promotional preventive measures will go a long way in their mental health system, even with the limited resources that they have. Alongside the recommendations to Rwanda these countries should be able improve on the poor mental health of their people.

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