

Addressing Urgent Community Mental Health Needs in Rwanda: Culturally Sensitive Training Interventions

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Rwandan leaders in the health and educational sectors have begun to discuss the necessity for establishing culturally appropriate community-based mental health counselling services in Rwanda, especially trauma counselling. The need for a community psychology approach is anchored in the lingering effects of the genocide and the continuing post-traumatic stress symptoms suffered by many in the population. Capacity building in an effort like this would require the design of multi-level counselling curricula that are sensitive to the social structures within Rwandan culture. These curricular endeavours call for the development of a National Counselling Centre to serve as a structural mechanism for organizing community-based counselling initiatives. We consider the community health services needs in Rwanda here, along with associated challenges and strategies for effective mental health services in a country with a recent history of genocide. A community psychology approach to mental health would benefit Rwandan society by making trauma counselling and recovery services available and accessible to citizens throughout the country.

KEY WORDS: community psychology, trauma, counselling, bioecological model, curriculum development, Rwanda

Introduction

The 1994 genocide in Rwanda decimated the country. Nearly one million people were killed, representing approximately 11% percent of the population (Magnarella, 2002), and about two million people were uprooted and forced to flee to neighbouring countries, leaving many of those who survived severely and repetitively traumatized. Although a case might be made, categorically, for a nation-wide diagnosis of Post-Traumatic Stress Disorder, the official psychiatric designation does not speak adequately to the severity and depth of loss and grief experienced by most Rwandans (Shyaka, n.d.). The nation's developing and over-burdened health-care system collapsed at the time of genocide. For example, over 80% of Rwanda's health and mental health professionals either fled the country or were killed (Kumar, Tardif-Douglin, Manikas, Sheckler, & Knapp, 1996). The same can be said in reference to the educational system, including higher education and other institutions that are essential to a civil society. Many community-level support structures disappeared, leaving citizens traumatized and vulnerable in the absence of protective civil institutions.

Communicable diseases like malaria, tuberculosis, and HIV/AIDS continue to take their toll on the society. Psychosocial problems associated with circumstances like poverty and the plight of the most vulnerable children remain high priorities. Mental health professionals presently report an increase in the number of suicides, but the accounts are anecdotal, because minimal resources exist to collect such data.

To the credit of Rwandan leadership, much has been accomplished since the genocide to restore macroeconomic structures, to rebuild infrastructures, to deal with justice issues, and to restore civil order. However, for the numerous reasons associated with this complex situation, dealing with the psychosocial issues of the populace largely has had to wait. While reconciliation efforts and forgiveness are essential, the human costs no longer can remain unattended. Adopting community action programs that draw from principles of community psychology has great potential for addressing the psychosocial consequences of the genocide.

Community psychology deals with the mental health-related issues of communities, as well as the associated relationships and

systems within the communities. Community psychology and community-based counselling are action-oriented endeavors, and the assumptions underlying this approach are (1) that environments can engender either protective factors or risks, (2) that multifaceted helping approaches are more efficient than single-service approaches, (3) that prevention is more effective than remediation, and (4) that the community counselling model may be applicable in any human-service setting (Lewis & Lewis, 1989).

According to Rudkin (2002), the five guiding principles of community psychology are: (1) a view of knowledge as fluid and value based; (2) the belief that one cannot understand an individual without also understanding the many-levelled social contexts in which the individual lives; (3) attention to the voices of diverse, and often disenfranchised, groups; (4) a commitment to improving the lives of individuals through intervention and social change; and, (5) an emphasis on a strengths-based model rather than a deficit model of mental health. She further identifies four orienting concepts that are viewed as fluid frameworks for community action; these include stress and coping, prevention, empowerment, and resilience. Unlike guiding principles, which provide a stable foundation upon which community psychology is built, the orienting concepts are intended to offer relevancy to community work in a changing world. In addition, Murray, Nelson, Poland, and Ferris (2004) suggest that the following values are associated with community health psychology: empowerment, social justice, caring, compassion, health promotion and prevention, and diversity. Applied to communities that have experienced severe trauma, such as in Rwanda, a community psychology approach can begin to address the interface between individual suffering and culture-based supports, and perhaps mediate positive and resilient interactions with social systems at multiple environmental levels.

This article illuminates the urgent need for training various levels of professionals and paraprofessionals, in adequate numbers, to address the psychosocial needs of Rwandans by providing trauma counselling in communities throughout Rwanda. We consider the following related aspects: background to Rwandan trauma, post-genocide situational analysis, and pathways to promoting community-based counselling interventions. Our review addresses the need for community psychology interventions that require culturally appropriate training. It is also significant in that policy makers are ready to begin strategic planning in this effort and can benefit from informed discussion of associated matters.

Background to Rwandan Trauma

Rwanda is a small, land-locked country in central Africa, having few natural resources and minimal industry. According to the Central Intelligence Agency's *World Factbook* (CIA, 2006), Rwanda is the most densely populated country in Africa, with a population estimated as slightly over 8.6 million. Approximately 90% of the population is involved in mainly subsistence farming, which highlights the social pressure to own land in a country where there may not be enough land for everybody. The median age is 18.6 years; those 0-14 years of age constitute 41.9% of the population, those 15-64 years constitute 55.6% of the population,

and those 65 years and over constitute 2.5% of the population (CIA). About 70.4% of the population, over age 15, can read and write (CIA). Rwanda has a high mortality rate due to AIDS, and the life expectancy at birth is presently 47.3 years (CIA).

