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Societal Healing in Rwanda: Toward a Multisystemic Framework for Mental Health, Social Cohesion, and Sustainable Livelihoods among Survivors and Perpetrators of the Genocide against the Tutsi

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Abstract

The genocide against the Tutsi in Rwanda left the country almost completely devastated, with tremendous consequences for mental health, social cohesion, and livelihoods. In the aftermath of such extreme circumstances and human rights violations, societal healing should be conceptualized and approached based on a multisystemic framework that considers these three sectors—mental health, social cohesion, and livelihoods—as well as their interactions. The aims of the present study are twofold: (1) to review evidence on multisystemic healing initiatives already applied in Rwanda using fieldwork notes from interviews and focus groups, alongside relevant scholarly and gray literature, and (2) to propose a

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scalable multisystemic framework for societal healing in Rwanda that builds on existing innovations. Within a participatory action research methodology, we used a grounded theory approach to synthesize fieldwork findings and compare them with literature to generate a set of principles for multisystemic recovery in Rwanda. Recognizing the strengths and limitations of the current mental health system and other initiatives, including sociotherapy and collaborative livelihood projects, we propose a scalable and rights-based multisystemic approach for recovery and resilience that would target mental health, social cohesion, and sustainable livelihoods within an integrative cross-sectoral framework, thus reducing the risk of post-genocide conflict.

Introduction

Starting in the late 1950s, Rwanda intermittently experienced periods characterized by community level conflict between the ethnic divisions of Hutu and Tutsi. Social tensions and discrimination policies continued after Rwanda gained formal independence from Belgium in 1962 and gradually led to a mass exodus of the Tutsi minority population to neighboring countries.[1] Extensive effort was made to ease tensions, including international mediation, culminating in an August 1993 peace agreement signed in Tanzania.[2] However, starting in April 1994, for over 100 days Rwanda was immersed in a brutal state-sponsored genocide instigated by extremist factions within Hutu leadership. According to the Rwandan National Commission for the Fight against Genocide, the genocide resulted in the death of 1,070,014 Tutsis and moderate Hutus, while almost two million persons were accused of having participated actively in the genocide (population 6 million at that time).[3] The genocide included highly local violence, as victims often lived in the same villages as perpetrators.[4] Extremist propaganda fueled sexual violence during the genocide against the Tutsi. As a result, 350,000 women and young girls, as a lower-bound estimate, were subjected to rape, torture, sexual slavery, and mutilation.[5] The Tutsi-led Rwanda Patriotic Front brought an end to the genocide after defeating the Hutu militia in late July 1994. Rwanda's political and socioeconomic infrastructure had been destroyed, while the country was left devastated, especially in the areas of social cohesion, mental health, and livelihood sustainability. Fearing reprisals or seeking to escape accountability, more than 2.5 million Rwandans fled to neighboring countries in the aftermath of the genocide.

According to the Rwanda Ministry of Health, a large segment of the Rwandan population experienced severe mental illness after the genocide. Numerous studies were conducted in the years following the genocide to establish prevalence rates for posttraumatic stress disorder (PTSD) and other clinical disorders among the survivor population, with estimates of PTSD prevalence in early post-genocide years ranging from 45% to 54%.[6] More than two decades after the genocide, mental health challenges appear to persist for a large proportion of survivors. The 2018 Rwanda Mental Health Survey conducted by the Rwanda Biomedical Centre revealed a high prevalence of several disorders both in the population of survivors and in the general population. Most commonly reported were major depressive disorder (found in 35% of genocide survivors and 12% of the general population) and PTSD (found in 27% of genocide survivors and 3.6% of the general population).[7] In

line with these findings, a recent meta-analysis of 19 original studies conducted in the country found that the proportion of genocide survivors who had PTSD was 37%.[8] When considering that perpetrators and survivors were often people from the same village, the damage extended beyond mental health, human capital, infrastructure, and available community resources, to severe societal wounds. The impact on society and economy and the severe magnitude of trauma in Rwanda resulted in what might be termed as "collective trauma" or "traumatized nation."[9] Collective and historical trauma are prevalent in populations that have experienced war, displacement, genocide, and poverty, causing considerable distress across whole communities and interference with functioning in multiple areas of educational, work-related, and social activities.

