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Alcohol addiction treatment programmes in Bujumbura, Burundi

A qualitative analysis towards the relationship between local perceptions of alcohol use and ideas about treatment strategies

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Foreword

For this investigation, I went to an unknown country, far away from home: Burundi. Living there for six months was a very intense experience. The only things I knew about the country were some dry facts that I learned from the literature study and that are often mentioned when dealing with African countries: poverty, weak policy, a history of ethnic violence, a very young population and apparently a high rate of alcohol consumption and related problems.

I was very happy to experience a much more nuanced reality than that. Despite aforementioned facts, I had the privilege to meet many motivated and optimistic people that haven't lost hope for the future. I got to know two mental health organisations that, with the little means they had, still mustered the same energy every day to keep on striving for their mission: better mental health care. I met critical people that were not afraid to question society or themselves and were patient with me and all my ignorance.

Therefore, there are many people that I want to thank. Without them, the realisation of this master's thesis would not have been possible.

First of all I would like to thank the director of the Neuropsychiatric Centre of Kamenge (later referred to as NPCK), brother Hippolyte, for his enthusiasm and his help during this investigation. Even before I arrived in Burundi, he was already of great help to me, as we were already in contact through e-mail and he assisted me with my literature study.

All the staff members that work in the NPCK deserve a big thank you, as they were always prepared to answer all my questions and they were very willing to collaborate during my research.

I am very thankful to the patients that were prepared to share their personal experiences with me. I learned a lot from them during many interesting conversations.

The same goes for the staff and the patients of 'Twagurumutima'. Just like the meaning of the word, they opened up their hearts to me. Likewise, Générose, the director, up to her name as she was a very generous and kind person that fights for the mental ill in Burundi. The psychiatrist that works there, doctor Sakubu, deserves all my thanks and respect as well. He is the only psychiatrist in Burundi at the moment and in contrast to most experts in Burundi, he decided to stay in his country instead of going abroad and have the chance to earn better money.

I want to thank my guest family for giving me a safe place to stay in Bujumbura. It was a pleasure to be part of the family Nyatanyi for a little while. So thank you Gilbert, Irène, Magali and Ivana.

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And last, but not least, I want to thank my family, friends and boyfriend for supporting me on this adventure and always listening to me when I had a hard time or sharing my enthusiasm when I had a great story. A special thanks goes to Evelien for helping me with the English language that is used in this report.

Table of contents

1. Introduction **4**
1.1. Context and problem setting 4
1.2. Conceptual basis 6
2. Research questions **9**
3. Methods **10**
3.1. Setting 10
3.1.1. NCPK 10
3.1.2. Twagurumutima 10
3.2. Participants 10
3.2.1. Service providers 10
3.2.2. Service users 12
3.3. Procedure for data collection 13
3.4. Procedure for data analysis 13
3.5. Ethics 13
4. Results **14**
4.1. Motives for substance use 14
4.1.1. Peer pressure 14
4.1.2. To forget 15
4.1.3. Influence of economical and political situation 16
4.1.4. Individual causes 17
4.2. Consequences of substance use 18
4.2.1. Health issues 18
4.2.2. Discrimination, stigmatisation and marginalisation 18
4.2.3. Problems in the family 18
4.2.4. Problems at work or at school 19
4.3. Key aspects in treatment 20
4.3.1. Occupation and fixing objectives 20
4.3.2. The importance of the environment 20
4.3.3. Separated treatment 21
4.3.4. Medication and a symptomatic treatment 22
4.3.5. Psychotherapy 22
4.3.6. Multidisciplinary team 22

4.4. Barriers for seeking treatment.....25
4.5. Community perceptions and cultural influences on alcohol use.....26
4.6. Awareness and formation.....28
4.7. Role of the government.....28
5. Discussion.....30
5.1. Limitations.....30
5.2. Discussion.....30
5.3. Conclusion.....33
5.4. Recommendations.....33
6. Bibliography.....35
7. Annex

1. Introduction

1.2. Context and problem setting

Burundi is a small country that is situated in the heart of Africa, sharing borders with the Democratic Republic of the Congo, Rwanda and Tanzania. The two main ethnic groups that live in this country are Hutus and Tutsis, respectively representing 85% and 14% of the total populace. They have a history of struggle and conflict resulting in civil wars. There have been several violent episodes which caused massive population movements and the destruction of social fabric throughout the country (Ventevogel, Ndayisaba, & van de Put, 2011). It is estimated that approximately 400 000 Burundians were killed in these conflicts during the last few decades and about 800 000 fled to neighbouring countries. Some hundreds of thousands of people were internally displaced (Wolpe, 2011). Since 1997, Burundi has begun to emerge from this violent civil conflict and has slowly been progressing towards peace.

Until April 2015, when president Nkurunziza announced that he would seek to run for a third term as president. Many Burundians considered this as illegitimate as it goes against the 2000 Arusha Peace and Reconciliation agreement, which stipulates that two terms are a maximum for elected presidents. The ruling party CNDD-FDD, however, argues that his 2005 presidential term does not count because he was indirectly elected by the parliament (Muvumba Sellström, 2015). Nkurunziza's announcement was followed by weeks of deadly protest and violence, wherein opposition politicians, civil society and marginalized or unemployed youth played a key role. The authorities' responses to the protests were amongst others the shutdown of social media such as Whatsapp and Facebook and the closing of independent media, amongst others the private radio station Radio Publique Afrique, better known as "the voice of the people". (Karimi & Kriel, 2015). Finally, president Pierre Nkurunziza won the elections in July for his controversial third term, but the opposition says that the results were set up in the electoral commission and that they were not expressed by the voters (BBC, 2015). According to the UN Refugee Agency, freedom of expression, assembly and association, and essential conditions for the effective exercise of the right to vote, remained severely impaired (MENUB, 2015).

The WHO data on alcohol consumption in Burundi show that there is a sudden rise that begins in 1989 and goes on till 1998, during years that the conflicts were at their worst (WHO, 2011). Another point of interest is that, according to Thompson (as cited by WHO, 2004), the majority of war crimes in Burundi was committed by armed men and children acting under the influence of alcohol. Sommers (2011, p. 45) makes a similar remark when he says that "alcohol and especially drugs are iniquitous in many war zones, and offer a response to the diversity of difficulties that civilians and former fighters face after wars end."

As far as alcohol use is concerned, data from 2003 (WHO; Rehm, as cited in Obot, 2006) showed that Burundi is amongst the four sub-Saharan countries that have the highest scores on recorded consumption per capita (15 + years). This measures the litres of ethanol per capita during one year. With a score of 9.33, Burundi came fourth in line after Swaziland (9.51), Nigeria (10.4) and the absolute leader Uganda (19.47). But when the estimated unrecorded consumption was counted, Burundi moved up to number two (a score of 14.3 compared to 13.54 in Nigeria, 13.61 in Swaziland and 30.17 in Uganda). Among the unrecorded consumption are the drinks that are not included in official records of alcohol production and consumption, such as traditional drinks. This goes from home brews to distilled beverages. Countries should pay attention to this hidden dimension because these drinks can contribute significantly to the overall consumption of alcohol. They should take this into account as they develop and implement policies (Obot, 2006).

According to Sommers (2013), Burundi has one of the youngest and poorest populations in the world. The CIA world fact book affirms this young age structure with the following facts: 45.7% is under 14 years old and 55% is under 24 (CIA, 2014). According to the Human Development Index (UNDP, 2011), Burundi is situated among the five least developed countries in the world. Beside this high poverty rate, the country has a serious lack of resources, poor education rates, a weak legal system, a poor transportation network, overburdened utilities, and low administrative capacity (CIA 2014). Sommers (2013) argues that young Burundians in rural areas face adulthood challenges that are related with issues of land, employment, education, fatalism, drug and alcohol abuse, and unmarried mothers

About the alcohol use, he observed the following:

> Beer is an ingrained element of Burundian culture. Sharing beer together is a way to encourage parties in conflict to resolve their differences and live peacefully. Many men and some women also drink even when there is no conflict. It is thus not surprising that some adolescents and youth turn to beer and drugs (particularly marijuana) when difficulties or boredom overtake them (...) In Burundi, it is hard for young Burundians to find work or become adults. Turning to drink and drugs may help ease frustrations and a sense of failure. They may also be used as a salve against hunger and weariness. (p.45)

The same author situates the fatalistically turning to alcohol and drugs among other problems that young people are being faced with in Burundi, such as poverty and hunger, the inability to stay in school or secure a reasonable job, being "tricked" into sex in exchange for a meal or the promise of marriage, and accepting the risk of dangerous occupations like prostitution, stealing and selling drugs. All these aspects contribute to the creation of low horizons for the youths (Sommers, 2013). The Neuropsychiatric Centre of Kamenge (further mentioned as NPCK) where part of this research has been done, also notes this trend by saying that observational investigations have demonstrated that children between eight and sixteen who spend their time on the streets of Bujumbura are the biggest drug users. According to NPCK (n.d.), this problematic lifestyle is a consequence of the civil war and has started to become more visible since the socio-political crisis between 1993 and 2006. Some children had become orphans, others had been separated from their parents and there were also children whose parents' houses and possessions had been destroyed. This aspect was also mentioned in a case study about interrelational reflexivity in Burundi (Sliep & Gilbert, 2006), where the youths highlighted the loss of their relatives, being orphaned as well as becoming street children and beggars. Other concerns they expressed were lack of education, possible exploitation, juvenile delinquency and substance abuse, things that were also mentioned by Sommers (2003). People living in these circumstances will often turn to drugs and alcohol and instead of finding a solution, their situation only will become worse. They are radically marginalized, discredited, despised in their communities and rejected by their families. When they suffer the withdrawal syndrome, they are seen as fools, mentally ill, violent, socially deviant etc. (NPCK, n.d.)

The World Health Organization's Global Status Report on Alcohol showed that several sub-Saharan African countries – Uganda, Nigeria, Swaziland and Burundi – rank among the 30 countries with the highest levels of per capita alcohol consumption in the world. Nigeria and Burundi were also among the twenty-two countries with the highest increase in per capita alcohol consumption per adult (+15 years) from 1970-1996 (WHO, 2004). Besides that, there is a worrying trend of high levels of consumption that are often episodic (Obot, 2006). This is alarming, because the most common way of drinking is one with high potential for causing health or social harm. Several studies have shown that drinking tends to be an "all-or-nothing" affair (Partanen; Obot, as cited in Obot, 2006). The way in which alcohol is consumed has consequences for the problems associated with drinking (Obot, 2006). Acuda et. al (2011)

mention an acute lack of resources and programmes to deal with the problem. Unfortunately, this lack of adequate and transparent research seems to remain one of the biggest challenges in African countries, and Burundi is no exception.

This research is to be understood in a context of poverty, lack of basic needs, damaged social fabric and neglect of the importance of mental healtn (Ventevogel et al., 2011). Out of the aforementioned facts, it seems that young people are a vulnerable group that face many problems, including alcohol abuse. Moreover, there is the critical political situation that takes away stabile future perspectives. Alcohol consumption data are very high and there is very little known about existing treatments.

