Non Hospital Services of Mental Health in Rwanda: Analysis of their Functioning and Challenges

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Abstract

Introduction: After the Genocide of 1994, NGOs and other public services supplemented hospitals in the care of mental patients. However, there is little research examining their functioning and challenges.

Aims: (1) to present the contribution of nonhospital services in terms of patients treated; (2) to report activities performed by these services; and (3) to assess challenges and remedial solutions.

Materials and Methods: A quantitative and qualitative study of 25 staff representing on hospital services of mental health. A questionnaire with open-ended and closed-ended items was used. Percentages and thematic analysis were used for data analysis.

Results: Nonhospital services of mental health are mainly local NGOs staffed by psychologists. Genocide Survivors and victims of rape are consulting population. Counselling, sensitization for mental health awareness and advocacy are the main activities organised. Not knowing the importance of mental health and ignorance of mental disorders are the main challenges. Increasing number of staff, and providing incentives and transportation fees are remedial solutions.

Discussion: Nonhospital services of mental health play a key role in increasing access and funds for mental health services. Their achievements in Rwanda can serve other countries or regions with similar situation.

KEYWORDS: NGOs, mental health care, PTSD, trauma.

INTRODUCTION

The Genocide of 1994has generated a serious issue of mental health: one million of people perished; the country's economy and its health infrastructure were destroyed (Binagwaho et al., 2014). As a result, rates for PTSD increased ranging from 24.8 % (Pham, Wenstein, and Longman, 2004) to 26.1% (Munyandamutsa, et al.,2012), as well as depression, ranging from 15.5% (Bolton, et al.,2002) to 46.4% (Schaal, et al.,2012) and anxiety symptoms that add up to 58.9% (Schaal, et al.,2012).

To cope with this, an effective integration of mental health care in district hospitals and in health centres (Ministry of Health, 2011) has been done; which increased the number of patients with mental illnesses treated in hospitals from 6000 consultations in 1976 to 34.238 in 2011 (Sebatukura, Philippot & Sezibera, 2016). However, the accessibility to qualified mental health services is still limited (Heim & Schaal, 2014).

In fact, the decentralisation of mental health in the primary care as recommended by the WHO (2010) is still in progress (WHO, 2005). After the genocide of 1994, NGOS and some public institutions intervenein mental health. The expression “nonhospital mental health services” covers all these mental health units outside hospitals. An experience exists where government officials and NGOs actors work together for mental health purpose (Nakimuli-Mpugu et al., 2014; Scholte & Ager, 2014). This paper aims (1) to present the contribution of nonhospital services in treating patients with mental illness in 2016; (2) to report activities performed by these services; and (3) to assess challenges met and remedial solutions proposed.

MATERIALS AND METHODS

Population: Composed by staff from local and international NGOs, and governmental units with mental health components.

Setting: Four Provinces and the Capital City Kigali.

Sampling: Nonhospital services of mental health were identified through (a) annual supervision of University of Rwanda psychology students’ internships and (b) a field research during the doctoral work of the first author in 2012 and 2013. On 17 nonhospital services existing in Rwanda, we considered one International NGO (Handicap International), six local NGOs: Association for widows of the Genocide (AVEGA), Rwandan Association for Traumatism Counsellors (ARCT-Ruhuka), an association for Genocide Survivors named “IBUKA”, which means “Remember”; Never Again Rwanda; Life Wounds Healing Association (LIWOHA); Solidarity for the development of Widows and Orphans aiming the Work and the self-promotion (SEVOTA). Two governmental units were selected: Fund for Assistance to Genocide Survivors (FARG) and the University Center for Mental Health (CUNISAM). The first helps the survivors of the Genocide with mental disorders, especially when they come to seek service. The second provides community service in psychotherapy to the university community and nearing population; it serves also for the practice of Clinical Psychology’s students and staff. For AVEGA which is organizing mental health services in 30 districts, 13 staff working in 12 districts and the national coordinator of the mental health program participated to the study. Convenience sampling was used to include the districts in the sample. In services with more than one staff, the head was selected.

