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Healing Trauma and Building Trust and Tolerance in Rwanda

Lessons learned from Peacebuilding Approaches to
Psychosocial Support Group Healing in Rwanda.

April 2019

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Executive Summary

This report summarises important findings from baseline and end line studies of the four-year Societal Healing and Participatory Governance for Sustainable Peace in Rwanda programme, funded by the Government of Sweden and implemented by Interpeace and Never Again Rwanda. The report explores the question of how peacebuilding approaches can address deep wounds from the past, reduce trauma and psychological distress, and build resilience, forgiveness and social tolerance in a post-genocide setting like Rwanda. By doing so, it is possible to not only address deep wounds and trauma that are the basis for marginalisation, exclusion, grievances and violent tendencies, but also improve levels of trust and the ability of individuals to non-violently resolve grievances. This can have the parallel impact of enabling individuals to more actively participate in society thus improving governance and social cohesion. It is a practical demonstration of a peacebuilding programme that achieved both important peacebuilding outcomes as well as mental health and development outcomes.

The data generated over the course of the programme empirically demonstrates the positive impact of psychosocial group therapy modelled on peacebuilding approaches on at least two major change aspects. (1) It effectively reduces trauma, revenge tendencies as well as anger, and builds positive psychological resilience, social trust and tolerance. These outcomes have direct benefits for individuals and broader society in terms of increasing general psychosocial wellbeing, economic participation and social cohesion. (2) It effectively reduces the likelihood of participants engaging in violence and victimisation and increases the likelihood of individuals engaging in formal mechanisms for formal civic participation as well as informal forms of family and interpersonal conflict resolution and mediation. The assessment and the intervention's experience however provide mixed evidence that healing facilitates leadership in initiating peace and reconciliation activities, at least in the short term. Qualitative data collection and a follow-up assessment in the future may provide deeper understanding of the links between healing and leadership in peace activism. The intervention is proven to be a practical and effective approach to help individuals and groups in post-conflict settings become constructive agents of peace which is critical for lowering the risk from conflict to reoccur and build long term sustainable peace in fragile and conflict-affected settings. There are also numerous indirect benefits on broader social cohesion which can impact other development objectives.

To measure the effectiveness of the programme, a survey module of over 150 questions was administered to 265 of the 400 participants at both the beginning and end of their experience with the programme. Their changes in behaviour were categorised into four broad thematic areas. These were, (1) Impact of Trauma which measured the experience of victimisation related to the genocide, levels of psychological distress and individual resilience, forgiveness and revenge tendencies. (2) Trust, which captured individuals' readiness for social interaction and personal sharing, trauma expression and general readiness for partnerships in daily life as well as trust in sharing personal histories with other groups and society. (3) Social Tolerance, which captures individuals' proximity to social ingroups, socially disadvantaged groups, inflowing populations, as well as genocide perpetrators and survivors among others. (4) Peace Activism measuring levels of participation in formal and informal forms of governance and peacebuilding. These four areas were also composed of sub-indices which provide further disaggregation of key attitudes and behaviours. All measures were scaled on a score out of ten and capture the change in individuals' behaviours and attitudes over two to four-year periods; their effect size was measured which is a rigorous way of quantifying the meaning of the changes participants experienced.

The key results of the programme were:

- **Psychosocial Support Group Therapy based on peacebuilding approaches work.** The intervention was successful in addressing the primary objective to reduce the impact of trauma and psychological distress and to build resilience, forgiveness and social tolerance for social cohesion and peace.
- **Impact of Trauma on average improved 25% for all participants.** Participants emerged from the programme with higher self-esteem and less guilt and were more willing to have interactions with other groups across society. There was also a 66% decline in the number of people who think about suicide very often from 15% of participants to 5%. Similarly, the number of people who reported to feel depressed or sad went from 44.5% to 23.4%, an improvement of almost 50%. The improvement was slightly greater for men than women.
- **Levels of Post Traumatic Distress (PTD) and Resilience also recorded significant improvement.** PTD symptoms decreased from 4.2 to 2.7 (35% improvement) and psychological resilience moved from 6.9 to 8.6 out of 10 (24% improvement) which was equivalent to a large effect size. This suggests that psychological healing is an important building block for broader individual level healing.
- **Levels of Trust between participants and society significant improved.** The change in the overall Trust Index broadly measuring readiness for social interactions, personal sharing, and partnerships in daily life recorded the most significant change. The improvement in the overall index score from baseline to end line was 57% which was equivalent to a 'huge' effect size indicating transformative change. This is directly linked to greater social capital and participation in informal forms of peacebuilding within their community and family which can have direct and indirect impacts on levels of violence.
- **Social Tolerance also improved.** The programme measured change of attitudes and behaviours such as frequency of contact with other ethnic and social groups, comfort to marry other groups, enter matrimonial alliance, attend social functions for, joining ikimina¹ with, as well as voting for and receiving financial assistance from various groups. All areas of the social tolerance index improved. Change was more significant amongst genocide perpetrators than other groups.

¹ Ikimana is a saving groups

- **There was limited progress in peace activism and independent peacebuilding activities.** There was small improvement in the overall Peace Activism index, however progress here was less clear than in the other dimensions. The percentage of participants who reported that they independently set-up initiatives to resolve conflict or implement community development decreased from 68% to 54% of participants. While youth cohorts also did not improve their engagement in peace activism, the percentage of participants that engaged in more informal forms of conflict resolution amongst their peers and others in their communities notably increased from 66% to 82%.
- **Participation in state organised formal spaces of governance improved.** The data shows an improvement in participation in government sponsored mechanisms for civic participation and reconciliation, such as Umuganda and commemoration activities. The data also showed a deepened engagement between baseline and end line as participants reported taking more initiative in organising these activities in their communities. Their increased leadership in organising these can have important knock-on effects to multiply the impacts beyond immediate beneficiaries.
- **The data suggests the most effective mechanism to increase motivation toward greater involvement in peacebuilding and governance is ‘love for country’.** In other questions on the motivation behind getting more engaged in forms of local governance and peacebuilding, individuals responded that ‘love for country’ was the primary motivator for getting engaged in peace activities followed by desire to contribute to development of a community and country.

What important lessons were learned?

- **Trauma healing is a viable part of the civilian peacebuilding ‘toolbox’ to indirectly support reconciliation processes and reduce the likelihood of violence reoccurring.** By healing individuals, addressing their trauma and increasing their psychological resilience it is possible to lower their tendency for revenge and increase forgiveness which has a direct relation to the likelihood of violent behaviour occurring. This type of intervention has the potential to form an important part of the civilian peacebuilding ‘toolbox’ and to build peace in a post-conflict setting. However, it does require tailoring to the participants and context.
- **Changing attitudes and behaviors can occur relatively quickly.** Much donor activity focused on governance that aims to change the formal institutions of the state. Many of these activities aim to build on capacities that take many years to develop i.e. improving domestic tax collection or judicial system reform. It is well established that many of these formal institutions develop very little over 10 to 15-year time periods, even with relatively sustained commitment. While there are multiple reasons for this, one is the fact that there is not enough focus on the informal behavioral changes that need to occur to enable formal institutions to improve in their operation. This programme outcome shows it is possible to achieve measurable outcomes and changes in behaviour in relatively short two-year time frames, which is important to properly sequence with other development and peacebuilding activities.
- **Healing is a sustained process, not an activity.** Although the results emerging after two to three years of engagement are impressive, they have been achieved thanks to long-term funding and support as well as patience to demonstrate the programme’s results. Over the two to four years that participants were engaged, groups met as frequently as once a month, a frequency that participants remarked should be increased. Short-term interventions of less than two years with dispersed activities and infrequent engagement risks doing more harm than good in taking wounded people through a healing process.
- **However, more work needs to be done to understand how trauma healing interventions could be tailored elsewhere.** The programme took great care to sensitise the intervention and to survey it to local needs and understandings. Similar work would need to be done in other post-conflict settings where the context and individual drivers of violence and peace are different to the Rwandan case. Whether this kind of intervention would be effective or counterproductive across different typologies of violence or in the context of more recent experiences of violence, conflicts and grievances is unknown. Rwanda also has a legal

framework that is politically and environmentally favorable to peace and reconciliation initiatives. Further, the fact that Kinyarwanda is a primary means of communication across groups facilitated communication and interaction between participants and professional psychotherapists. Replication of the model may lead to different outcomes in other contexts.

- **Do No Harm principles are essential in data collection processes around such sensitive themes.** The programme's commitment to Do No Harm was central not only to implementation but also to data collection. The programme considered randomised control trial approaches, but ethical concerns ensured that participants would be given adequate support to manage their wounds. Additionally, using data collectors who were programme staff helped to set a safe environment for participants. Even though, when administering the questionnaire, it became clear that close-ended questions provoked cathartic sharing by participants, to the extent that some participants experienced moments of crisis. The programme ensured the availability of psychotherapists throughout the process to be able to respond to these needs. Any similar efforts to collect such sensitive information should ensure that Do No Harm planning is considered from multiple angles to ensure the psychological security of participants.
- **Group psychosocial therapy can be effective across different cohorts and is an important intervention in post-conflict settings characterised by deep trauma and identity-based conflicts.** The data show the intervention is an effective generalised intervention that works across young and old generations, men and women and amongst perpetrators and victims. While effect sizes did vary across groups in some areas, the variance between effect sizes across different groups was marginal. The only areas where there was notable divergence was between women who had suffered serious trauma from sexual violence during the genocide and those that did not. For this cohort, more targeted individual level therapy is likely required. There is nothing in the data to suggest this would hold over different contexts, so further pilots would likely be required to test generalisability in different cultural contexts.

- **Group psychosocial therapy was more likely to help improve participation in formal spaces established by the government than to catalyse leadership in creating new mechanisms for peace and conflict resolution.** The data shows the willingness and the likelihood of individuals to participate in formal peacebuilding activities that fall within the established government frameworks for civic participation, specifically Umuganda and genocide commemoration. There was no solid evidence from the programme that it improved the actual levels or willingness of participants to initiate activities and processes to advance peacebuilding in the wider community, though their participation in spaces established by the government increased. This dynamic may be different in a context where the State is not as strongly engaged in peacebuilding and conflict resolution and is driving the reconciliation agenda. Conversely, it may also be perceived as not surprising as the creation of new mechanisms may also require technical skills which the programme did not provide. As the end line data was collected prior to the groups being phased out, it would be important to follow-up with group members to understand the longer-term connections between the intervention impacts on trauma, trust and tolerance with peace activism and community participation. This dynamic may differ depending on the context.

Key Reflections

- **The individual and social impacts of large-scale trauma and mental health issues associated with violent conflict tend to be under-prioritised, poorly understood and generally neglected.** Yet, large scale trauma and mental health issues associated with violent conflict have very significant negative implications not just for the prospects of immediate and future peace, but also for a variety of development outcomes. It is well established in the psychology and mental health literature that exposure to conflict can lead to a variety of mental disorders such as depression, anxiety, post-traumatic stress and in more extreme cases psychosis. For children this can have life-long impacts on cognitive, emotional, social development as well as academic behavioral disorders. PTSD, which this programme screened for amongst participants, is associated with comorbidity of a variety of negative symptoms such as attempted suicide, hypertension, peptic ulcers and alcohol abuse.² This has evident impacts for individuals, families and communities but has important knock-on effects on development outcomes.
- **In societies with large scale trauma, a greater number of individuals will suffer from poor functioning, resulting in a range of negative impacts for economic productivity, education, health and violence outcomes.** While there are relatively few studies looking at the link between PTSD/PTSD and social-material or development outcomes in post conflict settings, in high-income societies PTSD is closely related to unemployment, homelessness and marital breakdown.³ Related to this is poor functioning resulting in reduced productivity, fewer work days and higher absenteeism from work or school. Without healing individual trauma, in many cases, the resources allocated to achieving development gains whether in education, societal wellbeing and economic productivity will be significantly less effective and inefficient.
- **Trauma healing to prevent future conflicts and sustain long-term peace may be the most neglected intervention.** The data from the programme showed the link between violence and trauma mimicking other studies on trauma, PTSD and violence. While the purpose of this programme was not to deeply assess the link between trauma and perpetration of violence, other studies have shown the significance of this link. In the Ugandan context, it has been found that former child soldiers who were frequently exposed to severe violence also perpetrated more types of violence.⁴ Importantly, this is not just limited to reactive aggressive acts but rather to what is dubbed *appetitive aggression*.

2 Sareen, J. (2014). *Posttraumatic Stress Disorder in Adults: Impact, Comorbidity, Risk Factors, and Treatment*. Canadian Journal of Psychiatry, Vol. 59, No. 9, 460–467.

3 Schnurr, P., Lunney, C., Bovin, M. and Marx, B. (2009). *Posttraumatic stress disorder and quality of life: Extension of findings to veterans of the wars in Iraq and Afghanistan*. Clinical Psychology Review, Vol. 29, No. 8, 727–735.

4 Weierstall, R., Schalinski, I., Crombach, A., Hecker, T. and Elbert T. (2012). *When combat prevents PTSD symptoms—Results from a survey with former child soldiers in Northern Uganda*. BMC Psychiatry, Vol. 12, No. 41, 1–8.