With a legacy of Belgian colonialism, Rwanda remains one of the poorest countries in the world. The World Food Programme estimates that 60% of the population lives below the poverty line (United Nations Development Programme, 2005). The Gross Domestic Product, per capita, is US\$1,500 (CIA, 2006), and Rwanda ranks 159 out of 177, according to the Human Development Index (UNDP). Not surprisingly, then, few mental health resources have been available in Rwanda.

Immediately after the 1994 genocide and through to the present time, dealing with the sequelae associated with psychological trauma has been the responsibility primarily of the survivors and non-governmental organizations (NGOs). The *Psychosocial Service Centre* was established in 1999, in the capital city Kigali, by the Rwandan Ministry of Health's mental health program, to assist people experiencing psychological problems. It was designated as the national referral centre for outpatient services, and the *Ndera Psychiatric Hospital* was designated as the national referral centre for in-patient hospitalizations. While these are "national" in scope, resources have been limited, and pragmatically, services have been accessible mostly to those living in close proximity to the urban areas.

In order to understand current community mental health needs, it is essential to understand the events that occurred in 1994 surrounding the genocide. However, understanding this fully requires some knowledge about the nation's history (Palmer, 2002), and an adequate account of this is beyond the scope of this article. Other credible sources provide requisite historical details (e.g., Human Rights Watch, 1999; Magnarella, 2002; Rwanda Information Exchange, 2006). We note briefly that a history of ethnic tensions, combined with colonial influences, has contributed to the trauma of those who experienced the genocide. As put by Magnarella (2002, p. 25), "In 1994, Rwanda erupted into one of the most appalling cases of mass murder the world has witnessed since World War II." Our purpose for offering minimal background information as an antecedent for discussion about current community mental health needs is to reference the nature of trauma and the bioecological assumptions of the curricular project that we propose, as well as the effects of the genocide on Rwandan communities during and immediately after the genocide. These issues are discussed in the remaining parts of this section.

Defining Trauma

In their book, Briere and Scott (2006) have identified the major types of trauma as natural disasters, mass interpersonal violence, large-scale transportation accidents, house or other domestic fires, motor vehicle accidents, rape and sexual assault, stranger physical assault, partner battery, torture, war, child abuse, emergency worker exposure to trauma, and the problems associated with combined and cumulative traumas. Survivors' experiences during the Rwandan genocide involve several of these types of trauma. The *Diagnostic and Statistical*

Manual of Mental Disorders, 4th edition, Text Revision (*DSM-IV-TR*; American Psychiatric Association [APA], 2000, p. 463) has defined trauma as:

... direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one's physical integrity; or witnessing an event that involves death, injury, or a threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate (Criterion A1). The person's response to the event must involve intense fear, helplessness, or horror (or in children, the response must involve disorganized or agitated behaviour) (Criterion A2).

It seems clear that most survivors of Rwanda's genocide qualify, by definition, as having been severely traumatized. This is not to suggest the need for a collective diagnosis or to pathologize Rwandans' responses, but rather, to underscore the severity of most citizens' experiences during the time of genocide. Indeed, it seems equally clear that Rwandans have shown remarkable resilience in the face of so many risks associated with the traumatic events that they endured. It is in the face of these risks and protective factors, or traumas and resiliencies, that the bioecological model (Bronfenbrenner, 1979, 2004) of human development emerges as one important thread in understanding some of the complex psychosocial responses to the genocide. This model accounts for many of our underlying assumptions about community mental health needs in Rwanda at the present time and also about the requisite training to meet these needs.

Understanding the Bioecological Perspective

Bronfenbrenner (1979, 2004) articulated a theory of reciprocal influences upon the individual, who is nested within multiple environments. These influences represent both possible risks and potential protective factors that may occur within any of the systemic or physical environments in which a person is situated or located. For example, a young child living in a household that is headed by a teenaged sibling may face multiple environmental risks (e.g., the effects of poverty, lack of adequate nutrition, exposure to adults who may exploit the child in a variety of ways). In the same situation, if the child has access to a government- or NGO-sponsored day-care centre that caters to the psychosocial needs of vulnerable children in culturally responsive ways, where at least some of the child's basic needs are met (e.g., one or more nutritional meals per day, adult nurturance and mentoring, a sense of safety, outreach to the caregiver), this might be viewed as a protective factor that has the potential to mediate at least some of the risks in the child's environments.

Lynch and Levers (in press) have offered an analysis of ecological-transactional and motivational models that are useful in considering interventions for mitigating trauma. According to Lynch and Levers, it is the transactional nature of risks and resiliencies, as defined within the bioecological model, which offers potential pathways for recovering from trauma. The term transactional implies that person and environment are in mutual and reciprocal relationship with one another. While a risk in

the environment has the potential to cause suffering to the individual, the individual (or collective individuals) has the potential to mediate the effects of this risk by seeking the benefit of a naturally occurring protective factor (e.g., comforting communal mechanisms that are a part of traditional village life, like requesting advice from an elder) or of a constructed protective factor (e.g., establishing a peer-support group through a local church or NGO). This may involve a meaning-making process, which often has the power to mediate the effects of trauma and allow the individual to transcend some of the existential effects of the traumatizing events. Many Rwandan survivors, who have exhibited remarkable strength, are doing amazing things to help one another. For example, survivors are initiating programs, through schools and NGOs, to train other survivors in peer-support and crisis intervention endeavors; survivors are assisting other survivors who visit the genocide museum, in the capital city of Kigali, to work through their immediate responses to the exhibits. It is important to learn from their resilience, so that we can better understand what does and does not work, and so that we can seek culturally appropriate ways for facilitating or constructing resilience and for enhancing naturally occurring protective factors. This is an important aspect of initiating authentic community psychology programming that addresses trauma and recovery issues and that lays the groundwork for a shift to a more proactive model of mental health promotion.