Procedures

A questionnaire was used to collect data. Items’ elaboration was inspired by the three main research questions stated above and comprised three groups of items. The first group was made by quantitative items and comprised five items aimed to know the number of staff in charge of care of mental patients according to their speciality, the number of clinical departments and their names, the number of rooms for consultations/psychotherapies, the number of patients received in 2016 and the repartition of number of patient according to the gender and age. We considered 2016 to have the latest data of a whole year as the data were collected in 2017.

The second group of items consisted in multiple choice items. In the first item, respondents were asked to encircle the letter corresponding to the categories of patients treated in their institutions with the options: a) Survivors of the Genocide against Tutsi; b) Addicted to drug abuse or toxicomania; c) Victims of intimate

violence; d) patients with post-traumatic stress disorder (PTSD); e) Others (please specify). In the second item, respondents had to choose the psychotherapeutic approaches used in their facilities. Six options were given: a) Psychoanalytic approach; b) Biologic approach; c) Family approach; d) Humanistic approach; e) Cognitive Behavioural Therapy f) Eclectic approach; g) Others (please specify).

The third group of items consisted in qualitative items and aimed to collect information about the reasons justifying the creation of their service, their activities, and the collaboration with the Ministry of Health through the Mental Health Division and with other nonhospital services of mental health; their challenges and remedial solutions.

The ethical approval has been granted by Institutional Research Board (**Approval Notice: No 375/CMHS IRB/2017**)of the College of Medicine and Health Sciences of the University of Rwanda.

Data collection took place in October and November 2017 in Kigali and in some districts of the Northern Province, Western Province, Eastern and Southern Province. Each participant gave his written informed consent that data provided be used for research.

Data were analysed with qualitative and quantitative methods.Descriptive statistics were used for quantitative items while thematic analysis was used for presentation and analysis of data from open-ended items of the questionnaire**.** Attride-Stirling (2001) and Pope et al. (2000) say that thematic narrative analysis is an approach that takes an exploratory perspective, encouraging consideration and coding of all data, allowing for new impressions to shape your interpretation in different and unexpected directions. Answers of qualitative items were analysed and presented in different themes and under each section.

RESULTS

Involving more staff to heal more people

25 staff participated to the study. Analysis of data show that nonhospital services of mental health are dominantly local associations or NGOs (84% of participants)and staffed by clinical psychologists (96% of participants); which is in contrast to hospitals' units of mental health dominated by psychiatric nurses (Sebatukura, Philippot & Sezibera, 2016). Also,data show an evolution in the objectives and targets of these services: AVEGA, SEVOTA, IBUKA, and ARCT created after the Genocide aimed to heal survivors suffering with PTSD, trauma disorders and other comorbidities. Those created after 2000 have broader objectives and targets: Peace Building working on societal healing and on supporting victims of sexual violence (Never Again); rehabilitation of street patients (homeless) in their families (Health Care Foundation); prevention and care of victims of sexual based violence and Epilepsy (Handicap International). However, staff reported that even there are specific objectives and population, doors are opened to other categories of the population. Services targeting the care of Genocide's survivors have the highest numbers of clients treated in 2016; which reveal the persistence of traumatic disorders 23 years after the Genocide. Finally, addiction to drug abuse, family and intimate partner violence appear as new causes of mental illnesses.

About staff's duration in the service, 76% started working since 2011 up to 2016 when 24% were recruited before 2011; which explains that almost all nonhospital services are young units.

Nonhospital services of mental health use both permanent (17.89%) and volunteering staff (82.11%). Using volunteers is very common in Rwanda. The Ministry of Health use "Health Community Workers" working at the Village level in programs of prevention and of care. ARCT-Ruhuka, MHDF, AVEGA and Health Care Foundation use trained volunteers; which is an example of task-sharing (Kakuma et al., 2011; Van Ginneken et al., 2013) suggested by the Mental Health Gap Action Program (WHO, 2008) as a remedial solution to the shortage of recruited qualified staff in mental health.

