AFRICA BRIEF
A FOCUS ON PSYCHOSOCIAL SUPPORT

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SDC SWISS AGENCY FOR DEVELOPMENT AND COOPERATION
DIVISION EAST AND SOUTHERN ARICA

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East and southern Africa constitutes one of the regions most affected by recurring conflicts. These conflicts further debilitate people who are already living in extremely precarious situations. Women in particular face various types of discrimination exposing them to all kinds of violence. In this environment, where the HIV/AIDS prevalence is among the highest in the world, access to adequate health services that also incorporate a psychosocial element is fundamental.

Over the past decade, psychosocial work and the considerations it has provoked have grown in magnitude in the area of international cooperation. It is now widely recognised that instability and insecurity, coupled with violence against women and children, high morbidity and mortality rates, and increasing numbers of orphans and vulnerable children result in multiple traumas and debilitated inhabitants.

A firm believer in the relevance of the psychosocial dimension in fragile socio-political environments, the SDC has made a commitment to ensuring that its operations incorporate treatment of the past, traumas and other injuries left behind by conflict, poverty and HIV/AIDS. The SDC focuses on an integrated approach that aims to promote women's rights, the support and socioeconomic reintegration of victims of violence, and legal assistance. The articles below provide an overview of operations supported by the SDC and their effects on vulnerable groups in three countries in southern and eastern Africa.

Presence of the Swiss Cooperation in Africa :

Priority Countries :
Benin, Mali, Burkina Faso, Niger, Chad, Tanzania, Mozambique.

Regional Programmes :
Great Lakes (Rwanda, Burundi, RDC)
Southern Africa (SADC countries)

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SOUTHERN AFRICA : OFFERING VULNERABLE CHILDREN A BETTER FUTURE THROUGH THE REGIONAL PSYCHOSOCIAL SUPPORT INITIATIVE PROGRAMME - REPSSI

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Bekumuzi is a 15-year-old orphan boy raised by his grandmother who lives in a rural area of Swaziland and dreams of becoming a doctor. Having started school at a late age due to AIDS-related illnesses, his treasured dream was born out of sombre circumstances: *"When I was sick, I had sores all over my body. It was hard to think about school. But I was taken to hospital where I was tested and treated. The doctor gave me some medicine. I feel better now and am back at school. One day I want to be a doctor so that I, too, can help others like they helped me."*

Southern Africa holds the unfortunate record of the highest number of orphans worldwide. Armed conflict, poverty and HIV/AIDS have strongly affected the living conditions and psychosocial well-being of children. Emotional and physical deprivation, abuse, forced early marriages and the burden of caring for sick parents or siblings are all part of the daily lives of children in this part of the world. Their suffering has put huge social and psychological strain on individuals, families and entire communities.

Despite many programmes geared to addressing the physical and material needs of orphans and vulnerable children, little attention is paid to their psychosocial needs. It is within this context that, since 2002, the SDC has been providing psychosocial support to vulnerable children in 13 southern African countries through its Regional Psychosocial Support Initiative (REPSSI). This programme develops the knowledge and tools to mitigate the social and emotional impact of HIV/AIDS, poverty and conflict in Angola, Botswana, Kenya, Lesotho, Malawi, Mozambique, Namibia, South Africa, Swaziland, Tanzania, Uganda, Zambia and Zimbabwe. The programme supports and trains over 100 organisations working with children. It helps governments and NGOs so that families and communities have access to care and can protect their children.

"Vulnerable children in southern Africa are not victims but survivors. Their resilience, resourcefulness and their will to find the hero inside themselves are the survival attitudes that the REPSSI is trying to support and strengthen," stresses Noreen Huni, executive director of REPSSI.

REPSSI considers psychosocial well-being to be every child's right. Children who are more positive about themselves, assert themselves and take action are more likely to help their communities. Psychosocial support addresses all facets of a child's well-being, such as his or her immediate environment, family and community relationships, but also his or her values, hopes and dreams.

Despite an increase in the number of psychosocial support programmes for children in southern Africa, little research has been conducted to evaluate their effectiveness. With support from the SDC and the Novartis Foundation for Sustainable Development, the REPSSI, in partnership with the Swiss Academy for Research, is conducting studies in the rural parts of Kafue in Zambia. The research focuses on the impact of the REPSSI programme's activities on the psychosocial well-being of 900 vulnerable children in four separate communities. The study looks at both the educational manuals developed by the REPSSI (Hero Book, Tree of Life, Memory Work) and also the actions undertaken, such as those designed to ensure livelihoods for communities that care for children, or the creation of community committees of orphans and vulnerable children. The results of this research will improve the project's procedures and performance.