This subtype of aggression means the infliction of harm upon an individual is in itself rewarding, fascinating, and a source of enjoyment – above and beyond secondary rewards like status or material benefits.⁵ Beside the direct impact on violent behaviors, the way in which PTSD affects the ability of individuals to socialise, collaborate and to exhibit stable and rational behaviour is a major impediment to participation in more proactive forms of reconciliation, social cohesion building and peacebuilding.

- **It is possible to measurably change the ‘software’ for peacebuilding and not just the ‘hardware’.** It is often the case that societal healing, reconciliation and social cohesion building is underprioritised in international peacebuilding strategies. This reflects the very lop-sided priority given to formal state building in post-conflict development and peacebuilding planning and the much smaller resources allocated to civilian peacebuilding activities such as reconciliation, healing and social cohesion building. There are multiple reasons for this, but one is the difference in tangibility and perceived measurability and impact the different types of programming can have. This project shows it is possible to develop locally owned and generated evidence on attitudinal, behavioral and wellbeing change. It further shows that when there is treatment, many of the attitudinal factors can move dramatically in a relatively short period of time.
- **In developing and post-conflict settings where there are limited mental health services, group-based approaches like this are a good example of how trauma healing efforts can be scaled up.** In an immediate post-conflict setting, the domestic capacities for mental health care and coverage is likely to generally be very limited. It is well established that especially in resource-poor developing countries, there is a substantial gap between the burden caused by mental disorders and the resources devoted to treat and prevent them.⁶ It is estimated that more than 75% of people with trauma-related and other mental health disorders do not receive any official mental health care at all in these countries.⁷ That is why the World Health Organization (WHO) advocates for larger scale programmes in post-conflict regions, targeting communities or societies as a whole.⁸ Individual level trauma healing requires highly tailored and expensive individual care by a trained professional. While deep forms of trauma will always require such individual care, group-based approaches are developed via the accompaniment of a professional together with others that can expand the capacity of such care.

5 Hecker, T., Hermenau, K., Maedl, A., Elbert, T. and Schauer, M. (2012). *Appetitive aggression in former combatants– Derived from the ongoing conflict in DR Congo*. International Journal of Law and Psychiatry, Vol. 35, No. 3, 244-249.

6 Collins, P. Y., Insel, T. R., Chockalingam, A., Daar, A., Maddox, Y. T. (2013). *Grand challenges in global mental health: Integration in research, policy, and practice*. PLoS Medicine, Vol. 10, No.4, e1001434.

7 Maercker, A., Hecker, T. (2016). *Broadening perspectives on trauma and recovery: a socio-interpersonal view of PTSD*. European Journal of Psychotraumatology, Vol. 7, No. 1, 29303.

8 Epping-Jordan, J. E., Van Ommeren, M., Ashour, H. N., Maramis, A., Marini, A., Mohanraj, A., et al. (2015). *Beyond the crisis: Building back better mental health care in 10 emergency-affected areas using a longer-term perspective*. International Journal of Mental Health Systems, Vol. 9, No. 1, 15.

- **More evidence could be collected to further reinforce the findings of the programme.** This project did not use a randomised controlled trial (RCT) approach to measure the evolution of behaviors in other groups of people that did not go through the programme. It is possible that other environmental factors could be positively or negatively impacting the levels of trauma, trust, tolerance and peace activism and an RCT approach could help confirm this. However, this would need to be treated with sensitivity to take into account the ethical obligations that come with posing such personal questions to respondents and the potential for re-traumatisation without applying the psychotherapy intervention. It is well established that simply asking questions of past trauma can exacerbate or reignite traumatic experiences. It would also be valid to potentially revisit the participants in several years' time to see whether there is sustained change in their behaviours versus the rest of the population and especially against a randomised control group.
- **The programme underlines the value and need for more evidence-based peacebuilding work.** The UK Department for International Development (DFID) commissioned a meta review of the programmatic literature and impact evaluations of 149 peacebuilding interventions and found there was no high-quality evidence on justice and reconciliation and more broadly very little that exists on 'what works' in general. This follows similar findings from the 3ie impact evaluation repository which found that only 2 out of 25 categories of peacebuilding activities have adequate evidence. Policy makers and donors need to consider more deeply evidence-based civilian peacebuilding activities such as this which can measurably improve social and cultural factors often thought of as too difficult to change or for which there are limited tools available. While the survey was extensive, its cost was equivalent to only 1% of the total programme, underlying the fact such data driven M&E does not need to be onerously expensive.

Why Societal Healing for Peace Building in Rwanda?

The 1994 Genocide against the Tutsi left the social fabric of Rwandan society in ruins. In 2002, the Ministry of Local Government (MINALOC) in Rwanda estimated that 1,074,017 people were killed during the 100 days of the genocide.⁹ The United Nations estimates that 150-200,000 women were raped.¹⁰ According to a 2007 study by the National Institute of Statistics of Rwanda, approximately 37,000 were widowed and 74,000 were orphaned.¹¹ Varying estimates suggest that between 175-200,000 and 600-800,000 people actively participated in the violence¹² and countless others bore witness to the atrocities. The interpersonal nature of the violence ruptured already tenuous relations that had been strained due to decades of cyclical conflict, marginalisation and violence. Since the Genocide, Rwanda has navigated its post-conflict phase without a re-onset of mass violence, despite the fact that victims and perpetrators live side by side. A 2012 study found that 14 years after the genocide the rate of PTSD was 26.1%.¹³ However social mistrust, suspicion and fears stemming from wounds directly and indirectly related to the genocide remain. While Rwanda has achieved significant development gains and stability since the genocide, efforts towards long term sustainable peace must be sensitive to the presence of trauma within Rwandan society and seek to redress it.

Societies that have experienced long-term exposure to violent conflict undergo significant transformations which have lasting effects on individuals, communities and the state. It is well established that post-conflict settings face decreasing levels of civic trust both vertically, between the state and its people, and horizontally, between individuals and between communities.¹⁴ Further, while there are divergent perspectives on the intergenerational transmission of trauma, societies that are traumatised by ethnic conflict, younger generations are often asked, consciously or unconsciously, to perpetuate a certain mental representation of the historical event and to maintain large-group ethnic markers.¹⁵ Thus, societies that have undergone large scale violence, trauma can affect those who directly experienced violence as well as those who have not, including perpetrators or passive bystanders.

9 Republic of Rwanda, Ministry for Local Government (2002). *The counting of the genocide victims*. Final report. Kigali, Rwanda: Ministry for Local Government.

10 <http://www.un.org/en/preventgenocide/rwanda/education/rwandagenocide.shtml>

11 Republic of Rwanda, National Institute of Statistics of Rwanda. (2008). *Genocide survivors census report–2007*. National Institute of Statistics of Rwanda.

12 Cyanne E. Loyle (2009). Why Men Participate: A Review of Perpetrator Research on the Rwandan Genocide. *Journal of African Conflicts and Peace Studies*. Volume 1, Issue 2, pg. 37

13 Naason Munyandamutsa, Paul Mahoro Nkubamugisha, Marianne Gex-Fabry and Ariel Eytan (2012). *Mental and physical health in Rwanda 14 years after the genocide*. *Soc Psychiatry Pscyhiatr Eidemiol*. Volume 47, Issue 11, pg. 1753-1761

14 Bubenzer, F. and Tankink, M. (2015). *Conference Report: Healing Communities, Transforming Society. Exploring the interconnectedness between psychosocial needs, practice and peacebuilding*. The Institute for Justice and Reconciliation and War Trauma Foundation, 1-32.

15 Barsalou, J. (2001). *Special Report: Training to Help Traumatized Populations*. United States Institute of Peace, 1-8.

The potential of trauma to compromise efforts for reconciling and rebuilding societies after violent conflict is increasingly recognised by the peacebuilding and development communities. Studies from various countries have shown that people exposed to traumatic experiences run a greater risk of poor life outcomes, including compromised physical health, risky behaviors like dropping out of school or substance abuse, poor economic self-sufficiency or poor parenting skills for the next generation.¹⁶ Further, because trauma can be easily exploited to incite future conflict and violence, efforts towards sustainable peace must be sensitive to and address trauma. There is also a more general impact on development outcomes associated with redress of trauma and mental health wounds from conflict and violence. It is estimated that 25% of the Rwandan population would meet the criteria for PTSD.¹⁷ While the Rwandan Government has invested heavily in health care services since 2004, in the wake of the genocide there were few resources for mental health care and there was little domestic capacity in terms of trained professionals who could provide mental health services. Hence, PTSD symptoms may have been prevalent throughout society for some time and can manifest in many ways, including negatively affecting ability to productively participate at work and school. This may manifest in terms of absenteeism from work, unemployment or poor school attendance and anti-social behaviour. While these indirect costs are difficult to assess, they are potentially important factors that underpin other development gains in education or economic development. Since the genocide against the Tutsi, strong political will and initiatives by both the government and civil society have fostered peaceful coexistence between individuals and groups. While Gacaca played an instrumental role in creating the foundation for state-building in the post-genocide period, subsequent studies have estimated that survivors who testified in Gacaca were at a 20% higher risk of depression and 40% higher risk of PTSD than survivors who had not testified.¹⁸ The National Unity and Reconciliation Commission (NURC) has facilitated reconciliation processes, many of which have been conducted through large scale public events such as Ingando (solidarity campus) and Itorero ry'igihugu (civic education programme) and Umguanda (community work for national reconstruction).¹⁹

16 Willman, A. (2014). *Trauma and Psychosocial Well-being: Is it our Business?* The World Bank. See: <http://blogs.worldbank.org/publicsphere/trauma-and-psychosocial-well-being-it-our-business>

17 Ng, L.C. and Harerimana, B. (2016). *Mental health care in post-genocide Rwanda: evaluation of a program specializing in posttraumatic stress disorder and substance abuse*. Global Mental Health (Cambridge Core), Vol. 3, No. e18, 1-11.

18 Brouneus, K. (2010). *The Trauma of Truth Telling: Effects of Witnessing in the Rwandan Gacaca Courts on Psychological Health*. The Journal of Conflict Resolution, Vol. 54, No. 3, 421.

19 National Commission for the Fight Against Genocide, *Background*. See: <http://www.cnlg.gov.rw/genocide/background/>

A mapping of healing actors and approaches conducted by Never Again Rwanda and Interpeace found that while experts, practitioners and beneficiaries alike appreciated the government policies and framework for fostering reconciliation, they also highlighted that healing remained an important challenge to address in order to transcend peaceful coexistence to profound long-term reconciliation.²⁰ Participants of this research expressed a need to undertake a societal healing process that restores inter-communal relations after genocide, helps to rebuild torn-up relations and promotes human interactions that allow a society to function.²¹

In recent years, the integration of healing and psychosocial approaches has featured in reviews of the National Policy on Reconciliation. In 2018, the Mental Health division of the Ministry of Health held a meeting of mental health actors to discuss the integration of community and psychosocial approaches to supplement the department's clinical approaches to healing. In 2016, healing was also elevated as a national priority during the 14th National Umushyikirano Council, an annual national dialogue.²² Hence, trauma healing is increasingly recognised as an important aspect in the advancement of peace and reconciliation in Rwanda. This has provided a strong basis for the Societal Healing and Participatory Governance programme and has led to a call for research and empirical evidence to understand the contribution of healing to overall peace and reconciliation initiatives in Rwanda.

20 Never Again Rwanda and Interpeace (2015). *Societal Healing in Rwanda: Mapping of Actors and Approaches. A Report conducted by Never Again Rwanda and Interpeace as part of the Societal Healing and Participatory Governance for Sustainable Peace in Rwanda*, 1-79. See: <http://neveragainrwanda.org/research>

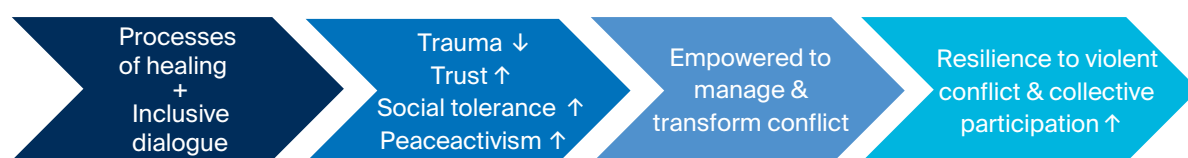
21 Ibid.