As a small part of a Ph.D. study aiming to evaluate some of the existing alcohol treatment programmes in Uganda, this research tends to do a similar investigation in Burundi. As said, country-level information on mental health systems in general and addiction programmes in particular still has substantial gaps and inconsistencies (Jakob et al., 2007). Especially now, in these times of political unrest and the influence this has on youth and alcohol use, it is important to gain more insight in this matter. It is therefore this master thesis' aim to explore alcohol treatment programmes and strategies in Bujumbura and to ascertain to which extent local perceptions about alcohol use are reflected in them. To do so, an investigation has been conducted in two mental health organisations. One is in the only psychiatric hospital that exists in Burundi, 'le centre neuropsychiatrique de Kamenge'. The other is a very modest mental centre that also receives patients with addiction problems, called Twagurumutima ("open your heart"). Both organisations are based in Bujumbura and they are general mental health institutions that do not offer specific (alcohol) addiction treatment. Thus alcohol treatment is very new in Burundi. The aim of this study was to investigate the perceptions of service users and service providers on alcohol use and how they are reflected in ideas about (future) treatment strategies

1.2. Conceptual basis

There is a big research gap when it comes to Burundian addiction treatment, as there hasn't been found literature about perceptions towards alcohol use and treatment in Burundi. Therefore, the focus in this literature review has been broadened to the region of Sub-Saharan Africa. Alcohol abuse is also being approached in a broader way, because this investigation took place in two mental health organisations that treat a variety of mental health problems, without offering specific (alcohol) addiction treatment. Most literature does not clearly differentiate between drug and alcohol addictions.

In this report, alcohol abuse is considered within a mental health perspective. The World Health Organisation defines mental health as 'a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community' (WHO, 2013). In return, if people show mental health conditions, the situation of mental health described above could get affected because of a negative economic impact on their families and communities, and the associations with stigmatization, discrimination and exclusion (Funk, Drew, Freeman, & Faydi, 2010). An investigation in Burundi on mental health and socio-economic outcomes affirmed this aspects and argued that poor mental health conditions diminish people's participation in work. It also has a negative influence on the effort they put in their children's education through dysfunction resulting from psychiatric trauma and depression (Baingana, Dabalen, Menye, Prywes, & Rosholm, 2004). If people's mental health situation is precarious, this can, therefore generate some very serious and diverse problems that don't only have an individual impact but also on the society. Within

precarious mental health situations, WHO mentions alcohol use as one of the top ten causes of disability due to health related conditions in all countries.

Unfortunately, there is a significant treatment gap for a large proportion of people with mental health conditions in most African countries, together with a lack of specialized facilities for treating people with alcohol-related problems (Odejide, 2006). Also, there is a severe scarcity of mental health research resources in most low-income countries, and we can find the greatest shortage of mental health research capacity among the poorest African and Asian countries (Razzouk et al., 2010). The need to revise more insight in this is very present, as the countries who lack the most resources face a significant burden of mental, neurological and substance use disorders (Patel & Thornicroft, 2009) and a large treatment gap (Eaton et al., 2011).

However, the relationship of causes and consequences between substance abuse and mental illness is not clear. For example, Obot (2006) mentions that it is imprecise how much influence alcohol has in the psychiatric morbidity resulting in hospitalisation. In several sources, alcohol consumption is indicated as a cause of severe behavioural disturbance, and neuropsychiatric disorders such as psychosis, epilepsy and alcohol use disorders (Ventevogel, Jordans, Reis, & de Jong, 2013; Patel, 1995; WHO, 2014). In others sources, such as the DSM, substance use is more seen as a mental health disorder itself (National Institute on Alcohol and Alcoholism, 2013). Alcohol is thus linked both to the incidence as to the course of disease (WHO, 2013). Whether they are caused or to which extent they are caused by alcohol consumption is again not clear (WHO, 2011).

Another important aspect to consider regarding the planned investigation is the common comorbidity with other mental health conditions. According to the psychiatric hospital NPCK, 90% of their clients younger than 25 are excessive alcohol users. This stresses again the importance of considering alcohol abuse within a broader perspective of mental health conditions. It also reflects the finding that young people are a vulnerable group when it comes to alcohol abuse. People under 24 represent more than half of the Burundian population, a common scenario in Africa. This has made them the target group of alcohol commercials that represent alcohol as an integral part of their lives. According to Sommers (2013), youths drink alcohol to face difficulties and boredom. It can help them to ease frustrations and it can counteract hunger and weariness. These are problems that are mostly present in poor populations including street children.

Several authors, including the NPHK, suggest an integration of mental health care into routine health care programmes such as primary health care (PHC) and community care. NPHK highlights the need to consider mental health as an integral aspect of health, instead of an isolated one (Manirakiza, 2012). These arguments reflect the growing evidence that specific interventions to increase coverage of mental health services need to be part of a broader and integrated process. (Eaton et al, 2011; Patel et. al, 2007). Many authors state that PHC should be strengthened to tackle the lack of specialized facilities and to deal with addiction and other mental health conditions. They should provide an integrated mental and physical treatment and thus decentralise mental health services and resources (WHO, 2004; Odejide, 2006; Manirakiza, 2012; Saraceno et al., 2007). A study on the scale up of services for mental health in several low-income and middle-income countries proved that the mere decentralisation of any mental health expertise to district level would have an enormous effect on the access to care (Eaton et al., 2011). All aforementioned authors stress the importance of adequate training, supervision and continuous support for primary care workers so that they can better identify and manage mental disorders. The specific roles they should have, the training and supervision they need and the way that they relate to the overall health system are aspects that should be evaluated (Eaton et al., 2011).

Another aspect of integrated mental health care includes that treatment interventions should not be principally designed to serve the needs of individual patients, but should also raise public awareness and influence national and community agendas (Obot, 2006; Manirakiza, 2012). Primary healthcare services that establish formal linkages with their communities can help ensure healthy and facilitative environments for people, for example by encouraging and supporting changes in health behaviour (Beaglehole et al., 2008). Saraceno et al (2007) add that mental health investments in primary care should be accompanied by the development of community mental health services. Unfortunately, recognition of alcohol use disorders tends to be poor in primary-care settings in low-income and middle-income countries (Patel et al., 2007). Nevertheless, brief intervention delivered by primary-care professionals has proved effective for management of hazardous alcohol use (Patel et al. 2007). Furthermore, non-specialist health workers could safely and effectively deliver treatments for mental, neurological and substance use disorders within a functioning primary health care system, on condition that this is done within collaborative care models. In these models, specialists play diverse roles of capacity building, consultation, supervision, quality assurance, and provide referral pathways which could enhance the effectiveness and sustainability of programmes in which non-specialist health workers provide treatment (Patel & Thornicroft 2009). This could be part of the solution for the disproportionate ratio of people who need mental health care to the number of qualified psychiatrists. However, Patel et al (2007) suggest that the voices that opt for an integration of mental health care into routine care settings in low-income and middle-income countries have to be investigated, because of the lack of evidence of their feasibility and effectiveness. Most evidence for effective treatment interventions has been derived from high-income countries, so there is an important research priority towards culturally appropriate and acceptable treatments (Patel et al, 2007).

The aforementioned shortage of mental health research in African countries and the concern that Patel et al. (2007) express on culturally appropriate treatments, stress again the importance of exploring local perspectives. As Patel (1995) highlighted, it is essential to investigate the explanatory models of mental illness held by patients and care providers as they reveal sickness labelling and cultural idioms for expressing the experiences of illness and their influence on the search for help (Fosu, as cited in Patel, 1995). Dein (1997) also emphasizes the importance of considering differences between these explanatory models, especially with regard to patients and doctors with ethnically or culturally diverse backgrounds. Treatment should be based on clients' needs, so that it can be made more effective. However, this aspect has mostly been neglected, as the focus on objective and socially desirable indicators of change has been predominant (De Maeyer et al 2008). Krygier (2014) states that diagnostic systems for mental health used in Africa don not differ from the ones used in Europe or the US, even though it has been recognized a long time ago that cultural perceptions and even symptoms of mental disorders do differ. Many of the traditional beliefs, especially in rural areas, represent a very different understanding from the western concepts (Krygier, 2014). For example, in Burundi, severe mental disorders are commonly believed to be due to spirit possessions or to war experiences (WHO, 2013). Vandevelde et al (2003) remark that ethnic and cultural origin are crucial factors in the treatment of substance-abusing clients.

Eaton et. al (2001) identified some important barriers that should be considered while evaluating treatment programmes in low and middle-income countries: (1) absence of financial resources and government commitment; (2) over-centralisation; (3) challenges of integration of mental health care into primary care settings; (4) scarcity of trained mental health personnel; and (5) shortage of public health expertise among mental health leaders

(Eaton et al 2011). These are all aspects that have been mentioned by the authors named in this chapter.

Many of these barriers are a consequence of the low priority that is given to mental health by many countries. That this is a complex situation, is shown by a self-perpetuating circle, suggested in a study by Eaton et. al (2011). Although this study had its focus on four countries in Africa (Ghana, South Africa, Uganda and Zambia), the authors suggest that similarities between the experiences in the countries, and with previous studies, indicate that these findings may be applicable for other countries too. This circle is the following: mental health is a low priority, which results in a lack of mental health services. Therefore there is insufficient data that can be collected for the planning of mental health care. This means that mental health remains a low priority. This circle has great consequences for the legitimacy of the problem.

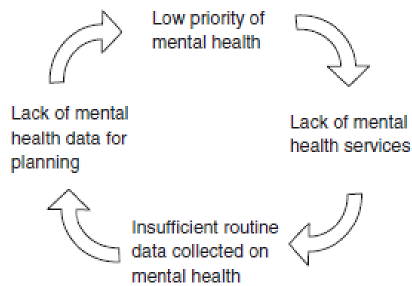

Figure 1 Cycle of low priority and insufficient data on mental health.

When it comes to the evaluation of addiction treatment, several authors emphasize the need of local perspectives. Cultural responsiveness has shown to be a very influential aspect within the success of addiction treatment. The few addiction treatment services that exist in Africa are influenced by western perspectives, but research has shown that western diagnostic criteria do not always correspond with local perceptions of mental health. For example, respondents from Ghana, South Africa, Uganda and Zambia stated that many local people consider mental illness as a spiritual, supernatural or moral issue instead of a disease that should be treated within mental health services. This perspective is in contrast with the growing western vision that considers addiction as a brain disease and thus the addict as a patient with a chronic illness (van den Brink, 2005).

However, if these local perceptions are misunderstood and if the treatment is based on criteria that do not meet these perceptions, then an adequate evaluation is not possible. That is why it is necessary to revise the local perspectives on key aspects in treatment so that treatment programmes can take them into consideration.

2. Research questions

As there is a lot unknown about this research area, the research questions are quite broad. Moreover, it is important to start from an emic perspective, as most treatment programmes come from developed countries and are simply implemented into underdeveloped countries such as Burundi, without paying attention to cultural responsiveness. Patel (1995) already expressed the need of developing emic psychiatric instruments by local care providers, to evaluate phenomena from within the culture and it's context. That is why a focus in this research was to investigate local perceptions and mentalities about alcohol use and to which extent these perceptions are reflected in ideas about treatment strategies.

The overall research question is: “What is the relationship between local perceptions of service users and service providers in mental health settings in Bujumbura on alcohol use and ideas about treatment strategies?”

In order to give an answer on this overall research question, it was translated into more concrete subquestions.