Historical genocidal trauma, combined with socioeconomic adversities, represents severe threats to development and mental health. Social cohesion, or its absence, has been implicated in the etiology and recovery from both physical and psychological illnesses.[10] Additionally, a significant correlation has been reported between income deprivation and low social cohesion with poor mental health.[11] The United Nations Special Rapporteur on the right to health advocates that good mental health cannot exist without human rights, peace, and security. While the currently prevalent biomedical model of mental health focuses predominantly on individual determinants of mental distress, by emphasizing, for instance, the role of neurochemical imbalances and maladaptive personality traits, advocates of rights-based approaches, such as the Special Rapporteur, argue that a greater emphasis should be placed on the social determinants of mental illness. Notably, the Special Rapporteur argues that mental distress is caused primarily by contextual factors that include human rights violations, such as violations of the rights to life, food, housing, education, work, development, nondiscrimination, and equality.[12] Denial of such rights leads to experiences of trauma, fear, isolation, and despair which, from a biomedical perspective, can meet the diagnostic criteria for mental illness and trigger an attempt to cure such disorders at the individual level—even though the factors that have led to such adverse psychological experiences are primarily social and political in nature. The case of Rwanda, where a significant burden of ongoing mental distress has been detected among survivors of the genocide against the Tutsi, provides strong evidence in support of the Special Rapporteur's position: more than two decades after the genocide, the severe human rights violations it entailed constitute social determinants of a significant mental illness burden that is still felt by a substantial proportion of the Rwandan population.

Conceptualizing multisystemic recovery and resilience as a rights-based approach for mental health in post-genocide Rwanda

To the extent that the mental health burden experienced in Rwanda today can be attributed to the experience of the genocide and its consequences across multiple social and economic systems, it is reasonable to assume that efforts to restore mental health in affected communities through a purely biomedical approach would likely fall short of the objective due to not addressing the social determinants of psychological distress, such as extreme poverty, social isolation, and ongoing community polarization. A general principle in resilience science is that multisystemic adversities need to be met with multisystemic solutions.[13] Addressing mental health issues that accompany societal wounds while developing community livelihoods and strengthening local social cohesion could promote resilience and contribute to a more complete recovery. From a systems perspective, individuals, households, communities, and higher-level institutions are considered to be mutually evolving and adjusting to meet oncoming challenges. All these diverse layers of society are required to achieve system-wide resilience.[14]

There are several plausible mechanisms through which multisystemic interventions might influence mental health. These include psychosocial processes (for example, enhancement of self-es-

teem, community support, and respect), adoption of health-promoting activities and norms in the community, and increased social organization and trust levels that encourage the utilization of existing mental health services while directly contributing to psychological well-being.[15] In addition, diversity and sustainability of livelihoods have been shown to be essential for social sustainability, as measured through key indicators of social cohesion, inclusion, and gender equality.[16] Finally, UNICEF studies have shown that providing humanitarian assistance and basic livelihoods to displaced or vulnerable populations predicts better health, including mental health and higher levels of well-being.[17]

Approaching mental health from a multisystemic perspective is not just empirically sound but also consistent with a rights-based perspective. According to the Special Rapporteur on the right to health, mental health interventions should acknowledge social and economic determinants of mental illness and address these through multisectoral policies and programs. In contrast, an excessive medicalization of mental health, combined with a singular emphasis on the individual level, can serve as an excuse to violate social and economic rights while labeling the resulting psychological distress as mental illness.[18] Therefore, only a multisystemic approach to recovery and resilience—where rights in one domain (for example, the right to development or the right to peace and security) are understood to beget rights in other domains (for example, the right to mental health)—can be considered to be consistent with a rights-based approach.

Adopting a rights-based lens of multisystemic recovery and resilience, as outlined above, the present study has a twofold aim. First, we seek to review existing initiatives in Rwanda for multisystemic recovery and societal healing. In its efforts to overcome the extreme challenges posed by the genocide against the Tutsi, Rwanda has become a breeding ground for innovation and leadership within the field of multisystemic recovery. Understanding such efforts can provide essential insights into multisystemic recovery and resilience processes, with potential applications in other conflict-affected or genocide-affected countries. The study's second aim is to propose an integrative and scalable public health framework for multisystemic recovery and societal healing in Rwanda, building on local innovations while strengthening them with evidence-based practices that have already been validated in other contexts. While the immediate objective is to propose scalable solutions to be implemented across the various districts of Rwanda, it is our hope that the proposed framework can have broader utility within the field of post-conflict and post-genocide recovery and resilience.