22 The 11th resolution of the 2016 National Dialogue Council was "to conduct research with the aim to deeply understand all issues and consequences pertaining to trauma among Genocide survivors in order to address them. http://gov.rw/newsdetails2/?tx_ttnews%5Btt_news%5D=1659&cHash=f2354dbcc1165fc4495fe708efecc19

About the Programme

Since January 2015, Never Again Rwanda (NAR) and Interpeace have implemented the Societal Healing and Participatory Governance in Rwanda programme. This is a four-year programme funded by the Swedish International Development Cooperation Agency (Sida). NAR and Interpeace designed the programme based on their understanding of the peacebuilding needs and gaps from over 15 years of experience implementing peacebuilding programmes in Rwanda. A thorough context analysis identified two key areas in which the two organisations could contribute to the Government of Rwanda’s efforts to foster sustainable peace in Rwanda: Societal healing and participatory governance. The programme’s overall theory of change is:

Figure A. the Theory of Change behind the programme



The theory of change: *If Rwandans, young and old, engage in processes of healing and inclusive dialogue to overcome social divisions and wounds of the past, to work collaboratively across divides, and to utilise spaces for informing decision-making responsive to their needs and priorities, then they will deepen their resilience to violent conflict and be empowered to manage and transform conflict through greater collective participation as well as the use of strengthened Rwandan institutions.*

The societal healing axis of the programme seeks to transform two boundary partners, i.e. community members and youth. It aims to create safe spaces where 1) Rwandans of diverse backgrounds engage in dialogues that allow them to openly discuss sensitive issues, settle differences, overcome wounds of the past and work together towards a common vision for the future and 2) youth of diverse backgrounds use dialogue to think critically about the past, tolerate difference, manage diversity and collectively promote peace, healing and reconciliation in their communities.

The strategy that has been employed to-date to achieve these outcomes include:

- **Mapping of Actors and Approaches.** To inform how the programme would establish safe spaces for community members and youth to engage in processes of dialogue and to ensure complementarity to existing initiatives, the programme commenced with [a mapping of the actors and approaches in healing and reconciliation in Rwanda](#). Among the key wounds identified in the mapping were: refugee-related wounds, genocide-related wounds, loss of loved ones and incomplete mourning, rape, labelling and stigmatisation, loss of identity, transferred guilt and witnessing violence first-hand, among others. The mapping identified four types of healing approaches being used in this context: individual, group, community and holistic approaches. The mapping informed the programme’s decision to adopt a psychosocial support group therapy approach and to focus on participants with a variety of the wounds identified.
- **Psychosocial Support Group Therapy.** In total, the programme established 15 groups of approximately 30 participants each: five Spaces for Peace for community members, five Youth Peace Dialogues of schooling youth and five Youth Peace Dialogues for non-schooling youth.²³ Some groups have homogenous profiles such as one Space for Peace composed of women married to men of different ethnic backgrounds, one Youth Peace Dialogue composed of single young mothers and one Spaces for Peace and Youth Peace Dialogues each composed of genocide survivors. Some groups are composed of individuals who represent a mix of the experiences in their communities, including survivors, families of perpetrators, returnees from Uganda, refugees from DRC, orphans and people from marginalised communities among others. Each group met approximately once a month through meetings (therapy sessions) that were co-facilitated by psychotherapists and group facilitators who were called “peace agents” and were selected by the groups based on NAR and Interpeace’s criteria. In-schooling groups in selected secondary schools were additionally supported by one teacher each. Based on the findings of the intervention baseline, meetings for in-school youth groups focused more on psycho-education and critical thinking activities. The groups were designed to provide a safe space for participants as it is commonly accepted that safe spaces are integral for psychological restoration and healing.²⁴

²³ More information on each group can be found in Annex 2 on participants.

²⁴ Hamber, B. (1995). *Do Sleeping Dogs Lie? The psychological implications of the Truth and Reconciliation Commission in South Africa*. Paper presented at the Centre for the Study of Violence and Reconciliation, Seminar No. 5, 26 July; Zelizer, C. (2008). *Trauma Sensitive Peace-Building: Lessons for Theory and Practice*. *Africa Peace and Conflict Journal*, Vol. 1, No. 1; Hester, L. (2016). *Examining Peacebuilding Through a Trauma Lens: Practitioner Reflections on Programmes for Youth Exposed to Traumatic Stressors in Intergroups Conflict*. *Peace and Conflict Studies*, Vol. 23, No. 2.

- **Psychosocial Education.** This report does not explore the full results of the psychosocial education element of the programme, but some details are provided here for background. The baseline assessment revealed that youth, particularly schooling youth, had lower levels of trauma exposure and PTSD. In order to achieve the intended outcomes with youth, the programme focused directly on increasing critical thinking and young people's ability to engage on issues related to wounds and the events of past periods of violence in Rwanda's history through psycho-education. A psycho-education manual was developed and shared with teachers in the engaged institutions. The programme also used audio-visual material, presentations and lectures by experts, experience sharing by individuals who had experienced violence and participatory theatre to engage youth on issues of the past and the challenges to reconciliation.
- **Community Exchanges.** In order to reach those beyond the limited number of people who could participate in long-term dialogue processes, the programme supported primarily non-schooling Youth Peace Dialogues (sometimes in collaboration with community groups) to conduct community outreach activities to engage typically a 100 or so people around issues of wounds and healing.
- **Study visits.** Study visits were conducted to selected sites such as National genocide memorial sites to enable youth to learn about Rwandan history. Study visits between the established groups were conducted to facilitate exchanges, experience sharing and learning among members of various groups.
- **Youth arts and sports competitions.** Beyond Youth Peace Dialogues, arts and sports events were used to extend the outreach efforts towards youth members. These competitions and events used arts and sports as a means to provide psychosocial education and to promote critical thinking.

What was measured, why and how?

Never Again Rwanda and Interpeace's societal healing strategy was based on two simple premises. (1) If people were provided a safe space to heal their wounds and given opportunities to build trusting relationships with people of different backgrounds through solidarity and sharing in these safe spaces, then they would increase their tolerance of people of different backgrounds and experiences than their own. They would then (2) be compelled to engage with others around them to build the same tolerance they had newly built. A more complex representation of this theory of change intervention logic can be found in Annex 1, figure 19.

To measure participants' process of change, the programme measured four key elements²⁵: the levels of trauma of the participants (called *Impact of Trauma*); how much participants trusted others in the groups (called *Trust*); the social proximity of participants to people of other backgrounds in their communities (called *Social Tolerance*), both those represented in their groups and those who were not; and how active participants were in promoting peace in their community (*Peace Activism and Community Participation*).²⁶ Four indices were developed in partnership with Interpeace partner, the Centre for Sustainable Peace and Democratic Development (SeeD). These were developed from a factor analysis of 39 different attitudinal and behavioural questions conducted at the baseline and allow comparison between baseline and end line of the four multidimensional factors of *Impact of Trauma*, *Trust*, *Social Tolerance* and *Peace Activism*. Table 1 provides an overview of what was measured under each index.

²⁵ A fifth domain, participation in governance processes, was added at the baseline and is not discussed in full detail here.

²⁶ The National Unity and Reconciliation Commission (NURC) periodically administers comprehensive surveys to collect data for the [Rwandan Reconciliation Barometer](#). Although the barometer and our Trauma, Trust, Tolerance and Peace Activism assessment both measure trust and tolerance, the programme's measurement was not intended to repeat the study of NURC. Instead, it is intended to help the programme understand the participants of the programme, to measure change over time and to understand the linkages between the variables.

Table 1. Four-part taxonomy guiding the Societal Healing and Participatory Governance in Rwanda Program

<p>Impact of Trauma</p> <p><i>Trauma Index (experience and effect)</i></p> <ul style="list-style-type: none"> • Victim of violence • Victim of property crimes • Exposure of violence against others • Victimization in the community <p>This was cross referenced against two other indices:</p> <p><i>Psychological Distress and Resilience</i></p> <ul style="list-style-type: none"> • Post traumatic distress • Poor self-esteem and guilt • Anger • Psychological resilience <p><i>Forgiveness and Revenge</i></p> <ul style="list-style-type: none"> • Forgiveness in practice • Forgiveness in theory • Revenge tendency 	<p>Trust</p> <p><i>Healing Spaces Index</i></p> <ul style="list-style-type: none"> • Readiness for social interaction • Readiness for personal sharing • Readiness for trauma expression • Readiness for daily life partnerships <p><i>Readiness for trauma expression beyond groups</i></p> <ul style="list-style-type: none"> • Readiness to share personal stories with different categories within the wider society
<p>Social Tolerance</p> <p><i>Social Tolerance Index</i></p> <p>Frequency and quality of interaction as well as level of comfort in engaging in intimate social interactions²⁷ with:</p> <ul style="list-style-type: none"> • Social ingroups • Social outgroups • Socially disadvantaged groups • Inflowing populations • Ex-genocide perpetrators • Genocide survivors • Others 	<p>Peace Activism and Community Participation²⁸</p> <p><i>Peace Activism Index</i></p> <ul style="list-style-type: none"> • Peace Activism of Healing Spaces • Peace Activism of Peace Dialogues <p><i>Community Development Participation Index²⁹</i></p> <ul style="list-style-type: none"> • Community Development Participation • Comfort in Community Development Participation <p><i>Participation in Governance Index</i></p> <ul style="list-style-type: none"> • Participation in planning of policies, programs and projects • Participation in implementation of policies, programs and projects <p><i>Motivation</i></p> <ul style="list-style-type: none"> • Motivation for Peace Activism • Motivation for participation in community development

²⁷ Intimate social interactions include marrying, attending or inviting others to family functions, joining savings groups and receiving financial assistance.

²⁸ Sections measuring community participation (Community Development Participation Index, Participation in Governance Index, Leadership and Motivation) were measured only at the end line to better understand the connection between progress in trauma healing and participation in community development and governance.

²⁹ Community Development Participation was measured only at the end line to better understand the connection between progress in trauma healing and participation in community development and governance.

Impact of Trauma, Trust, Social Tolerance and Peace Activism and Community Participation were measured through a survey of over 150 questions.³⁰ The survey was administered only to group members who were participating in the Spaces of Peace and Youth Peace Dialogues once the groups were established. Four hundred participants were interviewed to collect baseline data which was collected in the beginning of year two³¹ and a second round of baseline data was collected at the end of year two, depending on when groups were formed. The questionnaire was again administered to 265 participants³² in the beginning of the fourth year of intervention, including additional questions to understand the link between healing processes and participation in governance.

The data was analysed through collaboration between NAR staff, Interpeace and SeeD. SeeD, which has extensive qualitative analysis experience and staff with psychological data analysis expertise, supported NAR and Interpeace staff as well as selected experts who accompanied programme implementation, in the analysis and interpretation of the baseline and end line data. The six indices are composed of sub-components (presented above) which provide more specific measurement on specific items. All measures were scaled on a score out of ten and capture the change in individuals' behaviors and attitudes over two to four-year periods.

The two rounds of data collection and analysis amounted to less than 1% of the project budget. The assessment not only served as a basis to measure and monitor progress but also as a tool for strategy improvement. The results of the baseline were used to refine the methodology for working with the different types of groups based on both their level of trauma and their social proximity to various actors in the community. Additionally, the results of both assessments can be used as a basis for knowledge sharing and learning among healing and peacebuilding practices and actors, in and beyond Rwanda.

30 The questionnaire was developed by NAR and Interpeace staff with additional consultation of trauma healing and reconciliation experts in Rwanda, including staff of NURC, and from SeeD.

31 Baseline data collected in year two was complemented by qualitative data collection and analysis to produce an initial baseline report and inform implementation of the programme with the first groups established. Qualitative information was not collected during the second baseline or follow-up assessments but emerged during programme implementation.

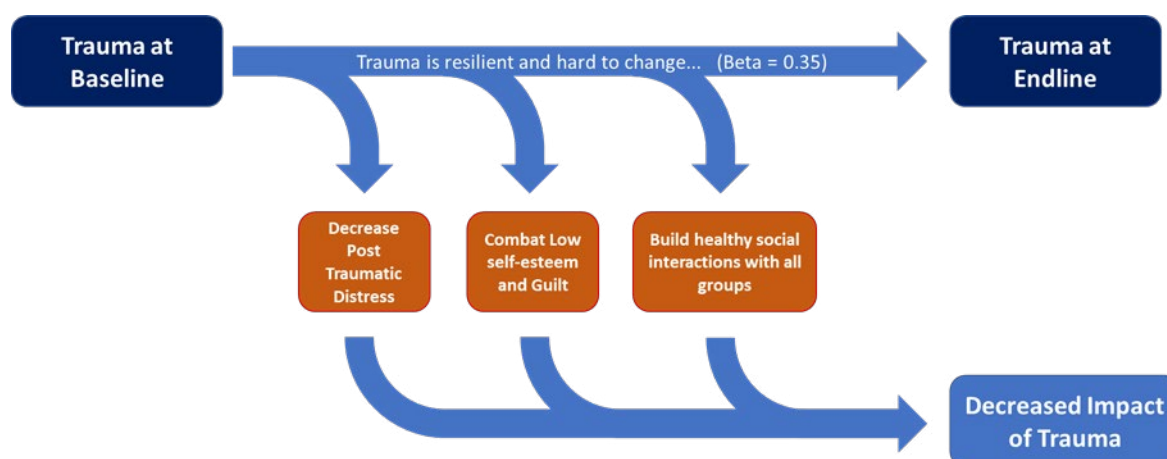
32 One third of programme participants were in-schooling youth. At the time of end line data collection, some youth had graduated and since left the institution, others had moved institutions and others were no longer in the group. The end line was administered to current and former members of the youth peace dialogues who were contactable.

What changes did participants undergo?

