The land of a thousand broken hearts:
Trauma and reconciliation in post-genocide Rwanda

August 2016
Student: Bob Erinkveld (b.f.h.erinkveld@students.uu.nl)
Supervisor: dr. P.A.M. Malcontent
Word count: 31 707

Table of contents

Prologue

Following years of ethnic strife between the Hutu majority and Tutsi minority, tensions escalated immediately after the plane of president Habyarimana was shot down on April 6, 1994. The Tutsi were designated scapegoat by Hutu extremists and subjected to a systematic and barbaric genocide. Within a hundred days, approximately 800.000 Tutsi and moderate Hutu were slaughtered.[1] The killings only grinded to a halt when the Rwandan Patriotic Front (RPF), a Tutsi rebel militia, seized the last stronghold of the regime on July 17 that same year.

The genocide was not only unprecedented in terms of speed, but was also unique in terms of its brutal violence. As killing came to be seen as communal work and Tutsi as cockroaches or bad weeds, the seeds of dehumanization and monstrous slaughter were laid.[2] Many killers reveled in their brutality. Some people were forced to drink their family member's blood after witnessing them being killed mercilessly. One man was castrated and had his hands chopped off before being skinned and thrown into a pit latrine. Many women were subjected by vaginal impalement, several pregnant women saw their fetuses cut out while others were raped countless times before having their intestines pulled out of them with hooks.[3]

This unrestrained violence has left deep imprints on Rwandan society. Approximately 55% of the estimated pre-war population of 7.5 million have been directly affected by the genocide. Of these, 2.5 million children were estimated to have experienced significant traumatic memories, and 640.000 of them have severe problems coping with their past.[4] After the genocide, many women (70% of the survivors being female) were left with unwanted children, as an estimated five thousand women were impregnated by killers of their spouses and family members.[5] Many had been widowed, rendering them ineligible for property rights. More than a 100.000 children had been orphaned by the end of 1994.[6] The genocide scattered the population, as approximately 200.000-300.000 Tutsi fled during the slaughter and another 2 million Hutu fled after cessation of hostilities. Hutu's awaiting forced repatriation fear reprisal killings on their return home.[7] The stressful living situation as a result of a war-torn region deprived of many economic, political, social and other assets and necessities only add to a survivor's distress.[8]

Whereas now, by and large, Rwanda can be said to have emerged a peaceful nation, the war has scarred the country not only physically, but left deep wounds in the minds of survivors as well. At the individual level, traumas caused by the war pose a number of barriers in once again returning to a normal life. Even twenty years after the genocide, the sound of children whistling may trigger

[1] The death toll of 800.000 has come to be the most frequently cited number, although estimates have varied between 500.000 and 1.000.000. This number has risen in the years after the genocide, which is very likely as a result of the discovery of burial and slaughter sites even many years later. The Rwandan government puts the death toll at 1.071.000 (Survivors Fund, n.d.), which seems more credible in light of excavations of killing and burial sites after the figure of 800.000 had already been established.
[2] Brouneus 2008, p. 56.
[3] Williamson 2014, p. 5.
[4] Chauvin, Mugaju & Comlavi 1998, p. 385.
[5] Kumar 1997, p. 24.
[6] Palmer 2008, p. 18.
[7] Muhumuza 2013.
[8] Kumar 1997, p. 205.

some to panic, expecting another raid by Hutu militias. [9] At the societal level, reconciliation still seems to be impeded by the difficulties of survivors in coming to terms with the perpetrators and their own past. [10]

The repercussions of trauma inflict severe damage on society and the economy, particularly in Rwanda, where the prevalence of trauma has been of such a magnitude that often terms such as 'traumatized nation' or 'collective trauma' are invoked to do justice to the psychological costs arising from the genocide. But although the consequences of the trauma resulting from the genocide are now widely recognized, the country still faces a hard time becoming self-sufficient in providing adequate mental health care. With over 80 per cent of health care staff and educators killed or having fled during the civil war, primary health care centers and schools have been rendered incapacitated. This gives some idea of the magnitude of the challenge Rwanda is faced with: providing adequate mental health care with minimal external assistance in order to 'restore' past relationships and individual lives. This thesis is the story of how 'the land of a thousand hills' became the land of a thousand broken hearts and how to look forward in a country that once seemed bereft of its sanity and, above all, its humanity.

[9] Jaberg 2013.
[10] Staub et al, 2005; Staub, 2006

Ni ryari izuba, rizagaruka, hejuru yacu,
Ni nd' uzaricyeza ricyeza.

When will the sun return above us?
Who will reveal it to us once again?

- Wyclef Jean, Million Voices
Hotel Rwanda

I. Introduction

Harrowing cries echoed in the Kigali football stadium on April 7, 2014 as Rwanda commemorated the genocide that took place in Rwanda exactly twenty years ago. Statesmen from all over the world were present to pay their respects to those who had lost their or a loved one's life in the mass killings. Yet their words, about the importance of 'never forgetting' and parallels with current events, were not nearly as piercing as were the screams from female spectators who fell into uncontrollable fits of crying. Unable to comfort, calm or soothe them, medical staff was often at a loss of how to aid the distraught women overcome with grief. According to a Rwandan health ministry official, "It is so hard for the people, because it opens mental wounds, hearing the testimonies of those who survived, they are reminded of what happened to them".[11]

In the past decades, the international community and domestic authorities alike have adopted several instruments in the stabilization of post-conflict societies through reconciliation efforts. These instruments have predominantly taken the form of official apologies, material compensation and judicial proceedings with the goal of enforcing justice. However, despite the constructive potential of these efforts, a more profound component of enduring civil strife has been largely neglected. Psychological traumas are often highly prevalent in post-conflict societies, which have usually witnessed excessive violence and dehumanization, and have profound sociological implications. The magnitude of this issue is hardly commensurate with ongoing efforts and interventions to combat the prevalence of psychological traumas, even though the issue has received wider recognition over the past two decades and substantial progress has been made in addressing mental health needs in various crisis regions.[12]

As psychological well-being is vital to socio-economic progress, a good case can be made that the phenomenon poses a significant obstacle to recovery and reconciliation. Indeed, it has been argued that trauma, often coupled with bitter resentment and feelings of victimhood, can plant the seeds for future violence.[13] Psychological healing may allow a person to genuinely forgive, regain control over their lives and move forward. In this paper, reconciliation is conceptualized as the mutual acceptance of groups by each other with the essence of reconciliation being a changed psychological orientation towards each other. It means that members of hostile groups come to see the humanity of each other and the possibility of a constructive relationship.[14]

Though many scholars on post-genocide Rwanda note that the violence traumatized many individuals, or even speak of a traumatized nation, the word 'trauma' is employed rather arbitrarily. By invoking the word as such, it is often not followed by an elaboration of the effects of trauma. Various studies have investigated the psychopathological epidemiology of the post-genocide population and a few others have adopted a more context-driven approach by exploring how trauma is experienced in daily life (although these usually explore trauma from a therapeutic setting and thus neglect how trauma is experienced in settings not mediated by therapy or

[11] Martell 2014.
[12] Herrmann 2012, p. 84.
[13] Mamdani, cited in Clark 2010, p. 41.
[14] Staub 2006, p. 868.

counselling). But despite the fact that it is generally recognized that traumas can cause social dysfunction and that the genocide has left a significant share of the population psychologically scarred, very few studies have investigated how trauma impacts on social behavior in the post-genocide world. A few studies have probed into the social realm and explored how various therapeutic interventions can alleviate emotional suffering and address the strained social relations as a result of mass trauma.[15] But as yet, it remains unclear how trauma has affected and altered social interaction in the aftermath of such a destructive episode of violence.

The vast reconciliation effort initiated by the Rwandan government after the genocide has sparked a commensurate wealth of literature. In the same vein that the Rwandan government casts reconciliation primarily in national/political terms, most scholars have taken a similar top-down perspective as well. However, this approach neglects the individual and interpersonal component of reconciliation and omits the question whether the reconciliation process is in tune with personal healing processes. Although healing and reconciliation are two terms often used in concert, it remains unclear whether the reconciliation effort in fact benefits the healing process. Does it alleviate suffering, or is it insufficient in responding to the exigencies of emotional healing?

Any examination of mass trauma is incomplete without taking into account how trauma is regulated and mitigated through psychological care and counselling. How have the government as well as non-governmental organizations (NGOs) addressed this pressing issue of 'mass trauma'?[16] Research in this regard is negligible, save from a cursory overview of the person-centered approach in the Rwandan mental health care sector.[17] A focus on how has trauma been mediated by psychological care and counselling and how this has reconfigured post-trauma social dynamics leads to a better understanding of how these programs and interventions can contribute to the reconciliation process.

This research intends to fill these voids and connect the respective dots. In doing so, I address the following main research question:

> To what extent have traumas acquired during the Rwandan genocide (1994) posed an impediment to the inter-ethnic reconciliation process in post-genocide Rwanda (1994-2015)?

To answer this question I will address the following sub-questions:

1) How is the reconciliation process conceived in Rwanda and what role does trauma play within this process?
2) How does trauma manifest itself in Rwanda and how does this affect social dynamics?
3) How has trauma been addressed since the aftermath of the genocide and what does this mean for the reconciliation process?

[15] c.f. King 2011; Richters 2009; Richters et al. 2010.
[16] Throughout this thesis, I refer to mass trauma to denote a society with a significant number of traumatized individuals. As will become evident in the next chapter, in instances where so many are psychologically scarred as a result of mass violence, this poses grave consequences for social interaction and dynamics.
[17] Kayetishonga 2012b.

The purpose of this research is thus to investigate the link between trauma and reconciliation by looking at how trauma affects everyday life and how psychological and psychosocial interventions in Rwanda have addressed this phenomenon.[18] How is trauma represented, manifested and managed at every level of society and what does this mean for social interaction and dynamics that coalesce into the grander reconciliation process? The sub-questions address the representation, manifestation and management of trauma more specifically by looking at various social levels – individual, familial, community and national – and how these levels interact with one another.

This thesis is structured as follows. Chapter II postulates a theoretical framework that explicates in particular how trauma affects social interaction and, at a macro level, how it affects post-conflict societies in general. Chapter III puts the Rwandan reconciliation process in context, in particular by emphasizing how three foundational elements of the national reconciliation strategy – justice, memorialization and commemoration, and identity formation – coincide with many lingering traumas. Chapter IV examines the prevalence of trauma in Rwanda, how it is experienced in daily life and how this affects social dynamics at various social levels. Chapter V illustrates how the government has facilitated psychological care while Chapter VII describes how NGOs have addressed trauma. Chapter VII concludes this thesis and summarizes the findings through a critical engagement with the theory and lists a number of recommendations.

[18] In this thesis, I use terms such as trauma counselling, relief, psychological care and synonymous terms interchangeably to refer to any application of trauma relief. In cases where I explicitly wish to differentiate between one approach, I adopt the terms clinical care and psychosocial interventions to refer to any specific type of care (the exact implications of each will become evident in this thesis).

Chapter II - Trauma and reconciliation

Violent conflict impacts heavily on society. Individual and social identities are undermined, human dignity is compromised and a general climate of fear and mistrust develops. Mass violence creates ripple effects that shatter political, economic and social relationships as entire societies are traumatized and the social and political fabric is severely ruptured.[19] After episodes of mass conflict, violence can become normalized in daily life and as social cohesion plummets, the likelihood of future violence increases.[20] Statistics show that such a relapse in domestic violence is very likely. Of the 103 countries that experienced civil war in 1945-2009, 44 countries experienced a return to domestic conflict. This pattern seems to increase over time: all the civil wars that erupted during 2003-2009 were continuations of previous conflicts.[21] Because so many states experience a relapse in violence, many regimes preach reconciliation in an effort to avoid such a cataclysm.

Through reconciliation, a 'transitional society' aims to prevent such a relapse and pave the way towards a brighter, peaceful future. A recurrent theme in the literature of reconciliation is that of healing,[22] although it is less clear who exactly needs healing and what needs to be healed.[23] Is it the individual suffering from psychological ailments, or is there something beyond the pathological manifestation of trauma that affects society as a whole?

Although in many post-conflict societies that engage in a reconciliation effort the population is referred to as being traumatized, the link between trauma and reconciliation has not been clearly explicated in the academic literature. When trauma and reconciliation are considered to be related, scholars usually speak of collective trauma. However, I find the concept of 'collective trauma', as it is typically invoked (for instance in the context of the Holocaust or Afro-American slavery), [24] a rather vague concept that is not particularly well suited to establish causality. In particular, given the concept's exclusive focus on trauma as identity formation, it does not elucidate how large-scale psychological ill-health as a result of mass violence affects social dynamics. Because the concept does not encapsulate many of the psychosocial consequences of trauma, it is insufficient in detailing how trauma and reconciliation interact. To date, and to my knowledge, no comprehensive efforts have been undertaken to construct a framework for how psychological traumas affects social relations and reconciliation in post-conflict societies in particular.

The following framework aims to close this gap. This provides a basis for positing mental health care and psychosocial recovery as means to reconciliation in post-conflict societies. Moving beyond the mere pathological manifestation of trauma at the individual level (e.g. intrusions, flashbacks, distress), I question how communities and even whole societies are transformed as

[19] Hamber 2001, p. 131.
[20] Wessels, 2009, p. 349; Abramowitz, 2014, p. 15.
[21] Gleditsch et al. 2002.
[22] C.f. Martz 2010, p. 1; Hamber, Gallagher & Ventevogel, 2014.
[23] Parent 2010, p. 277.
[24] E.g. Alexander 2004.

new modes of social interaction develop, the normative environment is shattered and traumatized individuals are at paints to reintegrate into society.

I. What is reconciliation?

There is no consensual definition of reconciliation. Part of the reason for this is that the dynamics of reconciliation arise from the dynamics and context of violence, which varies across cases. Another reason is that scholars disagree on the necessary conditions from which reconciliation is thought to ensue. For instance, John Paul Lederach asserts that reconciliation can only occur in spaces in which the conditions of truth, mercy, justice and peace are satisfied.[25] Others stress the emotional significance of peacebuilding, in particular the need for empathy[26] or trust-building.[27] Daniel Bar-Tal emphasizes the cognitive dimensions of conflict and suggest that reconciliation is dependent on an ethos of peace[28]. Finally, Herbert Kelman asserts that this process is ultimately one of identity change.[29] For him, reconciliation is different from conflict settlement and resolution and he conceives "conflict settlement as operating primarily at the level of *interests*, conflict resolution at the level of *relationship*, and reconciliation at the level of *identity*".[30] However, not only does this distinction fail to appreciate the connection between relationships and identity, it also implies a mechanical causality between identity formation and reconciliation. Certainly, given that many contemporary conflicts - including the Rwandan genocide - are identity-based, a focus on identity within the reconciliation process seems logical. What is most relevant, however, is how identities are represented, perceived and how they define inter-group interaction. Such a focus on identity signifies the attitudes and worldviews of groups and these mindsets are foundational in social dynamics. Engagement with individuals or groups is not likely if an individual or group is fearful of or does not trust the other. This fear or lack of trust stems from socially constructed views about particular identities. I argue, therefore, that what separates both identities – i.e. the psychological orientation of the out-group – is the main determining factor in the social dynamics between both groups.

Scholars have also expressed different perspectives on where reconciliation should lead. Some authors have hinted at 'ultimate reconciliation',[31] whereas others take a far more tentative approach, suggestion that reconciliation is not always feasible and that in some form the past will continue to loom over society.[32] In this thesis, I too will adopt a less ambitious approach. The case of Rwanda, as will be illustrated in this thesis, makes evident that while people can learn to live with the burden of the past, the past can never be erased. As it will continue to effect social dynamics for years to come, it would be unrealistic to think that a state of blissful peace can be

[25] Lederach 1997, p. 31.
[26] Halpern & Weinstein 2004.
[27] Nadler & Liviatan 2006.
[28] Bar-Tal, 2000
[29] Kelman, 2004.
[30] Ibid. 2004, p. 117.
[31] e.g. Kelman 2010.
[32] e.g. Hamber 2009.

achieved in the near future, if ever. The focus should therefore be on crafting ways of dealing with trauma and developing new modes of co-existence.

A plethora of definitions of reconciliation have been proposed, but I find that the International Institute for Democracy and Electoral Assistance (IDEA) offers the most thorough and instructive definition of reconciliation:

> "As a backward-looking operation, reconciliation brings about the personal healing of survivors, the reparation of past injustices, the building or rebuilding of non-violent relationships between individuals and communities, and the acceptance by the former parties to a conflict of a common vision and understanding of the past. In its forward-looking dimension, reconciliation means enabling victims and perpetrators to get on with life and, at the level of society, the establishment of a civilized political dialogue and an adequate sharing of power."[33]

As post-conflict societies experience a rupture in their continuity, they will often refer to their histories into a pre-conflict, conflict, and post-conflict trichotomy. This is why the distinction between reconciliation as both a backward- and forward-looking process is so important. Not only is coming to terms with the past essential, but this reckoning provides the basis on which a forward-looking dimension can be established. The definition also differentiates between individuals and society. Reconciliation processes are often cast in national and political terms. But such a top-down perspective overlooks the fact that at the individual level there may still exist deep grievances and sentiments that are only loosely connected to the national/political process. The effect of the public politics of reconciliation may therefore be completely lost to individuals, for instance those who feel that justice elides them.[34] As a consequence, reconciliation can vary substantially across cases and spaces (e.g. at the local, national and international level),[35] as macro-level processes are contingent on interpersonal trust and the degree of cooperation within society.[36] In this thesis, I adopt a bottom-up approach where the individual is the locus from which reconciliation ensues and where the sociocultural context plays a large role in facilitating the reconciliation process.

An often invoked theme in the reconciliation discourse, particularly in Rwanda, is that of forgiveness. The popular assertion is that forgiveness invariably leads to healing. But such a position neglects that the capacity to forgive is contingent first of all on the agency of an individual. As trauma compromises one's agency, the capacity to forgive is compromised too. In addition, the inclination to forgive is not likely to be present in cases where individuals still struggle with their psychological wounds, whereas a general sense of psychological well-being is linked to having more favorable attitudes towards reconciliation.[37] As long as traumatic events continue to impact upon one's mental well-being, unresolved emotions such as fear and anger

[33] Bloomfield, Barnes & Huyse 2003, p. 19.
[34] Mukashema & Mullet 2012, p. 122.
[35] Parent 2010, p. 279.
[36] Govier (cited in Kohen, Zanchelli & Drake, 2011, p. 11)
[37] Mukashema & Mullet 2012, p. 127.

will obstruct any inclination to forgive. Addressing trauma thus constitutes the first step before one can proceed to a genuine act of forgiveness and move towards healing.

II. What is trauma?

Mental health is intrinsic to health and corresponds closely with one's behavior. The World Health Organization (WHO) defines mental health as "a state of well-being in which the individual realizes his or her own capabilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community".[38] But violent conflict such as the Rwandan genocide transcends the "normal stresses of life" above and beyond. In this context, psychological traumas and stress disorders can seriously impede an individual from reintegrating into society and the economy, as well as pose major difficulties within a family household. In places where so many are psychologically scarred by the events, communities become dysfunctional too, as many people turn inward as a result of their traumas and the general climate of fear and distrust.

Individuals may suffer from a wide array of symptoms, typically of a psychosomatic or dissociative nature, that are commonly labelled under three headings: re-experiencing, avoidance and hyperarousal. *Re-experiencing* entails heightened sensory impressions and/or nightmares (intrusions) during which the trauma is re-lived vividly.[39] *Avoidance* refers to strategies typically used by traumatized individuals to avoid thoughts and re-experience of anything related to the trauma. Most common in this regard are numbing symptoms (e.g. loss of interest in activities, affect and engagement in social relations). *Hyperarousal* refers to generally psychosomatic symptoms where serious physiological reactions are triggered; e.g. hypervigilance, anxiety and agitation, insomnia, startle reactions, tension headaches, nausea, tremors, chocking sensations and abdominal, back or pelvic pain.[40] People who have experienced multiple traumatic events are more likely to develop mental disorders or experience exacerbated traumatic symptoms.[41] Clearly, these symptoms complicate social engagement as trauma not only triggers fear and distrust, but the lack of interest in (social) activities and affect seriously impedes any social interaction. In addition, psychosomatic complaints may bound individuals to their homes or cause a loss in productivity, potentially leading to unemployment and/or poverty, which severely diminishes one's social integration.

Additionally, the cognitive state of a traumatized individual is altered through the practice of dissociation, resulting in a loss of personal identity, hallucination and disturbances in memory, concentration and time sense. As a result, traumatic memories catalyze a dialectic between past and present, where the traumatic events continue to affect individuals in their daily life.[42] Traumatic experiences leave survivors feeling powerless,[43] isolated and with bleak outlooks to the

[38] Herrman & Swartz 2007, p. 1195.
[39] Herman 2001, p. 37.
[40] Schönenberg 2013: 74; Shock & Knaevelsrud, 2013: 61
[41] Suliman et al., 2009; Green et al., 2000; Breslau et al., 2014.
[42] Porter, 2007.
[43] By survivors I refer to anybody who felt their physical and/or psychological integrity significantly compromised during the genocide, for instance by being attacked, escaping death or witnessing traumatizing events.

future, all of which destabilizes their interest in social engagement.[44] Their sense of personal integrity, identity and safety as well as the predictability of the world is severely shaken. The outside world is no longer comprehensible to them as long-held assumptions and beliefs are shattered as a result of the violence. [45] The individual no longer feels invulnerable as the external world transforms to a place of stress and anxiety. Thus, after major traumatic events, any illusion of safety or security is broken and social order ruptures.[46] As trauma amplifies feelings of fear, mistrust and aversion towards the out-group held responsible for the violence committed, the process of reconciliation is seriously impeded.[47]

Cross-cultural variations of trauma

In charting mental health issues, aid workers have generally relied on Western diagnostic tools. The most prominent construct – post-traumatic stress disorder (PTSD) – has attracted a lot of criticism in particular.[48] Common critiques include: its slight regard for the socio-political, cultural and historical context and its Western 'clinical' paradigm that disregards local approaches to healing. For instance, it has been argued that the concept clashes with traditional African healing practices that revolve around transforming the self by transforming the structures within which one operates. African societies emphasize (inter)dependence between families and communities and regard sociality as a platform within which the self can be expressed.[49] In Rwandan culture, too, the family and community are central elements within the social cosmology. Here, individual identities are closely bound up with the social environment and there is a strong sense of group belonging.[50] It has also been argued that the 'medicalized' category fails to appreciate the manifestation of and the meaning accorded to trauma, which is considered to be vital for healing.[51] My personal objection with the sole use of mental health diagnostic constructs such as PTSD is that because it quantifies trauma, it neglects how exactly trauma is experienced at a deeply personal level. In particular at societal level, such a perspective fails to appreciate how social dynamics are transformed as a result of mass violence and what resultant challenges lie ahead in the reconciliation context.

The purpose of this framework is not to discuss the validity of either approaches. Indeed, mental health professionals have argued that the clinical and social approach may well work in concert with one another.[52] However, I do note that the individualistic perception of psychological distress hides the permeability of trauma into the social realm. In particular in a reconciliation context, where social dynamics are highly relevant, the individualized and isolated notion of trauma is insufficient in capturing how mass trauma affects society. As individual pathologies fail to take into account the socio-political and historical context in which the violence occurred and

[44] Williamson 2014, p. 123.
[45] Staub, Pearlman, Gubin & Hagengimana 2005, p. 299.
[46] Edkins 2003, p. 4.
[47] Herman 1992, p. 380-382.
[48] Young & Breslau, 2007; Summerfield, 1999; 2001; Burstow, 2005.
[49] Palmer 2002, p. 22.
[50] Williamson 2014, p. 98-106.
[51] Hamber, 2009, p. 21.
[52] Scholte 2013, p. 150.

present suffering is located,[53] the 'clinical' paradigm does not fully capture the link between trauma and reconciliation. In contrast, a 'psychosocial' trauma paradigm locates the impact of violence in the social realm and addresses individual and social suffering together.[54] This paradigm incorporates attenuating factors such as poverty and injustice that add to the psychological burden of affected individuals.[55] According to this paradigm, the reaction to a traumatic event is determined in large part by the historical and cultural context in which the individual lives, and proponents argue that treatment should focus on drawing on the broader sociocultural context rather than 'pathologizing' the individual.[56] Thus, interpreting the traumatic event cannot take place without accounting for the community context as well.

III. The trauma-reconciliation nexus

As individual lives are constituted by way of the many social contexts in which the individual is involved,[57] the most devastating effects of violence are not on individuals per se but on the interrelationships that constitute their daily lives.[58] As a consequence of mass violence, traumas pose malignant effects on society, as social relationships are strained, social activities disrupted, social structures damaged, value systems fractured and economic productivity suffers a blow. Mass violence leads to a breakdown of personal outlooks and social values which turns the social climate into one of fear and distrust. People's sense of identity are uprooted and make way for experiences of victimhood which engender collective emotions of grief, fear, anger, distrust and revenge, which can give rise to new forms of social antagonism.[59] In addition, social networks and other support mechanisms to which they normally turn are shattered, leading to disempowered individuals and fragmented communities.[60]

The trauma membrane

The effects of psychological distress can thus affect the relation of the individual and their social realm. More accurately, trauma can severely disrupt social worlds by damaging family, social and political dynamics.[61] Research by Rosenquist, Fowler and Christakis suggests that depression can spread across social networks and that the strength of this 'contagion effect' depends in particular on the social distance between individuals. Close friends and family members were more likely to be affected by depressive symptoms than colleagues with whom one has a strictly professional relationship. Women were more influential in this regard than men on account of being more emotionally expressive.[62]

Exactly how trauma creates such ripple effects is best explicated by the 'trauma membrane', the mediating interface between the person and the traumatic reminders within the external world. A

[53] King 2011, p. 11.
[54] Ibid., p. 131.
[55] Abramowitz 2014, p. 13.
[56] DePrince & Freyd 2002, p. 77.
[57] Rudkin, cited in Levers et al. 2006, p. 262.
[58] Jackson, cited in Richters 2009 p. 175; Abramowitz 2014, p. 14.
[59] King 2011, p. 27; Bar-Tal 2000; Hughes & Pupavac 2005.
[60] Ajdukovic 2004, p. 121.
[61] Abramowitz 2010, p. 362-363.
[62] Rosenquist, Fowler & Christakis 2011.

psychosocial buffer zone, the trauma membrane comprises intrapsychic, interpersonal and communal processes that protect individuals and communities from being overwhelmed by the trauma and allow for the trauma to be processed.

At the intrapsychic level, the individual forms a protective psychological barrier around traumatic memories in order to facilitate the healing process or circumvent obtrusive memories. For instance, the individual also dictates who is allowed access to the traumatic memories as a way of regulating which elements would facilitate healing.[63] Internal defenses, such as denial, disbelief, dissociation, and disavowal, act as the regulatory mechanisms within this membrane.[64] While individuals may differ in their susceptibility to developing psychological distress, the trauma membrane is always present in regulating the effect of trauma on the individual, family and community. At the individual and interpersonal level, the trauma membrane consists of both conscious strategies to try to avoid any intrusions that may affect their behavior and functioning as well as unconscious side effects of trauma that can affect their behavior and functioning.

The interpersonal membrane mediates between traumatized individuals and their close social environment. The family is typically the closest environment and the effects of trauma can be strongly felt here: inconsolable children, abusive husbands and irresponsible mothers are common characteristics of families affected by trauma. Outside the family environment other social peers can play a role in regulating trauma too; friends may be able to alleviate some of the psychological stress, whereas enemies or members of the hostile group may trigger traumatic symptoms.

At the community level, these ripple effects of trauma can disrupt social relations as fear, distrust and animosity permeate into the larger collective. At this level, we may speak of the sociality of trauma, which "can be thought of as the performance of trauma, as manifestations of trauma [...] or as the externalization of trauma".[65] Here, the trauma membrane is constituted in particular by the socio-political and cultural context as well as the recovery environment that provide a structural environment in which trauma is regulated. Cultural practices regarding how traumatic and emotional expressions are evoked are a clear example how the cultural context influences the way trauma is expressed at the communal level, whereas the way traumas can be expressed within national reconciliation strategies and events evokes how the socio-political context shapes the way trauma is regulated. The recovery environment (i.e. social support structures and trauma relief) can do much to assuage the effects of trauma.

Because trauma wields a significant force on the social realm, the external world is highly influential in regulating trauma through protective factors and risk factors.[66] Risk factors, or stressors, can compound the psychological ill-health of individuals significantly. Especially in the aftermath of violence, a plethora of issues, events and structural conditions – e.g. poverty, injustice, alcohol and drug abuse, additional trauma, dire life conditions, social marginalization, denial of suffering by others, etc. - can compromise the delicate psychological state of affected

[63] Martz 2010, p. 35.
[64] Ibid.
[65] Abramowitz 2014, p. 5.
[66] Levers et al. 2006, p. 262.

individuals and consequently strain families and communities alike. [67] These effects can create additional stressors that add to the psychological burden that people already face. For example, unemployment typically leads to lower reported levels of psychological well-being.[68] While not everyone is equally susceptible to developing psychological trauma, these stressors play a significant role in shaping the extent of trauma. In order to avoid such vicious cycles in which traumatized individuals are trapped, more comprehensive trauma interventions have developed over the past two decades that also target these additional risk factors (e.g. education, employment support).

Risk factors can lead to vulnerability and passivity, to 'helpless victims', where *resilience* can lead to 'empowered survivors' and can be enhanced by reinforcing the protective environment.[69] Trauma therefore does not mechanically imply malignant effects on and dysfunctionality among individuals and within society. Indeed, others learn to cope with the intrusion of their past into the present or even transcend themselves through a process of 'post-traumatic growth'. It is well-known that as a result of the genocide, with so many men slaughtered, women have come to take up new roles in society. For instance, Rwanda is often lauded for the high number of women in Parliament and many women are engaged in associations that bring together widows and survivors of rape and help foster their resilience. Where individuals regain control over their lives by utilizing the protective factors around them, they show resilience, or the capacity of individuals and collectives to meet their psychological, social and physical needs that allows them to sustain their mental and physical well-being.[70] An individual's resilience determines their ability to cope with the traumatic experiences and maintaining their psychological integrity.[71] But resilience can also be found at the communal level, where it is associated with the resources and support structures employed in in order to maintain the community's integrity.[72] Here, the adverse effect of stressors can be avoided or mitigated by protective factors that originate from social support systems (family, friends, etc.) or support structures (e.g. relief programs).[73] Through social support, an individual's suffering can be acknowledged and shared, and they can find a sense of belonging in doing so. Trauma relief programs are a clear example of how protective factors can contribute to one's psychological well-being. For instance, traumatized children in day-care centers where their basic needs are met are a clear example of how protective factors mediate the trauma that would otherwise be compounded by a lack of clothing, food and security.

Victimhood

Survivors may also come together to form an inclusive community-wide trauma membrane. [74]

[67] Palmer 2002, p. 21.
[68] McKee-Ryan et al., 2005.
[69] Levers et al. 2006, p. 268.
[70] Ungar, cited in Dushimirimana, Sezibera & Auerbach 2014, p. 220.
[71] Lambourne & Gitau 2013, p. 26.
[72] Ibid.
[73] The Johns Hopkins and the International Federation of Red Cross and Red Crescent Societies n.d., p. 208-212.
[74] Lindy, Grace & Green, cited in Martz 2010, p. 34. (2014).

