ADOLESCENT MENTAL HEALTH LANDSCAPE ASSESSMENT IN RWANDA

Final Report

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List of acronyms

AA-HA	Accelerated Action for the Health of Adolescents
AFRIYAN	African Youth and Adolescents Network
ANC	Antenatal consultation
ARBEF	Rwandese Association For family Welfare
ASRH	Adolescent sexual and reproductive health
CHUB	University Teaching Hospital of Butare
CHUK	University Teaching Hospital of Kigali
CHW	Community Health Worker
CIDI	Composite International Diagnostic Interview
CSE	Comprehensive Sexuality Education
DALYS	Disability Adjusted Life Years
DH	District Hospital
DHIS	District Health Information System
DHS	Demographic and Health Survey
DSM	Diagnostic and Statistical Manual of Mental disorder
ECD	Early Childhood Development
FGD	Focus Group Discussion
FP	Family planning
GBV	Gender-Based Violence
HAPPi	Health, Aptitude/Attitude, Patriotism, Productivity, Innovation
HAT	Health Adolescents Thrive
HC	Health center
HEADSS	Home& Environment, Education &Employment, Activities, Drugs, Sexuality, Suicide/Depression
HIRC	Huye Isange Rehabilitation Center
HIV	Human immunodeficiency virus
HPA	hypothalamic-pituitary-adranal
HQs	Headquarters
HSSP	Health Sector Strategic Plan
IMCC	Inter-ministerial coordination committee
IMCC	Inter-ministerial coordination committee
IOSC	Isange One Stop Center
IZU	Inshuti z'Umuryango (Family's friends)
KII	Key Informant Interview
MCCH	Maternal, Child and Community Health Division
MHPSS	Mental health and psychosocial support
MICS	Multiple Indicator Cluster Surveys
MIGEPROF	Ministry of Gender and Family Promotion
MINEDUC	Ministry of Education
MINICT	Ministry of Information Technology and Communication and Innovation
MMAP	Measurement of Mental Health Among Adolescents at the Population Level
MoH	Ministry of Health

MYICT	Ministry of Youth and Information Technology
NCC	National Commission for Children
NCDA	National Child Development Agency
NISR	National Institute of Statistics of Rwanda
OCD	Obsessive compulsive disorder
OPD	Outpatient Department
PH	Provincial Hospital
PNC	Postnatal Consultation
PTSD	Post-traumatic stress disorder
RBC	Rwanda Biomedical Center
RH	Referral Hospital
RIB	Rwanda Investigation Bureau
RMH	Rwanda Military Hospital
RMNCAH	Reproductive, Maternal, Newborn, Child and Adolescent Health
RSSB	Rwanda Social Security Board
SCID	Structured Clinical Interview for the DSM-IV
SMS	short message service
STI	Sexual Transmitted Infections
TB	Tuberculosis
TV	Television
UMU	Umugoroba w'Umuryango (Household Evening)
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UR	University of Rwanda
USD	United Sates Dollar
VACYS	Violence against children and youth survey
VCT	Voluntary Counselling and Testing
WHO	World Health Organization
YEGO	Youth empowerment for global opportunity

Executive Summary

Background: Adolescence is concisely conceived as a period of transition from childhood to adulthood, spanning from 10 to 19 years of age. It is predominantly characterized by a plethora of changes, including biological, psychological, and social changes that can sometimes be stressful to adolescents. This critical period is recognized worldwide as a scourge of adolescent mental health problems ranging from emotional problems such as depression, suicide, anxiety disorders, trauma, and stressor-related disorders to behavioral problems such as disruptive behaviors and substance abuse. In Rwanda, in spite of the available evidence on adolescent mental health, the true picture of the needs, interventions, and problems related to adolescent mental health is not yet known due to the lack of a focus on the adolescent period. Conversely, the wealth of evidence maintains that nurturing adolescent mental health remains the foundation of psychological well-being, and effective social interaction and integration result in the maximization of adolescent mental health potential. It is against this background that UNICEF conducted a landscape assessment aimed at examining adolescent mental health needs, identifying entry points in the health system for interventions, and recommending priority actions for strengthening the adolescent mental health program in Rwanda.

Methods: A cross-sectional and purely qualitative assessment was conducted among adolescents (aged 10–19 years), their parents, and various stakeholders in adolescent health in Rwanda at all levels, through focus group discussions (FGDs) and key informant interviews (KIIs). This was supported by a deep scoping review of adolescent mental health in Rwanda. Other information was collected about the adolescent mental health context in Rwanda, including the policy and legislative framework for adolescent mental health in Rwanda, existing mental health and psychosocial support services, human resources, and monitoring and research. All suggested interventions were objectively scored, and priorities were costed over a five-year implementation plan. Entry points in the current health system that will enable the effective implementation of an adolescent mental health program were clearly identified. This assessment was commissioned by UNICEF, and it was carried out under ethical approval from the institutional review board for ethics of the University of Rwanda, College of Medicine and Health Sciences.

Results: Drawing on the landscape assessment findings, it is appalling to highlight that the adolescent mental health situation in Rwanda is likely to be mainly negatively affected by family conflicts, poverty, exposure to non-age-appropriate media, childhood traumatic experience induced by the 1994 Genocide against the Tutsi, violence inflicted on children and women peculiarly resulting in unintended teenage pregnancies, substance abuse and addiction, and risky behaviors. There are many gaps in addressing these problems. The existing policy and legislative framework is not adolescent responsive, and the reporting

system does not specifically depict the age range of 10–19 years. All activities are integrated, rather than being adolescent focused or friendly. No human resources with specialties in child and adolescent mental health are available. Evidence-based priority interventions included strengthening community-level settings (e.g., UMU, IZU, and ECD centers/NCDA facilities) to tackle the root causes of and risk factors for mental health among adolescents, setting up and capacitating the school-based mental health program, providing special support to pregnant adolescents and adolescent mothers, equipping youth-friendly centers with psychosocial support programs, and importing and adapting successful digital interventions from other countries with similar settings as Rwanda. This required an overall budget of $7,585,210, together with technical support that UNICEF will provide with the Government of Rwanda since the program currently seems to not be well articulated.

Conclusion: Adolescent mental health in Rwanda is not depicted as a priority problem requiring an urgent response. Therefore, it needs to be supported and strengthened through promotion, preventive, rehabilitation, curative, and support interventions from different stakeholders.

Key words: Adolescent, mental health, Rwanda, programming

1. INTRODUCTION

1.1 Background

Adolescence (10–19 years) is a unique and formative time. Multiple physical, emotional, and social changes, including exposure to poverty, abuse, or violence, can make adolescents vulnerable to mental health problems. Promoting adolescents' psychological well-being, equipping them with the skills and resources they need to prevent or cope with mental ill-health and protecting them from adverse experiences and risk factors that may impact their potential to thrive are critical for their well-being during adolescence and for their physical and mental health in adulthood[1]. Mental health is more than the mere lack of mental disorders, and its substantive dimension is intertwined with the meaning of health, which is defined as a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity. Thus, mental health comprises subjective well-being, perceived self-efficacy, autonomy, competence, intergenerational dependence, and recognition of the ability to realize one's intellectual and emotional potential[2]. While adolescence is often seen as the healthiest time of life, a formative period that presents an opportunity for growth and development, it also represents a period of vulnerability for mental health. Depression, anxiety, eating disorders, self-harm, and suicide are primary causes of disability, disease, and mortality among adolescents[3]. It is estimated that one in six people are aged 10–19 years[4]. Mental health conditions account for 16% of the global burden of disease and injury among people aged 10–19 years[5]. Most studies have found that roughly half of all lifetime mental disorders start by the mid-teens and three-fourths start by the mid-20s (Kessler, R. C., et al., 2007), but most cases are undetected and untreated. Globally, depression is one of the leading causes of illness and disability among adolescents. Suicide is the third leading cause of death among 15–19-year-olds[6].

The consequences of not addressing adolescent mental health conditions extend to adulthood, impairing both physical and mental health and limiting opportunities to lead fulfilling lives as adults. The social and financial costs of mental health conditions and associated disabilities are significant. The World Economic Forum estimates that between 2011

[1]WHO (2020). Facts sheets, accessed on https://www.who.int/news-room/fact-sheets/detail/adolescent-mental-health

[2]WHO (2003). Investing in mental health. World Health Organization. accessed on https://apps.who.int/iris/bitstream/handle/10665/42823/9241562579.pdf?sequence=1&isAllowed=y

[3]UNICEF (2020). Adolescent health dashboard, accessed on https://data.unicef.org/resources/adolescent-health-dashboards-country-profiles/

[4][4]WHO (2020). Facts sheets, accessed on https://www.who.int/news-room/fact-sheets/detail/adolescent-mental-health

5 Ibid.

6 Ibid.

and 2030, mental health conditions, if not addressed, will cost the global economy $16 USD trillion in lost economic output, which is more than the economic costs of cancer, diabetes, and respiratory diseases combined (Patel, V., et al., 2018).

Adolescent mental health remains stigmatized, underfunded, and underserved in most countries, rich and poor. Less than one percent of governmental health budgets in low-income countries go towards mental health, and there are large disparities in access to care and support worldwide, particularly in low- and middle-income countries[7].

1.2 Purpose

The purpose of this landscape assessment was to identify adolescent mental health needs, identify entry points in the health system for intervention, and recommend priority actions for strengthening adolescent mental health programs in Rwanda.

1.3 Specific objectives

This adolescent mental health landscape assessment had three objectives:

- To identify the need for an adolescent mental health program in Rwanda and the existing gaps;
- To identify entry points in the current health system that will enable effective implementation of an adolescent mental health program;
- To identify priority interventions and a costed implementation plan for such a program.

1.4 Rationale

The United Nations Children's Fund (UNICEF) Strategic Plan 2018–2021 outlines a commitment to promote and protect the physical, mental, and social wellbeing of children and adolescents. Adolescent-specific results are mainstreamed under all five goal areas of the Strategic Plan, including a learning agenda on key emerging issues facing adolescents. Adolescent suicide and mental health are part of this learning agenda, and UNICEF is working with partners to build the evidence base for developing appropriate and scalable models for response with

[7] WHO (2003). Investing in mental health. Geneva: World Health Organization

programmatic emphasis on prevention and promotion of mental wellbeing. A few key areas of work include:

- Country-level technical support in designing, testing, and evaluating (i) promotion and prevention measures (such as safe spaces for adolescents in schools, youth centers, peer counselling, parenting program, and the provision of mental health and psychosocial support interventions); and (ii) screening and referral measures (through strengthened health systems and community- and school-based mental health services).
- Joint development (with World Health Organization [WHO]) of evidence-based guidelines and intervention packages on the promotion of mental health, prevention of mental health conditions, and reduction of risk behaviors among young adolescents (10–14 years old) as well as older adolescents (15–19 years old).

The mental health survey conducted in 2018 in Rwanda provides limited information on mental health among adolescents. This survey was conducted for persons aged 14–65 years, and was not disaggregated for those aged 10–19 years. Adolescence covers the age group of 10–19 years, and is a critical and unique life period during which many risk behaviors develop (at school and with peers in socializing environments). Although adolescent mental health has increasingly become a priority for the Government of Rwanda, a country where human capital is an important economic growth factor, investments towards adolescent mental health programs remain limited. The present adolescent mental health landscape assessment will provide UNICEF, Government entities, and partners with a clear picture of the mental well-being among adolescents for evidence-based actions.

2. METHODS

2.1 Design

The present assessment was cross-sectional and purely qualitative with non-probability sampling. It serves as a baseline for adolescent mental health programs, against which indicators should be set to measure program performance after a certain period of time. Furthermore, a scoping review was conducted for reviewing the existing literature on adolescent mental health needs, gaps, and interventions. In the future, both midterm and end-line assessments will be conducted to inform the implementation and measure the achievements of the adolescent mental health program. This assessment sets the tone for our approach to the measurement of adolescent mental health and provides strategic recommendations for each of the areas to be delivered in an effective way.

2.2 Setting

This assessment was nation wide and was conducted in few purposively sampled sites in Rwanda (hospitals, health centers, and community groups of youths aged 10–19 years, the age range targeted by the program). It also covered all key stakeholders at the central level, namely, the Ministry of Health (MoH), the Ministry of Youth and Culture, the Ministry of Gender and Family Promotion (MIGEPROF), the Ministry of Education (MINEDUC), WHO, UNICEF, United Nations Population Fund (UNFPA), United Nations Entity for Gender Equality and the Empowerment of Women (UN WOMEN), Rwanda Education Board (REB), Rwanda Biomedical Center (RBC), National Child Development Agency (NCDA), and National Rehabilitation Service (NRS).

2.3 Population

This assessment intended to hear from the following entities, regarding adolescent mental health programs:

- Community level: adolescents (aged 10–19 years) in different settings (10–14 years and 15–19 years, rural and urban settings, and boys and girls). The parents, both mothers and fathers, of the adolescents were also approached in the same place.
- Health facilities: mental health service providers at health centers, district hospitals, and national-level entities serving adolescents with mental health conditions.
- District level: Youth Empowerment for Global Opportunity (YEGO) centers, private youth-friendly centers, directors in charge of good governance (with children and

adolescents under their responsibilities), and National Commission for Children representatives at the district level.

- Central level: Representatives of key stakeholder institutions, namely, the MoH, RBC, the Ministry of Youth and Culture, the MIGEPROF, NCDA, the MINEDUC, REB, and NRS. United Nations agencies dealing with adolescent matters were also included in the assessment, specifically, WHO, UNFPA, and UN WOMEN.

2.4 Sample size and sampling techniques

This assessment used a purposive sampling technique to find adolescents to be involved in focus group discussions (FGDs) at village level and key informants at different levels concerned with adolescents in different sectors. In each district, we conducted four FGDs of 10 participants each. Boys and girls were separated for the FGDs, but adolescents in and out of school were not. Adolescents were selected from two settings: rural and urban. One FGD per district was conducted for adolescents' parents, and included both mothers and fathers. In addition, mental health service providers at different levels and representatives from partner organizations and government entities were also included.

In total, we planned and conducted 20 FGDs, as we expected to reach a theoretical saturation of information after 20 discussions. Also, the assessment involved other categories of participants as suggested by UNICEF. Appendix 1 displays the selection of participants according to location, occupation and approach used for data collection.

2.5 Data-collection procedures

This landscape assessment started with a deep desk review (scoping review) of available documents and publications relevant to adolescent mental health programs in Rwanda and other countries. Country policies and strategic plans in relation to adolescent health were reviewed. These included but were not limited to the Rwanda Mental Health Policy (2012), Rwanda Health Sector Strategic Plan IV (2018–2024), RBC/Mental Health Division documents (reports, studies, Rwanda Mental Health Survey, etc.), Rwanda health sector performance reports, national youth policy, national gender policy, WHO and UNICEF updates/information, and journals about issues that can impact adolescent mental well-being.

UNICEF recently developed the "Situation Analysis Tool: Adolescent Mental Health & Psychosocial Support Services" with a checklist on: adolescent mental health context, policy and legislative framework for adolescent mental health, mental health and psychosocial

support (MHPSS) services for adolescents, human resources, monitoring, and research. This tool was field-tested and fully applied during this assessment.

Key informant interviews (KIIs) and FGDs were conducted among all sampled convenient respondents to get their insights, perceptions, and experiences in relation to adolescent mental health in Rwanda. KIIs were conducted with mental health program partners or persons concerned with adolescent matters at all levels to get their insights into the qualitative aspects of adolescent mental health programs and their recommendations/suggestions for the effective implementation of such programs in Rwanda. UNICEF headquarters have shared a KII guide for mental health stakeholders. It is meant to be implemented in any country; however, additional questions were added to this guide to reflect the country-specific context. Key questions were around adolescent mental health context, policy and legislative framework for adolescent mental health, and existing interventions related to adolescent mental health. We also added questions for identifying gaps in effective programming (specifically in mental health and psychosocial support services for adolescents, human resources, monitoring, and research), and for assessing inter-agency collaboration and investments in quality and other critical factors related to the existing health system with potential to influence the implementation of Adolescent Mental Health programming . In addition, we included questions for exploring other critical factors that are related to the existing health system and have the potential to influence the implementation of adolescent mental health programs. Finally, it was also deemed relevant to include questions eliciting funding sources, government commitment, government response, priorities, and budget.

KIIs and FGDs were conducted by the consultant (moderator) and one qualified and well-trained qualitative note-taker and transcriber with mental health skills (clinical psychology students and mental health nurse educator) after a one-day training session. Interviews were conducted at the workplaces of the key informants or in any other comfortable place proposed by the key informant. Interviews were predominantly conducted face to face, but virtual data collection was also used for some participants depending on their availability. The note-takers started by filling out a prepared logbook with participant-identification variables such as socio-demographic information and all information deemed necessary to understand the source of the collected qualitative data. For the FGDs, participants were seated in a semi-circle to facilitate discussion, while fully complying with COVID-19 prevention directives (hand sanitizing before entering the room, social distancing, and properly wearing face masks). Participants were labelled to allow the note-taker to know who said what in an anonymous way, and voice recorders were used for both the KIIs and FGDs in addition to the everyday field note-taking. At the end of each day, the field notes were expanded by the field note-takers to create a summary of the information collected on that day. Then, there was an

extended verbatim transcription of the records. Some KIIs were collected in Kinyarwanda and others in English, depending on the language with which the key informant felt more comfortable. FGDs were conducted in Kinyarwanda, and key quotations were translated into English and back translated before the submission of the report.

2.6 Data management and analysis

All English transcripts from the FGDs and KIIs were read and re-read for a deep understanding and interpretation of the collected information. Then, a codebook was developed whereby all key themes were identified regarding the research-specific objectives, and the transcripts were coded, that is, labels were attached to lines of text, so that the research team could group and compare similar or related pieces of information. The qualitative data were analysed by a consultant with expertise in qualitative research; for this purpose, the consultant used Atlas ti 7.5.18, a qualitative data-analysis software, to capture every single element of the transcripts. Finally, reducing and displaying of the key information or quotations were done, together with producing concurrence tables to know the saturation of information, i.e., quantifying the qualitative information to know the number of participants who reported any given piece of information. In brief, all five steps of qualitative data analysis, namely, reading, interpreting, coding, reducing, and displaying, were performed in this assessment. These five steps collectively formed the thematic analysis of content, which was preceded by tables summarizing the UNICEF checklist on adolescent mental health context, policy and legislative framework for adolescent mental health, MHPSS services for adolescents, human resources, monitoring, and research.