Impact of Trauma

Figure 1. Change in the impact of trauma driven by improvement in PTSD, self-esteem and guilt and healthier social interactions with all groups

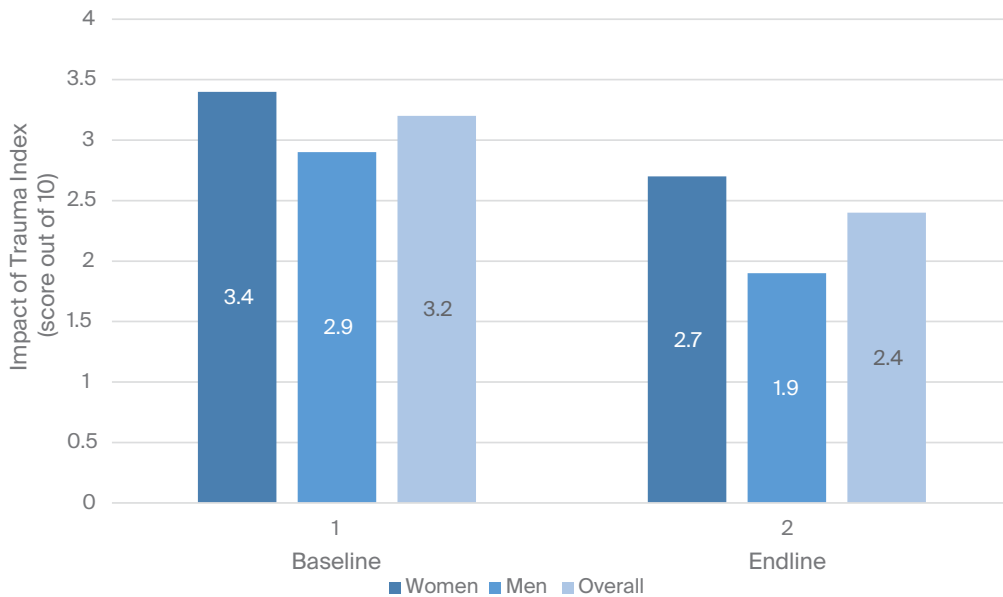
The results of the end line survey indicate that the intervention was successful in addressing the primary objectives to reduce the impact of trauma and psychological distress and to build resilience, forgiveness and social tolerance for social cohesion and peace. Of the 39 different behaviors and attitudes measured in the program, 24 or 62% of the targeted behaviors and attitudes saw a moderate or greater effect size, indicating very notable change. Nine behaviors or attitudes saw large, very large or huge effect sizes, indicating very significant positive changes in the attitudes and behaviors of individual participants.



The analysis of the changes in trauma revealed that the impact of trauma had strong correlations with PTSD, low self-esteem and guilt as well as social proximity to groups such as genocide perpetrators and survivors. Figure 1 visualises the changes observed during implementation and the pathway of changing the impact of trauma through directly addressing PTSD, improving self-esteem and guilt and by building healthier social interactions with different groups of survivors and perpetrators.

Figure 2. Change in Impact of Trauma Index, baseline to end line change, men and women

The impact of trauma improved 25% on average for all participants engaged in the programme.



The Impact of Trauma index captures the extent to which individuals are traumatised and experience post-traumatic distress from genocide and non-genocide related experiences of violence. The Index captured a notable, moderate effect size change among both men and women participating in the programme. The most significant changes were found among a group of elderly genocide survivors and youth from different backgrounds (survivors, perpetrators, historically marginalised, orphans, etc.). This confirmed that the intervention was appropriate for addressing trauma needs of both homogenous and heterogeneous groups.

Figure 3. Impact of trauma by most common wounding experiences, baseline versus end line

Lack of parents or closer friends is the most wounding experience for participants, but impact of that trauma was substantially reduced by the programme.

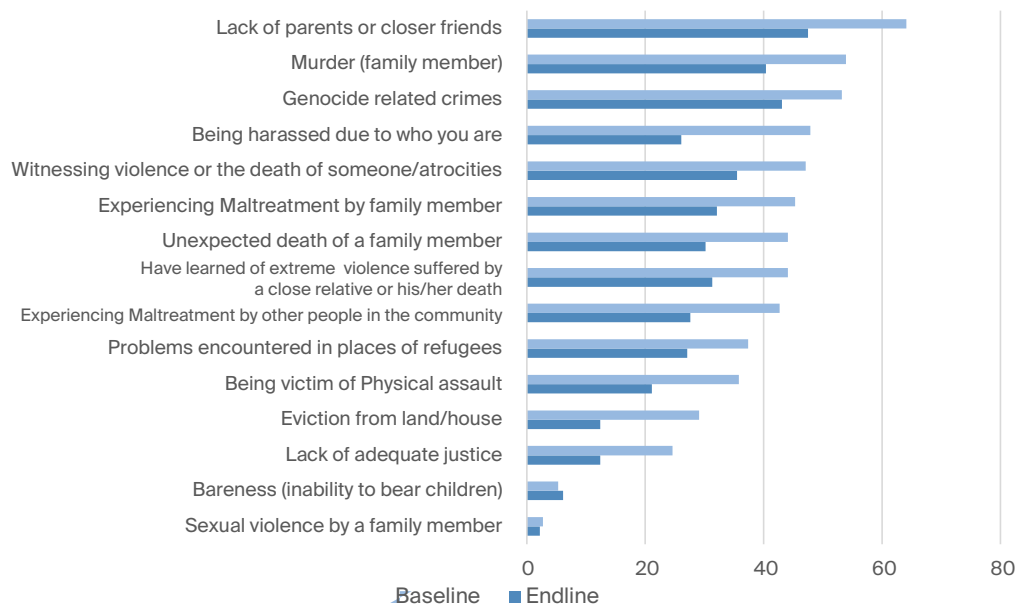


Figure 3 shows the wounds that participants most commonly reported, having a moderate to extreme impact on them. Those wounding experiences that were expressed to have the most significant impact on participants at baseline were still the most significant at the end line. However, there were noticeable changes in the percentage of participants reporting that those wounds still have a moderate or extreme impact on them. Significant changes include: 21.8% decrease in people reporting “being harassed for who they are”, 16.7% decrease in those reporting traumas from “eviction from land/house” and 16.6% decrease in those reporting “lack of parents or close friends” as a moderate to extreme wound.

Lack of parents or close friends was the wounding experience most commonly reported as having a moderate to extreme impact. The decrease in this figure confirms that the intervention provided participants with a community and a sense of belonging, important factors for long-term healing. It is important to note that the percentage of people reporting moderate to extreme wounds from being unable to bear children was the only indicator that increased (by 0.8%). There was only a 0.5% decrease in those reporting that experiencing sexual violence has a moderate to extreme impact on them.

Figure 4. Change in Post Traumatic Distress Index, baseline to end line

The change in post-traumatic distress was equal to a 54% improvement from the baseline which is classified as a large effect size.

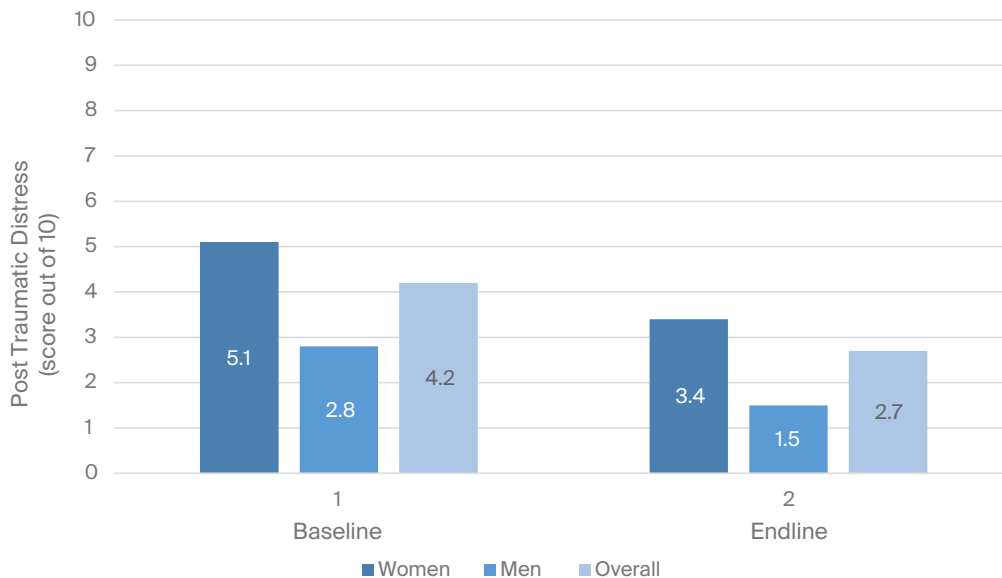
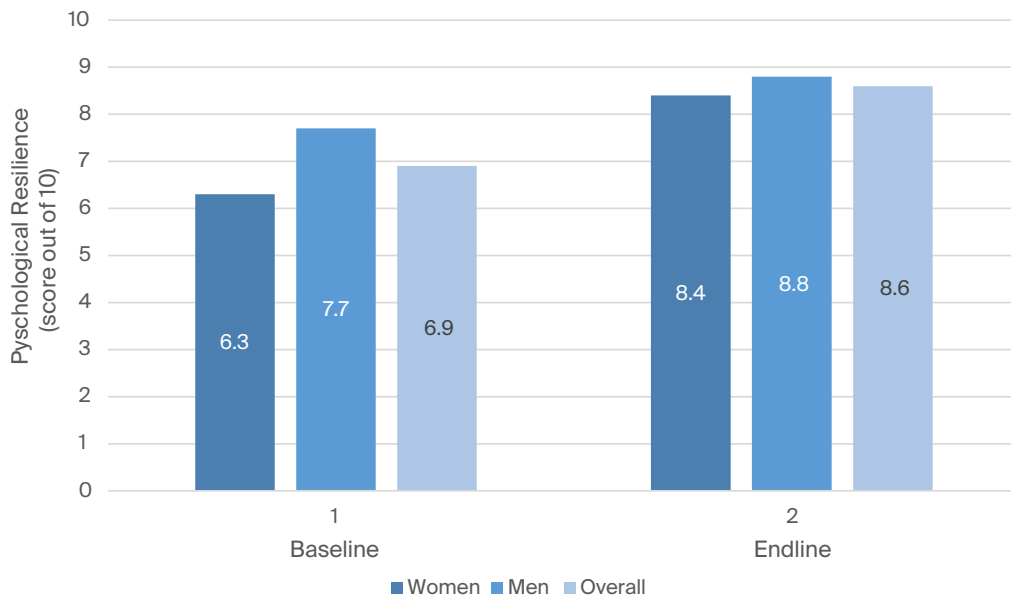


Figure 5. Change in Psychological Resilience Index, baseline to end line

Psychological resilience positively improved 24% which was equivalent to a large effect size change.



Levels of *Post Traumatic Distress and Resilience* also recorded significant improvement; Post Traumatic Distress³³ symptoms decreased from 4.2 to 2.7 and psychological resilience moved from 6.9 to 8.6 out of 10, reflecting a large effect size change in both cases. All the sub components of this index also improved. These include: low self-esteem and guilt, levels of anger and levels of psychological resilience. This is critical as statistical analysis carried out after the programme shows psychological healing is an important building block for broader individual level healing. Levels of anger amongst participants also showed a medium effect size decrease.

³³ The measurement of post traumatic distress was influenced by established international scales for measuring post traumatic distress syndrome (PTD). Measuring PTSD requires administration and analysis by a mental health professional in a clinical setting.

Post-traumatic stress was higher for female participants as they were more likely to be directly impacted from the genocide and had experienced sexual violence and/or were married to men from other ethnic groups. Most significant of the changes in psychological resilience was a 66% decline in the number of people who think about suicide very often from 15% of participants to 5%. Similarly, the number of people who reported to feel depressed or sad went from 44.5% to 23.4%, an improvement of almost 50%. The number of people at risk who suffered bad dreams or memories went from 43.7% to 23.3% from the beginning to the end of the programme.

The rationale behind using the concept PTD in comparison to PTSD

This report refers to Post Traumatic Distress (PTD) as the potential stress reaction people may have after going through a traumatic event, like combat, assault or disaster. PTD is distinct from Post-Traumatic Stress Disorder (PTSD) in the way that PTSD is the clinical definition of the term and is recognised as a specific disorder by the American Psychiatric Association and the Diagnostic and Statistical Manual of Mental Disorders (DSM-V). PTSD can therefore only be clinically diagnosed by medical professionals and be treated through different types of trauma-focused psychotherapy or medication. PTD, on the other hand, measures the same symptoms, however, is not administered by medical professionals and is not measured for the purpose of diagnosis but for programme planning, monitoring, and evaluation. As a screening test through surveys does not equal a diagnostic test, the measurement of symptoms was influenced by international scales for measuring PTSD. It used similar questioning to screen for PTSD symptoms, however, the analysis cannot be considered as a diagnosis of a PTSD disorder, as it was not administered by medical professionals.