Here, a victim identity provides a protective function for survivors that imbues them with a sense of security and acknowledgement of their suffering. But such a victim consciousness also has important implications for the reconciliation process. Finding commonality with the out-group through common perceptions, emotions, beliefs and attitudes is a key component of reconciliation.[75] Yet finding commonality is complicated during processes where victim identities are forged in which the out-group is excluded.

Vollhardt and Bilali's distinction between inclusive and exclusive victim identities is particularly helpful here. Exclusive victim identities refer to instances where the suffering is presented to be unique and isolated from other groups. Exclusive victim identities are typically the result of competitive claims over victimhood where different groups argue for acknowledgement of the uniqueness and degree of their suffering. Inclusive victim identities refer to instances where the suffering is not necessarily presented as unique and the suffering of others is also acknowledged. The distinction between both is highly relevant to reconciliation, as the authors found that an exclusive victim identity was associated with negative intergroup attitudes, whereas inclusive victim identities were linked to positive intergroup perceptions.[76] These findings have been supported by similar research in which a common victim identity was fostered among Israeli Jews and Palestinians, leading to decreased competitive victimhood and more favorable attitudes towards forgiveness.[77] Often, however, political discourses reinforces victim consciousness, in which case the prospects for reconciliation are severely diminished.

Pre-requisites for reconciliation

According to the IDEA, four essential conditions for reconciliation can be discerned.[78] Each of these conditions ties in with the consequences of trauma and the necessary conditions for healing. Ideally, these conditions arise sequentially, although they are by no means mutually exclusive and will overlap in practice.

i. Absence of fear

At the very least, there must be a general absence of fear. In order to re-engage in community life, people must first feel secure in the presence of others. Politically, an effective government needs to be able to indiscriminately ensure the safety of its citizens through the rule of law with due respect for human rights. Especially in the aftermath of mass violence, the normative environment is severely shaken. Through the rule of law, the normative and moral environment can be stabilized. Human rights are of particular importance, as they can promote mass social change, normative correction and social reintegration.[79] Yet this absence is not only contingent on the political stability in any given community or polity, but also on the state of mind of traumatized individuals. Fear is the central reaction to traumatic events and pathological fear is at

[75] Zembylas 2007, p. 208.
[76] Vollhardt & Bilali 2014.
[77] Schnabel, Halabi & Noor 2013.
[78] Bloomfield, Barnes & Huyse 2003, p. 19
[79] James, cited in Abramowitz 2014, p. 191.

the core of post-traumatic distress.[80] As violence communicates to victims their relative value as a human being and their place in society,[81] victims of violence thus feel subjected and this feeling feeds into their sense of insecurity. It is imperative, therefore, that survivors become aware of their security.

ii. *Trust*

Violent conflict shatters trust. When people are betrayed by others who they assumed to be trustworthy, one of their core assumptions in their personal outlooks is shattered.[82] After mass violence, people see hazards and dangers rather than a comfort zone. They become socially disconnected as political trauma breeds insecurity and distrust,[83] which restrains individuals from engaging in social life. This leads to social cleavages that divide society further and can consequently undermine the legitimacy and effective functioning of the state as well as civil society. As contact often reduces negative feelings towards out-groups and may even enhance positive feelings towards them,[84] trust-building measures must ideally include both parties so that they can learn to re-engage with each other. Obviously, for contact to ensue a certain degree of trust must first be attained, which arises from the general absence of fear. After this threshold is reached, contact and trust become mutually supportive.[85] Trust is therefore pivotal in rebuilding fractured communities as it facilitates engagement with the out-group.

iii. Empathy and sympathy

In particular after instances of genocide, where the targeted population is usually dehumanized in the words and deeds by the perpetrators, an appreciation of the victims' humanity serves as one of the first steps towards establishing normalcy in society. Empathy allows one to identify with another person and accept another person's narrative of past events, even though this may be incongruent with one's own beliefs. Like trust, empathy develops within a social space where both parties are involved and is pivotal in fostering a renewed psychological orientation of the out-group. Empathetic concern for the other thus leads to a recognition of their humanity and allows for the restoration of commonality between the two.[86] Recognizing another's humanity includes recognizing the violence and abuse to which they were subjected. In the absence of acknowledgment, victims are less likely to find closure and therefore show a decreased willingness to reconcile.[87]

iv. Recovery environment

In many post-conflict settings, social support systems are damaged. People can generally become more inward-looking after events of mass violence as people come to inhabit a climate of fear and

[80] DePrince & Freyd 2002.
[81] Hamber, 2009, p. 23.
[82] DePrince & Freyd 2002, p. 75.
[83] Staub 2006.
[84] Pettigrew, 1998.
[85] Hutchinson & Bleiker, 2008, p. 387.
[86] Halpern & Weinstein 2004, p. 308.
[87] Vollhardt, 2014.

mistrust and become more isolated themselves as a result of their traumatic experiences. The rule of law and civil society are fragile. Family members and friends, the first ones to provide emotional support for traumatized victims, may have been killed, further adding to the 'trauma cocktail'. In addition, in cases of mass trauma most people may not bother asking for support considering the burden others toil with.

The social environment must surmount these challenges and become conducive to the healing process by providing some relief and support to facilitate the healing process. Its members must not shy away from providing social support structures, which can be more easily developed and maintained through an effective civil society. The recovery environment comprises both social support systems (family, friends, etc.) with whom traumatized individuals can share some of their suffering and find a sense of belonging as well as support structures that provide a protective environment and mitigate some of the stressors (e.g. poverty) that compound the psychological ill-health of these people.

Trauma counseling and reconciliation in practice

In practice, this would require a climate where the harm of survivors is acknowledged and respected and a pro-active approach to restoring social relations is stimulated. In such a setting a decent outlet for the grief can develop where the past can be adequately addressed. Interaction between the former opposed parties is essential here. Through interaction, agreement that carries higher levels of commitment can be reached, basic needs and fears are addressed, a degree of trust is built, new relationships are forged and public support for the agreement as well as renewed and more positive psychological orientations of the other develop.[88]

Trauma counseling and psychosocial interventions can do much to alleviate suffering, but in order to contribute to reconciliation they must be premised on creating interactive spaces where both sides actively engage in empathy and compassion so as to work towards a more unified configuration of community. This space must provide a stage on which negative emotions such as fear and hatred can be transformed into more positive emotions, such as empathy and optimism, which ultimately lead to a less divisive sense of identity and community. Another advantage of this approach is that it takes place in a depoliticized setting, where victimhood is not as likely to become a rallying cry for demands of certain rights and compensation.

IV. Conclusion

Political violence does not only create physical damage. This framework has discussed the pathological manifestation of trauma and its implications, but also moved beyond to discuss the transformative power that trauma wields on behavior and social interaction. As social relationships are ruptured and an individual's sense of reality, meaning and belonging is undermined, the obstacles of reconciliation only seem to mount. New identities and modes of interaction and ways of dealing with the outside world develop as a result of mass trauma. Ways of dealing with the traumatic legacy must therefore be tailored according to an understanding of

[88] Kelman, 2004, p. 118.

the events and their meaning. Accordingly, the process of reconciliation is highly idiosyncratic and care should therefore be taken to avoid adopting a 'blueprint for reconciliation'. I do argue, however, that there are some requisite components for reconciliation to progress: a general absence of violence and fear, trust-building measures, a more empathetic stance towards the out-group and a robust recovery environment.

In this framework, I have focused on how wars can continue to inhabit the mind even years later and continue to affect people in daily life. I have emphasized how the effects of trauma can permeate into the social world. The trauma membrane, constituted by individual strategies of dealing with trauma, the social environment and risk and protective factors, regulates traumatic symptoms and explains how traumatic repercussions can reach beyond the individual. This is particularly true in the case of mass violence and resultant mass trauma. I have argued that dispelling or alleviating the psychological burden of many traumatized individuals can pave the way for acts of forgiveness and a renewed, more positive psychological orientation of the out-group.

Rather than employing a top-down approach in which the reconciliation process is captured as being inherently national and political, I have argued that the primary locus from which reconciliation should ensue is the individual. In order to advance the reconciliation process, what is needed is to detach the individual from politics, to perceive of them as ends in themselves rather than a means to effect a more peaceful society. Psychological healing offers such a strategy, although closure is always partial and is never complete. The traumatic memory will remain, but one can learn to cope with the grief and continue to lead a more fulfilling life. The same is true of a society haunted by the legacy of the genocide: the past can, nor should, ever be forgotten, but it is not impossible to live in peaceful or even harmonious co-existence thereafter.

Chapter III – Ubumwe n'ubwiyunge: reconciliation in Rwanda

Reconciliation has become a central feature of post-genocide Rwanda and is actively pursued by the Rwandan government. Indeed, the efforts of this 'Government of 'National Unity' to instill *ubumwe n'ubwiyunge* ('reconciliation and unity') in its nation are ubiquitous. One is hard-pressed to escape the overwhelming presence of the genocidal legacy: memorials litter the country, entire communities were involved in the process of mass justice and a renewed, national identity is imposed on the people. Rwandans continue to live scattered over the country and in mutual dependency. [89] Life in the hills, in particular, is characterized by intimacy.[90] Thus, in the absence of a clear geographical divide, reconciliation seems to be the sole option for moving towards the future.

According to President Paul Kagame, reconciliation "really means [thinking about] why we have done what we did",[91] but this reflective approach to reconciliation is hardly congruent with the authoritative peace-building strategies by the government. This remark notwithstanding, a clear vision of what reconciliation in contemporary Rwanda should look like according to the government remains elusive. Furthermore, despite acknowledgement that "every Rwandan has their own wounds",[92] the reconciliation effort in post-genocide Rwanda is primarily based on a one-sided (i.e. Tutsi) victimization as well as a national and political process. There is little regard for individual grievances and interpersonal reconciliation and this proves a significant obstacle to peacebuilding at the national level.[93]

Much of the reconciliation effort is organized and monitored by the National Unity and Reconciliation Commission (NURC) which was established in March 1999 and whose main goal is "the achievement of a unified country".[94] In 2012, the NURC published a report stating that "reconciliation in the country has increased 80 [by] percent, the highest level of national harmony since the 1994 genocide against the Tutsi" adding that "we are now embarking on the remaining 20 percent".[95] Exactly what an 'increase in reconciliation' means is left open to interpretation and the implied assertion that it is possible to reach a state of '100 per cent reconciliation' is questionable too. A more recent report of January 2016 stated that 92.5 percent of Rwandans believed that reconciliation has been achieved and social harmony restored.[96] Similar progress

[89] Ansoms 2012, p. 437.
[90] Buckley-Zistel 2008b, p. 14.
[91] Foreign Policy 2014, p. 42.
[92] Purdekova 2015, p. 142.
[93] Kohen, Zanchelli & Drake 2011.
[94] National Unity and Reconciliation Commission (n.d.-a). Not only is the Commission tasked with designing and implementing measures aimed at reconciliation, it also "monitors how public institutions, leaders and the population in general comply with the National Unity and reconciliation policy and principle". As we will see in this chapter, the oversight on compliance with the reconciliation effort is very strict.
[95] Kabeera 2012. The survey (Rwanda Reconciliation Barometer 2010) reported here involved a sample of 3.000 participants. Subsequent reports by the NURC have reported gradually increasing levels of popular satisfaction, an issue I will revisit later in this chapter. In addition, the levels reported in the reports are suspiciously high and do not align with many other reports and scholarly work concerning the reconciliation process in Rwanda.
[96] Jean Louis 2016. This survey (Rwanda Reconciliation Barometer 2015) involved a sample of 12.000 respondents spread over 60 sectors (Mugabo 2015a). At the time of writing, the 2015 Reconciliation Barometer report was not yet available.

was noted for other criteria too: 22.5 percent of Rwandans still believe that genocide may ensue under certain conditions, a 17.5 percent decrease since the last gauge.[97] But not only are the numbers cited extremely positive and contradict observations that I will review in this chapter, they also indicate of trend of continuous improvement. This suggests that, as long as reconciliation remains incomplete yet progress continues to be made, the regime legitimizes itself partly through the reconciliation effort. Having ended the hostilities in 1994, the government presents itself as the harbinger of peace, and the genocide serves as the core legitimizing aspect of the current regime.

The purpose of this chapter is to provide an understanding of the reconciliation process in Rwanda so far, both in terms of strategy and its effects. In Rwanda, as we will see, human conduct is tightly configured along the state's interpretation of the genocide, providing a significant legitimacy boost to a government that owes its power mainly through the 'genocide credit'.[98] Rwanda remains very much a country in transition, where the past is invoked to legitimize the present-day regime and to construct a vision of the future in order to command civic obedience. Many Rwandans have also argued that the Rwandan government uses the lingering traumas to discredit the former regime.[99] While this, in itself, may not be particularly controversial, in this chapter I argue that traumas are being used primarily for political purposes by fostering an exclusive victim consciousness among many survivors that is used to legitimize the current regime. This observation is highly relevant in light of the reconciliation process, which is conceived primarily in national and political, rather than interpersonal, terms in Rwanda.[100] I argue that the most prominent pillars of the reconciliation strategy in Rwanda maintain, rather than assuage, the many lingering traumas in Rwanda and that this poses a major obstacle to the reconciliation process as it severely affects social dynamics in daily life. In doing so, I discuss how the political and economic context, a system of grassroots justice (*gacaca*), commemoration ceremonies and memorials as well as the state's de-ethnicization process affects the reconciliation process and how it suppresses personal emotional healing.

I. Post-genocide politics

The socio-political and economic context has important implications for the reconciliation process as it affects how individuals perceive their worlds as well as other people and their actions.[101] To many observers, Rwanda stands as a model nation of successful post-conflict reconstruction.[102] Presiding over this model example is President Paul Kagame. Though hailed as a 'successful leader'[103] and credited with having "forged a strong, unified and growing nation with the potential to become a model for the rest of Africa and the World",[104] Kagame's RPF-regime

[97] Jean Louis 2016..
[98] Strauss & Waldorf 2011, p. 12.
[99] King 2011, p. 169.
[100] Bagnetto, L.A. 2014. Williamson 2014, p. 175; Hatzfeld 2007, p. 212.
[101] Burnet 2012, Ch. 4, Loc. 3694.
[102] Longman 2011, p. 25
[103] The Economist 2010.
[104] Kagame received the Global Citizenship Award by the Clinton Foundation in 2009. Source: Reyntjens 2012, p. xiii.

follows the Rwandan tradition of authoritarianism.[105] Ostensible displays of 'benevolent leadership'[106] hide the daily reality that citizens are coerced into complying with government-imposed codes of conduct. Even more disconcerting, while the government's prides itself as having ceded the hostilities in 1994, the regime has been involved in large-scale reprisal killings. After the genocide, hundreds of thousands of refugees as well as the remnants of the genocidal regime alongside other Hutu extremist groups (e.g. *Interahamwe*) fled to the North and South Kivu regions in former Zaire, the current Democratic Republic of the Congo (DRC). Collectively known as the *Forces armées rwandaises* (FAR), by early 1995 the groups started launching coordinated incursions into their former homeland to regain control. This provided the rationale for the RPF-regime in Kigali to invade the DRC in October 1996, replacing the dictatorial Mobutu Seseko with Tutsi rebel leader Laurent-Désiré Kabila. Backed by the RPF, Kabila secured control over the country through a violent crackdown of the remaining Mobutu strongholds and in May 1997 declared himself president and proclaimed the Democratic Republic of the Congo. Though presented as a security issue given Zaire's instability, reports by the United Nations stated that "about 200.000 Hutu refugees could well have been massacred"[107]. They were collectively held responsible for the genocide, even though only a tiny fraction (an estimated 5 percent) comprised Hutu extremist groups.[108] Confronted with many allegations these massacres and other severe human rights violations, Rwanda denied any involvement in the coup. Relations between Kabila and Rwanda turned sour when in July 1997 Kabila ordered the remaining foreign forces, many of them Rwandan, to leave the country. This angered the Tutsi in eastern Congo, who subsequently conducted a rebel offensive against Kabila. Backed by Rwanda, large-scale violence once again erupted in 1998. With many other African states taking part, it was not until 2003 that a peace agreement was brokered, although a proxy war has continued ever since. It is estimated that nearly 7 million people have lost their lives in what is now known to be primarily a 'resource war', given the DRC's wealth of natural resources. More recently, Rwanda is accused of supporting the Tutsi rebel group M23 that is reported to be training child soldiers in their effort to oust the incumbent President Joseph Kabila.[109] Yet though even a UN commission accused the RPF-regime of 'crimes against humanity',[110] Kagame and his cronies have continued to rule with impunity even though highly controversial support of rebel groups in the DRC continues unabated. [111]

The Rwandan government has spared no effort in silencing the voices that tell this story or any other narrative that does not comply with the government's account on several controversial issues. Those who highlight the RPF killings of Hutu are often accused of 'revisionism', whereas Law 47/2001 facilitates legal accusations on grounds of discrimination and sectarianism. The 2008 'Genocide Ideology Law' prohibits propaganda aimed at "exterminating or inciting others to

[105] Molenaar 2005 p. 47; Samset 2011; Beswick 2010.
[106] Desrosiers & Thomson 2011.
[107] Reyntjens in Strauss & Waldorf 2011, p. 136.
[108] Newbury 1998, p. 8. For instance, "[i]n March 1997, more than 100,000 [...] refugees found themselves blocked at Ubundu, on the banks of the Congo river", fleeing from violent Tutsi forces.
[109] International Coalition for the Responsibility to Protect (n.d.).
[110] Human Rights Watch 2008.
[111] Reyntjens 2012, p. 221

exterminate people basing on ethnic group, origin, nationality, region, color, physical appearance, sex, language, religion or political opinion".[112] In addition, in December 2001 Organic Law No. 47 instituted punishment for offences of 'divisionism', defined as being "the use of any speech, written statement, or action that divides people, that is likely to spark conflicts among people, or that causes an uprising which might degenerate into strife among people based on discrimination".[113] In 2003 Organic Law No. 33 was adopted, which extended the offence of 'divisionism' with 'ethnic ideology' and 'genocide mentality', the latter defined as being 'the negation, minimizing, justification or approval of the genocide, as well as destruction of its evidence'. Yet while these laws may seem self-evident and sincere *prima facie*, they are all too often used as legal tools to muzzle dissidence and opposition through the broad application of offences.[114]

Examples of how the 'genocide ideology' law is used to rein in political space abound. For instance, in April 2010 the chair of opposition party *FDI-Ingiku*, Victoire Ingabire, returned to Rwanda after sixteen years in exile with the aim to run for the presidency. After a statement at a genocide memorial site where she stated that "Hutu were also victims of crimes against humanity and war crimes" and that "Hutu are also suffering", the RPF was quick to seize upon these remarks as a justification for her imprisonment. For the verdict seemed to have already been determined at the time of her arrest: in a pre-scripted charade where the presumption of innocence was blatantly violated, Ingabire was sentenced to eight years in prison on October 30, 2012.[115] In October 2014, a BBC documentary that quoted US researchers who suggested that "many of the more than 800,000 Rwandans who died in the 1994 genocide may have been ethnic Hutus, and not ethnic Tutsis as the government maintains" met with serious criticism by a Rwandan committee, stating it had 'serious evidence of criminal offences' and urged the government to take criminal action.[116] The government responded by prohibiting BBC broadcasts in Rwanda.

Even though civil society flourished before the genocide, and was extremely quick to recover soon after, it was less impervious to a government crackdown that ensued after the RPF had consolidated its power.[117] Though increasing in number over the past years, civil society organizations face increasing pressure to conform to the regime's demands. Through the

---

[112] *Rwanda: Law No. 18/2008 of 2008 Relating to the Punishment of the Crime of Genocide Ideology.* Source: Refworld 2015. Article 2 of the law defines 'genocide ideology' as the "aggregate of thoughts characterized by conduct, speeches, documents and other acts aiming at exterminating or inciting others to exterminate people basing on ethnic group, origin, nationality, region, color, physical appearance, sex, language, religion or political opinion, committed in normal periods or during war".

[113] Refworld 2007.

[114] Beswick 2010, p. 238

[115] Reyntjens 2012, p. 48-49. American Professor of Law and attorney Peter Erlinder, who defended Ingabire, was arrested in Kigali and charged with 'genocide denial'.

[116] Baird 2015. The documentary, titled 'Rwanda's Untold Story', was broadcast on BBC2 on October 1, 2014 and sparked condemnation also on grounds of suggesting that President Kagame may have been involved in shooting down Habyarimana's plane on April 6, 1994. On October 23, 2014, Rwandan parliament had already called for the ban of BBC broadcasts on its airwaves in response to the documentary (source: Smith 2014). The next day, BBC radio broadcasts in Rwanda's local language, *Kinyarwanda*, were banned (source: Baird 2014).

[117] Longman 2011, p. 31

development of a legal framework, in conjunction with a repressive application of Organic Law No. 33, the government is able to effectively rein in civil society. It seems that, in particular, larger organizations have the most to fear and many civil society activists have been imprisoned, 'disappeared' or killed.[118]

But despite these controversies, Rwanda has continued to attract substantial sums of foreign aid,[119] which some scholars attribute to the 'genocide credit' enjoyed by the Kagame regime[120] as well as the guilt complex the international community harbored after being a passive bystander in the genocide.[121] Presently, foreign aid represents about 40 percent of the national budget.[122] Despite contentious policies, including the involvement in the Congo war, all donors except the Netherlands have maintained a steady flow of aid to Rwanda with no or minor strings attached.[123] Though most West-European and Scandinavian donors applied conditionality to their aid concerning political governance in Rwanda (e.g. democratization, human rights), the most significant contributors (UK, USA, World Bank) abstained from applying conditionality, even though a report by the network of donors (Joint Governance Assessment) noted a number of pressing issues.[124] Although the UK did make clear that aid was not to be used for the purpose of funding the wars in the Congo (1996-1997 and 1998-2003), the RPF circumvented this stipulation through some 'creative accounting', despite accumulating evidence of Rwanda's involvement in the wars as well as the massive scale of human rights violations.[125] In fact, though many donors recognized that there was a serious risk of authoritarianism and expressed concerns about it, in nearly all cases they have been reluctant to apply conditionality to their aid.[126] Arguably, this was because of their inability to grasp the Rwandan sociopolitical context ("Reconciliation is so complex and it is difficult for us to know what is going on")[127] and the lack of strategic interest in Rwanda.[128] However, the need for reconciliation is recognized as a top priority by donors[129] or

[118] Longman 2011, p. 30
[119] Marysse, Ansoms & Cassimon 2007.
[120] Reyntjens 2010.
[121] Reyntjens 2012, p. 5. Philip Reyntjens notes that when the USA pledged $ 634 million of foreign aid in January 1995, the funds were not conditional on any improvements in the human rights and political situation. Yet while he is correct in criticizing this transaction, it must also be noted that this pledge was made a mere six months after the end of hostilities. At that time, the country was still in complete ruins, and due respect for democracy and human rights was probably a luxury the government could then ill afford. Furthermore, even if the international community already had suspicions about the totalitarian nature of the RPF-regime by then, it could be argued that it was justified in reasoning that the RPF-regime was the lesser evil of the two.
[122] For 2014/2015, foreign aid represented almost 40 percent (source: Uwiringiyimana 2015). The previous year, it represented 42 percent, down from 80 percent just after the genocide ended in 1994 (source: Foreign Policy 2014, 47).
[123] Zorbas (p. 109) in Strauss & Waldorf 2011. The Netherlands cut support to Rwanda twice, first on account of the presidential and parliamentary elections in 2003 and after evidence emerged of Rwanda's involvement in the Congo war through the support of M23, a Congolese rebel group, in 2008 (Ibid., 111).
[124] Rwanda Joint Governance Assessment 2008. The report notes, among others, a need to "promote inclusive governance" as well as "constructive state-society engagement around participatory processes" (p. 78).
[125] Vos 2015. With regard to mounting evidence of mass violence, for instance, donors apparently disregarded a UN report that stated that 250.000 refugees had 'disappeared' in the First Congo War (1996-1997).
[126] Hayman (p. 125) in Strauss & Waldorf 2011.
[127] Zorbas (p. 108) in Strauss & Waldorf 2011.
[128] Ibid., p. 109.
[129] Rwanda Joint Governance Assessment 2008; Melvin 2012, p. 5

even as the "ultimate goal".[130] In short, the reconciliation effort, or the practice of averting a relapse into mass violence or genocide, is a central feature of Rwanda's political image as a safe and stable nation[131] and thus seems to be a convenient pre-text for attracting foreign aid.

Rwanda is one of the poorest countries in sub-Saharan Africa. Notwithstanding a booming yet somewhat volatile growth in GDP in recent years[132], around 50% of the country remains in poverty, whereas 90% depends on subsistence farming. Income inequality remains high: in 2011 the Gini-coefficient was set at 50.82.[133] To many Rwandans, reconciliation seems particularly remote in light of these economic difficulties. [134] However, there is good reason to hope that with continued GDP growth poverty levels will decline as well. Poverty levels have decreased from 58.9 percent (2001) to 56.7 percent (2006) to 44.9 percent (2011). Extreme poverty fell by 40 percent (2000) to 35.8 percent (2006) to 24.1 percent (2011)[135]. These developments conform to an ambitious scheme of reform and development that commenced in 2000, *Vision 2020*, which so far seems to be living up to its grand expectations.[136] Thus, despite the many challenges that lie ahead, the socio-economic prospects for many Rwandans seem to be providing a dim sense of relief.

In sum, Rwanda's authoritarian post-1994 regime can be criticized on many counts, but so far the nation has been peaceful since the genocide. Although tensions still remain, so far the "repressive peace" has proven durable as there have been no cases of overt and large-scale intra-state violence in Rwanda after 1994.[137]

II. Justice

Transitional justice mechanisms have become somewhat of a standard feature of post-conflict societies.[138] The chief rationales of these mechanisms are: fostering dialogue within divided communities, individualizing guilt in instances of mass violence, stabilizing and legitimating the regime by de-legitimizing the violence and solidifying shared norms, and national and individual healing.[139] These rationales all pertain to the case of Rwanda too, when the nation faced the question of how to account for such horrific violence on such a massive scale after the genocide

[130] Beswick 2010, p. 231
[131] Melvin 2012.
[132] Rwanda is one of the fast growing economies in Central Africa. The growth rate in Gross Domestic Product (GDP) averaged 5.83 during 2000-2015. It peaked in 2007 at a growth rate of 13.4 % but hit a record low in 2013 at -5.1 %. Source: Trading Economics 2016.
[133] The Gini-coefficient measures inequality where 0 represent perfect equality and 100 represent perfect inequality. The most recent available data on income inequality in Rwanda is based on 2011. Besides 2011, the most recent year was 2000, when the Gini-coefficient was 51.5. Thus, income inequality has slightly decreased in these years (source: Trading Economics (n.d.). An Ansoms puts the 2011 Gini-coefficient at 0.49, still far exceeding "the UNDP Gini 'alarm boundary' of 0.40, which corresponds to a situation where the richest 20% enjoyed the same consumption level as the poorest 80%" (2012, p. 430).
[134] Clark 2010, p. 180. As a consequence, participation declined as it became an economic burden (Ibid. 184).
[135] Poverty is defined as 64,000 Rwandan Francs ($ 84.1) per adult equivalent per year; the extreme poverty line is set at 45,000 Rwandan Francs ($ 60.5). Source: National Institute of Statistics of Rwanda 2012, p. 5.
[136] Ansoms 2012.
[137] Samset 2011.
[138] Leebaw 2008, p. 116
[139] Ibid., p. 111; Ibid., p 105.

ended. Justice was clearly needed, even though no form of justice conceivable was able to adequately address the unprecedented violence. Yet much like the rest of the nation and the political system, the judicial system was virtually non-existent in the aftermath of the violence. The judicial infrastructure was largely destroyed and legal professionals were either dead, had fled or even committed atrocities themselves.[140] Nevertheless, justice has come to take up the most prominent place within the reconciliation context.[141] It was addressed in four different domains: at the international level (the International Criminal Tribunal of Rwanda, or ICTR), the domestic level, the local level (*gacaca*) and through the application of universal jurisdiction in third countries. Suspects were categorized in three different categories based on the severity of their crime(s).[142] This section will deal with the *gacaca* courts, as these local-level trials have overshadowed all other trials in terms of scope and connection to Rwandan society.

Gacaca

In the early years after the genocide at least 110.000 prisoners flooded the penitentiaries in the country.[143] Conditions inside the prisons were appalling.[144] By December 1996, two and a half years after the genocide, the first trials started. But when it transpired that by March 1998 a mere 330 persons had been judged, the efficiency of the system was critically put into question. It was estimated that at that rate it would take at least 400 years to try all suspects.

To that end, some officials advocated the return of the *gacaca* (pronounced "ga-chá-cha") courts as early as 1999. *Gacaca,* which roughly translates as 'a bed of soft geen grass', refers to a traditional practice of informal gatherings in order to settle disputes. In January 2001 the Transitional National Assembly adopted the law "on the establishment of *gacaca* jurisdictions" and in October of that year 250.000 judges (*inyangamugayo*, or 'persons of high integrity'), very few of whom were Hutu, were elected.[145] From 2002 until 2004 the program ran a pilot phase

[140] Forced Migration Online 1996.
[141] Reyntjens 2012, p. 214
[142] Three categories of offenders were established through Organic Law No. 86/96 of 30 August 1996 (the 1996 law initially created four different categories, but a 2004 law merged category II and III into a single category). Category I offenders were individuals who played a critical role in planning and/or organizing the genocide; category II offenders were those who killed or injured others as well as those who aided such offences; category III offenders were those individuals implicated in offences of property (e.g. destruction or looting). Source: Sasaki 2011, p. 266.
[143] Oomen 2006. This tally was made in 1998. Reyntjens (2012, p. 217) puts the figure at 130.000 prisoners in 1998, adding that thousands died as a result of AIDS, malnutrition, dysentery and typhus that year. For instance, in November 1998 400 prisoners died of typhus in Rilima prison. Rossouw cites 124.500 prisoners (source: Rossouw 2002, p. 1), whereas Uvin and Mironko put the figure at 115.000 (source: Uvin & Mironko 2003, p. 223). Regardless, the number was too high to accommodate all prisoners in the penitentiary system, as the country's jails could accommodate no more than 45,000 inmates (source: International Centre for Prison Studies, cited in Clark 2010, p. 50).
[144] For instance, when André Sibomana visited the Gitorama prison in 1995, what he saw "[…] defied imagination. There were three layers of prisoners: at the bottom, lying on the ground, there were the dead, rotting on the muddy floor of the prison. Just above them, crouched down, there were the sick, the wounded, those whose strength had drained away. They were waiting to die. Their bodies had begun to rot and their hope of survival was reduced to a matter of days or even hours. Finally at the top, standing up, there were those who were still healthy." (quoted in Molenaar 2005, p. 53).
[145] Kohen, Zanchelli & Drake 2011, p. 10. Ultimately, however, nearly 170.000 judges presides over the *gacaca* courts. Source: Gacaca Community Justice (n.d.-a).

before starting to function nationwide in 2005,[146] backed by popular support.[147] *Gacaca*, it was argued, would contribute to the aims of truth, peace, justice, healing, forgiveness and reconciliation[148] as well as foster a 'renewed sense of identity'.[149] It was promoted as a means for cohabitation, restoring unity and creating new social dynamics.[150] Unsurprisingly, therefore, comparisons between *gacaca* and the South African Truth and Reconciliation Committee (TRC) abound.[151] However, whereas the TRC was premised on Bishop Tutu's rhetoric of restorative justice, *gacaca* has in practice been far more retributive-oriented.[152] Indeed, *Gacaca* was born out of practical necessity to relieve the state's prisons and judicial system as well as provide some measure of justice to survivors,[153] rather than out of an ideologically charged felt need for a community-centered, native approach to mass justice.