Finally, information from the desk and scoping reviews was complemented with findings from the FGDs and KIIs to highlight the need for an adolescent mental health program in Rwanda, reveal the existing gaps in adolescent mental health, identify the entry points in the current health system that will enable the effective implementation of an adolescent mental health program, identify priority interventions, and develop a costed implementation plan for such a program.

2.7 Ethical considerations and child protection

This study used a qualitative approach whereby KIIs and FGDs were conducted, and most respondents were adolescents aged 10–19 years. This required ethical approval from the institutional review board of the University of Rwanda, College of Medicine and Health Sciences, which operates under the mandate of the Rwanda National Ethics Committee. This approval was secured under the approval no. 311/CMHS IRB/2020.

Any information obtained from the respondents was kept confidential. Tape recording was performed together with field note-taking. Participation in the study was voluntary. The study participants did have not to respond to any questions that they did not feel comfortable with, and could withdraw from the study at any time without any negative effect to them, their family, or the services they are offered at any level. Before the interview or discussion, consent was obtained from adolescents aged 18 and 19 years. For those aged 10 to 17 years, signed parental authorizations were obtained before the adolescents' assents. The researchers are aware of ethical considerations during research involving human beings, especially children and vulnerable populations. As the survey directly involved children, parental authorization was sought as the first step, followed by the targeted child's assent, without any direct/indirect coercion. Also, consent was obtained from all key informants, and a consent form was signed between both the respondent and the interviewer.

This survey did not incur any major risks; therefore, we expected the participants to be fully engaged in the interviews/FGDs after good explanations. All data were kept in a locked room, and all computers with survey records were password protected. The findings were shared with UNICEF for decision-making, and all voice records were destroyed after verbatim transcription.

In brief, the three research ethics principles, namely, respect for the person, justice, and beneficence, were complied with during the course of this study, without any exception.

2.8 Assessment timeline

The assessment was conducted from October to December 2020.

Table 1. Assessment timeline

Date	Deliverable	Observation
October 06–15, 2020	*Application for ethical approval *Submission of the inception report to UNICEF *Testing of tools before starting the FGDs	The application for ethical approval and the inception report will depend on the feedback from RBC and UNICEF
November 02–15, 2020	FGDs with the youth (ages, 10–19 years)	Depending on the availability of the RBC recommendation letter
November 16–24, 2020	KIIs with district-level and central-level informants and partners Preliminary analysis plus a costed implementation plan to address existing gaps	Depending on informants' availability
November 25–December 08, 2020	Submission of the draft report to UNICEF and RBC for review and comments	Depending on the finalization of data collection
December 18, 2020	Submission of the final report to UNICEF	Depending on the provision of feedback by UNICEF

3. FINDINGS

3.1 Adolescent mental health context in Rwanda: needs and gaps

3.1.1 Scoping review of adolescent mental health in Rwanda

Adolescent mental health in Rwanda has sparked the interest of several researchers with a view to understanding the lived experience of the adolescence period, the risk factors associated with this critical period, as well as youth-identified solutions aimed at supporting their mental health. In the Rwandan context, there is no policy document with clear references on adolescents, rather on youth in general. "Youth" was defined as a category of all people aged between 14 and 35 years (Rwanda Ministry of Youth, Culture, and Sports, 2005) until a recent redefinition of this group as those in the age range of 16–30 years old (Republic of Rwanda, 2015). The World Bank (2020) estimates that the total population of Rwanda was around 12.4 million in 2019. The National Institute of Statistics of Rwanda (NISR; 2018) through the Integrated Household Living Conditions Survey EICV5 (2016/17) indicated that about 78% of Rwandans are below 35 years of age, and the total youth in Rwanda consists of 3,170,311 people (1,657,014 females and 1,513,297 males), representing about 27% of the Rwandan population.

3.1.1.1 Adolescent mental health and genocide

The literature underlines the 1994 Genocide against the Tutsi to be a major adverse childhood experience negatively impacting the mental health of today's adolescents in Rwanda and having a lasting impact on the population as a whole (Roth et al., 2014). Neugebauer et al. (2009) conducted a study to document post-traumatic stress reactions among Rwandan children and adolescents in the early aftermath of genocide and found that 90% of respondents had witnessed killings and had had their lives threatened; 35% had lost immediate family members; 30% had witnessed rape or sexual mutilation; and 15% had hid under corpses. These traumatic experiences concur with the findings of Schaal and Elbert (2006), who reported that post-traumatic stress disorder (PTSD) was present among 44% of Rwandan adolescents. While the prevalence of PTSD in adults is estimated to be around 26.1% at twenty years after the experience of genocide, Stefan et al. (2020) suggest possible transgenerational transmission of PTSD. This transgenerational transmission is likely to be experienced by the offspring of genocide-exposed mothers through the transmission of alterations of the hypothalamic-pituitary-adrenal axis and epigenetic modifications of the glucocorticoid receptor (NR3C1). This finding was refuted by Roth et al. (2014), who found that poor mental health outcomes observed in children aged 12 years were not related to the transgenerational consequences of PTSD, but rather to parental child-rearing practices. In

other words, the mother's exposure to family violence during her own childhood was associated with the magnitude of adversities that her child experiences at home, a phenomenon termed as the "cycle of violence" (Roth, M., Neuner, F., & Elbert, T. 2014).

3.1.1.2 Mental health and violence against children and women

Violence among and against adolescents is another important factor that is widely reported to negatively affect adolescent mental health (Golshiri, et al. 2018). In a study by Rieder and Elbert (2013) in Muhanga District, the rate of child abuse and neglect among descendants was below 10%. Similarly, a 2017 MoH survey revealed that sexual violence had been inflicted on approximately 12% of females and 5% of males aged 13–17 years in the 12 months prior to the survey, which is likely to expose them to mental health problems. In corroboration, Verduin et al. (2013) highlighted a high level of violence among intimate partners leading to common mental health disorders and mental health problems among adolescents. Violence committed against children was further reported in the Rwanda Investigation Bureau report of 2019–2020, which documented that the number of victims of child defilement increased from 3,215 in 2019 to 4,265 in 2020 (Bishumba, 2020). Of the 4,265 victims of violence in 2020, 1,239 (29.1%) were under 10 years old, and 98% were girls (UNFPA, 2020). Similarly, Meyer et al. (2017) explored violence and its related psychological consequences among adolescents who fled Uganda and Rwanda, and confirmed a strong association between violence and adverse mental health outcomes.

The Violence Against Children and Youth Survey (VACYS) conducted by the MoH (2017) in Rwanda in 2015–2016 found that 28% of young men and women aged 19–24 years had experienced at least one form of violence in the past year. Specifically, physical violence against boys was the most common form of violence, followed by physical violence against girls, sexual violence against girls, and emotional violence against boys. Children of all ages experience violence, although adolescents are often most at risk. As a consequence, 12% of physically abused boys were reported to have been violent towards another person, compared to 4% of boys who had not been physically abused. This is due to externalizing behaviors as a result of adverse childhood experiences. The VACYS reported mental distress as the most prevalent health outcome among young females and males who had experienced violence in childhood.

A qualitative study conducted by the MoH (2018) on violence against children and youth with disabilities in institutional settings in Rwanda reported that while physical violence was less pervasive, sexual and emotional violence were more prevalent among children and youth with disabilities with their families and communities, until most of them find the institutional

setting to be the most convenient environment in which to fulfill their needs and realize their potentials to the fullest.

Tetteh et al. (2020) reported that pregnant teenagers are prime targets of violence perpetrated by intimate partners, family members, and miscreants in their neighborhoods. In Rwanda, this type of violence exposes adolescents to pregnancies, which have steadily increased from 6.3% (DHS 2010) to 7.3% (DHS 2014-15) in recent years. About 49.6% of teen mothers are documented to have their first pregnancy between the ages of 12 and 17 years (UNFPA, 2020). Furthermore, the wealth of the evidence associates the likelihood of HIV/AIDS transmission among adolescents with the violence they are enduring (Chiang, et al., 2015). In Rwanda, the rate of HIV infection is estimated to be around 3% among adolescent girls and young women, which precludes them from achieving and accomplishing their future plans, and it is associated with having sex with one or multiple partners (Kayitesi, 2019). To conclude, Rieder and Elbert (2013) maintained that poor physical health, exposure to war and genocide, parental PTSD symptoms, and reported childhood trauma were significantly associated with depressive and anxiety symptoms, while only exposure to war and genocide and poor physical health predicted the level of PTSD. In a survey of youth-headed households in Rwanda by Boris (2006), depressive symptoms were reported to be very common. Similarly, Niyonsenga and Mutabaruka (2020) conducted a study for understanding the risk factors for postpartum depression among teen mothers in Rwanda, and found that in their sample, the rate of depressive symptoms was as high as 48%. They identified parental distress, weight/shape disturbances, income, and parental-child dysfunctional interaction as important risk factors for depressive symptoms.

3.1.1.3 Mental health and substance abuse and addiction

Substance abuse is a worldwide phenomenon of concern among adolescents, and shows a cyclic relationship with mental health (Somani & Meghani, 2016). In Rwanda, a recent study (Kanyoni et al. 2015) aimed at determining the prevalence of substance abuse within 30 days prior to the survey among persons aged 14–35 years found the following prevalence rates: 34% for alcohol, 8.5% for tobacco smoking, 2.7% for cannabis, 0.2% for glue, and 0.1% for drugs such as diazepam. In addition, the study found that 1 in 13 (7.46%) youth were alcohol dependent, 1 in 20 (4.88%) were nicotine dependent, and 1 in 40 (2.54%) were dependent on cannabis. Despite several prevention initiatives over the last nearly two decades, substance abuse remains a serious problem among adolescents with significant disparities in Rwanda (Ngamije, J., & Yadufashije, C. 2020).

3.1.1.4 Existing interventions and gaps in adolescent mental health

The Government of Rwanda in collaboration with different stakeholders, namely, UNICEF, WHO, and UNFPA among others, has put forward various strategies to support adolescent mental health, including developing a youth policy, youth centers, national rehabilitation centers, and youth corners (Kayiteshonga, et al. 2018). However, youth-friendly health services are still limited in scope and coverage; currently, only 13.6% of health facilities nationally offer these services. Adolescent pregnancy may also be a consequence of sexual violence against adolescents (MoH, 2017), and inadequate or no access to adolescent sexual and reproductive health (ASRH) services and information (UNFPA, 2020). For those with mental health and psychosocial problems due to traumatic experiences, including teenage pregnancies and violence, Kayiteshonga et al. (2019) reported an underutilization of available mental health services. This underutilization of mental health services may be related to stigma experienced by people with mental health problems (Caserta et al., 2016). Furthermore, the evidence shows that family-based intervention focused on reinforcing strong parent-child relationships would be well-suited in the context of families affected by HIV in Rwanda and could be implemented as a preventive intervention as families came into contact with care systems, and would have an impact on reducing mental health problems among adolescents in Rwanda (Betancourt et al., 2014). The same study showed that caregiver-reported improvements in family connectedness, good parenting, social support, and children's pro-social behavior resulted in reducing mental health problems among HIV-affected children. Finally, it is worthwhile to highlight that mental health screening tools have been developed and tested, including those to screen for depression among children and adolescents in Rwanda (Betancourt, et al., 2012; Binagwaho, et al. 2016) along with a tool that detects conduct disorders in children and adolescents (Ng, et al. 2014). However, there is no evidence whether these tools are being used in health facilities for screening and diagnosis to lead to care/treatment/support.

3.1.2 Current estimates of adolescent mental health status in Rwanda

3.1.2.1 Quantitative estimates of mental health status among Rwandans

The table below (Table 2) shows figures about the socio-demographic burden of mental health disorders as estimated by the UNICEF, Rwanda Demographic and Health Survey, and Rwanda Comprehensive Food Security and Vulnerability Analysis.

Table 2. Socio-demographic and mental health context data in Rwanda

Demographic Indicators[8]	
Country	Rwanda
Total population (n)	12,627,000
Population 10–19 years Girls (n) Boys (n)	 1,424,000 1,413,000
Adolescent birth rate (per 1000 girls aged 15–19 years; 2016)	41
Adolescent mortality rate 10–14 years 15–19 years	 5 6
Burden of Mental Ill Health	
Mortality rate due to road injury (2016)[9] Girls, 10–14 years Girls, 15–19 years Boys, 10–14 years Boys, 15–19 years	 24% 23% 32% 42%
DALYs (per 100,000) from injuries and NCDs, respectively Girls, 10–14 years Girls, 15–19 years Boys, 10–14 years Boys, 15–19 years	 15%, 38% 15%, 40% 22%, 32% 31%, 36%
DALYs (per 100,000) from mental health and substance use disorders Girls, 10–14 years, 15–19 years Boys, 10–14 years, 15–19 years	Not reported
% adolescents with functional difficulties (including depression and anxiety)	Not reported
Behavioral Risk Factors	
% heavy episodic drinking	Boys (23%), Girls (40%)
% tobacco use	Boys (13%), Girls (10%)
Age of sexual debut[10]	

[8]UNICEF, Adolescent health dashboard, accessible at https://data.unicef.org/resources/adolescent-health-dashboards-country-profiles/

[9] Idem

[10]Rwanda Demographic and Health Survey 2014-15

Before age 15 years By age 18 years	5% of women (15–24 years) and 11% of young men 20% of young women and 23% of young men
Social Determinants	
% population living below the poverty line	38%
% population with moderate-to-severe food insecurity	18.7%[11]
% completed lower secondary school: Girls Boys	 30% 25%
% completed upper secondary school: Girls Boys	 16% 19%
% out of school: Girls Boys	 49% 50%
% not in education, employment, or training: Girls Boys	 27% 21%
Percentage of girls aged 15–19 years currently married or in union	7%

DALYs, disability-adjusted life years; NCD, non-communicable disease

The recent Rwanda Mental Health Survey (RMHS 2018) showed that major depressive episode was the most prevalent mental disorder affecting 12% of the population, followed by panic disorder (8.1%), PTSD and obsessive-compulsive disorder (3.6% for each), and epilepsy (2.9%). Other mental disorders were not prevalent and had rates of less than 1%, for example, antisocial personality disorder, suicidal behavior disorder, substance use disorder, and bipolar disorder. Psychotic disorder and social phobia had a prevalence rate of 1.3% each, while major depressive disorder with psychotic features and alcohol use disorder both had a prevalence of 1.6% each.

Of the population who met the criteria for major depressive episode, 78.6% reported a lifetime loss of someone or something dear to them, 33.1% reported a family history of mental illness, while 33% reported having experienced violence in their lifetime. Also, among those who met the criteria

[11]Rwanda Comprehensive food security and vulnerability analysis 2018

for major depressive episode, 15.3% met the criteria for PTSD, 14.9% reported having a chronic condition, and 5.8% met the criteria for psychotic disorder. Comorbidity of major depressive episode with alcohol use disorder, suicide behavior disorder, and substance use disorder was less than 5%. Table 3 represents the current figures as per the Rwanda Mental Health Survey of 2018.

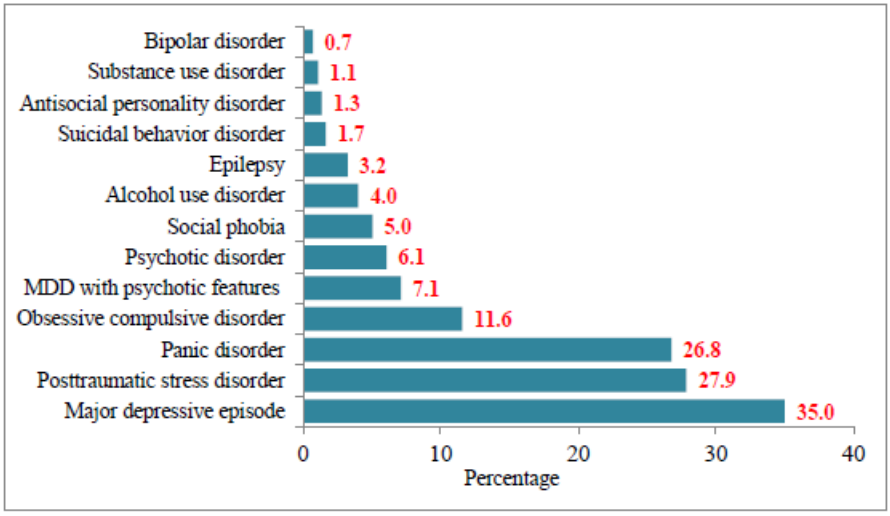
Table 3. Prevalence of mental health conditions among young Rwandans, 2018

Type of disorder	Sex (Overall)		Age	
	Male	Female	14–18 years	19–25 years
Major depressive episode	8.2%	14.4%	**4.0%**	**8.3%**
Suicide behavior disorder	0.3%	0.7%	0.2%	0.5%
Panic disorder	5.2%	10.2%	**4.2%**	**6.9%**
PTSD	2.6%	4.4%	0.4%	2.3%
Social anxiety disorder	1.2%	1.3%	0.9%	1.5%
Obsessive-compulsive disorder	2.7%	4.2%	**2.1%**	**4.0%**
Alcohol use disorder	3.4%	0.3%	0.4%	1.5%
Substance use disorder	0.4%	0.2%	0.3%	0.2%
Psychotic disorder	1.4%	1.3%	0.4%	1.0%
Antisocial personality disorder	1.7%	0.2%	1.1%	1.1%
Epilepsy	3.2%	2.7%	**2.8%**	**3.0%**
Bipolar disorder	0.2%	0.1%	0.1%	0.1%
Any mental disorder	16.6%	23.2%	**10.2%**	**17.2%**

Source: Rwanda Mental Health Survey, 2018

The main survey instrument for RMHS 2018 was the Mini-International Neuropsychiatric Interview (MINI) version 7.0.2 for DSM-5. With a special consideration of genocide survivors, the figure below (Figure 3.1) summarizes the prevalence of mental disorders, of which major depressive episodes, PTSD, panic disorder, and obsessive-compulsive disorder were the most prevalent. This survey did not find anybody aged 19 years and below as a genocide survivor, as the youngest one was aged 24 years in 2018. However, it underscored the impact of probable intergenerational trauma ravaging adolescents in Rwanda (Mutuyimana, C, et al. 2019).