Effects of the Genocide upon Communities

We have elected to offer a brief focus here on the community impact of the genocide, during and immediately following the bloodshed, to highlight why the issues surrounding trauma are so problematic and potentially long lasting. Unspeakable atrocities occurred in Rwanda during the 100 days of genocide in 1994. Nearly one million Rwandans lost their lives. How the genocide occurred, from a moral perspective, and how bystanders, both locally and globally, stood by and watched it transpire, still needs to be better understood (Staub, 2000, 2003; Staub, Pearlman, Gubin, & Hagengimana, 2005; Staub & Pearlman, 2003). As emphasized by Staub, "Genocide is not simply political...it is also psychological and cultural" (cited in Clay, 1999, ¶9).

Neighbours killed neighbours, children watched parents being murdered, and women and children were raped—often repetitively and by multiple perpetrators—and frequently deliberately infected with HIV. Survivors of the genocide experienced multiple traumatic events, and most also suffered betrayal trauma (e.g., Freyd, 1998) and survival guilt (e.g., Hass, 1995) in the aftermath of the genocide. Consequently, a Human Rights Watch Report (2004) has outlined the lasting legacies of the violence that will continue to recapitulate further trans-generational trauma, unless adequate culturally relevant interventions are initiated.

The lack of adequate resources for strategic planning has contributed to a lingering generalized sense of suffering. Within a short period of time immediately following the genocide, a plethora of international donor organizations and UN agencies arrived in Rwanda to assist the nation. Many NGOs sprung up to support these efforts. For example, in reference to vulnerable

children, Kumar et al. (1996, Executive Summary, ¶ 17), reported that “Some NGOs rushed into the country staking claim to or opening up new centres for unaccompanied children and orphanages without any long-term planning and without the guidance and direction of a strong coordinating body.” Most of the responses were made in a crisis mode; many were health-related and aimed at restoring primary health care. Perhaps understandably, but still unfortunately, sustainable community-based psychosocial programming was not a part of the initial response.

The effects of the genocide have been seen in the immediate fragmentation of Rwandan society and in the ensuing social anomie in Rwanda. The family and the community are systems that have been essential in buffering against risks and in building or reinforcing protective factors. These systemic units have served as support networks for both adults and children. In sub-Saharan Africa, the extended family network traditionally has fostered orphans (United Nations Children’s Fund, 2003). However, in Rwanda, poverty and social fragmentation have reduced the capacity of households to care for additional children. Therefore, it is important that Rwandans not be viewed as passive and in need of being “rescued” from mental health crises. Rather, as traditional protective structures have been destroyed, the population has become increasingly more vulnerable; it has been in this regard that attention to psychosocial environments and ongoing stressors remain an important aspect of any intervention (Richter, Foster, & Sherr, 2006; UNAIDS/UNICEF/USAID, 2004; World Bank Africa Region & World Bank Institute, 2004). Exclusively individualistic approaches are not going to work; instead, individual difficulties have been bound up closely with those of the community. These need to be addressed simultaneously. The revival of traditional support networks, for example, caring for orphans and vulnerable children (OVCs) (Palmer, 2002), is proving to ease the psychosocial problems of OVCs. This is demonstrated, for example, by CARE *Nkundabana* model (*Nkundabana* means “I love children” in *Kinyarwanda*).

Post-Genocide Situational Analysis

While it is critical to have insightful, evidence-based analyses regarding the post-genocide situation in Rwanda, few Rwandans are involved in research for public or international consumption. There are no proper mechanisms for disseminating research findings nationally or internationally, and apart from training institutions, the lack of public libraries makes it difficult for scientific research to be disseminated. Despite the existence of research ethics committees, it is surprising, then, to find that research has been done in Rwanda and published by foreigners, without Rwandan citizens necessarily having any knowledge about it. For this reason, it is understandable that we have been limited in our analysis by research that primarily has been conducted by Westerners.

Given the legacy of colonialism in Rwanda, as well as the implications of colonialism within the history surrounding the genocide, we remain cautious in this expository endeavour. We feel that we need to be careful when citing studies that have

been conducted either by Westerners, or Western-trained individuals, or that have employed scales or psychometric instruments developed for use in the West to study trauma interventions in Rwanda. We remain dubious about such practice, especially when cultural sensitivity is ignored, results are presented *as if* they are culturally salient, and real needs become masked. However, a growing number of cross-cultural studies of the psychosocial and health effects of war take culture into account and give at least some indications of the scale of the problem (e.g., Bracken, Giller, & Summerfield, 1995; Dyregrov, Gupta, Gjestad, & Mukanoheheli, 2000; Jones & Kafetsios; Levers, 2002; Slied, & Gilbert, 2006). More alternative modes of research, such as participatory action research and ethnographic methods, are important to building greater understandings of cultural specificities and priorities of Rwandans. We need more efforts in this qualitative vein (e.g., Glesne, 2006; Merriam, 1998; van Manen, 1997). In the absence of much of the latter research, we only can proceed with sharing the empirical evidence as it exists.