Though portrayed as a traditional mechanism, contemporary *gacaca* deviates strongly from the traditional mechanism of dispute settlement. It has undergone several changes in order to adapt to the difficulties encountered as a result of addressing an unprecedented scale of violence. Its inception was greeted with great enthusiasm as it provided a mixture of both retributive and restorative elements of justice.[154] Furthermore, the community-centered aspect of *gacaca* fitted neatly into Rwandan culture that regards the community (and the family) as the most important human units. This emphasis on the community is most strongly present in the philosophy of *Ubuntu*, which carries significant weight in sub-Saharan cultures. Most concisely, *Ubuntu* states that people are people through other people. *Ubuntu* signifies humanness, empathy and community and conveys the view that one's humanity is inextricably connected to other's humanity which is presumed to open up pathways to forgiveness.[155] It teaches the individual that "whatever happens to the individual happens to the whole group, and whatever happens to the whole group happens to the individual".[156] Indeed, during *gacaca* sessions many witnesses spoke with a striking preponderance in "we" rather than "I" terms, indicating that the events were experienced together rather than individually.[157] However, this preponderance of the group

[146] Reyntjens p. 225
[147] Fisiy 1998, p. 22.
[148] Clark 2010, p. 31. A comment made by Professor Sam Rugege, Deputy Chief Justice of the Supreme Court, is emblematic of the importance attached to *gacaca* in the reconciliation process, stating that "gacaca is our only chance at reconciliation" (Ibid., p. 240).
[149] Ibid., p. 136; Sasaki 2011.
[150] Clark 2010, p. 328
[151] I am rather reticent about comparisons between the South African TRC and the Rwandan *gacaca* courts, in particular with regard to the nature of the violence and scale. The South African TRC investigated cases of political violence over a time span of 34 years (1960-1994) in which 8500 people were killed (source: Truth and Reconciliation Commission 1998, p. 232). The Rwandan genocide entailed ethnic cleansing on such a massive scale that at least 800.000 people were killed within 100 days. In addition, a large share of the Rwandan population took part in the killings.
[152] Graybrill, 2004.
[153] Uvin (cited in Taylor 2014, p. 306).
[154] Clark 2010, p. 33-46.
[155] Graybrill 2004, 1118. Graybrill notes that *Ubuntu* derives from the Xhosa expression '*Umuntu ngumuntu ngabanye*' which translates as 'people are people through other people'.
[156] John Mbiti (quoted in Ibid, p. 1118).
[157] Eramian, 2008, p. 16.

exacerbates the risk that individual experiences become homogenized at the collective level,[158] so that the unique characteristics of personal suffering may be failed to be acknowledged.

Gacaca has been criticized on several counts: for not complying with international legal standards and procedures[159] and for being a textbook case of 'victor's justice' given the impunity the RPF enjoys for their crimes outside of Rwanda's borders,[160] an argument that gains substantial credibility in light of significant political pressure and rampant monitoring.[161]Although *Gacaca* was meant to individualize guilt, many Hutu are still suspected of involvement in the genocide, despite the fact that about between 8 and 24 percent of the pre-genocide population is presumed to have been involved in the killings.[162] As Mamdani notes: "Every time I visited post-genocide Rwanda, I would ask responsible state officials [...] how many ordinary civilians they thought had participated in the genocide. Every time the answer was in the millions. Even more troubling, the estimate grew with each visit."[163] At the same time, many accused Hutu have since been found to be innocent, to which many Tutsi retort that there have been too many acquittals.[164]

Initially, *gacaca* enjoyed widespread support as a means to punish the guilty and establish the truth.[165] The much-touted state rhetoric on the need for forgiveness in the reconciliation process also resonated well with the population. In a 2003 survey, 95 percent of respondents agreed that, for reconciliation to advance, genocide perpetrators must ask for forgiveness from survivors and 94.3 percent agreed that survivors must be prepared to forgive the perpetrators.[166] Many of the

---

[158] Eramian 2008., p. 18.

[159] For instance, there was no presumption of innocence, no right to representation by a lawyer and no cross-examination of witnesses (Taylor 2014, p. 306; Teitel 2005, p. 852). These issues were compounded by many instances of investigative bias, corruption among judges, witness intimidation and weak or no defense counsel. Legal advice was difficult to obtain (Clark 2010, p. 163) and *gacaca* proceedings could vary substantially among courts just a few kilometers away (Ibid., p. 11). The fact that a total of 169,442 judges presided over court hearings and reached verdicts (Gacaca Community Justice (n.d.-a)). These judges received minimal legal training, which consisted of 6 full days where each group of 70 to 90 judges received instruction on the basics of the *Gacaca* law, management skills, ethics, and trauma (source: Human Rights Watch 2011, p. 65).

[160] Nagy 2008, p. 282.

[161] Uvin 2003, p. 116

[162] Strauss (cited in Lemarchand 2006, p. 24) puts the figure at around 8 percent. By my own calculations, I arrive at a percentage of 23.66. This figure must, however, be interpreted with some reservations in mind. First, pre-genocide demographics differ significantly per source, although the *CIA World Factbook* seems to be the most endorsed number. It puts the pre-genocide census at 7.107.000, whereas 1.681.648 people were found guilty through *Gacaca*, yielding the percentage quoted above. This finding is in line with Hilker, who states that the "most pessimistic estimate of Hutu involvement was 25%" (2009, p. 91). Reyntjens (2012, p. 227) puts the figure at almost 70 percent of the male Hutu population in 1994, but this number is slightly misleading as it excludes Hutu women who are also representative of Hutu identity. However, Reyntjens figure is indicative of the percentage of the population that was actually physically able and, as adults, can be held accountable for their deeds, which indeed is far higher than the number I quoted. Furthermore, it should also be noted that, depending on the number cited of people who were killed (the commonly cited 800.000 or the government figure of 1.071.000) also comprises a substantial percentage (respectively, at 11.26 or 15.14 percent).

[163] Mamdani (quoted in Hintjens 2008, p. 22).

[164] Tekeuchi 2011, p. 16. In two cells where research was conducted, the acquittal rate was around 30 percent which, the research team inferred, was a credible rate and in line with similar findings.

[165] In a study of 2.059 respondents divided over four communities, 92.3 percent of respondents said they strongly supported *gacaca* as a punitive instrument and 94 percent said they strongly supported *gacaca* as a means to establish the truth. Source: Longman, Pham & Weinstein in Stover & Weinstein (2004, p. 212).

[166] Babalola et al. 2003. The survey was conducted across six provinces and included 1756 respondents.

prisoners were urged to confess their acts, led by promises of the prospect of safe returns to their villages and incentivized by schemes that would reduce their prison term in half in exchange for community work. Some prisoners noted that they received daily training to prepare them to confess. Yet although this policy induced many to confess, coupled with the popular protestant view of receiving forgiveness immediately after confessing,[167] the sincerity with which many offenders asked for forgiveness was virtually absent. [168] Many offenders also attributed responsibility to the state, arguing that they had no choice, and that the authorities made them do it. Many survivors therefore regard forgiveness as a distant reality in Rwanda.[169] The feeling that perpetrators were not adequately punished[170] consequently leads to deep mistrust and resentment.[171]

To minimize their punishment, many suspects told lies or incomplete testimonies. Many judges were coerced[172] and many witnesses intimidated, harassed, or even assassinated.[173] A lack of active popular participation[174] was countered by the government by requiring its citizens to attend through an amendment in the *gacaca* law in 2004. Though this measure certainly led to an increase in participation, it also fostered a feeling among individuals of 'doing the government's work' and 'helping the government solve the problems of the country'.[175] Thus, even though *gacaca* was hailed for its restorative potential at its inception, there is much evidence that the courts did not succeed in mutual accommodation of both parties, due to the retributive orientation that has developed over the years.[176]

Inkiko Gacaca: does the truth heal?

Transitional justice mechanisms, and truth commissions in particular, have been advocated as important components in addressing the psychosocial repercussions of mass violence due to the

[167] Clark 2010, p. 291.
[168] Molenaar 2005, p. 62. Arthur Molenaar notes that during the many *Gacaca* proceedings he attended offenders "did this, generally, without emotion, but in an arrogant way, implying that they expected to be forgiven immediately, as if they had automatically earned the right to be pardoned because they had taken the trouble to confess or as if they had forgotten that the victims might reject their apologies." Similarly, in a *gacaca* hearing dealing with a case of a 75-year-old woman whose house was attacked by four men, including one of her sons from a previous relationship with a Hutu, Regine King notes that the statements of the accused "were more of a form of self-defense than a testimony" (King 2011, p. 138). One survivor admitted that "certain *genocidaires* do not have the right to rejoin the community, since *basabye imbabzi* ("they have asked for mercy") before the courts by pleading guilty and admitting the acts they committed but have not *batyicuza* ("shown remorse"). Source: Burnet 2008, p. 181.
[169] Clark 2010, p. 305.
[170] Ibid., p. 251; Verdicts can be dissatisfying as sentences may be perceived as being too lenient, ultimately overturned on appeal or even allow for those who are guilty to be released on a technicality. Thus, the notion that the justice served is congruent with the prerequisites for individual healing is an oversimplified one and need to be critically revisited. In other words, far from contributing to the reconciliation process, personal attitudes may well conflict with domestic realities. Source: Hoven & Scheibel 2015, p. 179.
[171] Clark 2010, p. 250.
[172] Ibid., p. 122
[173] Buckley-Zistel 2008a, p. 26.
[174] Reyntjens 2012, p. 229.
[175] Clark 2010 p. 141. With regards to increases in participation, the government reports "a near-absolute degree of popular participation in gacaca" (Ibid., p. 156).
[176] Burnet 2008, p. 177.

presumed cathartic potential of testifying.[177] But although survivors can certainly feel a sense of recognition, dignity, self-empowerment and a feeling of closure through testifying, this effect is usually fleeting and evidence suggests it is generally detrimental to their psychological wellbeing in the long run. [178] In the case of the South African TRC, suspects of political violence have been reported to show signs of psychological distress (e.g. depression, PTSD) after testifying.[179] The Trauma Center for Victims of Violence and Torture also found that 60% of witnesses felt worse after testifying before South Africa's TRC,[180] despite initial feelings of relief.[181] This is primarily a result of the re-evocation of traumatic experiences that causes a subsequent increase in the negative emotional climate. In addition, the burden of coming to know the truth can seriously impede emotional recovery.[182] As courts are not adequately equipped to address this psychological impact, this process of re-traumatization can leave the victim even worse off.

According to the National Service of the *Gacaca* jurisdiction, in 193 cases (out of nearly 2 million) serious trauma complicated the proceedings.[183] Exactly how it complicated the trial and what qualifies as serious trauma is not mentioned. Similarly, the Ministry of Health, responsible for mental health issues connected to *gacaca*, is ambiguous about what the Ministry's role exactly entails.[184] Other scholars, who have conducted more systematic inquiries across larger samples, contest the figure by the National Service. Although they do not provide any alternative estimate, they note that there was a significant amount of cases of 're-traumatization'.[185] Sometimes hearing the truth was excruciating, even unbearable, as diabolical facts and events were disclosed.[186] In part, the effects may be compounded by the lack of mental health professionals,[187] an inability to express trauma which leads to further isolation[188] as well as insecurity as a result of testifying.[189]

---

[177] C.f. Hamber, 2009: 4; Kaminer et al., 2001; R. King (2011), p. 139; Martín-Beristain et al., 2010: 48; De Ycaza, 2011. The assumption here is that the expression and acknowledgement of grievances provides a therapeutic effect for victims.
[178] The authors also noted that that there were no significant differences across victims who provided either a public testimony or a closed statement versus victims who did not testify in the South African Truth and Reconciliation Commission (TRC) in terms of psychological health. The authors tested for PTSD, depression and other anxiety disorders. Furthermore, the authors observed that a lack of forgiveness could be an important predictor for psychiatric risks among victims.
[179] Hamber 2009, p. 57; Allan 2000.
[180] Karbo & Mutisi 2008, p. 18.
[181] Graybrill 2004, p. 1120
[182] Hayner, cited in Gilbert 2014, p. 72.
[183] Gacaca Community Justice (n.d.-b).
[184] Clark 2010, p. 260.
[185] Ibid., p. 85 & p. 276.
[186] Hatzfeld 2007, p. 32.
[187] One *gacaca* witness stated that "if you begin to feel trauma in the *Gacaca* [trial], you cannot go anywhere" (quoted in Burnet, p. 181). Staub, Pearlman & Miller (2003) all point to the necessity of providing adequate trauma support during trials. During the *gacaca* trials, trauma support was virtually non-existent. During the pilot phase of *gacaca*, 45 trauma counsellors were trained by 2 American mental health professionals (source: IRIN News 2004b). No sources confirm that additional staff have been trained for psychological support of *gacaca* attendees by the authorities. In a unified effort, several NGOs however, have been able to train 20 trauma counsellors and 336 psychosocial assistants by 2007 (source: Ibuka, Kanyarwanda & DED/ZFD 2007). Nevertheless, given that *gacaca* comprised 12.103 courts altogether, all counsellors combined would only be able to cover 3.3 percent of all courts.
[188] Clark 2010, p. 263.
[189] Karen Brouneus (2008) notes that in a small-scale study of 16 female witnesses in *gacaca*, all experienced insecurity and harassment after testifying. Five could not continue testifying due to '*traumatisme*', or severe psychological breakdowns. Several re-lived their traumatic memories so vividly they felt as if it was happening again.

Indeed, truth telling can act as a catalyst to depression and PTSD.[190] *Gacaca* participation led to marked increases in fear, anxiety and sadness, with survivors noting a more negative emotional climate after having participated in *gacaca*.[191] Conversely, but equally detrimental to healing, many woman have been unable to bring up the issues that troubled them most, in particular rape.[192] These findings therefore not only contradict the frequently espoused view that truth telling and the expression of emotions is healing, but also the National Service of Gacaca Jurisdiction's slogan that 'the truth heals' (*la vérité guérit*). For some, therefore, the trauma invariably remains repressed. This repression is mainly due to the fact that the justice system does not provide a decent outlet for trauma. As testimonies become depersonalized and reduced they lose their meaning and significance to the individual and wider society.[193] Rather than provide a platform for the expression of personal experiences, *gacaca* has only facilitated selective testimonies in order to advance the state's policy of unity and reconciliation.[194] In doing so, the traumatized individual is rendered an intermediary object for the purpose of national reconciliation while leaving their personal demons unaddressed.

Participation in *gacaca* led to a significant decrease in survivors' personal and collective guilt and to an increase in prisoners' personal guilt. Survivors who participated in *gacaca* were generally distrustful of the court system and the prisoners brought before it, although participation and testifying generally improved self-esteem among survivors.[195] They were also less inclined to forgive, even harbored vengeful feelings and tended to seek intragroup over intergroup contact.[196] Participation in *gacaca* therefore does not seem to advance individual healing – and consequently, reconciliation – but it may have enhanced survivors' empowerment by reducing their guilt feelings.[197] While participation in *gacaca* trials fostered a negative emotional climate, it did have a positive effect on social cohesion as it led to reduced in-group identification and a more positive and heterogeneous image of the out-group. Genuine apologies and expressions of emotions by suspects that led to the acknowledgement of the victim status of survivors also contributed to increased social cohesion.[198] However, as noted, the opposite occurred as a result of many cases of false testimonies, intimidation of witnesses and judges or pragmatic requests of forgiveness by suspects to mitigate their verdicts. And, as survivors generally feel unable to express their true

[190] Brouneus (2010) conducted a multistage, stratified random cluster survey among 1200 participants. *Gacaca* witnesses exhibited 20 and 40 percent more depression and PTSD-related symptoms, respectively, than non-witnesses. Among *inyangamugayo* and neighbors the respective rates were even more significant, at 60 and 75 percent respectively. The degree of participation (low or high) had no effect on PTSD or depression.
[191] Rime et al (2011). This experimental study observed the effects of *gacaca* participation in 755 volunteers who were at least 18 years old at the time of the genocide. Among them, 395 were survivors and 360 were alleged perpetrators.
[192] King (2011), p. 138. According to King, these women "were not allowed to say anything related to rape because doing so could lead the rapist *genocidaire* back to prison and in turn be considered as a crime committed by these women. Further, they did not see any support from the judges or other community members."
[193] Quoted in Hamber 2009, p. 61.
[194] Eramian 2008, p. 17.
[195] Kanyangara et al. (2007).
[196] Similarly, a study by Pham et al. (2011) noted that among Cambodians subjected to the violations of the Khmer regime, 40 per cent wished to exact revenge and 70 percent wanted to see perpetrators hurt or miserable.
[197] Kanyangara et al. (2014).
[198] Rime et al. (2011).

emotions in *gacaca,* [199] they often wind up frustrated with the national reconciliation agenda. In addition, many defendants practiced *ceceka* (Kinyarwanda for 'keep silent'), which bars people from speaking the truth at *gacaca.*[200] Due to this silence, suffering is not acknowledged, and this can be very damaging for traumatized individuals.[201] As a result, traumas of the massive violence have endured and these negatively impact on attitudes towards justice and reconciliation.[202]

Despite ethnicity being outlawed in contemporary Rwanda (see paragraph V), it remained particularly salient in the *gacaca* sphere, and has even reinforced the divisions among Rwandans.[203] Far from counteracting feelings of inter-group animosity and transforming identities,[204] in Rwanda it has been exceedingly difficult to move beyond the dichotomies of Hutu and Tutsi.[205] Instead of facilitating 'reconciliation as identity change',[206] *gacaca* has only aggravated ethnic tensions. Despite much evidence, this hardening of ethnic relations is, however, blatantly denied by the government.[207] Furthermore, the failure of *gacaca* to reach its lofty goals has left many Rwandans, mostly Tutsi survivors, increasingly distrustful of the government.[208] Yet Hutu's have every reason to be distrustful too. Although *gacaca* was tasked to deal with the pre-1994 'culture of impunity', RPF crimes and the mass killings of Hutu refugees after the genocide have failed to receive acknowledgement, let alone prosecution, leading to anger and frustration among Hutu who criticize the RPF-regime for imposing a 'victor's justice'.[209]

The question therefore remains whether transitional justice can assuage severe traumatization, especially at the individual level. Victims of serious crimes whose offenders are acquitted experience disappointment and mistrust in the legal system, a decreased belief in a just world, reduced self-esteem and optimism for the future.[210] Conversely, many perpetrators feel wronged by the retributive-oriented justice mechanisms. Rather than provide a space of healing, transitional sites of reconciliation then become a stage for strife and contestation. In Rwanda, this strife and contestation has not only exacerbated lingering tensions, but has impeded the acknowledgement of personal suffering and therefore healing at the personal level.

---

[199] Hatzfeld 2007, p. 90.
[200] Rettig in Strauss & Waldorf 2011, p. 203. Rettig notes that "more than 70 percent of non-survivors and 90 percent of survivors said that people tell lies at *gacaca*. [...] Nearly 40 percent of the time, judges deemed the confessions incomplete and imposed prison terms at or near the maximum – on average, twenty-five years." (Ibid., p. 201). As Clark notes, public testimony opposes the cultural preference for silence and secrecy is pervasive in Rwandan culture (Clark 2010, p. 201).
[201] King 2011, p. 139.
[202] Buckley-Zistel 2008a, p. 17.
[203] King 2011, p. 140; Ingelaere & Waldorf in Reyntjens, 2012, p. 230. For example, Phil Clark noted that "cheering Hutu lined the streets to welcome the returning [Hutu] prisoners as if they were a liberation army" (Clark 2010, p. 333). Burnet (2008, p. 186) reaches a similar conclusion.
[204] Aiken 2013.
[205] Sasaki 2011.
[206] Kelman 2004.
[207] Eramian, 2009.
[208] Burnet 2008, p. 188.
[209] Buckley-Zistel 2008a, p. 26; Kohen, Zanchelli & Drake 2011, p. 11; Reyntjens 2012, p. 219.
[210] Orth, cited in Hamber, 2009: 124.

III. Memorialization and commemoration

Collective memory, shaped and manifested through memorialization and commemoration rituals, encapsulates collective experiences and attitudes that form identities. It not only enshrines the relationship between parties, it is also constitutive of it, as it forms a space where identities can be negotiated and identity transformation can ensue.[211] Rwanda's memorialization and commemoration practices are therefore representative of how collective experiences and mental representations permeate into a collective identity that is constitutive of inter-group relations.

To "show solidarity for Tutsi lives lost",[212] every year the genocide is commemorated during the week of 7-13 April. Various events organized by the National Commission for the Fight against Genocide are hosted throughout the country, at different administrative levels and in many different ways. Each year, one genocide memorial is chosen for the commemoration ceremony, which is led by the President and attended by many other high-profile leaders and dignitaries. In addition to speeches by the President and other dignitaries, as well as survivor testimonies and marches, it is marked by the burial of victims' remains that have been exhumed from nearby massacre sites.[213] These commemorative rituals frequently trigger traumatic crises among survivors, many of whom experience emotional problems, relive traumatic memories and become recluses during the week.[214] Because reliving traumatic memories can lead to chronic mental illness,[215] it is questionable whether these commemorations can actually contribute to emotional healing.

In addition, traumatic crises frequently spreads among traumatized individuals attending the commemoration ceremonies. In 2014, a minute of silence during the ceremony in a Kigali stadium was punctuated by screams of survivors, quickly followed along by one another.[216] The Rwandan Ministry of Health even spoke of a 'contamination effect':[217]

> "In the grandstand muffled tears begin. Gradually, in every corner people start to cry first, then scream. Within minutes, others start to run and panic reigns in these places. Some shout saying they are attacked by the *Interahamwe* militia. Others try to flee forcefully shoving people around them. It is as if suddenly we returned in 1994 during the genocide."[218]

One survivor states that during the annual commemoration:

[211] Buckley-Zistel 2008a, p. 9.
[212] Statement by NURC official (quoted in Thomson 2009, p. 220).
[213] Sasaki 2011, p. 360.
[214] Ibreck in Lee & Thomas 2012, p. 110.
[215] Kayetishonga 2012.
[216] Straziuso, & Sullivan (April 7, 2014)
[217] Gishoma 2008, p. 241.
[218] Translated from French. Source: Gishoma 2008, p. 242.

> "I feel as if I'm reliving the situation. I always dream about my children. I see them as they would have been today, all grown up. And I imagine the atrocities that they went through during the genocide and I feel as if I have died."[219]

The number of traumatic crises during the commemoration ceremonies has steadily increased over the years. In 2005, 627 cases were reported,[220] whereas during the commemoration events in 2014, over 3000 cases of traumatic crises were reported.[221] To that end, over the past years thousands of support staff have been trained to support these people during the events.[222] An additional 1800 were trained by the Rwandan Red Cross[223] and another 3800 by the survivors' organization *Ibuka*.[224]

During the commemoration events, Tutsi survivors are united in their grief, while Hutu who may grieve the loss of their loved ones are basically denied their suffering by the government. Even those not participating in ceremonies are often overcome by their traumatic memories during commemoration week. They may shut themselves up in their homes, only to be overcome by emotions of sadness, fear and anger.[225] At the community level, social relations deteriorate as people keep their distance and distrust, suspicions and individualism increases.[226]

In 1995, thousands of sites of genocidal massacres were identified and have since been preserved as memorial sites. In some of these sites, including churches, human remains are left as an enduring testament to the atrocities committed during the genocide.[227] Many genocide survivors are opposed to this as they want to give their loved ones a proper burial.[228] Indeed, over 90 percent of survivors have not been able to bury their loved ones and perform mourning ceremonies and therefore their healing process has not been able to complete its course.[229] In 2006, the government ordered that the remains within mass graves be exhumed and reburied in smaller graves as designated by local authority offices. This has caused bitter resentment among survivors of all ethnicities, in particular because they do not want the government to decide on the whereabouts of their loved ones' remains.[230] The macabre display in many memorials also runs counter to both Christian doctrine as well as a traditional Rwandan religious beliefs that the dead remain in our world as ancestor spirits (*abazimu*) and cause trouble (e.g. illness, failed crops) for the living if they are displeased.[231] The many burial places serve as memorials that remind Rwandans of the 'genocide *against Tutsi*'. But as omnipresent as genocidal massacre sites and burials are, any references to Hutu being killed are avoided, a lack of acknowledgement that

---

[219] African Rights 2004, p. 40.
[220] Gishoma 2008, p. 241.
[221] Ngoboka 2015.
[222] Ibid.; The New Times 2016. These people ranging from social and mental health workers, even policemen.
[223] International Federation of Red Cross and Red Crescent Societies 2014.
[224] Karahunga 2016.
[225] Straziuso, J. & Sullivan, K. 2014.
[226] Richters et al. 2010, p. 62.
[227] Ibid., p. 359.
[228] Schotsman, cited in Burnet 2012, Ch. 2, Loc. 2336.
[229] Petersen-Coleman & Swaroop 2011, p. 91; Bagalishya 2000, p. 347.
[230] Thomson 2009, p. 221.
[231] Burnet 2012, Ch. 2, Loc. 2232.

has greatly contributed to Hutu suffering and increased the lingering Hutu-Tutsi divide.[232] In 2014, during the commemoration event in Kigali stadium, Kagame took the opportunity to attribute culpability for the genocide to the French and Belgians for having laid the seeds of the genocide.[233] By denying the suffering of many Hutu as well as attributing partial responsibility to the French and Belgians, the commemoration events have provided a perfect avenue for shaping exclusive victim identities among Tutsi's.

During the month of commemoration, there is hardly any space for public dialogue concerning the genocide.[234] Indeed, the Rwandan government openly states that "the diversity of memories must be sacrificed on the altar of national reconciliation".[235] Attending commemoration ceremonies is obligatory for all Rwandans, who are forced to show emotions of sadness and weep. Not only is this forced display of grief stressful for them, and they are uncertain as to what kind of emotional enactment is exactly expected of them, but public displays of excessive emotion is taboo in Rwanda as it is commonly regarded as a sign of weakness or madness.[236] Hutu are not allowed collective mourning and instead must attend ceremonies that in which exclusively Tutsi victims are commemorated. [237] Although this 'selective memory' is conveniently exploited by the regime to legitimize its rule,[238] these practices reinforce ethnic divisions that are officially prohibited. Genocide commemorations and national mourning practices therefore reinforce the Hutu-Tutsi dichotomy to the extent that certain Tutsi genocide survivors have sought revenge against Hutu under the logic of 'collective guilt'.[239] On occasion, this 'guilt logic' has even sparked retributive murders.[240] Furthermore, the public and highly politicized performance of commemoration in Rwanda causes resentment among many who feel that these events are inadequate in channeling their deeply personal emotions and hence prefer to commemorate in the private sphere in a more personal way.[241] In sum, the genocide commemorations are rituals through which genuine grief are politicized to the extent that it legitimizes the rule of the current regime rather than actively facilitating personal healing processes.

---

[232] Vidal 2000.
[233] Shortly before the event, Kagame made the accusation against France and Belgium, to which France responded that it would not send it Secretary of Justice, but its ambassador to Rwanda. However, the ambassador was not allowed and Kagame said it was impossible to "change the facts" about the genocide. Source: http://news.nationalpost.com/news/dozens-of-traumatized-mourners-carried-from-stadium-as-rwandans-mark-20th-anniversary-of-horrific-genocide
[234] Burnet 2012, Ch. 4, Loc. 3477.
[235] Excerpt from Senate of Rwanda report 'Rwanda: Genocide Ideology and Strategies for Its Eradication" (quoted in Sasaki 2011, p. 358).
[236] Thomson 2009, p. 221.
[237] Remy (cited in Hintjens 2008, p. 31).
[238] Rene Lemarchand (quoted in Moritz-Schubert 2013, p. 86).
[239] Burnet 2008, 184
[240] Hatzfeld 2007, p. 31; Ibid., p. 135.
[241] Thomson 2009, Ch. 6; Buckley-Zistel 2008a, p. 17; Burnet 2012, Loc. 2106.

IV. The politics of nation-building

The word 'reconciliation' derives from the Latin *reconcilare*, meaning 'to bring together again'[242]. But what, exactly, does it mean for Rwandan society to be brought together again? Was there ever a situation where Hutu and Tutsi all lived in a society free of mutual antagonism? The government maintains that in pre-colonial times there was a time of 'harmonious co-existence' that provides a template for the future. Ethnic violence in Rwanda is represented as the result of identities constructed by colonial rulers (Germany and Belgium) that have grown ever more antagonistic over the years.

One of the pillars of Rwanda's reconciliation strategy is identity transformation. Rwanda's 'Government of National Unity' argues that the ethnic distinction between Hutu, Tutsi and Twa was merely a ploy for the colonial powers to exert their rule over Rwanda It. seeks to remold identities along national lines, arguing that all ethnic categories are ultimately all *Banyarwanda*. The *Banyarwanda* speak the same language, share the same cultural practices, religions and myths, form integrated communities and even intermarry regularly. According to President Kagame, "[t]he Rwandan nation, known in the region since the 11th century, is founded on the common history of its citizens, on the shared common values, on unity of language and culture".[243] The RPF-regime aims to ensure that this reinvigorated, 'traditional' national identity surpasses other identities and commands the strongest allegiance for state purposes, in blatant disregard of the fact that no sense of 'Rwandanness' was existent in pre-colonial times, nor are claims of 'harmonious coexistence' warranted.[244] It does not shun the use of the 'divisionism' and 'genocide mentality' laws in imposing the idea of national unity upon its citizens. As one government spokesman stated: "[t]he truth is that Rwandans are one people. If you deny this, you are driven by something else."[245] Yet despite pervasive discourse on 'Rwandan unity', in particular the incessant emphasis on 'unity' in the *Ingando* camps,[246] "only few people refer to a reversion to former 'unity'".[247]

But despite the imposition of a new identity on Rwandans and the assertion by the authorities that virtually all Rwandans (98 percent) prefer to be identified as Rwandan rather than Hutu, Tutsi or Twa,[248] ethnicity remains particularly salient in contemporary Rwanda.[249] The Rwandan

[242] Online Etymology Dictionary (n.d.).
[243] Purdekova 2008, p. 14.
[244] Ibid., 2008, p. 14.
[245] Eltringham (cited in Strauss and Waldorf 2011, p. 270).
[246] Purdekova 2008, p. 20.
[247] Clark 2010, p. 316.
[248] Kabeera 2012. The article also notes that "[t]he researchers also points out that 98 percent of nationals blame the way history was taught believing it inflamed divisions while 94.7 percent consider that the way it is being taught now encourages reconciliation." This is a highly contentious statement, as it contradicts virtually all other academic observations concerning nation-building in Rwanda.
[249] Longman et al. in Stover & Weinstein 2004, p. 19.

saying that people speak with two tongues, one when the door is open and another when it is closed,[250] rings particularly true in this regard.[251] In the words of one Tutsi survivor:

> "Some Hutus behave nicely because they feel ashamed, but others speak on the sly about starting it up again. Some Tutsis murmur words of vengeance. If lips repeated what the heart is whispering, they would sow panic, revenge, and killings in every direction. It's best to mute your sorrow and hide your resentment, or share them with a companion in misfortune."[252]

While ethnic identification has been outlawed since 2003, ethnic identities remain a central factor in the private sphere. For many Rwandans, ethnicity allows them "to find guidance on who they should trust and with whom they should reconcile in the present".[253] There is a strong desire to know the ethnic identities of other Rwandans in private social interactions as this defines how they interact with one another. [254] It has already been remarked that through the *gacaca* courts ethnicity has increasingly become a mediating factor in social interaction. Many survivors remain fearful: they may feel too unsafe to spend a night in their village or avoid eating with their Hutu neighbours for fear of being poisoned.[255] Even where ethnic identities are unknown, these are usually inferred from physical characteristics based on 19th-century stereotypes developed by European colonists.[256] In short, ethnicity remains the most dominant identity in daily life, influencing the way people interact, mutual trust and the intimacy of their relationships.

