

Ines-Lena Mahr and [Catherine Campbell](#)

## Twenty years post-genocide: the creation of mental health competence among Rwandan survivors through community-based healing workshops

Article (Accepted version)  
(Refereed)

**Original citation:**

Mahr, Ines-Lena and Campbell, Catherine (2016) *Twenty years post-genocide: the creation of mental health competence among Rwandan survivors through community-based healing workshops*. [Journal of Community & Applied Social Psychology](#), 26 (4). pp. 291-306. ISSN 1052-9284

DOI: [10.1002/casp.2263](https://doi.org/10.1002/casp.2263)

© 2015 [John Wiley & Sons, Ltd.](#)

This version available at: <http://eprints.lse.ac.uk/64880/>

Available in LSE Research Online: November 2016

LSE has developed LSE Research Online so that users may access research output of the School. Copyright © and Moral Rights for the papers on this site are retained by the individual authors and/or other copyright owners. Users may download and/or print one copy of any article(s) in LSE Research Online to facilitate their private study or for non-commercial research. You may not engage in further distribution of the material or use it for any profit-making activities or any commercial gain. You may freely distribute the URL (<http://eprints.lse.ac.uk>) of the LSE Research Online website.

This document is the author's final accepted version of the journal article. There may be differences between this version and the published version. You are advised to consult the publisher's version if you wish to cite from it.

# **Twenty years post-genocide: The creation of mental health competence among Rwandan survivors through community-based healing workshops**

## **ABSTRACT**

Twenty years after the genocide, many Rwandans still suffer from the psychological wounds of the past. The country's mental health agenda is based on individualised and psychiatric approaches that help some but cannot be provided on a large-scale. Further, many reconciliation initiatives have been based on public testimonies, which have been shown to be potentially re-traumatising, leading to calls for small-scale community-based approaches to healing, which constitute a middle way between individualised and public approaches. Drawing on the concept of "mental health competence" (Campbell and Burgess, 2010) this study evaluates one such approach: the Life Wounds Healing workshops offered by the African Institute for Integral Psychology (AIIP). 21 semi-structured interviews were conducted with former workshop participants, staff members and the Institute's founder to investigate their views of how these workshops can help genocide survivors. The results suggest that the workshops succeed in creating mental health competence by establishing a safe social space for people to open up, increasing peoples' critical understandings of the processes of pain - and potential for healing - that informs behaviour change, generating bonding social capital and offering participants income generating possibilities. The training of community health workers is presented as a potential way to overcome a lack of human resources and funding which currently constrains the work of the AIIP.

Keywords: Rwanda; genocide; mental health competence; community; community mental health

## INTRODUCTION

2014 marked the twentieth anniversary of the devastating genocide in Rwanda. It is estimated that more than 1 million Rwandans perished within three months through machete and gun-fire attacks, mostly perpetrated by extremist Hutu on the Tutsi minority of the country. About two million people were forced to flee to neighbouring countries (Clark, 2010). Due to these events, many Rwandans remain deeply traumatised and require mental health support (Saraceno, van Ommeren, Batniji, Cohen & Gureje et al., 2007; Republic of Rwanda Ministry of Health, 2012). Importantly, trauma in this context is to be defined as a socially and historically dependent form of psychological suffering that can be alleviated or sustained through the social fabric of communities (Martin-Baró, 1990). Based on the severity of violence, loss and grief during the genocide, community relations were damaged or destroyed and many support-networks collapsed. In the years since, however, the government has taken important steps to begin to address psychological suffering through two different approaches.

First, several reconciliation initiatives have been implemented, including an annual genocide commemoration during which people can publicly testify and listen to other people's testimonies. Further, a series of village-level hearings into the crimes committed during genocide were established in 2002, the *Gacaca* trials (Clark, 2010). Although public testifying is claimed to lead to psychological health, it has been found that many witnesses in the *Gacaca* trials suffered from higher levels of depression and post-traumatic stress disorder than non-witnesses. To testify in public and to listen to testimonies constitutes an intensive exposure to past experiences and might therefore rather reinforce emotional pain (Brounéus, 2008). Second, Rwanda has a public mental health agenda that aims to provide Rwandans with individual-level psychological support, primarily through psychiatric treatment and counselling (Republic of Rwanda Ministry of Health, 2012). However, despite the outstanding need for mental health support, the government does not have the capacity to scale up individual treatment methods.

Based on the limitations of these initiatives, there is a need for a middle way between public and individual approaches to healing psychological wounds. Small-scale community-level approaches could fill this gap, potentially having a wider reach than individual approaches, and being less threatening than public approaches. The strengthening of community ties and the healing of social fabric has already been shown to be effective in improving mental health in post-conflict areas such as Guatemala (Anckermann, 2005). In Rwanda, such approaches have been used over the years in a piecemeal fashion, but, as discussed below, there has been little formal research conducted on their effectiveness. In this study one such approach is evaluated: the 'Life Wounds Healing' (LWH) workshops, facilitated by the African Institute for Integral Psychology (AIIP).