Figure 3.1. Prevalence of mental health disorders among genocide survivors (N = 1271)



Source: Rwanda Mental Health Survey, 2018

The above survey did not clearly show the burden of mental health conditions among adolescents (10–19 years) since it only considered the age range of 14–65 years, with disaggregation for the age groups 14–18 years and 19–25 years. With these figures, it is difficult to know the real picture of mental health status among adolescents in Rwanda. That is why FGDs were conducted among adolescents aged 10–19 years and their parents/caregivers to know their estimation of the burden of mental health problems among adolescents in the country.

3.1.2.2 Awareness of mental health services among the population and mental health service utilization

The 2018 Rwanda Mental Health Survey found that only 38.3% of the general population, including adolescents, and 23.8% of genocide survivors were aware of where to seek support for mental health (health facilities, community health workers [CHWs], and traditional and religious healers). Reported utilization of mental health services stands at 5.3% among the general population and 14.1% among genocide survivors (from health facilities, religious healers, traditional healers, and CHWs).

The main reasons behind the low mental health services utilization were fear of stigma, failure to know where services are provided, lack of money, and not knowing that mental health is a problem. Some of the barriers to mental health service utilization are embedded in the culture, such as not recognizing mental health disorders as diseases that require support and care, and considering mental health problems as "poisonings and spiritual possessions" that need traditional healing. Such barriers will require enormous resources to be addressed, but

nonetheless, the information underscores the need for programs and activities that educate people about mental health to raise the awareness around mental health in general and encourage adolescents to seek mental health care when in need.

3.1.2.3 Causes and risk factors of mental health problems

The table below (Table 4) summarizes the findings from the FGDs and KIIs with adolescents, their parents/caregivers, and stakeholders in the youth sector and mental health. Please refer to Appendix 2 for more details.

Table 4. Main causes or risk factors of mental health problems among adolescents in Rwanda

Cause/ Risk factors	Effects on adolescents mental health
Family conflicts	Conflicts between couples and between parents/caregivers and their children lead to intimate partner violence, child violence (physical especially among boys, sexual especially among girls and emotional for both boys and girls). Divorced or separated couples, irresponsible parents towards their children including delinquent acts, poor parenting practices (child abuse in families, lack of parental affection and support or accompaniment during problems, puberty, adolescence, severity towards children, very busy, neglect or abandonment of children and adolescents with disabilities, and many other households related issues; all lead to mental health affects in young children and adolescents who end up with negatively coping with the stress and become delinquents, adopt risk behaviors (suicide, drug/substance abuse, etc) and develop mental health disorders
Poverty	Very poor families do not respond to basic needs of adolescents, which leads to high school drop-out rates and lack of social interaction/positive peer influence, ending in adolescents joining the street, ending up in risky behaviors such as sex work, drug use, suicide, etc
Biological factors	Genetic patterns, difficult to address given limited diagnostic tools/technologies. Examples include children and adolescents with disruptive/very aggressive behaviors with unknown reasons
Drug/substance abuse	Mental problems/disorders and delinquent behaviors, especially in towns and centers whereby adolescents can easily access them
Orphanage	Some orphan adolescents residing in adoptive families feel maltreated and/or uncomfortable, which leads to depression, anxiety and adoption of risk behaviors and mental health disorders

Cause/ Risk factors	Effects on adolescents mental health
Genocide against the Tutsi	Children and adolescents from criminal parents (Genocide perpetrators) and victims of Genocide, penal crime witnesses: victimization, feeling guilty, missing their owns due to Genocide; and all this leads to trauma, mental or psychological problems
Exposure to social media	Huge exposure of children and adolescents to non-age adapted movies and internet-based issues leads them to adopting bad and risky behaviors, thus mental health and psychosocial problems
Lack of knowledge in adolescence	Seeking the information from risky sources makes adolescents contract some illnesses and health conditions such as HIV, cancer and physical disability, ending up with mental affect
Violence	Violence has a devastating impact on mental health and places children and adolescents at high risk of early pregnancy and sexual risk-taking among adolescents in general and among those with disabilities in particular, until some find institutional setting as the most convenient environment to fulfill their needs and realize their potentials at the fullest
Teen pregnancy	Teen pregnancy ends with bad mental health among pregnant adolescents and adolescent mothers (very critical and high in Rwanda), especially when there is not parental and community support towards positively coping with the traumatizing experience, school drop-out, violence (neglect, abandonment, moral), failure to realize their potentials
Homeless parents	Homeless parents give birth to homeless children, who will no longer go to school, constituting a delinquent community, drugs abusers, beggars, prostitutes, thieves, etc.
Bad company	This constitutes the basis for root risky behaviors that negatively impact the mental well-being among adolescents (school drop-out, theft, drugs/substance abuse, prostitution, etc)

3.1.3 Policy and legislative framework for adolescent mental health in Rwanda

A deep desk review found that the mother guiding document of the next five years in the health sector does talk about mental health in general, and does not focus on adolescent mental health. This document is the Fourth Health Sector Strategic Plan, July 2018–June 2024, and contains broad statements on "Increase Mental Health Services Coverage, ensure access to specialized mental health services and other services to people living with disabilities" (MoH HSSP-IV, 2018).

The country does not have any guiding document on the provision mental health care and psychosocial support to of minors; however, some positive considerations were highlighted, such as the limitation of involuntary placement of minors in mental health facilities and adult representation in all matters affecting the minor. A KII with a high official from the MoH revealed that there is no provision of a separate living area from adults in mental health facilities, expect at Ndera Neuropsychiatric reference hospital; no age-appropriate environment and developmentally appropriate services; no banning of all irreversible treatments on children; and partial consideration of opinions of minors in all issues affecting them, depending on their age and maturity.

> *"The youth is somewhat represented. For instance, during the elaboration of ASRH guiding documents (policies and strategies), the youth is represented through fora [like African Youth and Adolescents Network (AFRIYAN)] or partners representing them."*
>
> Key informant, MoH

Another key informant from the MoH reported that Rwanda does not have any law governing mental health care, and all services are regulated by the Art of Healing law, which is now under revision to be called the "health services law" in collaboration with the Rwanda Law Reform commission.

> *"The mental health law has been drafted, and it was rejected by the Inter-ministerial coordination committee before reaching the cabinet since it could not go out as a stand-alone health law, rather it should be part of the entire health services law. Still, the law will be out in general, not mental health-specific, and the Government considers it as effective. In addition to the overall health services law, specific policies and strategies should be enough to support the compliance."*
>
> Key informant, MoH

The current National Mental Health Policy in Rwanda of 2011 (MoH, 2012) is not adolescent responsive, but youth responsive in general, since there is no specification of the target ages for special interventions. However, a few issues have emerged as the most pressing among adolescents, such as its field of intervention 9 about the "Fight against drugs and other psychoactive substance abuse" with strategies like having competent structures in prevention, treatment, and rehabilitation of persons suffering from addiction as one of the strategies. Other strategies include having a functional communication system with other institutions of care and involvement of the community in the prevention and treatment process as well as in the rehabilitation of addictive problems.

Currently, the Huye Isange Rehabilitation Center (HIRC) is the only national institution treating people with drug and substance addictions. A key informant from this center reported that it cannot accommodate everybody in need of the service due to the fact that its services are also quite expensive for people to access, yet many people are suffering in the country. There is a close collaboration among the RBC, Rwanda National Police, and the local administration in the struggle to fight against drug and substance abuse, and many efforts are ongoing with high political commitment and very strong law enforcement.

There is a need for more rehabilitation services for people with drug and substance addictions, especially for adolescents. There is a national plan to prevent drug and substance abuse that has a budget of 500 million Rwandan francs per year, and all partners are called upon to join that effort through financial support.

Field of intervention 10 of the National Mental Health Policy (2012) talks about "Mental health care for children and teenagers." It has three strategies: promote skills in the provision of mental health care to children and teenagers, integrate the practice of mental treatment of children and teenagers with existing mental health care structures, and involve all actors, beginning with families, who have responsibility towards children and teenagers.

The above field of intervention is not implemented as per the policy direction. There is only one psychiatrist at Ndera Neuropsychiatric Hospital (the only mental health referral hospital in the country, owned by Brothers of Charity). There are no psychologists specialized in mental health care for children and adolescents due to a lack of resources and the settings to train them. A KII revealed a lack of multidisciplinary care due to a lack of human resources and knowledge in the domain as well as a lack of discussion groups within the community to talk about mental health problems among children and adolescents. Very little clinical supervision in mental health is conducted and not in all health facilities; moreover, not all cases of interest are covered.

> *"The MoH would like to have enough mental health infrastructure in place, and a well and fully functional decentralized mental health care system that reaches the community, and to assess the model of mental health care and restructure it at all levels in Rwanda. No funds, only relying on government funds."*
>
> High-level government official, MoH

The new Mental Health Strategic Plan of 2020–2024 is not clearly adolescent responsive since it does not state the age range of adolescents (10–19 years), but rather uses the term

"youth"[12]. Also, the development or updating of the national mental health policy and strategy does not consider engaging young people to be adolescent responsive/specific.

Strategy 3.2.1 of the Rwanda Mental Health Strategic Plan, under its Prevention and Early Intervention Section, is "Strengthen community-based mental health promotion and prevention by improving mental health literacy and resilience": Deliver relevant mental health information through different channels (radio, TV, print, community talks, and theatre with beneficiaries/testimony, success story sharing, Urunana and others; school clubs and youth community-based activities by trained youth peers; and community- and family-based platforms like community work "Umuganda," and parents' gathering/family gathering "Umugoroba w'ababyeyi").

The same mental health strategy plan states that the ministries of health and education will develop and implement a health program in schools. Through this program, teachers will learn about basic counselling and emergency mental health first aid and referral, which they will then pass onto the learners. Schools are a unique target site for such interventions to provide kids with an early opportunity to improve mental health literacy and to develop resilience and coping skills." The initial trainings of trainers have been conducted, and the program is launched. However, this is not based on a national curriculum; it is planned to run as extracurricular activity, but is compulsory in all primary and secondary schools of the country. Currently, there are good teacher-training materials on school health and nutrition, with a huge module on mental health[13]. Mental health is one of nine modules and contains eight sections: (1) concept of mental health, (2) factors contributing to mental disorders or mental health problems, (3) identification of symptoms of mental disorders, (4) stigma and discrimination, (5) child and adolescent mental and behavioral disorders, (6) effective communication, (7) strategies for addressing psychosocial problems in schools, including prevention of alcohol, tobacco, and drug abuse in schools, and (8) enhancing counselling services in schools by trained teachers.

With respects to gaps in mental health care provision, the high-level key informants reported that the community mental health program in the country was not functional and had minimal information, and thus the population is not aware of mental health. The stated channels to improve mental health literacy and resilience are not utilized. The strategy is not being implemented as per the policy direction. The school-based mental health program has targets

[12]MoH (2019). Rwanda mental health strategic plan 2020-2024. Kigali, Rwanda

[13]MINEDUC (2020). Teacher training materials on school health and nutrition. Kigali, Rwanda

teachers, who already have high workloads and do not have enough time to dedicate to the provision of effective support to young children and adolescents who are suffering from mental health problems. The best option would be to have clinical psychologists in schools. However, considering the limited resources and the large number of schools in the country (estimated to be around 4,650 primary and secondary schools), it is suggested that having clinical psychologists at the district level with responsibilities of supporting the whole district would yield more positive outcomes in terms of school performance. In this regard, they would be rotated across all schools in the district, under coordination from the central level, and would train and engage both teachers and parents in promotion and prevention activities. Ultimately, they could provide psychological first-aid support where problems occur and make referrals for appropriate care when needed.

Strategy 3.2.2 of the Rwanda Mental Health Strategic Plan is about the implementation of prevention and early mental health intervention programs for children and their families through partnerships between the RBC, Early Childhood Development (ECD) facilities (now called NCDA), pre-schools, and other organizations. This strategy is a key one, and once implemented and complemented with the school-based mental health program with skilled providers, it is expected that children and adolescents will enjoy a very conducive environment, assuring improved mental well-being.

Strategy 3.2.3 is "Expand access to community-based youth mental health services and promote greater integration of mental health, alcohol and other drug services in primary health care". This will be done through strengthening the capacities of the NRS and health facilities to provide youth-focused mental health services, and through the development, promotion, and use of appropriate technology-based platforms to disseminate mental health information to the youth (adolescents), given the fact that technology-based solutions hold promise due to the high phone and expanding internet penetration. There is a need to support this intervention that would yield extensive results in a short period of time. In the primary health care setting, integrating mental health education for pregnant women and mothers through antenatal care (ANC)/postnatal care (PNC) would be very effective and efficient in tackling adolescent mental health problems induced by unintended pregnancies.

Strategy 3.2.5 also targets adolescents through its statement "develop tailored mental health care responses for vulnerable groups (e.g., children and young victims of physical, sexual, or emotional abuse, and others)." In this case, "others" includes but is not limited to infants, children in early and middle childhood, adolescents, elderly people, people living with disabilities or chronic illnesses, street children, people in transition centers, children and adults with special needs, and mental health disabilities.

This strategy has a few youth-specific indicators or targets, and these are:

- National principles and guidance on youth-focused, relevant, and accessible mental health services developed
- Number of NRS staff trained
- A capacity assessment of facilities (including health facilities) to offer youth-focused mental health services conducted, to offer recommendations for improvement
- A digital system for disseminating mental health information to the youth developed
- Meetings held with community-based organizations, non-governmental organizations, associations of people with mental health problems, teachers, and youth groups on mental health

Youth-specific actions are highlighted, though the age range is not clear to represent adolescence, allocation of resources for adolescents is not highlighted, and the role adolescents and/or young people in the formulation of this strategy is not mentioned.

The Rwanda Mental Health Strategic Plan 2020–2024 is new, and does not have full support in terms of implementation. There is a need for each partner investing in mental health to focus on a selected area. Some actions can include capacity-building through short-term course certificates in child and adolescent psychiatry and psychotherapy. However, strengthening of non-specialized health sector capacity and interventions through peer support, religious institutions, traditional healers, and community youth civil society organizations are also required. From this perspective, considering these community mental health resources would not only serve as an invaluable channel towards mental health promotion and prevention but also as referral strategies for support/care at the community level.

Although the National Reproductive Maternal, New-born, Child & Adolescent Health (RMNCAH) Policy of 2018 provides policy orientation on adolescent health through different priorities such as "*Implement and monitor a harmonized, integrated, and sustainable package of quality client- and youth-friendly essential RMNCAH promotion, prevention, and treatment interventions, commodities, and innovative technologies at the hospital, health center, and community levels and conduct research on the cost-effectiveness of interventions,*" it does not provide any special focus on mental health. Yet, it recognizes that it is important to integrate mental health and substance abuse into RMNCAH interventions, as unprotected sex is more likely to take place when adolescents are under the influence of substances, including alcohol[14].

[14]MoH (2018). National reproductive maternal, newborn, child and adolescent health (RMNCAH) policy. Kigali, Rwanda

This goes hand-in-hand with the National Family Planning and Adolescent Sexual and Reproductive Health (FP/ASRH) Strategic Plan (2018–2024), which clearly states key strategies towards effective FP/ASRH among adolescents in Rwanda, through youth corners and youth clubs, but without any aspect on mental health though it is directly linked with ASRH. The only mental health highlight in this plan is "offer screening and psychosocial support service interventions, such as counselling, mental health therapeutic approaches for adolescents, and 'second chance' programs for juvenile offenders."[15] Furthermore, the national manual for ASRH in Rwanda only includes some information on mental health, mainly adolescent risky behaviors (risky sexual behavior, drug abuse, and alcohol and tobacco smoking among young people), and it does not clearly state the setting to provide care to adolscents with mental health problems due to risky behaviors.

Youth corners are well stated in guiding documents, but they are not operational in many health facilities (especially in health centers), and the stated mental health services do not match the strategic plans. A KII with an officer in RBC highlighted the need to have a comprehensive youth corner that includes the whole package for youth-sensitive issues, including adolescent mental health.

> *"We have focused our attention on ASRH among the youth, but the documents are under review, both the strategic plan and training manual, after realizing some inconsistencies. You are free to suggest other components, including adolescent mental health, to make it holistic and more comprehensive."*
>
> Key informant, central level (RBC)

Apart from the mental health policy and strategy, other sectors have highlighted adolescent mental health as one of the aspects to address in their respective sector activities.

The Ministry of Youth and Culture (2015), in its **"National Youth Policy *Towards a HAPPi*[16] *Generation*"** puts forward the promotion of youth good health and social welfare with strategies to fight delinquency and drug abuse, and promote reproductive health, comprehensive sexuality education, and family planning in addition to the now traditional programs on the fight against gender-based violence, HIV/AIDS, and TB as well as programs contributing to promoting the welfare of youth with disabilities. These objectives are meant

[15]MoH (2018). National Family Planning andAdolescent Sexual and ReproductiveHealth (FP/ASRH) Strategic Plan(2018–2024). Kigali, Rwanda

[16]*HAPPi stands for* Health, Aptitude/Attitude, Patriotism, Productivity, Innovation

to be achieved through the promotion of the provision of youth-friendly health services and strengthening national capacities to prevent youth delinquency and drug abuse[17].

The National Youth Policy towards a HAPPi Generation is well formulated and provides clear guidance on its implementation, but it is partially implemented. Specifically, the promotion of the provision of youth-friendly health services is not fully considered due to a lack of staff in all 27 YEGO centers since they were handed over to the districts by the Ministry of Youth and Information Technology. Very few YEGO centers with proactive partners who have health packages in their area of interventions provide ASRH services. However, mental and psychosocial support services are not offered in any YEGO center. YEGO centers have six programs (health and sport, vocational training, entrepreneurship, job desk information, talent development, and civic education and volunteering). Under the health and sport program, these centers have an information desk on HIV/AIDS, voluntary counselling and testing, family and life skills, and education on Rwandan culture through different arts and sporting activities such as songs, drama, anti-drug campaigns, etc.

There is a need to support YEGO centers, especially where there are no partners in the health area with a focus on mental and psychosocial support services, so that they can serve as one-stop adolescent-friendly services.