Identity and victimhood

Post-genocide identities in Rwanda are closely tied up with victimhood.[257] Victimization is an on-going process,[258] and one that is conveniently exploited by the Rwandan government, as it specifically maintains that the mass violence entailed "genocide *against Tutsis* [italics added]".[259] Other official and semi-official (e.g. civil organizations and media, all strictly monitored by the authorities) accounts either exclude Hutu victims or note that "some moderate Hutus" were

---

[250] Brouneus 2010, p. 427.
[251] Freedman et al. 2008, p. 256. The authors also note that ethnic discrimination (e.g. in seeking employment) remains rife in Rwanda.
[252] Hatzfeld 2007, p. 83.
[253] Eltringham (cited in Strauss and Waldorf 2011, p. 277); Hilker (2009) notes similar findings.
[254] Hilker 2009, p. 92
[255] Buckley-Zistel 2006, p. 111.
[256] Hilker 2009, p. 87. Such 'identification' based on physical stereotypes typically includes height, physical build and the shape of the nose.
[257] Burnet 2012, Ch. 2, Loc. 2392.
[258] Afflito 2000.
[259] National Unity and Reconciliation Commission (n.d.-a). Another report, published by the National Commission for the Fight against Genocide, or CNLG (the acronym is the one most commonly used and derived from the French translation, which reads *La Commission Nationale de Lutte contre le Génocide*), notes that "Genocide against the Tutsi in Rwanda was perpetrated with unprecedented violence and took the lives of 1,074,017, of whom 934,218 have been identified by names. The great majority of these victims were killed because they were identified as Tutsi (93.6%). Others because they resembled Tutsi (0.85%), had friendship relations with Tutsi (0.37%), were married to Tutsi (0.32%), had hidden Tutsi (0.17%), or had shown opinions opposed to the regime that perpetrated genocide (0.64%)". The percentage of Tutsi is far from credible, given how many accounts stressed that moderate Hutu's were slaughtered with similar ease and brutality as their ethnic counterparts. Furthermore, the report fails to account for, or mention, what to make of the remaining 4.08 per cent (source: Damascène (n.d.)).

killed.[260] Independent research, however, contradicts such statements. For instance, Reyntjens calculated that the number of 'moderate Hutu' killed would likely total around 200.000.[261] The 2008 Law against Genocide Ideology probably best reflects the victim role the RPF regime accords to herself and the Tutsi's: by August 2009 912 persons had reportedly been incarcerated on accusations of 'genocide ideology'.[262]

Exclusive equation of victimhood with the Tutsi's explicitly denies victimhood among Hutu's, as evidenced by the fact that Hutu's are forbidden any collective mourning or that the Fund for Survivors (FARG) is in practice only accessible to Tutsi. As shared suffering is more powerful than shared joy in forging group identities,[263] this exclusive acknowledgement of victimhood strengthens ties within the victim group, only leading to further bounded identities. A parliamentary commission concluded in 2007 that there were "damning revelations on the extent of genocide ideology in some schools, with some secondary schools registering 97 percent cases of the ideology".[264] As a result, during the annual commemoration period in April 2008, all primary and secondary school teachers took part in *ingando*[265] training to fight 'genocide ideology'.[266] Clearly, schools are but one of the spaces where citizen conduct is molded along the lines of a very narrow view of the history of the genocide.

The genocide also catalyzed and galvanized a huge exodus. It is estimated that up to 1.5 million Hutu were internally displaced whereas 2.1 million fled Rwanda. Immediately after the genocide, Rwanda's borders were flooded with a staggering 700.000 exiled Tutsi herding back to their homeland, many of them newcomers to a country they had never actually set foot in.[267] Since 1994, a record number of 2.1 to 3.4 million refugees, or 25 to 40 percent of the 2006 census, have returned to Rwanda and resettled.[268] Not only does such an influx strain state resources, but their reintegration is compounded by their quest to resettle unnoticed in order to avert retribution. Unwanted by many Tutsi who experienced the genocide, they are struggling to adapt in their new homeland.[269] This suggests that being a Tutsi is strongly connected to victimhood after having experienced the mass violence.

Collective victimhood of the Tutsi's and collective guilt of the Hutu's thus poses a major obstacle to reconciliation in Rwanda. Collective guilt may completely eviscerate individual victimhood, even where one seems to be warranted. For example, a male survivor whose Tutsi mother was killed and Hutu father killed for trying to defend her, became a pariah within the Tutsi community in his hometown after it became evident that his uncle was a high-profile

[260] Survivors Fund (n.d.).
[261] Reyntjens 2004, p. 178.
[262] Reytens 2010, p. 16. The law was promulgated on July 23, 2008 (source: Refworld 2008).
[263] Candeau (cited in Ndikumana 2011, p. 72).
[264] Freedman et al. 2008, p. 679.
[265] *Ingando* camps play a central part in the government's reconciliation effort. Here, students (from all corners of society) take lessons in for instance 'Rwandan history', social behavior and military drills.
[266] Sasaki 2011, p. 357.
[267] Prunier 2009, p. 5.
[268] Purdekova 2008, p. 5.
[269] Fisiy 1998, p. 19; Gilbert 2014, p. 59.

perpetrator.[270] Although certainly not all Rwandans are guided by similar stereotypes, it is emblematic of how collective guilt can trump individual innocence.

In sum, the Rwandan government has sought to impose a renewed, national identity among the Rwandan population through a particular reading of Rwandan history that leaves little room for interpretation, or even contestation. But identity transformation fails when there is no space allocated for differences and the expression of legitimate grievances.[271] Such differences are a healthy component of society, as long as it is coupled with a renewed psychological orientation of the out-group that is free of negative stereotypes. However, in Rwanda the persistence and power of these stereotypes fosters a deep-seated sense of insecurity and an enduring need to know another person's identity.[272] In erasing ethnic identities the government is actively denying personal histories. While this may not be the case for Tutsi, whose ethnicity is cloaked underneath its victim status, the same is not true for Hutu, who instead continue to be haunted by the shadow of 'collective guilt'.

V. Conclusion

Given the overwhelming prevalence of genocide memorials, the long duration of commemoration, the frequency of *gacaca* hearings and the ubiquitous appeal to reconciliation and the 'unity of Rwandan's', Rwandan citizens seem to be force-fed reconciliation, which diminishes their individual agency for coming to terms with the past. The vast reconciliation effort comprises an infrastructure through which the government is able to exercise much of its authority and manifest its presence in its citizens' lives. The 'post-genocide paradigm' has provided a frame for 'proper conduct' by which citizens must conform to beliefs, attitudes and desires as defined by the RPF regime. The denial of personal histories, identities and suffering has created a vacuum in which the government seeks to reconfigure common customs and ways of thinking. Yet although this 'post-genocide paradigm' for the "conduct of conduct" is contested by a significant share of Rwandans, this contestation is forcibly repressed by the authoritarian regime. For now, the curtailment of individual freedom may be worth the price to pay for a repressive peace, but the enduring prevalence of contestation, resentment and the salience of ethnic identities in Rwanda render it questionable whether this peace is sustainable.

Underneath the veneer of 'national unity' there are still significant divisions, and in some cases, reconciliation efforts have only aggravated former tensions and antagonisms. By invoking the myth of 'national unity' and 'traditional' rituals, the government mirrors contemporary Rwanda on pre-colonial Rwanda. Though presented as an aberration in Rwanda's history, the genocide serves both a legitimizing function for the regime as well as the currency through which citizen conduct is shaped. Despite observations to the contrary, the government projects continuous improvements in reconciliation. This implies a line of reasoning that as long as the reconciliation process is not completed, which "will probably go on for decades",[273] the current regime is

[270] Hintjens 2008, p. 28.
[271] Buckley-Zistel 2006.
[272] Hilker 2009, p. 96.
[273] Foreign Policy 2014, p. 48.

legitimated. One of the most prominent features of post-genocide Rwanda is how the regime legitimizes its rule by virtue of not only of having ceded hostilities in 1994, but also by projecting a one-sided victim consciousness (i.e. Tutsi). Even though thousands of moderate Hutu were slain during the genocide, their former lives and the grievances by their surviving loved ones remains muted as the genocide is presented as having been committed solely against Tutsi.

Given the strictly politicized spaces allocated for national reconciliation, personal traumas are neglected and even suppressed. *Gacaca* and memorialization events and burials provide little support for traumatized individuals. Survivors testifying at *gacaca* are forced to recount their memories through a selective hearing that is imposed on them by the courts. There has been scarce, if any, opportunity for them to express their emotions. Such an objectified experience sparks little empathy in the perpetrators on trial. Similarly, commemoration events and memorials do not provide an outlet for personal healing, as both are inherently political in nature and homogenize the experience profoundly. Lingering insecurities are often tied to ethnicity, and Rwandans find it difficult to make sense of them and discuss them as references to ethnicity are outlawed. What is needed is both an appreciation of reconciliation at the interpersonal level through processes whereby individual grievances are adequately addressed. Trauma counselling and psychosocial interventions offer the prospect of alleviating traumas in such a way that renewed psychological orientations towards the out-group develop that positively impact on formerly opposed individuals. Such an approach will move beyond the simplistic reduction of the Hutu-Tutsi dichotomy and can provide a stage where the wealth off diversity and differences are acknowledged and are adequately discussed.

Chapter IV – *Guhahamuka*: trauma in Rwanda

Life in Rwanda continues, but at the margins of tolerable existence. Many people's loved ones are gone, homes are ravaged and destroyed and for many, common activities, ranging from work to social activities, have become impossible. In a society where it is estimated that up to 95 percent of people witnessed or participated in "extreme acts of violence",[274] traumatic memories are ingrained in the psyches of most Rwandans. This chapter illustrates how trauma continues to affect Rwandan society at different levels and discusses the implications for reconciliation. The main premise of this chapter is that reintegration and reconciliation will remain distant realities if individuals continue to experience the effects of their traumatic experiences and cannot cope successfully. In narrating how trauma affects everyday life and social interaction, I draw on scholarly work concerning the lived experiences of traumatized survivors and I illustrate the extent of trauma through a brief overview of epidemiological surveys of trauma and mental disorders in post-genocide Rwanda. After discussing the daily experience of trauma, I proceed to detail how some people face additional stressors and discuss the social implications of trauma in light of the reconciliation process.

I. The nature of trauma in Rwanda

In Rwanda, there is a lack of knowledge about what constitutes trauma, with people using different words to describe their psychological state.[275] In some cases, traumatic crises were sometimes conceived as hysterical manifestations. Especially in the immediate aftermath of the genocide, traumatic crises were attributed to being possessed by spirits (*yahanzweho not amazimu*) or madness (*ibisazi*). Such notions continue to remain in use, although these native explanations have become less commonplace over time.[276] Conversely, there are traumatized survivors who are not even aware that they are traumatized and instead think that their reaction is normal.[277]

After the genocide, the first trauma relief organizations imported the concept of PTSD, which Rwandans translated into *guhahamuka* ("to be unable to speak because of fear") to refer to traumatic manifestations.[278] They describe sensations of *guhahamuka* as "constricted feelings in the chest, a sensation that one cannot breathe properly, that the heart is out of place, and that the air one has inhaled remains trapped in the chest".[279] As it is sometimes perceived to be lethal, it can cause great fear.[280] *Guhahamuka* denotes a state where the individual is no longer able to control him- or herself, despite the virtues of discretion and calmness inherent in Rwandan culture. The person cries, running in every direction, hides, sees things that others do not see.[281] Topping the list of traumatic expression are psychosomatic complaints, in particular fatigue,

[274] Ndayambajwe, cited in Thomson 2009, p. 199.
[275] Scholte 2013, p. 44.
[276] Gishoma 2008, p. 247.
[277] Gilbert 2014, p. 27.
[278] King 2015, p. 388.
[279] Taylor 2014, p. 312.
[280] Hagengimiaa et al 2003, p. 7.
[281] Gishoma 2008, p. 249.

backache, headache and stomach ache.[282] *Guhahamuka* closely resembles *ihungabana*, which means to be overcome by emotions.[283]

These symptom clusters can come to take up a unique meaning in a local setting, even where modern medical diagnoses are able to capture the symptoms. For instance, some women who complained of having *inzoka* (snakes or worms) writhing inside their extremities and back, causing intense pain, were actually suffering from Type II diabetes. They became suspicious when the doctors recommended a physical regimen and several dietary constraints, as they experienced living organisms eating away inside them.[284] They may also experience a headache as a harbinger of insanity.[285] Here, we witness a disparity between the relevant medical diagnosis and the lived experience of patients. In that sense, *guhahamuka* may have become something of an umbrella term for a whole range of illnesses, even though some illnesses are clearly different from one another. Though *guhahamuka* in many cases was used to refer to PTSD, it has thus come to take up an almost autonomous meaning, at the risk of spreading much confusion regarding trauma. This lack of knowledge significantly hampers the way trauma is 'managed' at the social level, through social support structures and trauma relief interventions, as traumatized individuals do not know what to do and outsiders do not know how to recognize and respond to trauma. In addition, this lack of knowledge about trauma also reduces the possibility that others acknowledge the suffering of traumatized survivors.

The indigenous religion of Rwanda is replete with taboos and these take a central part in Rwandan culture and serve to regulate social relations. According to the native religion, breaking a taboo could cause disease and 'moral impurity'. Cleansing oneself of this impurity required a purification ritual in which traditional healers communicated with the spirits to protect the living from misfortune. In a similar way, mental illnesses were thought to be provoked by witchcraft, supernatural powers or taboo breaking. As a result, mental illnesses are mystified and stigmatized and people are generally apprehensive towards modern approaches to psychological healing. Many patients continue to prefer traditional healing and are at best ambivalent towards psychiatric hospitals.[286] For instance, they do not understand how words can contribute to the healing process.[287] This explains why public displays of emotions, especially among men, are prescribed in Rwanda and why people do not want to make too much of one's problems, arguing instead that "others have had it worse".[288] The healing process in Rwanda is therefore somewhat paradoxical: while Rwandan culture stresses the social context in which the individual is located, manifesting one's emotional state is considered a taboo. As people generally do not want to make

[282] Gishoma 2008., p. 240; Burnet (2012, Ch 1, Loc. 368) also emphasizes the psychosomatic complaints, in particularly among rape survivors. In her novel 'Nous existons encore', Kayitesi describes suffering similar symptoms, i.e. insomnia, intense fatigue, headaches, caused by trauma (Gilbert 2014, p. 93). *Guhahamuka* is the verb derived from the noun *ihahamuka*. Initially a folk syndrome, *ihahamuka* was rarely uttered before the genocide but became quite common after (Psychiatric Times, 1998).
[283] King 2011, p. 272; Gishoma 2008, p. 249.
[284] Burnet 2012, Ch. 2, Loc. 2037.
[285] Hagengimana 2003, p. 7.
[286] SciDevNet 2010.
[287] Jacob 2009, p. 238.
[288] The Atlantic 2014; Eramian 2014, p. 18; Gilbert 2014, p. 69.

too much of one's own problems, stating that "[…] my own suffering is shared by others who have suffered even greater than I did", [289] suffering and healing both become shared experiences and 'performed' in their social conduct.

II. Prevalence of trauma in Rwanda

Despite the fact that Western constructs of mental illness may not entirely capture the social ramifications of psychological ailments in developing countries shattered by mass violence, the use of these constructs nevertheless provides a thorough indication of the prevalence of trauma in Rwanda. The WHO estimated global prevalence of PTSD in 2000 between 0.4 – 0.6%.[290] The burden of depressive disorders in that same year was estimated between 3.7% and 4.4%.[291] In contrast, in Rwanda the prevalence of PTSD ranges between 25 and 60 percent and at least 15 percent for depression. The general picture that can be distilled from a meta-analysis of epidemiological surveys is that mental illness is significantly more prevalent in post-genocide Rwanda than societies that have experienced a protracted period of peace. Table 1 provides an overview of several epidemiological surveys regarding common mental health disorders in post-genocide Rwanda.

Table 1: Overview of epidemiological surveys of mental health in post-genocide Rwanda

Year	**Sample**	**N**	**PTSD (%)**	**Depression (%)**	**Anxiety (%)**	**Suicidal thoughts**	**Authors**
1999	Kinzenze commune	373		15.5			Bolton, Neugebauer & Ndogoni, 2002.
2000	Refugees	854	50				De Jong et al. 2000
2009	Youth	1547	53.9 and 61.6 (different samples) [292]				Neugebauer et al. 2009
2008	Orphans	206	28.2	34	42	39	Jacob 2009
2008	Widows	200	41.4	49	59.1	37	Jacob 2009
2005	Orphans	68	44				Schaal & Elbert 2006.

[289] King 2011, p. 229.
[290] WHO 2006.
[291] Üstün et al. 2004.
[292] Sydor & Phillipot 1996. However, all orphans resided in a non-accompanied orphanage, which suggests that they did not require significant psychological care as a result of having experienced extremely horrific incidents during the genocide.

1999	Children (8-19)	3030	79[293]				Dyregrov et al. (2000)
2011	Random sample[294]	962	26.1				Munyandamutsa et al. (2012)
2012	Young men and women (20-35)	427			42.7		Rugema et al. 2015
2002	Random sample	2074	24.8				Pham et al. 2004
2007	Orphans	206	29	34		42	Schaal et al. 2011
2007	Widows	194	41	48		59	Schaal et al. 2011
2011	Widows	100				40[295]	Hagengamina et al. 2003

These studies also provide insight as to which factors account for a greater likelihood in developing trauma. First, the prevalence of trauma varies strongly among regions, depending in large part on the scale of the violence.[296] The severity of traumatic events experienced is thus a major factor in determining who develops mental disorder. Also, the more victims were exposed to traumatic events, the more mental health problems were present. Second, girls and women have proven more susceptible to develop trauma than boys and men: in two different studies, it was ascertained that girls and women were approximately twice as likely to develop a PTSD, depression or anxiety disorder. [297] Third, although there have been no longitudinal studies investigating the prevalence of mental health disorders in post-genocide Rwanda to my knowledge, time does not seem to be a remedy for post-traumatic stress. In fact, a significant share of Rwandans have developed trauma even years later.[298] Fourth, risk factors such as economic suffering and social marginalization aggravate psychological suffering, [299] and were found to be the main rationales for taking their lives among suicidal patients.[300]

[293] The authors could not account for any mediating variables (e.g. education levels, current or recent exposure to security risks) and did not use a commonly accepted instrument for trauma research (e.g. Harvard Trauma Questionnaire). Furthermore, respondents were sampled from 11 different districts (although these were not proportionally represented in their sample size).
[294] Across five districts.
[295] In the study's sample, 40 respondents were dealing with panic disorder.
[296] The studies differed in methodology, sampling and measuring instruments (although almost all of them used the Harvard Trauma Questionnaire or the John Hopkins Symptom Checklist), but all of them considered PTSD on the basis of the DSM-IV diagnosis.
[297] Rugema et al. 2015; Neugebauer et al. 2009. Of the respondents, over 90% witnessed killings and had their lives threatened; 35% lost immediate family members; 30% witnessed rape or sexual mutilation; 15% hid under corpses.
[298] Kayetishonga 2012.
[299] Rugema et al. 2015. The study was conducted among 477 females and 440 males, of whom 83.9% and 73.4% respectively had witnessed traumatic events.
[300] Jacob 2009, p. 97.

Another indicator of the traumatic legacy is the egregious consumption of alcohol in the country. Despite the high costs, many find solace through a state of inebriation in order to avoid the stress and anxiety caused by a traumatic past. Average consumption of alcohol in Rwanda is 9.8 liters a year, significantly more than the African average of 6 liters.[301] Alcohol-dependency in Rwanda is estimated to be as high as 6.7 percent among survivors.[302] In comparison, the average in Western societies is 2.4 percent.[303]

A few studies have also investigated the relationship between mental illnesses and attitudes to reconciliation. Pham et al. (2004) found survivors who met the criteria for PTSD were less likely to have positive attitudes towards the Rwandan national trials, belief in community and interdependence with other ethnic groups. In particular, those who had been exposed to multiple trauma events were less likely to believe in a blissful future. The authors found that attitudes towards reconciliation were associated with level of education, perception of change in poverty level and access to security compared with 1994.[304] Similarly, Mukashema and Mullet found a significant relation between reconciliation sentiment and mental health. Respondents who suffered from mental health disorders were less inclined towards reconciliation.[305] Staub et al. (2005) also concluded that trauma indeed proved to be an impediment to a positive attitude to reconciliation, but that this effect could be remedied by means of a psychosocial intervention.[306]

Clinical suffering thus impacts strongly on the daily life of traumatized individuals and poses a major obstacle to reconciliation. But statistical correlation between common mental health disorders and inclinations to reconciliation does not explicate the link entirely. The issue I take with the PTSD concept in particular, which is emblematic of diagnostic constructs for common mental health disorders, is that it is applied in a binary fashion: one either suffers from PTSD or not. Although PTSD severity scales have been developed, these are hardly ever applied. Moreover, quantifying trauma runs the risk of neglecting the lived experience of traumatized individuals: how exactly they experience trauma and how this affects them in daily life. In addition, because the PTSD concept incorporates a wide array of symptoms it is difficult to identify the idiosyncrasies and unique characteristics of personal suffering and healing. Thus, the relatively high rate of PTSD prevalence may be explained by the fact that PTSD includes many symptoms which renders all constructs mutually exclusive.[307] Among Rwandan children suffering from PTSD, too, high co-morbidity with other mental disorders was found (anxiety, depression and somatic problems).[308] In other words, while screenings of PTSD prevalence give some sense of the

[301] AllAfrica 2014. In terms of alcohol consumption, the only African countries whose average was higher than Rwanda's were Uganda and Nigeria, both countries with violent pasts and broken communities. Source: AFK Insider 2015.
[302] Rieder & Elbert 2013, p. 8.
[303] Wittchen, cited in Jacob 2009, p. 25.
[304] Pham, Weinstein & Longman 2004.
[305] Mukashema & Mullet 2013. Previously, the authors had found a similar relationship in another sample (Mukashema & Mullet 2010).
[306] Staub et al. 2005.
[307] Rugema et al. 2015, p. 9.
[308] Murorunkwere, cited in Jacob 2009, p. 42.

breadth of the issue, it does not provide a sense of the depth of the issue. The next section therefore explores how trauma is experienced by and manifested in Rwandan society.

IV. The experience of trauma

To achieve some perspective on the general nature of suffering in contemporary Rwanda, a number of common themes can be derived.[309] These themes are derived primarily from survivor testimonies. As survivor testimonies are laden with a dialectic between past and present they show how their traumas continue to affect them in daily life.[310] These testimonies thus show how the past diffuses into the present as well as shape outlooks into the future. And as narratives provide a sense of both the description and the construction of self,[311] and because the self is constituted through interaction with the social realm, these analyses shed light on how trauma is experienced within Rwandan society.
The general themes that can be identified and that are particularly relevant to the reconciliation process are lack of trust, fear, incomprehension and loss of meaning, loss of faith, intrusions and reliving events, the feeling of not being alive and loss of identity.

Fear and lack of trust

Both Hutu's and Tutsi's experience feelings of fear, solitude, distrust and feelings that their lives have been ruined and friendships broken.[312] Traumatized survivors report physical illness and emotional and social difficulties resulting from stressful environments, as well as lacking sleep and trust. In particular, traumatic flashbacks impacts strongly on social relations and often results in physical and verbal violence. These feelings aggravate when traumatic symptoms are present, leading to a vicious circle in which trauma adversely affects the conditions that facilitate healing, such as their socio-emotional environment. Intimate partner violence is common in Rwanda, with over 30 percent of women having experienced domestic abuse since age 15 and nearly 20 percent in the 12 months preceding the survey.[313] Intimate partner violence is strongly correlated to common mental health disorders (e.g. PTSD, depression) because of the hyperarousal resulting from traumatic crises.[314] Nearly 40 percent of Rwandan men almost 50 percent of Rwandan women accepted intimate partner violence (e.g. wife beating)[315] and domestic abuse is very frequent here, with nearly 20 percent of women claiming to have experienced it in the previous 12 months.[316] As a consequence of traumatic expressions violence thus becomes normalized within a family sphere. At the community level, trauma can translate into hostile interaction as words, looks and other demeaning gestures (e.g. spitting on the ground when someone is saying hello)

[309] In doing so, I employ Boyatzis' method of reducing interviews to key ideas, subsequently into key themes and finally collapsing them into category data (cited in King 2015, p. 383).
[310] Germanotta 2010, p. 31.
[311] Baddley & Singer 2007.
[312] King 2011, p. 32.
[313] Republic of Rwanda 2005, p. 177.
[314] Verduin et al. 2013.
[315] Uthman, Lawoko, & Moradi, 2009, p. 10.
[316] Republic of Rwanda 2005, p. 177.

and result in what King described as 'broken communities'.[317] In such a community, people are generally fearful and suspicious of one another.[318]

Incomprehension and loss of meaning

The genocide uprooted may people's outlooks on the world. To many, the world becomes incomprehensible as essential assumptions about safety, predictability and meaningfulness break down,[319] leading to a sense of estrangement and solitude.[320] To paraphrase one survivor, their eyes no longer gaze the same on the face of the world.[321] For some, living becomes so unbearable that they give up.[322] Unable to adapt to their shattered outlook, they may attempt to commit suicide or never move beyond the stage of survival, becoming what is colloquially known as 'a living dead' (see below). Survivors of rape, for instance, were unable to rely anymore on assumptions of finding safety within their families, communities and churches.[323]

> "Life betrayed me. To be betrayed [...] is a staggering blow. It can make one behave badly. For example, a man turns to drink and refuses to take up the hoe, or a woman neglects her little ones and won't take care of herself anymore. But to be betrayed by life ... who can bear that? It's too much. You lose all sense of where the right direction lies. Reason why, in the future, I will always stay one step to the side. [...] Good fortune has offered me a second life, and I won't push it away. But it will be half a life, because of the complete break."[324]

Because the external world becomes 'unknowable' to survivors, their outlook on the world becomes fraught with uncertainty. This uncertainty feeds into their feelings of fear and trust, as mentioned above.

Loss of faith

Traumatic effects can destroy religious faith, leaving the survivor feeling disorientated and abandoned. Leaving religion can also lead to social isolation.[325] Needless to say, the genocide had a major impact on the spiritual outlook of survivors. Some lost their faith entirely, while others switched churches or even religion (many Christians switched to Islam)[326] and some even developed a firmer religious belief.[327] In one study on the types of persons consulted for mental or emotional needs, only 6 out of 52 reported that they turned to God.[328] This loss of faith ties in

[317] King 2011, p. 143.
[318] Ibid., p. 220.
[319] Janoff-Bulman, cited in Mukamana & Collins 2006, p. 159.
[320] Gilbert 2014, p. 77
[321] Hatzfeld life laid bare p 190
[322] Ibid., p. 5.
[323] Sandole & Auerbach 2013, p. 133; Janoff-Bulman, cited in Mukamana & Collins 2006, p. 159.
[324] Hatzfeld 2009, p. 7.
[325] Herman, cited in Mukamana & Collins p. 159.
[326] Williamson p. 137
[327] Hatzfeld 2009, p. 174 – 186.
[328] Bolton & Ndogoni 2000, p. 29.

with feelings of an incomprehensible world. The comfort that religion previously bestowed on them, is suddenly taken away from them, leading to outlooks replete with uncertainty, fear and distrust.

Intrusions and re-living events

Despite precautions to avoid any re-traumatizing events or intrusions, many survivors are often forced to relive their traumatic memories.[329] Avoiding this is very difficult, as many of the things that take them back are embedded in daily life. The previous chapter already elaborated on how commemoration ceremonies can trigger traumatic crises. But intrusions can also occur rather more haphazardly. For instance, many are still haunted by memories of being hunted down like animals in the marshes:

> "Sometimes sleep takes me back into the marshes. I see again all those people stretched out in the slime and soaking in blood. [...] When I awake, I feel an awful anguish, or heavy grief, as if I had gone to the land of the dead."[330]

In order to avoid traumatic crises, some people move to a new place or give birth to new children. Yet despite best efforts to practice this kind of 'selective amnesia',[331] people continue to be taken back in time to "the events of 1994" through specific places, objects, or sounds.[332] The current Rwandan landscape remains littered with historic sites and memorials that evoke the traumatic memory of the past. In everyday life, circumventing traumatic re-lapses can be extremely difficult, if not impossible. One woman was reminded of the violent deaths of her husband and children as she slept in a hotel room with a double bed: "that night [...] I thought my heart would explode and suffocate me".[333]

Some survivors cope with scars, physical wounds, even disabilities, that tangibly perpetuates the trauma into the present. Over the years, survivors therefore develop conscious strategies to avoid any intrusions that may affect their daily functioning.[334] Their success, and thereby their ability to return to the normalcy of everyday life, in this regard varies. Some learn to cope, while other's 'go crazy'. Although some individuals are more prone to developing trauma, the trauma membrane – i.e. the triggers of their intrusions - they are able to form around them determines in large part whether they are successful in coping with their memories or not.

---

[329] Gilbert 2014, p. 224.
[330] Haztfeld 2009, p. 102.
[331] Burnet invokes the term 'collective amnesia', akin to Buckley-Zistel's coinage of 'chosen amnesia' to refer to the politics of memory in post-genocide Rwanda as discussed in the previous chapter. These terms, however, miss the personal nature of how many traumatized survivors in Rwanda seek to avoid things or phenomena that may cause them to lapse into a traumatic crisis.
[332] Burnet 2012, Ch. 2, Loc. 1700.
[333] Ibid., Loc. 1770.
[334] Ibid.

Loss of hope in the future

The psychological health of traumatized survivors often compounds their ability to ensure a livelihood. Their minds debilitated by the loss of hope, troubles and sorrows,[335] many have become apathetic and "spend their days doing nothing, won't look for work anymore, won't build themselves a new home. They are overcome, crushed by mourning and the onslaught of misfortunes, no longer even looking for a way out."[336] When so many people have lost hope in the future, the prospects for reconciliation as a forward-looking process are significantly diminished. Moving towards a shared future becomes a distant reality when so many feel that such a vision is utopian.