Table 1 leads to some observations: First, associations organising activities targeting a high number of people like IBUKA and AVEGA have received more clients than others. Second, ARCT-Ruhuka, Handicap International, LIWOHA and SEVOTA show also a high number of clients because they are operational in several districts. Third, more female (58.03%) seek mental health services than male (41.97%); which was also found in a study on patients with mental illnesses treated in hospitals (Sebatukura, Philippot, Sezibera, 2016).

The different important target groups of clients were: survivors of the Genocide against Tutsi (92%); patients with post-traumatic stress disorder (84%); victims of rape, of sexual or intimate partner violence (60%); the group of addicted to drug abuse or toxicomania (56%).

Other studies and initiative found the importance of these four target groups. About survivors of the Genocide and patients with PTSD, the Ministry of Health of Rwanda was requested by the "15th National Dialogue of 2016" to conduct detailed research on the challenge of trauma among survivors of genocide against Tutsi. In 2011, 8.91% of all consultation in mental health facilities of hospitals had psychosomatic disorders (included PTSD) (Sebatukura's thesis, 2015). This confirms what other researchers have written about the intergenerational transmission of trauma on future generations of survivors (Boyadjian, 2016).

For victims of rape of sexual or intimate violence and addicted to drug abuse, Sebatukura (thesis, 2015) found in 2011 that only 307 patients have consulted hospitals' units of mental health; which illustrate that, in Rwanda, people with addiction to drug abuse do not consult mental health facilities because they don't consider it as necessary or they find it shameful.

Assessing psychotherapeutic technique used

The use of the six psychotherapeutic approaches proposed follows this order: eclectic approach (68%); psychoanalytic approach (60%) and family approach (60%), Cognitive Behavioural Therapy (48%), Humanistic approach (32%) and Biological Approach (24%).

Motivations behind the creation of mental health service and collaboration between them

Table 2 indicates that healing psychological wounds and other mental disorders consecutive to the Genocide of 1994 (84%) and dealing with other consequences of the Genocide on mental health (65%) are the most important motivations for nonhospital services to contribute in mental health. In fact, theGenocide in Rwanda will continue to be the most challenging problem of mental health. The last study on PTSD prevalence indicates 26.1% of the population (Munyandamutsa, et al.; 2012); which was extremely high 18 years after the Genocide. Trauma consecutive to genocide goes largely untreated given the extremely limited access to mental health and psychiatric services (Talbot et al., 2013).

In the item 2, individual and collective counselling (84% of respondents)are the most important activity organised by nonhospital services of mental health. Talbot et al. (2009) state that group and individual counselling interventions did appear to be effective in reducing symptoms of trauma. However, compared between them, group therapy offers a greater opportunity for learning coping skills than individual therapy (Nakimuli-Mpugu, et al., 2014).

Sensitization on mental disorders and other prevalent issues of mental health is also one of the important activities (80%). Illiteracy in mental health is a challenging barrier to care in LICs. In Rwanda, studies noted the importance of improving people's mental health literacy to be able to recognize mental disorders… (Umubyeyi et al., 2016).

Advocacy for varied needs of patients is also an important activity(68%). For clients without shelter, food or school fees for their children, there could not be a mental wellbeing obtained only by psychological intervention. In addition to mental health activities, professionals are involved in presenting the needs of their clients to administrative authorities or NGOs; which illustrates their extended responsibilities.

Collaboration with government services exist in mutual transfer of patients between nonhospital services and hospitals (68%) and in the coorganisation of activities of the annual commemoration of the Genocide (65%). In fact, Governance is a key determinant for overall health systems development (Upadhaya et al., 2017). Also, Colleta and Cullen (2000) provide clear examples of how governments and even internal actors promote social inclusion, empowerment, and the strengthening of grass roots movements. Between nonhospital services, collaboration is more significant in trainings (64%) and in supplementing each other in serving clients (64%). WHO (2011) highlights the importance of regular refresher trainings opened to all interveners in mental health and needed by young professionals. Supplementing each other in serving clients (64%) is seen in internal transfers of clients towards the service capable to offer the needed service (psychotherapy, social or financial assistance, etc.). Coordination and collaboration with stakeholders in service delivery has to be sufficient (Upadhaya et al., 2017).