The Integrated Child Rights Policy of 2011 (MIGEPROF, 2011) and the Integrated Child Rights Policy 2019–2024 (NCC, 2019) provide clear guidance around child protection, with a consideration about mental health promotion and prevention of risk factors towards all aspects that may negatively impact children in Rwanda. A few examples from the Strategic Plan for the Integrated Child Rights Policy 2019–2024 are:

- Act 5.1.1: Identify, train, and support community-based child protection mechanisms for the prevention of and response to violence against and abuse, neglect, and exploitation of children
- Act 5.1.2: Strengthen the capacity of child protection frontline workers (including professional social workers, psychologists, healthcare workers, teachers, police officers, investigators from the Rwanda Investigation Bureau [RIB], prosecutors, and community-based child protection and health workers) with the skills and capacity to prevent and respond to child abuse, through pre- and in-service training
- Act 5.1.6: Establish/strengthen child-friendly and safe spaces for children and adolescents at health centers, and police and RIB stations

[17]MYICT (2015). National Youth Policy towards a HAPPi Generation". Kigali, Rwanda

- Act 5.1.10: Conduct in-service training of Inshuti z'Umuryango (IZU) on child protection
- Act 5.1.12: Conduct situation analysis of online violence against children, abuse, and exploitation, and develop and implement an action plan based on the findings
- Act 5.2.1: Develop a standardized national parents' and caregivers' training manual on positive parenting and non-violent methods of child discipline and conduct regular trainings/sensitization with parents, caregivers, and community leaders
- Act 5.3.4: Sensitize adolescents and young people to prevent instances of violence, especially different forms of gender-based violence (NCC, 2019).

The policy and strategic orientations towards child's protection in Rwanda are clear, but their implementation is limited due to a lack of funds. There is a need to approach the new NCDA to know its urgent needs for support. Although the focus of this program is adolescents (ages, 10–19 years), a focus on mental health promotion during early childhood (through ECD centers, for children aged 0–6 years) was highlighted by different key informants at different ministries as a good entry point towards a promising mental health status among adolescents.

Lastly, the MINEDUC, through its revised comprehensive school health policy (MINEDUC, May 2020), recognizes that it is important to train teachers that act as peer educators at all schools and to provide counseling to students and teachers on mental health issues and other psychosocial issues. Having at least one counselor at school with a background in clinical psychology, where possible, would help. Effective partnership between schools and parents is crucial to ensure that children get regular follow-up to mitigate challenges like drug abuse and related psychosocial issues. There is also a place for the Parent-Adolescent Communication approach that has been demonstrated to address many communication barriers between two individuals, especially around sexual and reproductive health (SRH). It is believed that by integrating issues, mental health promotion would be effective. The regular awareness campaigns organized in partnership with the National Police about drug abuse should be maintained, and schools should prepare more campaigns on their own as well. Adequate referral systems between schools and health facilities should be put in place to help students with mental health issues.

The revised National School Health Strategic Plan aims to meet the needs of all school children and youth with mental health issues and drug addictions, by providing adequate counseling at schools through the following interventions:

- Establishing teacher and peer educator counselors as focal points to assist students and teachers with managing mental health issues (in primary and secondary schools)
- Setting up a clear referral mechanism between health facilities and schools

- Raising regular awareness campaigns about drug abuse
- Setting up monitoring mechanisms to rehabilitate children with drug/alcohol abuse

As an alternative way of addressing mental health issues in schools, the MINEDUC and RBC launched a school-based mental health program on December 4, 2020 in Gashora, Bugesera District.

Trained teachers and peer educator counselors do not have enough skills to address mental and psychosocial problems among children and adolescents in schools. As suggested by all consulted ministries, there is a need to explore the possibility of having clinical psychologists in primary and secondary schools. In case financial limitations persist, joining the current efforts towards scaling up the school-based mental health program is key[18]. Helping the implementation of the well-elaborated "Teacher training materials on school health and nutrition"[19] would effectively help promoting mental health and preventing mental health and psychosocial problems among adolescents in schools.

In brief, many policies and strategic plans across concerned ministries and agencies are not adolescent responsive in terms of mental health. However, since many of them are under revision, an advocacy to consider adolescent mental health as a key aspect across all social cluster ministries should be done.

3.1.4 Mental health and psychosocial support services for adolescents

The country has 27 YEGO centers run by government institutions and other private youth-friendly centers, such as Vision Jeunesse Nouvelle from Rubavu. These services are supposed to have youth-friendly health services, but this is true in only a few cases, especially where there are proactive partners in the area. However, there is no single district-level youth-friendly center that provides mental health and psychosocial support services, though there is a massive need among adolescents visiting youth centers.

All health centers should have youth corners that provide youth-friendly services. The exact number of youth-friendly services established in health facilities is not known, but only 25% to 30% of health facilities have established youth-friendly corners (MoH, 2018), and only 29.4% of the youth are aware of the existence of a youth corner within the health facility (MoH, 2019). Moreover, the services offered in youth corners are not fully functional due to a lack of

[18]MINEDUC (2020). Concept note for school-based mental health, substance abuse & ASRH program. Kigali, Rwanda
[19]MINEDUC (2020). Teacher training materials on school health and nutrition. Kigali, Rwanda

permanent staff, equipment, and convenient locations to really serve as youth corners. There is no mental health and psychosocial support provided as a package in youth corners, yet there is a direct link between ASRH and mental health, and this could be a marvelous opportunity to integrate mental health services with existing programs.

During the landscape assessment, adolescents, through FGDs, reported that they were not aware of any prevention and promotion interventions in their residence. However, the country has some interventions in place, as stated by one key informant from a central-level agency. There are:

- Anti-drug clubs in schools
- School-based mental health programs in schools (recently launched)
- Public awareness campaigns are conducted, and messages are spread
- There is a drug and substance abuse prevention task force at the national level, and its recommended actions are implemented nationwide
- Support groups at the community level (anonymous clubs of former drug and substance abusers)

A KII with one high official from the MoH revealed that there is no screening and identification of mental-ill health in place. Treatment, care, and support services are not adolescent friendly, and the only mental health institution with a consideration of children and adolescents is Ndera Neuropsychiatric Referral Hospital. HIRC provides individualized mental health services for people with drug and substance addictions, but there are no specific settings for adolescents due to a lack of trained personnel. A key informant from the MoH reported that the country has an integrated health treatment, care, and support services system due to a lack of resources.

> *"The country implements an integrated health care system, differently from developed countries, due to a lack of infrastructure and personnel. There are no psychiatric units in hospitals, and all mental health patients are hospitalized in private places, separately from others due to their disturbing status."*
>
> Key informant, central level (high-level official, MoH)

There is an ongoing big project of setting up the Rwanda Mental Health Day-care institution in Gasabo District. There is hope that it will offer child- and adolescent-friendly mental and psychosocial support services.

3.1.5 Human resources

A review of the Rwanda 10-year national strategy for health professionals' development[20] provided a situational analysis, and identified gaps and targets related to the mental health workforce in the country.

Clinical psychologists: There is no target in place to train them since they act in various sectors, but the University of Rwanda graduates 30–40 clinical psychologists each year. Currently, there 2500–3000 clinical psychologists in the country, and very few are hired in the health sector. Interestingly, the MoH is about to appoint 215 clinical psychologists in health centers with a plan to have one per health center.

Psychiatrists: The country has a target of 44 psychiatrists by 2030, with a forecast of 39. The plan is to have 1 per district hospital, 2 per provincial hospital, 4 per referral hospital, and 6 per teaching hospital. There is a collaboration between the Government of Rwanda and Switzerland and Belgium to train psychiatrists by taking some classes in Swiss Universities and others at the University of Rwanda. At present, there are 14 residents in training. There are no sub-specialties in psychiatry, such as pedopsychiatry. To be able to have the country's own training faculty, there is a need for 7 general psychiatrists, 2 child psychiatrists, 2 forensic psychiatrists, and 2 addictologists.

Mental health nurses: The country has a target of 664 mental health nurses by 2030, to reach the norm of one per health center, 2 per district hospital, 4 per provincial hospital, 4 per referral hospital, and 4 per teaching hospital. To date, there are no sub-specialties in mental health nursing, nor any additional training in psychiatric nursing available in the country apart from an advanced diploma being offered by the University of Rwanda.

Table 5. Human resources in mental health services in Rwanda

Personnel	Number	Brief description of role	Training, supervision, and support structures
MHPSS professionals in primary health care system			
Clinical psychologists	65 (in all hospitals and few HCs), with 215 under recruitment process for health centers	Psychological diagnosis and psychotherapy, teaching coping skills and educate patients and family members about	Bachelor's training in clinical psychology at the UR, Master's training in Clinical psychology and therapeutics. There are quarterly

[20] MoH (2020). Rwanda 10-year Government program: National strategy for health professions development 2020-203. Kigali, Rwanda

Personnel	Number	Brief description of role	Training, supervision, and support structures
		specific mental health disorders or illnesses, psychological follow-up of patients	mentorship and supervision. They receive RBC's support to supervise HCs under their responsibilities.
	15 clinical psychologists employed by NCDA	They are employed for child protection and they are based at the district level (in districts with more child protection issues). These work with all cases of child abuse, neglect, abandonment and exploitation.	These are trained clinical psychologists (Bachelor's degree) and they work in close collaboration with the district unit of Good governance (having child protection in charge) and NCDA
Psychiatrists	13 psychiatrists (3 at Ndera, 3 at CHUK, 1 at CHUB, 2 at RMH, 1 at Kibuye referral hospital, 2 at HIRC and 1 in private facilities)	Provide psychiatric care to patients, follow-up and decide on the outcome. Be part of the patient treatment team in a holistic approach	Master training in psychiatry at UR in collaboration with Swiss Universities. Clinical supervision from central level around cases.
Psychiatric nurses (Mental Health Nurses)	235 in different hospitals and health centers	Examine the patient in establishing the case, prescribe drugs and follow-up the case until discharge (mental health nursing care)	Diploma training in mental health nursing at UR. Same supervision and support at clinical psychologists
Therapists	0	-	-
Other, please specify: Neurologists	Three Neurologists (2 at Ndera 1 at CHUK).	Examine and treat patients with neurological problems	Training in master of medicine at the UR
Professionals with MHPSS training in the Education and Social Protection System			
Social workers	671 in health centers and hospitals	Providing counselling and social support in various services, including IOSC with victims of violence (one overall in HC, 1 per	Bachelor's training at the UR and other private universities in Rwanda

Personnel	Number	Brief description of role	Training, supervision, and support structures
		unit in hospitals). Support the social reintegration of mental health patients	
	15+ social workers employed by NCDA	They are employed for child protection and they are based in districts. These work with all cases of child abuse, neglect, abandonment and exploitation.	Bachelor's training at the UR and other private universities in Rwanda and they work in close collaboration with the district unit of Good governance (having child protection in charge) and NCDA
School counselors	0	-	-
Teachers	0	-	-
Other, please specify: Trauma counsellors	Unknown	Providing counselling in to Genocide survivors with trauma. They work with victims associations and CHWs trained on how to deal with mental health detection and referral for treatment.	Trained at initiation of the approach, with refresher training during commemoration. No academic training
Non-specialized community providers			
Community members	59,348 (4 per village)	They are not actively involved in adolescent mental health, yet they should serve in promotion/prevention and referral	Only one online training during Genocide commemoration
Religious leaders	Unknown	There are few organizations that take care of people with mental disabilities	-
Traditional healers	14,000 practicing traditional healers across the country	None is known to be intervening in mental health, yet they should in	-

Personnel	Number	Brief description of role	Training, supervision, and support structures
	yet only 3,000 are registered to operate legally	promotion/prevention and referral	
Peers	0	-	-
Other, please specify:	0	-	-

Source: MoH, Human resources directorate and KII with a high MOH official

The country has 59,348 CHWs (4 per village) who provide community-based health services (community-based management of under-five children, non-communicable diseases, nutrition, and health promotion and disease prevention). However, their involvement in mental health is not remarkable, with minimal interventions during Genocide commemoration.

Many mental health problems are referred to as "spiritual or poisoning," and are attended to by traditional healers at the community level without success. There is a framework and umbrella of traditional healers, set up by the MoH with their roles highly recognized. However, very few are registered, and many practice illegally, which are the main stumbling blocks to health-sector performance.

There are no specialties in child and adolescent mental health in Rwanda. In addition to supporting the government towards reaching the set targets in general psychiatry and mental health nursing, a special consideration is needed towards training in pedopsychiatry, addictology, and child and adolescent psychotherapy. Furthermore, other strategies for optimizing adolescent mental health need to be put forward, including training and effectively engaging CHWs and traditional healers in mental health promotion/prevention and referral as well as involving religious leaders in promotion and prevention. Along with these strategies, it is suggested that setting up peer support groups in the community would also yield significant impact towards improving adolescent mental health in Rwanda.

To conclude this point, it is of utmost importance to mention that a two-fold ideal is behind these suggested improvements. The first expectation would be to have mental health clinicians providing specialized care and management for diagnosable conditions and providing prevention services. The second is likely to be to tap into non-specialized care providers to not only strengthen family- and community-level support but also deliver promotion/prevention interventions.

3.1.6 Monitoring and research

A desk review found that the MoH collects routine data on mental health using the District Health Information System-2 (DHIS-2), an electronic health management information system (HMIS) used in Rwanda, from the community level up to referral health facilities. Primary data are captured during consultation in outpatient departments and hospitalization, using registers and individual patient files. At the end of the month, tallying is done, and data are disaggregated as per the MoH reporting form (age category, gender, new and old case), entered into HMIS electronic forms through DHIS-2, and are accessible online at all levels of the health system administration upon entering the relevant credentials (user name and password). Mental health data are collected per age categories and diagnosis, as set by the MoH. However, these data are not disaggregated by age group as recommended by WHO, i.e., 10–14 years and 15–19 years; they are collected in two age groups (0–19 years and ≥20 years). Having strong data for the age categories of 10–14 and 15–19 years can help with advocacy and making a case for increased investment in the government budget on adolescent mental health. Appendices 1 and 2 clearly show the list of reportable conditions and disaggregation from healthcare settings (government and private facilities). There are no screening and diagnostic tools used in healthcare facilities, apart from national guidelines and protocols.

There are no evaluated MHPSS interventions reaching adolescents or their caregivers, nor costing studies in the area. The most current data on the prevalence of mental health conditions in the general population is the 2018 Rwanda Mental Health Survey. It used the MINI to measure mental health status. Findings from validation and reliability studies have shown that the MINI has similar validity and reliability properties as the Structured Clinical Interview for DSM-III-R and the Composite International Diagnostic Interview, but can be administered in a shorter period of time.

Considering that the recent mental health survey seemed to be purely descriptive, and therefore, did not include the whole adolescence period, it would be useful if the next surveys take into consideration this category, which has thus far been left behind. In a similar vein, the available data-collection tools are likely to not be sensitive in the sense that they do not capture all mental health conditions that have been reported through the Rwanda Mental Health Survey. From this perspective, there is an obvious and compelling need to update the reporting forms and add all conditions.

3.2 Suggested interventions at the population and district levels for adolescent mental health programs in Rwanda

Respondents from this adolescent mental health landscape assessment at the community level (FGD) and district level (KII) proposed different interventions to address mental health problems among adolescents, including those addressing violence, poverty, pregnancy, HIV/AIDS, emotional problems, and disruptive behaviors, as per WHO recommendations through its guidelines on mental health promotion and prevention interventions for adolescents: helping adolescents thrive (WHO, 2020). More details are presented in Appendix 2.

Table 6. Proposed interventions for adolescent mental health programming in Rwanda

Critical issue	Proposed interventions
Adolescents exposed to violence	*Raise public awareness and provide timely information on any form of violence inflicted on promotion and prevention interventions *Psychosocial rehabilitation interventions (individualized care and dispensing community-level interventions by decentralizing Isange One stop centers in health centers –in youth corners- and continuous follow-up in the community to allow social and psychological reintegration. *Have professional social workers and psychologists in all districts/communities in order to not only respond but also to prevent and follow up cases of violence/abuse; under the responsibility of NCDA
Adolescents exposed to poverty	*Investing in quick income generating activities; such as start-up kits after vocational training, competitive start-up funds for community adapted projects *Economic empowerment of adolescents' families *Schooling support towards children from very poor families may prevent them from getting in risky behaviors
Adolescent pregnancies and adolescent mothers	*Family psychosocial support of adolescents during pregnancy period and after giving birth rather than giving up with them *Support in formal training and projects to continue realize their potentials *Financial support through Saving and Lending Schemes to be able to take care of their babies
Adolescents living with HIV/AIDS	*Promote adherence to medication through health education/counselling

Critical issue	Proposed interventions
	*Strengthen the peer support groups that are already in place *Psycho-education for parents on how to live with the infected child
Adolescents with emotional problems	*Psychological counseling to understand their experiences and underlying causes *Recreational activities and making youth clubs work, both in and out-of-schools; together with competition for talent detection and development *Home visits to the adolescent's family using peer education and support "ubukangurambaga bw'urungano" *Raising awareness among parents on child and adolescent mental health
Adolescents with disruptive/ oppositional behaviors	*Explore underlying factors with parents and adolescents and provide appropriate therapies *Educate parents/caregivers on positive parenting practices

4. PRIORITY INTERVENTIONS TO CONSIDER FOR ADOLESCENT MENTAL HEALTH PROGRAMS IN RWANDA

4.1 Possible interventions

4.1.1 Evidence-based recommended interventions from Global Accelerated Action for the Health of Adolescents

WHO, Joint United Nations Programme on HIV/AIDS (UNAIDS), United Nations Educational, Scientific and Cultural Organization (UNESCO), UNICEF, UNFPA, World Bank, and UN WOMEN, through the Global Accelerated Action for the Health of Adolescents (AA-HA!), recommend key evidence-based interventions for mental health, substance use, and self-harm. The following interventions are based on evidence collected from various stakeholders at all levels, from the community to the central level, regarding adolescent health in Rwanda as well as from AA-HA! (WHO et al., 2017).

WHO recognizes investment in adolescent health as"a never-before moment for adolescent health." The 2030 Agenda for Sustainable Development and its Global Strategy for Women's, Children's, and Adolescents' Health provide a unique opportunity for AA-HA! Investment in adolescent health will build on and sustain earlier gains in young child health, and will further enable adolescents to become healthy adults who are equipped to contribute positively to society. Such investment brings a triple dividend: benefits for adolescents now, for their future adult lives, and for their children (AAHA!).