### *History and strategies of the African Institute for Integral Psychology*

The LWH workshops are community-based mental health interventions, which were first implemented in Rwanda in 1995 by a Rwandan psychologist, who studied clinical psychology and psychopedagogy in Belgium and returned to Rwanda in 1994, right after the genocide had ended. His aim was to relieve psychological suffering, however, he realised that the individual-based methods he had learned in Belgium did not effectively help people. In the Rwandan context, emotional wounds may often have to be healed within a community setting. Therefore, he began to develop what he calls a 'community mental health' approach, which aims to improve the self-healing capacities of communities.

Based on this approach the LWH workshops emerged, which entail a combination of Western and Rwandan methods of healing (King, 2011). They are designed for vulnerable groups of adults, including genocide survivors, former prisoners, people affected by HIV/AIDS, and other members of their household. The LWH workshops are run by the AIIP, which was founded in 2009 in order to provide this work with an institutional context. The AIIP hosts workshops in Burundi, the Congo

and in two communities in Rwanda, Mageragere (in the outskirts of Kigali) and Mbazi (close to Butare).

Since 1995, the LWH workshops have been continuously adapted to fit the context and the communities' needs. The AIIP currently offers different types of workshops, including one on 'raising critical community consciousness about life wounds', and a series of four workshops on 'community healing of life wounds'. The four parts of the latter include a workshop on acknowledging grief, on the management of emotions, on forgiveness and reconciliation, and on envisioning life goals.

Throughout the last years, four other modules have been added. There is one on 'raising critical consciousness on domestic violence' and one on 'community healing of couples'. Further, a workshop on entrepreneurship and micro-businesses in response to poverty related difficulties and another one on law, that helps participants understand their own and others' rights, have been implemented.

### *Research on community approaches and interventions to mental health in Rwanda*

Only four studies explore the impact of psychosocial support groups on people's mental health in Rwanda. One study found that community based support augmented perceived physical and mental health, quality of life and perceived social support among HIV patients (Thomson, Rich, Kaigamba, Hakizamungu & Bagiruwigize, et al. 2014). Another study on HIV-infected, traumatised Rwandan women showed that the attendance of psychosocial support-groups led to a significant improvement in mental health (Walstrom, Operario, Zlotnick, Mutimura & Benekigeri, et al.2013). Further, a psychosocial intervention presented by Staub (2006; 2000), investigated the benefits of promoting healing and reconciliation in small groups and through radio programs. Those who participated showed significant reduction in trauma symptoms (Staub, 2006). Finally, Scholte and Alastair (2014) evaluated a participatory socio-therapy program in Rwanda revealing that these interventions increase mental health and social cohesion.

These studies present the beneficial effects of psychosocial support-groups on the mental health of Rwandans and their communities. However, the approaches and projects evaluated so far rather focus on specific issues such as HIV/AIDS or the immediate aftermath of the genocide. In contrast, the AIIP's workshops are continuously adapted to the needs of communities. A broad variety of adversities are taken into consideration, such as domestic violence and poverty. Further, the development of citizenry is fostered. Based on this holistic approach, the LWH workshops are unique in Rwanda. The AIIP itself has mainly been evaluated through grey literature. Further, a PhD thesis was written on its approach, illustrating how story sharing can support individual and community healing (King, 2011).

Importantly, so far no study has taken a community psychology approach to evaluate programs in Rwanda. The need to take such an approach is expressed by Levers et al. (2006). They emphasise the great potential of community action programs that draw from the principles of community psychology to address the psychological consequences of the Rwandan genocide. Community psychology deals with the relationships and systems influencing mental health related issues of communities. Therefore, it constitutes a promising approach to address mental health in Rwanda on a larger scale (Levers et al. 2006). Based on the scarcity of literature on community mental health interventions in Rwanda and the lack of literature that draws upon a community psychology approach to evaluate these interventions, this study constitutes a valuable contribution.

## **CONCEPTUAL FRAMEWORK**

### *Community mental health competence*

This study is framed by Campbell's and Burgess' (2012) conceptualisation of "mental-health competence". This concept draws upon the field of community health psychology, which

emphasises the need to not only heal individuals, but also to create supportive social contexts. These contexts for healing should ideally constitute health enabling social environments, which facilitate health-enhancing attitude and behaviour change (Campbell, Cornish, 2010). Mental-health competence emerges out of such an environment and is defined by three psychosocial resources. (1) Sharing of mental health-related *knowledge* of how to identify signs of stress and illness and how to access local support structures and culturally resonant services. (2) *Safe social spaces*, in which people can develop ‘critical consciousness’ about the underlying social and cultural determinants of distress and mental health problems (Freire, 1973). This includes discussions of ways to tackle illness, next to official health services. Thereby, a sense of local ownership and responsibility is developed and individual and collective skills are recognised (Campbell, Burgess, 2012). (3) *Partnerships* between local communities and more powerful stakeholders that have additional resources and are willing to support the improvement of mental health in the community. This reflects Bourdieu’s (1986) notion of social capital, which is defined as the increased accessibility of social networks that can foster the interests of marginalised people and communities.

### *Community mental health competence in the Rwandan context*

This study seeks to investigate what constitutes mental health competence in the Rwandan context, twenty years post-genocide. The data analysis showed that the notion of mental health competence slightly changes in adaption to this context.