Challenges encountered and Remedial solutions proposed

Table 3 lists varied challenges faced and possible remedial solutions. In Rwanda, psychological services involved in mental health started when first graduates finished their studies in 2002. Therefore, their importance is not known by the public (56%); and sensitisation is required to promote mental health awareness (Rugema et al., 2015). One of the consequences of low mental health awareness is to make difficult both the use of existing services and the funding of its activities. Ignorance of mental

disorders by the population (48%) was identified by the WHO as a major problem in LICs (WHO, 2011). Therefore, WHO notes that ¾ people with serious mental disorders living in LICs do not receive the expected mental health services (WH0, 2011).Table 3 shows that increasing the number of mental health professionals in Districts and having them at Sector level (92%) is most important solution because it refers to the increasing of accessibility of the care. WHO's plan is to integrate mental health care into the primary health care (WHO, 2010).

"Providing rooms, logistics and incentives for staff; and transportation fees for patients (64%) is also a solution for the functioning of nonhospital services. In fact, they enable staff to work and reach his goals and motivate them. *Another important solution is that the Ministry of Health and mental health professionals could sensitize the community leaders and other people on mental disorders and on the importance of mental health (56%)*. In Rwanda, Televisions, Radios and meetings with the community are used for sensitizing the community on various themes of mental health.

DISCUSSION

Contribution of nonhospital services of mental health in the care of Rwandan population.

The study showed a total of 36.311 clients (21.073 or 58.03% of female and 15.238 or 41.97% of male) received in 2016. Sebatukura et al. (2016) have found 37.644 consultations of mental health patients (34.238 "old cases" and 3.406 "new cases")in 39 hospital mental health services during the year 2011. The types of patients treated in hospitals differ, however, with respectively epilepsy (42.74%), schizophrenic disorders (23.06%), psychosomatic disorders (8.91%), neurotic disorders (8.13%), mood disorders (7.62%), neurologic disorders (5.80%), toxicomania (1.42%) and others (2.27%) (Sebakutura, 2015). This comparison gives us information on how they complete each other: (1) nonhospital services of mental health receive mild cases of mental disorders when hospitals treat essentially severe cases and use medication; (2) mental health units of hospitals treat also neurological disorders like epilepsy when nonhospital don't.

Also, the study shows that more female consult nonhospital services of mental health than male. Among the clients received in hospitals' units of mental health in 2011, the same imbalance was observed (Sebatukura et al., 2016). In another study, Rugema et al. (2015) observed that more women than men were perceived to seek help for mental disorders.

Activities performed by nonhospital services of mental health

The study shows activities that can be summarised as counselling and psychotherapy, sensitisation, advocacy, training, social and financial assistance. All those activities are supplementary to those of hospitals' units of mental health. Mental Health Policy of Rwanda (MoH, 2011) gives the following fields of intervention and the strategies to implement them: mental health care, raising public awareness, focusing on training mental health staff, sensitisation of people to adhere to the health insurance scheme, etc. A comparison between activities performed by nonhospital services of mental health and the fields of interventions or strategies of the mental health policy show that they perform the same activities. However, there are differences in the domain of

(1) *targeted population* because mental health units of hospitals exist in each district and receive all categories of clients when each nonhospital service of mental health is operational in a limited territorial entity and in the categories of population served; of (2) *the categories of the population served*, mental health units of hospitals are opened to all residents of Rwanda; when each nonhospital service of mental health considers a specific group and (3) *competencies or capabilities of hospitals to treat patients with mental disorders needing chemotherapy*: all severe cases frequenting nonhospital services are transferred to mental health units of hospitals.