In view of adolescent mental health, the following were drawn the WHO team's recommended evidence-based interventions:

Table 7.WHO evidence-based interventions to promote positive adolescent mental health development

Intervention area	Further explanation
Adolescent-friendly health services (to target psychosocial development)	Make health care accessible and acceptable. Promote health literacy and provide an appropriate package of services, including routine, age-appropriate appointments. Adolescent-friendly sexual and reproductive health (SRH) services are especially important, as stigma and discrimination prohibit adolescents from accessing them in many settings.

Intervention area	Further explanation
School health (to target psychosocial development)	Make every school a health-promoting school in line with WHO guidance. Provide skills-based health education, including comprehensive sexuality education (CSE), with focuses on the development of knowledge, attitudes, values, and life skills needed to make, and act on, the most appropriate and positive decisions concerning health.
Child online protection	Develop and implement a national strategy for child online protection, including a legal framework, law enforcement resources and reporting mechanisms, and education and awareness resources.
e-health and m-health interventions for health education and adolescent involvement in their own care	Explore the potential of adolescent e-health and m-health interventions focused on particular issues (e.g., illness management, SRH education, drugs and substance abuse, and sexually transmitted illness prevention), employing a variety of positive digital-engagement approaches (e.g., web-based learning, active video games, text messaging, and mobile phone or tablet software program apps).
Adolescent participation initiatives	Facilitation of adolescent participation includes involving them in program design, implementation, governance, monitoring and evaluation, and policy and strategic plans development
Interventions to promote the 5 Cs	Interventions to promote adolescent **competence**, **confidence**, **connection**, **character,** and **caring** involve diverse approaches, including those focused on (a) increasing adolescent resilience (e.g., mentoring) and (b) building knowledge, skills, and resources (e.g., educational programs for at-risk youth and vocational training).
Parenting or caregiver interventions	Work with parents to promote positive, stable emotional connections with their adolescent children, promoting connection, regulation, psychological autonomy, modelling, and provision/protection. This includes psychological education for parents to promote adolescent well-being. Parents can also be supported to communicate with their children about SRH, as a complement to school-based CSE.

Intervention area	Further explanation
HEADSSS21 assessment	A HEADSSS assessment in primary care evaluates an adolescent's home, education, employment, eating, activity, drugs, sexuality, safety, suicidal thinking, and depression status to prevent and respond to related concerns.
Brief, sexuality-related communication	Trained health workers should provide a brief, sexuality-related communication to promote adolescent sexual well-being, help them establish clear personal goals, and address gaps between intention and behavior.

Source: WHO et al., 2017

The same team also recommends the following strategies as part of mental health, substance use, and self-harm interventions among adolescents:

- Care for children with developmental delays (e.g., developmental disorders, including autism spectrum disorders)
- Responsive caregiving and stimulation (to reduce parenting risk factors such as low supervision, neglect, rejection, and harshness)
- Psychosocial support and related services for adolescent mental health and well-being (e.g., unipolar depressive disorders and anxiety disorders)
- Parent skills training, using a Parenting for Lifelong Health style (Murray, M. T., & Wessels, I. M. 2014), as appropriate, for managing behavioral disorders in adolescents (e.g., conduct disorder)
- Prevention of substance abuse (e.g., alcohol and drug use disorders)
- Detection and management of hazardous and harmful substance use (e.g., alcohol and drug use disorders)
- Prevention of suicide and management of self-harm and suicide risks (WHO et al., 2017)
- Roll out Measurement of Mental Health Among Adolescents at the Population Level (MMAP) in Rwanda and invest in data for specific actions towards improving mental health among adolescents through increasing investment in the government budget on adolescent mental health (with data on the age categories of 10–14 years and 15–19 years)
- Explore the possibility of having Rwanda as one of the priority countries for implementation of the Helping Adolescents Thrive (HAT) package

21 HEADSS: **H**ome& Environment, **E**ducation &Employment, **A**ctivities, **D**rugs, **S**exuality, **S**uicide/Depression

4.1.2 Possible interventions at community level

The following are suggested interventions by key informants at the district and central levels:

Capacitate "Umugoroba w'umuryango (UMU)[22]" (literally, in English "family's evening"). UMU is a platform initiated by the MIGEPROF and partners, and is a reformulation of "Umugoroba w'Ababyeyi (Parents' evening, put in place back in 2016) as a forum that gathers all households from the village to share ideas on actions to take towards socioeconomic development and solve conflicts that may emerge from households, neighbors, and anywhere else in the village. It is made up of all husbands, wives, children, and youth living in the village. As per MIGEPROF, the main purpose of the UMU is to have a household that is financially capable and peaceful, in which all members are in harmony about everything that happens in mutual respect. Although these initiatives have neither been evaluated nor costed, experiences and testimonies around them are very supportive towards their purposes. Specifically, UMU has the following responsibilities:

- To promote the social well-being of households in the village
- To prepare young boys and girls who are planning to get married
- To prevent crimes from happening in households
- To prevent and solve conflicts in households of the village
- To promote care, education, and the rights of children and all household members
- To promote the gender principle in households
- To promote the economies of households as a way to promote the social well-being of the household members through their active participation
- To mobilize all household members to participate in all government initiatives/activities

This forum was highlighted by almost all assessment participants (parents and key informants at all levels) as a mechanism to indirectly promote adolescent mental well-being and effectively address family-related root causes of mental health problems among adolescents, in case it is really functional. The suggested approach through UMU would be to:

[22] MIGEPROF (2020). Amabwiriza ya Minisiteri agenga imiterere n'imikorere y'umugoroba w'Imiryango. Accessible at https://www.migeprof.gov.rw/fileadmin/user_upload/Migeprof/Publications/Guidelines/Amabwiriza_ya_Minisitiri_agenga_imiterere_n_imikorere_y_Umugoroba_w_Imiryango.pdf

- Capacitate the UMU with education/training on all matters affecting household well-being and the best ways to address them, through **positive parenting and conflict resolution**
- Authorize CHWs to provide the forum with the right information on mental health, early child development, problem detection, and seeking care/support if needed
- Call upon experts in the area (mental health nurses and/or clinical psychologists from the nearest health facilities, etc.) to come and provide the forum with education on mental health (promotion, prevention, and care in adolescent mental health)

Capacitate "Inshuti z'umuryango (IZU)[23]" (literally, in English "Family's friends"). IZU is a cadre (made of one man and one woman, publicly elected by members of the village) that was put in place by MIGEPROF and partners in 2016 with the following responsibilities:

- Prevent any form of violence within households and against children
- Support households and children exposed to violence against their rights and follow-up on the living conditions of children with special needs (children with disabilities, chronic diseases, heads of households, etc.)
- Capacitate households and make them work under performance contracts
- Coordinate actions/initiatives aiming to protect households in general and children in particular

This cadre was highlighted by almost all assessment participants (parents and key informants at all levels) as a channel to ensure effective child and adolescent protection through addressing underlying family-related causes, with a direct impact on mental well-being. The suggested approach through IZU would be to capacitate the IZU with education/training on all forms of violence affecting household and child well-being and the best ways to address them.

Economically empower very poor families: Economic empowerment is required in cases where poverty is the root cause of the negative mental health outcome among children/adolescents living in the family. On average, 800,000 Rwf to 1,000,000 Rwf per very poor family can help. Then, a close follow-up of the implementation of agreed-upon projects,

[23] MIGEPROF (2016). Imirongo ngenderwaho ijyanye n'ishyirwaho n'imikorere y'Inshuti Z'Umuryango (IZU). Accessible at https://www.ncc.gov.rw/fileadmin/templates/document/IMIRONGONGENDERWAHO_IJYANYE_N_ISHYIRWAHO_N_IMIKORERE_Y_INSHUTI_Z_UMURYANGO.pdf

especially in urban areas is required. The NCDA does this, but it is not enough. There is a need for further support from various partners.

Set-up an adolescent mental health promotion model at the community level, behaving as a youthful CHW, i.e., "Abajyanama b'urungano". These volunteer CHWs could intervene in burning issues related to adolescents like drug and substance abuse, violence, ASRH, and other adolescent health-related matters.

U-Report in Rwanda: As in other UNICEF-supported countries, the U-Report maybe leveraged. Successful stories are told about Brazil and Jamaica when it comes to providing a chat-line mental health support service for adolescents through the Voice Matters slogan. The U-report was developed by UNICEF to reach out to communities, gather relevant information, and empower the target public. In addition, it was designed for families to address issues relevant to children and adolescents. Furthermore, it is worthwhile to use this information to exert influence on local- and national-level stakeholders as part of a larger governance and accountability strategy. To this end, a specific consideration would be made about adolescent health, namely ASRH and mental health.

4.1.3 Interventions in education settings

A joint interview highlighted that the MYCULTURE model, together with partners (especially MINEDUC), is exploring the way to have clinical psychologists in all schools. In the meantime, there is an urgent need to capacitate teachers towards mental health promotion, prevention of mental health and psychosocial problems, and effective support of young children and adolescents with mental health conditions. The current school-based mental health program was highly commended as an alternative, but it has its limitations. School pupils will be supported by people who are not well-skilled in mental health and who have other responsibilities. Having clinical psychologists in all primary schools would be the ideal and more effective intervention in the matter.

> *"The 2019 National Children's Summit, under the theme "Uburere buboneye nk'umusingi w'iterambere" recommended the Government of Rwanda to have highly skilled staff in schools to provide the following services with school pupils: active listening to their psychosocial problems, and provide psychosocial support in a holistic manner, involving their families. Those are clinical psychologists. The current initiative of having trainer teachers through the school-based mental health program is serving as an alternative, while leveraging resources to have clinical psychologists."*
>
> Key informant, central level (MYCULTURE).

To ensure the sustainability of the intervention, there is a need to join the efforts of the MINEDUC and RBC to cascade the training of school teachers in adolescent mental health, until the government opts for appointing clinical psychologists in schools. More details are presented in the "*Training Manual for School Health and Nutrition*" by the MINEDUC.

That training manual contains detailed information about sexual and reproductive health and rights, HIV/AIDS and sexually transmitted infections, malaria, non-communicable diseases, and mental health–*factors contributing to the mental health disorders or mental health problems, identifying symptoms of mental disorders, stigma and discrimination, child and adolescent behavioral disorders, effective communication, substance abuse, strategies for addressing psychosocial problems in schools*–nutrition, environmental health, gender, and the basis, culture, and values of physical education and sports.

The second intervention is to have a guidance and counseling policy in place for both teachers and students in primary and secondary schools. The current policy is mainly career oriented, and there is a need to make it broader, so that it can also cover the psychosocial counselling aspect at the school level. This goes hand in hand with developing a guidance and counseling training manual for teachers.

4.1.4 Interventions in health care setting

At different levels, key informants suggested to increase the number of skilled mental health professionals in all health centers (at least one clinical psychologist per health center).

Youth-/adolescent-friendly services in youth corners should incorporate a mental health component into their existing ASRH services to keep up the adolescent-friendly spirit. The youth corner has been found to be a very conducive environment for all sensitive services that adolescents and the youth deserve, but mental health was left behind though it is subject to self and community stigma. There is an urgent need to integrate these services in the youth corner, given that SRH is directly linked with mental health among adolescents, especially when it comes to the difficult and sometimes painful transition from puberty to adulthood. The MoH has revised the ASRH manual to reflect all aspects that are critical to the well-being of adolescents.

Prenuptial counseling on social living, positive parenting, ASRH, and mental health was suggested by key informants from MYCULTURE, to encourage new couples to be fully responsible for the new generation in all aspects of life, with a special focus on family planning

and positive parenting for good mental health. To extend these interventions, it is anticipated that integrating the into the ANC/PNC platform as well as MHPSS services for pregnant adolescents would also serve as early and timely acts towards promotion/prevention and support in the matter.

4.1.5 Interventions in YEGO centers and private youth-friendly centers

District-level youth-friendly centers are very attractive to the youth, including adolescents, and they should be empowered to serve their purpose. There is a need to make them operational, i.e., to have the whole package functional, where there are no partners in place, by **adding mental and psychosocial support** as an item to the youth-friendly health service package (ASRH). This implies equipping them with mental health education, promotion, prevention, and support with the help of skilled permanent staff, peers, and a clinical psychologist. Some youth-friendly services are charged, especially in private centers, such as Rwandese Association for Family Welfare (ARBEF). The financial burden for such services should be addressed.

4.1.6 Special considerations

- **Revisit the process of reintegrating adolescents after rehabilitation** (from the national rehabilitation centers in Iwawa, Gitagata, and Nyamagabe, and HIRC and detention) to resume normal life. These adolescents are brought to rehabilitation centers because of mental health problems, which have their causes in the society they are rejoining (problematic families, delinquent gangs, etc.). A close follow-up between centers, the local administration, associations of rehabilitated adolescents, and health facilities would help in effectively integrating them into society, through psychosocial support as well as quick job placements to ensure they are busy right from the center; this can be accomplished through advocacy towards employment institutions such as masonry, carpentry, tailoring, welding, and plumbing.
- **Support to pregnant adolescents/adolescent mothers**: In addition to high-quality psychosocial support that they strongly need after the pregnancy, there is a need to re-introduce them into formal education. Providing them with very short vocational training does not effectively improve their livelihoods, and they remain dependent. The government has rightly instructed parents to bring back pregnant adolescents to schools when the schools resume after the COVID-19 pandemic. This spirit should be kept up inn other circumstances, and partners in the area should consider this so that we have adult mothers who fulfill their needs through full potential realization and positive coping to the normal stress of life. These women go for short-term training because they do not have

anybody to take care of their babies, and their families are not supportive. Under the advocacy and support from **IZU, UMU**, and the local administration, these women should get the support they require to attend school. The ECD services, once fully functional at the village level, could serve as an alternative, where they could leave their babies with assurance that they will fed and taken care of by trained/skilled caregivers. In this respect, the involvement of **NCDA** and local administrations is key.

4.2 Interventions scoring and final interventions to consider

There are not enough resources to implement all possible interventions. The systematic problem-solving approach suggests that from a set of possible interventions to address the root cause in any program, an objective scoring should be carried out in terms of agreed upon criteria. According to WHO and collaborators, the prioritization process requires a systematic approach and a transparent set of criteria, and should include meaningful participation and contributions by adolescents. All relevant stakeholders should be consulted in a structured manner. Governments should consider the following criteria and any others they deem important in identifying priority adolescent vulnerabilities and health issues:

- **Magnitude of the issue:** Resources should be directed at the main causes of death and illness or injury, but should also go beyond them to address risk behaviors and exposures that could affect adolescents' health now and in the future, using a life-course approach.
- **Groups of adolescents most affected:** All adolescents have health-related needs and can experience difficulties, but not all are equally vulnerable to health and social problems. Some adolescents have overlapping vulnerabilities that make them particularly at risk of the poorest health outcomes (e.g., prior existing disease or injury burdens, low education, and poverty). Special consideration should be given to those adolescents who are most vulnerable and/or in need.
- **Availability of effective interventions:** It is important that scarce resources are used to deliver interventions that have the highest chance of effectiveness for the subpopulations of adolescents that need them the most. The choice of interventions should be guided by the strongest available evidence on their effectiveness.
- **Feasibility of delivering interventions:** Social, economic, and cultural constraints, including the lack of recognition of adolescents' rights, may make it difficult to deliver certain interventions. Priority-setting should be based on a careful and pragmatic analysis of the feasibility of delivering interventions in the particular country with fidelity, at scale.
- **Potential to go to scale:** An assessment of current and needed capacity to deliver interventions is necessary. Strong government and community ownership and political will

help drive scale-up. Costing exercises can inform overall resource needs and how plans can be implemented in a phased approach (WHO et al., 2017).

This assessment used the following criteria to identify priority interventions to consider for the new adolescent mental health program in Rwanda: Magnitude of the issue being addressed, Groups of adolescents most affected, Feasibility of delivering interventions, Appropriateness, Acceptability/political support (Potential to go to scale), Cost, Time bound, and Impact. Each possible intervention was scored on a five-point scale, from least significant (1 point) to most significant (5 points).

From the list of all possible interventions and considering all agreed-upon criteria, we performed objected scoring to create a list of priority interventions for implementation planning and costing. The scoring table is presented in Appendix 5.

4.3 Priority interventions

From the scoring/prioritization exercise, the following interventions were retained as priority ones:

1. Capacitate UMU and IZU through trainings and motivation towards addressing mental health issues in families and amongst adolescents, with a focus on positive parenting practices, role model families, etc.
2. Set up an adolescent mental health promotion/prevention model at the community level (Abajyanama b'urungano) to increase proximity to services and strengthen adolescent clubs at the community level
3. Engage civil society organizations, CHWs, religious leaders (through the Rwanda Interfaith Council on Health [RICH] and church-affiliated youth movements such as scoutism and Xaveri movement), and traditional healers in adolescent mental health (promotion and prevention)
4. Revisit and scale up the school-based mental health program (primary and secondary), by hiring one clinical psychologist at the district level, who would be responsible for supporting the implementation of the school-based mental health program (training teachers) across all schools in the district, intervening in cases of big mental health issues, and mentoring school champions
5. Increase the number of skilled psychologists and social workers at the district level (working in child protection)
6. Revisit the reporting system and include 10–14 years and 15–19 years as age categories in all health facilities (including HIRC) and youth centers in Rwanda, and include in the

reporting system other mental health conditions that are becoming more prevalent among adolescents

7. Update the ASRH training module with mental health modules and integrated adolescent mental health services in youth corners
8. Promote e-health and m-health interventions for mental health education and adolescent involvement in their own care (e.g., SMS, radio drama, radio messages airing, TV messages airing, and social media) and positive digital-engagement approaches
9. Set up fully functional psychiatric units in all hospitals (district, provincial, and referral hospitals)
10. Integrate mental health and ASRH in youth corners of YEGO centers (and all youth-friendly centers), with a psychosocial support program
11. Support anti-drug club competitions in schools as a strategy to prevent drug and substance abuse among in-school adolescents
12. Provide special support for pregnant adolescents/adolescent mothers, focusing on education on self and child care, empowerment to start up in life, and skilled-based education
13. Conduct prenuptial counselling on social living, positive parenting, ASRH, and mental health (module development and distribution in health facilities)
14. Empower the rehabilitation process (effective community integration through continuous psychosocial support, and district advocacy towards quick employment by job providers)
15. Strengthen ECD services in all villages (integrate mental health matters: positive parenting, early stimulation, care for children from teen mothers, promotion/prevention, and referral through UMU and IZU)
16. Support the implementation of online child-protection actions
17. Leverage the U-Report in Rwanda as a mental health chat-line support service for adolescents in Rwanda
18. Engage CHWs and traditional healers in mental health promotion, prevention, and referral at the community level
19. Include an MHPSS component in PNC/ANC targeting pregnant women and mothers, especially for pregnant adolescents
20. Roll out MMAP in Rwanda and invest in data for specific actions towards improving mental health among adolescents through increasing investment in the government budget on adolescent mental health (with data on the age categories of 10–14 years and 15–19 years). This may also include local-level validation and an integrated MMAP tool in Demographic and Health Surveys (DHSs)/Multiple Indicator Cluster Surveys (MICSs).