The feeling of not being alive

Unable to articulate their suffering, many survivors lose their sense of belonging. With no words to describe the events that they experienced and no framework to comprehend them, many a Rwandan survivor became *yaphuye buhagazi,* the "walking dead".[337] As one survivor put it, "In fact, you're a zombie, living dead. [...] After the genocide, I was a living dead." [338] Despite having survived, they feel 'non-existent' and have lost their sense of self-worth entirely.[339] Their spirits withered, they have lost the willingness to live and many have committed suicide as a result of having lost the real meaning of life.[340] to shed their former status as dehumanized subjects who "preferred to endure every indignity rather than die".[341] They struggle to move beyond the stage of mere survival to living life.[342] Unable Amidst total carnage and robbed of their humanity, survivors of killing sprees in the marshes half believed they were corpses themselves.[343] Some went crazy, seeing ghosts and hearing dead souls coming back to chastise them. As the genocide tore their lives apart, they now find themselves in a state of mere survival, detached from their blissful, pre-genocide past:

> "Until 1994, I had a life, it doesn't matter what kind of life, but I had one. [...] In another life returning to the country in 1997, I did not know what was left of the first and what was the second."[344]

Whereas formerly they were living lives over which they exercised a sense of control, their strategy of mere survival implies a far more passive stance towards life.[345] Faced with such a loss of

[335] Hatzfeld 2009, p. 64; Ibid., p. 160;
[336] Ibid., p. 228.
[337] King 2011, p. 221.
[338] Ricci 2009, p. 121.
[339] Gilbert 2012, p. 220.
[340] Gitau 2012, p. 4.
[341] Hatzfeld 2009, p. 47; Hatzfeld 2006, p. 117.
[342] Sandole & Auerbach 2013, p. 135.
[343] Hatzfeld 2009, p. 110.
[344] Gilbert 2014, p. 223
[345] Ibid., p. 216

agency, social interaction, let alone reconciliation, become distant realities to those whose present lives are dim shadows of their former lives.

Loss of identity

Traumatized survivors may experience a 'rupture of the self', which translates into a loss of control, of one's identity and the ability to describe or comprehend a horrific event.[346] As one female rape survivor questioned: "Am I a Rwandan women? Am I a woman? Am I, even?"[347] The questioning of such constitutive elements of her identity - her nationality, her gender – and even her very existence illustrates how alienated many survivors have become in the aftermath of the genocide. As personal identities and the social world are so closely bound up, such a loss of identity and resultant alienation is grossly detrimental to a person's social integration and relations.

V. Vulnerable groups: orphans, victims of sexual violence and widows

Particularly vulnerable groups, ones that face additional stressors, are orphans, victims of sexual violence and widows.[348] The genocide left many orphaned children as well as women, many of whom were widowed and repeatedly raped, to fend for themselves and reconstruct their lives in an environment that completely shattered their outlook on life. The genocide skewed the country's demographics as men were typically killed, but many women survived as they were raped by perpetrators who thought it more fitting to degrade and terrorize them through sexual violence. The loss of a father or husband complicates the financial situation for many orphans and widows and this significantly aggravates their suffering.[349]

Orphans

Although the genocide left a profound mark on everybody, children in particular were vulnerable to having danger, defenseless and terror inscribed on their psyches. UNICEF has estimated that over two-thirds of Rwandan children witnessed a killing or a serious injury.[350] Many of them were used as soldiers by both Hutu's and Tutsi's.[351] Children who previously gathered to witness the arrival of a foreigner, ecstatically welcoming them, now lay despondent around the road.[352] Almost one-third of genocide victims treated by physicians in western Rwanda were children. They had incurred physical wounds, such as amputated limbs or machete cuts across their faces or necks; an enduring testament to how children, regardless of age, were also targeted in the

[346] Gobodo-Madikizela & Van der Mere, cited in King 2011, p. 32.
[347] Quoted in Gilbert 2014, p. 130. Translated from French.
[348] Jacob 2009, p. 98.
[349] Jacob 2009, p. 92.
[350] The study (a survey of over 3.000 children) also concluded that "80 percent of children interviewed experienced a death in the family during the period of the genocide; 35 percent saw other children killing or injuring other children; 88 percent saw dead bodies or body parts; 31 percent witnessed rape or sexual assault; 80 percent had to hide for protection; 61 percent were threatened that they would be killed; and 90 percent believed that they would die." Source: Human Rights Watch 2003, p. 8.
[351] Venter 2007, p. 10.
[352] Burnet 2012, Ch. 1, Loc. 1519.

genocide. In Kaduha, when children went back to school after the hostilities, the bones of other children still littered the schoolyard in which they played.[353] Many children remained too traumatized to study as they suffered from uncontrollable crying, insomnia, depression, hallucinations and fearfulness.[354]

Up to 400.000 children, or 10 percent of Rwandan children, have lost one or both parents in the genocide.[355] Struggling to meet the daily challenges of feeding and sheltering themselves after hostilities ended, the overwhelming majority of them was mired in poverty, with no access to basic education and health care.[356] Nowadays, many children are ostracized from the community and less likely to be adopted by virtue of their parents having died from HIV/AIDS. These children suffer a stigma of being 'contaminated' by the virus, regardless of whether they are infected themselves. Others suffer the stigma of association with a family member suspected or condemned on the count of participation in the killings. Community members fear that "Those children will grow up to be killers" as "you can see it in their eyes that their parents were killers".[357] While before 1994, the care for vulnerable children was common in Rwandan children, society has increasingly turned a blind eye towards children in dire need. As such, they feel isolated, exploited and ignored.[358] Most orphans have not found alternative caregivers and lacking the comfort of a home and a sense of belonging through family, they feel isolated and abandoned.[359] Thousands of street children (*mayibobo*) struggling to survive suffer the most vehement demonization of all of them,[360] even though they face the most degrading exploitation. Estimates of rape of street girls range from 80 to 93 percent.[361] Consequently, in the absence of enticing opportunities or affection by caregivers, many street children end on a criminal path.

Victims of sexual violence

Rape survivors are overly represented among the mentally distressed in Rwanda. Usually, this is the result of both the grief and distress as a direct result from the traumatic events they experienced as well as structural factors, such as isolation, stigmatization and extreme poverty.[362] Hundreds of thousands of women experience sexual violence during the genocide with estimates of up to 90 percent of Tutsi women survivors having been raped.[363] The genocide was unprecedented in the sense that rape was rampant and used as a means of violence within the genocide. In fact, rape was so widespread during the genocide that the ICTR established that rape

353 Human Rights Watch 2003, p. 8.
354 Freedman 2004, p. 254.
355 Human Rights Watch 2003, p. 1.
356 Ibid., p. 44.
357 Ibid., p. 45.
358 Ibid., p. 46.
359 Kaplan 2013, p. 101.
360 Ibid., p. 62.
361 Ibid., p. 73.
362 Richters 2009 p. 174; Sandole & Auerbach 2013, p. 134.
363 Rinaldo, cited in Mukamana Collins p. 141

was carried out with the intent to destroy a specific group and that sexual violence was therefore a systematic part of the genocide.[364]

Rape touches all aspects of a person's life, destroying the mental, physical and social integrity of an individual.[365] Survivors of wartime rape experience their sense of self as having been invaded and broken down, often resulting in feelings of shame and self-loathing.[366] But many women who were raped or were subjected to other forms of sexual violence not only carry traumatic memories with them and perceive themselves as morally inferior and ashamed,[367] but also experience stigmatization, which keeps them from speaking out.[368] This stigma dissuades many from seeking the help they need[369], often resulting in social isolation which compounds their psychological trauma.[370] In addition, they often feel guilty for having survived and have grown disillusioned with the rule of law as justice continues to elude them.[371] These are some of the issues that adds to their psychological suffering, creating a 'building block' of multiple traumatic components. Debilitated by their state of mind, all rape survivors are deeply traumatized, and most have developed clinical forms of suffering. Even many years later, the traumatic events continue to haunt them:

> "The cruelties I experienced during the genocide have affected me profoundly. I can't forget them. […] Our morale was badly tortured and even now the feeling hasn't gone away. It's impossible to put it out of your mind."

Because women are pivotal in family life and cultural reproduction they became strategic targets in the genocide.[372] Rwandan culture values marriage and its sanctity highly as women are conventionally expected to manage the household and raise children. [373] Furthermore, it is presupposed that upon marrying women are virgins. Disclosing their status as rape survivors severely constrains their chances of getting married. As a result, survivors of sexual violence are extremely reticent in publicly recognizing these events, let alone talk about it, instead trying to maintain the illusion of virginity.[374] Furthermore, they often feel isolated in a community that ostracizes them on account of having experienced rape:

---

[364] Askin 2005. However, despite its landmark ruling of 'rape as genocide', several scholars point out that its historical significance is largely symbolic. African Rights (2004, p. 76) also observes that justice remains elusive, stating that "Very few of the women we encountered had seen their abusers prosecuted—another concern affecting their state of mind negatively."
[365] Hilsum, 2014.
[366] Herman, cited in Sandole & Auerbach 2013, p. 128.
[367] Mukamana & Brysiewicz 2008.
[368] Gilbert 2014, p. 28.
[369] Mukamana & Collins 2013, p. 141.
[370] Gilbert 2014, p. 206.
[371] African Rights 2004.
[372] Madre, cited in Mukamana & Collins p. 144.
[373] Sandole & Auerbach 2013, p. 131; Burnet 2012, Ch 1. (Loc. 1038).
[374] Ibid., Loc. 2922.

> "They don't respect you, they ostracize you, people say that we were no different from prostitutes because we accepted having sex with any man who wanted to have sex with us during the genocide."[375]

Adding insult to injury, infertility was another common consequence of rape.[376] Because of their diminished chances to marry and raise a child, they often sink into deep depressions, feel isolated and lose their hope in the future.[377] They become trapped in a downward spiral with their illness reducing their ability to sustain themselves and their dependents.[378]

Widows

Many women were widowed during the genocide. As remarriage in Rwanda is not socially tolerated[379] and since women traditionally find their value in Rwandan society as a wife and mother, many have lost hope in the future: "How could live have meaning without kids, without a husband?".[380] Losing their husband implies the loss of their most important social network. As one widow put it:

> "Widows are without families, without houses, without money… We become crazy. We aggravate people with our problems. We are the living dead."[381]

Other women were impregnated by their loved ones' killers, bearing a child that was a permanent reminder of what had occurred during the genocide. For many women, this reminder was so painful that they wanted - or even tried to - kill them. Levine, a rape survivor, failed to abort her baby and frequently assaulted her at home, saying "this is a Tutsi house, and you don't belong here". Another rape survivor who was impregnated with an unwanted boy stated that

> "[…] whenever he asked me for something to eat, I wouldn't give him anything, so that he would die. I was very aggressive towards the little thing. Whenever he called me mum, I would tell him that my children, who would've been able to help me, were dead and that he was of no importance to me at all."[382]

Within the community, children born of rape face additional hardship and stigma. Tutsi survivors call them *Interahamwe* or 'son of a snake'; relatives of the Hutu rapists blame them as their mothers testified against their fathers and put them in jail. They do not qualify for government assistance and most of them live in poverty. Traumas cause tension in the family sphere which can result in additional behavioral problems among the children. Girls are ashamed and take on the suffering of their mothers, losing their trust in men at an early age, while boys often throw

375 Mukamana & Collins 2013, p. 158.
376 Ibid., p. 154.
377 African Rights 2004, Ch. 4; Sandole & Auerbach 2013 p. 134-135.
378 African Rights 2004, p. 38.
379 Schaal et al. 2011, p. 8.
380 Mukamana & Collins 2013, p .155.
381 Nowrojee, cited in Schaal et al. 2011, p. 8.
382 African Rights 2004 p. 40.

tantrums.[383] They may harbor dormant feelings of rage, in some cases even an urge to kill, in order to quell the fear they experience during re-traumatizing events.[384]

Perpetrators: invisible suffering?

Although several studies have addressed the psychological impact of committing violence,[385] to my knowledge only two such studies have been conducted among perpetrators of the Rwandan genocide, a major limitation in research in the reconciliation process. The study found that although survivors were far more likely to suffer from PTSD (46 versus 14 percent) and anxiety symptoms (59 versus 36 percent), both groups suffered from high levels of depression (46 versus 41 percent). Among perpetrators, PTSD severity was associated with trauma exposure and participation in killing.[386] In a comparative study of common mental health disorders in survivors and former prisoners, it was found that former prisoners suffered nearly as much from debilitated minds as survivors.[387] Prisoners were far more likely than survivors to turn to alcohol abuse (14.6 versus 6.7 percent).[388] Some signs of the mental hardship of participating in the killings in 1994 can be glimpsed from a story of a Hutu who buried his Tutsi neighbor alive:

> "Eight months later, he felt himself called by his victim in his dream. He went back to that garden, he dug up the dirt, unearthed the corpse, and got himself arrested. Since then, in the prison, he wanders day and night with that man's skull in a plastic bag he holds tight in his hand. He cannot let go of the bag even to eat. He is haunted down to the last extremity."[389]

An anecdote by a rape survivor also revealed how one perpetrator who felt guilty about the crimes he committed was unable to cope with the allegations against him in the *gacaca* courts and died as a result of psychosis.[390] Although only recently there seems to have been some more attention to the suffering of perpetrators,[391] they are mostly shunned by survivors. Their suffering denied by survivors as well as the authorities, they are unable to find any outlets for their emotions. This kind of demarcation of suffering maintains an exclusive victim identity among Tutsi and perpetuates the Hutu-Tutsi and survivor-perpetrator divides and is therefore major impediment to the reconciliation process.

VI. Living with trauma: the cultural context

Healing does not take place in isolation. Despite the emphasis on community within the social cosmology, Rwandan culture is not particularly conducive to emotional healing. Survivors not

[383] Hilsum 2014. Estimates of the number of children born of rape run from 5.000 (UN) to 20.000 (Survivors' Fund). Source: Ibid.
[384] Kaplan 2013, p. 106.
[385] For an interesting perspective on the psychological consequences of killing, see MacNair 2002.
[386] Schaal et al. 2012.
[387] PTSD was diagnosed in 22 percent of the cases (versus 24.7 percent among survivors) and anxiety as well as depression severity was slightly less severe (15.4 versus 17.2 and 19 versus 20.7 respectively). Source: Rieder & Elbert 2013, p. 7.
[388] Ibid., p. 8.
[389] Hatzfeld 2006, p. 114.
[390] Richters & Kagoyire 2012, p. 134.
[391] Richters et al. 2010, p. 56.

only assert that their experiences are 'unsayable',[392] they also experience difficulty in making themselves heard.[393] At both the individual, familial and community level, silence concerning 'the events of 1994' is pervasive. One survivor described it thus: "No one has explicitly asked us to keep quiet, we immediately felt the need to be quiet". [394] Indeed, Rwandan culture insists that the experience of pain should be quiet and internal. Proverbs, which are of great importance in Rwandan culture, illustrate this social convention eloquently.[395] Quite literally, the proverbs *agahinda ntikajya ahabona* ("grief is not displayed"), *ubonye ntavuga* ("great griefs are silent") and *agahinda if uguhora ulira* ("grief does not appear") attest to this need for silence.[396] In fact, Rwandans even take great pride in hiding their emotions, as the proverb *imfura ishinjagira ishira* ("a noble man walks with his head high even when he is in pain") illustrates.[397]

Rwandan cultural law thus prohibits people from losing self-control when faced with painful emotions. But with barely no one to discuss their memories, they are effectively 'muted' in the social realm. This silence, in particular, can be alienating for survivors who already feel isolated. In Rwanda, they became known as *nyamwigendaho,* or someone who selfishly lives in isolation. They state being lonely, locking themselves inside their houses, or simply try to hide from a world they perceive as violent.[398] Many of them refuse to talk or to reply to people's greetings.[399] As these are not merely forms of recognition, but also a way to recognize another human being his or her humanity, *nyamwigendaho* are often shunned in society.[400]

Another reason that explains the silence and social isolation of many survivors is that they are afraid to 'open up' their traumatized selves. They are suspicious of a world that has proven extremely unsafe and horrifying, and fear that relinquishing control and showing their vulnerability can create permanent damage to their hearts and minds.[401] Thus, they form an intrapsychic membrane around them in order to shield them from what they perceive as intrusions that can affect their mental well-being. But this silence has prevented many from discussing the past openly, thereby creating more fear and suspicion by driving a wedge of uncertainty between people.

---

[392] Gilbert 2014, p. 31. By stating that their experiences are 'unsayable', survivors feel that language is inadequate in conveying their memories "to others as there is no shared frame of reference or meaning between the survivor-witness and the audience, often resulting in silence on the part of the survivor-witness" (Ibid. 176). This brings to mind Primo Levi's statement that "After Auschwitz, we cannot write poetry about Auschwitz" (quoted in Ricci 2009, p. 227).
[393] Gilbert 2014, p. 32.
[394] Burnet 2012, Ch. 3, Loc. 2489.
[395] Ibid., Loc. 3285; Bagalishya (2000, p. 341) notes: "In Rwandan tradition, the proverb is a mode of communication often used to express what a person has seen, heard and experienced at the level of emotions, feelings and states of mind, as well as to indicate to someone that they have been understood."
[396] Gishoma 2008, p. 253.
[397] Gitau 2012, p. 6.
[398] King 2011, p. 232.
[399] Kaplan 2013, p. 102.
[400] King 2011, p. 225.
[401] Ibid., p. 232.

VII. The social effects of trauma

How then, does the prevalence of trauma, array of traumatic effects and cultural context feed into the reconciliation process? This section discusses how trauma affects the reconciliation process in light of the requisite conditions for reconciliation as established in Chapter II.

Fear

In the previous chapter it was made clear that due to the level of domestic stability, albeit a 'repressive peace', inter-ethnic violence has largely subsided. Despite this, there remains "a sense of personal or group insecurity that contrasts with international and government reports of the physical safety for which post-genocide Rwanda has been praised."[402] Many survivors still live in fear, while many Hutu fear revenge attacks. This creates deep tensions between Rwandans.[403] In the public sphere, most Rwandans simply try to engage in what I call 'pragmatic co-existence'; in the private sphere, they remain suspicious. As trauma ruptures the pre-supposed consistency and predictability of the external world, survivors generally remain fearful. Many survivors who lost their loved ones in the genocide continue to feel that, under certain circumstances, genocide can still happen again.[404] As discussed, an individual's outlook can become fragmented and incomprehensible. This uncertainty within one's worldview can translate into fear:

> "After the genocide, life was very meaningless and I did not care whether I lived or not. The world seemed to have ended. I was very scared of people and the things I had experienced…. People looked like killers to me."[405]

Yet although most survivors still fear Hutus, they cannot open their hearts and spit out their feelings, afraid that it could bring chaos to the country.[406] Even several years after, many children who had managed to cross the border during the genocide to find safe refuge (e.g. in Tanzania) refused to be reunited with their families in Rwanda or even to be accompanied by their families when they were still alive.[407] Other child survivors in an orphanage expressed a constant fear that the perpetrators would strike again; indeed, "they were seeing killers everywhere." Traumatic crises and anxiety could be triggered, for instance, by hearing a whistling sound that reminded them of the perpetrators communicating amongst each other. [408] Their sense of safety is too fragile.

Trust

Under normal circumstances, the rule of law provides citizens with a sense of comfort and security. The 'culture of impunity' that cleared the way for the genocide to ensue has led to a

[402] King 2011, p. 142.
[403] Gilbert 2014, p. 263.
[404] King 2011, p. 220.
[405] Ibid., p. 135.
[406] Hatzfeld 2009, p. 90.
[407] Human Rights Watch 2003, p. 12.
[408] Kaplan 2013, p. 102.

shattering of security and trust.[409] In a society where neighbors were of great importance, but who turned to killing each other as the genocide commenced, trust is completely shattered:

> "Someone who has seen atrocious suffering for so long can never live again among others as before, because this person will remain on guard, suspicious of people, even if they have done nothing."[410]

Unsurprisingly, Rwanda ranks among the countries with the lowest scores of social trust. Some 95 percent of Rwandans agree that one has to be 'very careful' in dealing with other people. With the Hutu-Tutsi divide having become entrenched along religious and linguistic lines, nearly one-third of Rwandans state they do not trust others who practice a different religion and 40 percent refuse a neighbor who speaks a different language.[411] Rwandans experience suspicion and mistrust among the most pressing issues; poverty and a lack of food were the only problems of greater concern.[412]

Empathy and sympathy

Trust can develop from reciprocal relationships where suffering and problems are mutually acknowledged.[413] But a general lack of empathy and sympathy among both survivors and perpetrators impedes constructive dialogue or engagement. Indeed, the isolation in which many traumatized survivors entrench themselves create barriers between the in- and out-group which increases the social distance and mistrust within both groups.[414] Survivors are generally incapable or reticent in expressing any sympathy towards the suffering of perpetrators, for instance ex-prisoners who consequently experience much hardship in re-integrating into their communities.[415] In addition, a general apprehension revolves around trauma in Rwanda. Much of survivors' suffering is not acknowledged by those who claim that 'survivors are crazy' and that 'survivors fake their trauma'.[416] This often stems from a lack of knowledge regarding trauma as well as a lack of interaction with traumatized survivors. [417]

Recovery environment

It has already been noted that many traumatized survivors live in isolation and many of them did not turn to anybody to address their mental and emotional needs.[418] In Rwanda, the rupture of

[409] King 2011, p 11.
[410] Hatzfeld 2009, p. 69.
[411] Foa 2009, p. 7. In comparison, 73 percent of Russians agreed with the same statement and 56 percent of people in the Netherlands.
[412] Bolton & Ndogoni 2000, p. 27.
[413] Ibid., p. 160.
[414] King 2015, p. 385.
[415] Ibid., p. 386.
[416] King 2011, p. 141.
[417] Ibid., p. 169.
[418] Bolton et al. 2008, p. 28-29. In a survey among 50 respondents (25 male, 25 female), 24 stated they did not consult anybody for their mental or emotional needs.

the social fabric and the absence of many social support environments caused additional hardship in many cases:

> "But it was very difficult to live here because of the way neighbors treated me. I decided to not approach them. I did not want to talk to them. They were bad people. Then I started getting re-traumatized again."[419]

A key support environment is the family, which Rwandan culture values highly.[420] As one proverb states: "Only intimate can understand the grief of someone" (*agahinda k'inkoko kamenywa not yatoreyemo ikike*).[421] Indeed, the psychological well-being of Rwandans cannot be isolated from that of their families and those close to them.[422] The previous chapter already hinted at the strict demarcation between the public and the private in the Rwanda. The family sphere is a confined space in Rwanda, as the proverb *akari murugo karuguma imbere* ("what is in the home remains inside") puts it.[423] However, the psychological consequences of the genocide caused huge strains within family structures. With 27 percent of Rwandans reporting that they trust their families only 'a little' or less – among the highest levels of family mistrust in Africa – it seems that too many family can no longer provide the consolation and emotional support they need.[424] Those who do want to turn to their families may not be able to because their relatives are dead. They feel disoriented in their solitude and are forced to deal with their traumas on their own:

> "When you haven't had anybody, somebody you can talk to, even if that person may not understand what you are saying, but someone there, a person with whom you can share your suffering and feel some release in your heart, the problems fall on you alone and keep you captive because there is nobody else to care them with you".[425]

An issue that seems to be underprivileged in the literature regarding the recovery environment is the fact that trauma may affect the recovery environment as well. For instance, traumatized survivors were more likely to engage in family quarrels that led to physical or verbal violence. This leads to stressful environments, causing additional emotional and social difficulties and somatic complaints.[426] It has already been remarked how violence is normalized in many Rwandan families. Similarly, Rwandan children that experienced family violence were far more likely to develop mental disorders.[427] One survivor of rape states that "Our children also need help. I

---

[419] King 2011, p. 139.
[420] Mironko and Cook, cited in Burnet 2012, Ch. 3 Loc. 2522.
[421] Gishoma 2008, p. 252.
[422] Bagalishya 2000, p. 352.
[423] Gishoma 2008, p. 253.
[424] Foa 2009, p. 5.
[425] King 2011, p. 134.
[426] Ibid., p. 142.
[427] Roth, Neuner & Elbert 2014. Similar findings have been reported by Rieder & Elbert (2013, p. 8), who concluded that descendants of traumatized survivors develop a psychopathology very close to their parents: 15.5 percent of descendants of survivors developed PTSD, versus 24.7 percent among direct survivors; anxiety severity was measured at 13.9, versus 17.2 among survivors and depression severity was measured at 17.1, versus 20.7 among survivors. Similarly, descendants of former prisoners developed anxiety disorder (severity: 12.2 versus 15.4) and depression (severity: 16.1 versus 19.0). However, only 1 percent of children was diagnosed with PTSD, compared to 22 percent in the former prisoner population.

cannot deny my abuse towards them, and I do believe that even if I get help, they are already damaged and lived with the hurt and fear forever". Thus, trauma can have a long-lasting impact on people close to traumatized persons and therefore on social support structures.

VIII. Conclusion

Beyond the physical destruction, the Rwandan social fabric was severely ruptured after the genocide, as basic familial and community networks – if they even continued to exist in some form – no longer provided the safety and support as they did before. The violence in Rwanda did not only destroy relationships but created new ways of relating in daily life as traumatic memories shape individual's thoughts and actions in the present.

At the start of this chapter, I referred to several studies which found that survivors suffering from trauma and mental health problems were less inclined towards reconciliation. I have elaborated on several effects of trauma at the individual, family and community level that pose a barrier to reconciliation. At the individual level, isolation and solitude, as well as a lost zest for life, prevents them from getting the support they need. In addition, they have become wary of society, as they do not easily speak their troubled minds. The incomprehension with regard to the outside world and the fear they still harbor in their hearts and minds often translates into an outlook on society where people are categorized according to their ethnicity, or possibly in survivor-perpetrator terms. This rigid classification of society dictates social functioning in post-genocide Rwanda and is a major impediment towards a more constructive relationship among Hutu and Tutsi, survivors, bystanders and perpetrators. At the family level, traumatized survivors do not find the support they may need. In fact, their debilitated minds often only aggravate family issues. At the community level, Rwandans engage in 'pragmatic co-existence': only doing what is necessary in order not to incite any violence or inflame any hatred. But the effects at the community level are clear: many survivors have become apathetic, there are high levels of fear, low levels of trust, a general lack of empathy and sympathy amongst each other and recovery environments are ruptured. The next chapter will deal primarily with how trauma relief has affected post-genocide Rwanda and, in particular, which challenges still lie ahead.

Chapter V – The Rwandan mental health sector

Low-income, post-conflict societies often have very limited mental health resources and interventions.[428] Rwanda is no exception. Even years after the genocide, those who were in most need of mental health care did not receive any treatment from the few programs operating at the time. In fact, the sheer lack of trauma counselling has dissuaded them from seeking help.[429] As one survivor observed:

> "In a normal situation, one can get support and assistance from school, extended family, work, the state. All these are gone in war. There is nothing. You can't trust anyone. All is gone. There is no protection. The teachers, the mayors, even the family has killed."[430]

As early as 1996, a comprehensive scheme by the USA to rebuild Rwanda's war-torn society was developed as a result of all on-going projects and needs at the time. It noted how vulnerable groups – i.e. (sexually abused and/or widowed) women and (orphaned) children – were affected psychosocially and how community-level initiatives had already been undertaken by various NGO's. It also noted how a combination of Western and indigenous approaches to trauma counselling have alleviated suffering and made early inroads into community healing.[431]

But despite this early recognition of the need for psychotherapy, mental health care remains unprivileged in Rwanda. The country is still heavily reliant on donor aid from other countries and NGOs, most of which is directed to emergency assistance, HIV/AIDS interventions and community and agricultural development projects (e.g. food-for-work programs, care for the disabled and street children and services for orphans). Health-wise, the allocation of resources is poor, and no mention is made of mental health by donors contributing large sums of financial aid.

What role does the government play in addressing the highly pressing issue of trauma in post-genocide Rwanda? Does it recognize the plight and is it equipped to address the issue adequately? This chapter focuses on the role of the Rwandan government in addressing trauma since 1994. It will become evident that the mental health sector has adopted a primarily Western psychopathological approach, most likely as a result of being dependent on financial and human resources in the mental health sector. However, this invites critical questions regarding the sustainability of this approach which will addressed in this chapter.

I. Addressing trauma in the immediate aftermath

In October 1994, UNICEF, in close collaboration with the Rwandan Ministry of Rehabilitation and several NGOs developed and began implementing the Trauma Recovery Program. The program targeted children traumatically affected by the genocide through a community-based intervention in which they were stimulated to express their emotions through cultural therapeutic practices such as storytelling, drawing, writing, dancing and drama, all of which was centered within the Rwandan cultural context. The primary objective of the program was to build a national capacity for dealing with traumatically affected children by training (para-)professionals who work directly

[428] Jacob 2009, p. 104.
[429] Bolton & Ndogoni 2000, p. 10; Thomson 2009, p. 199.
[430] Kumar 1997, p. 207
[431] U.S. Agency for International Development 1996.

with children (e.g. teachers) through, for instance, strengthening their knowledge about child development. A number of Trauma Advisors were trained through the Trauma Recovery Program and tasked with training (para-)professionals as well as screening and possibly referring children to a mental health institute. Furthermore, the program provided support to the Ministry of Education to establish a National Trauma Center in Kigali in June 1995. The aim of this Center was to provide outpatient treatment of severely traumatized children and families, train counsellors, raise awareness and knowledge about post-genocide trauma, conduct research and contribute to mental health policies.[432] The National Trauma Center originated from the Ndera psychiatric hospital which remained closed in the months following the genocide. With the assistance of the International Committee of the Red Cross (ICRC), however, the Ndera psychiatric hospital was able to open again in August 1994, exclusively catering to people deeply traumatized by the genocide.[433] Still, its capacity was limited at around 100 in-patients and was only able to provide rudimentary mental health care, such as handing out tranquillizers. After receiving medication, patients were often at a loss on how to cope as many had nowhere to go to.

II. The struggle against self-sufficiency

While the international community has recognized the need for trauma counseling at an early stage, this fact is far less commendable in light of the reluctance of said actors to meet the financial demands required to meet the needs. In 1995, the Rwandan government requested $ 19 million, chiefly to facilitate care for unaccompanied children (25%) and women (16%). Yet donors initially pledged $ 6.3 million which, only after several months and arduous campaigning, rose to the requested $ 19 million. Difficulties in raising sufficient funds were compounded by the lack of a clear policy and legal framework for psychosocial help that has rendered evidence-based mental health care extremely difficult. Whereas several NGO's wanted to terminate their activities, they refrained from doing so knowing the government was not able to fill the gap.[434] After the genocide and up until 1999, most donor contributions were directed at NGOs, with only a few countries channeling their financial assistance directly to the government. As the country acquired economic and political stability, however, this trend was reversed and after 2000 most donor contributions were directed to the authorities.

Given that Rwanda is one of the poorest countries in sub-Saharan Africa,[435] addressing the mental health needs of the Rwandan population adequately is a daunting task. The most challenging problem is to render Rwanda self-sufficient in providing mental health care and in procuring their own financial means to facilitate this. A 1998 national accounts study in Rwanda showed that 50% of health sector costs are covered by donors, and only 9% is provided by the national government. Even fourteen years after the genocide, when the country has re-established much of its infrastructure, it became evident that the health sector still coped with a serious shortage of public financing. According to Rwanda's health financing policy:

> "The high dependence of the Rwandan health sector on external assistance raises concern about the financial sustainability of health improvements in the country. The share of

[432] Dyregov et al. 2000; Chauvin, Mugaju & Comlavi 1998, p. 387.
[433] ICRC 1995.
[434] Ibid. p. 40.
[435] Government of Rwanda: Ministry of Health 2009, p. 8.