It's important to highlight the close collaboration between the two parties in mental health; especially in mutual transfer of some patients, in co-organising the care of people with trauma during the commemoration period, in the elaboration and implementation of projects and activities. This collaboration is a proof of good governance, which is necessary to ensure effective care delivery (Lewis, 2006) and policy implementation (Marais & Petersen, 2015).

Challenges and remedial solutions

Lack of awareness of the importance of mental health services and ignorance of mental disorders are some of the main challenges met. In a previous study, Rugema et al. (2015) observed poor awareness of mental disorders at community level. Not knowing the importance of mental disorders leads to not inserting mental health activities among priorities in the annual action plan of the districts; which leads also to the lack of funding by donors who find that "*results of intervention in mental health are for long term and don't know its importance and are interested to fund mental health in emergencies (wars, natural disasters,…*). In fact, the low priority to mental health issues by governments is a fundamental problem underlying the scarcity of human and material resources in mental health services in LMICs (Saxena et al., 2007; Bird et al., 2011). To make mental health a priority even at district level in Rwanda, nonhospital services of mental health ask "*the Ministry of Health and mental health professionals to use different ways to sensitize the community leaders and other people on mental disorders, on the importance of mental health*". This is supported byAlmeida et al. (2013) who say that effective advocacy has to be a central component of efforts directed at generating political will. Another strategy that has been used in five Anglophone countries of West Africa is to organise a training course targeting mental health leaders, senior and mid-level government officials, policy makers, leaders of civil society, and user and caregiver organizations with the objective of creating a critical mass of informed and empowered opinion leaders who can generate action for positive change in their communities (Abdulmalik, et al., 2014).

Budget allocated to mental health in African countries is insignificant. A study conducted by the WHO on mental health expenditure as percentage of the health budget in 89 countries shows that 79% of the African countries included have no specific budget for mental health. The African countries with specific budget for mental health problems use less than 1% of their total health budget on mental illness (Saxena, et al., 2003). Poor funding is one of the barriers to mental health services in all LMICs (Saraceno et al., 2007). This lack of enough funding explains why the main challenges raised by nonhospital services.

Lack of collaboration between nonhospital services of mental health offering the same service to the community was also stressed as a challenge. These services collaborate informally in being together during meetings, seminars, etc. Instead of this informal collaboration, respondents suggested "to have aforum of services of mental health in Rwanda" for fostering more collaboration and partnership. The creation of this forum can foster partnerships and can lead to tangible achievements; as state Abdulmalik et al. (2014).

Limitations

The initial plan was to include all the existing nonhospital services of mental health. However, during the field research, two small nonhospital services have not filled the questionnaire:WE-ACT has refused to participate to the study; "Uyisenga N'imanzi", which works on mental health of adolescents, has not been contacted because of lacking time. Even if nonhospital services considered work on the different ages of the population, including adolescents, "Uyisenga n'Imanzi" would bring more information on what nonhospital services is doing specifically among youth.

Conclusion

This study presents mental health services of NGOs and public services in the care of the Rwandan population. Their number increases with years; the number of the clients in 2016 is high, and the activities performed are rich. They supplement efficiently the Ministry of Health as each service deepens its activities in specific component of the population needing mental health care.

The study proposes some recommendations to address challenges met:(1) it highlights the need for the Ministry of Health and all its partners to use all ways for sensitisation on mental health awareness and on prioritizing its care at district level; (2) it suggests the creation of a forum for all mental health services; which will allow these services to exchange ideas to their common challenges and to enhance collaboration; (3)it proposes to increase their sources of funding in agreeing payment of psychotherapies done by clinical psychologists.

The study recommends other countries or regions that have undergone traumatic events or crises to be inspired by the Rwanda's experience in creating these services and supporting their activities as they contribute to (1) increase the coverage of mental health services, (2) to attract funding from several donors, and (3) to supplement the government in rebuilding mental wellbeing.