First, critical consciousness created in *safe social spaces* needs to be defined more broadly. In Rwanda, it is more than an awareness of how individual issues are implicated in broader social issues. It is also a process of self-reflexivity, of understanding personal emotional wounds and seeing oneself through the eyes of the other. Through this awareness, it becomes possible to acknowledge the wounds of others and to change own behaviours in ways that improve one’s own mental health and the health of the community. This broader definition also resonates with Freire’s (1973) approach to critical consciousness, who argues that thought already implies action.

Second, the data analysis revealed that partnerships in the Rwandan context are rather explained by Putnam’s (2000) concept of bonding social capital than Bourdieu’s (1986) notion of it. Putnam split social capital into two forms. First, bridging social capital, which is closer to Bourdieu’s (1986) definition, as it relates to the creation of social ties among socially heterogeneous groups. Second, bonding social capital, which includes social networks of reciprocity, trust and solidarity among more homogenous groups such as communities or families. Especially bonding social capital turned out to be central in this study, since a recovery of community relations in the Rwandan context includes the recreation of trust among victims and perpetrators, who live door to door in the same communities.

## **METHOD**

### *Study design and ethical concerns*

Prior to the commencement of the study ethical approval was obtained by the Research Ethics Committee of the Department of Social Psychology at the London School of Economics and Political Science. Research was conducted in partnership with the AIIP in the community of Mageragere and the office of the AIIP in Kigali between March 23rd and April 14th, 2014. Interviews were carried out with former workshop participants, staff members of the AIIP and the founder of the institute.

All participants signed a consent form prior to participating in the interviews. Interviews were conducted by the first author and a Rwandan interpreter, himself a genocide survivor. Each

participant was assured that they could withdraw from the interviews at any time, or choose not to respond if they felt uncertain or unwilling to discuss. As the content of the interviews was sensitive at times, a qualified psychosocial support worker employed by the AIIP was on call during the interviews. Further, as planned in advance, each interview was followed by a meeting between individual participants and the psychosocial worker in the event that the interview had caused any undue distress. However, none of the participants reported any sense of additional psychosocial strain arising out of their participation in the research.

### *Data collection and participants*

Data collection included interviews and field notes. In order to get a profound insight into people's personal stories and their understanding of their own situation 21 semi-structured interviews were conducted (Gaskell, 2000). Part of each interview consisted of life story interviews, focusing on the childhood, adolescence and adulthood of the participant, treating the genocide as a key moment in their lives (Atkinson, 1998). Overall, the interviews focused on participants' perception of the workshops and their impact. Thereby, it was possible to evaluate how the workshops added to previously existing support networks and if they helped alleviate pre-existing problems.

Participants were between 26 and 70 years old and included 9 men and 12 women. The sample of 21 participants consists of 5 staff members and the founder of the AIIP, and 15 former workshop participants including orphans, widows and couples who had participated in the workshops together with their spouse. Most had participated in the workshops throughout the last five years before the study and one had participated in the late 1990s. The group of participants contained Hutu as well as Tutsi. Purposive participant sampling was applied, since former workshop participants were recruited by the psychosocial worker of the AIIP, who lives in Mageragere. The other participants were recruited through personal contact by the researcher.

### *Data analysis*

Each interview was audio-recorded and then transcribed. Based on the technique of thematic analysis the data was coded using the Atlas.ti coding software. The interviews were analysed adhering to the principles of thematic analysis developed by Attride-Stirling (2001), which provides a flexible tool to cluster data into themes and to rearrange those themes based on the discovery of new details or nuances in the data. During analysis similar codes were arranged together into basic themes, basic themes were clustered into organising themes and finally the organising themes were grouped into more abstract global themes, which constitute the overarching interpretation of the data. Eventually, two coding frameworks were established: one for the context of participant's lives, one for participant's experiences with the LWH workshops (See appendix).

## **RESULTS**

### ***Context***

#### *Theme 1: Support-networks and everyday experiences of adversity before genocide*

*Avenues to support before genocide.* When asked about emotional support during childhood and adolescence, almost every participant emphasised caring and supportive family relationships. Also, close friendships and other community members, such as teachers and spirituality in the form of praying were mentioned as an important source of emotional support.

The family also emerged as central in the provision of instrumental support. In particular, people spoke about parents who had work and property, could pay for school fees, provide food or save money for their children. Others received such support from the church or supported themselves financially through work, such as farming and selling goods.

*Everyday experiences of adversity before genocide.* Even though most participants referred to a good childhood and/or adolescence, several also mentioned adverse experiences, mostly related to their family. For example, people described the adversity of orphanhood, intimate partner and domestic violence:

“[...] my father’s mother was not good to me. She didn’t care how hungry I was when I came from school.” (Int. 6)

Moreover, some people had to work at an early age, take care of sick and destitute family members, and lost family members due to old age or illness. Family conflict and marriage difficulties were also encountered before the genocide.

In the broader community, people were confronted with rape, the loss of friends, stigma due to being Tutsi, teen-pregnancy, and HIV-infection. Several participants also experienced poverty, resulting in food insecurity and/or the inability to pay school fees. Finally, some people faced health challenges, including infection with HIV resulting from rape or other physical illnesses.