3. Methods

This is an exploratory, qualitative study. The choice for a qualitative analysis is because of the emic perspective that this investigation aims to start from. According to Neale, Allen, & Coombes (2005), qualitative research studies phenomena in their natural settings and their aim is to understand how people account for, take action and otherwise manage their day-to-day situations. Qualitative addiction research in particular seeks both to describe the social meanings that participates relate to substance use and social processes by which such meanings are created, reinforced and reproduced. It focuses on the experiences of people and tries to investigate how drug use is understood in different contexts among different social groups. Qualitative research is related to the use of data that are deep and rich to explore subjective understandings and values.

3.1. Setting

The research found place in two organizations that offer general mental health treatment: the Neuropsychiatric Centre of Kamenge (NPCK) and Twagurumutima. They are both situated in Bujumbura and offer ambulant treatment as well as in hospitalization. The networking to find mental health organizations was not easy, as many small, national as well as international, organizations work alongside each other without knowing what the other does. They were mostly not recognized by de government and their existence was not always written down, as a lot of communication happened in an oral way. After careful investigation, the following two local centers were found that offer a kind of addiction treatment. However, this was mostly imbedded into a broader mental health treatment.

3.1.1. NPCK

This hospital with approximately 150 beds is Burundi's national reference as it comes to mental health care. It is the only psychiatric hospital in the country, except for two small departments in Gitega and Ngozi, where treatment is based on formations given by service providers that work in the NPCK. Approximately 60 service providers are working here. They have a close attachment with the Brothers of Charity and the NGO fracarita, that partly support them financially.

3.1.2. Twagurumutima

After doing more networking and getting in contact with the only psychiatrist in the country, Twagurumutima was found. This modest centre has only eight hospital beds, but it offers treatment that is based on the expertise of the psychiatrist, as he works there and not in the NPCK. Twagurumutima is Kirundi for "open your heart" and arose from an association of nurses that wanted to fight for a better understanding of mental illness, and for a better mental health care. Patients that are treated for addiction are staying in hospitalization under a severe contract between them and the service providers.

3.2. Participants

3.2.1. Service providers

A representative number of participants was chosen within each existing function of service providers, which shows the proportion of these function in both organizations. Where possible, heads of services were chosen because they are the link between practice and strategies. In total, there were 18 service

providers that participated from the NPCK, among which six heads of services. In Twagurumutima, one of each existing function was selected.

Table 1 : Participants amongst service providers

NCPK			
Pseudonym	**Gender (Male/Female)**	**Function**	**Years of experience in mental health**
Cécile	F	doctor	4
Michel	M	doctor	3
Stéphanie	F	doctor	2
Annabelle	F	nurse	6
Charlotte	F	nurse	20
Astrid	F	nurse	1
René	M	nurse	4
Norbert	M	nurse	2
Judith	F	psychiatric nurse	24
Antoinette	F	psychologist	2
Irène	F	psychologist	3
Marie	F	psychologist	3
Jean	M	psychologist	20
Micheline	F	psychologist	2
Simonne	F	pastoral service	6
Jacques	M	director	8
Baptiste	M	occupational therapist	8
Quintin	M	social assistent	8
Twagurumutima			
Pseudonym	**Gender**	**Function**	**Years of experience in mental health**
Josephine	F	director	16
Bernard	M	nurse	8
François	M	psychiatrist	21
Charles	M	psychologist (volunteer)	1

3.2.2. Service users

NCPK (2012) notes that over 90% of the young people under 25 year who they receive, are excessive alcohol users. This clearly shows the high rate of comorbidity among the patients in the centre. During the investigation, the following profile characteristics of addiction patients have been identified: young, not motivated, aggressive, suffering withdrawal symptoms and neglect of personal care.

Some of these aspects hindered a sampling based on a good representation of the service users. Therefore, there has been chosen to do a convenience sampling, were service users were chosen based on the following selection criteria: language, mental stability and willingness to participate. In the NPCK, eight service users were selected. In Twagurumutima, the only patient that was treated in hospitalization for an addiction treatment at the moment of the investigation was interviewed.

It should be noted that few participants were being treated for an alcohol problem only. This was only the case with two participants. The other ones were combining alcohol use with marihuana or were also treated for another psychiatric problem.

In this report, pseudonyms have been used instead of real names. All patients were male. Vincent is an exception as he was in the hospital for another reason, but used to have a severe alcohol problem seven years ago and stopped with help of a priest. All other interviewed patients suffered symptoms from other psychiatric illnesses, such as hallucinations, anxiety, aggressiveness and behavior disorders. Medical hypotheses varied strongly per person, were very extensive and not always clear and consistent. That is why they are not mentioned in the following scheme.

Table 2: Participants amongst service users

NCPK			
Pseudonym	**Age (in years)**	**Treatment**	**Substance use**
Georges	30	ambulant	alcohol & marihuana
Gilbert	45	ambulant	alcohol & marihuana
Vincent	29	residential (but not for addiction)	alcohol
Olivier	40	residential (first time)	alcohol
Christophe	33	residential (tenth time)	alcohol, marihuana & heroin
Arnaud	31	residential (third time)	alcohol & marihuana
Laurent	36	residential (fourth time)	alcohol & marihuana
Marc	22	residential (third time)	alcohol & marihuana
Twagurumutima			
Pseudonym	**Age (in years)**	**Treatment**	**Substance use**
Philippe	21	residential	alcohol & marihuana

3.3. Procedure for data collection

In-depth, face-to-face interviews were conducted, using the same interview guide as the PhD-study in Uganda, to make comparison possible. These interviews involved open-ended questions that sought the interviewees' opinions regarding (personal) alcohol use and how they were experiencing the related treatment. All interviews, except for one (that was held in English), were conducted in French and were recorded and kept in a safe place. Both interview guides, one for the service providers and one for the service users, can be found in the annex in the English version. Some of the topics that were questioned in the interviews were: perceptions of the treatment programme and of alcohol use, approach and philosophy, encountered challenges and local community perceptions of alcohol abuse treatment.

After, a member check was done where some first general tendencies and findings were presented to some additional participants in the NPCK. This has been done in the form of two group discussions, one with a group of service providers and one with a group of service users. Unfortunately, in Twagurumutima this has not found place because of practical barriers and time limit. During this discussion, the researcher presented 10 statements and participants could give a reaction on this. The first group discussion was held in French and the discussion was led by the researcher. The service users discussion group was held in Kirundi and translated with the help of two occupational therapists that work in the NPCK.

A last method that was used to collect data, were rigorously kept field notes. It should be kept in mind that the study has been taken place during the same period as the researcher was doing an internship in the NPCK. This means that there were a lot of (informal) moments in which the researcher had the chance to observe and collect other interesting data than the ones that were derived from the interviews and the discussion groups. However, these field notes have been used as additional data and were more confirming the dats from the interviews and discussion groups then that they were bringing new, interesting insights. Therefore, there aren't specific references to these notes.

This data triangulation made it possible to formulate the conclusions of this research more substantially.

3.4. Procedure for data analyses

Taking into account that addiction treatment in Burundi is almost a virgin area to investigate, there wasn't a strong theoretical framework to start from. Therefore, the guidelines of thematic analysis offered a useful and accessible method for identifying, analyzing and reporting patterns within the data. It made it possible to explore, organize and describe the data in rich detail and even go further and interpret various aspects of the research topic (Braun & Clarke, 2006) To give more insight in the analyzing process, a number of decisions that were made towards the analysis approach are pointed out below:

Because of the rich and complex data, analysis concerned a rich description of the whole data set rather than a detailed account of one particular aspect. This means that some depth and complexity are necessarily lost.

Because of the weak theoretical framework and the exploratory characteristic, the analysis was based on an inductive approach wherein the themes were strongly data-driven rather then it was a theoretical thematic analysis.

As it comes to identifying themes, there are some levels on which this can be done. Braun & Clarke (2006) point out that there are semantic and latent levels. In this analysis, themes were mainly chosen on a semantic level. This is because the communication between researcher and participants couldn't go deep enough to really understand underlying assumptions, as a result from cultural and language barriers.

The epistemology where the researcher started from was rather constructionist than essentialist, as she considered meanings and experiences more as socially produced and reproduced instead of inhering within individuals (Burr, 1995), as the essentialist view does.

3.5. Ethics

With regard to the ethics, an informed consent was signed by each participant before starting with the interview, where the participant could get all the information they needed. This can be found in the annex.

4. Results

Based on the thematic analysis, there have been identified seven themes that are described below. First, some main motives and consequences of substance use and alcohol use in particular are described. After, key aspects in treatment are pointed out. However, there were also identified some barriers that people face when they seek treatment. They are briefly described, as they should be kept in mind when reviewing treatment. After, community perceptions and some cultural influences are named. Some of these influences can also be seen as a motive for alcohol use, but it has been chosen to put it under a separated theme. This is followed by a chapter about awareness and formation. To end, the role of the government in all of this is mentioned.

It is important to note that the themes are not self-contained but connected. However, the division is useful for a better understanding of the reality.

4.1. Motives for substance use

Many reasons why people began to use and abuse substances (*n=113 codes*) were given, but they can be sorted into four main reasons.

4.1.1. <u>Peer pressure</u>

The most important reason mentioned in 27/30 interviews, was the influence of friends and sometimes even family or society . In Burundi, a group of young people who spend a lot of time together and share alcohol or other substances such as marihuana, is called 'ligala'. A young man who stopped drinking alcohol seven years ago with help of a priest, describes it in this way:

> *"Oooh, la cause ça sont des amis. Oui, ça sont des amis. Donc, nous étions à presque 10 personnes que nous aimons beaucoup (…) L'argent que nos pères envoyaient pour nous ou nos parents, on devrait le partager en prenant de cette alcool. Vraiment c'est… la cause principal c'est ce que je peux dire en Kirundi, on disait, non 'le ligala' . Je sais pas si vous savez ça. On utilise le terme 'ligala' c'est-à-dire c'est… ça sont les jeunes, des adolescents qui s'aiment et qui partagent tout. La conversation, l'alcool, tout…" (Vincent, 29)*

A nurse who used to have a severe alcohol problem himself, but has stopped completely for four years, says that you are almost obligated to drink if you want to prove that you are a man:

"D'abord il y a l'influence social. L'influence social : les amis, les collègues boivent et ils vous disent : 'non, toi monsieur, toi jeune homme, il faut prendre de l'alcool pour être un bon homme.' (...) Là vous êtes obligé voir les collègues que vous êtes ensemble, ils consomment de l'alcool. Vous ne pouvez pas prendre du Fanta alors qu'ils prennent de l'alcool" (René, nurse)

Service providers as well as service users commented that some people drink to be "like the others"

"Souvent c'est la compagnon. Les compagnies avec la maturité de la personnalité des jeunes adolescents, souvent ça se consomme en équipe. Donc à l'école, le fait de suivre les autres, le fait d'essayer le modèle des autres."(Michel, doctor)

In eight interviews it was mentioned that the use of alcohol can occur within the family. Three patients reported that their father bought them alcohol when they were young or they gave them beer during festivities and ceremonies. This way they got used to it and they did not consider this problematic at all.