The broad scope of devastating events has taken its toll across Rwandan society. The Ministries of Health and Education have worked together since the genocide, in the pre- and in-service preparation of many health and allied-health professionals to cater to public health needs. Although Rwandan adults have numerous health and mental health needs, children and youth have special needs in these areas. In the remaining parts of this section, we focus on these topics: defining the scope of trauma, the health sector, the education sector, children and youth, and the need for community-based interventions.

Defining the Scope of Trauma.

The events of the Rwandan genocide left the remaining population of Rwanda traumatized and in a state of emergency. Framing the situation as a complex emergency, Kumar et al., (1996, Executive Summary, ¶ 18) commented that the “... brutal nature and extent of the slaughter ... swiftly and profoundly destroyed Rwanda’s social foundation ... [and that] ... essential trust in social institutions has been destroyed, replaced by pervasive fear, hostility and insecurity.” The Harvard Program in Refugee Trauma (Harvard, 1996) reported that Rwanda was facing a nationwide mental health crisis as a result of the genocide. The authors predicted serious implications for the country’s economic and political future and reported that large segments of the population were suffering from PTSD symptoms, describing “the entire Rwandan population ... [as] ... in a state of psychological shock and social withdrawal ... as a result of violence, including rape and torture” (Harvard, ¶ 2-3). Although Rwandans have not had resources to conduct much large-scale research, such claims have been substantiated by the local investigations that have been possible (e.g., Mukanoheheli, n.d.; Mutamba & Izabiliza, 2005).

The Harvard team offered the following recommendations for response to the mental health crisis: (1) the use of mass communication, especially radio, to address psychosocial trauma; (2) additional international support for traditional mechanisms for conflict resolution; (3) the creation of a Mental Health

Task Force; (4) the rebuilding of primary health care and traditional healing systems; and, (5) the training of traditional and primary health care workers to recognize trauma (Harvard, ¶ 5). Most of these recommendations have been or are being implemented. For example, Radio Rwanda has set up time on a regular basis for health communication about mental health disorders. Air time affords the opportunity for Rwandan experts to explain, in *Kinyarwanda*, how to assist those suffering from acute psychological trauma responses and how to focus attention on prevention strategies. Unfortunately, there have not been enough resources during the post-genocide decade to address adequately the mental health-related concerns of the public. Presumably, with efforts put toward rebuilding the primary health system, parallel efforts concerning mental health have had to wait.

After more than a decade, the traumatic effects of the genocide have not abated. While events can have healing effects, like the commemoration services or the reconciliation process, they also can serve as psychological triggers of trauma or grief. Everyday occurrences may induce flashbacks for many who have not sufficiently healed. There is still no systematic and accessible recovery process available to most survivors, and to some, it may seem as if not much progress has been made.

The Health Sector

The genocide had a chilling, almost paralyzing effect on the health care sector, both biomedical and traditional. However, Rwanda has embarked on reforming its national health system and has followed the primary health care model of decentralized district health services; the Ministry of Health also has begun a process of liaising with the traditional healers. One situation that has changed health care over the past decade is the increased prevalence in Rwanda of HIV/AIDS. Rape was a deliberate tactic of the genocide; many women were infected with HIV (Human Rights Watch Report, 2004).

The pandemic has slowed post-genocide trauma-recovery efforts, and an individual's status as HIV-positive may complicate PTSD treatment. However, certain features of long-term PTSD often exacerbate symptoms that may lead to some of the risky behaviours typically associated with contracting HIV. The situation of HIV/AIDS, already one of great complexity, is further complicated within the context of trauma. According to a National Institute of Mental Health publication (NIMH, 2001, ¶8), "Depression, alcohol or other substance abuse, or other anxiety disorders frequently co-occur with PTSD." Such co-morbidity has implications for a nation with a high-prevalence rate of HIV/AIDS. The NIMH (2001, ¶8) further states that, "The likelihood of treatment success is increased when these other conditions are appropriately diagnosed and treated as well." Rwandans' high potential for co-occurring PTSD and HIV/AIDS is reason enough to consider counselling as a national priority. However, traditional Rwandan culture is typical of African cultures; the Cartesian notion of a separation of mind and body, and hence medicine and spiritual or existential concerns, does not exist (Bracken, 2002; Levers, 2006a, 2006b). It is an important traditional aspect of Rwandan cosmology that issues of

health, religion, and existence be addressed concurrently.

The Education Sector

International assistance to Rwanda has focused mostly on rehabilitating and restructuring the primary level of the educational system, including information and communication technology development. Attention understandably has concentrated on primary education, particularly with the provision of free education. However, there has not been adequate funding for investment at the tertiary level, which is necessary to train healthcare professionals. In spite of a lack of international funding for tertiary education following the genocide (Kumar et al., 1996), the Kigali Health Institute (KHI) was established to train qualified health personnel to meet the health needs of the population. As a part of this effort, the mental health department also was launched. Since then, the education movement has continued to grow and to become stronger than ever before. One recent progressive move, as an example, has been the inauguration of culturally sensitive and age-appropriate youth clubs in schools. The Ministry of Education has recommended that each school establish a club through which youth health needs are met, including HIV and AIDS.