Methods

Participatory action research framework

This study adopts an action research approach.[19] Action research begins with an effort to understand the facts of a situation within the context in question, leading to planning and action to address the problem (that is, implementing a targeted intervention) and then reflecting on the result of the action. All research activities within this Rwanda-specific study were designed to pursue tangible solutions to real-world problems and were outlined in the following action agenda: (1) determine how Rwanda can be assisted in transitioning beyond the legacy of the genocide in ways that simultaneously address genocide-associated mental health challenges and disrupted social cohesion while contributing to livelihoods development and poverty mitigation, and (2) determine how these solutions build on the progress already made in order to provide a scalable framework that can reach and benefit the majority of Rwandans.

Participatory action research is a variant of action research that brings in community stakeholders as co-directors of the research process.[20] In this study, the stakeholders involved included the formal mental health sector, government-appointed commissions that focus on societal healing and reconciliation, municipal authorities in districts that were severely impacted by the genocide, and international partners with a strong interest in supporting Rwanda's transformation. Numerous consultations with such stakeholders took place

over five field missions to Rwanda between May 2019 and October 2020.

Field-based service mapping

In support of the participatory process described above, we conducted interviews and focus groups to map out the field of services currently provided in Rwanda within the domains of mental health, social cohesion, and sustainable livelihoods. We then discussed our findings with participating stakeholders, further informing the direction of the action research process.

Participants and recruitment

We recruited 31 participating service providers from various organizations based in Kigali (Rwanda's capital) and Bugesera (a district south of the capital). Bugesera was chosen as the area of focus for the fieldwork based on guidance from participating senior stakeholders. Bugesera was among the hardest hit during the period of the genocide; therefore, any future intervention program for multisystemic recovery and resilience would be more credible and promising for countrywide scaling if it were first shown to be effective in the particularly challenging context of Bugesera. Senior project stakeholders recommended which service providers should be interviewed, suggesting organizations (governmental, nongovernmental, or private) that were actively providing services in the domains of mental health, social cohesion, or sustainable livelihoods. Executives and other staff from these organizations had the choice to participate through individual interviews or focus groups. Participants included, among others, clinical psychologists, trauma counselors, public health professionals, development specialists, dialogue facilitators, and community workers.

Materials

We used unstructured interviews due to the flexibility they offer and to allow for the generation of qualitative data through the use of open questions. Moreover, this approach offered time and space for participants to talk in depth and express themselves in their own words, which helped us obtain a better sense of respondents' experiences and perspectives. To explore current gaps in service provision, we made sure to ask participants about service gaps, beneficiary needs, potential areas of improvement, and recommendations for practice and policy.

Interview procedure

All interviews and focus groups took place at a mutually agreed-on and convenient place and time. Individual interviews lasted 30 to 90 minutes, while the duration of focus groups was 120 to 180 minutes. Field notes were taken by three authors. To mitigate unforeseen risks, we have protected participants' identities in the reporting of results.

Ethical considerations

The study design was reviewed and received ethical clearance from the Rwanda National Ethics Committee, which is registered under the US federal-wide assurance for the protection of human subjects for international institutions.

Review of relevant scholarly and gray literature

We also reviewed scholarly and gray literature about policy frameworks and available services for mental health, social cohesion, and sustainable livelihoods, sharing our insights with community stakeholders within the action research process. The literature under review was based on electronic database searches in PubMed, PsychArticles, and Google Scholar. Our review aimed to scope the body of literature and identify gaps in services while mapping the available evidence. We accessed the following reports through the above websites: the 2019 report on healing practices by the National Unity and Reconciliation Commission; the report on future drivers of growth in Rwanda, which was prepared by the government of Rwanda and the World Bank Group; and the mental health strategy report published by the Rwandan Ministry of Health.[21] We also reviewed relevant international scholarly and gray literature on global emerging practices to identify advances and innovations that could be applied in the Rwandan context.