Abbreviations

ARES: "Académie de Recherche et d'Enseignement Supérieur" (in English: Academy of Research and High Education); **AVEGA**: Association des Veuves du Genocide Agahozo; **IPSY**: Institut des Sciences Psychologiques; **MHDF:** Mental Health Dignity Foundation; **UCL:** Université Catholique de Louvain; **UR:** University of Rwanda

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Competing interests

The authors declare that they have no competing interests

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APPENDIX

Table 1: **Human resources, number of clients treated in nonhospital services of mental health**

Number	Name of the institution	Year of creation / mental health service	Number of mental health staff in Nonhospital services			Number of rooms	Number of clients in 2016		
			Permanent staff	Volunteers	Tot		Male	Female	Total
1.	AVEGA	1995	35	40	75	40	6899	1727	8626
2.	ARCT - Ruhuka	1998	11	350	361	10	1018	1375	2393
3.	IBUKA	1998	30	0	30	2	4000	10302	14302
4.	LIWOHA	2008	7	0	7	3	997	2268	3265
5.	NEVER AGAIN	2012	2	0	2	1	59	179	238
6.	SEVOTA	1995	3	0	3	4	166	309	475
7.	HANDICAP INTERNATIONAL	2007/2014	19	0	19	101	1936	4474	6410
8	FARG	2011	1	0	1	1	3	208	211
9.	CUNISAM	1997	9	0	9	3	16	13	29
10	Health Care Foundation/Psychosocial Reintegration	2010	3	1	4	2	73	98	171
11.	MHDF	2012	2	169	171	4	71	120	191
	TOTAL		122	560	682	171	15238	21073	36,311
	%		17.89 %	82.11%	100%		41.97 %	58.03 %	100%

Table 2: Reasons of creation, activities, and collaboration of mental health services

Items	Themes	Frequencies and %
1.Reasons justifying the creation of nonhospital services of mental health	1. Healing psychological wounds and other mental disorders consecutive to the Genocide of 1994	20 (80%)
	2. Dealing with other consequences of the Genocide on mental health	13 (65%)
	3. Helping raped women and girls during the Genocide and children born from this rape	5 (20%)
	4. Helping widows and orphans of the Genocide	3 (12%)
	5. Treating epilepsy and fighting stigma and discrimination in families	2 (8%)

	6. Using knowledge of clinical psychologists for the interests of Rwandans and for preventing mental disorders	2 (8%)
	7. Creating a center for internship and practical sessions of students and community service for staff	2 (8%)
2.Activities organised	1.Counselling	21 (84%)
	2. Sensitization on different mental disorders and their prevention; on small projects, and on fighting against domestic violence and rape	20 (80%)
	3. Advocacy for varied needs (nutrition, health care, justice, education, houses, …) of patients	17 (68%)
	4. Psychotherapies	11 (44%)
	5. Training on small techniques generating of income	7 (28%)
	6. Training & clinical supervision of mental health staff & Community Psychosocial Workers	7 (28%)
	7. Social and financial assistance to patients in needs (transportation and medical fees)	3 (12%)
	8.Working with hospitals and health centers for patients needing medical treatment	3 (12%)
	9.Creating solidarity through forums and festivals	2 (8%)
	10. Physical exercise to refresh the mind (like relaxation)	2 (8%)
	11.Camps to heal the life's wounds(intended for therapy and autonomy)	2 (8%)
	12. Walks of mothers and their children born through rape	2 (8%)
3.Collaboration with the Division of Mental Health of the Ministry of Health	1.Mutual transfer of patients between nonhospital services of mental health and hospitals	17 (68%)
	2.Coorganisation of activities of the annual commemoration of the Genocide	13 (65%)
	3.Collaboration in the elaboration & implementation of projects & activities	12 (48%)
	4.Attending meetings on mental health organised by the Ministry of Health	5 (20%)
	5.Collaboration in sensitizing people to avoid drug abuse	2 (8%)
	6. Collaboration in organising trainings	2 (8%)
	7. Partnership through Memorandum of understanding, visits, etc.	2 (8%)
	8. No collaboration	2 (8%)
4.Collaboration with other services of mental health existing in Rwanda	1. Mutual invitation for trainings, seminars, colloquiums, supervision, and other associations to promote our careers	16 (64%)
	2. Supplement in offering services	16 (64%)
	3. Meeting in different trainings, seminars, colloquiums, supervision, and other associations to promote our careers	9 (36%)
	4. Collaboration in the training of different groups (staff, target group, …)	5 (20%)
	5.Collaboration in the follow up of patients	3