### *Theme 2: Adverse and traumatising experienced during genocide*

*Relational and structural experiences of adversity during genocide.* In relation to the time period of the genocide, people exclusively mentioned adverse experiences. For many it was hard to talk about these devastating events. Almost every participant had a family member killed and several spoke of going into exile and living in refugee camps.

Further, the inability to save others from being killed, and losing friends, neighbours and other community members was brought up. Moreover, the experience of being raped was described:

“[...] the Interahamwe Hutu militias didn’t want to kill me because they wanted me to be their wife. [...] I experienced consequences because they raped me and they removed parts of my body.” (Int. 2)

The constant threat of being killed, witnessing killings, seeing dead bodies, and having to hide for weeks or even months in places, such as under a bed, behind a wardrobe or in a ditch, emerged as formative. Additionally, adversities to physical health came up, including being beaten and cut with machetes. Finally, people experienced poverty in the form of food insecurity and the loss of property.

### *Global theme 3: Support-networks and everyday experiences of adversity after genocide*

*Avenues to support after genocide.* Even though live after genocide was hard, a broader variety of support structures were mentioned in comparison to the time before genocide. Emotional support mainly came from remaining family members, neighbours, friends and orphans who were adopted after genocide. Spirituality also provided an important emotional backing, in the form of faith in god and praying. Further, the church and the government offered meetings that encouraged reconciliation and forgiveness and some NGOs offered counselling.

Instrumental support stemmed partly from supportive family members, the inheritance of property, being adopted as an orphan by non-family members, getting support from adopted orphans in the household and friends in relation to housing or finding a wife. Additionally, the government, and the church provided material support. Finally, several participants supported themselves by working after the genocide.

*Everyday experiences of adversity after genocide.* The adversities after genocide consisted of the loss of family members and domestic violence. Further, some people were obliged to take care of their destitute family and several participants also experienced various difficulties with their marriage. Being raped by neighbours or being stigmatised in the community based on an HIV-

infection also constituted experiences of adversity. Many also emphasised the loss of trust in their community:

“Before genocide I saw them as good citizens, good neighbours, but after genocide it became really bad. [...] During genocide it was them who were burning houses, stealing properties, so I couldn’t trust them.” (Int. 4)

Poverty also plays a significant role until today, expressed in homelessness, food insecurity and the inability to pay school fees. Importantly, in contrast to the health problems described before genocide, physical *and* mental health problems were prevalent. For example, participants mentioned disabilities, psychosomatic problems, trauma and becoming infected with HIV. Others also started to abuse drugs.

Finally, participants also experienced negative personal changes such as the loss of the motivation to live and a lack of self-care and of perceived self-worth:

“[...] the genocide was for me the end of life. I felt that I didn’t want to live. I was dirty and I didn’t want to wash my body, I didn’t want to wash my clothes.” (Int. 2)

### ***Experiences with the Life Wounds Healing workshops***

#### *Global theme 1: Safe social space*

*Feeling free and safe to open up.* Many former participants perceived the workshops as a safe social space in which they felt free and safe to open up to others. Campbell and Burgess (2012) describe this as an essential step for community members to assume responsibility for their own mental health. There were three elements that facilitated this safe space. First, during the workshops the group of usually about 20-30 participants is divided into smaller groups of 4-5 people, which helped some people talk, since larger groups can seem intimidating. Second, at the beginning of each workshop ‘rules of protection’ are established, such as attentive listening, confidentiality and respect. The rule of confidentiality was an especially important and culturally appropriate element:

“It was not easy to be open in a big group but it was a must, it happened after having established the internal rules, like confidentiality. Then I was able to talk because I was sure that the information will be kept confidential.” (Int. 10)

The third element that helped people to open up was the staff that was perceived as both sensitive and professional by several people.

#### *Global theme 2: Critical consciousness informs behaviour change*

*Critical (self-) reflexivity on own qualities and on the ability to change own behaviour.* Through dialogue with others and exercises in the workshops, participants went through a process of reflexivity that provided them with a deeper understanding of themselves and others. This process informed behaviour change in several cases. As defined in the conceptual framework, this constitutes a form of critical consciousness (Freire, 1973). The process of self-reflexivity led to a realisation of self-worth and the value of life. This in turn increased self-acceptance and self-care among many participants:

“And I felt I’m a human like others, because before training I thought I was nothing, I was useless, I believed that living alone with no family meant I’m useless.” (Int. 1)

Further, several participants realised their own mistakes and found ways how to respond to them:



“The most important thing I experienced in the training is that I understood what violence is and how to prevent being violent to my children, to my wife and my relatives.” (Int. 14)

This reflexivity also helped participants become more capable of responding to adverse experiences and negative behaviours. This implies the perception of an increased ability to cope with experiences of adversity.