> domestic resources to public health expenditure has decreased while external health resources increased. Donors' share of THE [Total Health Expenditure] have increased to over 53 percent in 2006 compared to 42 percent in 2003."[436]

Even more striking is the fact that only 1% of the health budget is spent on mental health. This, however, should be put in perspective with regard to the fact that the government is not the only allocator of health resources. In fact, the government is responsible for about one-quarter of all health resources in Rwanda, whereas development partners and households facilitate - by and large – an even share of the remaining health resources. This private and social insurance scheme was initiated in 1999, when the government initiated a pilot program of mutual health insurance scheme known as *mutuelles de santé* or *mutuelles*. It was adopted as a matter of national policy in 2005 and has become obligatory for every Rwandan since 2008. The scheme requires an annual payment of 1000 Rwandan francs ($2) per person. It is partly financed by external aid, from partners such as the Global Fund to fight AIDS, Tuberculosis and Malaria, that covers insurance for about 1.5 million vulnerable Rwandans. But as of 2008, the system only covered approximately 85 percent of Rwandans, excluding those living in remote areas and in extreme poverty.[437]

The payment scheme may be conceived as a form of solidarity that fosters social cohesion within communities by enabling the poor to be referred to relevant and necessary health care. But those facing dire poverty experience difficulty in gathering the required premiums, even if in some cases they are aided by church-based organizations.[438] In theory, the *mutuelles* scheme provides access to all levels of the health care system, but in practice people are often confined to receiving care at local clinics, rather than at the specialized, larger hospitals.[439] Even if they do manage to pay their fees, many traumatized Rwandans are very unlikely to see a return on investment and get access to mental health care. The reciprocal relationship between trauma and poverty compounds the situation of many traumatized Rwandans who live in poverty, making it all the more difficult for them to escape the trauma-poverty gap.

III. Mental health policies in Rwanda

A number of recommendations to address the poor state of mental health care have been proposed in a 1998 evaluation of the trauma recovery program in Rwanda. For one, the positive effects of training of social agents have been noted, resulting – among others – in higher school attendance and better grades for children taught by teachers who finished training at the NTC. Still, given the prevalence and magnitude of trauma in Rwanda, there continues to be a serious shortage of capable trauma advisors. This lack is aggravated by restrictions of access to psychological help. For instance, the remote location of the NTC in a Kigali suburb causes problems for access, which prohibits many in need of help from actually receiving it,[440] although the establishment of mobile teams led to a "significant increase in the number of clients attended [to]".[441] No large-scale, longitudinal studies on trauma and psychological ill-health have been conducted as yet. Nor have attempts been undertaken to add and retrieve data to and from the

[436] Government of Rwanda: Ministry of Health 2009, p. 10.
[437] Twahirwa 2008.
[438] Schneider & Diop 2001, p. 20.
[439] Zraly 2008, p. 388.
[440] Chauvin, Mugaju & Comlavi 1998, p. 390.
[441] Ibid.

national epidemiological system under the Ministry of Health. Most strikingly, no system has been implemented to monitor the effects of psychological care in Rwanda. The general lack of coordination between mental health agencies inhibits a streamlined approach of facilitating mental health care. No comprehensive legislation and practice was developed by the relevant authorities, coordination across various aspects of the UNICEF program was poor and the absence of a national level monitoring system impedes the construction of program interventions that are large (national down to community level) and comprehensive in their scale.

Most of these recommendations have been addressed in the Rwanda National Health Sector Policy for 2005. Although most of the policy objectives are directed at combating HIV/AIDS and malaria, specific mention of mental health care is made through the plan to ensure that mental health problems are managed at the community level and to integrate mental health care into primary health care. In addition, legislation regarding mental health was to be revised, community-led health initiatives stimulated and geographical and financial accessibility improved. [442]

The 2005 National Mental Health Sector Policy was revised in 2007. This revision emphasized the shift of services and resources from mental hospitals to community mental health facilities and integration of mental health services into primary care.[443] A number of shortcomings in Rwandan mental health care were outlined in the policy, such as a lack of quality care, problems of accessibility, inadequate state financial assistance and research promotion, weak integration of the community and the absence of a legal framework governing mental health principles. In order to improve the quality of mental health care it was proposed to adopt a new coordination mechanism, optimize the level of reference service and to provide mental health professionals with more and better knowledge and tools to carry out their tasks. To address the accessibility issue, the policy outlined measures to integrate mental health care into regular health care (e.g. incorporate mental health facilities in ordinary hospitals) and bring mental health care closer to the community. To promote research and evidence-based intervention, the most relevant measure proposed in the policy was to adopt a research unit that is part and parcel of the mental health division. Still, no clear actions to establish a legal framework (e.g. patients' rights) were elaborated in the policy, despite previous calls to enshrine access to mental health care in law.

Even today, Rwanda remains heavily reliant on donor contributions, which may explain why it's health care system is under close supervision by the World Health Organisation (WHO). But because the disease burden of infectious diseases and malnutrition ranges far and far in Africa, mental illnesses generally do not receive the same amount of attention.[444] Despite this, there has been a growing recognition of the necessity to combat mental illness and this has sparked specific action plans for mental health care in Africa. The 11th General Programme of Work by the WHO (2006) included mental illnesses in the category of chronic non-communicable diseases for the first time,[445] after which it was adopted as a strategic objective to prevent and reduce mental disorders in their Medium-term Strategic Plan 2008-2013.[446] More specifically, a Strategic

[442] HRH Global Research Center (n.d.).
[443] World Health Organization 2011, p. 1.
[444] IRIN News 2012.
[445] World Health Organization 2006.
[446] World Health Organization (n.d.-b).

Orientation for WHO Action in the African Region (2005-2009) was drafted to recognize the precarious and fragile situation of a region fraught with civil strife, poverty and malnutrition, with the overall objective of strengthening national capacities to improve their health care system.[447] However, such a continent-wide approach does little justice to the uniqueness of Rwanda. This negligence of the Rwanda's specific context, particularly as it pertains to mental health, is grossly detrimental to the facilitation of psychological care and trauma counselling here.

Although the WHO has developed a country cooperation strategy for Rwanda (2009-2013) in which mental health features as a 'strategic objective' and a 'public priority', in practice this seems to amount to not much more than hollow rhetoric: a mere $ 215.000 out of a total budget of $ 9.749.685 (or 2.2 %) is devoted to this 'priority area'. With this amount, the WHO envisages to act in a capacity of counselling and support in order to adapt and implement the framework for surveillance of non-communicable chronic diseases; implement strategies for prevention and control of common risk factors of these diseases; development of a policy for prevention of violence and traumas and management of disabilities; review of the national mental health policy and mental health management; integration and decentralization of mental health services as well as to provide support in the development of a plan for strengthening capacities in the area of mental health.[448]

These objectives invite several critical questions and remarks. First, in what way is the WHO responsible for the prevention of violence and trauma and what strategies allow for the latter to be actually prevented (other than controlling violence)? Since no mention of it is made, it would be insensible to think that the WHO actually believes that trauma counselling could prevent violence. Second, since no mention is made of supporting the mental health sector other than through providing strategic advice, how can Rwanda equip its mental health sector if it is still reliant on external assistance that is channeled outside the WHO? Third, although mental health is indeed recognized as a priority area (although veiled by the overarching objective of prevention non-communicable diseases), no reference is made as to why it is so. Sadly, the shadow of trauma cast by the genocide remains unmentioned. Finally, and most importantly, the budget allocated for mental health seems negligible in light of these rather vague, yet ambitious strategic objectives. The clinical approach, the endorsed method of mental health care by the WHO, is particularly costly given the individual-centered perspective (i.e. much time and effort is given to each patient), many patients stay in clinical facilities, staff are often non-native professionals that require high salaries, and treatment itself (e.g. medication) can be very costly too. This disparity between objectives and available resources suggests that what can realistically be done is negligible in light of what actually needs to be done.

IV. The legal framework for mental health care

A number of treaties impose an obligation on the Rwandan state to provide individuals with an enforceable right to reparation. These include Article 2(3) of the International Covenant on Civil and Political Rights, Article 8 of the Universal Declaration of Human Rights, Article 14 of the UN Convention Against Torture, Article 39 of the Conventions on the Rights of the Child and Article

[447] World Health Organization 2005.
[448] World Health Organization (n.d.-a), p. 19.

7 of the African Charter on Human and Peoples' Rights.[449] While international law does not dictate a clear definition of rehabilitation as a form of reparation, it is commonly accepted that in certain situations persons who have suffered serious violations of their rights as a human being should be redressed, *inter alia*, by way of psychological care.[450] Thus, Article 16 point 1 of the African Charter on Human and Peoples' Rights states that "[e]very individual shall have the right to enjoy the best attainable state of physical and mental health" and the Convention on the Rights of the Child, which Rwanda ratified in 1990, provides that children have a right to psychological recovery and reintegration in the aftermath of conflict (Article 39). Article 15 of the Rwandan Constitution provides that "every person has the right to physical and mental integrity" and Article 41 states that the population has both rights and duties for "promoting good health and to assist in the implementation of these activities".[451]

In 2012, the United Nations General Assembly adopted Resolution 66/228 for the 'Assistance to survivors of the 1994 genocide in Rwanda, particularly orphans, widows and victims of sexual violence' which called on the Secretary-General

> "to continue to encourage the relevant agencies, funds and programmes of the United Nations system to implement resolution 59/137 expeditiously, inter alia, by providing assistance in the areas of education for orphans, medical care and treatment for victims of sexual violence, including HIV-positive victims, trauma and psychological counselling, and skills training and microcredit programmes aimed at promoting self-sufficiency and alleviating poverty[.]"

The resolution added that the Assembly was "[f]irmly convinced of the necessity of restoring the dignity of the survivors of the 1994 genocide in Rwanda, which would help to promote reconciliation and healing in Rwanda[.]"[452]

At the international level therefore, the plight of those in need at least seems to have been heard. Domestically, however, there is still much to be gained. Specific mental health legislation can provide a framework within which these grander objectives can be attained, but despite many previous calls to enact such a framework, no specific mental health legislation is yet in place.[453] What comes closest to this kind of legislation is the 1998 Law No. 2/98 that created the 'Fund for the Neediest Survivors of Genocide in Rwanda' (*Fond d'Assistance aux Rescapés du Génocide*, or FARG) which was established "to provide assistance to survivors of the genocide perpetrated against the Tutsi" who lost property or loved ones who were breadwinners before the genocide.[454] It specifically targets vulnerable groups such as widows, orphans and handicapped by providing

[449] IBUKA, Survivors Fund & REDRESS 2012, p. 5.
[450] Villalba 2009, p. 9.
[451] Government of the Republic of Rwanda 2003.
[452] United Nations General Assembly 2012.
[453] Pathare, Shields & Nardodkar. 2014.
[454] Republic of Rwanda (n.d.-a).

assistance through education, health care and housing[455] as well as through various programs aimed at developing income generating activities for them (e.g. skills development, entrepreneurship).[456] Although in theory anyone who is a victim of the genocide and in need of social support is eligible to join, in practice Hutu are excluded.[457] Despite the fact that over $ 255 million has been spent through FARG (from 1998 until 2015),[458] or a steady 5 percent of the annual national budget, some survivors are still experiencing vast difficulties in obtaining funds,[459] causing them to grow disillusioned with the compensation scheme.[460]

In sum, there is no absence of laws that enshrine the recognition of the physical and mental integrity of the individual, nor the right to treatment where the person's bodily or psychological integrity is violated. But despite the wealth of legal provisions that should provide assistance to traumatized Rwandans, the relevant laws and conventions have been implemented and enforced inadequately.[461] This stems not so much from a half-hearted commitment on part of the Rwandan government, but derives primarily from various logistical difficulties (mainly a lack of resources) as well as lingering taboos revolving around trauma. This probably explains why a comprehensive legal framework for mental health care remains elusive, but it also painfully signifies the barriers that inhibit so many survivors from obtaining mental health care. An even more resolute statement by the Rwandan government would be to emulate the Peruvian Truth and Reconciliation Committee, which provided for mental health reparations for victims-survivors through which they could demand the public health sector to attend to their mental health needs,[462] but as the next section demonstrates, Rwanda sadly is nowhere close to ensuring access for all those in need.

V. Meeting the needs: a titanic effort

The current status of mental health care in Rwanda can be characterized by scarcity and a lack of coordination. At present, there is only one psychiatric hospital in Rwanda. The National Trauma Center, located just outside of the capital Kigali, has 250 in-patients and cares for another 100 day patients.[463] It has three psychiatrists and one neurologist, who have to divide their time between two other mental health hospitals as well.[464] There is a consistent lack of accommodation for patients: according to an employee at Ndera hospital, it is quite likely that 80 patients will be accommodated in rooms that have only 60 beds. As a result of this woeful lack of capacity, many patients spend their time wandering in the gardens, many of them oblivious to their surroundings and the Ndera employees, who simply do not have the time to tend to all of them.[465]

---

[455] Republic of Rwanda (n.d.-c). Between 1998 and 2015, almost 100.000 students have completed secondary school, over 12.500 students have completed higher learning schools, nearly 25.000 have received medical care, over 43.000 houses have been constructed and over 46.500 survivors have been assisted under income generating activities.
[456] Republic of Rwanda (n.d.-b).
[457] Thompson 2009, p. 187.
[458] Republic of Rwanda (n.d.-a).
[459] Mgbako 2005, p. 216; IBUKA, Survivors Fund (SURF) and REDRESS 2012.
[460] Sasaki 2011, p. 388.
[461] Republic of Rwanda 2003, p. 11.
[462] Laplante & Holguin 2006.
[463] Jaberg 2013.
[464] Belgian Development Agency 2014.
[465] Karinganire 2012.

Although the genocide left the country with hardly any psychiatric professionals, as most of them were either killed or fled during the war, there has been a notable increase in the number of mental health professionals since the war, and especially in more recent years. As of April 2012, 80 mental health nurses resided in the 40 district hospitals, with each hospital having at least one doctor trained in mental health issues. Of the 40 district hospitals, 6 have specialized psychiatric wards. Of the 433 health centers, 133 have 2 or 3 nurses trained in mental health. A further 10 aspiring doctors, almost 270 mental health nurses and over 500 psychologists were pursuing their degree at the time. Another 12.000 community workers have received training in mental health of some kind.[466] Contrast this with the Netherlands, for instance, where in 2011 approximately 90.000 people (out of a population of 16.69 million at the time) were treated by one of the 12.500 psychologists working in mental health care.[467] In addition, at least 2.195 psychiatrists were known to be working as such in the Netherlands as of April 2016. They were divided over 419 mental health centers, 395 psychiatric wards and 199 miscellaneous centers.[468] The estimated prevalence of serious mental disorders (including, other than stress disorders and depression, schizophrenia, bipolar disorder and similar issues) was 1.8% of the entire Dutch population.[469]

Considering the total Rwandan population of 12 million,[470] it is clear that mental health professionals in Rwanda cannot meet the needs of all traumatized survivors. The prevalence of mental health disorders in Rwanda has already been discussed through studies previously conducted. Based on these results,[471] approximately 25% to 35% people in post-conflict regions (having witnessed severe civil strife) suffer from mental disorders. This would mean that 3 to 4.2 million Rwandans[472] suffer from severe stress disorders as a result of the genocide. However, at a rate per 100.000 people, Rwanda as of 2007 had 0.05 psychiatrists, 1.3 nurses, 0.07 psychologists, 0.03 occupational therapists and 0.03 health workers. In terms of current capacity and access to mental health care, substantial work lies ahead as well. As of 2007, Rwanda totaled just 72 psychiatric beds in general hospitals, 22 beds in community health centers and 310 beds in mental hospitals. Out of a population rate per 100.000, 25 people were treated in day treatment facilities, while 21.8 were admitted to psychiatric beds in general hospitals and 31.9 were admitted to mental hospitals. [473] In short, bearing in mind that between one-quarter up to two-thirds of survivors suffer from PTSD and one-third up to half suffer from depression (see Chapter IV), there is a vast treatment gap within the Rwandan mental health sector.

---

[466] Kayetishonga 2012.
[467] Christiaan (n.d.).
[468] Zorgkaart Nederland (n.d.).
[469] Trimbos Instituut 2008.
[470] Index Mundi 2013.
[471] Depending on sample, type of mental disorders and associated assessment criteria, severity of trauma incurred, and so forth.
[472] This figure includes traumatized perpetrators and people who were not targeted during the genocide but still experienced traumatic events. The prevalence (in percentages) of trauma as inferred through a meta-analysis of epidemiological surveys is rather difficult to project on the entire Rwandan population as most studies have focused on survivors and no definitive numbers of survivors in the current Rwandan population are present. In addition, more research is needed to survey how the genocide has psychologically affected perpetrators and, in particular, Rwandans who were not specifically targeted during the genocide but still experienced deeply horrifying events.
[473] World Health Organization 2011 p. 1.

VI. Conclusion

The continuing dependence on foreign countries and international organizations by Rwanda to support its mental health care system explains to a large extent how the country has not been able to tailor its mental health care system to the needs of its citizens and the general society. Although impressive developments have taken place, most notably in the training of qualified staff (concurrent with the way that many professionals have also become versed in trauma support, e.g. at commemoration ceremonies), the road ahead remains steep and long. Despite significant increases, there remains a lack of qualified personnel and financial resources. With only one specialized mental health institution the overwhelming majority of Rwandans remain deprived of access to care. The *mutuelles* scheme fails to accommodate all Rwandans and urgent action is thus needed to facilitate access of poor Rwandans to mental health care. The poor understanding of mental health issues and the enduring stigmas around trauma only aggravate the issue of limited care provision and accessibility as informal support structures (friends, family, communities) can complement or serve as an alternative to institutionalized care, but these informal structures are generally not up to the task of providing adequate care, support and relief given this lack of knowledge about and stigma around trauma. This lack of appraisal of the widespread traumas and their profound effects is also exemplified in institutionalized settings, where the strong influence of the WHO in Rwanda's health sector has impeded the country from looking for creative and cost-effective approaches that is sensitive to the local context and takes into account the unique characteristics of the genocidal legacy.

Calls for more detailed mental health legislation may seem perfectly legitimate, but given the limitations of the Rwandan mental health care system, such legal provisions would have to be extremely precise and detailed in order for them to be in tune with the capacity of the health sector. A more disconcerting issue with very specific legislation which recognizes the limitations of the health sector is that it will be forced to prioritize and hence exclude care seekers. In addition, the legal provisions and the care provided may be limited to the extent that treatment is incomplete. Rather than alleviating the psychological toll among survivors, it may subdue them or even aggravate their suffering as they lose faith in care provision. Conversely, broad provisions as provided for in several international treaties seem hardly enforceable in practice given the gargantuan implications (i.e. overload of care seekers) if such laws were broadly enacted. Therefore, the priority must not be on legislative drafting but on building what such laws can actually provide for. The focus should be on building a strong and comprehensive mental health sector that does not differentiate among care seekers and that offers a range of approaches to suit the wide array of needs among Rwandans.

That will not only require significant resources, but will take time too. Rwanda must recognize that the overwhelming number of psychological disorders in its society stem primarily from the genocide. It should also recognize that trauma counselling directly contributes to social stability and that the ultimate payoffs of counselling far surpass the status quo. By looking beyond the clinical paradigm, Rwanda could find more cost-effective ways that address the issue in a more context-sensitive fashion. The next chapter offers some guidance in this regard by reviewing how other organizations have approached this.

Chapter VI – Trauma relief by NGOs

It has already become clear that the genocide shattered many social relations and that traumas continue to impact on social interaction in post-genocide Rwanda. In addition, the destruction of many institutions that under normal circumstances would provide a support system (e.g. schools, churches, health care) left many people extremely vulnerable in the aftermath of the violence.[474] Survivors experienced isolation, lack of cooperation and support, stigmatization and lack of empathy. As traumatized survivors perceive that the community does not support them they feel vulnerable, diminished and isolated as a result.[475] Given that the effects of mass trauma have significantly affected communities too, trauma relief by NGOs has focused chiefly on the psychosocial aspects of trauma. Psychosocial interventions recognize that social environments can provide either protective factors as well as entail risks.[476] They strengthen individual and community resilience, trust and social cohesion through individual psychological counselling and community-building practices, providing an important step in working towards sustainable peace in Rwanda.[477]

Soon after the genocide many international organizations arrived in Rwanda to provide relief.[478] However, most of these efforts were "made in crisis mode", focused on the provision of primary health care and lacked any long-term planning.[479] A lack of experience in the region and needs assessments in addition to poor coordination, however, contributed to a highly inefficient response where many efforts were duplicated and scarce medical resources were wasted.[480] What few programs and interventions were initiated typically came from international NGOs, which have been criticized for projecting their own 'textbook approach' in trauma relief rather than providing an approach that is grounded in the contextual realities of the specific situation.[481] At the end of 1994 and throughout the next year, many of the 102 international organizations present started to focus on rebuilding the country's institutional infrastructure. Still, the vast share of the funds allocated to agencies and organizations present in Rwanda at the time ($2 billion) was directed at refugees in asylum countries, causing much resentment among Rwandans who had lived through the horrors of the genocide.[482]

Around 1999-2000, as Rwanda's government began to invest more effort in mental health care, most organizations moved from short-term emergency interventions and began to develop longer-term activities. Trauma programs were scaled down and more attention was paid to training local people involved in Rwandan organizations in trauma counselling. The trauma model shifted from the 'Western', medical-oriented approach to a psychosocial perspective that

474 Levers et al. 2006, p. 261.
475 Petersen-Coleman & Swaroop 2011, p. 12.
476 Ibid., p. 262.
477 Lambourne & Gitau 2013, p. 24.
478 Levers et al. 2006, p. 262.
479 Kumar, cited in ibid., p. 264.
480 Steering Committee of the Joint Evaluation of Emergency Assistance to Rwanda 1996, p. 35.
481 King 2011, p. 2.
482 Steering Committee of the Joint Evaluation of Emergency Assistance to Rwanda 1996, p. 33.

included assistance in income-generation and HIV/AIDS, among others.[483] Other programs that have developed later on have come to include indigenous approaches to healing and the social environment, for instance through family support and at schools.[484] Over time, international organizations have taken on more of a supervisory role and transferred some of its tasks to local organizations. For instance, Catholic relief organization CAFOD has provided technical and financial support to seven Rwandan partner organizations that have since implemented psychosocial programs. This has empowered domestic organizations that draw more on culturally relevant approaches in their psychosocial programs. For instance, the Rwandan children's organizations *Barakabho* and *Uyisenga N'Manzi* involve art, dance and drama in their programs to encourage participants to express themselves.[485] In 2002, World Vision started to provide trauma counselling as a core element of its long-term development program. In their Healing, Peacebuilding and Reconciliation program, developed by Rwandan psychologists, World Vision adopts a community-centered approach by bringing together survivors and fortifying their communal resilience in dealing with their traumas.[486] This program is complemented by Personal Development Workshops that explore their grief, emotions and forgiveness with the aim of rebuilding trust and enable people to express and manage their emotions.[487] These approaches enhance socialization by encouraging engagement with others and participation in community events.[488]

But challenges remain. Currently, the main hurdles to foster resilience at the individual level are lack of family support, the burden of early child-rearing responsibility, lack of access to education, health and rehabilitation services, lack of appropriate shelter, problems with heritage and access to property, marginalization and stigmatization, HIV/AIDS, limited reach of relief and counselling programs in remote areas, lack of knowledge of existing support services and a general lack of psychosocial support and counselling services. Associational life is extremely important and has provided the best protective structure for traumatized individuals to cope.[489] But the genocide has not left civil society unscathed. Only between 3 and 7 percent of Rwandans belong to a cultural or sports association, community user committees, local charitable organizations or local NGOs.[490] This abysmally low percentage is indicative of how the rupture in communities has disrupted associational life in Rwanda.

---

[483] Steering Committee of the Joint Evaluation of Emergency Assistance to Rwanda 1996, p. 36.
[484] Petersen-Coleman & Swaroop 2011, p. 5.
[485] Levers et al. 2006, p. 266.
[486] Lambourne & Gitau 2013, p. 31.
[487] Steward, cited in ibid., p. 31.
[488] Ward & Eyber 2009, p. 29.
[489] Dushimirimana, Sezibera & Auerbach 2014. Aside from the limitations noted by the authors (p. 227), the research is based on a rather small sample (N=20), all of whom were students at the time. Each had lived through the genocide as a child (13 of them were younger than 10 years old at the time) and each had lost at least one parent. However, they were all based in Kigali, pursuing higher education and were members of an NGO (Association of Students and Pupils Survivors of the Genocide, or AERG). These factors have provided them with additional protective factors that is likely to have a positive impact on their resilience. For instance, their education has imbued them with a new hope for the future.
[490] NURC 2014, p. 4.

I. Trauma relief interventions and priority groups

Women

Women in particular have faced daunting realities in the aftermath of the genocide, but despite having to cope with additional stressors such as sexual violence, widowhood and being impregnated by their rapists, Rwandan female survivors have generally shown remarkable resilience in the aftermath of the genocide. Thousands of women's organizations have emerged over the past 20 years, providing supportive environments for women to share their experiences and allow them to regain a sense of control over life.[491] Membership in such an organization is entirely common among female genocide survivors and the organizations actively seek vulnerable survivors.[492] These associations have provided legal and medical assistance services, business advice, assisted them in obtaining cultivable plots of land and emotional support groups.[493] AVEGA, one of the largest widow organizations in Rwanda, provides legal advice and representation, facilitates socio-economic development and medical and psychosocial care.[494] By training other women in these domains, many survivors develop far more positive outlooks on life by becoming empowered and being enabled to help others:

> "I owe my life to AVEGA, because it trained me in trauma, it has provided me with confidence, I am now the representative of AVEGA in Rwamagana, and I enjoy helping others."[495]

Traditionally, Rwandan women were strongly dependent on men. Even after the genocide, many widows were living with their rapists because they had nowhere else to go.[496] But the disproportionate death toll of men during the genocide uprooted the patriarchal nature of Rwandan society. Gender roles were gradually redefined as women stepped in to assume responsibilities formerly taken up by men. Women have broken traditional gender roles and taboos because having to meet the harsh demands of post-genocide life has imbued many with a previously unknown sense of self-reliance.[497] This is no better exemplified that through the fact that women have assumed important political positions after the genocide. With 64 percent of the parliamentary seats taken up by women, Rwanda has been lauded for female participation in politics.[498] This increase in female participation has contributed to an increased sense of gender equality and greater acceptance of women in positions of power.[499]

Under Rwandan law, property passes through male members of the family. Consequently, widows or orphaned daughters lose their property to male relatives of the deceased husband or father.

---

[491] Gilbert p. 214; Burnet 2012, Ch. 1 (Loc. 267).
[492] Zraly 2008, p. 334-335.
[493] Gervais 2003.
[494] AVEGA (n.d.).
[495] Williamson 2014, p. 85.
[496] Williamson 2014, p. 6.
[497] Ibid., p. 83.
[498] Ighobor 2014; Powley 2005; Burnet 2008.
[499] Burnet 2008.

Save the Children, UNICEF and several women's groups have advocated to change the laws pertaining to property, land and women's rights.[500] These efforts have resulted in progressive gender policies that include new legislation on land and property rights as well as the adoption of a law in 2009 on the protection against gender-based violence.[501]

Children

The genocide also disrupted traditional social structures for the care of vulnerable youth as the death of many men eviscerated traditionally paternal support networks.[502] Rwanda has the highest proportion of orphans in the world: in 2008 there were 825.000 orphans (*mayibobo*) and 2 million Other Vulnerable Children (OVC)[503] out of a total youth population of 9.6 million.[504] Where previously there was a tradition in Rwandan culture of community support for vulnerable youth, the deepening of social divisions after the genocide strained community solidarity to the point where Rwandans adopted a far more individualistic outlook and neglected these youth.[505] In the words of one adult female, "helping these days is calculations, when someone helps it is because she or he wants to gain something from you".[506] In addition, poverty and social fragmentation has severely strained families' ability to care for orphaned children.[507] If a child has access to a support system provided either by a surrogate family, the government or an NGO that caters to their basic needs such as nutrition, shelter and clothing, then at least the most elementary protective factors are provided.[508] But despite the African maxim that 'no child is an orphan',[509] traditional support structures and values for the care of orphans have withered after the genocide.