While in an ideal world, the programme would measure PTSD through diagnosis by medical professionals, taking in mind the post-conflict context, the number of people showing symptoms and the limits of mental health infrastructures, this is an unrealistic objective. Therefore, the programme aimed to explore other interventions to address these symptoms in the best way available and possible.

Table 2. Forgiveness in theory, in practice and revenge tendency sub-indices, baseline to end line, male and female

Both forgiveness in theory and practice improved, but there was a tendency for individuals in the programme to be more forgiving in theory than in practice. Revenge is a characteristic not necessarily just felt by victims of violence.

	Female		Male		Overall	
	Baseline	End line	Baseline	End line	Baseline	End line
Forgiveness in Theory	5.2	6.1	5.9	6.4	5.5	6.3
Forgiveness in Practice	3.5	4.3	4.5	5.1	3.9	4.6
Revenge Tendency	0.6	0.1	0.5	0.1	0.5	0.1

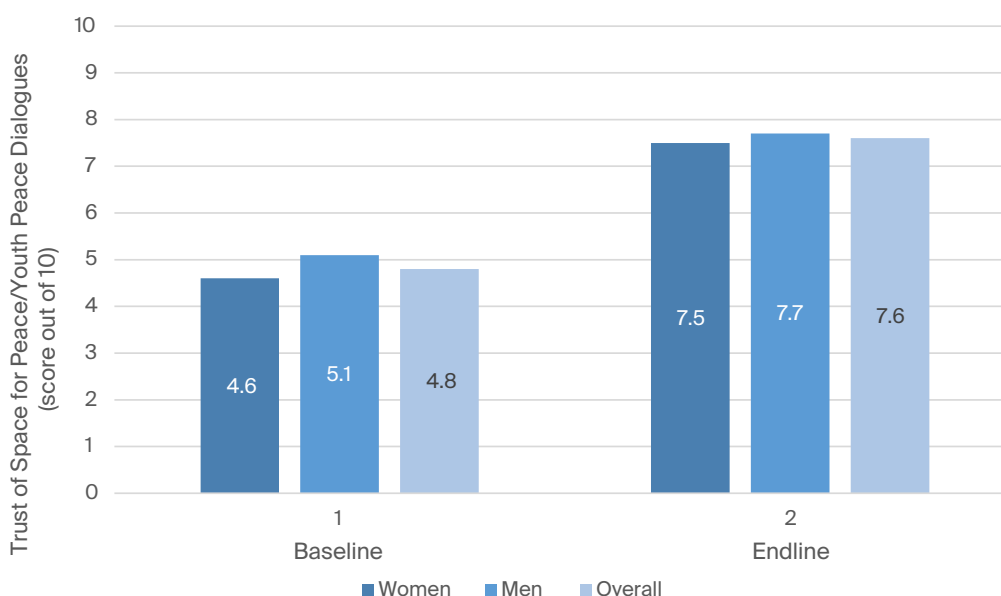
Forgiveness and revenge improved as did all the sub components underlining it. This meant levels of forgiveness and revenge positively improved from the beginning to the end of the programme for all cohorts and all dimensions, i.e. forgiveness in theory, forgiveness in practice and tendency for revenge. At the baseline, the factor analysis of items measuring forgiveness revealed an interesting distinction between supporting forgiveness in theory (e.g. endorsing the statement that ‘without forgiveness a conflict can never be resolved’) and the actual practice of forgiveness as experienced in real-life personal contexts (e.g. If happened, I feel that I can forgive someone who killed my parents/children/relatives). As for revenge tendency, factor analysis revealed this to be a unified construct, i.e. a person is either a believer in revenge, regardless of the specific insult, or a person is not a believer in revenge, whatever the provocation. This may suggest targeting revenge tendencies as a behaviour exhibited in specific sub groups because victims may be misguided as the experience of violence may not necessarily be a trigger for revenge tendencies. Hence, specific interventions targeted at revenge in this context may be better suited to broader cohorts rather than any assumed sub-group.

Trust

The *Trust of Youth Peace Dialogues* Index captured aspects of social capital such as readiness for social interaction, readiness for personal sharing, readiness for trauma expression and readiness for more partnerships in daily life. The measured impacts were all in either the huge, very large and/or large effect sizes, indicating this was the dimension which improved the most consistently for participants across the programme duration. This is directly linked to greater social capital and participation in informal forms of peacebuilding amongst community and family which can have direct and indirect impacts on levels of violence.

Figure 6. Change in Trust Index, baseline to end line

Levels of trust increased very significantly over the course of the programme with the overall level of trust index improving 57%.



The change in the overall *Trust Youth Peace Dialogues* Index was the most significant out of any other area. The effect size was categorised as ‘huge’, which reflects the fact that the trust score of participants (out of a possible score of 10) - when going from 4.81 to 7.56 - is a change of almost 1.5 standard deviations or 57%. To understand this change better, this shift is roughly equivalent to a majority of participants at the end of the programme becoming as trusting as the top 15% most trusting participants at the beginning of the programme. It is also important to note the commonalities between younger generations that have not directly experienced the genocide and older generations that have suffered significantly from the genocide. The levels of trust for both were equal, indicating the relative nature of trust in Rwandan society.

The Humura group (composed of genocide survivors) and Turuhurane group (composed of women married to men of different ethnicities) were the groups with the highest trauma levels and lowest levels of trust at the baseline. Both groups saw the most significant increases in trust at the end line, with the Humura witnessing a 3.9-point change and the Turuhurane witnessing a 3.3-point change. During implementation, members of these groups shared that their wounding experiences had caused them to feel alone and isolated and that the groups provided them with a sense of belonging and community.

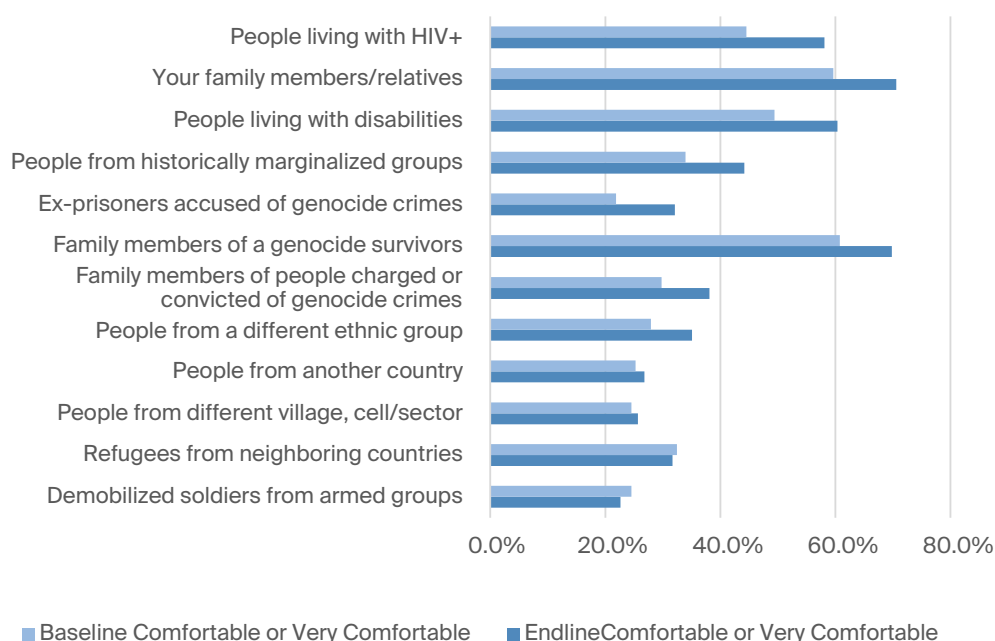
Among other groups of special interest, readiness to share personal stories at the baseline was lowest among those who self-identified as ex-perpetrators or relatives of perpetrators (3.7), followed by survivors and relatives of survivors (4.3) and then those who identified as having not participated in the genocide (4.4). At the end line, these individuals who self-identified within these categories also witnessed the most significant change in trust.³⁴ Readiness for daily life partnerships, which include: accepting marrying or having matrimonial alliances with group members, leaving children with group members and letting group members make important decisions on their behalf, also saw significant increases, with changes of over four points in some groups.

An important aspect to note is that the programme previously assumed that groups with homogenous wounds, such as the Turuhurane, would be more ready to trust and share in healing spaces, but the results of the baseline and end line do not prove this theory. Further, no significant correlations were found between trauma and trust in the group, suggesting that while participation in the group helped reduce PTSD and increase psychological resilience, trust in the group was not the driver of these changes in impact of trauma.

³⁴ Ex-perpetrators and relatives of perpetrators (4-point change), survivors and family of survivors (3.6-point change) and those who did not participate in the genocide (3.5-point change).

Figure 7. Change in Level of Comfort with Sharing Personal Stories with others in the community

Comfort in sharing stories with people living with HIV, people living with disabilities, ex-prisoners accused of genocide crimes, and people from historically marginalised groups rose most significantly.



Beyond measuring the level of trust in the Spaces of Peace and youth groups, the baseline and end line assessments also measured the extent to which participants were comfortable sharing their personal stories with others beyond the group. At the baseline it was identified that out of the 25 categories of people³⁵, ex-prisoners accused of genocide crimes (21.9%), demobilised soldiers from armed groups (24.5%), people living in different villages/cells/sectors (24.5%) and people from other countries (25.3%) were the groups of people with whom the fewest participants indicated they were comfortable or very comfortable sharing their personal stories. People who have the same wounds/history (80.4%), close friends (75.5%), genocide survivors (64.5%), family members of the genocide survivors (60.8%) and family members/relatives (59.6%) were the groups with whom most participants indicated they were comfortable or very comfortable sharing their stories.

³⁵ This ranged from family members to people from other countries.

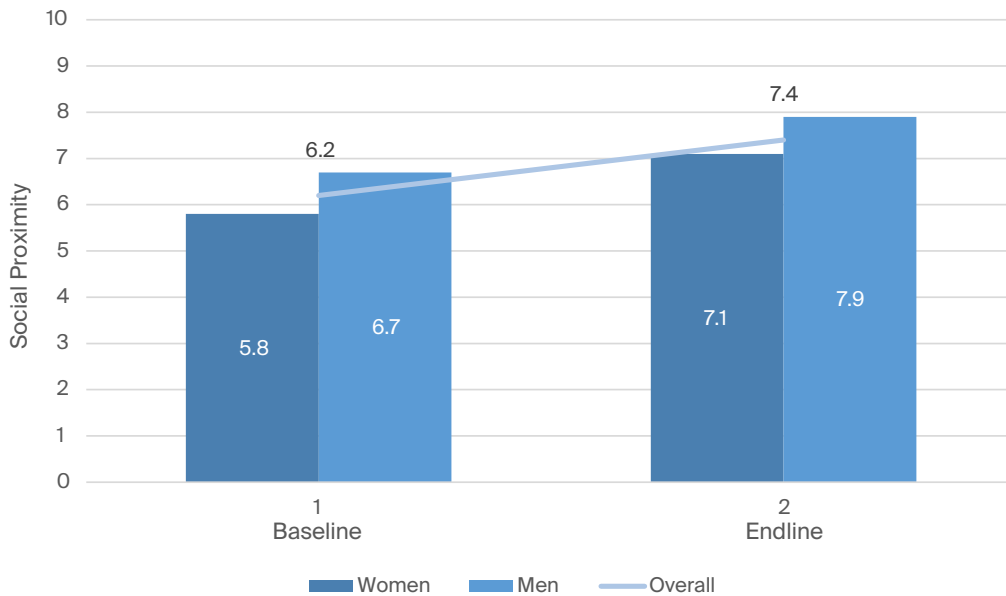
The groups with whom the participants indicated least or most comfort with sharing personal stories largely remained the same at the end line, suggesting there is still a lot of work to be done to increase trust between certain segments of society. However, there were notable changes in the levels of comfort in sharing with certain groups. For example, there was a significant increase in the number of people who reported being comfortable or very comfortable sharing personal stories with people living with HIV (13.6% increase); people living with disabilities (10.9%); ex-prisoners accused of genocide crimes (10.2%); people from historically marginalised groups (10.2%) as well as family members of both survivors (9.1%) and people charged or convicted of genocide crimes (8.3%). On the other hand, slightly fewer people reported being comfortable or very comfortable sharing their personal stories with demobilised soldiers from armed groups (excluding former RDF/RPA soldiers) and fewer with refugees from other countries. These negative shifts and the limited impact on perceptions towards sharing with people from different villages/cells/sectors or countries suggest a need for increased efforts to enhance a sense of unity with those living in different locations.

Social Tolerance

Social Tolerance was measured by a range of attitudes and behaviors towards other groups. The *Social Tolerance Index* measures overall social proximity based on level of comfort to engage in a range of activities with various categories of people whom the participants were likely to encounter in Rwandan society. *Social Tolerance* increased from 6.2 to 7.43 for men and women, a shift of almost one standard deviation and which is classified as a large effect size. Shifts in social tolerance were most prominent among schooling youth (1.5-point shift), followed by women, Spaces of Peace members whose social proximity to various groups shifted an average of 1.3 points.