One insidious effect of trauma is its trans-generational feature when appropriate interventions are lacking. In other words, children who were not even born at the time of genocide, that is, those born any time afterward, may be affected vicariously by the unresolved trauma of parents and other significant family (or foster family) members. The experience of vicarious or secondary trauma can have the same deleterious effects as the experience of the original traumatizing event(s). Since children spend many of their waking hours in school, it is reasonable to view the schools as an environment where trauma recovery activities can be interwoven effectively into the curriculum. This only can be accomplished with care and caution, especially related to issues of cultural sensitivity and the age/stage appropriateness of instructional content. This is not to suggest that therapy now be conducted in Rwandan classrooms. Rather, well-trained school counsellors and teacher/counsellors can initiate skills-based modules of instruction that are tailored to the ages of the children, like teaching conflict resolution skills to grade-three learners, for example, who are showing aggressiveness during at-school play and in the classroom. Through such activities, if any child is identified as having serious emotional problems, the child (and family) can be referred for counselling. The *Association Rwandaise des Conseillers en Traumatisme* (ARCT) has initiated some activities in the schools, training children in peer support with basic listening skills and awareness of trauma-related issues.

Children and Youth

The psychosocial needs of children in post-genocide Rwanda, like vulnerable children in many situations around the world, must be evaluated and addressed very carefully (Foster, 2005; Kaplan, 2005). Not only do children have a right to life, survival, and development, of which psychosocial wellbeing is a part, but addressing this right is crucial in breaking intergenera-

tional transmission of trauma and cycles of violence. Pells (in progress) has been conducting an in-depth case study of Rwanda regarding the psychosocial concerns of children and youth. Her fieldwork in Rwanda has focused on the everyday lives of children and young people and the legacies of the genocide, in addition to the responses of governmental and non-governmental organizations (NGOs) and the changing trends of trauma-related work in Rwanda since 1994. The remaining parts of this children- and youth-based section are informed by the interviews that Pells has conducted, mostly with Rwandans, as part of her broader research agenda. The data presented here represent only a preliminary analysis of Pells' larger study, but they have assisted in shaping our understandings of the everyday lives of youth in Rwanda.

First responses. According to Pells' research, initially following the genocide, many of the international NGOs working with children in Rwanda initiated trauma programmes that were based primarily upon the biomedical model of service delivery. In 1995, UNICEF devised a trauma-recovery programme for children and young people (Dyregrov, Gupta, Gjestad, & Mukanoheheli, 2000). The programme was sponsored initially by UNICEF, for a short time during the period of emergency, and then handed over to the public sector at the end of 1997; this included the establishment of the *National Trauma Centre* in Kigali, but since closed, due to funding problems.

Paraprofessional training of early responders. Around 1999–2000, most organizations shifted their operations from focusing on short-term emergency interventions to longer-term development activities. This coincided with the scaling down of trauma programmes. At the same time, working practices moved towards training local people—especially those who had responded early—and building the capacity of Rwandan organizations to conduct counselling and provide sensitization in the community around trauma issues. For example, *Trocaire*, the development organization of the Irish Catholic church, trained Rwandan staff members, who subsequently formed the *Association Rwandaise des Conseillers en Traumatisme* (ARCT). Typically, the trauma model was broadened out from the narrowly medical, to a psychosocial approach that encompassed a more holistic outlook. This has tended to combine issues such as livelihoods, income-generation, and education with psychological assistance, as illustrated by CARE International's approach to OVC programming explored in more depth below. More recently, large amounts of donor funding have been allocated to HIV and AIDS programmes. While these tend to include a psychosocial component, there has been some confusion amongst staff and donors over the services this should entail.

A number of organizations, including CARE International, Hope and Homes for Children, and World Vision are operating mentoring programmes for orphans and vulnerable children (OVC), particularly those living in child-headed households (CARE International, 2005; Thurman et al, 2006). In these cases, the adult volunteers, who do not have professional train-

ing, are selected from the community by children and by the community at large to act as caregivers. For instance, CARE has developed the *Nkundabana* [I love children] model. Another partner is *Haguruka* [stand up], a Rwandan rights organization that works on issues affecting children and women and trains the *Nkundabanas* on child rights to advocate on behalf of children, or support them to do it themselves, on issues of land or inheritance “grabbing” and other abuses.

Present Trends. A number of international NGOs have been working in partnership with Rwandan NGOs, acting as technical advisors and providing financial support. For example, CAFOD, the UK-based Catholic overseas development agency, has supported seven Rwandan partners, and all have implemented psychosocial programmes. The local organizations then operate at the community level, combining livelihoods assistance with psychosocial work. There has been a widespread recognition that the people with whom staff members have been working frequently suffer from trauma, whether related to the genocide, HIV/AIDS, or other abuses. Such suffering has been exacerbated by stressors such as poverty, hunger, lack of shelter, or the inability to continue with secondary schooling. Staff members have argued that such essential needs must be tackled simultaneously.

Equally important is attention to local cultural norms. Rwandan organizations *Barakabho* [let the children live] and *Uyisenga N'Manzi* [*Uyisenga* and *Manzi* are *Kinyarwanda* names of children], both working with children and young people, have drawn upon Rwandan culture as part of their psychosocial programmes. This involves using art, dance, and drama to encourage participants to develop self-expression, to voice ideas and opinions, and to build relationships with others in tackling the grief and isolation experienced by many children who have lost parents and other family members. Similarly, these organizations arrange football, volleyball, basketball, and other game tournaments as occasions for children and young people to have fun, meet others, and stay in touch informally with adults who can provide support and advice.