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"The answers supplied on a daily basis regarding the psychosocial support of vulnerable communities in southern Africa is a treasure trove of knowledge proudly passed from the southern hemisphere to the northern hemisphere," confirms REPSSI's Executive Director, Noreen Huni.

Concrete results of the REPSSI programme :

- 3 million children have access to psychosocial care and receive quality support;
- The psychological and social needs of children and vulnerable families living with HIV are now considered a priority by international organisations as well as by regional and national programmes;
- 494 people were trained through the "Youth and Children Certificate" programme, developed in partnership with UNICEF, on how to work and interact with vulnerable children and young people;
- National and regional strategic plans have been developed in the fight against HIV/AIDS, poverty reduction and psychosocial care;
- Knowledge about psychosocial support (PSS) is being disseminated via the tools developed by the REPSSI programme. Several of them have been adapted to many parts of the world.

GREAT LAKES : STANDING TOGETHER TO OVERCOME VIOLENCE AGAINST WOMEN

The wars and conflicts that have ravaged the Great Lakes region for over a decade have plunged women into a very precarious physical, psychological and social situation. Gender-based violence, often used as a weapon of war in the eastern Democratic Republic of Congo (DRC), has reached catastrophic proportions.

The Swiss Development Cooperation Programme in the Great Lakes region (Rwanda, Burundi, eastern DRC) is part of the wider Federal Department of Foreign Affairs' Great Lakes 2009–2012 Strategy, which has two priority action areas: (i) health, and (ii) consolidation of peace and good governance. Within this framework, the Swiss Agency for Development and Cooperation (SDC) has initiated the first year-long phase (April 2010 – March 2011) of a regional programme to fight gender-based violence and provide psychosocial support for victims. The studies conducted and the results obtained over this period will enable planning for the programme's next three-year phase. The SDC will rely on the skills and expertise available in the three countries, particularly Rwanda, for the implementation of the programme. In this respect, the *Centre de Guérison des Blessures de la Vie*, led by Professor Simon Gasibirege, has been identified as a key partner in this programme. Professor Gasibirege has developed a theoretical framework and a community-based psychosocial approach that he kindly shared with us in this interview.

How would you explain violence committed against women in the environment of the Great Lakes region?

Violence against women is part of a general prevalence of violence that is also committed against children and men and which is tied to cyclic wars that have taken place in the region. This violence contributes to the disintegration of Rwandan as well as Burundian and Congolese values and cultures. In fact, sexual violence is used as a weapon to destroy another ethnic group, tribe or opponent by harming women, mothers, givers of life. These acts of violence are often carried out publicly and on a large scale. In this instance, we talk about a transgression of taboos, in other words, this is all done simply to show one's disregard for life, to show that there is nothing left to fear, that there are no longer any taboos!

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Your institute works with victims of violence, their families and traumatised people. What approach have you adopted?

We have developed a psychosocial approach based on the community. We believe that the problem of violence is not an individual problem but a community problem: it is not enough to treat the individual, because the dysfunction lies at the heart of the community. This approach emphasises the close relationship between the psychological and social areas of human experience. Psychological aspects concern thinking, emotions, behaviour, memory, and learning ability, while the social aspects are related to the effects on relationships, traditions, culture and values, family and the community, including even the economic sphere, and its effects on networks and status. Our point of view is that mental health is based on three pillars: communication, solidarity and conflict management ability. With our community-based (psychosocial) approach we address the important issues affecting society, such as grief, justice, or domestic violence. We organise healing workshops which provide individuals and their families with simple tools to help them understand the mechanisms of trauma and to heal one another. These workshops bring together diverse groups from different backgrounds and religions, as in society itself. A shared space is created from these different perceptions and traumatic experiences, where we can work on wounds, illusions and taboos.

What is special about your approach and its added value compared to other approaches?

Other than the fact that it is community based, it also has curative, preventive and forward-looking elements which make it unique. It is not only that those participating in the workshops are healed and changed; they also become a model of change for others by disseminating what they have learned. We work extensively with couples: they constitute a unique point of entry into families and communities.
As regards domestic violence, for example, in the Great Lakes region women are still caught in a process of victimisation from which it is difficult to escape. When it comes to domestic violence, we offer an approach that focuses on family and community rather than on the woman alone. We bring together all components of the household: husband and wife, or the widow and her eldest child. We get them to gradually become aware of their life wounds formed as a result of childhood, genocide or any other situation that influences their home lives. Couples and families learn to self-heal and become resources within their community.

Why is a community-based approach appropriate in the Great Lakes region?

It is largely due to the cultural context in which we live and our collective culture that a community-based approach is relevant in this region and in Africa in general. We still believe that the individual is a free and rational being capable of making choices. But the rationality of human beings and their ability to choose are closely intertwined with the community in which they live and to which they belong.

