# Mental health in post-genocide Rwanda

**Ian Palmer[1] and Nsanzumuhire Firmin[2]**

[1]Consultant Psychiatrist, London, UK, email ianpalmer@doctors.org.uk;
[2]Nurse Specialist in charge of mental health at Ngarama Hospital, Rwanda, email muhirefir@gmail.com

The children who experienced the genocide against the Tutsi in Rwanda are now in their mid to late 20s. It is almost impossible to comprehend the scale of the terror and destruction of Rwanda's societal infrastructure between 6 April and 16 July 1994. While the world remained inactive, Rwanda, a small impoverished central African state, experienced the murder of about 1 million of its citizens; it also saw the terrorising, humiliation and rape of countless thousands. Although women and children were directly targeted, some actively engaged in atrocities. About 300 000 children were murdered, a significant number at the hands of other children. The level of terror differed across the country and escape was frequently by luck alone. A UNICEF (2004) study of 3000 children revealed that 80% had experienced death in the family, 70% had witnessed a killing or injury, 35% saw other children killing or injuring other children, 61% were threatened with being killed and 90% believed they would die (Human Rights Watch, 2003). Of the 250 000 women raped, 30% were between 13 and 35 years of age, 67% developed HIV/AIDS and 20 000 births resulted (Donovan, 2002).

Rwanda is Africa's most densely populated country. Forty-three per cent of the population are 14 years of age or under, the median age is 18.7 years and life expectancy at birth is 58 (CIA, 2011). The frames of reference in relation to children's developing identity within families and communities were disrupted for the thousands of children who suffered at the hands of family members or neighbours during the genocide. Such a legacy colours all contemplations of mental health in Rwanda today. While justice, trust and safety have improved immeasurably over the past 17 years, individuals can find themselves isolated from their collective past and current social and political realities. About 95 000 were orphaned in 1994 and subsequently through violence, infectious diseases, HIV/AIDS or imprisonment of parents. Women and girls were raped and some genitally mutilated; some remain open to sexual exploitation and abuse. Children as young as 7 were recruited, manipulated, incited or forced into perpetrating atrocities and some were combatants. Many have since become heads of household and now care for ill, injured or disabled relatives; most will have had their education severely disrupted (UNICEF, 2004).

## Justice

Rwanda's National Policy of Reconciliation has the object of recovery and reconciliation for individuals and the nation, and justice is paramount in this process. The problems of providing justice are uniquely difficult. In 1994 Rwanda had to create a new criminal justice system and legislation to address the situation but the involvement of the international community in this could have undermined Rwanda's own progress (Unvin, 2001).

There are three levels of justice:

- the International Court of Justice
- the usual judicial process
- local *gacaca* restorative justice courts.

At an individual level, involvement in the justice system can be deeply distressing and even dangerous. How successful it will be remains to be seen, especially as survivors and perpetrators continue to live together and some perpetrators show no remorse and do not seek forgiveness.

## Education

The Rwandan government has utilised education to aid reconciliation and healing. In 1994 the educational infrastructure was destroyed and many teachers killed. Since this time a university and 13 institutes of higher education have been created, as well as schools. Nine years of free education is provided for all. Through the FARG (Fond d'Assistance pour les Rescapes du Genocide), the government funds fourth-, fifth- and sixth-form fees and 4 years of higher-education fees for survivors' children unable to pay. For homeless children collective accommodation is provided, for example in orphanages (as part of the *imidugudu* housing policy), sometimes with the inclusion of vocational training. The government has encouraged the population to abandon ethnic affiliation and to see themselves as Rwandans and in 1994 the National Unity and Reconciliation Commission established the Ingando programme to educate all Rwandans about the causes of the genocide and to promote messages of peace and unity, through seminars and workshops. One non-governmental organisation (Radio La Benevolencija) uses the media to present educational material through radio plays, documentaries and local workshops.

## Commemoration

Every April there is a week of national mourning in which the collective memory is revisited across the country. The Rwanda Ministry of Health (through its hospitals) provides ambulances, medicines and mental health professionals for medico-psychosocial interventions at the sites of commemoration across the country as numerous survivors

become agitated, anxious, fearful and very distressed, particularly those with flashbacks who relive the events of 1994. Some require hospitalisation but not all seek help.