*Critical awareness of own and other’s rights.* Through the workshops on law, people became aware of their own and other’s rights. For instance, they became aware of children’s rights:

“I found out that I was not respecting the rights of my children. [...] Sometimes I didn’t cook for them, with that training I realised that that was a kind of violence.” (Int. 8)

They also became aware of gender equality:

“With this training I found out that the laws for women and men say that they must be treated the same. Before this training, I thought that some properties like cars, cows and so on are the husband’s personal properties [...]” (Int. 8)

### *Global theme 3: Bonding social capital*

*Commitment to provide others with advice and support.* Bonding social capital, as described by Putnam (2000), emerged as one of the most salient themes in the interviews. Many expressed their commitment to provide others with advice and support after having participated in the workshops. Further, participants stated that due to the workshops, they give advice to and take care of other community members:

“When my friend has a problem I go there to help her [...]. This training helped me a lot because I am also able to help others emotionally.” (Int. 2)

*Development of community cohesion.* Bonding social capital also emerged in the form general community cohesion, which was created since participants developed empathy for one another, such as between Hutu and Tutsi:

“When Hutu were talking about their life wounds Tutsi cried. When I saw them crying I thought that may be Tutsi love us because they understood our life wounds, and that was mutual. [...] we found that if people could get over their wounds they could coexist and we could reach unity and reconciliation.” (Int. 5)

Further, a variety of participants stated that they are now able to forgive those who have caused harm to them and their family:

“During the training, they taught us that we have to forgive those who killed our family members; they told us that the killers also have wounds. After the training, I was able to forgive.” (Int. 2)

Several participants also expressed that participation in the workshops recovered their trust in the community, which has been shattered through the genocide:

“[...] before these trainings I saw anyone as a killer, I was seeing anyone as an animal but thanks to these trainings I’m recovering from what I was feeling.” (Int. 4)

*Improved relationships with others.* Bonding social capital was also created through improving relationships among families and community members. For instance, participants stated that they got to know their spouse better in the workshops and that their communication with their spouse and other family members was improved:

“Before the training I was ignorant, I was never happy, never social, I didn’t want to talk to anyone. But since the training I talk to my wife, my children and my neighbours.” (Int. 4)

Some also stated that they stayed connected with other workshop participants through the establishment of a common micro-business.

#### *Global theme 4: Financial gains*

*Improved financial situation.* Some, who had participated in the training in entrepreneurship, mentioned that their financial situation has improved from implementing what they learned. For example, they had established their own new business, either alone or with other participants. Others said that they were better able to manage their finances after attending the workshops.

#### *Global theme 5: Limitations and challenges*

*Emotional and relational challenges faced by participants.* Several participants described emotional difficulties to open up in front of others during the workshops. However, those who expressed these problems also said they were able to overcome them during the course of the workshops. Others said that they were sceptical about the AIIP and the workshops before participating.

Further, at first, some participants did not adhere to the rule of confidentiality. Some people shared what had been talked about during the workshop with outsiders in the wider community. A staff member explained that this is not unusual after the first workshop, but that this problem is normally solved by confronting those who have not respected the rule of confidentiality during the second workshop.

*Structural challenges former participants are facing today.* Several participants stated that they are facing structural challenges, including physical illness, such as physical disability, HIV and chronic pain. Further, poverty is a crucial challenge for most participants:

“Yes, in our village people have few means; we have only the houses, only these small lands where we can cultivate vegetables.” (Int. 2)

*Structural challenges the AIIP is facing today.* In the interviews, every staff member expressed the lack of more qualified staff and funding. The AIIP is considering establishing an education programme for community health workers. However, so far there is no clear concept of how to realise this programme. This relates to the second major challenge, which is the high demand for more workshops. Every participant interviewed expressed the need for more workshops, not only for genocide survivors, but also for other groups, such as youth. Some participants felt that the workshops should be conducted nationwide. However, the AIIP does not have the means to respond to this demand.

## **DISCUSSION**

As the findings reveal, the LWH workshops succeed in creating mental health competence on three levels: the personal level, the household and community level, and the economic level. However, limitations and challenges also have been identified through the interviews, which considerably limit the impact of the workshops.

On the personal level, mental health competence is created by providing workshop participants an opportunity to talk about experiences of adversity in a safe space. Some of the people interviewed stated that they had never shared their experiences or feelings of the genocide with others before participating in the workshops. As argued by Campbell and Burgess (2012), the creation of a safe social spaces supports the development of critical consciousness (Freire, 1973).

The effects of the workshops support this argument, since several people engaged in critical reflexivity and thereby recovered a positive sense of self by realising their self-worth and the value of their own life. Based on this recovery, people began to consciously take better care of themselves, by praying, socialising with others or improving personal hygiene. This also led to an enhanced ability to accept and deal with adverse or traumatising experiences.

At the household and community level Putnam's (2000) concept of bonding social capital turned out to play a crucial role in establishing mental health competence. This stands in contrast to the focus of Campbell and Burgess (2012) on Bourdieu's (1986) definition of social capital, which implies that marginalised communities can only create mental health competence through the outside support of more powerful stakeholders. However, in Rwanda the recovery of shattered relationships is more central to ease emotional pain, since many had lost trust in their community through the harrowing experience of the genocide. Empathy and forgiveness were key elements in this process, as was the commitment of participants to help those in their community who experience trauma, family conflict or other problems.