Figure 8. Change in Social Tolerance Index, baseline to end line

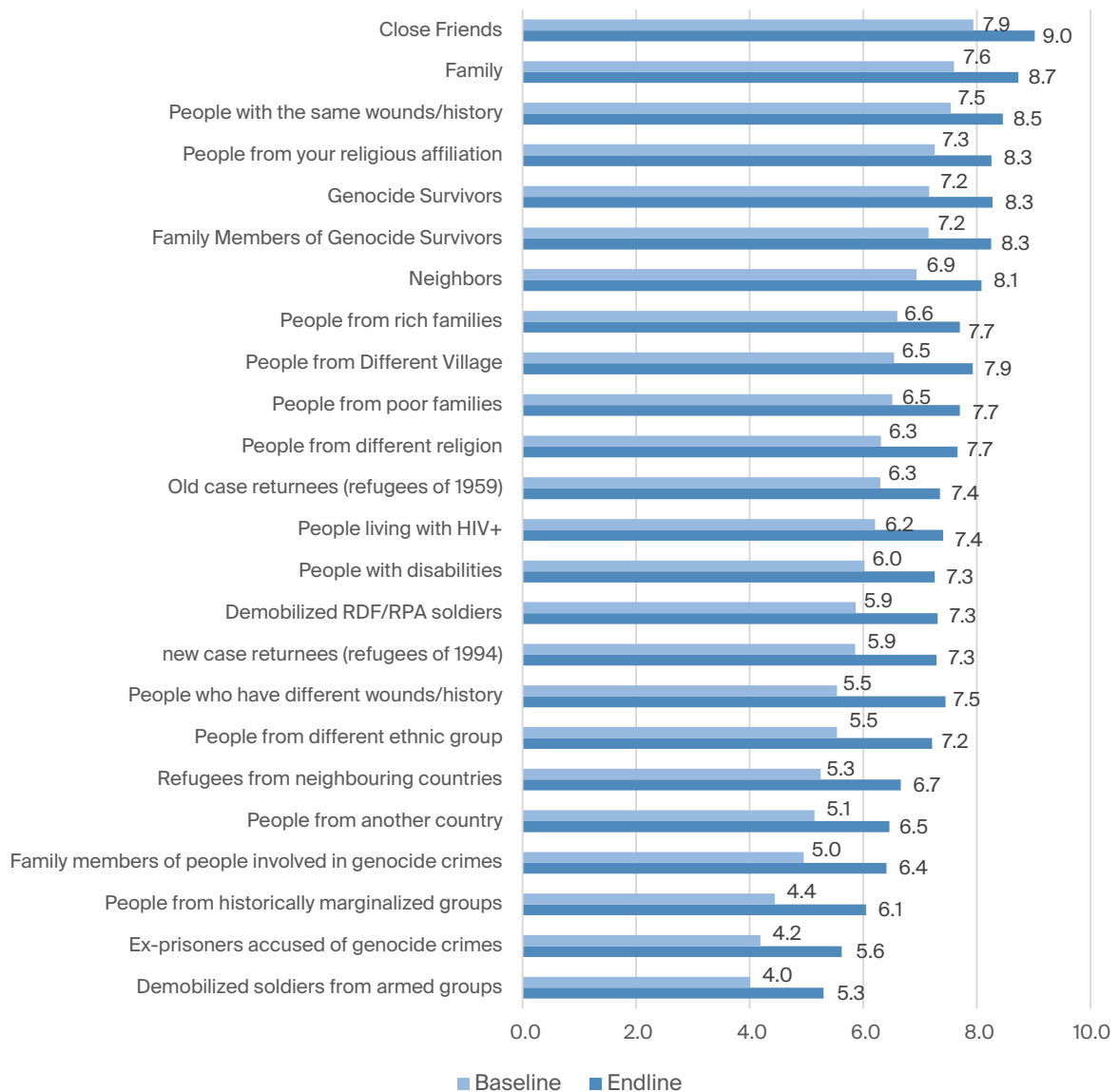
The social tolerance index was composed of 24 different categories of different ingroups and outgroups and improved overall.



The Social Tolerance index captures the overall proximity of individuals to 24 categories of people that are likely to be found in their communities. These ranged from members of their ingroups (family, friends, neighbors), to social outgroups (people with different religious or ethnic affiliations), to special interest groups for the programme such as ex-genocide perpetrators and their families as well as genocide survivors and their families. Social proximity was measured based on willingness to develop intimate familial relationships (marriage), to socialise in intimate settings (attendance of a wedding), to engage in joint economic activity (Ikimana), to be dependent upon (receive financial and/or material support) and to vote for people from the 24 categories.

Figure 9. Change in Social Tolerance per category of people, baseline to end line

Social proximity towards all groups shifted at least one index point and the most significant changes in social proximity among all groups was between people who have different wounds/ histories and people of different ethnic groups.



Social proximity towards all groups shifted at least one index point, except for the social proximity to people with the same wounds/histories which increased by 0.9 points, from a high base of 7.54 at the baseline. The most significant changes in social proximity among all groups was towards people who have different wounds/histories (1.9-point increase), people of different ethnic groups (1.7-point increase), people from historically marginalised groups (1.6-point increase) and family members of those involved in genocide crimes (1.5-point increase). However, it is important to note that comfort in engaging in forming matrimonial alliances and voting for demobilised soldiers from armed groups (excluding the RDF/RPA) and ex-prisoners accused of genocide crimes remain quite low at the end line. Equally important is that comfort in joining *Ikimana* increased.

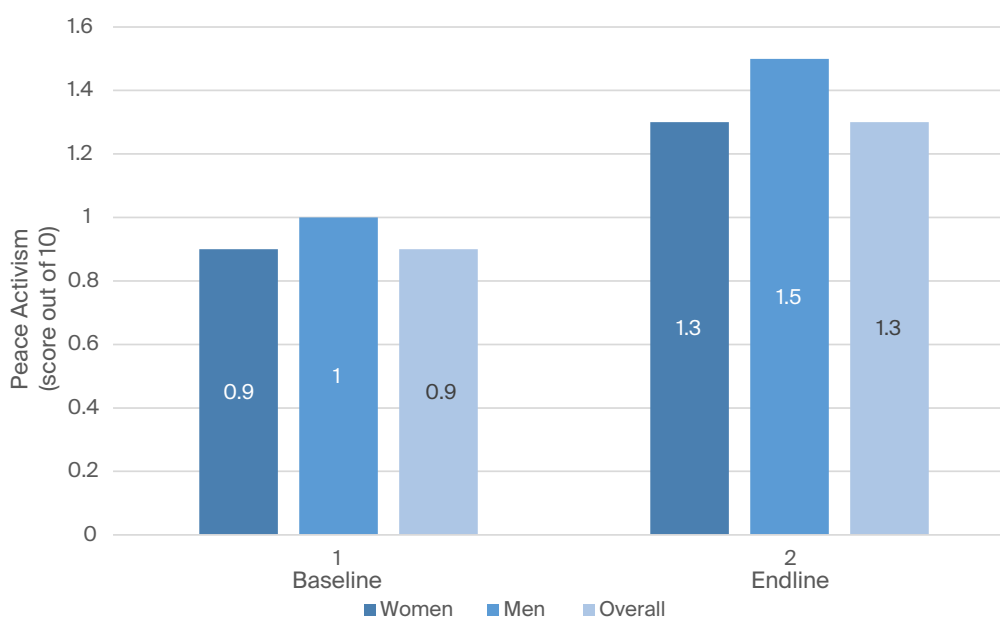
When disaggregating the data by age cohorts, under 20, 21-37, 38-54 and 55 and over, there was little to no difference in the level of progress from baseline to end line. Similarly, when looking at different groups of participants, schooling groups, genocide survivors and relatives and perpetrators and relatives there were only slight differences in the extent of change in social tolerance. The group demonstrating the highest increase in social tolerance were self-identified ex-perpetrators and relatives (1.6-point increase), those who indicated that they didn't participate in the genocide (1.5-point increase) and schooling youth (1.4-point increase). There were strong correlations between trust in groups, level of education and comfort in sharing stories with ex-perpetrators and overall social tolerance. While this suggests it is important to provide spaces for positive social interactions between groups in implementing the programme, it was important to provide safe spaces in order to achieve a level of psychological resilience prior to integrating them into the mixed spaces.

Peace Activism and Community Participation

The percentage of participants who reported to independently set-up initiatives to resolve conflict or implement community development in fact decreased from 68% to 54% for participants of Spaces for Peace. Members of the Youth Peace Dialogues also did not improve their engagement in peace activism. However, youth overall reported higher engagement, from 66% to 82%, in informal forms of conflict resolution in their communities. While Spaces of Peace members witnessed the most significant improvements in leadership in formal civic activities, youth improved most in leadership of informal activities to promote peace and help others in their communities. The results presented here are broken into two categories – the results for the Spaces for Peace group and the youth group as the programme recognised the need to focus on different elements of participation for the two cohorts.

Spaces for Peace

Figure 10. Changes in the Peace Activism Index among members of Spaces for Peace, baseline to end line



While there was some improvement in the Peace Activism index, progress was less clear in this area than in others. Members of Spaces for Peace grouping were asked about their participation or leadership in 15 activities related to the promotion of peace and reconciliation. Overall, the great majority of people did not participate in most of such activities and this did not significantly change from baseline to end line. However, for four categories of these peace activities, decreases in participation were balanced by significant increases of participants who reported independently organising or assisting the organisation of these activities. This seems to explain that participation where it exists became deeper because of the programme. These findings are seen in figures 11 through 15. It shows some elements of participation in specific types of civilian peace building and community engagement that actually got deeper, while general levels of participation across a broad range of activities got thinner.

Figure 11. Changes in Spaces for Peace Members' setting up a unity and reconciliation club or association, baseline to end line

More participants reported "not participating" in activities in the 12 months prior at the end line than at the baseline.

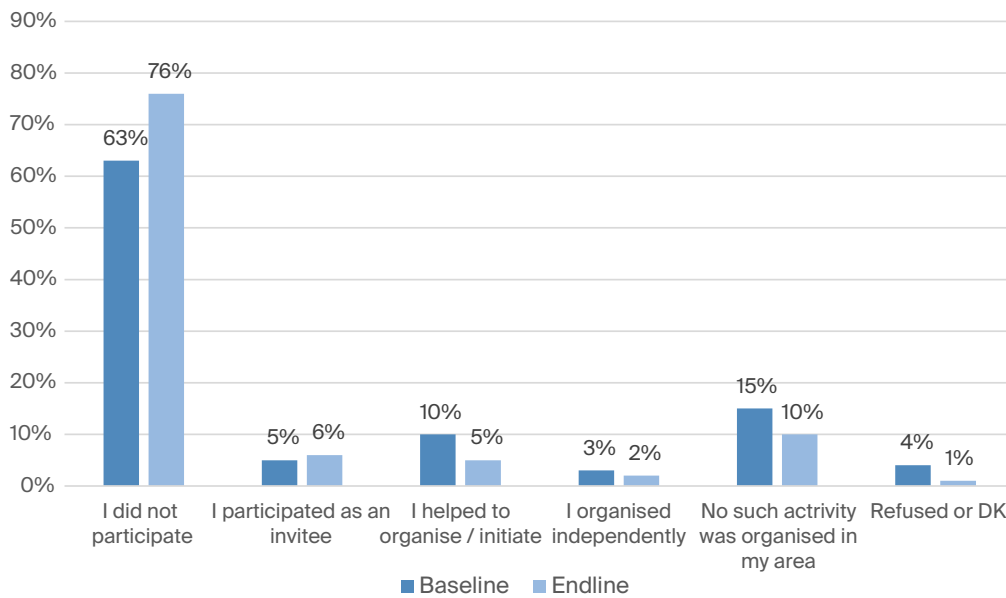
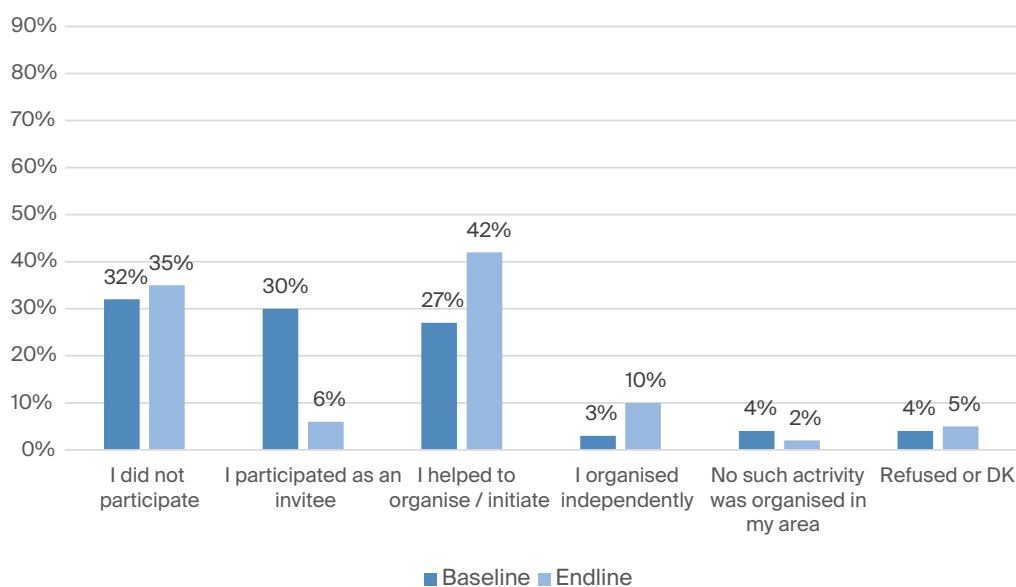


Figure 12. Changes in Spaces for Peace Members' participation in construction of a house for a vulnerable person, baseline to end line

The number of people reporting to help organise the construction of a house for a vulnerable person improved. This showed more participants of the programme increasing their leadership role. This increased from 27% to 42% from baseline to end line.