"(...) most of the children they grow up, they see my parents drinking, my brother drinking, my sister drinking. They think drinking is not a problem."(Olivier, 40)

Peer pressure was also seen as one of the hardest difficulties to abandon drugs or alcohol. For most people it was very hard to say 'no' to their friends and in the psychological treatment it suggested that you should abandon your friends in order to be able to abandon the substance. Hence, it was also a very important aspect that influenced relapse.

4.1.2. To forget

Ten participants mentioned that people consume substances to forget their problems, and fifteen said they do it to escape their lives.

"C'est comme un refuge souvent. Un refuge aux problèmes énormes de la vie courante." (Astrid, psychologist)

" Souvent ils commencent à boire pour éviter de penser aux problèmes. C'est ça qu'ils nous dissent. Ils veulent éviter de penser aux problèmes ou de difficultés dans la vie." (Simonne, pastoral service)

« ça peut dépendre des problèmes qu'on a. Si on ne parvient pas à gérer tout ces problèmes, on fait refuge à l'alcool » (Bernard, nurse)

« c'était comme un refuge (...) pour me relaxer » (Christophe, 33)

Many of these problems have to do with conflicts within the family or problematic parenting situations, as was mentioned in 19 interviews, including two patients.

"Pour les couples, les gens qui abusent l'alcool étant en couple, il y a le stress de la famille. Par exemple si un homme ou une femme est en conflit avec son conjoint, il va prendre l'alcool ou abuser les substances psycho actives pour inhiber le stresse. Pour chercher le sommeil, pour diminuer le temps de rester à la maison avec la femme. Pour diminuer le temps de rester à la maison avec le mari. Donc, ça devient un moyen vraiment pour inhiber les problèmes qu'il vit en couple." (Marie, psychologist)

« Parce que je m'entendais pas avec la famille. On venait de vivre des situations carrément difficile à gérer. Il y avait la crise au pays. Je crois qu'on ne pouvait pas vivre avec les parents en permanence et ils avaient toujours des problèmes avec la société, le gouvernement de l'époque, les choses… Donc ils avaient pas le temps de

s'occuper vraiment de notre éducation, de notre vie quoi. Et à un certain moment on se sentait délaissé et puis on a vécu beaucoup de perturbations à l'école, dans la vie, on était pas vraiment forcément bien compris (...) Je voulais m'évader, me faire une vie. Je rêvais d'une vie ailleurs que celle des parents. Je trouvais que les parents me fatiguaient. Donc je voulais seulement être libre, vivre ma vie ailleurs quoi, essayer des trucs pour voir ce que je peux trouver de mieux que mes parents. » (Georges, 30)

This patient said he found understanding in the substances he took, as he called himself world-weary, without any objective. Another patient mentioned that it helped him to feel free and relaxed.

" Et à un certain moment j'ai une soif exagérée de la liberté et voila, j'ai commence à abusé toute la drogue. Je trouvais que c'était un monde qui me comprenait un peu. En fait, ce qui me rendait un peu vivant quoi, si je peux m'expliquer ainsi. » (Georges, 30)

« Pour m'enivrer. Pour changer de penser (...) pour me détendre » (Marc, 22)

4.1.3. <u>Influence of economical and political situation</u>

As Georges already mentioned, the economical and political situation had some influence on the use of alcohol and drugs. In his case indirectly, but there are other people that mentioned a more direct relationship. For example, a social assistant talked about how young men drugged themselves to commit war crimes and finally find themselves dependent, even after the war. They do not find a place in society anymore and keep on using.

"J'ai des cas des gens qui ont… c'est un mélange des gens qui ont participé dans des violences, oui de Burundi, dans une période de crise, ils ont participé dans les émeutes comme ça ils ont tué les gens, ils ont volé. Alors quand ils faisaient ça, il se droguaient pour avoir un peu de… pas mieux de force mais… donc faire tout quand.. violer, comment vous violez sans avoir peur. Alors il a eu une diminution de crise et c'était une résolution qu'on a mis sur place. Alors ils n'ont pas de place finalement dans la société. Ils ont continué à se droguer, ils ont continuer à fumer, à boire. Et finalement maintenant ils ont un problème de dépendance." (Quintin, social assistant)

The problem of young Burundians who do not find their place anymore after participating in the war and as a consequence start to drink or take drugs, is also pointed out by other people. Field observations furthermore mention the plight of a young man who had severe substance abuse problems and suffered strong hallucinations wherein he constantly relived the time that he participated in war. A psychologist explains how they become mental ill and how substance use is related to that:

"Par exemple ces ex-combattants qui étaient dans les forets les années passées, et qui sont démobilisées. Etant dans la foret, il pensait qu'il serait quelque chose. Qu'il serait des officier, qu'il serait je ne sais pas parce que on leur donner des grades qu'il ne méritaient pas. C'est lui qui a fait le huitième il était lieutenant, alors que dans l'armée burundaise, le lieutenant il doit avoir été passé par le camp. Et arrivé sur terrain, ils sont démobilisés. Comme ça il est déçu. Et il commence à faire des comportements bizarres à cause de la déception. A prendre ces substances qu'il amène a tomber malade mentale." (Micheline, psychologist)

Another frequently mentioned reason why people start to drink or why they relapse is unemployment or the fact that they do not have anything to do. Also in this case, it is mostly the youth who is affected by this. Sommers (2013) already pointed out the unemployment as one of the main challenges that young Burundians have to face.

"Ils n'ont pas de travail et ils n'ont pas d'occupation. Et la journée ils passent la journée à la télé et après la télé ils vont voir les amis et puis d'un coup, ils fument, ils boivent et je ne sais pas. Oui." (Simonne, pastoral service)

One patient commented that while he had a job, his drinking was not problematic. It is in the periods that he is unemployed that he searches the company of his friends and to comfort him, they share their beer with him.

Finally, it was mentioned that alcohol and drugs are very cheap and accessible. Especially, traditionally or illegally brewed alcoholic drinks that are sold in little sachets for a very cheap price (about 300 Burundian Francs, approximately 0,18 Euros) seem to play a big role in this. This can be problematic because there is no regulation or check on these drinks, as they are illegal. Often they have a very high degree of alcohol. Also the "chanvre" (type of marihuana) is very cheap.

"Il y a un problème qu'on a ici au Burundi. Les jeunes qui prennent ces boissons en sachets, le Kanyanga, ça sont des boissons moins chère. Si il n'est pas capable de s'acheter l'Amstel ou le Primus, il y a là ces boissons, le Kanyanga qu'on achète une petite bouteille de 300 franc et là il devient ivre. Et il prend ça, ça suffit. Avec les 300 francs, je vais à supprimer ma soif et je serai ivre." (cornélie)

4.1.4. Individual causes

Eight participants consider substance abuse as something that depends on the individual. Some people do not have the capacity to handle the alcohol in their body. For others it does not cause any problems.

"Abuser c'est individuel. Il y a des gens qui ne sont pas capacités. Quand ils prennent deux Amstels, ils sont ivre. Et d'autres qui prennent quatre et ils restent.." (Charlotte, nurse)

" ça dépend de la capacité. Si il a la capacité de six bouteilles, ça ne cause aucun problème. " (Marie, psychologist)

Others say that a weak personality or an identity crisis is the reason for substance abuse.

"Il y a les problèmes individuels comme faiblesse de la personnalité." (Norbert, nurse)

"C'est pendant cette adolescence où il y a d'abord une crise d'identité, identification. Il acquêt d'une identité angoissé, besoin de connaissance, d'appartenance. Et tout ça, ça... fragilité intrinsèque pendant cette période-là" (François, psychiatrist)

Also, other psychiatric disorders were named as a cause of drug use. For example, the director of Twagurumutima remarked that sometimes, people who suffer schizophrenia, take drugs to be less fearful. The psychiatrist said that a psychiatric disease can be the cause of substance use. One doctor at the CNPK said that that another cause could be an antisocial personality disorder.

"Et aussi on a déjà remarqué, par exemple schizophrènes, quelqu'un qui va être schizophrène normalement il y a ceux qui font dans la drogue. Avec d'état morbide entant que schizophrène. (...) Je pense que c'est pour essayer de calmer les angoisses parce que les schizophrènes sont très angoissé alors ils essaient de camoufler ou bien de lutter contre l'angoisse avec la drogue." (Stéphanie, doctor)

4.2. Consequences of substance use

4.2.1. Health issues

Though some participants identify it as a cause of substance abuse, other say it is the consequence. Three patients mentioned that they got hallucinations or that they became mentally ill due to alcohol use. This patient said that he could not see the difference anymore between reality and the world he lived in:

> *"Tu entres vraiment dans le système illusion. Il y a trop d'illusion dans le cannabis, mais tu n'arrives pas à savoir que c'est une illusion. Parce que tu penses que tu penses réellement. Et des fois tu peux avoir même des hallucinations." (Gilbert, 45)*

Others felt physically very weak after they had drunk. They stopped eating and taking care of themselves. Some also reported that they began to forget things and one got involved more than once in severe car accidents. It also made them very aggressive, sometimes to a degree which made them a danger to themselves or others.

> *"Je vomissais parfois lorsque je prenait beaucoup, je vomissais. Encore que, encore j'entendais souvent de mal à l'aise. De mal à l'aise chaque fois après ça. Donc même le manger était négligé. Je ne mange pas. Je ne mange pas et prenais ça mais en mangeant même, je pouvais même abandonner la nourriture pour aller prendre de l'alcool seulement. Et c'était vraiment trop mauvais." (Vincent, 29)*

4.2.2. Discrimination, stigmatisation and marginalisation

People who abuse substances, especially drugs, are not fully integrated in society. They do not find a job and this keeps the vicious circle going. This way it is easy to end up in a criminal environment where drugs are even more present. So far as alcohol is concerned, opinions vary, but from the moment that people are treated in a mental health setting, they feel that they are rejected by society. They are viewed as fools, as evident in the following extracts :

> *"Puis aussi dans la société. Ce n'est pas accepté, on est marginalisé. On vous traite, on vous dédaigne, on vous décret, on vous maltraite des fois même." (Georges, 30)*

> *" Pour la drogue, ils sont intolérant. Pour la drogue ils sont vraiment intolérant. On trouve que faire ça c'est de la folie. Ils prends ça pour la folie et les toxicomanes ne sont pas facilement acceptés. Pour qu'un toxicomane puisse imposer sa vie, il faut vraiment qu'il soit trop talentueux, trop bourré de talent pour que il puisse imposé cela c'est toujours difficile. Donc ils sont intolérant coté toxicomanie." (Georges, 30)*

> *"Oui c'est un grand problème, c'est un grand problème. Lorsque on nous amène ici c'est comme si on nous jette. Oui. C'est si on nous jette. C'est comme c'est quelqu'un qui ne va plus fonctionner à le normal." (Vincent, 29)*

4.2.3. Problems in the family

Five patients reported that they faced problems in their family as a consequence of their substance use, especially with their mother or wife. Their relatives complain because they come home late, are aggressive or they steal goods from the house in order to buy alcohol or drugs. All the money is wasted on the substance.