21. Develop and validate screening and diagnostic tools that are age appropriate and culturally relevant in Rwanda
22. Explore the possibility of having Rwanda as one of the priority countries for implementation of the HAT package
23. Create safe spaces in community groups for adolescents to engage in dialogue about genocide
24. Revisit existing policies and strategies, and include adolescent mental health as a key pillar and set its directions at all levels. Each ministry should recognize the gap in showing policy directives towards adolescent mental health, and this should be addressed during the ongoing and yet-to-start process of revising existing policies

4.4 Suggested actions without financial engagement from UNICEF

There are actions that need to be implemented that do not require any investment, but rather require simple advocacy through meetings that can be easily convened by the concerned ministries. Other actions are already being implemented and are highly commended towards the effective implementation of an adolescent mental health program in Rwanda. These include, but are not limited to, the following:

1. In collaboration with the MoH, the Rwanda Social Security Board and other private health insurance companies should cover HIRC services under health insurance to address the financial burden and cover mental health service fees for the most vulnerable children and adolescents. Many people with addiction cannot afford the cost of these services. Advocacy is needed for everybody in need to access the services under health insurance, especially under the community-based health insurance scheme (Mutuelle).
2. The MoH process of increasing the number of skilled mental health professionals in all health centers (to have at least one clinical psychologist per health center) is highly commendable. Once each health center has at least one clinical psychologist, the existing mechanisms towards adolescent mental health, promotion/prevention, and support will be effective.
3. The NCDA should increase the number of professional social workers and psychologists in all districts/communities in order to not only respond but also prevent and follow up on cases of violence/abuse.
4. Engage with young people while updating the national mental health strategy to be adolescent responsive/specific. They have been left behind and are just called upon to implement policies and strategies to which they did not provide inputs. This should change to ensure the sustainability of the suggested actions.

5. Re-establish the full functioning of YEGO centers in the country (staffing as before handing them over to the districts). Since MYCULTURE is no longer managing these centers, advocacy among district partners to support the YEGO centers is key. Districts with active partners in youth empowerment report higher performance than those without any external support.
6. Explore the possibility of having Rwanda as one of the priority countries for the implementation of the HAT package. This can be done through a short meeting to show the relevance of the initiative before any financial commitment.

5. ENTRY POINTS IN THE CURRENT SYSTEMTO ENABLE EFFECTIVE IMPLEMENTATION OF AN ADOLESCENT MENTAL HEALTH PROGRAM

This assessment aims at identifying entry points in the current system that will enable the effective implementation of an adolescent mental health program. Since mental health is a cross-cutting issue (that affects social protection, education, and health), considering only the health system would not yield the expected impact, rather considering different systems (holistic approach) that are concerned with adolescent mental health will yield a more comprehensive health outcome.

From the perspective of adolescent mental health programs, no single institution can implement all interventions, rather a collaborative approach is required. Fortunately, all consulted ministries and government agencies share the same concerns and converge on almost all interventions.

Since it is health program, its oversight would be provided by the MOH/RBC through its mental health division. Then, UNICEF would pass its support through at all levels.

5.1 Entry points at community level

There is a need for financial support to build the capacity of community structures (UMU, IZU, ECD centers, adolescent/youth forums, clubs and organizations, CHWs, and traditional leaders) in adolescent mental health promotion, prevention, and referral. Some settings that are not functional will be revitalized, such as adolescent/youth forums, clubs and organizations, and traditional leaders, so that they can play their roles in this matter. In addition to the support for the out-of-school adolescent population, there is a school-based program that is run through the RBC and REB. This program will be financially supported by hiring clinical psychologists who will be rotated across all schools, and will train teachers, raise awareness among teachers and students, and mentor and provide psychosocial support for adolescents in need. There also will be a direct link between schools and the nearest health facilities for the adequate management of cases that cannot be managed in schools.

5.2 Entry points at sector level and district levels

UNICEF will financially support the MOH/RBC to set up and strengthen the link between the community, schools, health centers, and hospitals. UNICEF will conduct a close follow-up with district-based staff on the implementation of the program and will cross-check the reliability

of information between district reports and line ministry reports to track the implementation of the program and suggest changes/adjustments when needed. UNICEF will also support the setting up of psychosocial support services in youth-friendly centers as well as the reintegration of adolescents graduating from rehabilitation centers (economic and psychosocial reintegration).

5.3 Entry points at central level

There is need for a close collaboration towards the implementation of retained interventions. In addition to providing line ministries with financial support, there will be specific interventions that will need direct involvement by UNICEF during their implementation. Specifically, direct involvement is required for importing and adapting successful interventions around adolescent mental health from other countries, as suggested in this assessment (e.g., U-report, MHPSS services for pregnant adolescents, rolling out of MMAP in Rwanda, exploring the possibility of having Rwanda as one of the priority countries for the implementation of the HAT package, and developing, testing, and implementing diagnostic/screening tools). UNICEF will provide the government with overall advice (expertise) and learnings from success stories/experiences in other countries where adolescent mental health programs are being implemented.

One big meeting to launch the program would be convened by UNICEF and the MoH/RBC to present the retained priority interventions, and have final discussions on the buy-in of the activity by each concerned ministry/agency before the start-up of the program.

6. IMPLEMENTATION PLAN AND COSTING FOR THE ADOLESCENT MENTAL HEALTH PROGRAM IN RWANDA

The costing of the priority interventions towards a comprehensive adolescent mental health program in Rwanda came up with an estimated budget of six billion two hundred four million two hundred thirty-six thousand and five hundred twenty Rwandan francs (**7,509,357,920**Rwf), equivalent to six million two hundred sixty-six thousand and nine hundred six United States Dollars ($7,585,210). Details about each intervention (activities and related costs) are presented in Appendix 6. The implementation will depend on the availability of funds, over a period of five years.

Table 8. Implementation plan and costing for the adolescent mental health program in Rwanda

Intervention	Line institution	Timeline	Overall budget (In Rwf)
Capacitate UMU and IZU through trainings and motivation towards addressing mental health issues in families, with a focus on positive parenting practices (e.g., Parenting for Lifelong Health), role model families, etc.	MIGEPROF, NCDA	2021–2022	2,033,524,800
Set up an adolescent mental health promotion/prevention model at the community level (Abajyanama b'urungano) to increase proximity to services and strengthen adolescent clubs (e.g., anti-drug clubs, scoutism clubs, and Xaveri clubs)	MYCULTURE	2021	292,840,000
Engage civil society organizations, CHWs, religious leaders (through RICH and church-affiliated youth movements [e.g., Scoutism and Xaveri]) and traditional healers in adolescent mental health promotion and prevention	MoH/RBC	2021	316,860,000
Revisit and scale up the School-based mental health program (primary and secondary), by hiring one clinical psychologist at the district level, who will be responsible for supporting the implementation of the school-based mental health program across all schools in the district (e.g., training teachers, intervening in cases of big mental health issues, and mentoring school champions)	MINEDUC/ REB & MoH/RBC	2021	303,075,000
Increase the number of skilled mental health professionals in all health centers (through training and mentoring of existing staff in adolescent mental health)	MoH	2021	139,100,000
Increase the number of skilled psychologists and social workers at the district level (working in child protection)	NCDA	2021	303,075,000
Revisit the HMIS and include 10–14 years and 15–19 years as age categories in all health facilities (including HIRC) and youth centers in Rwanda, and include in the reporting system other mental health conditions that are becoming more prevalent among adolescents	MoH/RBC	2021	272,619,500

Intervention	Line institution	Timeline	Overall budget (In Rwf)
Promote e-health and m-health interventions for mental health education and adolescent involvement in their own care (e.g., SMS and radio dramas, radio messages airing, TV messages airing, and social media), and positive digital-engagement approaches.	MoH/RBC & MINICT	2021–2022	310,991,800
Set up fully functional psychiatric units in all hospitals (district, provincial, and referral hospitals)	RBC	2021–2022	8,149,320
Integrate mental health and ASRH in youth corners of YEGO centers (and all youth-friendly centers), and include a psychosocial support program	MYCULTURE & MoH/RBC	2021–2022	132,000,000
Provide special support to pregnant adolescents/adolescent mothers: education on self and child care, empowerment to start up in life, and skills-based education	MYCULTURE & UNICEF	2021–2024	1,800,000,000
Prenuptial counselling on social living, positive parenting, ASRH, and mental health (module development and distribution in health facilities)	MoH/RBC	2021–2022	13,705,600
Empower the rehabilitation process (effective community integration through continuous psychosocial support and district advocacy towards quick employment by job providers)	RNS, MINALOC, MoH/RBC	2021–2024	331,972,200
Strengthen ECD services in all villages (integrate mental health matters: positive parenting, early stimulation, care for children from teen mothers, promotion/prevention, and referral through UMU and IZU)	NCDA & RBC	2021–2024	446,424,000
Support the implementation of online child-protection actions	MIGEPROF & MINICT, NCDA	2021–2022	55,300,000
Revisit existing policies and strategies, and include adolescent mental health as a key pillar and set its directions at all levels	UNICEF	2021	5,000,000
Have the Mental Health Division work closely with the Maternal, Child and Community Health (MCCH) division to have one comprehensive manual (ASRH	RBC	2021	47,684,000

Intervention	Line institution	Timeline	Overall budget (In Rwf)
and mental health) and integrated guidelines for service provision in youth corners			
Leverage the U-Report in Rwanda as a mental health chat-line support service for adolescents in Rwanda	MINICT & RBC & MYCULTURE & UNICEF	2021–2022	29,596,000
Support anti-drug club competition in schools	RBC & MINEDUC/ REB	2021–2022	50,634,800
Include an MHPSS component in PNC/ANC targeting pregnant women and mothers, especially pregnant adolescents	MoH/RBC & UNICEF	2021–2022	39,984,000
Roll out MMAP in Rwanda and invest in data for specific actions towards improving mental health among adolescents through increasing investment in the government budget on adolescent mental health (with data on the age categories of 10–14 years and 15–19 years). This may also include local-level validation and an integrated MMAP tool in DHSs/MICSs.	MoH/RBC & UNICEF	2021–2022	300,000,000
Explore the possibility of having Rwanda as one of the priority countries for the implementation of the HAT package	MoH/RBC & UNICEF	2021	2,450,000
Develop and validate screening and diagnostic tools that are age appropriate and culturally relevant in Rwanda	RBC & UR	2021	3,967,900
Create safe spaces in community groups for adolescents to engage in dialogue about genocide	NURC & CNLG & MYCULTURE & NCDA	2021–2024	300,000,000
Overall budget			**7,509,357,920**

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APPENDICES

Appendix 1. Selection of assessment participants and approach for data collection

District	Area	Participants	Number	Approach
Rusizi (Rural)	Gashonga sector	Boys	20	2 FGD
		Girls	20	2 FGD
		Adolescents' parents	10	1 FGD
	Mibirizi HC	Mental health nurse	1	KII
	Mbirizi DH	Head of mental health	1	KII
	Rusizi YEGO center	Coordinator	1	KII
	Rusizi district	Director of Good Governance	1	KII
Nyarugenge	Kimisagara sector	Girls	20	2 FGD
		Boys	20	2 FGD
		Adolescents' parents	10	1 FGD
	Kimisagara YEGO center	Coordinator	1	KII
	Club Rafiki	Coordinator	1	KII
	Muhima HC	Mental health nurse	1	KII
	Muhima DH	Head of mental health	1	KII
	Rusizi district	In charge of youth	1	KII
	NCC/Nyarugenge	Coordinator	1	KII
Rubavu	Gisenyi sector	Boys	20	2 FGD
		Girls	20	2 FGD
		Adolescents' parents	10	1 FGD
	Gisenyi HC	Mental health nurse	1	KII
	Gisenyi DH	Head of mental health	1	KII

District	Area	Participants	Number	Approach
	Rubavu district	Director of Good Governance	1	KII
	Rubavu YEGO center	Coordinator	1	KII
	Vision Jeunesse Nouvelle	Director General	1	KII
Kirehe	Nasho sector	Boys	20	2 FGD
		Girls	20	2 FGD
		Adolescents' parents	10	1 FGD
	Mulindi HC	Mental health nurse	1	KII
	Kirehe DH	Head of mental health	1	KII
Kicukiro	Icyizere center	Head of institution	1	KII
Huye	Huye Isange rehabilitation center	Head of institution	1	KII
Kigali City	Ministry of education/REB		2	KII
	Ministry of Gender and Family Promotion		1	KII
	Ministry of Health/RBC		2	KII
	National Child Development Agency		1	KII
	Ministry of Youth and culture		1	KII
	UNWOMEN		1	KII
	WHO		1	KII
	UNFPA		1	KII
	WHO		1	KII

1. Understanding of mental health

The participants had different understandings of adolescent mental health, but all of them converged their meaning on behaviors as key terms in the definition of mental health. For many, there is good mental health and bad mental health depending on the way people behave, feel, and think. There was also a common tendency to refer to mental illnesses as the definition of mental health.

> *"When someone talks about mental health, most of the time, I refer back to his/her thoughts, sometimes good or bad. When thoughts are very bad, I consider the mental health as not good. That is how I understand mental health."*
>
> FGD participant, adolescent girl, Nyarugenge District

> *"Someone who abuses drugs like cannabis or cigarettes and cannot leave them, feels okay, yet it is not the case. For instance, someone who abuses cannabis feels energetic, while it is not the case; and those abusers get diseases from it, such as cancer."*
>
> FGD participant, adolescent boy, Rusizi District

2. Causes of mental health conditions/issues/problems

Different reasons were reported as the underlying causes of mental health problems among adolescents.

Poverty was reported by the majority of respondents as a cause of mental health problems among adolescents and parents/caregivers. Many adolescents are in school age, and feel uncomfortable to continue studying while they cannot survive as a consequence of the poverty of their families. Poverty leads to high school drop-out rates among adolescents and a lack of social interaction/positive peer influence. As a coping strategy, they take to the streets, and end up engaging in risky behaviors such as sex work, drug use, and suicide.

"You wonder what you will eat or drink tomorrow because of poverty with nothing at home."

FGD participant, adolescent boy, Kirehe District

"For instance, we used to eat lunch, but we cannot since there is nothing to do to get what to eat; there is no job. Because of poverty, people's mind is troubled with a lot of negative feelings."

FGD participant, adolescent girl, Rubavu District

"Another thing that shows that an adolescent has a mental health problem is poverty in the family. A child may go to school hungry, until a teacher gave tea and bread to him/her to save her/him after fainting. That means he/she is mentally troubled by that situation, which was manifested by fainting."

FGD participant, parent (adult), Rusizi District

Household/family social situation: Family conflicts (between couples and between parents and their children) were highlighted at all levels of the assessment as the main reason behind a bad mental health status among adolescents. Adolescents, parents, and all key informants (at the district level, and inn ministries and agencies) agreed on the fact that the social situation in households is the foundation towards mental well-being among children and adolescents. The following household-related issues were identified: frequent conflicts; violence against children and adolescents (physical violence, especially among boys; sexual violence, especially among girls; and emotional violence against both boys and girls); gender-based violence, especially intimate partner violence among couples; divorce or separation of couples; and irresponsible actions of parents towards their children, including delinquent acts, poor parenting practices, child abuse in families, lack of parental affection and support/accompaniment during problems, puberty, and adolescence, harshness towards children, inability to have enough time for their children (very busy parents), neglect/abandonment of children and adolescents with disabilities (tying them, hiding them, beating them), and many other issues.

"Another thing is when your parents have divorced, and youth father does not care for you, refuses some rights from you, until you may get involved in risky behaviors, even accidently get pregnant."

FGD participant, adolescent girl, Nyarugenge District

"Because of poverty, most families are characterized by mistreatment and violence of various kinds, and these are risk factors to mental health problems. Children and adolescents who are born from families with mistreatment/violence are more likely to mistreat/violate others. Parents who have good culture or are well educated are more likely to treat their children well, regardless of the socioeconomic situation; they will always struggle to give good values to their newborns, which is a protective factor against mental health problems. You will find wealthy housseholds, but with mistreatment/violence, without love. Members from such households will struggle on their own to survive mentally, with different coping strategies, including negative ones. This mentally affects not only children and adolescents but also the entire personal, societal, and country development."

Key informant, National Rehabilitation Service (adult)

"I felt very anxious. One day, mummy came from home from the job and very exhausted. Daddy also came from his job but drunk. He immediately hit mummy; I intervened to break the fight until I was also hit by daddy. I went out very anxious and crying and thinking of what I could do to overcome the situation, until I joined the street adolescents, and I was initiated to drink alcohol, Kanyanga. I met someone called Eric Cyubahiro who took me out of the street and brought me in Indaro family, where he takes care of many adolescents from the street, trains us in various issues such as drumming, dancing, etc. In fact, our mothers suffer a lot for us to survive; that is why I love my mum better than my dad, given that he even left us alone with my mum."

FGD participant, adolescent boy, Nyarugenge District

A suicide case was highlighted in Kirehe District, due to a conflict between a child and his mother.

> *"This is because of parents. One lady got married with a man, and later the lady got in trouble with his husband's brothers until she left the family, but she went out with her son. Few years later, she started stressing the son, threatening him to join his father or be left alone. The son insisted that his mum keeps her where she was going to get another husband, and her mum refused; until the son got mentally troubled and committed suicide.*
>
> FGD participant, parent (adult), Kirehe District

Biological factors: These are internal factors, such as genetic factors, which are too complicated to address given the limited diagnostic tools/technologies.