Within households, reciprocity, trust and solidarity were often created between couples who had participated together. After the workshops, partners were better able to treat each other with respect, communicate and listen, and make decisions together. They attributed this improvement to knowledge they gained about their partner during the workshops, as well as to knowledge on how to live with others in a community peacefully. This reflects the element of mental health related knowledge, necessary to create mental health competence (Campbell and Burgess, 2012). In this regard, the perception of being in a safe space during the workshops played a key role, since some partners had never talked to each other about what their life was like before their marriage and/or during the genocide.

Further, other family and community members indirectly benefited from workshop participation, since former participants stated to actively intervene in family and community conflicts. This is particularly important because domestic violence was mentioned to be a prevalent problem in Rwandan communities. Since confidentiality and discretion are important Rwandan values, this kind of violence is often kept secret, with intervention only coming from the police in extreme circumstances. Therefore, the commitment of community members to help each other to solve family conflict constitutes a valuable contribution to making the community a safer place.

On the economic level, mental health competence was produced through the workshops on entrepreneurship, which led to the establishment of small, income-generating projects among former participants. Since, according to Campbell and Burgess (2012), mental health problems are frequently based on structural problems, such as poverty, these modules constitute a highly important element in building mental health competent communities.

The positive effects of the workshops also lead to limitations and challenges. The staff and finances of the AIP are used to capacity and therefore answering the high demand for more workshops is currently not feasible. The founder of the AIP argued that it would be nearly impossible to scale up the workshops, since they are conceptualised for small groups and require a lot of time, funding and commitment. Therefore, the AIP is working on the development of a strategy to train new people to pass on the knowledge of the workshops.

### *Study limitations and recommendations for future research*

Since this is an exploratory study, the findings must be treated with caution given that the interviews with workshop participants were only collected in one community. Further, the participants were purposively sampled by the psychosocial worker of the AIP and during the first two interviews the psychosocial worker was present in the room. This might have biased the sample and responses received during these two interviews.

Future research could focus on projects using a similar approach within and outside of Rwanda to show what aspects of the approach are generalisable and what is more specific to the locality. This could help inform the national mental health agenda and provide opportunities to integrate a more community-based mental health approach.

## CONCLUSION

### *Future outlook for practice*

As previously stated, the AIIP is currently considering a programme to train other people in their approach to pass on their knowledge. Even though this is a challenging undertaking experiences from other African contexts demonstrate how training community health workers (CHWs) can be effective.

In the context of mental health and non-communicable diseases in other sub-Saharan African countries the training of CHWs was observed to lead to significant benefits. For instance, in South Africa and Uganda research demonstrated that lay counsellors could offer counselling for common mental disorders. Further, CHWs can improve access to mental health services and health-seeking behaviour, provide cultural congruence through the provision of local knowledge, and enhance the community's skills pool (Petersen, Fairall, Egbe, Bhana, 2014; Petersen, Bhana, Baillile, 2012; Petersen, Ssebunnya, Bhana, Baillile, 2011; Alexander, Mollink, Seabl, 2010). Petersen et al. (2012) also illustrated that peer-facilitated psychosocial support groups can lead to the enhancement of coping capacities and personal empowerment, which in turn improves mental health and the quality of life among participants. These experiences can offer important insights for the AIIP as they consider future CHW training. Since the AIIP already has a well-established network of people who are interested in helping training could be implemented in the form of a 'cascade system', which might lead to similar benefits as described above (Campbell, Nair, Maimane, Sibiya, 2008).

However, the previously mentioned research has also highlighted a variety of challenges faced by CHWs. These include limited professional stability and recognition, as well as complicated relationships with medical professionals (Schneider, Hlophe, van Rensburg, 2008). Moreover, Petersen et al. (2012) have found that CHWs may have limited power to address structural drivers of mental health problems because of their own economically marginalised position and they might need technical and emotional support since this work can be challenging for their own mental health. These challenges bring up important considerations about the position and treatment of CHWs, for example whether they are paid and what their professional status is. The difficulties faced by CHWs in other African contexts are likely to apply to Rwanda as well.

### *Concluding remarks*

This study maps out the psychosocial processes through which the LWH workshops create mental health competence among Rwandan genocide survivors. As demonstrated, the establishment of a safe social space in which people can open up to others and share their experiences triggers critical self-reflexivity. This not only contributes to an improved sense of self, but also to enhanced family and community relations. Further, workshops on law and entrepreneurship provide people with opportunities to overcome structural challenges like gender inequality.

In conclusion it can be stated that the workshops demonstrate a path to improving mental health in Rwanda that falls between current government efforts, including public reconciliation initiatives and individualised psychiatric approaches. Thereby, the work of the AIIP could be potentially valuable to inform the national mental health agenda. By listening to the demands of local communities and by emphasising their potential, the workshops help participants to recover from adverse experiences, and to build mental health competence twenty years after the genocide