> *"A cause de la drogue, une chose qui est très terrible.. ça fonctionne pas dans la famille quand tu prends la drogue."(Georges, 30)*

4.2.4. Problems at work or at school

Three patients did not finish secondary school because of their substance use. This patient describes how his drinking behaviour affected his performances at school:

> *"Chaque fois que je faisais ça, j'utilisais un peu de sagesse parce que lorsque j'ai bu beaucoup dans le premier trimestre, le deuxième trimestre je devais prendre concentration. Il faut bien sur, pour récupérer. Pour changer les notes que j'avais. Mais lorsque j'ai utilisé de l'alcool chaque fois, c'étaient des échecs dans mon bulletin. » (Vincent, 29)*

Other patients forget their responsibilities, both at work as in their families and begin to forget things. This patient testifies how he lost his clients'trust:

> *"That affected from the alcohol is in my job. Yeah... because this business work.. normally, people there is trust. Business is trust. And then every time people come and give you a deal to do, they know this business. They have maybe to make some orders to make deals and to want to share the business or to do this. But every time when they see me drunk, drunk... they take me as not serious person who they can make deal with. So this really affected my business to be honest."(Olivier, 40)*

4.3.Key aspects in treatment

4.3.1. Occupation and fixing objectives:

> *"Un client qui progresse… lui aussi il commence à parler des projets, il a un projet de vie." (Josephine, director)*

> *"Et que j'ai envie de vivre, d'organiser ma vie, de organiser la vie dans mon foyer. J'ai abandonné , j'ai abandonné de prendre de l'alcool, je ne prends que de limonade et j'ai évolué bien" (Baptiste, occupational therapist)*

Being unemployed or not taking initiatives is considered then as a risk factor for relapse. Occupational therapy is the most concrete example of how the treatment programme meets the need to have something to do, but there are also voices for organising socio-professional education. They even see it as a solution for the hospital's financial problems.

> *"Mais si il avait du travail à faire, là on pouvait sortir facilement. On pouvait sortir facilement, donc la plupart des gens toxicomanes pouvaient abandonner ses substances. Par exemple, vous voyez comme ici au centre, il devrait y avoir par exemple un centre approprié où on enseignait des métiers pour ces gens, pour disant les malades mentaux. Et après ils quittent ici par exemple étant mécanicien, étant quelqu'un qui connait bcp des choses, qui a bcp des choses à faire à domicile. Si ils arrivent chez eux, ils pouvaient continuer soit a fréquenter le cnpk pour faire ses propres activités ou bien faire les activités pour les autres."(René, nurse)*

In psychotherapy it is mentioned that clear objectives on short, middle and long term can positively influence the patient. During psychotherapy, service providers gradually work from short to long term objectives. Seven patients and nine service providers said that it is important to do something else on every occasion that they feel like using their substance, such as eating a candy or doing sports.

> *"Par exemple, souvent moi je lui propose, (...) les alcooliques de prendre au moins deux bouteilles, euh…, du lait, de l'eau. Et pour des gens qui prend du tabac, de prendre un*

haricot, un bon-bon, etc. etc. et je propose aussi souvent de faire du sport. C'est ce que moi je propose. Je n'ai même trouvé pas, mais puis ce que moi je sais que le sport détend tout le monde, je propose souvent aussi du sport. " (Irène, psychologist)

After giving advice that has to do with these short term objectives, the focus shifted to long term aims, such as thinking about going (back) to school, looking for a job and even looking for a wife to start a family with. Georges explains how this aspect in treatment helped him to organize his life again.

"Mais je l'ai fait et après c'est, le fait de pouvoir me fixer un objectif. Avoir je n'avais aucun objectif. Avant je courrait partout, je faisait tout ce que je voyais pour essayer de me sentir. Mais aujourd'hui j'ai pu quand-même organiser ma vie, je me dis : je dois faire ceci, je ne dois pas faire ça. Ça c'est tout nouveau et je n'ai même pas encore bien compris comment j'ai pu faire un tel exploit." (Georges, 30)

4.3.2. The importance of the environment

The environment is often seen as a major trigger for substance use and thus in order to be able to quit, a change of environment can be a key aspect. The start of that can be the therapeutic environment itself, as eight service providers said that it was very important to avoid craving, so that they should strive to a complete drug and alcohol free hospital. Unfortunately, that was not always the case. The context a person lives in is often seen as the biggest cause of relapse, since their friends and their 'ligala' are still in the same place.

"Il faut d'abord corriger l'endroit, il faut corriger d'abord. Il faut chercher à savoir le motif parce que ils citent d'un motif, il peut avoir les hommes dans le.. dans le toxicomanie. Il faut d'abord changer son environnement, il faut chercher à changer l'endroit. Ou le motif." (Antoinette, psychologist)

Service providers as well as service users are convinced that they should change their relationships if they want to be able to stay sober. In most cases this is even seen as a bigger challenge than quitting the drugs themselves.

"Il s'agit de d'abord m'en construire des nouvelles relations avec des gens qui ne prennent pas des stupéfiants." (Georges, 30)

Three patients said that in order to stay sober, you have to fight the drugs and instead of just avoiding your friends, you have to influence them and even convince them of the negative consequences.

"Et je me suis dit que, pour vaincre la drogue, je dois la vaincre que de dans cette manière. Vivre d'une manière convaincante, qu'on peut la vaincre, qu'on peut vivre sans drogue. Qu'on peut être dans une société non-drogué. Responsable, lucide. C'est ça. Donc influencer les autres c'est une manière de vivre ma vie d'artiste, si je me peux permettre de le dire ainsi. (...) Et j'ai aussi des comptes à régler avec la drogue. Si elle a pu prendre autant d'années dans ma vie, je dois au moins prendre quelques années dans la sienne (laught) c'est une revanche normale et simple." (Georges, 30)

It is not only about changing your connections, but it is also about a drastic change of lifestyle. Five patients said that it was necessary to make a break with their past. The testimony of the following patient is an example of the power of religion and how it helps people to change their lives and to stay sober.

"Et il m'a dit, tu dois être toujours dans l'église. J'ai dit, ah c'est bon. J'ai accepté ça. Lui il le faisait consciemment parce que il voulait que chaque fois je… il voulait que je trouves d'autres amis. Il voulait que je m'en occupe en fait à dieu. Puis ce que il y

avait… puis ce que j'avais encore des amis qui m'appelaient. Beaucoup m'appellent. Ils m'aimaient chaque fois. Parce que je faisais du bien à eux, je compélé à des amis. Et moi-même parfois c'était très difficile d'abandonner mes amis, mes anciens amis. (lacht) c'est vraiment, c'était très difficile. Mais lui l'évangéliste il m'a dit : tu dois fréquenter chaque fois l'église à fin de trouver d'autres amis. Et je trouvais d'autres amis à l'église. J'ai enregistré de conseils de monsieur. Je les ai pratiqué. Les conseils bibliques, les conseils sociales, les conseils familiales." (Vincent, 29)

In the NPCK, there was also given a considerable importance to religion as part of the healing process, as there was a pastoral service. Rather than focusing on going to church regularly and looking for new friends, Simonne said that she supports the patients in retrieving their self-confidence. She did this by focusing on the love that God has for them.

"C'est accompagner le malade. D'abord lui faire reprendre confiance en soi et en dieu, que dieu l'aide, que dieu l'aime, que dieu le voit. (...)Alors, on essaie de leur dire que dieu les aime, dieu veut les aider et la solution c'est d'abandonner vraiment l'alcool." (Simonne, pastoral service)

However, there were also found some inconsistencies when it came to religion. Two service providers even named religion as a reason for alcohol abuse, because it is allowed to drink in catholic communities.

4.3.3. Separated treatment

Fourteen sources were convinced that there should be a separated, specialised treatment for people with an addiction. Seven said that they needed a separated unit and eleven said that they should even be treated in a whole different place, away from the psychiatric hospital. They need better buildings and a more profound treatment model. They want specialised techniques and activities in order to meet the needs of the addicts, because they are "special cases", not to be confused with other people who suffer mental illness.

This doctor explains how she sees a big need for a specialised centre, that goes further than only treatment. She also sees it playing a role in prevention and education and she expressed again the need to keep people with an addiction problem busy.

"C'est ce que je disais, c'est encore à ce centre spécialisé. Parce que ce centre spécialisé, ça dit tout. Parce que même pour les formations c'est très concerné par ce centre. Oui, l'information ça dit beaucoup des choses. Non seulement on fait des, je dirais les émissions, mais on rencontre les jeunes aussi, peut-être dans les quartiers. Ça serait l'idéal, de voir leurs problèmes. Peut-être il y a un problème qu'ils ont mais on ne sait pas. Et voilà, ça serait vraiment une solution, voir… être dans ces groupes de jeunes qui sont souvent dans la rue. Savoir leur problème, leur informer. Leur donner à faire, ça, parce que avec ça on peut diminuer les cas des toxicomanes." (Stéphanie, doctor)

On the other hand, some patients and also the psychiatrist, who after all has a very important voice as he is an expert, do not see it as problematic if addiction patients and patients with other mental illnesses are treated in the same place. He criticises our European model where we tend to put people with mental diseases apart. One patients said that he had the chance to form a better image about what mental illness is and that it took away his prejudices. Three others did not mind so much that they were in contact with the other patients, they even liked it because they were company.

"Appart, complètement appart, non. Je ne vois aucun argument. (...) on ne peut pas mettre les malades mentaux seuel, votre culture Européenne, on essaie de maintenir, d'amener une communauté des gens normaux entre guillemets et d'autres malades mentaux entre guillemets. Quand vous mettez une communauté seulement que des malades mentaux, c'est purant, il faut maintenir et des gens normaux qui peuvent les aider. Et ça a tenu, ces relations » (François, psychiatrist)

So although more than half of the participants said that it is better to have a separated treatment and that patients with addiction problems do not feel at ease between the other patients, there are also some strong voices that call for an approach of inclusion.

4.3.4. Medication and a symptomatic treatment

Medication seems to be considered as a very important aspect of treatment, as it is mentioned by twenty participants among whom six patients. An important first stage in the treatment is to treat the withdrawal symptoms with medication and vitamins. Five patients said that the medication was an important basis for them. Those who suffered hallucinations got rid of them and they felt like they were in reality again. They were able to find some rest and got the chance to recover physically, which was what they needed if they wanted to start the psychotherapy with motivation.

"J'avais remarqué l'évolution avant lorsque j'avais commencé le traitement et ils ont commencé par me donner des médicaments pour le sommeil, j'avais un sommeil très mal. Alors ça m'a reposé. J'ai remarqué que j'avais besoin de repos et que ça faisait vraiment longtemps que je me reposait pas suffisamment. Ça m'a convaincu. Après les anti-hallucinations que j'ai pris, ça m'a donné la paix au cœur, en fait j'en avait aussi besoin. Si non, les hallucinations ça me gênait beaucoup. Je vivais des situations peu difficilement compréhensible. Peu compréhensible plutôt. Mais j'ai fini par comprendre que j'avais besoin d'un médicament et pour le moment ça va bien." (Georges, 30)

According to eight people, among which one patient, there should be a more progressive treatment instead of the abrupt stop of substance use that is applied for the moment. Some service providers argue that in a specialised treatment setting, it should be possible to gradually reduce the substance use or to apply a substitution treatment. This should also diminish the number of patients that try to escape as a consequence of the withdrawal syndrome they are suffering. Now this is hard to implement because of the mix with other mentally ill people and the negative influence that these substances could have on them. René, who used to have an alcohol problem himself, argues that it is better to keep on giving small amounts of alcohol while alcohol addicts are in treatment. He also points out why this is not happening for the moment.