Developing a grounded theory for multisystemic recovery and resilience in Rwanda

Data from the participatory action research process was analyzed and interpreted to propose a grounded-theory framework for multisystemic recovery and resilience in Rwanda, to be validated by community stakeholders. Grounded theory is described by its founders as "a theory derived from data, systematically gathered and analyzed through the research process, which is structured but still flexible."[22] It is considered a method for "creating conceptual frameworks through building inductive analysis from the data."[23] Purposive acquisition of relevant data through all methods described earlier was followed by open coding to assign meaning to the data, followed by theoretical sampling to collect additional data that would enrich the emerging framework. The outcome of this process was twofold: first, a conceptual taxonomy of existing innovations in post-genocide Rwanda and, second, a set of principles to enrich, systematize, and scale up existing efforts for multisystemic recovery and resilience across all Rwanda districts.

Results: Toward a conceptual taxonomy of existing innovations for multisystemic recovery and resilience in post-genocide Rwanda

One of the most remarkable insights from the research process as a whole is the breadth and scope of innovation for multisystemic recovery and resilience in Rwanda—but also specifically in Bugesera district. This innovation appears to cut across the formal and informal sectors at the national and district levels, while frequently combining methods and approaches from the mental health, social cohesion, and livelihoods domains. Various aspects of this multidimensional effort are outlined below.

The post-genocide emergence of a sophisticated mental health sector in Rwanda

The genocide left a significant proportion of the population suffering from posttraumatic stress and other mental health disorders, with almost no services to meet this unprecedented mental health emergency. Thus, the development of a fully functioning mental health sector soon became a priority of the Rwandan government. After an initial stage of building up core capacities at the national level, the focus rapidly shifted to decentralizing the mental health system to the district level, to more effectively reach beneficiaries.[24] By 2012, Rwanda had established a functioning referral hospital in its 30 districts, each coordinating a network of up to 20 primary health centers at the sector level. These infrastructure development efforts have been complemented by a mentoring and enhanced supervision framework, which has strengthened monitoring and evaluation practices while enabling the implementation of clinical protocols.[25] Preliminary results from these evaluations have identified the need for a better diagnostic assessment for depression, posttraumatic stress, and alcohol-related disorders.[26] Concerning genocide perpetrators, targeted psychotherapeutic interventions were generally missing or applied in small-scale studies only for research purposes, while local mental health professionals' training and education systems were still insufficient.[27] In 2019, the Ministry of Health upgraded the Rwanda Health System Package to include guidelines on psychological interventions conducted in health centers.[28] However, the absence of an integrated mental health strategy that would operate across the public sector and nongovernmental organizations limited the potential of such interventions to achieve mental health outcomes at scale. Cognizant of these challenges, the government formulated an updated national mental health strategy for 2020–2024, which is compatible with a rights-based multisystemic approach. It highlights the need to integrate recovery with social inclusion and recommends organizing campaigns to reduce mental health stigma in communities while encouraging the private sector's engagement in efforts to reintegrate individuals with mental health disorders, following their treatment at district-level mental health units. Currently, the private sector utilizes mainly individual integrative psychotherapeutic approaches that include narra-

tive exposure therapy, trauma-informed therapy, cognitive behavioral therapy, humanistic therapy, functional analysis of behavior, psychoeducation, and art-based therapy. Within the state sector, implementing the mentoring and enhanced supervision framework at health centers has resulted in the development of care packages for individuals struggling with schizophrenia, bipolar disorder, major depressive disorder, and epilepsy. These assist mental health providers in delivering more targeted interventions at the individual level.[29]

While the mental health care system has made tremendous efforts to support recovery in post-genocide Rwanda, there are still challenges ahead.[30] A medicalized mental health care model still prevails, with patients seeking mental health care typically being referred for individual treatment at district-level hospitals. Western approaches in conceptualizing mental health provision in Rwanda have limited the scaling up of the services provided and resulted in a "treatment gap" between the people who need care and those who receive care. Compounding this challenge is the severe shortage of fully trained mental health personnel. For instance, by 2019, only 12 psychiatrists were registered in Rwanda, and no child psychiatrists were reported as practicing. Another factor that contributes to the treatment gap is the possible unwillingness of sufferers to utilize individual one-on-one treatment services, which appear to be a poor fit for collectivist sub-Saharan African cultures, where most issues and challenges of daily life are addressed in the context of group-based processes at the community level.[31]