## Mental health services

Ninety per cent of mental health service costs are met by community-based health insurance (the figure is 100% for those on the lowest incomes). Those who are better off financially have access to other types of health insurance. A stepped-care approach is provided, from health centres in rural areas, to district hospitals and the central referral facility in Kigali (Ndera Neuropsychiatric Hospital). The Ministry of Health has created the Psychosocial Consultation Service (Service de Consultation Psycho-Social; SCPS), based in Kigali, for all Rwandans. There now five psychiatrists in Rwanda. Specialised nursing staff and psychologists work in district hospitals and are trained at the Kigali Health Institute and the National University of Rwanda, and the Institute of Agriculture, Technology and Education (INATEK), respectively; they provide pharmacological, psychological and social support. Attempts are made to provide outreach and home-visiting programmes and classic out-patient clinics remain in district hospitals. Other than the Commité Technique Belge (CTB), which continues to collaborate with the Ministry of Health's programme of mental health, there are few non-governmental organisations involved with mental health issues (their endeavours are more related to infectious diseases).

Although there are some problems with the epidemiological studies (Rodin & Van Ommeren, 2009), post-traumatic symptoms were common soon after the genocide and in one study done 10 years on the prevalence rate was 44% (Schaal & Elbert, 2006). Those children caught up in the holocaust are now adults and in 2009 depression and substance misuse were common in the 29% of the general population who were found to have post-traumatic stress disorder (PTSD) (Munyandamutsa & Mahoro Nkubamugisha, 2009). There is no similar national experience to draw from nor consensus as to how to proceed (Staub *et al*, 2005; Gupta & Zimmer, 2008) but traumatic exposure and post-traumatic symptoms are among the factors associated with attitudes towards justice and reconciliation (Pham *et al*, 2004) and need to be addressed.

In the district hospital in Ngarama, as well as post-traumatic symptoms, common mental health conditions are managed; these include depression, anxiety, brief psychosis, drug (mainly cannabis) and alcohol misuse, and somatoform disorders. Sadly, despite continuing fears of being killed and emotional and dissociative re-experiencing phenomena that plague many, delayed presentation seems common. As yet there is no specific service for children and adolescents, among whom substance misuse is increasingly problematic, as are ongoing family and community adjustments to the genocide and frequent sexually transmitted infections, including HIV/AIDS. The mental health needs of women are important, especially as 34% are heads of household. The most powerful nationwide women's group is Avega Agahozo, founded in 1995 by the widows of genocide. Women who were raped have been particularly stigmatised (Newbury & Baldwin, 2002) and children affected by HIV/AIDS have complex needs. Children may be infected or have to care for affected relatives, with all the attendant issues of poverty, stigma and loss (Cluver & Gardner, 2007).

## Conclusion

A functioning mental health service is a small yet important part of recovery from the social and moral consequences of war. As with the Rwandan criminal justice system, the task for mental health services is unique. We can only support and learn from Rwanda as the country seeks to find a distinctive cultural solution to a unique problem.

## References


CIA (2011) *The World Fact Book: Rwanda*. At http://www.cia.gov/library/publications/the-world-factbook/geos/rw.html (accessed 30 May 2011).

Cluver, L. & Gardner, F. (2007) The mental health of children orphaned by AIDS: a review of international and southern African research. *Journal of Child and Adolescent Mental Health*, **19**, 1–17.

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

Gupta, L. & Zimmer, C. (2008) Psychosocial intervention for war-affected children in Sierra Leone. *British Journal of Psychiatry*, **192**, 212–216.

Human Rights Watch (2003) *Lasting Wounds*. At http://www.hrw.org/en/reports/2003/04/02/lasting-wounds (accessed 30 May 2011).

Munyandamutsa, N. & Mahoro Nkubamugisha P. (2009) *Prévalence de l'État de Stress Post-Traumatique dans la Population Rwandaise. Diversités de Figures Cliniques, Abus de Drougues et Autres Co-morbidités*. Ministere de la Sante Programme National de Sante Mentale & Organisation Mondiale de Sante.

Newbury, C. & Baldwin, H. (2002) *Aftermath: Women in Post-Genocide Rwanda*. Working paper 303. Center for Development Information and Evaluation, US Agency for International Development.

Pham, P., Weinstein, H. & Longman, T. (2004) Trauma and PTSD symptoms in Rwanda. Implications for attitudes toward justice and reconciliation. *JAMA*, **292**, 602–612.

Rodin, D. & Van Ommeren M. (2009) Commentary. Explaining enormous variations in rates of disorder in trauma-focused psychiatric epidemiology after major emergencies. *International Journal of Epidemiology*, **38**, 1045–1048.

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

Staub, E., Perlman, L. A., Grubin, A., *et al* (2005) Healing, reconciliation, forgiving and the prevention of violence after genocide or mass killing: an intervention and its experimental evaluation in Rwanda. *Journal of Social and Clinical Psychology*, **24**, 297–334.

UNICEF (2004) *Rwanda: Ten Years After the Genocide*. At http://www.unicef.org/infobycountry/rwanda_genocide.html (accessed 30 May 2011).

Unvin, P. (2001) Difficult choices in the new post-conflict agenda: the international community in Rwanda after the genocide. *Third World Quarterly*, **22**, 177–189.