"Alors si ils entrent dans l'état de manque, ils cherchent tous les moyens possibles à quitter le centre. En plus, comme ils sont déjà internés avec les autres patients qui ne sont pas des toxicomanes et on donne par exemple de l'alcool, c'est que d'entrainer les autres à prendre de l'alcool. On ne peut pas… donc donner l'alcool étant internant avec les autres. Si cette odeur revient à quelqu'un qui est malade, il peut dire : « non, sans trouver de l'alcool, moi… » si, on ne donne pas aujourd'hui. Alors, là on donne pas ces quantités et ce qui pousse souvent à ces patients d'évader, pour aller se procurer de l'alcool ou bien du chanvre." (René, nurse)

4.3.5. Psychotherapy

Eighteen service providers and two patients, deemed psychotherapy the most important aspect in treatment, although nine mentioned that the psychotherapy can only get started after

stabilisation and thus medical treatment. As a theoretical basis, analytical and cognitive-behavioural therapy are suggested. They set a very important role for motivational interviewing and counsels. The psychologists named some important attitudes during these interviews such as active listening, comprehension, non-judgment, empathy, and acceptance. Thirteen service providers and two patients mentioned that it is important that the patient himself make the decision because it is he and he alone who holds the solution, otherwise treatment is not useful. On the other hand, five service users mention that the task of a psychologist is to convince. They do that amongst others by means of working very strongly on the negative consequences and the health risks that substance abuse entails. During the field observations, it was regularly observed that it was mostly the psychologists that spoke and convinced the patient instead of it being the patients themselves who had a leading role. Collaboration between the service providers and the patients is regarded as a key aspect, but by that some meant following the advice given by the psychologists.

However, three patients pointed out the importance of a critical self-awareness and the role of psychotherapy . It helped them to accept themselves, to take responsibility for their actions, and to critically think about the consequences of their substance use.

> *"La psychothérapie ! Oui. Parce que ça m'a aidé à comprendre qui j'étais vraiment. Et je crois que j'avais plutôt besoin de ça. Je pouvais accepter les insomnies, je pouvais accepter les hallucinations, mais il est très difficile de ne pas s'accepter soi-même. C'est, je crois que c'est le problème principale que j'avais dans ma vie. Et la psychothérapie m'a aider à accepter moi-même. A me faire un image de ce que je suis moi-même. Et les autres traitements aussi ils m'ont aidé. Parce que physiquement parlé je devais aussi géré mon corps et l'insomnie, les hallucinations, je devais gérer ça. Mais l'élément le plus fort je trouve que ça a été le psychothérapie. Ça m'a aidé à avoir une idée claire de moi-même." (Georges, 30)*

The same patient even points out that he believed that the treatment was not strict enough and that if service providers had put him before his reality sooner, he would have recovered sooner as well. He was blind to the negative consequences of his substance use and was not aware of how strong and 'brutal' they were. According to him, treatment was too tolerant.

> *"Ils ont trop toléré (...)Il fallait mettre les gens devant leur réalité. C'est vrai que le faite qu'ils soient doux ça m'a aidé à avoir confiance, mais je crois qu' à un certain moment il fallait me mettre devant ma réalité. Ça aurai peut-être plus… je pense que ça m'aurais aidé à améliorer vite"*

The psychologists five other service providers point out that dialogue is important to the patient's life and environment, but one patient clearly marked that he was not listened to at all. He found that there was no dialogue and that he was treated like a child. They did not consider his opinion, which could have been an important contribution to improving the treatment. According to him, patients should be listened to and treatment should largely be based on these opinions. It is important to note that he made clear that he does not have faith in African hospitals, as was a business man that regularly went to Europe and he has been in the hospital there a few times. He and two other patients complained about the fact that they did not get informed at all about their treatment.

> *"I think the first thing is all the people, all the people working in this place, first go to sit down and check with some patient's opinions and some patient's ideas. And then try to discuss all of you, try to discuss about this matters. You say some of the treatment you've been saying this.. like 90 percent of the patients, have been saying or proposing, they say my idea. Because if you get 90 percent of the patients, they keep talking about one thing, that thing that need to be changed... because they cannot say*

one thing, one thing, one thing. Maybe 90 percent of the patients, and that thing that needs to be changed must be wrong complete. So, to make change is to keep listening to the patients, talking with the idea, try to see what's going on." (Olivier, 40)

Self-help and testimonies are also considered to be valuable methods. I observed a few times how psychologists organised group therapy sessions and invited ex-addicts to testify. Also, there are voices to organise self-help groups such as the AA, where they can share their experiences and support one another. However, it is mostly the service providers who argue this instead of the patients themselves. Still, field note observations of such group therapies say that they were perceived enthusiastically by the patients.

"Et puis, une autre chose plus importante est que, quand ils sont ensemble il y a parmi eux des gens qui ont déjà abuté le changement, qui vont dire aux autres. Surtout dans les psychothérapies de groupe. Là, ils vont essayer de changer. Et ça sont des gens améliorés qui vont aider les autres à changer."(Irène, psychologist)

A good entourage is considered an indispensable aspect. Not just during the treatment itself, and mostly by the family. During the time of the investigation, it became clear that the involvement of the family was very important during treatment, as service providers focused on home monitoring and social reintegration. There were familial and systemic psychotherapy sessions and there were regularly contact moments with family members. Sometimes family members were even heard more than the patients themselves. During intake sessions for example, it was mostly the family that answered the questions of the service providers. Another aspect of family involvement, is the "garde-malade", people that stood by the patient during his hospitalisation, took care of their personal hygiene and sometimes brought them food. These people were mostly family members and were almost 24/24 in the hospital. Most of them slept in the same bed as the patient. There were group sessions of psycho-education where the garde-malades were involved as well.

Fifteen participants, among which one patient, expressed the importance of family involvement.

"Il faut faire les psychothérapies familiaux pour enseigner au famille la meilleure prise en charge, rester avec eux, les aider, les encourager, les considérer dans la société. Si non, sans les familles, on ne peut rien." (Marie, psychologist)

4.3.6. Multidisciplinary team

The multidisciplinary team was highly valued and pointed out as a key aspect by both organisations. In this team, it is important to have qualified service providers and specialists. Eight service providers are convinced that it is the doctor (or the specialist) that has to make the final decision. The need for education and formation for the members of this multidisciplinary team is very clearly mentioned by thirteen service providers, preferably by foreign organisations. Still, eight of them opined that theory should be adjusted to practice and cultural reality. Two service providers clearly mentioned that theories coming from abroad are not always working in Burundi.

"Nous essayons de connecter avec les autres hôpitaux avec les… nos partenaires Européens pour voir comment on pourrait développer certains pratiques, mais adapté à la réalité du terrain. Mais même la compréhension de la maladie mentale est différente. Le langage qu'on utilise pour parler à un patient ici n'est pas le même langage que je pourrais utiliser pour parler à un patient Belge. C'est différent, on adapte."(Jacques, director)

“Je pense qu’il y a des différences. Presque toutes les théories, tous les modèles nous sommes venu de l’étranger. Alors, nous comme Burundais, nous avons d’autres donc.. d’autres particularités, surtout culturelles je dirais, morale je dirais… beaucoup de choses. Donc, tu ne peux pas vraiment penser à utiliser seulement les théories en provenance de l’étranger, donc l’Europe et l’Amérique, Amérique du nord surtout. On ne peut pas vraiment s’en sortir. Tu dois essayer d’utiliser par tous les moyens d’utiliser la vérité qu’ils ont eu en Europe ou en Amérique puis essayer de l’appliquer à la Burundaise. Alors on a un peu un mélange qui est là. Alors, des fois on échoue parce que ça consiste pas directement avec la réalité du Burundi.”(Quintin, social assistant)

This means that, if we want to bring changes, we have to consider culture. Culture is valuable and we have to be attentive that we do not just implement changes without taking the local context into consideration.

“C’est la culture, c’est dure mais on va changer doucement et progressivement tout en marchant avec la culture. Oui. on ne peut pas… on va les mettre ensemble, chercher de sauver ça. Mais pas pour gâcher la culture, parce que la culture aussi nous aide à l’éducation de base. Oui. Chaque culture pour les nationaux c’est important” (Marie, psychologist)

An example of what has not worked in the NPCK, was the construction of an addiction service, approximately two years ago. Quintin explains why in the following quote.

“On a construit cette pavillon pour les toxicos, mais on a échoué parce que il y a personne qui est venu. Je me souviens qui a eu des sensibilisations au niveau locale et au niveau du centre, au niveau des médias, au niveau… disons, on s’arrête là au niveau des médias. Mais sur une année on a eu deux patients. On a vu que c’est une perte, un grand bâtiment comme ça, avec des bureaux, avec des salles d’internement. Avec même du personnel ici sur place sans rien faire, on a vue que c’était vraiment une perte. On a du déménagé les femmes, ils ont occupé le bâtiment des toxicos. Oui, parce que au Burundi, quand vous parlez de l’alcool, et quand on dit que quelqu’un est dépendent de l’alcool, c’est quand il a vraiment dépassé presque tout les stades. Donc on voit que, quand on parle de l’alcool au Burundi c’est normale, les gens boivent, les gens n’ont pas de problèmes à boire. Mais quand-même des difficultés sont là. Il y des gens qui ne travaillent plus, il y a des gens qui pensent seulement à l’alcool, il y a des gens qui gaspillent beaucoup à l’alcool. Donc il y beaucoup des problèmes au niveau de la société, mais comme on voit que l’alcool c’est normale, on n’est pas vraiment… on n’a pas besoin de venir consulter parce que il y a un abus d’alcool” (Quintin, social assistant)

4.4.Barriers for seeking treatment

Next to the key aspects in addiction treatment, there were also mentioned some challenges that hindered the development of these aspects. They were responsible for most patients not seeking help and never getting into treatment at all, whatever its effectiveness. Main challenges are shortly pointed out below.

The NPCK is, except for two little departments in Ngozi and Gitega, the only psychiatric hospital in Burundi. This means that distance is a big problem for most people. The strong decentralisation of mental health care thus seems to be a barrier for people to seek and find help.

Secondly going to the centre is humiliating , because they will be considered as fools and rejected by society. Addicts feel that they do not belong in the centre and do not come at all.

Thirdly, there is the belief in witchcraft or religious alternatives such as pray houses where demons are tried to be expelled. They prefer these practices instead of going to the psychiatric hospital. As it comes to service providers, they haven't mentioned the importance of taking these into account in psychiatric treatment. Observations showed that they found this beliefs, that were coming mostly from uneducated people that lived in small villages, problematic for the offer of good mental health care.

Lastly, there are no means, neither for the hospital nor for the patients. People do not have money and they cannot pay for hospitalisation . The same goes for the hospital, that has limited resources (both financial and human). This hinders them in applying treatment strategies, however efficient they may be. The problem of being understaffed results in patients not receiving the individual care that they deserve and service providers getting frustrated and tired.