It has been estimated that the genocide left between 95,000 and 150,000 children unaccompanied, although some organizations believe the number is even higher. A wide array of organizations have implemented programs to support unaccompanied children mainly through registration, tracing and reunification and the provision of foster care. Larger organizations have coordinated closely with the government and other large relief agencies. For instance, the ICRC established a data bank with the names of over 120,000 children and shared this information with other agencies.[510] By the end of 1995, over 10,000 children in Rwanda were reunited with their families.[511]

Amid the chaotic coordination of emergency relief immediately after the genocide, several NGOs quickly built centers for unaccompanied children and orphanages without any long-term

[500] Burnet 2008..
[501] Gervais 2003, p. 309; Richters & Sarabwe 2015.
[502] Donà et al 2001, p. 12.
[503] Minister in the Prime Minister's Office in Charge of Gender and Family Promotion 2008, p. xvii.
[504] Country Meters (n.d.).
[505] Republic of Rwanda 2003, p. 11; Thurman et al. 2008, p. 1558; Veale 2001, p. xiv.
[506] Thurman et al. 2008 p. 1561.
[507] Levers et al. 2006, p. 264.
[508] Ibid., p. 262.
[509] Foster, cited in MacLellan p. 265
[510] Donà et al. 2001, p. 12.
[511] Steering Committee of the Joint Evaluation of Emergency Assistance to Rwanda 1996, p. 36.

planning and outside the purview of a coordinating body.[512] Children were the preferred beneficiaries of relief and aid programs, although they have not benefited as much from psychosocial programs as much as women. In one trauma counselling program that catered to 950 people, the overwhelming majority were women.[513] Still, a few psychosocial recovery programs have been directed specifically at children. For instance, UNICEF launched its recovery program Children in Especially Difficult Circumstances in conjunction with the Ministry of Rehabilitation and Social Reintegration,[514] which eventually led to the development of the National Trauma Recovery Centre (NTRC). Several other large organizations, including CARE, Hopes and Homes for Children, and World Vision, have developed mentoring programs for orphans and vulnerable children.[515] These programs offer the prospect of building existing social linkages and support structures within the community.[516] But despite the disconcerting extent of psychosocial issues faced by vulnerable youth,[517] trauma counselling programs directed at children have been scarce.[518] This observation is painfully illustrated by the fact that at the end of 1997 a mere 300 children were reached by the National Trauma Center and the involved NGO partners.[519]

Schools offer a protective environment for children through which they can build social relationships and engage in self-development.[520] Rwanda has made outstanding progress in terms of primary school participation: attendance increased from 73.5 percent in 2000[521] to 98.7 percent in 2012.[522] Completion rates of primary schools increased from an average of 21.5 in 2000 to 87 percent in 2015, with female student rates catching up to male student rates and passing them in the previous years.[523] However, in chapter IV it was observed that traumatized children were often unable to continue their studies not only because of their condition, but because of lack of adequate support as well as a lack of knowledge concerning trauma among school teachers. The *Association Rwandaise des Counseillers en Traumatisme* (ARCT) has initiated several projects at schools with the aim of educating children in peer support and raise awareness of trauma-related issues.[524]

---

[512] Steering Committee of the Joint Evaluation of Emergency Assistance to Rwanda 1996, p. 36. Before the genocide, 37 orphanages catered to 4800 children; by April 1997, 77 centers received 12,704 children (Vaele and Donà, cited in Williamson p. 95).
[513] Vaele & Donà 2002, p. 14.
[514] Favila & Fellow, cited in Lambourne & Gitau 2013, p. 32.
[515] Levers et al. 2006, p. 266.
[516] Ward & Eyber 2009, p. 29.
[517] Veale 2001 p. xvi.
[518] MacLellan 2010, p. 258.
[519] UNICEF 1997. The report estimated that at least 300,000 children were in need of trauma counselling, not accounting for thousands of children who may also have been traumatized during the genocide but are better off due to protective factors. A 2001 report by UNICEF estimated that 600,000 children were in need of psychological treatment (UNICEF 2001, p. xii).
[520] Veale 2001, p. xiv.
[521] The World Bank 2001.
[522] Binagwaho et al. 2016, p. 3.
[523] Education Policy and Data Center 2013.
[524] Levers p. 265

After 2000, it became evident that the situation of vulnerable youth was deteriorating. As a result of sexual abuse and exploitation, a large number of children face marginalization from community structures and protective family care systems that compounds their ability to cope .[525] In 2003, a National Policy for Orphans and Other Vulnerable Children was adopted which recognized the plight of these youth. The policy therefore called for a community- and family-based approach in which other issues, such as poverty, would be addressed concurrently. In addition to protecting children from abuse and exploitation and improve their socio-economic situation, the main objectives of the policy were to assure access to health services, psychosocial support and strengthen the capacity of families, communities and social service providers to care for and protect vulnerable children.[526]

The policy can hardly be called a success. Estimates of the number of children currently living in child-headed households vary from 60,000 to 300,000.[527] One of the most pressing issues that vulnerable youth continue to face in post-genocide Rwanda is marginalization and isolation. [528] Despite the fact that children expressed some expectation of community support, most have no one to turn to. A few may turn to a local NGO or the church, but most "keep [their] worries inside [their] hearts".[529] Many children in poverty feel disliked and neglected as they are not invited to social events because they lacked nice clothes or proper hygiene. In addition, they often feel unable to relate to others who do not experience financial hardship. The majority of orphans whose parents were perpetrators, returnees or even survivors face different stigmas that may isolate them.[530] Orphans whose parents died of AIDS also report being stigmatized and ostracized.[531] Youth that do not receive support envy those who do and feel even more isolated as a result. They note a lack of food, shelter, health care, security and protection and support structures that also cater to their emotional needs.[532] In cases where they do receive assistance, they are often unable to fully exploit these opportunities due to the need to meet basic survival needs.[533] These two factors, poverty and marginalization, have given rise to delinquent behavior which, in turn, engenders such stereotypes as untrustworthy children and young troublemakers.[534] As orphans still face severe financial difficulties, lack access to health care and counselling and the provision of care and support structures, the National Orphan Policy has thus failed miserably in complying even with its core priorities.

---

[525] Veale 2001, p. xi.
[526] Republic of Rwanda 2003.
[527] In 1999, BBC put the figure at 60,000 (BBC World Service 1999), while a more recent observation by ACORD put the figure at 300,000 (ACORD International, n.d.). UNICEF (2003) estimates 100,000. HRW (2003, cited in Ward & Eyber 2009, p. 19) put the estimate at 227,500. It is likely that the number has grown significantly since 1999 given the HIV/AIDS pandemic in Rwanda.
[528] ACORD, cited in MacLellan 2010, p. 257.
[529] MacLellan 2010, p. 272.
[530] Thurman et al. 2008, p. 1561.
[531] Veale 2001, p. xiii.
[532] Ibid., p. xiv.
[533] Ibid., p. xvi.
[534] Thurman et al. 2008.

Disabled

Despite the merciless slaughter during the genocide, thousands of people escaped death by the skin of their teeth. Definitions of disability differ, usually including physical disability, loss of sight/hearing and mental handicaps. Here, I focus specifically on disabilities resulting from the genocidal violence, which has predominantly caused physical disabilities. In 2010, Rwanda numbered 522,856 disabled people, of which 44 percent had physical disabilities.[535] The impact of the genocide on disabilities is most clearly evinced by the fact that around 300,000 disabled genocide survivors receive aid from a national survivors' fund.[536]

Disability in Rwanda is still seen as a source of shame.[537] Disabled people are perceived as helpless victims and counted among the most vulnerable, which is hardly surprising given that virtually all face extreme poverty. In fact, it has been noted that they are overprotected. Since around 2000, legislation and policies have been developed especially for them by the state and several organizations are committed to protect and aid disabled Rwandans. There are 16 NGOs active in disability aid[538] and in 2010 the National Union of Disabilities' Organizations of Rwanda (NUDOR) was established to serve as the civil society platform for 8 national disabilities' organizations.[539]

Yet despite the political will, the disability sector still faces several challenges. Costs barriers, especially to specialist rehabilitation services, is the most significant one. The lack of specialist knowledge in disabilities is also a major obstacle in providing adequate relief. Access to health care remains a troubling issue for the disabled, with only 5 percent being able to receive the care they need.[540] In 2012 the government initiated a project to map the services for disabled people and in conjunction with the work of NUDOR, this is a good step in responding to the lack of coordination and coordination and the resulting duplication of effort that previously impeded project in the disability sector. Yet the most formidable challenge lies in combating extreme poverty and the ensuing social exclusion among the disabled. One way to stimulate income generation is obviously through education, but many disabled persons experience difficulty in access to education, despite the express provision of the right to education (Article 40 of the Constitution). [541] The General Association of the Handicapped in Rwanda is one of the few organizations that promote self-reliance through income generation activities among the disabled.[542]

---

[535] Republic of Rwanda: Ministry of Local Government 2010, p. 16. Because definitions of disability can vary a lot, I abstain from any cross-country comparisons on the disability prevalence. I was unable to ascertain what exactly constitutes disability in Rwanda.
[536] Blaser 2002, p. 61. However, because the fund virtually excludes Hutu from receiving assistance, the number of disabled as a result of the genocide is likely to be a good deal higher, as many moderate Hutu were also targeted during the genocidal campaign.
[537] Thomas, cited in Williamson 2014, p. 45.
[538] Aid Evaluator (n.d.). Not counting organizations for the deaf (7) and blind (5).
[539] RENCP (n.d.).
[540] Thomas 2005, p. 36.
[541] Thomas 2005, p. 39.
[542] Ibid., p. 33.

Lost minds, forgotten voices?

Psychosocial programs have largely been directed at women and - to a lesser extent - at children, not boys and men. [543] In one trauma counselling program that reached 600 clients, only 10 were men.[544] The only organization I could find dedicated to prisoners is Prison Fellowship Rwanda which is involved in an outreach program where prisoners are educated in Christian doctrine on forgiveness and reconciliation. This is in line with a similar observation that there were very few projects that directly addressed the antagonistic relationship between Hutu and Tutsi.[545] This may be because international NGOs in particular have been accused of spreading genocide ideology.[546] It is much easier to exclude rather than include perpetrators. One of the few NGOs that has allegedly provided outreach through workshops and dialogues to prisoners is World Vision.[547]

While it is important to recognize the vulnerability of woman and children who often struggle with additional risk factors and lack the means to cope adequately, this runs the risk of not recognizing the debilitated minds among boys, men and even perpetrators. But because organizations providing trauma relief have adopted a restrictive focus on traumatized survivors and vulnerable groups, this approach runs the risk of excluding a significant share of Rwandans who may also benefit from counselling. This does not allow all sides of the Rwandan population to get in touch with one another and re-establish a renewed psychological orientation in the process.

Sociotherapy

One of the few programs that has explicitly linked trauma and reconciliation is sociotherapy. It provides a structure within which often suppressed traumatic experiences can be expressed.[548] In Kinyarwanda, such a place is called *isangano*, a place where people feel comfortable expressing themselves. The programs focused on fostering feelings of dignity, safety and trust as well as reducing mental and social distress.[549] By guiding the groups through phases of safety, trust, care and respect, it closely resembles the reconciliation approach of absence of fear, rebuilding trust and fostering empathy for both sides.

Several studies have found positive effects on mental health and inclinations towards reconciliation among participants of sociotherapy programs.[550] One woman's story is most indicative of the potential effects of sociotherapy. She was raped and lost her husband during the genocide, only to take care of two severely traumatized children afterwards, became severely traumatized herself and completely lost her hope for the future. Sociotherapy allowed her to put

[543] King 2011, p. 388.
[544] Government of Rwanda/UNICEF, cited in Veale & Donà p. 14.
[545] Buckley-Zistel 2008, p. 12.
[546] Sasaki 2011, p. 365.
[547] Sedon, cited in Peterson-Coleman & Swaroop 2011, p. 6.
[548] Kaplan, cited in Gilbert p. 122.
[549] Richters et al. 2010, p. 58.
[550] C.f. Staub 2005; Scholte 2013; Verduin 2013.

down her grief and establish friendly relations with others, even Hutu, who she formerly feared and avoided. It has enabled her to transform from a passive victim to an empowered survivor:

> "Sociotherapy made me feel strong. I now have a value in front of people. Sociotherapy helped me to join a group of people with the same problems. Now, I am fine. I control myself. I have hope for the future. My sickness has lessened. I sleep well. I communicate with my children. I now experience my neighbours as being alive, whereas before it was as if they did not exist. I came out of isolation. I now feel secure. Because of getting out of loneliness, I became a member of a number of small assocations in which every member contributes some amount of money."[551]

Through its focus on relational aspects, sociotherapy is one of the few interventions that also specifically addresses family issues and has led to significant improvements in the family sphere.[552] By addressing the social aspect of healing it has a much stronger impact upon one's social life and therefore, potentially, to the reconciliation process. Such a program not only offers the prospect of linking psychosocial counselling and reconciliation in a cost-effective way, but it does not distinguish between victims and non-victims, thereby allowing for a more unified configuration of participants.

II. Religiosity and religious organizations

In a country overwhelmingly represented by Christians (nearly 94 percent),[553] churches would seem to be the primary space for the emotional and spiritual healing of a traumatized nation. But churches hold an ambivalent, if not contentious, place in post-genocide Rwanda. During the genocide, churches became one of the major sites of slaughter. Many devout Christians, even the clergy, were actively involved in the massacres. As Tutsi's and moderate Hutu's sought refuge in parishes, death squads surrounded these 'sacred spaces', "tossing grenades through church windows, firing into the crowds with rifles, then finishing off the survivors with machetes, pruning hooks, and knives".[554] Churches have therefore lost much of their credibility after the genocide.[555] Nevertheless, churches are currently actively engaged in the reconciliation process through nation-building as well as by offering a space for spiritual and psychological healing. [556] Many have provided for places where individuals may recount their suffering through a ritual

[551] Verduin 2013, p. 133.
[552] Richters & Sarabwe 2015.
[553] US Department of State: Bureau of Democracy, Human Rights and Labor 2013. In 2013, the Rwandan census was estimated at 12 million. Of these, 56.5 percent were devoted to the Roman Catholic Church, 11.1 percent were Seventh-day Adventists, 26 percent was comprised of other Protestant denominations, 4.6 percent were Muslim and 1.7 held no religious beliefs. The remaining 0.1 percent was made up primarily of people still practicing traditional religion (e.g. animists).
[554] Longman 2001a, p. 163.
[555] As Tom Ndahiro, a former Human Rights Commissioner in Rwanda, wrote: "The church has failed in her mission, and lost her credibility, particularly since the genocide" (quoted in Hong 2014, p. 13).
[556] Ndikumana 2011, p. 76.

called *ubahamya*, an account of God's acts in a Christian's life, which individuals may do spontaneously during worship or prayer groups.[557]

Aside from people's spiritual or psychological needs, religious communities often provide material assistance to vulnerable groups in particular.[558] Many organizations dedicated to healing and reconciliation in Rwanda are faith-based, such as World Vision. It is particularly focused on assistance to vulnerable children by addressing basic needs as well as spiritual, psychological and relational needs.[559] The organization began operations immediately after the genocide and has been involved in communities to combat poverty and injustice since 2000. It is currently supporting more than 2,500,000 people through 29 long-term, child-focused Area Development programs.[560]

The Quaker church of Rwanda initiated a series of psychosocial programs that explicitly links healing, reconciliation and livelihoods. The Healing and Rebuilding Our Communities program, for instance, aimed to address feelings of anger, depression and a loss of hope and trust among survivors and fear, shame, anger, guilty, anxiety and suspicion among Hutu's. Each workshop is divided into three steps: education about trauma, understanding and relating to other people's experiences and working together through joint income-generation projects such as goat-raising and crop farming on shared land.[561]

While these interventions have arguably done much to restore the legitimacy and credibility of religion in post-genocide Rwanda , the relative wealth of faith-based programs may be conflictual for those who have started to question their faith or even lost it entirely after the genocide. Although religiosity continues to be important for the construction of identities and meaning among many survivors,[562] with some even developing a firmer religious belief after the genocide, [563] a significant share has also critically started to question their faith in the aftermath of the hostilities. Some lost their faith entirely, while others switched churches or even religion (many Christians switched to Islam)[564]. The question remains whether these people are able to reconcile the assistance they are offered with the faith-based background they do not personally identify with.

III. Conclusion

Organizations such as AVEGA have enabled women to regain control of their lives and achieve a new sense of purpose. These organizations have been instrumental in reconfiguring gender roles in post-genocide Rwanda, which certainly boosts Rwanda's outward image towards donor countries. But few organizations have embraced all-inclusive approaches in their interventions,

[557] Ndikumana 2011, p. 77.
[558] Ibid.
[559] World Vision International (n.d.-a).
[560] World Vision International (n.d.-b).
[561] Lambourne & Gitau 2013, p. 31-32.
[562] Ricci 2009, p. 234.
[563] Hatzfeld 2009, p. 174 – 186.
[564] Williamson p. 137

preferring instead to target specific groups, such as widows and orphans. The focus on vulnerability has alleviated psychological distress among many traumatized survivors, but has not brought together Hutu and Tutsi, victim and perpetrator. Although psychosocial interventions can generally be lauded for recognizing and addressing the plight of vulnerable groups, it has also reinforced the exclusive victim identity among those catered to. This critique is not to discredit the plight of the vulnerable, as this thesis has detailed how many face severe risk factors that often push them to the margins of society and thus severely compound their opportunities for social integration. Rather, it is a call to also look beyond the vulnerability paradigm and search for ways in which not just the vulnerable, but anybody in Rwandan society, is able to benefit from counselling and assistance. Such an approach, one that directly targets survivors and perpetrators alike, links lingering traumas and tensions directly with the reconciliation effort by focusing on the psychosocial and relational aspects of participant. Sociotherapy is one of the few programs initiated in Rwanda that has adopted such an approach and one that deserves wider application if both trauma counselling and reconciliation are truly to be pursued.

“True reconciliation does not merely involve forgetting the past.”

- Nelson Mandela

Ahabaye inkovu hadasubirana.
(“A wound does not heal completely.")

- Rwandan proverb

Chapter VII - Conclusion

Main findings

In the immediate aftermath of the genocide, Rwanda was described as "a country of corpses and orphans and terrible absences, where the spirit withered".[565] The country had indeed become a place of missing and ruptured souls, one that seemed to have lost its humanity. Nowadays, in 'the land of a thousand broken hearts', traumas pose a major impediment to sustainable peace and social cohesion in Rwanda. In this thesis, I have addressed how trauma has affected the reconciliation process, taking into account the socio-political and cultural context, the specificities of the violence as well as the way trauma has been mediated by the various trauma relief programs and interventions.

Chapter III reviewed the reconciliation agenda as pursued by Rwanda's government and the sociopolitical context in which this took place. It concluded that the most prominent strategies employed to facilitate reconciliation - *gacaca*, commemorations and memorialization - often triggered traumatic manifestations among survivors rather than providing a decent outlet for their grief. In addition, it was noted that the reconciliation agenda was premised on the formation of a victim identity that not only serves to legitimize the rule of the RPF, but also provides an exclusive protective structure for survivors. However, this exclusive structure impedes any engagement with anybody not designated as victim and this significantly diminishes the prospect for reconciliation in a society that is frequently cast in victim-perpetrator dichotomies.

Chapter IV narrated how lingering traumas continue to affect individuals, families and communities alike in contemporary Rwanda. It identified how many women, children and disabled were particularly vulnerable to psychological distress due to the additional risk factors they face. In addition, Rwandan culture poses somewhat of an impediment to healing given the lingering stigmas and taboos around, for instance, rape survivors and the taboo on traumatic expressions. Coupled with a general lack of knowledge about trauma, this is arguably the main obstacle that prevents people from expressing their emotions and seeking treatment.

Chapter V discussed the way the government has addressed mental health issues since 1994. It was noted that this approach was largely premised on a Western, individual-oriented conceptualization of psychological distress. In addition, it became evident that while there is no lack of political will to address mental health issues, there is a remarkable disparity between policies and practice. Problems of accessibility, funding and relevant and adequate knowledge and skills are the key issues that account for this discrepancy. Due to this treatment gap, very few traumatized survivors receive the care they need.

Chapter VI elaborated on the trauma relief programs initiated by NGOs since 1994. Around 2000, these organizations shifted their focus from the 'Western' clinical approach to psychological healing and adopted approaches that also recognized and incorporated the socio-economic and cultural context. Understandably, vulnerable groups have been given preferential treatment, but at the expense of addressing traumas among groups that do not comply with the vulnerability

[565] Keane 1996, p. 3.

criteria. This lack of involvement of every segment of the population compromises the potential for psychological healing and reconciliation.

Recommendations

From a policy-oriented perspective, a number of practical recommendations can be distilled from this thesis:

- Rather than debate over the validity or effectiveness of each approach, stimulate complementary care structures, with due recognition for the logistical limitations of clinical care;
- One such approach could be sociotherapy, which explicitly targets relational health and psychosocial issues. By not differentiating between participants, it offers a platform for survivor-perpetrator reconciliation in the most constructive way, by taking into account personal histories, encouraging direct inter-group contact and building on past achievements and progress;
- A nation-wide trauma literacy campaign should be launched to reduce the stigma around psychological distress, raise awareness of the prevalence and significance of the issue and show people where to seek care;
- Revisit the *mutuelles* financing system to ensure that psychological support is not contingent on income;
- Deploy mobile relief teams to tackle the issue of limited access to care;
- Stimulate relief interventions not to remain fixed in one location but move places regularly to another place to attend to the needs of other segments of society too;
- Institute a central coordinating body that people can refer to, that coordinates efforts to ensure these are not duplicated and that facilitates the implementation of new approaches. Such a body should be the main link between the government health sector and NGOs;
- Chart psychological ill-health nation-wide along with due recognition for protective factors and stressors, from which the needs can more clearly be distilled.

Discussion

Before attempting to follow up on the next recommendations, however, the Rwandan government should first recognize the pervasiveness of trauma in Rwandan society. Above all, it should actively follow up on its propagated commitment to address widespread psychological issues. Indeed, traumas pose a major impediment to reconciliation in Rwanda. Not only are psychological traumas highly prevalent in Rwandan society and affects not only survivors, but perpetrators too, traumatic memories and ensuing disorders also cause effects far beyond the individual. Anxiety, shattered worldviews, social alienation and a lost zest for life and social engagement are but some of the phenomena, albeit the most common ones, that find their origin in many of the lingering memories. On top of that, additional stressors such as social marginalization are an always present danger that confronts a disproportionate number of orphans, widows and victims of sexual violence.

The effects of large-scale prevalence of trauma on society are profound and has not received the attention it deserves. Traumas impede the reconciliation process as anxiety and intrusions add significantly to feelings of fear and distrust that is rampant after episodes of mass violence. They can severely inhibit social engagement as people morph into lifeless shadows of their former selves and grow alienated in a society that has become incomprehensible to them. Regulating trauma is all the more difficult in a country where the traumatic legacy is omnipresent and where deep emotional expressions are often frowned upon and met with unsympathetic or ignorant reactions. Risk factors, ranging from poverty to stigmas, are all the more present in a society where people struggle to meet their material needs and where cultural practices and social mores have been slow to adapt to the changing social realities after the genocide.

The current strategies, many based on conventional methods of reconciliation, are insufficient on account of the lingering psychological damage that a large part of the Rwandan population continues to be burdened with. The Rwandan reconciliation agenda in many cases has the opposite effect of healing as the political and imposed nature of the strategies fail to appreciate the uniqueness of personal suffering. In particular, by fostering an exclusive victim consciousness among survivors, it creates rifts and divisions in society rather than the often-preached notion of unity. Trauma counselling efforts should endeavor to avoid the same pitfall of reinforcing an exclusive victim consciousness.

But despite all this, there is reason for hope. While trauma counselling is no panacea to individual healing and reconciliation, it can imbue individuals with a renewed outlook on life and the out-group. A therapeutic approach offers the prospect of advancing reconciliation in a more holistic way where the goals are more attuned to the needs of individuals and communities rather than to the goals of a national reconciliation agenda. Such an approach can range from specific treatment of mental health disorders to psychosocial interventions that stress the need to develop new modes of social interaction and co-existence. Clearly, these interventions are inherently confined by limited resources and beyond mere logistical issues other challenges are encountered too. Mental health practitioners and psychosocial workers in politically traumatized setting can face complicated questions of the interrelationship between intra-psychic process and the socio-political environment. It is necessary to recognize the organizational limitations of such approaches as well as the simple truth that reconciliation cannot be imposed and there is no recipe for success. The pain of the past may never disappear, but efforts should be directed in trying to transform this pain into a constructive force that that at the very least allows one to regain control over their lives. Hopefully, then, in the years to come Rwanda might come to be known not as the land of a thousand broken, but a thousand hopeful hearts.

IV. List of references

Abramowitz, S. A. (2010). Trauma and humanitarian translation in Liberia: The tale of open mole. *Culture, Medicine, and Psychiatry*, *34*(2), 353-379.

Abramowitz, S. A. (2014). *Searching for Normal in the Wake of the Liberian War*. University of Pennsylvania Press.

ACORD International (n.d.). *Changing lives in 20 child-headed households in Rwanda*. Retrieved May 4, 2016 from http://www.acordinternational.org/our-work/where/rwanda/changing-lives-in-20-childheaded-homes-in-rwanda/

Afflitto, F. M. (2000). Victimization, survival and the impunity of forced exile: a case study from the Rwandan genocide. *Crime, Law and Social Change*, *34*(1), 77-97.

Aid Evaluator (n.d.). *Dissabilities in Rwanda*. Retrieved May 11, 2016 from http://aidevaluator.com/countries/rwanda/topics/dissability.html

Ajdukovic, D. (2004). Social contexts of trauma and healing. *Medicine, Conflict and survival*, *20*(2), p. 121

Allyn, D. (March 25, 2016). *Invisible recovery in Rwanda*. Retrieved May 2, 2016 from http://brokentoilets.org/blog/invisible-recovery-rwanda/

Amnesty International (April 6, 2004). "Marked for Death": Rape Survivors Living with HIV/AIDS in Rwanda. Retrieved April 21, 2016 from http://www.refworld.org/docid/4129fd524.html

Annemiek Richters (2009) "Misery and resilience among war widows in the North of Rwanda: Individual and social healing through the mediation of sociotherapy", in Sjaak van der Geest & Marian Tankink eds. Theory and action: Essays for an anthropologist, pp. 170-178.Amsterdam: AMB

Ashoka's Changemakers (April 2008). *Mental health care for youth in post-conflict Rwanda: policy and recommendations.* Retrieved October 21, 2013 from http://www.corstone.org/html/downloads/CorStoneRWANDA.pdf p. 3

Askin, K. D. (2005). Gender Crimes Jurisprudence in the ICTR Positive Developments. Journal of International Criminal Justice, 3(4), 1007-1018

Author unknown (1999). Children of conflict. Child-headed households. *BBC World Service*. Retrieved May 4, 2016 from http://www.bbc.co.uk/worldservice/people/features/childrensrights/childrenofconflict/headed.shtml

Author unknown (September 2, 2012). Rethinking mental health in Africa. *IRIN News.* Retrieved April 13, 2016 from http://www.irinnews.org/report/98680/rethinking-mental-health-in-africa

AVEGA (n.d.). *What we do*. Retrieved May 5, 2016 from http://avega.org.rw/what-we-do/

Baddeley, J., & Singer, J. (2007). Charting the life story" s path. Handbook of narrative inquiry. Mapping a methodology, Thousand Oaks, 177-202.

Bagilishya, D. (2000). Mourning and recovery from trauma: In Rwanda, tears flow within. *Transcultural Psychiatry*, *37*(3), p. 341-342

Bar-Tal, D. (2000). From intractable conflict through conflict resolution to reconciliation: Psychological analysis. *Political Psychology*, *21*(2), 351-365.

Belgian Development Agency (May 13, 2014). Mental health: a national priority. Retrieved May 6, 2016 from https://www.btcctb.org/en/casestudy/mental-health-national-priority

Binagwaho, A., Scott, K. W., & Harward, S. H. (2016). Early childhood development in Rwanda: a policy analysis of the human rights legal framework.*BMC international health and human rights*, *16*(1), 1.

Blaser, A. (2002). From the Field--People with Disabilities (PWDs) and Genocide: The Case of Rwanda. *Disability Studies Quarterly*, *22*(3).

Bloomfield, D., Barnes, T., & Huyse, L. (Eds.). (2003). *Reconciliation after violent conflict: A handbook*. International IDEA.

Bolton, P. & Ndogini (August 2000). Cross-cultural assessment of trauma-related mental illness. Retrieved September 12, 2015 from http://pdf.usaid.gov/pdf_docs/Pnacm033.pdf

Bolton, P., Neugebauer, R., & Ndogoni, L. (2002). Prevalence of depression in rural Rwanda based on symptom and functional criteria. The Journal of nervous and mental disease, 190(9), 631-637.

Boris, N. W., Brown, L. A., Thurman, T. R., Rice, J. C., Snider, L. M., Ntaganira, J., & Nyirazinyoye, L. N. (2008). Depressive symptoms in youth heads of household in Rwanda: correlates and implications for intervention.*Archives of Pediatrics & Adolescent Medicine*, *162*(9), 836-843.

Breslau, N., Koenen, K. C., Luo, Z., Agnew-Blais, J., Swanson, S., Houts, R. M., ... & Moffitt, T. E. (2014). Childhood maltreatment, juvenile disorders and adult post-traumatic stress disorder: a prospective investigation. *Psychological medicine*, *44*(09), 1937-1945.

Brounéus, K. (2008). Truth-telling as talking cure? Insecurity and retraumatization in the Rwandan Gacaca courts. *Security Dialogue*, *39*(1), 55-76.

Burnet, J. E. (2008). Gender balance and the meanings of women in governance in post-genocide Rwanda. *African Affairs*, *107*(428), 361-386.

Burnet, J. E. (2012). *Genocide lives in us: Women, memory, and silence in Rwanda*. Amazon Kindle.

Burstow, B. (2005). A critique of posttraumatic stress disorder and the DSM. *Journal of Humanistic Psychology*, *45*(4), 429-445.

Chauvin, L., Mugaju, J., & Comlavi, J. (1998). Evaluation of the psychosocial trauma recovery programme in Rwanda. *Evaluation and Program Planning*, *21* (4)

Christiaan, P. (date unknown). *Websites van psychologen kwaliteitsonderzoek: populatie en doelgroep.* Retrieved April 15, 2016 from http://www.paulchristian.nl/websites-van-psychologen-populatie-en-doelgroep/

Colletta, N.J. & Cullen, M.L. (2000). *The Nexus between Violent Conflict, Social Capital and Social Cohesion: Case Studies from Cambodia and* Rwanda. Retrieved October 11, 2015 from http://siteresources.worldbank.org/INTSOCIALCAPITAL/Resources/Social-Capital-Initiative-Working-Paper-Series/SCI-WPS-23.pdf

Commonwealth Health Online (date unknown). Mental health care in Rwanda. Retrieved April 6, 2016 from http://www.commonwealthhealth.org/africa/rwanda/mental_health_in_rwanda/

Country Meters (n.d.). Rwanda Population. Retrieved May 2, 2016 from http://countrymeters.info/en/Rwanda

De Jong, J. (2002). Trauma, war, and violence. Kluwer Academic/Plenum Publishers, New York.

De Jong, J. P., Scholte, W. F., Koeter, M. W. J., & Hart, A. A. M. (2000). The prevalence of mental health problems in Rwandan and Burundese refugee camps. Acta Psychiatrica Scandinavica, 102(3), 171-177.

De Jong, J. T., Komproe, I. H., & Van Ommeren, M. (2003). Common mental disorders in postconflict settings. The Lancet, 361(9375), 2128-2130.

DePrince, A. P., & Freyd, J. J. (2002). The harm of trauma: Pathological fear, shattered assumptions, or betrayal. *Loss of the assumptive world: A theory of traumatic loss*, 71-82. New York: Brunner-Routledge.

Doná, G., Kalinganire, C and Muramutsa, F. (2001) The Rwandan Experience of Fostering Separated Children Science as Culture, Stockholm: Save the Children.

Donatilla Mukamana and Petra Brysiewicz, 'The Lived Experience of Genocide Rape Survivors in Rwanda', *Journal of Nursing Scholarship*, 40. 4 (2008), 379–384 (pp. 380–383);

Donovan, P. (2002). Rape and HIV/AIDS in Rwanda. *The Lancet*, *360*, 17-18.

Dushimirimana, F., Sezibera, V., & Auerbach, C. (2014). Pathways to resilience in post genocide Rwanda: a resources efficacy model. *Intervention*, *12*(2), 219-230.

Dyregrov, A., Gupta, L., Gjestad, R., & Mukanoheli, E. (2000). Trauma exposure and psychological reactions to genocide among Rwandan children.Journal of Traumatic stress, 13(1), 3-21.

Education Policy and Data Center (August 2013). EPDC EDUCATION TRENDS AND PROJECTIONS 2000-2025 Rwanda. Retrieved May 8, 2016 from http://www.epdc.org/sites/default/files/documents/Rwanda_trends_2013.pdf

Eramian, L. (2014). Personhood, Violence, and the Moral Work of Memory in Contemporary Rwanda. *International Journal of Conflict and Violence*, *8*(1), 16.

Foa, R. (2009. Social capital in Rwanda. Retrieved October 11, 2015 from http://roberto.foa.name/Foa_Rwanda.pdf

Germanotta, M. A. (2010). L'écriture de l'inaudible: Les narrations littéraires du génocide au Rwanda'. *Interfrancophonies-Mélanges*.

Gervais, M. (2003). Human security and reconstruction efforts in Rawanda: Impact on the lives of women. *Development in practice*, *13*(5), 542-550.

Ghosh, N., Mohit, A., & Murthy, R. S. (2004). Mental health promotion in post-conflict countries. The journal of the Royal Society for the Promotion of Health,124(6), 268-270.