> *"Biological factors are difficult to address. For instance, you will find someone with a mental health disorder and has someone else in the family with a mental health condition. In that case, it is a family issue."*
>
> Key informant, Huye Isange Rehabilitation Center (adult)

Participants reported many other underlying causes/factors of poor mental health outcomes among adolescents, such as:

Drug and substance abuse: As stated during the National Mental Health Survey, all assessment respondents reported drugs and substance abuse as a direct contributor to mental problems/disorders and delinquent behaviors, especially in towns and centers where adolescents can easily access them.

> *"There are very few street adolescents who do not abuse drugs and substances, and this affects their mind until they cannot think about what they do. Grabbing someone's belongings is something very easy, killing someone who doesn't want his/her things to be taken away. When drugs addicted, you are in a very critical mental health condition."*

FGD participant, parent, Nyarugenge District (adult)

Being orphans: Being in an orphanage is a risk factor in itself, especially when orphans are not cared for/adopted by their relatives.

> *"Being in an orphanage is a problem itself. It is all about waking up in the morning, eating porridge, going to school and back at noon, and so on. So, what do you expect from a child who has grown in that situation. There are some who positively cope with the situation, and others who think 'I would go to school and see my mum coming to visit me, to check my school report.' They go to school and see fathers and aunts coming to visit their mates, and they do not have anybody to do it for them. That is the source of depression and other psychosocial problems, especially among orphans."*

Key informant (adult), Rubavu District

Children and adolescents from criminal parents (genocide perpetrators) and victims of genocide (crime witnesses): These critical situations were highlighted by key informants from the central level. There is very serious victimization among adolescents whose parents are in jail because of committing genocide, and they feel guilty of being born from such bad parents, yet they cannot change this situation. Other children missed their relatives, grandparents, aunts, cousins, and uncles, and they find no answer from their parents for that gap in their life. These two categories of adolescents are struggling to maintain their mental health, and some end up being mentally affected and traumatized.

There is another category of children/adolescents who have witnessed or been involved in serious crimes, been convicted, and have come back to the place where they have committed crimes. They will never feel innocent, and this seriously shakes their mind until they become mentally or psychologically affected.

> *"You find adolescents who are considered as orphans, and they are not actually. Homicide, for instance, the father killed the mother (his own wife), now in prison, and the child does*

not have anywhere to go. Even someone receives the child, he/she will not feel comfortable. When he/she does something wrong, he/she will be blamed: "you are a killer like your father."

Key informant (adult), Huye Isange Rehabilitation Center

Exposure to social media: With technology and internet penetration, there is a huge exposure of adolescents to non-age-adapted movies and internet-based issues, which leads them to adopting bad and risky behaviors.

"Children and adolescents are exposed to non-age-adapted movies, such as pornography and criminality. We have found that social media is negatively mentally impacting children, regardless of their economic status."

Key informant (adult), Nyarugenge District

Lack of knowledge about adolescence among parents who do not have enough information to pass on to their children. This makes them seek it from risky sources. Some illnesses and health conditions such as HIV, cancer, and physical disability directly affect them mentally, especially when the affected people are not psychosocially supported by the environment.

"For instance, you find a child that was born with disability and is not treated fairly like others in the family. They neglect him/her; they do not eat the same food, which mentally affects him/her because he/she realizes that he/she is not normal like others."

FGD participant, parent (adult), Rusizi District

Violence: Sexual and gender-based violence inflicted on adolescent girls in Rwanda, exacerbated by the silence in the community, is a barrier towards effective preventive actions. The Violence Against Children and Youth Survey (VACYS) conducted in Rwanda in 2015–2016 found that 28% of young men and women aged 19–24 years had experienced at least one form of violence in the past year. Specifically, physical violence against boys was the most common form of violence, followed by physical violence against girls, sexual violence against girls, and

emotional violence against boys. Children of all ages experience violence, although adolescents are often most at risk. Children are usually abused by parents' friends, neighbors, teachers, boyfriends, and friends. As a consequence, 12% of physically abused boys were reported to have been violent towards another person, as compared to 4% of boys who had not been physically abused. This is due to externalizing behaviors as a result of adverse childhood experiences.

Violence in childhood and adolescence is has a devastating impact on mental health, and places children and adolescents at a high risk of early pregnancy and sexual risk-taking behaviors (MoH, 2017). While physical violence is less pervasive, sexual and emotional violence are more prevalent among children and youth with disabilities living with their families and communities, until most of them find an institutional setting to be the most convenient environment in which to fulfill their needs and realize their potentials to the fullest (MoH, 2018).

The majority of the qualitative assessment participants, from the community to the central level, reported that violence was one of the most prevalent risk factors for mental health problems among adolescents.

> *"Another thing I can say, going back to adolescent girls who are mentally and psychologically disturbed; I personally know one girl who was sexually abused at the age of 12. This had a very negative effect on her until she stopped her studies after Primary 6. When you find her, you easily find out that she is mentally affected, traumatized. She does not openly talk to everybody; she is very depressed. Sexual and gender-based violence is really bad, seriously traumatizing."*
>
> FGD participant, adolescent boy, Nyarugenge District

Teen pregnancy: The Government of Rwanda is confronted with the serious problem of teen pregnancies. Teen pregnancy can have a wide range of health (including mental health), social, educational, and economic consequences for young people. Teenage mothers in Rwanda are more likely to experience adverse pregnancy outcomes, and are more constrained in their ability to pursue educational opportunities than young women who delay childbearing.

According to official statistics, 17,849 underage girls got pregnant in 2016; this number slightly increased to 17,337 in 2017 before jumping to 19,832 in 2018, and was 15,696 between January and August 2019, i.e., an average of 1,962 a month. Broken down by district, Nyagatare registered 1,465 teen pregnancies in 2018, Gatsibo 1,452, Gasabo 1,064, and Kirehe 1,055 (Nasra Bishumba, 2020).

The most recent Rwanda Demographic and Health Survey 2019–20 reported that 5% of girls aged 15–19 years have begun childbearing. The proportion of teenagers who have begun childbearing rises rapidly with age, from less than 1% at age 15 to 15% at age 19. Teenagers with no education and those in the lowest wealth quintile tend to start childbearing earlier than other teenagers. Teenagers in East Province are more likely to start childbearing earlier than their counterparts (NISR et al., 2020).

All qualitative assessment participants also converged on teen pregnancies as the most common contributing factor to bad mental health among adolescent girls, especially when there is no parental and community support towards positively coping with the traumatizing experience.

> *"Like that case whereby an adolescent girl get unwanted pregnancy and ends up being rejected by her family, and becomes homeless, with at most a shelter among relatives who may not even support her as appropriately as it should be. Anyways, someone who deviates you from your virginity and leaves you with a newborn without any support kills you mentally. And that child who grows up without a father nearby does not grow mentally fit, bearing in mind the circumstances in which she/he was born, considering himself/herself as an illegal child."*

FGD participant, adolescent boy, Kirehe District

> *"You may have parents who do not understand you when you accidentally got pregnant, and they take you as a disruptive/delinquent girl, always insult and harass you until you decide to leave them."*

FGD participant, adolescent girl, Kirehe District

Homeless parents: The children of homeless parents are exposed to homelessness themselves. They will not go to school, and they may fall in with a delinquent community of drug abusers, beggars, prostitutes, thieves, etc.

> *"Delinquent parents do not have anything to give to their children as education. Comes then homeless parents who pass their time in Nyabugogo without any address. Then, you wonder the mental health status of the child who is born and grows in those conditions. He/she will no longer go to school, will grow up in drug- and substance-abusing communities …"*

Key informant (adult), central-level agency

Bad company among adolescents was also mentioned as a root risky behavior that negatively impacts the mental well-being of adolescents.

> *"In my opinion, when you have bad friends, you end up behaving like them, when you do not miss anything in your family. You may even leave your family and the school to join them. There is a proverb that says 'A bad goat is not tied to a good one' (ihene mbi ntawe uyizirikaho inziza)."*

FGD participant, parent (adult), Rubavu District

3. Suggested interventions for the adolescent mental health program in Rwanda

Respondents from this adolescent mental health landscape assessment proposed different interventions to address mental health problems among adolescents, including those addressing violence, poverty, pregnancy, HIV/AIDS, emotional problems, and disruptive behaviors, as per WHO recommendations through its guidelines on mental health promotion and prevention interventions for adolescents: Helping Adolescents Thrive (WHO, 2020).

a. Interventions for addressing violence among adolescents

For adolescents exposed to violence among adolescents, respondents suggested raising the public awareness and providing timely information on any form of violence inflicted, through promotion and prevention interventions, including saying "No" to gender violence. That will address the issue of stigma and victimization.

> *The first thing I can say is raising community awareness towards breaking silence in case of violence, as keeping it silent gives room for the offender to keep doing so. I saw a girl who gave birth at the age of 14, and I asked her "how did you survive the cesarean section?" She told me: people told me that I would undergo a cesarean section in case I do not keep doing sex with my partner." She kept doing it, even after delivery. Last time, we talked and I asked her to come for testing, she had a three months pregnancy, from the same man who is a driver, aged 25 years. They live as a husband and a wife, yet she stays at her parents' house. There is a need to organize frequent community awareness campaign on violence as to be aware of different types of violence that people are unaware of! By being informed, we should continue to reflect on it as to know how to behave."*
>
> Key informant (adult), Rubavu District

Psychosocial rehabilitation interventions were also proposed, including providing individualized care and dispensing community-level interventions by decentralizing Isange One-stop centers in health centers, specifically in youth corners, and performing continuous follow-up in the community to allow social and psychological reintegration.

> *"There is psychosocial support because we are not effectively addressing trauma among those who are violated. The Isange One stop services are very far from the community, and very few reach the place. There is a need for a continuum of services towards victims of violence. If you have been violated, that lasts forever, and there is a need for effective support. At a young age, you will grow up traumatized, and you may even die with it. There are things that entail regular follow-up throughout the person's lifetime."*

Key informant (adult), Rubavu District

Each case should be treated individually, by tackling/addressing the root cause to avoid any future violence towards the victims.

b. Interventions for dealing with poverty in adolescents

Poverty was widely highlighted as an important factor hindering mental well-being among adolescents, and thus, actions towards poverty reduction were recommended, such as investing in quick income-generating activities (e.g., start-up kits after vocational training and competitive start-up funds for community-adapted projects).

> *"In give directly program, there should be financial coaches/mentors to support them efficiently use the given money, to follow them during project implementation. It is very bad to give money to someone and find out that it was not used for its purpose, without even getting health insurance for children. Then for adolescents who are not directly given money, they should be involved in income-generating works, to keep them busy and get money at the same time."*

Key informant (adult), central-level agency

Such projects should be well studied, so that they can yield an impact in a short period of time since adolescents are not tolerant of poverty, a very traumatizing circumstance.

There is a belief that the schooling support towards children from very poor families may prevent them from getting into risky behaviors and ending up with some mental health problems.

> *"You know that we have a school-feeding program in our schools. Today, I was pushing these kids to bring money to be able to eat lunch here. Now, in case the family cannot afford it, the child will not survive, and that may deviate their minds towards risky behaviors;*

going out here to eat Mandazi from young shopkeepers, ending up in risky sexual intercourse, drug abuse, etc."

One head teacher (adult), Nyarugenge District

To be pragmatic, one respondent suggested an initiative of emulating one cow per family program among adolescents to deal with poverty.

"*As they put forward a one cow per family program may be emulated by giving one goat per adolescent for breeding it and handing it over to one another."*

FGD participant, adolescent boy, Kirehe District

c. Interventions for tackling pregnancies in adolescents

Adolescent pregnancy was underscored as one of the leading causes of mental health problems among adolescents since it affects not only the mother but also the child. Respondents suggested that parents should be at the forefront of supporting adolescents during pregnancy and after giving birth rather than giving up on them.

"*There are some who are willing and committed to resume studies as usual. Let us say, if she got pregnant while she was in junior secondary school and thereafter believes that she can go back to school. Why can't she go back to school? She replies saying 'my parents refuse it by rudely claiming: sit there to look after your baby because you chose to give birth! We strove to pay school fees!' As a way of telling you* that it is up to you since you opted to give birth! Parents need counseling to support their girls."

Key informant (adult), Rubavu District

In addition, other respondents advocated for availing vocational courses for adolescents who dropped out from school, but avoid creating a specific support group for adolescent mothers for fear of stigmatizing them.

"If we are to support people through vocational training schools to bring them back to school, we should do it anonymously because putting them in evidence is traumatizing by itself. I am actually in disagreement with them though I do not have power…"

Key informant (adult), Rubavu District

Those whose parents refuse to support them could be supported to attend formal vocational training, not merely short training courses because this undervalues them. Financial support through savings and lending schemes was also highlighted.

Finally, there should be awareness campaigns on how to prevent pregnancy and provide counseling/psychosocial support to those who are affected psychologically.

"There might be some talk mediated through television about pregnant adolescents, and I do support it. I think that even if you have given birth, you are still a human being! You are in need of someone to come in your life to support you to go through that tough circumstance, where possible."

FGD participant, adolescent boy, Kirehe District

In case affected pregnant adolescents/adolescent mothers are aware of health care services for them, they decide to seek them. Cases should be treated individually because the causes are different among individuals, and orientation towards potential realization should be done individually.

"There is a way that pregnant teens and teen mothers feel somehow desperate to such an extent that they are likely to end their life or tend to abort, but by interacting with them, that should not happen to feel hopeless with tendency to abort."

FGD participant, adolescent boy, Kirehe District

e. Interventions for supporting adolescents living with HIV/AIDS

For adolescents living with HIV/AIDS, the best support would be monitoring with the intent to motivate them to adhere to medication through health education. Antiretroviral therapy services are effective in Rwanda; there are also child and adolescent support groups, and one of their roles is to promote adherence to the program through individual counseling and problem solving.

> *"Still, those who are affected by HIV/AIDS should be closely approached and encouraged to take medication, and prevent them from despair! Those in school should be protected from stigma and should be accepted. Educators must not consider them as different from other children nor regard them as sick people who are disempowered…"*
>
> Key informant (adult), one health service provider

An additional intervention would be providing psychoeducation that would prevent the youth from engaging in unhealthy behaviors and get parental support where possible. Parents should be psychologically supported to disclose the HIV/AIDS status to their children at the right time since it was reported that there are cases of parents who never find the courage to do so, and the child feels mentally affected once he/she knows about it at a later age.

> *"I feel that what is needed is that we should be sensitized about it; for instance, they should prepare that training that teaches youth to refrain from engaging in sexual behaviors. And if a child is contaminated, he/she may not be abandoned by parents because afterwards life continues."*
>
> FGD participant, adolescent boy, Kirehe District

f. Interventions for assisting adolescents with emotional problems

Emotional problems are common among adolescents, and some strategies to assist those affected include dispensing psychological counseling to understand their experiences and underlying causes.

> *"It is of utmost importance to identify the underlying causes, as adolescents often experience different issues that explain their emotional disturbance. One needs to be talked to for being aware of the problem he/she might face. None is cared for as another, as everyone has his/her own past experiences, which direct behavior distinctly from one another*!

Key informant (adult), one health service provider

For promoting and preventing mental health and well-being, recreational activities and making youth clubs work, both in and out of schools, were also thought of as being helpful, together with competitions for talent detection and development.

> *"Let us not focus on sick adolescents! Instead, let us direct ourselves towards prevention by doing things that are sustainable by enabling schools to promote sport and recreational activities, adopting helpful and educative clubs that keep children busy. In addition, at the sector and cell levels, there should be promotion of reading books, but you cannot ask a child to read without books."*

Key informant (adult), central-level agency

A few people mentioned home visits and talking to the family to know how the child/adolescent lives, and interactions with the parents/caregivers through peer educators, namely, "abakangurambaga b'urungano." If possible, family therapies were envisaged since they are effective for such cases.

Others mentioned raising awareness among parents on child and adolescent mental health, so that any single problem can easily be detected, and quick and appropriate actions can be taken (counseling or referral for appropriate care by skilled counselors).

g. Interventions for mitigating disruptive/oppositional behaviors

Disruptive/oppositional problems are prevalent among adolescents, and the main reported cause was poor parenting practices. To mitigate disruptive/oppositional behaviors, the first intervention would be to explore underlying factors.

> *"There are many disruptive/aggressive adolescents, whereby you touch him, and he brusquely hits you. I know one who even hit his colleague from stage during theatre rehearsal until we had to pour water on him to save him. Later on, I approached the aggressive boy; we talked, and he told me that his behaviors are due to the fact that his parents mistreat him and neglect him. He is raised by his stepmother and is unfairly treated compared with the other children in the household."*

Key Informant (adult), Nyarugenge District

The best way to prevent this is to educate parents/caregivers on positive parenting practices. Issues of negative labelling of the child in the family or environment, violence, food deprivation, lack of care, non-response to needs, etc., should be part of the awareness-raising campaign or interpersonal communication between parents and counselors.

> *"Accompaniment towards what they like and helping them feel free to express themselves in clubs would prevent this kind of behaviors from occurring among adolescents."*

Key informant (adult), Rubavu District

Some pointed out that not everyone can understand and detect disruptive/oppositional behaviors in adolescents, and experts in psychological support are needed.