Sexual violence is still very taboo in the region. How should the issue be approached in these circumstances?

We strive to create a secure environment. There are a set of conditions where confidentiality is guaranteed, allowing people to speak freely. Often, people admit that this is the first time they have addressed the issue. Little by little, these personal accounts free other victims, who, in turn, dare talk about the violence they have endured.

How do you picture the future of women in this region?

In light of the results we have achieved (with nearly 3,000 people who have been healed and returned to normal life), I am convinced that if we can spread this approach widely enough, we will be able to reverse this situation of self-destruction and turn it into a situation of resilience and self-construction. The SDC pro-

gramme is very important; it will help us spread the approach and strengthen the professional abilities of NGOs and organisations that provide assistance to victims and their families. We are moving towards a society where women will be more widely recognised, along with men, as being in charge of society and of their families' future. It will be by means of changing the relationship between men and women that we will contribute to the peace process and stability in the region.

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Concrete results of the programme "female victims of violence" in the Great Lakes region (since April 2010):

- In the 13 listening centres belonging to the VOVOLIB organisation, an SDC partner located in the Province of South Kivu (DRC), 838 female victims of violence have received psychological support, 366 have been transferred to hospitals/healthcare facilities for medical treatment, and 546 have received financial support (20 USD);
- In Burundi, the Nturengaho association, an SDC partner that cares for young girls who have fallen pregnant as a result of rape, has housed 147 girls in its centre; 40 girls have been reintegrated into their families and 39 have received financial support. 7 rape complaints were filed.
- The SDC's second partner association, Seruka, has provided medical care and psychological support to 1,490 female victims of violence.

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CHAD: PSYCHOSOCIAL SUPPORT FOR WOMEN SUFFERING FROM FISTULAS

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Halima is only 20 years old but has suffered from an obstetric fistula for a long time, following a caesarean delivery in which the baby did not survive. In Kanem, her home region in north-western Chad, girls marry very young, between 13 and 15. At this age, pregnancy is highly risky and can cause significant anatomical damage that poses a risk to the life of mother and child and results in a fistula in 90 percent of cases. The situation is made worse by the fact that deliveries take place in very poor sanitary conditions. Transport to the nearest medical facility is usually by donkey or camel, with serious consequences for the health of the mother and her child. Additionally, health personnel, who are often underqualified, lack basic medicines due to frequent shortages of stock. In such circumstances, too few women give birth in hospitals, preferring to use traditional midwives with only limited means to intervene.

"It was the midwife who told me that I had to give birth at home. I told her that I had enough money and I could give birth in hospital. We used to live together, but now I resent her," says Halima.

Women who suffer from fistulas are stigmatised and discriminated against. They are often disowned or abandoned by their husbands and excluded from their communities.

"My illness not only affects the way my husband acts towards me but also others. Since I got sick, I have shut myself away, I don't go anywhere, and I'm not able to communicate with the outside world anymore. I stay at home and only speak to my sisters and mother," says Halima.

To help these women, the SDC has been backing a project aimed at reducing maternal and neonatal mortality in the Kanem region since June 2009. This project has been implemented by the "*Médecins du Monde*" ("Doctors of the World") organisation. Since January 2010, its activities have included a component specifically for the surgical and psychological treatment of women suffering from fistulas. Psychosocial support begins when sick women in the villages are identified, it continues during their stay at the regional hospital of Mao, where they are operated on, and comes to an end after they return to their families and village communities.

The project, which focuses on transferring skills, has trained psychosocial workers to ensure better monitoring of patients in hospital and their family environment. At the same time, in order to ensure adequate support, the project works with community bodies (health committees, traditional midwives). This approach facilitates the reintegration of women into their environment and also contributes to the detection and management of high-risk pregnancies.

However, psychosocial support in an environment such as Kanem remains a challenge. From a practical standpoint, most patients live too far from the regional hospital or any of the health centres, which makes them difficult to monitor. Socio-culturally speaking, the feeling of shame and exclusion experienced by patients makes return to their communities difficult. Yet even though most patients have been abandoned by their husbands, they continue to receive support from their mothers, their sisters and sometimes their fathers, who help them through their convalescence. All of them hope for a return to their old life.

"I haven't thought about my future yet. If I get better, I will go back to my husband," confides Halima.

Concrete results of psychosocial support (since January 2010):

- 103 individual consultations have been conducted with patients to assess their mental state upon arrival at the hospital and support them after their surgery.
- 11 home visits have been conducted to help reintegrate patients into their families and their communities, and to monitor the most difficult situations.
- 19 patients have been followed long term, as have 4 family members of some of them.

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IMPRESSUM

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