## BIBLIOGRAPHY

- Alexander, D., Mollink, C. & Seabi, J. (2010). Community oriented interventions to empower lay counsellors. *Journal of Psychology in Africa*, 20 (1), 105-107.
- Anckermann, S., Dominguez, M., Soto, N., Kjarerulf, F., Berliner, P., Mikkelsen, E.N. (2005). Psycho-social support to large numbers of traumatized people in post-conflict societies: an approach to community development in Guatemala. *Journal of Community and Applied Social Psychology*, 15, 136-152.
- Atkinson, R. (1998). *The life story interview*. Thousand Oaks, CA: SAGE Publications.
- AttrideStirling, J. (2001). Thematic networks: an analytical tool for qualitative research. *Qualitative Research*, 1 (3), 385-405.
- Bourdieu, P. (1986). The forms of capital. In: Richardson, J. *Handbook of theory and research for the sociology of education*. New York: Greenwood, 241-248.
- Brounéus, K. (2008). Truth-Telling as a talking cure? Insecurity and retraumatization in the Rwandan Gacaca courts. *Security Dialogue*, 39 (1), 55-76.
- Campbell, C. & Cornish, F. (2010). Towards a fourth generation of approaches to HIV/AIDS management: creating contexts for effective community mobilisation. *AIDS care*, 22 (1), 1569-1579.
- Campbell, C. & Burgess, R. (2012). The role of communities in advancing the goals of the Movement for Global Mental Health. *Transcultural Psychiatry*, 49 (3-4), 379-95.
- Campbell, C., Nair, Y., Maimane, S. & Sibiyi, S. (2008). Supporting people with AIDS and their carers in rural South Africa: Possibilities and challenges. *Health and Place*, 14 (3), 507-518.
- Freire, P. (1973). *Education for Critical Consciousness*. London, UK: Continuum.
- King, U., R. (2011). "A foolish adventure" in a country that went mad: Healing psychosocial suffering in post-genocide Rwanda. (Doctoral dissertation). Retrieved on December 15th, 2013, from [https://tspace.library.utoronto.ca/bitstream/1807/42603/1/King\\_Regine\\_U\\_201111\\_PhD\\_thesis.pdf](https://tspace.library.utoronto.ca/bitstream/1807/42603/1/King_Regine_U_201111_PhD_thesis.pdf)
- Levers, L., Kamanzi, D., Mukamana, D., Pells, K. & Bhusumane, D. (2006). Addressing urgent community mental health needs in Rwanda: culturally sensitive training interventions. *Journal of Psychology in Africa*, 16 (2), 261-272.
- Baro, M. (1989). The political violence and the war as causes of psychosocial trauma in El Salvador. *International Journal of Mental Health*, 18, 3-20.
- Petersen, I., Bhana, K. & Baillie, A. (2012). Understanding the benefits and challenges of community engagement in the development of community mental health services for common mental disorders: lessons from a case study in a rural South African subdistrict site. *Transcultural psychiatry*, 49 (3-4):418-37.
- Petersen I, Fairall L, Egbe C. O. & Bhana A. (2014). Optimizing lay counsellor services for chronic care in South Africa: a qualitative systematic review. *Patient Education and Counselling*, 95 (2), 201-10.
- Petersen, I., Ssebunnya, J., Bhana, A., Baillie, K., & the MHaPP Research Programme Consortium (2011). Integrating mental health into primary health care. Case studies from South Africa and Uganda. *International Journal of Mental Health Systems*, 5 (1), 8.
- Putnam, R. D. (2000). *Bowling alone: the collapse and revival of American community*. New York: Simon and Schuster.
- Scholte, W. F. & Alastair, K. A. (2014). Social capital and mental health: connections and complexities in contexts of post conflict recovery. *Journal of Mental Health and Psychosocial Support in Conflict Affected Areas*, 12 (2), 210-218.
- Republic of Rwanda Ministry of Health (2012). National mental health policy in Rwanda. Republic of Rwanda - Ministry of Health. Retrieved on July 15th, 2014 from <http://www.moh.gov.rw/fileadmin/templates/Docs/Posted-National-Mental-health-Policy-1.pdf>
- Saraceno, B., van Ommeren, M., Batniji, R., Cohen, A., Gureje, O., Mahoney, J., Sridhar, D. &

- Underhill, C. (2007). Barriers to improvement of mental health services in low-income and middle-income countries. *The Lancet*, 370, 1164–74
- Schneider, H., Hlophe, H. & van Rensburg, D. (2008). Community health workers and the response to HIV/AIDS in South Africa: tensions and prospects. *Health Policy Plan*, 23 (3), 179-87.
- Staub, E. (2006). Reconciliation after genocide, mass killing and intractable conflict: Understanding the roots of violence, psychological recovery and steps toward a general theory. *Political Psychology*, 27 (6), 867-895.
- Staub, E. (2000). Genocide and mass killing: Origins, prevention, healing and reconciliation. *Political Psychology*, 21 (2), 367-382.
- Thomson, D. R., Rich, M. L., Kaigamba, F., Socci, A. R., Hakizamungu, M., Bagiruwigize, Binagwaho, A. & Franke, M. F. (2014). Community-based accompaniment and psychosocial health outcomes in HIV-infected adults in Rwanda: a prospective study. *AIDS and Behaviour*, 18 (2), 368-80.
- Walstrom, P., Operario, D., Zlotnick, C., Mutimura, E., Benekigeri, C. & Cohen, M., H. (2012). 'I think my future will be better than my past': Examining support group influence on the mental health of HIV-infected Rwandan women. *Global Public Health*, 8(1):90-105.