Need for Community-Based Interventions

As echoed throughout this article, one of the most pernicious features of trauma is the ability of a traumatic experience to destroy the victim's essential trust in fellow human beings. Community-based interventions would be helpful in mitigating some of the effects of trauma, especially by assisting survivors who need to tell their stories and make meaning of traumatic events. This facilitates a shift in self-perception from victim to survivor. Community action programs could provide the spaces, tools, and trained personnel to assist in re-establishing trust and initiating transformational processes.

The lack of an ability to respond adequately to the psychosocial needs of Rwandans has become highly problematic. However, Rwanda can begin to address this problem by designing and implementing a National Counselling Centre that focuses on training multiple levels of counsellors to deal with trauma and other psychosocial issues across all sectors of Rwandan

society. Community-based interventions such as trauma counselling, recovery programs, mental health promotion, conflict resolution training, peer support training, and school mentoring programs address these needs.

Pathways to Promoting Community-Based Counselling Interventions

The necessity for designing culturally appropriate interventions associated with the post-genocide psychosocial needs of Rwandans is supported by recent research conducted in Rwanda (e.g., Bracken, Giller, & Summerfield, 1995; Dyregrov, Gupta, Gjestad, & Mukanoheli, 2000; Mutamba, & Izabiliza, 2005; Staub, Pearlman, Gubin, & Hagengimana, 2005; Staub & Pearlman, 2003). There is a great need for participatory action research strategies, whereby citizens have been highly involved in defining psychosocial problems and solutions (e.g., Khanlou N, 2005; Knightbridge, King, & Rolfe, 2006; Levers, 2002, 2006a, 2006b; Murray, Nelson, Poland, & Ferris, 2004; Nelson, Ochocka, Griffin, & Lord, 2004). Such research has emerged in recent years as an effective strategy for community-based change and development, and this has implications for the use of a community psychology model within Rwanda. These research strategies parallel the principles of community psychology that view knowledge as fluid and value based, understand an individual within multiple contexts, attend to diverse voices, demonstrate a commitment to improving the lives of individuals through intervention and social change, and emphasize a strengths-based model of mental health.

The need to train personnel expeditiously to provide the requisite counselling services is apparent. This is important because the frequency and severity of PTSD symptoms are increasing rapidly amongst the Rwandan population, and these symptoms can be associated with a myriad of health and mental health concerns, such as alcoholism, child abuse, sexual assault, suicide, and so forth. The following sections address issues related to developing and delivering community-based counselling services.

Need for Multiple Counsellor Training Curricula

Many people continue to suffer in the aftermath of the genocide. Various types of counselling services could assist in initiating and facilitating the recovery process. This has not been possible in Rwanda, for many reasons, but largely due to the lack of qualified human resources. While a large number of the existing workforce providing counselling services has some preparation, it largely has been based on short trainings organized either by the Ministry of Health or ARCT. Counselling is a specialized process of helping that requires education and training. Counsellors who deal with more complex areas of human psychosocial concern, like trauma, require even more specialized training.

The need exists in Rwanda for the design of multiple counsellor training modules to meet both pre- and in-service training requirements. Prior to inaugurating such a project, planning activities must include document identification and retrieval and a full review of all literature related to relevant aspects of the

problem (including governmental documents, NGO reports, white papers, grey papers, and so forth). The following goals could serve to initiate a training project and would match those presented in the National Strategic Health Plan Draft (Ministry of Health Republic of Rwanda, 2006) concerning a national counselling curriculum: (1) to design counsellor instructional modules for various levels; (2) to train various groups of counsellors at multiple levels; and, (3) to strengthen collaboration with other relevant bodies. Three additional goals do not pertain necessarily to curriculum development, but are essential to the promotion of community mental health; these are: (1) to identify children, youth, and adults to be counselled; (2) to provide counselling sessions; and, (3) to monitor progress.

In the beginning stages of such a curricular project, the following short courses need to be designed and developed: a health-counselling course, for nurses and other relevant health-care professionals; an education-counselling course, for teachers and other relevant education professionals; a community-based-counselling course, for community-based professionals; and, an advanced-student-in-training-counselling course. Such an approach is intended to build capacity, and capacity building requires a developmental process, involving a number of components. One of these components includes analyzing the situation as it relates to counselling needs and to the delivery of counselling and related services in culturally appropriate and culturally sensitive ways. Another set of components is carefully considering all contextual influences and cultural factors that have contributed to the ongoing emotional suffering of the survivors and that have served or could serve as protective factors, natural supports, or resiliencies. It is essential to address the stigma that many Rwandans experience, as it relates to their personal responses to receiving counselling services, while having a positive impact on psychosocial attitudes. The project needs to identify existing local positions, which could be used or transformed to build capacity related to counselling and educational activities, and to target trainees across sectors, including health, education, and community-based services. Finally, the project needs to develop curricula aimed at multiple levels, including pre-school, elementary school, secondary school, tertiary or university-level education, training-of-trainers (TOT), and all levels of in-service, pre-service, and paraprofessional training.

Risks and Challenges

Numerous Rwandan stakeholders (e.g., survivors, educators, health practitioners, pastors) have endorsed the underlying premise of this project, that is, that culture matters and that the absence of cultural considerations in genocide-related trauma-recovery strategies, largely based on Euro-American models of intervention, have had deleterious results. Such culturally inappropriate interventions have been criticized by Westerners, as well (e.g., Summerfield, 1999). Four major risks are associated with any project to train counsellors: first, Western donor organizations and Western-trained Africans may initially resist the culturally relevant endeavours of such a project; second, potential consumers of services initially may reject solicitations for

involvement, due to the personal nature of counselling interventions, in spite of cultural relevancy and for a variety of other reasons; third, the memory and history of the genocide are still fresh; and, fourth, there are a number of psychosocial stressors that currently are prevalent. These risks and challenges have been detailed in the remaining parts of this section: cultural sensitivity, damage control, community memory, and present psychosocial stressors.