One possibility for addressing Rwanda's mental health treatment gap might be to emphasize group-based, resilience-oriented psychological interventions. Such approaches could simultaneously address scalability challenges (since the limited number of mental health professionals would be in a position to serve a greater number of beneficiaries) and issues related to the cultural acceptability of interventions. To take one example, an invitation to participate in a group-based intervention to strengthen psychological resilience might not raise the same concerns about being stigmatized as a mentally ill person or being expected to discuss sensitive personal issues with an unknown professional as would a traditional Western-style one-to-one clinical intervention. In this regard, emerging evidence-based approaches in group-based therapy programs that focus on skills and resilience could also inform practices in Rwanda. For example, the McLean Hospital in Boston, United States, implements a Behavioral Health Partial Hospital Program, which is focused primarily on group therapy for individuals with various co-occurring mental disorders. The treatment program builds participants' psychological skills and resilience, simultaneously focusing on ameliorating cognitive, emotional, and social processes implicated in developing and maintaining mental health symptoms. This flexible treatment approach is set up in an outpatient, partial hospital setting, which is cost- and time-effective, while the diversity of skills taught in the program reinforces community reintegration after discharge.[32]

Sociotherapy as a hybrid intervention that cuts across psychological trauma healing and rebuilding of community trust

In Rwanda, community-based sociotherapy has been used as a hybrid intervention that integrates psychological trauma healing with rebuilding community trust and resilience.[33] Within a group setting that actively encourages the participation of both perpetrators and survivors in the same healing space, participants are given the opportunity to go through various phases of transition. Distinct sequential stages of the healing process include "safety," "trust," "care," "respect," "new life orientation," and "memory". The approach has often been described as promoting psychological and community resilience through shared storytelling.[34] Participants in sociotherapy are groups of 10–15 people who meet weekly for three hours, covering 15 sessions in total, with the support of two facilitators selected from the same community. Evidence shows that sociotherapy leads to improvements in interpersonal and community tolerance and trust while contributing to the mitigation of mental health symptoms. More than 20,000 Rwandans are

estimated to have participated in different variants of sociotherapy since the approach became popular in the early 2000s.[35]

However, because the focus of sociotherapy groups is not directly mental health, social reconnection objectives might be hampered for those presenting with more severe mental health problems or those with limited cognitive, emotional, and interpersonal skills. At the same time, the National Unity and Reconciliation Commission has recognized a need to assess sociotherapy more systematically and has noted that healing should be provided as an intervention with greater regularity, not only during the genocide commemoration period.[36]

Practical reconciliation in Rwanda through collaborative livelihood initiatives

One additional critique that has been levied against sociotherapy is that it might not adequately address practical livelihood challenges. In regions where the socioeconomic fabric and human capital have been devastated due to the genocide, often resulting in extreme poverty, a singular focus on meeting survivors and perpetrators' social and psychological needs runs the risk of putting participants into a situation where relapse is likely. Thus, in recent years, greater emphasis has been placed on ensuring that psychosocial processes related to sociotherapy are complemented with hands-on, collaborative livelihood initiatives, which lead to income generation for the whole community. In this way, graduates of sociotherapy groups have an opportunity to capitalize on the skills and relationships that they have developed through sociotherapy. The livelihood initiative, therefore, has positive effects on both the social cohesion and mental health of its participants.[37]

Such an integrated understanding of livelihoods development and social cohesion has been formally acknowledged in Rwanda's "Vision 2020," which prioritizes poverty reduction through rural development, increased productivity, and youth employment.[38] Inspired by contact theory, the strategy assumes that collaborative contact in the context of a community-based livelihoods initiative could be an effective pathway to strengthen social cohesion after the genocide, especially between survivors and perpetrators.[39] In this regard, the formation of "reconciliation villages" has been a notable initiative for integrated socioeconomic development and peacebuilding. In these communities, survivors and perpetrators are invited to coexist while being given resources, skills, and opportunities for cooperative economic enterprises.[40] Through engaging together in livelihood projects of all kinds, the previous, trauma-associated identities of survivor and perpetrator gradually become less salient, while citizens have an opportunity to rediscover each other through their present- and future-oriented socioeconomic roles and identities.[41]