		(12%)
	6. Collaboration with other services (Police, Social Affairs Mayor in the District, etc.)	2 (8%)

Table 3: Challenges encountered and remedial solutions proposed

Items	**Themes**	**Frequencies & %**
Challenges encountered in making nonhospital services of mental health known by the public	1. Importance of mental health services not yet known	14 (56%)
	2. Ignorance of mental disorders	12 (48%)
	3.Lack of transportation means for staff to reach people in remote areas	7 (28%)
	4. Insufficient number of staff	6 (24%)
	5. Not enough source of funding for psychotherapies and other psychological services	5 (20%)
	6. Value given more on material help	4 (16%)
	7. Lack of transportation fees for patients to come to mental health services	3 (12%)
	8. Discrimination of patients with mental illnesses	2 (8%)
Challenges encountered in funding their activities	1.Poor patients do not contribute to the service of mental health	5 (20%)
	2.Activities of mental health not attractive to donors	5 (20%)
	3. Some decision makers don't consider mental health as priority; and Districts don't have enough means to facilitate implementation of planned activities.	5 (20%)
	4. Some district authorities do not include mental health projects among their plans	5 (20%)
	5. Helping people with mental problems is a huge program requiring means beyond our Capability	2 (8%)
	6. Elaboration of projects not meeting donors' requirements	2 (8%)
	7. Problem of funding difficulties to be answered by the authorities of nonhospital Services of mental health.	2 (8%)
Challenges encountered in making their mental health service	1. Difficulties to reach clients in their homes because of lacking transportation and logistic Facilities	8 (32%)
	2.Patients not coming to counselling sessions because living far and not having transportation fees	6 (24%)

useful to the population	3. Insufficient number of staff for clients	7 (28%)
	4. Lack of collaboration between nonhospital services of mental health offering the same service to the community.	5 (20%)
	5. Patients not respecting appointments	3 (12%)
Remedial solutions proposed to the challenges on the functioning of nonhospital services of mental health	1. Increasing the number of mental health professionals in Districts, and in Sectors for a full time basis service delivery near the population.	23 (92%)
	2.Providing necessary and appropriate rooms; logistics and incentives for staff; and transportation fees for patients coming for counselling	**16** (64%)
	3. Ministry of Health and mental health professionals to use different ways to sensitize the community leaders and other people on mental disorders and on the importance of mental health	**14** (56%)
	4. Having a forum of services of mental health in Rwanda and signing MoUs with private services of psychotherapy	10 (40%)
	5. Increasing the funding of local NG0s in mental health to deal with the problem of trauma and other mental problems.	8 (32%)
	6. Scheduling many seminars, refresher trainings and supervisions on the practice of psychotherapies	7 (28%)
	7. Advocacy at all levels to be involved in solving different patients' needs	5 (20%)
	8. Local governmental organs to value mental health as they do for other domains and to include mental health services in their performance contract and action Plan	2 (8%)
	9. Valuing services done by clinical psychologist serving as counsellors or psychotherapists	3 (12%)
	10. Giving a special attention to street or homeless patients with mental illnesses; of people with AIDS; with identity disorder and of other kind of mental disorders consecutive to this homeless status.	2 (8%)
	11.Fixing official tariffs so that clients pay their psychotherapeutic sessions to ensure self-funding	2 (8%)