Cultural sensitivity. The donor community has operated within a relatively insular and culturally encapsulated framework, primarily by imposing Western standards and models and by not consulting more within local culture. Many local civilians, including professionals, have introjected these cultural biases. Although raising consciousness about this perspective may be appropriate, and the work of this project would entail strategies to develop community awareness, we would not advise beginning with a “forced” paradigm shift. In order to minimize risk, rather than overt criticism of current donor/local strategies, the project simply would begin with culturally relevant practices with local Rwandan participants. Wessells (2006) has argued that local people often reject indigenous knowledge and understandings in favour of Western scientific knowledge/methods. This is partly an artifact of colonial history, as well as a result of the more recent continual influx of consultants/NGOs with attitudes of superiority, leading many locals to discredit their own understandings, especially in order to secure donor funding; this could emerge as a sensitive issue.

After successful efforts are tracked and demonstrated, the project can begin to form networks with “project friendly” donor organizations and NGOs and to build support in this grass-roots manner. The training dimensions of the project can be successful without the support of these organizations, but gaining their trust and confidence will be essential to other capacity-building and policy-related activities.

Damage control. To date, participation of Rwandans in crisis counselling offered by donors has revealed a lack of confidence in current strategies, so it is possible that consumers may initially reject the efforts of the project. If this is the case, much work of a “damage control” nature will need to be done, and this would then become an initial priority of the counsellors trained by the project. If building trust with consumers of services takes longer than anticipated, the time-line of the project would need to be adjusted to compensate. However, once culturally sensitive interventions are adequately demonstrated, trust building should become easier.

There has been a tendency to misunderstand trauma as only needing crisis intervention rather than longer-term support. Assumptions have been made that the trauma work has been completed and that people are getting on with their lives—a prevailing sentiment seems to be that, after all, 12 years have passed since the genocide. Not to be unduly critical of the larger organizations, this shift may in part be due to their recognition of their mistakes made in the past and the realization that Rwandans are best placed to help one another in this field.

While we wish to emphasize the resiliency of Rwandans, and that Rwandans are best placed to help one another, it is also true that outsiders may serve as useful and important facilitators. Certainly sensitivity needs to be given to the issue of ethnicity in a place where everyone knows which group each person belongs to, but any talk of ethnic affiliation is prohibited. An example of the need for such sensitivity might be a woman who may not wish to discuss her rape and the murder of her entire family with a counsellor from the same ethnic group as her perpetrator(s).

Community memory. Understandably the past and history are sensitive issues in Rwanda and can be considered as divisive. In response, many people, whether from the international community or Rwanda, want to look to the future. However, both for an individual or a country, it is only possible to move on when the issues of the past have been dealt with. From speaking both with individuals and NGOs with staff members active in the field, it is clear that these issues have not been adequately addressed.

Especially in April, memorials and commemorations are particularly prominent issues. Conducted in a sensitive manner, these can be extremely helpful and healing for participants. Orchestrated in the wrong way, they can contribute to the damage already done and reinforce a sense of powerlessness.

Present psychosocial stressors. Not only are trauma issues being made more complex with the passage of time, present difficulties are contributing to this trauma and can undermine resilience. For example, one girl—head of a household of eight siblings and other relatives—said that she had “got used to” the fact that her parents had died during the genocide, but she could not cope with the constant uncertainty of not knowing how to provide for her family (Pells, in progress). This demonstrates the importance of not making prior assumptions about the root causes of an individual’s struggles and recognizing the existence of both risk and protective factors within communities. We need to consider how resiliency can be enhanced through the promotion of protective factors. Another major issue concerning young people is that those who were in their early years and at a critical stage in their development during the genocide, are now entering into adolescence, which in itself can be a difficult and challenging time. While not having shown clear signs of trauma previously, present stressors such as poverty and caring for siblings are triggering flashbacks and other symptoms. Amongst adults, it appears that the *Gacaca* process is acting in a similar manner, by triggering past memories. *Gacaca* is the participatory community court process traditionally used for dispute resolution in Rwanda, which has been formalized by the Government and appropriated for use as a tribunal process for genocide criminal suspects. The *Gacaca* is conducted in locales throughout Rwanda, and genocide offenders are held accountable for their crimes. Although justice is important and can contribute to healing, there needs to be support for people who are confronting painful memories, including victims, perpetrators, and bystanders (Mukanoheli, n.d.).

Assets for Beginning

A number of factors in the current situation in Rwanda positions the nation well for conducting an effective community mental health promotion campaign, including the training of trauma counsellors. Some of these factors involve the positive political will to move forward, institutional support for such a project, and the levels of managerial support necessary for the success of such training. Managerial support requires both internal and external management mechanisms, as well as monitoring and evaluation activities, to assure project quality and fiduciary responsibility. The following parts of this section address these issues.