The promising concept of utilizing collaborative livelihood initiatives as a pathway to simultaneously achieve social cohesion and local economic growth is not unique to Rwanda. Having reviewed numerous such initiatives around the globe, Ana Maria Peredo and James Chrisman have proposed a comprehensive theoretical framework for community-based enterprises (CBEs) as an alternative form of social and economic organization for communities experiencing social and economic stress.[42] CBEs build on preexisting social capital, skills, and natural assets in the community. Once initiated, such enterprises further strengthen social and human capital while serving as incubators for downstream independent entrepreneurship. However, CBEs are not without their challenges. In one review of community enterprises in the Songkhla Lake Basin of Thailand, several management problems were identified, particularly in marketing, finance, accounting, production, information systems, product design, and cost control.[43] While understandable, given the informal context in which such enterprises emerge, these are real challenges that must be addressed if CBEs are to become a mainstream solution to promote social cohesion and socioeconomic development in Rwanda.

Multidimensional approaches for the reintegration of convicted genocide perpetrators into their home communities

Genocide perpetrators are a large subgroup of the

Rwandan population, and their reintegration is considered crucial for social cohesion. An ethnographic study demonstrated that ex-prisoners who return home feel lost, carry the label of genocidaire, and are in an awkward position since they cannot become a part of the social world.[44] Other studies have also reported high levels of posttraumatic stress, emphasizing the need to facilitate the perpetrators' family relationships while providing mental health interventions to assist reconciliation.[45] Yet another critical dimension of the reintegration process is the need to prevent recidivism and ensure that the return of former perpetrators to their home communities does not lead to the retraumatization of survivors or to the reemergence of societal dynamics that had enabled the genocide.

While several organizations and government entities contribute to different aspects of prisoner care and community reintegration, some notable approaches deserve special mention. Prison Fellowship Rwanda (PFR), a local nongovernmental organization that is affiliated with Prison Fellowship International, is implementing a broad-based multidimensional approach to the reintegration of former genocide perpetrators. The PFR approach includes, among others, psychosocial support and behavioral activation while perpetrators are still incarcerated; motivational interviewing to assess readiness to engage in a reconciliation process; coaching through the process of experiencing remorse for the genocide and seeking forgiveness from survivors; civic education to orient perpetrators into the new post-genocide sociopolitical realities of Rwanda; the acquisition of vocational skills; family reintegration; and the socioeconomic integration of released prisoners through participation in collaborative livelihood initiatives.[46] Dignity in Detention Rwanda (DIDE), also a local nongovernmental organization, has a similar approach to PFR but with a more specific emphasis on the needs of detained women and youth. DIDE programs include the distribution of food, access to health services and education, skills development, human rights advocacy, and cooperatives aimed to help families of detainees become economically active.[47] While the initiatives of PFR and DIDE for prisoner reintegration in Rwanda are inspiring and effective, they are not yet the mainstream standardized approach by which prisoner reintegration occurs in Rwanda, nor have they been fully incorporated into relevant policy frameworks of the formal sector, even though efforts are currently being made toward that end.

Ongoing efforts to prevent the intergenerational transmission of trauma

While most healing efforts in the 25 years since the genocide focused on supporting direct survivors of the genocide, challenges related to the next generation, particularly children born to survivors or perpetrators of the genocide, have received increasing attention in recent years. Recent studies have shown that the offspring of survivors have a nearly threefold higher risk of PTSD compared to the general population (16.5% prevalence versus 6.2%), suggesting the presence of mechanisms that contribute to the intergenerational transmission of trauma.[48] Such findings are contributing to deliberations on how to mitigate the risk for intergenerational transmission of trauma and other mental health problems, but also on ensuring that intergroup tensions and pre-genocide conflict dynamics do not reemerge in the next generation.[49]