Beyond these activities, the most significant increases in leadership were in; community work/Umuganda to solve a problem (19% increase), supporting a genocide survivor or other vulnerable people (28% increase) and organising genocide commemoration activities (29% increase). Genocide commemoration activities are one of the most recognisable government mechanisms for promoting peace and reconciliation. Umuganda is one of the primary forms of civic participation in which most Rwandans engage. Participants evolved from simply participating in these spaces to taking a leadership role by helping to or independently organising these activities suggests that they ceased being passive bystanders in these activities and developed a sense of ownership of these activities. The fact that these two were among the top areas in which members increased their leadership during the intervention suggests that the intervention was successful in catalysing participation in formal processes rather than increasing self-initiative of participants in developing and leading their own processes to advance peace and reconciliation.

Figure 13. Changes in Spaces for Peace Members' engagement in community work/ Umuganda, baseline to end line

The number of people reporting to help organise the community work or Umuganda also improved. This showed more participants of the programme increasing their leadership role, although only a small number independently organised the work.

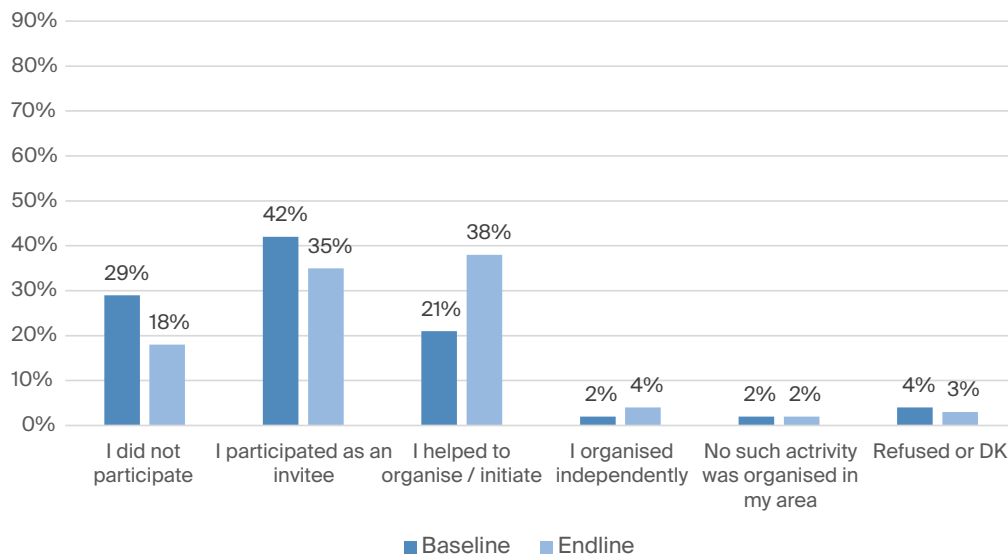
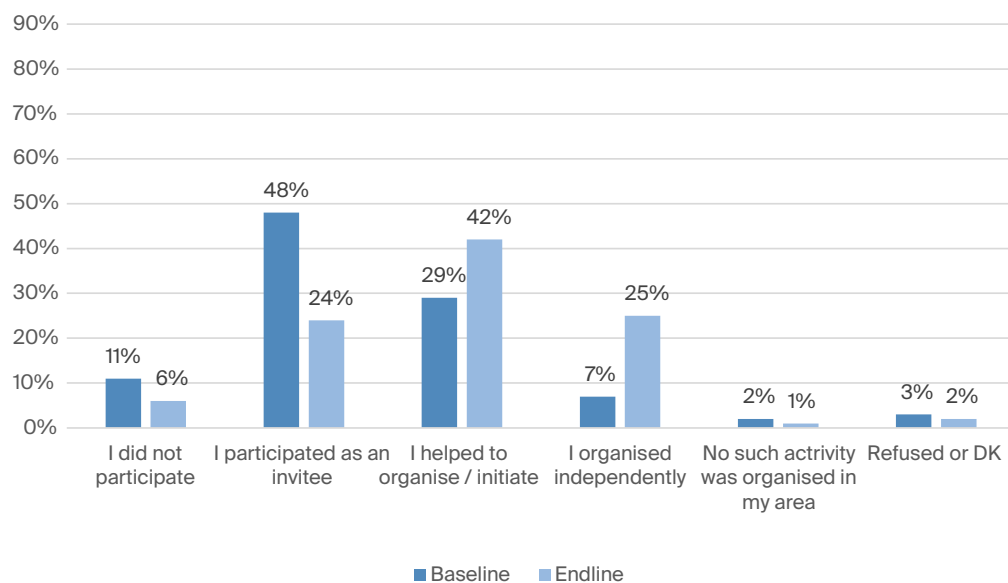


Figure 14. Changes in Spaces for Peace Members' engagement in commemoration activities, baseline to end line

The number of people reporting to help organise genocide commemoration also improved. This showed more participants of the programme increasing their leadership role and a significant number taking a role in independently organising such activity.

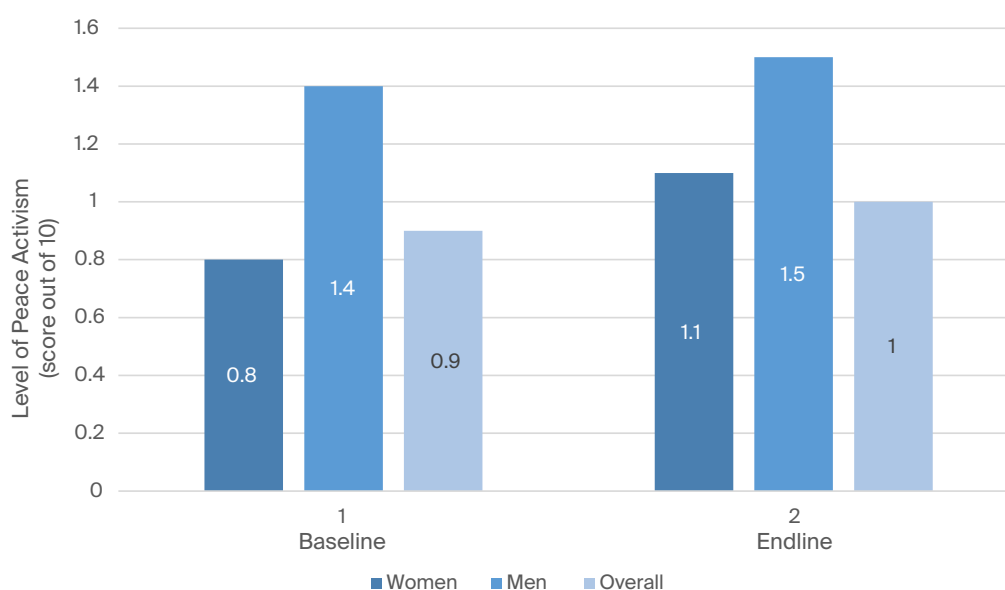


Youth Peace Dialogues

Improvements in peace activism were higher among Youth Peace Dialogues than among Spaces for Peace group. Nevertheless, trends remained similar. It is important to note that after the baseline findings revealed that youth, and specifically schooling-youth, have lower levels of trauma impact, the programs' youth approach centered on critical thinking and psychosocial expression, both related to peace activism.

Figure 15. Changes in the Peace Activism Index among participants of Youth Peace Dialogues, baseline to end line

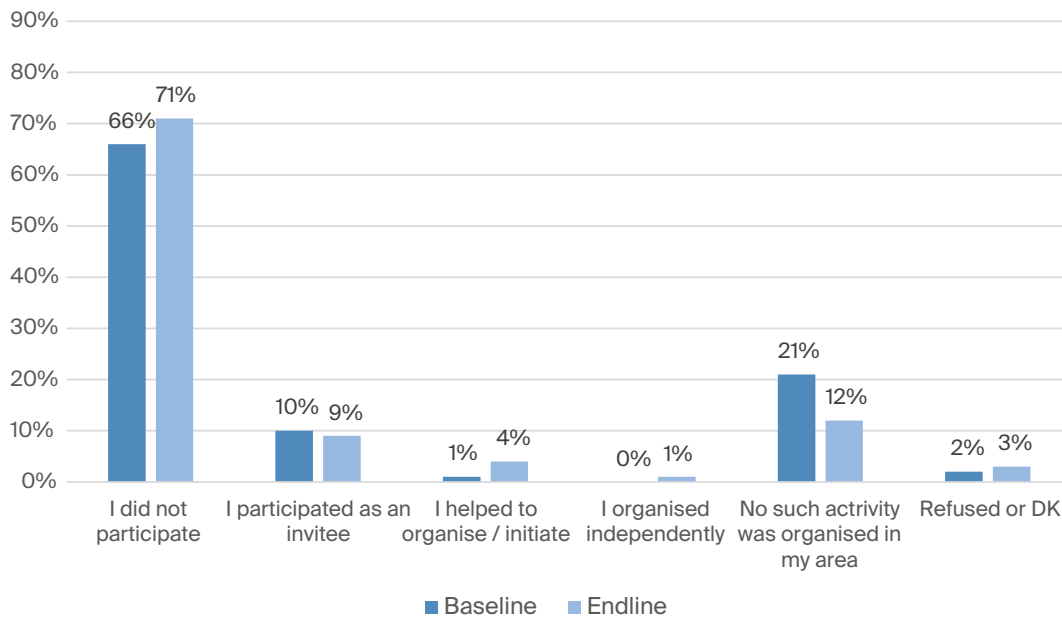
Peace activism did improve overall for all participants, albeit from a low base. The disaggregated results suggest fewer clear results with some forms of formal participation falling.



More youth reported “not participating” in 10 out of 13 activities at the end line than at the baseline. Similar to members of Spaces for Peace, youth were most likely to report “not participating” in setting up reconciliation clubs and associations, a radio or TV show to teach people about conflict resolution and assisting an ex-genocide perpetrator to pay back properties damaged during the genocide.

Figure 16. Changes in participation in a Radio/TV show to teach people about peaceful conflict resolution, baseline to end line

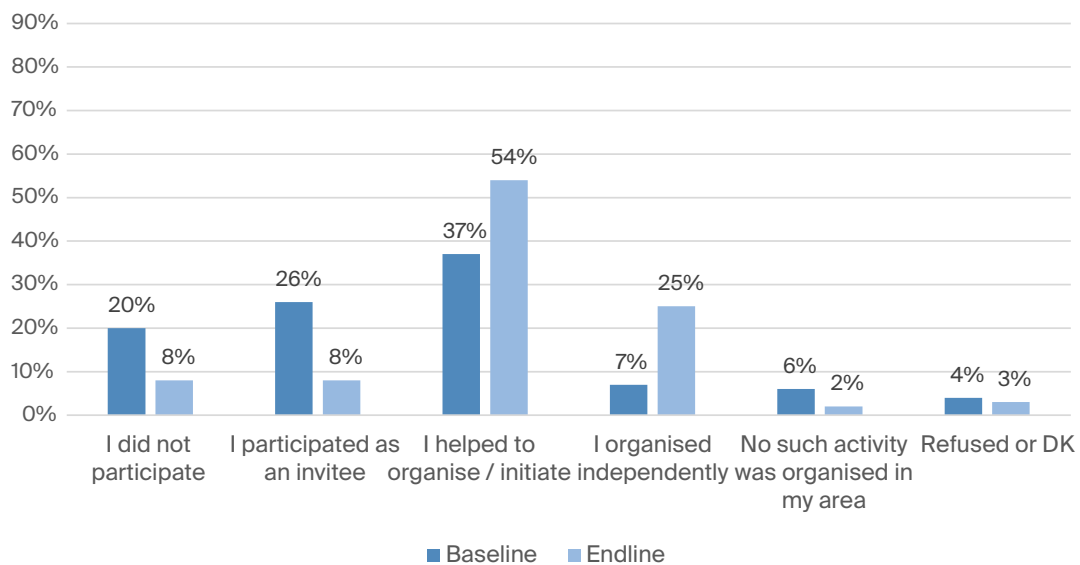
Participation in a peace activity, like a radio or tv show about peace, slightly fell even though the number of such activities in their area reportedly fell.