## APPENDIX

Table 1: Context

<b>Global themes</b>	<b>Organising themes</b>	<b>Basic themes</b>	<b>Examples of codes</b>
Support-networks and everyday experiences of adversity before genocide	Avenues to support before genocide	Family based support (Emotional)	Caring family relations
		Spiritual support (Emotional)	Praying
		Family based support (Instrumental)	Paying school fees
		Institutional support (Instrumental)	Church pays for education
		Self-support (Instrumental)	Self-support through work
	Everyday experiences of adversity before genocide	Family-based adversity	Being an orphan
		Community-based adversity	Rape
		Poverty-based adversity	Food insecurity
		Health-based adversity	HIV
	Adverse and traumatising experiences during genocide	Relational and structural experiences of adversity during genocide	Family based adversity
Community based adversity			Loss of friends/other community members
Poverty-based adversity			Loss of property
Health-based adversity			Physical maltreatment
Support-networks and everyday experiences of adversity after genocide	Avenues to support after genocide	Family based support (Emotional)	Caring/Supportive remaining relatives
		Community based support (Emotional)	Praying together with friend
		Spiritual support (Emotional)	Faith in god
		Institutional support (Emotional)	NGOs provide therapy, advise and space to meet
		Family based support (Instrumental)	Remaining relatives provide housing
		Community based support (Instrumental)	Adoption

<b>Global themes</b>	<b>Organising themes</b>	<b>Basic themes</b>	<b>Examples of codes</b>
		Institutional support (Instrumental)	Government provides housing and money
		Self-support (Instrumental)	Work
	Everyday experiences of adversity after genocide	Family based adversity	Domestic violence
		Community based adversity	Loss of trust
		Poverty-based adversity	Food insecurity
		Health-based adversity	Psychosomatic problems
		Personal/Psychological adversity	Loss of motivation to live



Table 2: Experiences with the workshops

Global themes	Organising themes	Basic themes	Examples of quotes
Safe social space	Feeling free and safe to open up to others	Rules of protection	It was not easy to be open in a big group [...] it happened after having established the internal rules.
		Division into small groups	But it was helpful when I talked in a small group of 4 or 5.
		Sensitive and professional staff	They listened, if you want to cry, you were free to cry, or if you want to laugh you did it.
Critical consciousness informs behaviour change	Critical (self) reflexivity on own qualities and on the ability to change own behaviour	Realising personal value and own qualities	The first training helped me with self-acceptance and to accept what happened to me.
		Realising own mistakes and how to respond to them	[...] in training [...] I understood what violence is and how to prevent being violent.
	Critical (self) reflexivity on ways to respond to adverse experiences and negative behaviours	Ability to cope with experiences of adversity	Today if someone does bad things to me, I stay humble, something different from the time before training.
		Critical awareness of own and other's rights	Becoming aware of children's rights
	Becoming aware of own rights		The third workshop helped me to know [...] the laws that protect us when our rights are violated.
	Becoming aware of gender quality		Before training, he believed that men should not help with the house activities; he believed that those are jobs for women.
Bonding social capital	Commitment to provide others with advise and support	Giving advise to and being asked for advise by other couples	They come to consult me because they never hear me and my husband fight.
		Development of community cohesion	Giving advise to and taking care of other community members
	Feeling empathy for others		They have taught us that when you see your colleague you see yourself in his/her eyes, and you find that you have the same problems.

<b>Global themes</b>	<b>Organising themes</b>	<b>Basic themes</b>	<b>Examples of quotes</b>
	Improved relationships with others	Increased ability to forgive	[...] my wife has changed. The violence against me has ended and when it happened she asked for forgiveness, and I ask for forgiveness when I do bad things to her.
		Recovered trust in community	I thought they [family] were the only innocent people [...]. It was with the training that I changed those beliefs
		Getting to know spouse better	Trainings helped me to know what my wife likes and what she dislikes.
		Enhanced communication with others	It helped me to build good relationships with others. I am no longer angry.
		Staying connected through micro-businesses after workshops	The business we share is also a reason that motivates us to meet in our subgroups.
Financial gains	Improved financial situation	Establishment of own business	We have a project of raising rabbits, and we meet several times. We didn't separate.
		Improved management of financial means	Before training we were not using the bank, but now we have a bank account.
Limitations and challenges	Emotional and relational challenges faced by participants	Initial difficulties to open up in workshops	It was not easy to express what happened to yourself because I lost my relatives, friends and others.
		Initial scepticism towards AIPP	We thought that they were coming to disturb us.
	Structural challenges former participants are facing today	It is painful to remember the past during workshops	The first workshop was about accepting yourself, which was difficult for me because it brought me back to my own sad stories.
		Initial lack of confidentiality among workshop participants	[...] especially at the first training people were not able to keep the secrets of the group.
		Poverty	Nothing we are doing generates incomes for us.
	Structural challenges the AIPP	Physical illness	Another issue is illnesses and we don't have anywhere to go to get treatment.

<b>Global themes</b>	<b>Organising themes</b>	<b>Basic themes</b>	<b>Examples of quotes</b>
	is facing today	High demand for more workshops  Limited means	It would be good if there were means to train more people. Not only survivors.  There are not many people who are trained in the community approach.