The developmental challenges experienced by descendants of survivors and of perpetrators are distinct but equally significant. Children born to survivors are likely to have been raised in an environment where the extended family network had been devastated by the genocide, with few or no mentally healthy adults to support their development, regular exposure to memories or commemorations of the genocide, and fears of renewed persecution. In contrast, children born to perpetrators were often raised under conditions where one or both parents were incarcerated. On many occasions, children grow up with the false belief that their parent's case was one of unjust imprisonment, contributing to sentiments of anger and bitterness against society.[50]

Interventions to support children of survivors and children of perpetrators are multifaceted, though not yet commensurate to the challenge at

hand. Some approaches include the establishment of youth clubs, where principles for peaceful living are taught while youth from all backgrounds can develop bonds of friendship and solidarity; individual and group psychotherapy, where young people can process traumatic memories while developing more secure identities; vocational counseling and guidance, to support genocide-affected youth in making responsible life choices; intergenerational dialogue, to heal the rift that is often experienced between post-genocide youth and their survivor or perpetrator parents; entrepreneurship programs, to encourage youth from all backgrounds to form enduring friendships and partnerships; and parent training programs, focused on vulnerable populations affected by the genocide.[51] While this is an impressive array of tools to support youth adaptation in post-genocide Rwanda, the greatest challenge is that most have not yet been systematized or tested for effectiveness, nor are they provided at a scale that is adequate to address population needs.

Toward a scalable public health framework for mental health, social cohesion, and sustainable livelihoods in Rwanda

The review of existing initiatives for multisystemic recovery and resilience in post-genocide Rwanda, outlined above, reveals a rich and dynamically evolving tapestry of initiatives, which display a high degree of complementarity and potential when it comes to developing a multisystemic, rights-based approach to mental health and societal healing. While recent and emerging developments within the formal mental health sector can play an important role in addressing biomedical and other individual determinants of mental distress, the social determinants of mental distress can more effectively be mitigated through community-based approaches, such as sociotherapy and collaborative livelihoods initiatives. At the moment, the challenge for Rwanda is not a shortage of societal healing efforts but rather an unregulated plethora of highly diverse and multidimensional initiatives by different actors at varying levels of sustainability and scale. From a public health perspective, the main challenges to a cohesive public health framework for multisystemic recovery and resilience revolve around standardization and coordination, both of which are essential prerequisites for scaled-up and sustainable service delivery. Ultimately, the unspoken objective of such scaling efforts is genocide prevention. Just like the 1994 genocide struck at the heart of every community of Rwanda, destroying lives, livelihoods, and the social fabric, so must the recovery effort achieve equivalent scale, so that every community and household in the country can have the opportunity to heal from the multidimensional impact of the genocide. Achieving impact at scale is an essential prerequisite for an intervention to be considered rights based: in the absence of scalability and access by all, therapeutic interventions can inadvertently reinforce preexisting patterns of inequity by leaving the most vulnerable behind.[52] Furthermore, a multisystemic approach to societal healing that simultaneously targets the protection of the rights to mental health, development through economic collaboration, and security through reconciliation is more likely to achieve sustainable social change for all segments of the population.

After contrasting the current state of affairs in Rwanda against its aspirations for societal healing and socioeconomic growth, we propose the following theoretical principles for a rights-based public health approach to societal healing:

Principle 1: Standardize protocols and approaches across sectors and initiatives

Currently, there appears to be a dearth of standardized protocols or approaches accepted as a "gold standard" within the various subdomains of societal healing (for example, in sociotherapy or prisoner reintegration). Without such agreed-on and standardized protocols, it is difficult to test the effectiveness of interventions and therefore determine what, precisely, should be scaled up within the context of a rights-based public health approach to societal healing. The standardization of protocols and approaches would require coordination between existing service providers and a willingness to empirically validate current approaches,

such as through randomized trials with wait-list control groups. A key benefit of having standardized approaches is that it would greatly simplify professional training in ways that would eventually enable scaled-up service delivery. Sociotherapy could be an early target for standardization, given the extensive literature that has been developed around this approach over the past 20 years. This would require close collaboration between the several nongovernmental organizations that are implementing different variants of sociotherapy, so that they can agree on a consensus approach or, at the very least, make explicit the divergences and similarities between alternative approaches.