> *"I am not sure as whether each school is covered by a psychologist, rather I am suggesting that every school should have a psychologist, as they are not there! There are only directors of discipline, but you cannot be a director of discipline for a child and become his/her psychologist at the same time. For us in psychology, we separate the crime from the criminal…"*

Key informant (adult), one health service provider

Appendix 3. *Health Centers Monthly HMIS Report (Mental health section)*

1. Mental Health / Santé Mentale			
A	**Summary**	**ICD-10**	**Number**
1	Mental patients under follow up		
2	Mental problems hospitalized *Troubles mentaux hospitalisés*		

	Mental Health		**New cases**				**Old cases**			
			0-19 Year		**>=20 Yrs**		**0-19 Yrs**		**>=20 Yrs**	
	Diagnosis	**ICD 11**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**
1	Post- traumatic stress disorder/*Etat de stress post- traumatique*									
2	Schizophrenia and other psychotic disorders									
3	Depression/*Dépression*									
4	Suicide attempted /*Tentative de suicide*									
5	Epilepsy /*Epilepsie*									
6	Others psychological/mental problems/*Autres troubles*									

Appendix 4. *District Hospital Monthly HMIS Report (Mental health section)*

1. Mental Health/ *Santé mentale*			
A	**Summary**	**ICD-10**	**Number**
1	Mental patients under follow up		
2	Mental problems hospitalized Troubles mentaux hospitalisés		

			New cases				**Old cases seen**			
			0-19Yrs		**>=20 Yrs**		**0-19 Yrs**		**>=20 Yrs**	
B	**Diagnosis/** *Diagnostique*	ICD-11	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**
1	Anxiety disorders/*Les troubles anxieux*									
2	Post-traumatic stress disorder/ *Syndrome de Stress Post-Traumatique*									
3	Schizophrenia and other psychoses / *Schizophrénie et autres Psychoses*									
4	Somatoform disorders/*Troubles somatiques*									
5	Mental disorders due to substance abuse/*Troubles mentaux dus à la toxicomanie*									
6	Depression/ *Dépression*									
7	Suicide attempted / *Suicide tentative*									
8	Bipolar disorders/*Troubles bipolaires*									
9	Epilepsy/*Epilepsie*									
10	Other mental problems/*Autre problèmes menteaux*									

Appendix 5. Interventions scoring

Level of intervention	Possible intervention	Magnitude of the issue being addressed	Groups of adolescents most affected	Feasibility of delivering interventions	Appropriateness	Acceptability/ political support (Potential to go to scale)	Cost	Time bound	Impact	Total score
Community	Capacitate UMU and IZU through Trainings and motivation towards address mental health issues in families, with accent on positive parenting practices, role model families, etc	5	5	5	5	5	5	5	5	40
	Economic empowering very poor families	5	3	1	5	1	1	1	3	20
	Set-up an adolescent mental health promotion/prevention model at community level (peers "Abajyanama b'urungano") to increase proximity to services and strengthening Adolescents clubs (Anti-drugs clubs, Scoutism, Xaveri)	5	5	5	5	4	4	4	5	37
	Engaging civil society, CHWs, religious leaders and traditional healers in adolescent mental health (promotion and prevention)	5	5	5	5	4	5	3	5	37
Education setting	Revisit and scale-up the school-based mental health program (primary and secondary), through hiring one clinical psychologist at district level (rotation), responsible for supporting the implementation of the school-based mental health program across all schools (training teachers), intervening in cases of big mental health issues and mentoring school champions	5	5	5	5	5	3	4	5	37
	Scale-up PAC in all schools and include mental health in addition to ASRH	4	4	3	3	3	5	3	3	28
	Support anti-drug clubs competition in schools	5	5	5	5	5	5	5	5	40
Health care setting	Increase the number of skilled mental health professionals in all health centers (through training and mentoring existing staff)	5	5	5	5	5	1	5	5	36
	Training of HC staff in adolescent mental health (awareness raising workshop)									

Level of intervention	Possible intervention	Magnitude of the issue being addressed	Groups of adolescents most affected	Feasibility of delivering interventions	Appropriateness	Acceptability/ political support (Potential to go to scale)	Cost	Time bound	Impact	Total score
	Update the ASRH training module with Mental health modules and integrated adolescent mental health services in in Youth corners	5	5	5	5	5	5	5	5	40
	Set up a IOSC in all health center to increase the geographical accessibility to services	3	5	5	5	2	1	1	3	25
	Prenuptial counseling on social living, positive parenting, ASRH and mental health	4	4	5	5	5	5	5	5	38
	Set-up fully functional psychiatric units in all hospitals (DH, PH and RHs)	4	3	1	2	3	1	2	4	20
	Revisit the HMIS and include 10-14 years and 15-19 years as age categories in all health facilities (including HIRC) and youth centers in Rwanda; and include in the reporting system other mental health conditions becoming more prevalent among adolescents	5	5	5	5	5	5	5	5	40
	Include MHPSS component in PNC/ANC targeting pregnant women and mothers, especially pregnant adolescents	5	3	4	5	5	5	5	5	37
	Include Huye Isange Rehabilitation center services under health insurance to address the financial burden	5	5	3	4	4	1	1	5	28
Youth centers	Integrate mental health and ASRH in all Youth friendly centers, (public and private), with a psychosocial support program	5	5	5	5	5	5	5	5	40
	Re-establish the full functioning of YEGO centers in the country (staffing as before handing them over to districts)	5	3	2	5	5	1	1	3	25
NRS	Empower the rehabilitation process (effective community integration through continuous psychosocial support, district advocacy towards quick employment towards job owners)	5	5	5	5	5	5	5	5	40

Level of intervention	Possible intervention	Magnitude of the issue being addressed	Groups of adolescents most affected	Feasibility of delivering interventions	Appropriateness	Acceptability/ political support (Potential to go to scale)	Cost	Time bound	Impact	Total score
Social cluster ministries	Revisit existing policies and strategies and include mental health as a key pillar and set its directions at all levels	5	5	5	5	5	5	5	5	40
MIGEPROF & MYCULTURE	Special support for pregnant adolescents/adolescent mothers: Education on self and child care, empowerment to start-up life, skilled-based education	5	5	5	5	5	5	5	5	40
MIGEPROF and MYICT	Support the implementation of online child protection actions	5	5	5	3	4	5	3	4	35
NURC and CNLG	Create safe space for dialogue about Genocide for adolescents with community groups	5	5	5	5	5	5	5	5	40
NCDA	Strengthen ECD services in all villages (integrate mental health matters: positive parenting, early stimulation, care for children from teen mothers, promotion/prevention and referral through UMU and IZU)	5	5	5	5	5	5	5	5	40
	Increase the number of skilled psychologists and social workers at the district level (working in child protection)	5	5	5	5	5	5	5	5	40
MoH	e-health and m-health interventions for mental health education and adolescent involvement in their own care (SMS and radio drama, radio messages airing, TV messages airing, social media-whatsapp, youtube, twitter. etc);positive digital engagement approaches.	5	5	5	5	5	5	5	5	40

Level of intervention	Possible intervention	Magnitude of the issue being addressed	Groups of adolescents most affected	Feasibility of delivering interventions	Appropriateness	Acceptability/ political support (Potential to go to scale)	Cost	Time bound	Impact	Total score
RBC	Mental health Division to work closely with MCCH division to have one comprehensive manual (ASRH and mental) and integrated guidelines for service provision in Youth corners	5	5	5	5	5	5	5	5	40
	Leverage U-Report in Rwanda as a mental health chatline support service for adolescents in Rwanda	5	5	5	5	5	5	5	5	40
	Roll out MMAP in Rwanda and invest in data for specific actions towards improving mental health among adolescents	5	5	5	5	5	2	5	5	38
	Development and validation of screening and diagnostic tools that are age appropriate and culturally relevant in Rwanda	5	5	5	5	5	5	5	5	40
	Explore the possibility of having Rwanda as one of the priority countries for implementation of HAT package	5	5	5	5	5	5	5	5	40
Agency TBD	Conduct a research on divorce and its impact on families and children in all the aspects of life, for evidence-based actions	3	4	5	5	5	1	2	4	29

Appendix 6. Interventions costing

There was a tentative planning and costing for one year, with a possibility to replicate the budget for activities that are meant to be annual.

Interventions	Budget (Rwf)
*Capacitate UMU and IZU **through** Trainings and motivation towards addressing mental health issues in families, with accent on positive parenting practices, role model families, etc;*	
Master training in community stakeholders participation on mental health issues and positive parenting skills (UMU and IZU)	
Hotel services	2,250,000
Transport	600,000
Domestic perdiems	4,560,000
Daily fees	900,000
Training of district teams and sector coordinators (4 per district and 1 per sector)	
Lunch	8,190,000
Transport	16,380,000
Printing of Training modules	6,552,000
Training of CHWs (2 people per village) for 3 days to moderate UMU education sessions in child and AMH	
Refreshment	445,110,000
Transport	445,110,000
Printing of Training modules	106,826,400
Training of IZU (2 people per village) for 3 days	
Refreshment	445,110,000
Transport	445,110,000
Printing of Training modules	106,826,400
Sub-total	*2,033,524,800*
Set-up an adolescent mental health promotion model at community level (Abajyanama b'urungano) to increase proximity to services and strengthening Adolescents clubs	
Providing mentorship and facilitation of access to services	
Train peers in mental health promotion/prevention (2 by sector) who will mobilize their peers	16,640,000

Interventions	Budget (Rwf)
Transport of psychologists from district to youth corners by quarter	1,200,000
Training of health care providers working in adolescents corners at HCs (500 HCs)	10,000,000
Purchasing of TV screens at all HCs for digital messages on adolescents and mental health	250,000,000
Plan for competition of a good project on adolescents mental health at district level (Awards)	15,000,000
Sub-total	*292,840,000*
Engaging civil society, CHWs, religious leaders (through RICH) and traditional healers in adolescent mental health (promotion and prevention)	
Strategic meeting at National level to involves those acting in promotion of adolescents mental health	
Transportation costs	2,000,000
Hotel services	2,000,000
Printing of manual on adolescents mental health in Kinyarwanda	120,000
Train CHWs, traditional healers at village levels (mental health promotion/prevention and referral)	
Manual development	5,000,000
Training of district teams	6,000,000
Training workshop at village level through district	296,740,000
Logistics	5,000,000
Sub-total	*316,860,000*
Revisit and Scale-up the School-based mental health program (primary and secondary), through hiring one clinical psychologist at district level (rotating in all schools of the district), responsible for supporting the implementation of the school-based mental health program across all schools (training teachers), intervening in cases of big mental health issues and mentoring school champions	
Salary of clinical psychologists	180,000,000
Supervision and mentorship of clinical psychologists from district to sector levels	24,300,000
Computer machine	15,000,000
Communication	10,800,000
Transportation cost	48,600,000
Domestic perdiems	24,300,000
Registers	75,000
Sub-total	*303,075,000*
Increase the number of skilled psychologists and social workers at the district level (working in child protection)	

Interventions	Budget (Rwf)
Salary of clinical psychologists and professional social workers (30 in total)	180,000,000
Supervision and mentorship of clinical psychologists from district to sector levels	24,300,000
Computer machine	15,000,000
Communication	10,800,000
Transportation cost	48,600,000
Domestic perdiems	24,300,000
Registers	75,000
Sub-total	*303,075,000*
Increase the number of skilled mental health professionals in all health centers (at least one clinical psychologist per health center)	
Training of MH professionals working in HCs	
Hotel services	37,500,000
Transport	10,000,000
Domestic perdiems	76,000,000
Daily fees	15,000,000
Training modules	600,000
Sub-total	*139,100,000*
Revisit the HMIS system and include 10-14 years and 15-19 years as age categories in all health facilities and youth firiendly centers in Rwanda	
National workshop	5,000,000
Mentorship and clinical supervisions from DHs to HCs and Youth corners	
Transportation costs	79,380,000
Daily fees	47,628,000
Registers	122,500
National Supervision and mentorship	
Transportation costs	17,374,500
Domestic perdiem	114,000,000
Conduct a workshop of system operators of HMIS and data managers from DHs to develop indicators to be captured during reporting of children and adolescents with other mental health conditions	
Hotel services	2,500,000

Interventions	Budget (Rwf)
Transport	2,814,500
Domestic perdiems	3,800,000
Sub-total	*272,619,500*
e-health and m-health interventions for mental health education and adolescent involvement in their own care (SMS and radio drama, radio messages airing, TV messages airing, social media);	
Mass media use to raise awareness on adolescent mental health	
Production of radio messages	250,000
Monthly radio messages airing	15,000,000
Production of digital messages to be aired on TV (1 per month)	300,000
Monthly TV messages airing (1 per month)	57,000,000
Customized SMS (for 2.837.000 adolescents)	142,984,800
Use of Urunana/ Seburikoko/ City maid, etc (TV live talk shows)	20,000,000
Digitalized system for online mental health services and support for adolescents	
CUG fro handsets at 49 DHs, Referral and Provincial	17,640,000
Buy Handset for the hspital	5,880,000
2 Adolescents Specialized professionals for follow up and monitorong of the System	19,200,000
Leverage U-Report in Rwanda as a mental health chatline support service for adolescents (Based on experiences of Brazil and Jamaica)	
System update to Rwanda context	20,000,000
T shirts	6,000,000
Blanded Tear drops	650,000
Blanded Stickers	837,000
Blanded Pull up banners	1,200,000
Decoration Costs	2,275,000
Digital mobile outdoors for mental health and adolescents messages	1,775,000
Sub-total	*310,991,800*
Integrate mental health and ASRH in youth corners of YEGO centers (all Youth friendly centers), to set up psychosocial support program	
Support the set-up of psychosocial support services in youth centers	60,000,000

Interventions	Budget (Rwf)
Conduct mentorship at HCs by Clinical Psychologists both from District administrative and MH pofesional from Hospitals	
Transportation costs	36,000,000
Domestic perdiems	36,000,000
Sub-total	*132,000,000*
Special support for pregnant adolescents/adolescent mothers: Education on self and child care, empowerment to start-up life, skilled-based education	
Support adolescents mothers in income generating activities through cooperative,	1,500,000,000
Support vocational training, re-school pregnant adolescents/adolescent mothers	300,000,000
Sub-total	*1,800,000,000*
Prenuptial counselling on social living, positive parenting, ASRH and mental health (module development and distribution in health facilities)	
Consultative workshop of experts in MH and ASRH (midwives, gynecologists)	
Hotel services	1,200,000
Transport	240,000
Domestic perdiems	2,265,600
Develop the education materials to spread in health facilities (consultancy), validate and share them with health facilities	10,000,000
Sub-total	*13,705,600*
Empower the rehabilitation process (effective community integration through continuous psychosocial support, district advocacy towards quick employment towards job owners)	
Start up toolkits to rehabilitation centers' laureates in 30 districts (10 laureates per districts)	150,000,000
Start up toolkits to cooperatives of laureates in 30 districts (1 cooper per district)	150,000,000
Post graduation orientation sessions (reintegration)	
Transport and mission fees for counsellors/psychologists, Transport for laureates, Notebooks and pens (3 sessions/30 districts)	10,132,200
Domestic perdiems of Health professionals	6,840,000
Transportation cost for the Laureates FF 1500	7,500,000
Hotel services for laureates and Mental Health professionals	7,500,000
Sub-total	*331,972,200*

Interventions	Budget (Rwf)
Online child and adolescent protection	
Conduct strategic meeting with Key people from RISA, Media, RURA, CSOs	
Hotel Services	4,000,000
Produce and disseminate messages on online child and adolescent protection	24,000,000
Produce and disseminate a warning messages through SMS to MTN&Airtel services	27,300,000
Sub-total	*55,300,000*
Strengthen ECD services in all villages (integrate mental health matters: positive parenting, early stimulation, to pray their primary roles and care for children from teen mothers, promotion/prevention and referral through UMU and IZU)	
Meet the Social affairs of Sectors	
Transportation cost	4,160,000
Domestic perdiems	31,616,000
Training modules	499,200
Training of ECDs facilitators ToTs (IZU) at sector level	
Training and transport allowances	296,740,000
Meet in charge of community services at DHs	
Transportation cost	490,000
Training modules	58,800
Conduct supervision and mentorship from national level	
Domestic perdiems	45,312,000
Transportation cost	67,548,000
Sub-total	*446,424,000*
Set-up fully functional psychiatric units in all hospitals (DH, PH and RHs)	
Conduct clinical supervisions and mentorship in all hospitals	
Transportation costs	6,079,320
Domestic perdiems	2,070,000
Sub-total	*8,149,320*
Mental health Division to work closely with MCCH division to have one comprehensive manual (ASRH and mental) and integrated guidelines for service provision in Youth corners	

Interventions	Budget (Rwf)
Update the ASRH training module with Mental health modules and integrated adolescent mental health services in in Youth corners, integrated guidelines for service provision in Youth corners	
Consultative workshop with experts in MH and ASRH	
Hotel services	1,000,000
Transport	200,000
Domestic perdiems	1,888,000
Updating the manual (consultancy)	15,000,000
Training of mental Health care providers and ASRH from District and Provincial Hospital on child and adolescents MH (2 people per Hospital)	
Workshop of experts in MH and ASRH	
Hotel services	9,800,000
Transport	4,900,000
Domestic perdiems	14,896,000
Sub-total	***47,684,000***
Support anti drug clubs competition in schools	
Awards per sector of the winner clubs (FF=100,000 FRW)	41600000
Transportation cost	6754800
Domestic Perdiems	2280000
Sub-total	***50,634,800***
Include mental health component in PNC/ ANC targeting pregnant women and mothers	
Training of Gynecologists and midwives from Provincial and district hospitals on mental health care during PNC/ANC 2 people per Hospital	
Hotel services	9,800,000
Transport	1,960,000
Domestic perdiems	14,896,000
Training of General Nurses working in maternity services on MH targeting pregnant women and PNC mothers to implement this activity through IEC	
Hotel services	4,900,000
Transport	980,000

Interventions	Budget (Rwf)
Domestic perdiems	7,448,000
Sub-total	*39,984,000*
Revisit existing policies and strategies and include adolescent mental health as a key pillar and set its directions at all levels	
A national meeting with different ministries and agencies to raise awareness about adolescent mental health and its inclusion in policies and strategies (FF)	5,000,000
Sub-total	*5,000,000*
Roll out MMAP in Rwanda and invest in data for specific actions towards improving mental health among adolescents	
Roll out (FF)	300,000,000
Sub-total	*300,000,000*
Explore the possibility of having Rwanda as one of the priority countries for implementation of HAT package	
Organize a one day strategic meeting on child and adolescent mental health	2,450,000
Sub-total	*2,450,000*
Development and validation of screening and diagnostic tools that are age appropriate and culturally relevant in Rwanda	
Conduct 5 days workshop to develop and contextualize diagnostic tools	
Hotel services	1,125,000
Transport	562,900
Domestic perdiems	2,280,000
Sub-total	*3,967,900*
Create safe space for dialogue about Genocide for adolescents with community groups (with a possibility to use ECD centers after their own activities)	
Set-up, training and follow-up (FF)	300,000,000
Sub-total	*300,000,000*
GRAND TOTAL	*7,509,357,920*

We say seven billion five hundred nine million three hundred fifty-seven thousand and nine hundred twenty Rwandan francs (7,509,357,920 Rwf), equivalent to seven million five hundred eighty-five thousand two hundred ten United States Dollars ($7,585,210).