4.5.Community perceptions and cultural influences on alcohol use

Drinking alcohol is considered as very normal in Burundian society. In some villages, people give alcohol to a new-born baby to make it strong. When there is something that has to be celebrated, it is in the presence of alcohol, as twelve of the participants reported. Eleven service providers said that people in the community do not accept that there is any harm in alcohol use. Actually, they have no information of what consequences it can have on their health. This was also pointed out by one of the interviewed patients. Burundians love alcohol and they start drinking it from a very young age. The social pressure to participate in this drinking behaviour is considerable, especially for men. As another patient pointed out, beer is an integral part of life, of society. It is normal to drink beer. Four patients and two service providers even say that it is a tradition.

> *"Sauf qu'il y a des enfants comme les enfants qui sont nés en buvant. Il y avait beaucoup de force aussi l'alcool. Nés en buvant, oui c'est traditionnel. Donc, on donnait, lorsque un enfant est né, on peut le donner de l'alcool. Ça c'est traditionnel. Oui, c'est traditionnel. La tradition nous dit que si l'enfant commence à boire depuis le matin, depuis son enfance, ça montre que il est un Burundais. Il est de nationalité Burundais, c'est culturel en fait. Nos grands-pères utilisaient ça. Même un enfant de 5 ans, on pouvait le donner des choses à boire. Même un enfant de 2 ans, 3 ans, on donne ça. Oui c'est traditionnel (laughs)."(Vincent, 29)*

Sharing is an important virtue in Burundi. This includes sharing beer. People share their alcohol with each other. Sharing thoughts and conversations has to happen in the presence of alcohol.

> *"Oui, dans la mentalité de voir de l'alcool donne.. donc permet aux gens de se rencontrer, d'être ensemble, de partager, de faire… Il y a même un adage kirundi.. mais je vais essayer de traduire en français… qui montre que les fourmis se rassemblent sur un l'os… Vous voyez ? Pour dire que si vous voulez parler de quelque chose, de demander quelque chose a quelqu'un, .. ou bien si vous voulez créer des habitus avec quelqu'un, vous devez le faire autour d'une bouteille.. oui (laughs) Donc cela on voit que , presque tout le monde ont cette conception. Ils disent que pour que tu reçois quelque chose, c'est quelqu'un devait le dire devant autour d'une bouteille." (Baptiste, occupational therapist)*

Many people believe that you just have to stop drinking and that is it. They do not consider alcohol problems as a disease, but simply as a weak personal characteristic. On the other hand, there are people who ask for a medicine that takes your craving for alcohol away. They believe in some kind of miracle treatment that just cures you like that.

> *"Si il est toxicomane, ils disent ça sont les ivrognes et la meilleure traitement c'est d'arrêter, puis c'est tout ! Il n'y a pas d'autre chose" (François, psychiatrist)*

> *"Et si c'est possible aussi retourner les médicaments parce que il y a ceux qui disent : moi vraiment, je veux abandonner, mais je ne peux pas résister devant l'alcool. Alors, si il y aurait un médicament, il y a ceux qui viennent : donne-moi un médicament vraiment pour m'aider à abandonner ! mais on n'a pas le médicament." (Marie, psychologist)*

In contrast, many people consider mental illness in general and sometimes addiction in particular as a fatality, something that you can never be cured of.

> *"Les gens ? il n'y croient pas. Ils croient que t'ont aller devant ?? soit rechuté. Ils considèrent en fait que la folie est une maladie incurable, ils disent quand on est toxicomane, quand on est fous.. ils ne séparent pas tellement les toxicomanes des fous. Ils disent 'quand on est fou, on est fou'. C'est de la fatalité, on ne peut pas guérir. Ils ne croient pas à guérison d'un toxicomane, c'est ça" (Norbert, nurse)*

Three participants pointed out a bizarre inconsistency: the community encourages drinking, but drunk people are criticised.

> *"C'est bizarre, c'est bizarre parce que à un certain moment ils disent: Il n'y a pas un homme qui ne boit pas de l'alcool. Quand tu prends, là ils valorisent l'alcool, mais quand tu l'as pris, tu te trouves dans un état (laughs a little) critique d'ivresse, ils te dirons : regarde cela: un homme sans paroles (laughs). Donc c'est deux choses différentes. Une pour valoriser, l'autre pour critiquer. Donc, c'est bizarre. C'est une société bizarre. A un certain moment, d'une ils te motivent de prendre, d'autre part ils te ridiculisent comme si tu as bu de l'alcool, tu n'as rien à dire. Donc, tu n'as rien à dire, c'est une affaire d'un alcoolique. " (Bernard, nurse)*

Alcohol is big business in Burundi. Many people make a living selling alcoholic beverages. There are 'cabarets' (little pubs) everywhere. So the comprehension of alcohol and its consequences is not the same for everyone.

> *"La compréhension n'est pas la même. Aussi pour les gens qui fabriquent de l'alcool, les commerçants. Ils vous disent : aaah à la Brarudi ici en bas. Il y a prix musiques. Tu achètes une bouteille, on te donne deux pour le même somme." (Quintin, social assistant)*

Many participants pointed out that people should mind their own business. Nobody talks about alcohol problems, and certainly not about treatment for alcohol problems.

> *"Et aussi, c'est quelque chose qui est encore… je ne dirais pas tabou, mais ça ne se parle pas dans la… c'est pas un problème de la santé publique ou un problème social qui est… il n'y a personne qui cri pour ça."(Josephine, director)*

In some regions, there is a common belief in witchcraft or alternative methods like going to prayer houses where they try to expel the bad demons. It is only when these practices do not work, that people may go to mental health organisations. I have seen many examples of this during the time of investigation.

"Même les membres de la famille lui commence à dire qu'on l'a ensorcelé, qu'il est ensorcelé, qu'il faut aller chez les tradi-praticiens parce que ils ne comprennent pas que c'est la maladie mental. A l'intérieur du pays, on croit qu'il a été ensorcelé. Et les protestant disent que c'est les esprits mauvais qui leur entrent. Dans des églises, on fait des séances de prières. Et si ça échouent, on décide de leur amené ici chez le gentil " (Micheline, psychologist)

Although most participants talked about the ignorance of Burundians when it comes to mental illness, six other service providers and one patients pointed out a starting awareness of mental illness and addiction, and what influence psychotherapy can have on this.

4.6.Awareness and formation

Treatment strategies should go further than solely treating addicts that end up being hospitalised and should also concentrate on prevention, education and sensitization of the population. The beginning awareness within the population is not enough and the centre (both participants from the NPCK and from Twagurumutima pointed this out) can play a role in this. Following facts illustrate the importance of this aspect according to the participants. Twenty-one, among which five patients, mentioned the ignorance of the Burundians (twelve mentioned that most Burundians do not even know that there exists a treatment for people with addiction problems) and twenty suggested that there should be a clear awareness and information programme. Fourteen, including two patients, said that education is the missing link in offering an effective treatment and twenty-one participants, among which four patients, claimed that there is no awareness about addiction and this clearly challenges an effective treatment.

"Moi je pense qu'il faut des séances de sensibilisation pour la population. Des séances de la sensibilisation, l'éducation pour les jeunes. Pour les sensibiliser sur les effets néfastes que on constate que c'est la grande majorité des jeunes abusent des substances psycho actives, même les conséquences, moi je pense si on se concentre à ses séances partout, ça peut donner quelque chose parce que ils le prennent inconsciemment. Ils ne savent pas ce qu'ils vont devenir après, après avoir pris ces substances." (Micheline, psychologist)

Six service providers and one patient mentioned that one of the strongest means to organise this awareness, is through the radio. This medium, playing an important role in Burundian society, has already been mentioned with regards to the political situation.

The ignorance about alcohol and its potential effects was also pointed out by the patients. In the following quote, a patient explains that he did not know of the risk factors of taking alcohol before he got into treatment.

"They really do not have an idea about what's the problem with alcohol, what's the matter with alcohol. For me it is the first time I know that alcohol affects the brain, to be honest, within 20 years. I knew that alcohol, you just get drunk. After drunk, maybe you forgot what you did yesterday. And after that I did not know that they can give you a very very serious disease, I did not know that. I know that just... even if you feel like you can spoke to many of people that drinking, they do not know about it. They know it is just enjoying. If you drink more than you're supposed to have, you get forget. Maybe you can fight, maybe you can say some things no right in your group. This effect they know, but they do not know that is affecting the body or that it can give you the very serious illness or disease. They do not know... I just knew before, people smoking, that's the one they get the disease from you know the brain. But I did not know that drinking behaviour can bring you to this. I did not know that before. I just experience

it now. And then sometime I sit by my own and I say: as just if I could know before that this alcohol can give you a disease like this when I come to... brain illness or disease, I could not take it in the beginning. In the first place." (Olivier, 40)

Education is very broadly approached, as they mention formation of staff, community education programmes for the whole population, education in schools (primary school and secondary school) and parental education. The director of the NPCK says that poor parental education leads to misbehaviour of the youth and even the abuse of their freedom and democracy. This view is seconded by a psychologist that considers children's rights as a factor that favours addiction, as according to her, they behave like they want.

"Et notre défi c'est que justement dans la société, c'est que les parents n'ont plus de force à dans l'éducation. L'éducation a rechuté bcp alors que dans le temps l'éducation d'un Burundais était très fortes les parents. Mais les parents, c'est comme ils n'ont plus de force, l'éducation à chuté beaucoup. Et ça, ça fait à ce que les jeunes font ce qu'ils font. Ici même à l'âge de 40 ans, on respecte encore les parents. Ici, il n'y a pas question de dire: 18 ans c'est une culture, non tu es enfant, tu es enfant. Et ça aide bcp. Mais maintenant avec tout ce qu'on annonce à la télévision, tout ce qui démocratie, tout ce qui est tout ça, liberté tout ça."(Jacques, director)

Seven service providers put the stress on the importance of research and complain about the fact that there are not any intellectuals in Burundi. Moreover, the little number of people that are well educated leave the country to earn more money and find a better future elsewhere. This means that there is nobody that can do this research, which is nevertheless very important if there has to be developed an effective treatment and education programme.

"Bien-sûr. Des moyens humains. Compétent, ... et des moyens… les gens qui peuvent même faire la recherche, vous avez vu, c'est un terrain vierge ici ! C'est vierge, personne fait la rechercher parce que… des gens qui sont formé, qui comprennent d'abord."(François, psychiatrist)

He remarks that this poor interest in mental health weakens society, because he considers mental health as an important developmental factor for the country.

"Moi j'allais dire moi, la santé mentale c'est pas un luxe. C'est pas du tout un luxe ! C'est un facteur de développement. Il faut que vous ayez des gens normaux"

4.7.Role of the government

A last, but equally important theme identified during analysis, is the role of the government. Ten participants complain that there are no policies on addiction treatment strategies, and if there are, they only exists on paper. The ministry does not support mental health centres and alcohol production is unregulated. Nothing is done to stop or even control the illegal brewery of strong alcoholic drinks. Fourteen participants thus say that the government does not take responsibility where it should. They suggest for example that they have to regulate alcohol production, raise prices of alcoholic drinks and offer jobs to the youth so that they do not face the risk of spending their time on the streets and get involved in the drug and alcohol business. They should take action and be a key player in the battle against drugs. The low priority that is given to mental health in general, and addiction in particular, results in the lack of adequate addiction treatment services. Treatment cannot be successful without the support of a clear policy.