Monitoring and evaluation activities. The conceptual framework for monitoring and evaluation activities intersects with cultural responsive and ethnographic approaches, emerging strategies in the evaluation field that aim to identify cultural context and variables as central to the evaluation enterprise. Responsive evaluation is one of several social agenda/advocacy approaches that ensure that all segments of society have equal access to educational and social opportunities and services. Also known as client-centred evaluation, responsive evaluation attends to engaging all stakeholders (Abma, 2005, 2006; Stake, 1975). The opportunity to involve stakeholders' concerns and issues in the necessary curriculum design activity and to encourage continuing discussion between the evaluators and the larger audience for purposes of discovery, investigating, and addressing programmatic issues are important tenets of responsive evaluation. Hood's (2001) notion of cultural responsive evaluation should be a specific approach used to develop a culturally sensitive training model. When particular and diverse cultural groups are intended to be primary beneficiaries, cultural responsive approaches yield unique ways to capture the direct lived experiences of target groups and key stakeholder issues.

The evaluation process also assumes ethnographic methods in understanding goals, objectives, and activities of the project. By operating from an ethnographic framework, the monitoring and evaluation efforts not only serve as a way to assess the project outcomes, but they also refine and improve training, interventions, and culturally sensitive models (Hopson, 2002).

Organizational support. The Kigali Health Institute (KHI) entered into an informal arrangement with the African Association of Guidance and Counselling (AAGC) to discuss the need for national counselling curricula that emphasize trauma-recovery efforts, as well as other pertinent psychosocial and health concerns. The momentum around this arrangement led to the Minister of Education's request for KHI to move forward with the development of a National Counselling Centre (NCC). The broad mandate for the NCC is the design and development of national counselling curricula, which offer instruction to multiple levels of pre-service professionals, as well as in-service training for multiple levels of professionals already trained. The AAGC plans to continue to mobilise resources in Rwanda and to advocate for training programs aimed at helping counsellors and other practitioners respond to the community-based mental

health needs and challenges faced by those dealing with trauma. The AAGC envisions the development of models in Rwanda that might be of assistance in other communities in Africa facing similar circumstances; it can provide fora for networking and can facilitate dialogue toward promoting culturally appropriate interventions.

Sustainability. Assistance for those suffering the effects of psychological trauma largely has come from local NGOs, and, to a lesser extent, from some of the international NGOs. But with Governmental Ministries (Education and Health) currently poised to train trauma counselling practitioners, through the creation of a NCC under the auspice of the KHI, the hope for sustainability emerges. As a bona fide component of training under the authority of the government, counsellors can be trained at multiple levels of disciplinary sophistication, in a manner that reflects strategic planning and that aims to deliver community-based services to the people who most need them.

Recommendations for Designing Rwandan Counselling Curricula

Present factors can exacerbate past trauma, so enabling a person to achieve well-being necessitates attention to all areas of daily living. In turn, this requires a systemic approach, building partnerships between the healthcare sector and other public-sector bodies, as well as with NGOs. There is also the demand for further training at this level. Importantly, the professionals and the volunteers operating at this level need to be able to develop long-term relationships, based on trust, with potential recipients of care. This is widely acknowledged as being the key to a successful healing process. Palmer affirms this in his discussion of the appropriateness of psychosocial intervention. He states that interventions should: (1) identify problems in consultation with those enduring them; (2) help in a culturally acceptable way; (3) avoid importing and imposing Western views—even subconsciously; and, (4) recognise when it is time to leave—when continuity has been established and self-sufficiency has been achieved (Palmer, 2002, p. 18). In light of these issues, the following recommendations are being offered as essential in reference to developing counselling curricula for use in Rwanda: service providers need to understand the importance of an holistic approach to trauma; the Ministries and NGOs need to develop training that is culturally sensitive and culturally appropriate; and, relevant stakeholders need to be involved at all levels. Following these can ensure coordination and economic and human sustainability of the model.

Implications for Trauma Counselling in Low Resource countries

The type of curriculum development project under discussion here has real implications for trauma counselling in severe trauma settings in low resource countries. This applies to a number of regions in Africa, as well as throughout the world. The first implication involves the reality that low resource countries usually represent a developing context, and donor agents are usually from a Western industrialized context. Donors often

are unaware of their own implicit cosmological perspectives, and matters of local culture versus the donor culture that go unchecked may actually undermine the success of a project. We often see interventions globally that are based on good intentions, but have the effect of perpetuating the very problems the interventions originally were aimed at resolving.

Another significant implication is the need for participatory action-oriented evaluation and research activities. Those who go into a low resource country, where citizens have experienced severe trauma, need to search for and identify voices of cultural authority, both traditional and modern. They need to consult with key cultural brokers, engaging stakeholders across multiple representative groupings. They need to empower stakeholders to determine for themselves what the salient issues are, and do so in culturally respectful ways.

Conclusion

The major aim of this article was to illuminate the need for addressing the aftermath of the genocide and for facilitating Rwanda's progress by building the capacity to provide counselling, trauma recovery and healing services, health promotion services, and related educational activities. We have taken the view that this can be accomplished, at least in part, by designing and developing a National Counselling Centre that provides curricula at the various levels of training needed to resolve the national psychosocial crisis.

Examining contextual influences and other cultural factors can lead to a clearer understanding of much-needed culturally appropriate interventions aimed at providing adequate community-based counselling and at resolving trauma and other psychosocial and health-related issues. The specific goal of training community-based trauma counsellors would be to decrease psychosocial problems, as well as to decrease trauma-related symptoms among Rwandan survivors, and to interrupt the transmission of trans-generational trauma so that the psychosocial aftermath of the genocide eventually will no longer be a threat to the public health and the socio-economic development of the nation.

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