Principle 2: Blend local innovations with emerging international practices

The scope and intensity of local innovation for societal healing in Rwanda over the past two decades is remarkable. Much of this innovation, for instance in the mental health sector, has occurred through the filtering of international practices through the lens of Rwanda's social and cultural context. In other efforts, such as the development of sociotherapy and of collaborative livelihood initiatives for social cohesion, innovation was inspired by Rwandan community-based culture, with international tools brought in to provide more cogent expression to Rwandan home-grown solutions. This confident blending of what is most valuable from Rwanda's culture with what is most beneficial from relevant international practices can and should continue. Specific directions for future blending include learning from international group-based mental health treatment approaches to strengthen the Rwandan mental health sector in culturally appropriate ways, as well as learning from international practices in community-based entrepreneurship to strengthen the effectiveness and strategic relevance of collaborative livelihood initiatives in Rwanda.

Principle 3: Strengthen the coordination of service delivery, particularly at the level of sectors and local communities

As has been noted throughout this study, societal healing in Rwanda's case requires services and initiatives across different sectors and levels—from psychosocial support, sociotherapy, and livelihood initiatives at the village level to clinical interventions for mental health at the sector or district level. It is essential to ensure effective coordination to maximize service complementarity while minimizing overlap. A potentially effective formal mechanism for coordination could be provided through the existing decentralized health sector system. This includes health centers at the sector level (typically staffed by psychologists and nurses), health posts at the cell level, and community-based psychosocial workers at the village level. While this network is part of the formal health sector, it can also serve as a coordination hub for additional societal healing efforts provided by the nongovernmental or private sector.

Principle 4: Develop standardized screening, assessment, and referral systems to prescriptively allocate beneficiaries to matching interventions

Given the multisystemic nature of recovery and resilience efforts in Rwanda, appropriately allocating beneficiaries to the interventions they can most benefit from (for example, sociotherapy, a clinical mental health group that focuses on skills and resilience, a family-based intervention, or a collaborative livelihood initiative) is a challenge that must be carefully considered and addressed. The establishment of appropriate assessment-to-allocation systems would help ensure that scarce human and financial resources are optimally allocated in ways that maximize overall impact. Through appropriate community mapping and screening methods, it may be possible to determine what mix of services should be made available in any specific community and which community members should be invited to participate in each program.

Principle 5: Establish a sustainable funding system to enable decentralized multisectoral service delivery for societal healing

Financial resources for societal healing in Rwanda are currently provided through a patchwork of funding streams, from government funds that are disbursed through the annual government budget

to international grants provided directly to nongovernmental organizations, to services that are self-funded by individual and institutional beneficiaries. While this is not necessarily problematic, it can be an obstacle to sustainability and scaled-up delivery. As protocols, assessment systems, and coordination systems become standardized, it might become feasible to offer a more comprehensive range of societal healing services under a national insurance framework. Within such a framework, funding could be available so that beneficiaries and providers can engage with one another regardless of whether providers originate in the public, private, or nongovernmental sectors. This would further ensure the provision of rights-based mental health care, an integral aspect of health care for all.

Conclusion

This paper outlines several notable innovations that have emerged in Rwanda through its efforts for recovery and resilience in the aftermath of the genocide against the Tutsi. At the current juncture, moving toward a public health framework for addressing mental health and societal healing could be the soundest approach to systematize, consolidate, and scale existing gains. Such a public health approach would require extensive collaboration between formal government and nongovernmental service providers, as well as a creative synthesis between local innovations and emerging international practices. The effort should be scholarly and evidence driven, diligently reflecting on theories and mechanisms of change, but at the same time pragmatic.

While Rwanda's challenges have been extreme in their intensity, the multidimensional impact of violent conflict and genocide on mental health, social cohesion, and sustainable livelihoods is, unfortunately, a widespread global phenomenon. From this perspective, several countries can learn from Rwanda's decades-long effort toward multisystemic recovery and resilience. Adopting a multisectoral rights-based public health approach for societal healing is a prospect that should merit serious consideration in any country emerging from violent conflict or genocide.

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Disclaimer

All views, thoughts, and opinions expressed in this article belong solely to the authors and cannot be ascribed to our academic institutions, Interpeace, or any of the stakeholders who were consulted in Rwanda.

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