"Les éléments clés c'est d'abord une politique. Quand il n'y a pas une politique, on ne peut pas réussir. Aussi longtemps qu'il n'y a pas une politique du ministère de la santé, c'est quelque chose comme on peut par exemple… une politique de vih sida,

malaria.. on devrait aussi par exemple d'une politique de lutte contre les maladies, contre les drogues tout ça. Quand il n'y en a pas, ça n'existe pas. Peut-être dans les livres seulement, mais il n'y a pas quelque chose qui se fait. Non." (Jacques, director)

Six service providers mentioned that they felt unsure and desperate to take the responsibility for starting changes. One said that he felt as if he is constantly "working in obscurity". They feel like the government should organise and set up a clear strategy as it comes to substance abuse. In this strategy, everyone has to take its responsibility and all actors, amongst others the authorities, public security, the education system, and the service providers, have to carry out their tasks. Integration and decentralisation of mental health care are indispensable in this.

Three service providers mentioned that it is important to take responsibility and not to be afraid to start changes. Signs of what happens in practice and recommendations should be send out to the ministry. According to them, a change should start at the basis.

"Il faut commencer et montrer au dessous de ce qu'on devrait faire. Mais parfois, une personne peut être à la base d'un changement d'une société (...) Le CNPK peut maintenant influencer à base de nos actions, de nos connections avec les autres partenaires, à un changement de la population et un changement de… mais d'ailleurs l'exemple. Le CNPK fait beaucoup sans toute fois avoir le support du gouvernement. Et le gouvernement commence maintenant à voir, je vois. Même si on nous donne pas bcp, mais ils ont déjà compris à base de ce que nous faisons. C'est-à-dire il ne faut pas croiser les bras parce que une personne peut être à la base d'un changement de son ami à coté, de sa famille, de sa société, même de son pays. Et parfois nous ne le voient pas, mais c' est très important » (Jacques, director)

5. Discussion

5.1.Limitations

Before discussing the results, I would first like to clarify some of this investigation's limitations.

The interpretation of data were inevitably coloured by personal perceptions, experiences and interpretations. Member checks were organised to partly eliminate these subjectivities.

The period I spent in the NPCK was much more intense than the time I was in Twagurumutima, which means that I was not always a neutral observer.

Another thing that could have hindered the research is the fact that the interviews happened in French, which is not my mother tongue, nor that of the Burundians. This also hindered a good representation of participants, as people that only spoke Kirundi could not participate.

There was the risk for giving socially desirable answers, especially within the service users. they might have said they had stopped using so as not to get punished or stay longer in hospitalisation. This also means that quotes from motivated patients and those that were in ambulant treatment, are overrepresented in this report, as they were more expressive than the short answers that the residential patients gave.

5.2.Discussion

Unfortunately, it seems that many negative aspects from the literature study have been confirmed, such as the effect of the economic and political situation on substance use, young

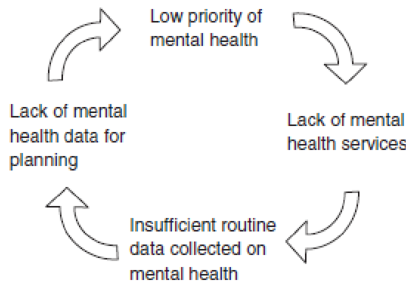

Figure 1 Cycle of low priority and insufficient data on mental health.

(male) Burundians that are most affected, the large research gap, the shortage of human and financial resources, the weak policy and the ignorance as it comes to addiction. These problems do not stand on their own, but have an important connection with each other. Therefore, it seems that that the self-perpetuating circle that Eaton et. al (2011) suggested (see conceptual basis), reflects an important mechanism behind these problems. This also means that if one aspect in this circle changes, the whole process can change.

Many problems, such as stigmatisation, the bad connotation that society contributes to mental illness, the fact that people do not accept that they need help, the ignorance, the heavy drinking behaviour, the young age of people who start drinking alcohol, and the social pressure to drink make the need for strong education and awareness programmes very clear. Awareness programmes may remedy people's silence and the atmosphere of taboo. It is important that the government takes responsibility. It should organise these programmes, and takes into consideration the recommendation of mental health services as the NPCK and Twagurumutima. They should take into account the expertise of people that work in practice and can also benefit from insights from abroad. In the latter case, however, it is indispensable to consider the local context. Therefore, local service providers should play a key role in the application of the information and education that comes from abroad and form the link between foreign expertise and local practice.

The psychiatrist pointed out what Funk et al (2010) already argued: that mental health is an important developmental factor. Consequences of alcohol use showed a negative impact on addict's families and communities and the associations with stigmatization, discrimination and exclusion. Moreover, Baingana et al (2004) mentioned the negative influence of mental illness on the effort they put in their children's education. This again stresses the importance of concentrating on prevention in the first place. Especially if we keep in mind the complex relationship between mental illness and alcohol use and the common morbidity that is pointed out several times by the participants, and was already mentioned in the literature study as well. Again, gaining more insights in this complex relationship is necessary. We should keep in mind the difficult political situation, the pressure this brings to young males, and the influence it has on alcohol use as well.

As we saw, the problems faced by people with an addiction are very connected with each other and often form a vicious circle. For example, the fact that they do not find work, that they don't have anything that occupies them, that therefore they spend more time on the street and with their friends, that they are stigmatised and do not find their place anymore in society, have conflicts with their parents, that they have a critical age at which they search for identity... This is all intertwined. Having an occupation may break the vicious circle. Therefore, socio-professional education can be a useful method that deserves further attention and investigation.

It thus seems that integration is an important concept in the success of treatment programmes. A continuing care approach should be implemented in which there is a decentralisation of services and resources; an integration of mental health services in PHC programmes; an adequate training, control and support for care providers; a connection between different views and stakeholders in the treatment programme; a contribution of clients' perspectives; a combination of different components in the treatment, ... Miller, Zweben & Johnson (2005) suggest that to move forward in the field of substance abuse treatment, there should be

‘cooperative dialogue among the stakeholders, with EBTs implementation plans developed through close collaboration.’ In this regard, Sliep & Gilbert (2006) stress the importance of reflective spaces for interrelational reflexivity between psychosocial workers and of the value for their work at community level.

Although there were some patients involved in this research, their voices remain a big gap in understanding the reality of addiction and effective treatment strategies. Many service providers mentioned the fact that it should be the patients him themselves that have to make a decision, and that collaboration is the key factor to a good recovery. Nevertheless, the practice showed some inconsistencies. Service providers try to convince patients and consider the treatment as successful if the patients collaborates and follows their advice. This does not leave much room for dialogue. The fact that some patients complained that they were not being listened to and the conjecture that some gave socially desirable answers instead of being honest, confirms this. On the other hand, it was also mentioned by patients that service providers were not severe enough and that they would have recovered more quickly if they hadn’t been that soft.

This raises some important questions. To which extent do we have to impose treatment? It is often mentioned that the motivation comes with the number of psychotherapy sessions and that the success rate increases with the number of hospitalisations. This may mean that forced hospitalisation can be the first step to recovery. On the other hand, keeping the high rate of patients that do not accept that they need a treatment in mind, who then has the right to decide that someone’s behaviour is problematic? Is it the community, the family, mental health workers, the government,...? As we saw, democracy and liberty are not always seen as positive for society, because according to some, it can be a risk factor for people to end up with an addiction.

It can be concluded that it all comes down to prevention, education and awareness. Just as Obot (2006) and Manirakiza (2012) already pointed out, treatment interventions should not be principally designed to serve the needs of individual patients, but should also raise public awareness and influence national and community agendas. Maybe if people are informed about the possible consequences of alcohol use and the fact that there exists a treatment, they will seek help voluntarily. The stigmatisation and prejudices that come with mental illness, should be battled with sensitization and awareness programmes. The community should play a key role in this. The described barriers make that people rarely search for help and if they do end up in hospital because of their family or the authorities, they are not intrinsically motivated at all. They are not aware of the possible dangers of alcohol use, so they do not accept that they need treatment. The bad connotation that mental health centres have in Burundi results in stigmatisation and neglect by society. Being viewed as fools that cannot be cured, results in reluctance to go to these centres. People are therefore not receiving any professional care. This means that there is only a small amount of people that are in hospital, so there is no clear image of the real problem.

The actual addiction treatment is based on the profile of the patients they receive. In this sense, the above mentioned strategies such as prevention and awareness reflect some main perceptions that people have about alcohol use. They consider it as normal and they do not know that there exists a treatment for it. In the best case, they think that you just have to stop, as simple as that, or that you can take a medicine that takes away the craving. Some of them prefer to go to traditional healers or prayer houses because they do not have faith in mental health care. This are some of the reasons that only the “worst cases”, people that developed hallucinations or other mental illnesses, and people that are severely disturbing society end up in hospitalisation. This means that their condition is much more complex than only addiction and that this addiction is often only treated secondarily.

5.3.Conclusion

It seems that the connection between local perceptions about alcohol use and ideas about treatment strategies are coming down to the following aspects:

- Education and prevention should eliminate barriers for seeking treatment and change perceptions, so that people search for help themselves. When mental health organisations receive these people, they can begin to develop a more specialized service. At the moment, this does not work in practice because only people with additional mental health diseases end up in hospitalisation. In the NPCK, this even led to the closing of the new built addiction department.

- During treatment, there is given a big role to psychotherapy where there should be worked on patient's motivation. This should make them more aware of their problem and critical towards themselves.

- In order to start these motivational sessions, many argue that medical treatment is an important basis to bring people back to a 'normal' state of mind. From the moment that they are stabilised, psychological treatment can start.

- Family is seen as an important link between the hospital and the community and therefore get an important place in treatment. Psychologist argue that family members should be formed and educated about addiction. From the moment patients are back home, the family partly has to take over the role of service providers.

This means that, in order to develop an efficient addiction treatment, there should be started at the very basis: education. It is only after focusing on this education, that there can be worked towards a specific, efficient and separated addiction treatment.

5.4. Recommendations

5.4.1. For further research

More insights should be gained in the reality of substance use in Burundi: profile of substance users, what drugs they take, what the effect is on them, what problems they face and how they can be motivated to seek help themselves.

Voices of the people that suffer addiction should be heard as well if we want to obtain a clear image about key aspects. Such research should always keep a strong cultural responsiveness in mind, as Patel (1997) and Krygier (2014) already pointed out.

The perspective of the "garde-malades" and other family members towards addiction treatment should further be investigated.

Further research has to focus on how Burundian ideas can meet western treatment models and what place cultural aspects such as religion, witchcraft and the traditional functions of alcohol use can have in this.

5.4.2. For policy

As the results already made clear, there is an important role for the government. If they organise awareness and education programmes, this can break the circle of the low priority that is given to mental health.

They should connect the key players in mental health care (service providers, ministry of mental health and even security instances). A first step in this should be the transparency of the social map, so that all organisations know what the other does and they stop working alongside each other.

In this way, the government can work further towards integration and decentralisation of mental health care towards community level.

They should take into account the signals that are given by scientific research and the practice, and be aware of mental health as a significant developmental factor. They should give more financial help and keep in mind that alcohol abuse costs a lot to society.

5.4.3. For practice

People working in the practice of addiction treatment should keep on being critical and sending signals to the government in order to raise priority. Also, they should be critical towards foreign formation programmes and apply them to their own reality.

They should organise themselves, better communicate amongst each other and work together.

They should take into account the patient's opinion and give it a considerable place in treatment.

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