Gilbert, C. (2014) Writing trauma : the voice of the witness in Rwandan women's testimonial literature. (Doctoral thesis, University of Nottingham, United Kingdom). Retrieved from http://eprints.nottingham.ac.uk/14260/1/THESIS_-_FINAL_VERSION_%28corrected%29.pdf

Gishoma, D. (2005). L'analyse de la situation du traumatism psychique dans les ménages dirigés par les enfants au Rwanda. Université Nationale du Rwanda, Butare.

Gishoma, D., & Brackelaire, J. L. (2008). Quand le corps abrite l'inconcevable. *Cahiers de psychologie clinique*, (1), 159-183.

Gitau, L.W. (2012). Resilience in survivors of mass violence and its contribution to reconciliation in post-genocide Rwanda. Retrieved September 12, 2015 from http://afsaap.org.au/assets/GITAU.pdf

NURC (March 26, 2014). Social cohesion in Rwanda. Retrieved October 11, 2015 from http://www.nurc.gov.rw/fileadmin/Documents/Social_cohesion_in_Rwanda.pdf

Gleditsch, N. P., Wallensteen, P., Eriksson, M., Sollenberg, M., & Strand, H. (2002). Armed conflict 1946-2001: A new dataset. *Journal of peace research*,*39*(5), 615-637.

Martz, E. (Ed.). (2010). *Trauma rehabilitation after war and conflict: Community and individual perspectives*. Springer Science & Business Media.

Hamber, B., Gallagher, E., & Ventevogel, P. (2014). Narrowing the gap between psychosocial practice, peacebuilding and wider social change: an introduction to the Special Section in this issue. *Intervention*, *12*(1), 7-15.

Gourevitch, P. (1998). We wish to inform that tomorrow we will be killed with our families: Stories from Rwanda. New York, NY: Farrar, Straus & Giroux.

Government of Rwanda: Ministry of Health (December 2009). *Rwanda Health Financing Policy.* Retrieved April 12, 2016 from http://www.moh.gov.rw/fileadmin/templates/Docs/RWANDA-HEALTH-FINANCING-POLICY-FINAL.pdf

Government of the Republic of Rwanda (2003). Constitution of the Republic of Rwanda. Kigali.

Green, B. L., Goodman, L. A., Krupnick, J. L., Corcoran, C. B., Petty, R. M., Stockton, P., & Stern, N. M. (2000). Outcomes of single versus multiple trauma exposure in a screening sample. *Journal of traumatic stress*, *13*(2), 271-286.

Hagengimana, A., Hinton, D., Bird, B., Pollack, M., & Pitman, R. K. (2003). Somatic panic-attack equivalents in a community sample of Rwandan widows who survived the 1994 genocide. *Psychiatry research*, *117*(1), 1-9.

Halpern, J., & Weinstein, H. M. (2004). Rehumanizing the other: Empathy and reconciliation. *Human Rights Quarterly*, *26*, 561.

Hamber, B. (2009). *Transforming societies after political violence: Truth, reconciliation, and mental health*. Springer Science & Business Media.

Hatzfeld, J. (2006). *Life laid bare: The Survivors in Rwanda speak*. Translated from French by Linda Cloverdale. Other Press LLC, New York City: USA.

Hatzfeld, J. (2009). *The antelope's strategy: Living in Rwanda after the genocide*. Translated by Farrar, Strauss and Giroux. Picador, New York City: USA.

Herman, J. L. (1992). Complex PTSD: A syndrome in survivors of prolonged and repeated trauma. *Journal of traumatic stress*, *5*(3), p. 380 - 382

Herman, J. L. (2001). Trauma and Recovery: From Domestic Abuse to Political Terror. 1992. *London: Pandora*.

Herrman, H. (2012). Promoting mental health and resilience after a disaster. *Journal of Experimental & Clinical Medicine*, *4*(2), p. 84

Herrman, H., & Swartz, L. (2007). Promotion of mental health in poorly resourced countries. *The Lancet*, *370* (9594), p. 1195

Herrmann, J. (2012). A critical analysis of the transitional justice measures incorporated by Rwandan gacaca and their effectiveness. *James Cook University Law Review*, *19*, 90-112.

Hilsum, L. (June 7, 2014). Rwanda 20 years on: the tragic testimony of the children of rape. *The Guardian.* Retrieved April 17, 2016 from http://www.theguardian.com/world/2014/jun/08/rwanda-20-years-genocide-rape-children

HRH Global Resource Center (date unknown). *Health Sector Policy: Government of Rwanda*. Retrieved April 8, 2016 from http://www.hrhresourcecenter.org/node/313

Hughes, C., & Pupavac, V. (2005). Framing post-conflict societies: International pathologisation of Cambodia and the post-Yugoslav states. *Third World Quarterly*, *26*(6), 873-889.

Hutchison, E., & Bleiker, R. (2008). Emotional reconciliation reconstituting identity and community after trauma. *European journal of social theory*, *11*(3), 385-403.

IBUKA, Survivors Fund & REDRESS (October 2012). RIGHT TO REPARATION FOR SURVIVORS:
ICRC (March 15, 1995). Rwanda: ICRC assisting psychiatric hospital in Kigali. Retrieved May 2, 2016 from https://www.icrc.org/eng/resources/documents/misc/57jlyy.htm

Ighobor, K. (April 2014). Celebratory rise in women's political participation. *Africa Renewal.* Retrieved May 6, 2016 from http://www.un.org/africarenewal/magazine/april-2015/celebratory-rise-women%E2%80%99s-political-participation

Republic of Rwanda (May 23, 2004). *The Constitution of the Republic of Rwanda.* Retrieved from ilo.org/dyn/natlex/docs/ELECTRONIC/64236/90478/F238686952/RWA64236.pdf.

Index Mundi (2013). *Rwanda demographics profile 2013.* Retrieved April 12, 2016 from http://www.indexmundi.com/rwanda/demographics_profile.html

Jaberg, S. (April 5, 2013). *Scar of the Rwandan genocide remain open.* Retrieved October 8, 2015 from http://www.swissinfo.ch/eng/politics/Scars_of_the_Rwandan_genocide_remain_open.html?cid=35395368

Clark, P. (2010). *The Gacaca courts, post-genocide justice and reconciliation in Rwanda: Justice without lawyers*. Cambridge University Press.

Jaberg, S. (April 5, 2013). *Scars of the Rwandan genocide remain open.* Retrieved April 8, 2016 from http://www.swissinfo.ch/eng/politics/Scars_of_the_Rwandan_genocide_remain_open.html?cid=35395368

Jacob, N. (2009). *Consequences of traumatic stress in Rwandan genocide survivors: Epidemiology, psychotherapy, and dissemination* (Doctoral dissertation, University of Konstanz, Germany). Retrieved from https://kops.unikonstanz.de/bitstream/handle/123456789/10130/Diss_Jacob.pdf?sequence=1&isAllowed=y

Kaplan, S. (2013). Child Survivors of the 1994 Rwandan Genocide and Trauma-Related Affect. *Journal of Social Issues*, *69*(1), 92-110.

Karinganire, E.D. (October 15, 2012). On World Mental Health day, care in Rwanda still woefully lacking. Retrieved April 10, 2016 from http://focus.rw/wp/2012/10/on-world-mental-health-day-care-in-rwanda-still-woefully-lacking

Kayetishonga, Y. (April 21, 2012). Handling trauma and other psychiatric disorders. Retrieved April 10, 2016 from http://www.newtimes.co.rw/news/index.php?i=14969&a=52749

Kayiteshonga, Y. (2012). Person-centered mental health care in Rwanda.*International Journal of Person Centered Medicine*, *2*(1), 109-113.

Keane, F. (1996). *Season of blood: A Rwandan journey*. Penguin UK.

Keepers of Memory: Survivors' Accounts of the Rwandan Genocide 2005, video recording, Link Media Productions/Vivid Pictures. Directed by: Eric Kabera.

Kelman, H. C. (2004). Reconciliation as identity change: A social-psychological perspective. *From conflict resolution to reconciliation*, 111-124.

King, R. U. (2011). A “foolish adventure” in a country that went med: healing psychosocial suffering in post-genocide Rwanda (Doctoral dissertation, University of Toronto, Canada). Retrieved from https://tspace.library.utoronto.ca/bitstream/1807/42603/1/King_Regine_U_201111_PhD_thesis.pdf

King, R. U., & Sakamoto, I. (2015). Disengaging from genocide harm-doing and healing together between perpetrators, bystanders, and victims in Rwanda.*Peace and Conflict: Journal of Peace Psychology*, *21*(3), 378.

Kumar, K. (1997). *Rebuilding societies after civil war: critical roles for international assistance*. Lynne Rienner Publishers Inc.

Kumar, K. (1997). *Rebuilding societies after civil war: critical roles for international assistance*. Lynne Rienner Publishers Inc.

Lambourne, W., & Gitau, L. W. (2013). Psychosocial Interventions, Peacebuilding and Development in Rwanda. *Journal of Peacebuilding & Development*, *8*(3), 23-36.

Laplante, L. J., & Holguin, M. R. (2006). The Peruvian Truth Commission's mental health reparations: empowering survivors of political violence to impact public health policy. *Health and human rights*, 136-163.

Lederach, J. P. (1997). Building peace: Sustainable reconciliation in divided societies. *Washington DC*.

Levers, L. L., Kamanzi, D., Mukamana, D., Pells, K., & Bhusumane, D. B. (2006). Addressing urgent community mental health needs in Rwanda: Culturally sensitive training interventions. *Journal of Psychology in Africa*,*16*(2), 261-272.

MacLellan, M. E. (2010). *'Child'Headed Households in Rwanda: Challenges of Definition and Livelihood Needs* (Doctoral dissertation, Coventry University, United Kingdom).

MacNair, R. (2002). Perpetration-induced traumatic stress: The psychological consequences of killing. Greenwood Publishing Group.

Martell, P. (April 7, 2014). *Emotional scenes as Rwanda marks 20th anniversary of genocide*. Retrieved October 10, 2015 from http://www.rappler.com/world/regions/africa/54908-scenes-rwanda-genocide-20th-anniversary

McKee-Ryan, F., Song, Z., Wanberg, C. R., & Kinicki, A. J. (2005). Psychological and physical well-being during unemployment: a meta-analytic study. *Journal of applied psychology*, *90*(1), 53.

McNeeley, A. (June 9, 2014). Rwanda: Alarm Bells As WHO Says Alcohol Kills One Person Every 10 Seconds. *AllAfrica*. Retrieved April 20, 2016 from http://allafrica.com/stories/201406100499.html

Mikva, K. (April 28, 2015). 17 Top Alcohol Drinking Countries in Africa. *AFK Insider.* Retrieved April 20, 2016 from http://afkinsider.com/28638/17-top-alcohol-drinking-countries-in-africa/18/.

Minister in the Prime Minister’s Office in Charge of Gender and Family Promotion (June 2008). *A Situation Analysis of Orphans and Other Vulnerable Children in Rwanda.* UNICEF. Retrieved May

2, 2016 from http://ovcsupport.org/wp-content/uploads/Documents/A_Situation_Analysis_of_Orphans_and_Other_Vulnerable_Children_in_Rwanda_1.pdf

Mollica, R. F., Cardozo, B. L., Osofsky, H. J., Raphael, B., Ager, A., & Salama, P. (2004). Mental health in complex emergencies. *The Lancet*,*364*(9450), p. 2059

Mugarura, R. (June 24, 2014). Drug abuse among youth on record high. *The New Times*. Retrieved April 20, 2016 from http://www.newtimes.co.rw/section/article/2014-06-24/76337/

Muhumuza, R. (April 19, 2013). Hutu's fear forced return to Rwanda. Retrieved March 10, 2014 from http://news.yahoo.com/hutu-refugees-fear-forced-return-rwanda-112904510.html

Mukamana, D., & Collins, A. (2006). Rape survivors of the Rwandan genocide. *International Journal of Critical Psychology*, *17*, 140-166.

Mukashema, I., & Mullet, E. (2010a). Reconciliation sentiment among victims of genocide in Rwanda: Conceptualizations, and relationships with mental health. Social Indicators Research, 99, 25–39.).

Mukashema, I., & Mullet, E. (2013). Unconditional forgiveness, reconciliation sentiment, and mental health among victims of genocide in Rwanda. *Social indicators research*, *113*(1), 121-132

Mukombozi, B. (December 31, 2015). From survival to living life; Rwanda's healing process at a glance. Retrieved March 2, 2016 from http://www.newtimes.co.rw/section/Printer/2015-12-31/195728/

Munyandamutsa, N., Nkubamugisha, P. M., Gex-Fabry, M., & Eytan, A. (2012). Mental and physical health in Rwanda 14 years after the genocide.Social psychiatry and psychiatric epidemiology, 47(11), 1753-1761.

Nadler, A., & Liviatan, I. (2006). Intergroup reconciliation: Effects of adversary's expressions of empathy, responsibility, and recipients' trust. *Personality and Social Psychology Bulletin*, *32*(4), 459-470.

Neugebauer, R., Fisher, P. W., Turner, J. B., Yamabe, S., Sarsfield, J. A., & Stehling-Ariza, T. (2009). Post-traumatic stress reactions among Rwandan children and adolescents in the early aftermath of genocide. International journal of epidemiology, 38(4), 1033-1045.

Njenga, F. G., Nguithi, A. N., & Kang'ethe, R. N. (2006). War and mental disorders in Africa. World Psychiatry, 5(1), 38.

Palmer, I. (2002). Psychosocial costs of war in Rwanda. *Advances in Psychiatric Treatment*, *8*(1), 17-25

Parent, G. (2010). Reconciliation and justice after genocide: A theoretical exploration. *Genocide Studies and Prevention*, *5*(3), 277-292.

Pathare, S., Shields, L. and Nardodkar, R. (2014). A review of mental health legislation in Commonwealth member states. *Commonwealth Health Partnerships.* Retrieved May 2, 2016 from

http://www.commonwealthhealth.org/wp-content/uploads/2014/05/3-mental-health-legislation-pathare.pdf

Pells, K. (2011). "Keep going despite everything": legacies of genocide for Rwanda's children and youth. *International Journal of Sociology and Social Policy*, *31*(9/10), 594-606.

Petersen-Coleman, M. N., & Swaroop, S. (2011). Complex trauma: A critical analysis of the Rwandan fight for liberation. *The Journal of Pan African Studies*, *4*(3), 1-19.

Pham, P. N., Weinstein, H. M., & Longman, T. (2004). Trauma and PTSD symptoms in Rwanda. JAMA: the journal of the American Medical Association,292(5), 602-612.

Porter, S., & Peace, K. A. (2007). The scars of memory a prospective, longitudinal investigation of the consistency of traumatic and positive emotional memories in adulthood. *Psychological Science*, *18*(5), 435-441.

Powley, E. (2005). Rwanda: Women hold up half the parliament. Women in Parliament: Beyond Numbers, 154-163

Rakita, S., & McClintock, M. (2003). *Rwanda, lasting wounds: consequences of genocide and war on Rwanda's children* (Vol. 15, No. 6). Human Rights Watch.

RENCP (n.d.). *NUDOR (National Union of Disabilities' Organizations of Rwanda*). Retrieved May 10, 2016 from http://www.rencp.org/about/member-organizations-1/nudor-national-union-of-disabilities-organizations-of-rwanda/
Republic of Rwanda (2003). National Policy for Orphans and Vulnerable Children.

Republic of Rwanda (July 2006). *Rwanda Demographic and Health Survey 2005*. Retrieved April 5, 2016 from https://dhsprogram.com/pubs/pdf/FR183/FR183.pdf

Republic of Rwanda: Ministry of Local Government (November 2010). *CENSUS OF PEOPLE WITH DISABILITIES IN RWANDA.* Retrieved May 9, 2016 from http://uphls.org/IMG/pdf/REPORT_CENSUS_PWD_01Janv11.pdf

Richters, A. & Kagoyire, G. (2012) "Pain and steps toward healing among female genocide survivors in Rwanda". LOVA (Journal of Dutch Society for Gender Studies and Feminist Anthropology) 33(1+2):128-138.

Richters, A. (2008). Trauma and healing: cross--cultural and methodological perspectives on post--conflict recovery and development. *Gender, Violent Conflict and Development. New Delhi: Zubaan*.

Richters, A. (2009). *Misery and resilience among war widows in the North of Rwanda: Individual and social healing through the mediation of sociotherapy*, in Sjaak van der Geest & Marian Tankink eds. Theory and action: Essays for an anthropologist, pp. 170-178. Amsterdam: AMB.

Richters, A., & Sarabwe, E. (2015). Everyday partner violence in Rwanda: The contribution of community-based sociotherapy to peaceful family life. *African Safety Promotion: A Journal of Injury and Violence Prevention*, *12*(1), 18-34.

Richters, A., Rutayisire, T., Sewimfura, T., Ngendahayo, E. (2010) "Psychotrauma, healing and reconciliation in Rwanda: The contribution of community-based sociotherapy", African Journal of Traumatic Stress 1(2):55-64.

Wulsin, L.R. & Hagengimana, A. (April 1, 1998). PTSD in survivors of Rwanda's 1994 war. Retrieved March 26, 2016 from http://www.psychiatrictimes.com/articles/ptsd-survivors-rwandas-1994-war

Richters, A., Rutayisire, T., Sewimfura, T., & Ngendahayo, E. (2010). Psycho-trauma, healing and reconciliation in Rwanda. The contribution of community-based socio-therapy. *African Journal of Trauma Stress*, *1*(2), 55-63.

Rieder, H., & Elbert, T. (2013). Rwanda–lasting imprints of a genocide: trauma, mental health and psychosocial conditions in survivors, former prisoners and their children. *Conflict and health*, *7*(1), 1.

Rights, A. (April 2004). Broken bodies, torn spirits living with genocide, rape and HIV/AIDS. Retrieved October 11, 2015 from http://preventgbvafrica.org/wp-content/uploads/2013/10/brokenbodies.africanrights.pdf

Roberts, B., Damundu, E., Lomoro, O., & Sondorp, E. (2009). Post-conflict mental health needs: a cross-sectional survey of trauma, depression and associated factors in Juba, Southern Sudan. BMC psychiatry, 9(1).

Rosenquist, J. N., Fowler, J. H., & Christakis, N. A. (2011). Social network determinants of depression. *Molecular psychiatry*, *16*(3), 273-281.

Roth, M., Neuner, F., & Elbert, T. (2014). Transgenerational consequences of PTSD: risk factors for the mental health of children whose mothers have been exposed to the Rwandan genocide. International journal of mental health systems, 8(1), 1.

Rugema, L., Mogren, I., Ntaganira, J., & Krantz, G. (2015). Traumatic episodes and mental health effects in young men and women in Rwanda, 17 years after the genocide. BMJ Open, 5(6).

Sandole, D. H., & Auerbach, C. F. (2013). Dissociation and identity transformation in female survivors of the genocide against the Tutsi in Rwanda: A qualitative research study. *Journal of Trauma & Dissociation*, *14*(2), 127-137.

Saraceno, B., van Ommeren, M., Batniji, R., Cohen, A., Gureje, O., Mahoney, J., ... & Underhill, C. (2007). Barriers to improvement of mental health services in low-income and middle-income countries. *The Lancet*, *370*(9593)

Schaal, S., & Elbert, T. (2006). Ten years after the genocide: Trauma confrontation and posttraumatic stress in Rwandan adolescents*. Journal of Traumatic Stress, 19(1), 95-105.

Schaal, S., Dusingizemungu, J. P., Jacob, N., & Elbert, T. (2011). Rates of trauma spectrum disorders and risks of posttraumatic stress disorder in a sample of orphaned and widowed genocide survivors. European Journal of Psychotraumatology, 2.

Schaal, S., Weierstall, R., Dusingizemungu, J. P., & Elbert, T. (2012). Mental health 15 years after the killings in Rwanda: imprisoned perpetrators of the genocide against the Tutsi versus a community sample of survivors. Journal of traumatic stress, 25(4), 446-453.

Ricci, S. (2009). La parole mémorielle de rescapées du genocide des Tutsi au Rwanda: vers une (re)construction du sens (Doctoral thesis, University of Quebec, Montreal, Canada).

Schneider, P., & Diop, F. (2001). *Synopsis of results on the impact of community-based health insurance on financial accessibility to health care in Rwanda*. World Bank, Washington, DC.

Schock, K., & Knaevelsrud, C. (2013). Retraumatization: The Vicious Circle of Intrusive Memory. *Hurting Memories and Beneficial Forgetting: Posttraumatic Stress Disorders, Biographical Developments, and Social Conflicts*, 59.

Scholte, W.F. (2013). *Mental health in war-affected populations* (Doctoral thesis, Universiteit van Amsterdam, Amsterdam, The Netherlands). Retrieved from http://dare.uva.nl/cgi/b/bib/bibidx?type=boolean&lang=en&c=uvadis&q1=Mental%20health%20in%20war-affected%20populations&rgn1=title&op2=And&q2=&rgn2=author&op3=And&q3=&rgn3=entire+record&op6=and&rgn6=faculty&q6=+&op7=and&rgn7=department%2Finstitute&q7=+&op8=and&rgn8=files&date1=2013&date2=2013;sort=publicationyear;cc=uvadis;view=reslist;fmt=long;page=reslist;start=1;size=1

Scholte, W.F. (2013). Psychosociale gevolgen van oorlog in niet-westerse landen. Retrieved April 11, 2016 from http://www.cogis.nl/uploads/documents/613.pdf

Schönenberg, M. (2013). Pathological Modes of Remembering: The PTSD Experience. *Hurting Memories and Beneficial Forgetting: Posttraumatic Stress Disorders, Biographical Developments, and Social Conflicts*, 71.

Shetty, P. (June 30, 2010). Place de la medicine traditionelle dans le système de santé: Faits et chiffres. *SciDevNet*. Retrieved April 16, 2016 from http://www.scidev.net/afrique-sub-saharienne/maladie/article-de-fond/place-de-la-m-decine-traditionnelle-dans-le-syst-me-de-sant-faits-et-chiffres.html

Shnabel, N., Halabi, S., & Noor, M. (2013). Overcoming competitive victimhood and facilitating forgiveness through re-categorization into a common victim or perpetrator identity. *Journal of Experimental Social Psychology*, *49*(5), 867-877.

Staub, E. (2006). Reconciliation after genocide, mass killing, or intractable conflict: Understanding the roots of violence, psychological recovery, and steps toward a general theory. *Political Psychology*, *27*(6), 867-894.

Staub, E., Pearlman, L. A., Gubin, A., & Hagengimana, A. (2005). Healing, forgiveness and reconciliation in Rwanda: Intervention and experimental evaluation. *Journal of Social and Clinical Psychology*, *24*(3), 297-334.

Steering Committee of the Joint Evaluation of Emergency Assistance to Rwanda (1996). *The international response to conflict and genocide: Lessons from the Rwanda experience*.

Suliman, S., Mkabile, S. G., Fincham, D. S., Ahmed, R., Stein, D. J., & Seedat, S. (2009). Cumulative effect of multiple trauma on symptoms of posttraumatic stress disorder, anxiety, and depression in adolescents.*Comprehensive psychiatry*, *50*(2), 121-127.

Summerfield, D. (1999). A critique of seven assumptions behind psychological trauma programmes in war-affected areas. *Social Science & Medicine*, *48*(10), 1449-1462.

Summerfield, D. (2001). The invention of post-traumatic stress disorder and the social usefulness of a psychiatric category. *Bmj*, *322*(7278), 95-98.

Survivors Fund (n.d.). Statistics. Retrieved February 20, 2016 from http://survivors-fund.org.uk/resources/rwandan-history/statistics/

Sydor, G., & Philippot, P. (1996). Conséquences psychologiques des massacres de 1994 au Rwanda. *Santé mentale au Québec*, *21*(1), 229-245.

Taylor, C. C. (2014). Rwanda's Gacaca Trials: Toward a New Nationalism or Business as Usual?. *Genocide and Mass Violence: Memory, Symptom, and Recovery*, 301.

The Johns Hopkins and the International Federation of Red Cross and Red Crescent Societies (n.d.). *Emergency Mental Health and Psychosocial Support.* Retrieved from

The World Bank (2001). Education Equality Profiles. Retrieved May 4, 2016 from http://datatopics.worldbank.org/education/files/HSProfiles/DHS/RWA_2000.xls

Thomas, P. (2005). Mainstreaming disability in development: Rwanda country report. *Disability Knowledge and Research*.

Thomson, S. M. (2009). *Resisting reconciliation: state power and everyday life in post-genocide Rwanda*. (Doctoral thesis, Dalhousie University).

Thurman, T. R., Snider, L. A., Boris, N. W., Kalisa, E., Nyirazinyoye, L., & Brown, L. (2008). Barriers to the community support of orphans and vulnerable youth in Rwanda. *Social Science & Medicine*, *66*(7), 1557-1567.

Thurman, T. R., Snider, L., Boris, N., Kalisa, E., Nkunda Mugarira, E., Ntaganira, J., & Brown, L. (2006). Psychosocial support and marginalization of youth-headed households in Rwanda. AIDS care, 18(3), 220-229.

Trimbos Instituut (2008). *Het aantal mensen met ernstige psychische stoornissen in de GGZ.* Retrieved April 10, 2016 from http://www.trimbos.nl/~/media/Themas/4_Behandeling_reintegratie/Aantal%20mensen%20met%20ernstige%20psychische%20stoornissen%20in%20de%20GGZ.ashx

Twahirwa, A. (2008). Sharing the burden of sickness: mutual health insurance in Rwanda. *Bulletin of the World Health Organization*, *86*(11), 823-825.

U.S. Agency for International Development (July 1996). *Rebuilding post-war Rwanda: the role of the international community.* Retrieved April 10, 2016 from http://www.oecd.org/derec/unitedstates/50189461.pdf

UNICEF (1997). An evaluation of the Government of Rwanda and UNICEF Trauma Recovery Program (1995-1997). Retrieved May 4, 2016 from http://old.alnap.org/pool/files/erd-2759-summary.pdf.

UNICEF (February 24, 2003). *Background*. Retrieved May 4, 2016 from http://www.unicef.org/infobycountry/rwanda_1717.html

United Nations General Assembly (March 15, 2012). Assistance to survivors of the 1994 genocide in Rwanda, particularly orphans, widows and victims of sexual violence. Retrieved May 5, 2016 from http://survivors-fund.org.uk/wp-content/uploads/2012/05/UN-Resolution-66-228.pdf

Üstün, T. B., Ayuso-Mateos, J. L., Chatterji, S., Mathers, C., & Murray, C. J. (2004). Global burden of depressive disorders in the year 2000. The British journal of psychiatry, 184(5), 386-392.

Uthman, O. A., Lawoko, S., & Moradi, T. (2009). Factors associated with attitudes towards intimate partner violence against women: a comparative analysis of 17 sub-Saharan countries. *BMC International Health and Human Rights*, *9*(1), 1.

Veale, A. (2001). *Struggling to survive: Orphan and community dependent children in Rwanda*. Rwanda, Ministry of Local Government and Social Affairs.

Veale, A., & Donà, G. (2002). Psychosocial interventions and children's rights: Beyond clinical discourse. *Peace and Conflict: Journal of Peace Psychology*,*8*(1), 47-61.

Venter, C. M. (2007). Eliminating fear through recreating community in Rwanda: the role of the gacaca courts. *Texas Wesleyan Law Review*, *13*, 577.

Verduin, F. (2013). *Measures and outcomes of a psychosocial group approach in Rwanda*. (Doctoral thesis, University of Amsterdam, The Netherlands).

Verduin, F., Engelhard, E. A., Rutayisire, T., Stronks, K., & Scholte, W. F. (2013). Intimate Partner Violence in Rwanda The Mental Health of Victims and Perpetrators. Journal of interpersonal violence, 28(9), 1839-1858.

Villalba, C. S. (2009). *Rehabilitation as a form of reparation under international Law*. C. Ferstman (Ed.).

Ward, L. M., & Eyber, C. (2009). Resiliency of children in child-headed households in Rwanda: implications for community based psychosocial interventions. *Intervention*, *7*(1), 17-33.

Wessells, M. (2009). Community reconciliation and post-conflict reconstruction for peace. In *Handbook on building cultures of peace* (pp. 349-361). Springer New York.

Williamson, C. (2014). *Posttraumatic identities: developing a culturally-informed understanding of posttraumatic growth in Rwandan women genocide survivors.* (Doctoral dissertation, University of Nottingham, United Kingdom).

Wolfe, L. (April 4, 2014). How Rwandans cope with the horror of 1994. *The Atlantic*. Retrieved April 4, 2016 from http://www.theatlantic.com/international/archive/2014/04/how-rwandans-cope-with-the-horror-of-1994/360204/?utm_source=SFFB

World Health Organization (2005). Strategic Orientations for WHO Action in Africa 2005-2009. Retrieved April 13, 2016 from http://afrolib.afro.who.int/RC/RC%2055%20Doc-En/AFR%20RC55%20Strategic%20Orientations%202005-2009%208-11-05.pdf

World Health Organization (2011). *Rwanda Mental Health Profile*. Retrieved April 8, 2016 from http://www.who.int/mental_health/evidence/atlas/profiles/rwa_mh_profile.pdf

World Health Organization (August 15, 2006). Global burden of post-traumatic stress disorder in the year 2000: Version 1 estimates. Retrieved April 6, 2016 from http://www.who.int/healthinfo/statistics/bod_posttraumaticstressdisorder.pdf

World Health Organization (May 2006). *11th General Programme of Work: Engaging for Health*. Retrieved April 14, 2016from http://whqlibdoc.who.int/publications/2006/GPW_eng.pdf

World Health Organization (n.d.-a). *Country Cooperation Strategy for Rwanda 2009-2013*. Retrieved April 13, 2016 from http://www.who.int/countryfocus/cooperation_strategy/ccs_rwa_en.pdf

World Health Organization (n.d.-b). *Medium-term strategic plan 2008-2013 (amended draft).* Retrieved April 13, 2016 from http://apps.who.int/gb/ebwha/pdf_files/MTSP2009/MTSP3-en.pdf

World Vision International (n.d.). Our work for children. Retrieved March 11, 2016 from http://www.wvi.org/our-work-children

World Vision International (n.d.). Rwanda. Retrieved March 11, 2016 from http://www.wvi.org/rwanda

Wulsin, L.R. & Hagengimana, A. (April 1, 1998). PTSD in survivors of Rwanda's 1994 war. Retrieved March 26, 2016 from http://www.psychiatrictimes.com/articles/ptsd-survivors-rwandas-1994-war

Young, A., & Breslau, N. (2007). Troublesome memories: Reflections on the future. *Journal of anxiety disorders*, *21*(2), 230-232.

Zembylas, M. (2007). The politics of trauma: Empathy, reconciliation and peace education. *Journal of Peace Education*, *4*(2), 207-224.

Levers, L. L., Kamanzi, D., Mukamana, D., Pells, K., & Bhusumane, D. B. (2006). Addressing urgent community mental health needs in Rwanda: Culturally sensitive training interventions. *Journal of Psychology in Africa*,*16*(2), 261-272.

Zorgkaart Nederland (date unknown). *Psychiaters*. Retrieved April 10, 2016 from http://www.zorgkaartnederland.nl/psychiater

Zraly, M. (2008). *Bearing: Resilience among genocide-rape survivors in Rwanda* (Doctoral dissertation, Case Western Reserve University).