Nevertheless, more youth reported leadership in peace activism than members of Spaces for Peace. This could be attributed to the fact that the strategy of engagement for youth promoted their active engagement in promoting healing rather than focusing only on the healing of the individuals themselves. For example, Twisungane, a group of young mothers reported the largest increases with 43% reporting having facilitated a conflict resolution activity and 38% reporting experience initiating a peace and reconciliation activity. While the group also saw significant decreases in low-self-esteem and guilt, their pro-activism in promoting the prevention of early pregnancy was among the first efforts at public engagement by any groups participating in the intervention. The most significant increases in leadership were in: supporting genocide survivors or other vulnerable people (35% increase), planting a tree for peace (25% increase) and community work/Umuganda to solve a problem (17% increase).

Figure 17. Changes in youth support to Genocide survivors and vulnerable people, baseline to end line

The most positive change was recognised in youth support to genocide survivors, where the number of youth who reported to help genocide survivors and vulnerable people increased from 37% to 54% and with 25% reporting to have done so independently.



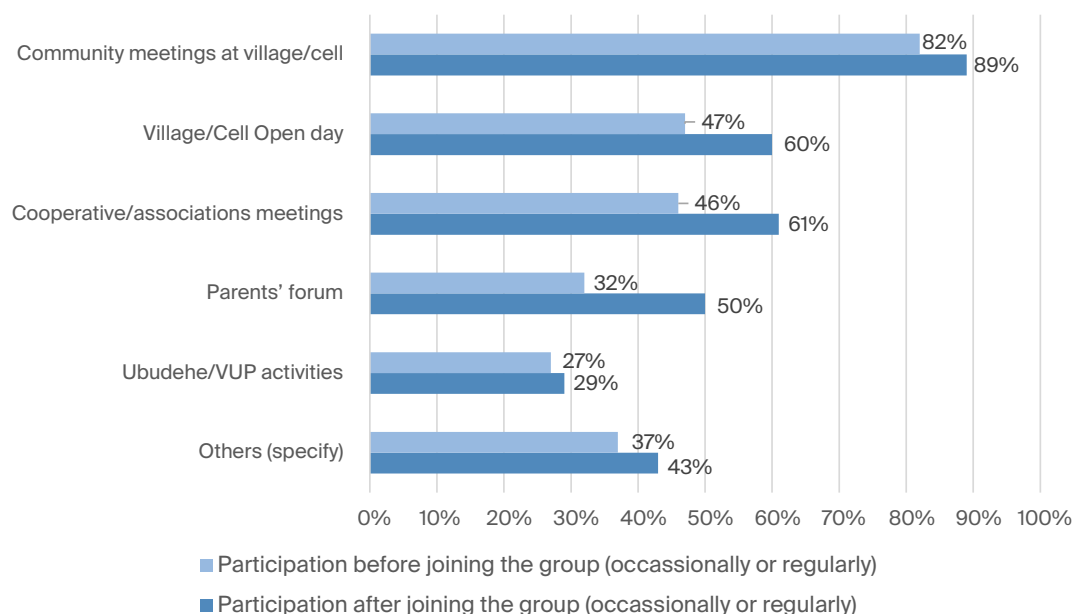
In additional questions on the motivation behind getting more engaged in forms of local governance and peacebuilding, individuals responded that ‘love for country’ was the primary motivator for getting engaged in peace activities, followed by desire to contribute to development of a community and country. Motivation did not come through family, nor community or local leadership pressure.

Participation in Community Development and Governance

The programme also sought to measure the impact of the activities on boosting participation in community development and leadership. This showed a modest but uptick of participants who became more engaged in a leadership position in the community as a consequence of the healing spaces. While 44.5% of people had been elected into leadership positions before and after their participation in the group, 9.8% of participants were elected after participating in the programme, having never been elected before. There are several potential qualifying aspects to this finding. Participants were asked if they held leadership positions in the past with no time restrictions. This was compared to holding a leadership position since joining the group, which ranged from two to three years. To truly understand the programme's impact on community development leadership, the questions would not only need to be posed at baseline and end line, they would need to include time limitations for requiring leadership positions before and after participation in the programme.

Figure 18. Participation in Community Development Events, before and after joining groups

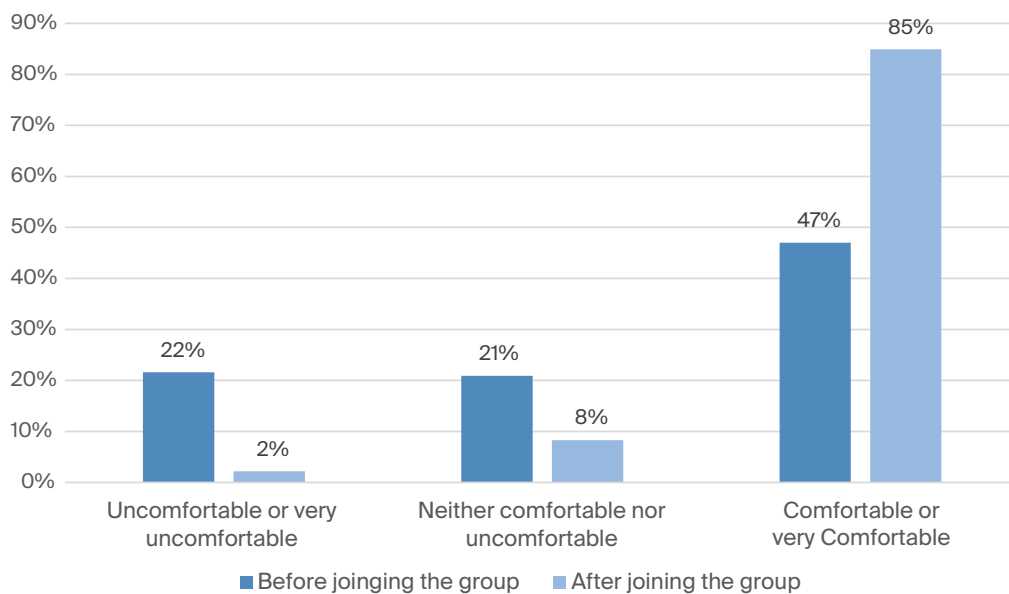
Participants reported that they participated in more community development events after joining the group than before joining the group. Participation in the Parents' Forum jumped most significantly, by 18%.



Participants were asked to rate their participation in a number of community development events which serve as a vehicle for public participation. The least significant changes in participation were in community meetings at the village and cell level, which most community members are expected to attend. While there were marked changes in participation in village/cell open day (13% increase), a mechanism for accountability, and cooperative/associate meetings (13% increase), the most significant change (18% increase) was participation in parents' forum. This finding is important because it suggests that the impacts on programme participants can have a spill-over effect on families, with parents playing a more active and engaged role in shaping the future of their children.

Figure 19. Comfort in participating in community events, before and after joining groups

Participants reported a significant increase in feeling comfortable in attending community events after joining the group.



Additionally, important changes were noticeable in the level of comfort of participants in participating in community events. While 47% noted that they felt comfortable or very comfortable participating in community events prior to joining the group, 85% reported feeling comfortable or very comfortable after joining the group, an increase of 38%. With regards to participation in consultation meetings organised by local leaders, 45% reported to regularly participate in these meetings, while 37% reported to occasionally participate in these meetings. In other questions on the motivation behind getting more engaged in forms of local governance and peacebuilding, individuals responded that 'love for country' was the primary motivator for getting engaged in peace activities followed by desire to contribute to the development of a community and country. Motivation did not come through family, nor community or local leadership pressure.

Annex 1. References

Barsalou, J. (2001). *Special Report: Training to Help Traumatized Populations*. United States Institute of Peace, 1-8.

Brouneus, K. (2010). *The Trauma of Truth Telling: Effects of Witnessing in the Rwandan Gacaca Courts on Psychological Health*. *The Journal of Conflict Resolution*, Vol. 54, No. 3, 421.

Bubenzer, F. and Tankink, M. (2015). *Conference Report: Healing Communities, Transforming Society. Exploring the interconnectedness between psychosocial needs, practice and peacebuilding*. The Institute for Justice and Reconciliation and War Trauma Foundation, 1-32.

Collins, P. Y., Insel, T. R., Chockalingam, A., Daar, A., Maddox, Y. T. (2013). *Grand challenges in global mental health: Integration in research, policy, and practice*. *PLoS Medicine*, Vol. 10, No.4, e1001434.

Epping-Jordan, J. E., Van Ommeren, M., Ashour, H. N., Maramis, A., Marini, A., Mohanraj, A., et al. (2015). *Beyond the crisis: Building back better mental health care in 10 emergency-affected areas using a longer-term perspective*. *International Journal of Mental Health Systems*, Vol. 9, No. 1, 15.

Government of the Republic of Rwanda (2016). Resolutions of the 14th National Umushyikirano Council (NUC). See:

http://gov.rw/newsdetails2/?tx_ttnews%5Btt_news%5D=1659&cHash=f2354dbcc11165fc4495fe708efecc19

Hamber, B. (1995). *Do Sleeping Dogs Lie? The psychological implications of the Truth and Reconciliation Commission in South Africa*. Paper presented at the Centre for the Study of Violence and Reconciliation, Seminar No. 5.

Hecker, T., Hermenau, K., Maedl, A., Elbert, T. and Schauer, M. (2012). *Appetitive aggression in former combatants—Derived from the ongoing conflict in DR Congo*. *International Journal of Law and Psychiatry*, Vol. 35, No. 3, 244–249.

Hester, L. (2016). *Examining Peacebuilding Through a Trauma Lens: Practitioner Reflections on Programmes for Youth Exposed to Traumatic Stressors in Intergroups Conflict*. *Peace and Conflict Studies*, Vol. 23, No. 2, Article 3.

Jones, W. and Murray, S. (2018). *Consolidating Peace and legitimacy in Rwanda*. LSE-Oxford Commission on State, Fragility, Growth and Development, 1-74.

Maercker, A., Hecker, T. (2016). *Broadening perspectives on trauma and recovery: a socio-interpersonal view of PTSD*. European Journal of Psychotraumatology. Vol. 7, No. 1, 29303.

Munyandamutsa, N., Mahoro Nkubamugisha, P., Gex-Fabry, M. and Eytan, A. (2012). *Mental and physical health in Rwanda 14 years after the genocide*. Social Psychiatry and Psychiatric Epidemiology, Vol. 47, No. 11, 1753-1761.

National Commission for the Fight Against Genocide, *Background*. See: <http://www.cnl.gov.rw/genocide/background/>

Never Again Rwanda and Interpeace (2015). *Societal Healing in Rwanda: Mapping of Actors and Approaches. A Report conducted by Never Again Rwanda and Interpeace as part of the Societal Healing and Participatory Governance for Sustainable Peace in Rwanda*, 1-79. See: <http://neveragainrwanda.org/research>

Ng, L.C. and Harerimana, B. (2016). *Mental health care in post-genocide Rwanda: evaluation of a program specializing in posttraumatic stress disorder and substance abuse*. Global Mental Health (Cambridge Core), Vol. 3, No. e18, 1-11.

Republic of Rwanda National Unity and Reconciliation Commission, *Reconciliation Tools: Home Grown Approaches*, See: <http://www.nurc.gov.rw/index.php?id=81>

Sareen, J. (2014). *Posttraumatic Stress Disorder in Adults: Impact, Comorbidity, Risk Factors, and Treatment*. Canadian Journal of Psychiatry, Vol. 59, No. 9, 460-467.

Schnurr, P., Lunney, C., Bovin, M. and Marx, B. (2009). *Posttraumatic stress disorder and quality of life: Extension of findings to veterans of the wars in Iraq and Afghanistan*. Clinical Psychology Review, Vol. 29, No. 8, 727-735.

Strauss, S. (2004). *How many perpetrators were there in the Rwandan genocide? An estimate*. Journal of Genocide Research, Vol. 6, No. 1, pg. 85-98.

United Nations, *Outreach program on the Rwanda Genocide and the United Nations*. See: <http://www.un.org/en/preventgenocide/rwanda/education/rwandagenocide.shtml>

Weierstall, R., Schalinski, I., Crombach, A., Hecker, T. and Elbert T. (2012). *When combat prevents PTSD symptoms—Results from a survey with former child soldiers in Northern Uganda*. BMC Psychiatry, Vol. 12, No. 41, 1-8.

Willman, A. (2014). *Trauma and Psychosocial Well-being: Is it our Business?* The World Bank. See: <http://blogs.worldbank.org/publicsphere/trauma-and-psychosocial-well-being-it-our-business>

Zelizer, C. (2008). *Trauma Sensitive Peace-Building: Lessons for Theory and Practice*. *Africa Peace and Conflict Journal*, Vol. 1, No. 1, 81-94.

Annex 2. Methodology

Questionnaire Design

The baseline questionnaire to assess trauma, trust and tolerance among participants was jointly designed by Never Again Rwanda (NAR), Interpeace, an advisory team of experts engaged to accompany the design and implementation of the healing initiatives under the programme as well as government institutions with mandates related to healing and reconciliation. NAR and Interpeace staff conducted a literature review of healing initiatives across the world and tools used to measure trauma, trust and tolerance. The elements of various tools were adapted to the Rwandan context and compiled into a questionnaire. NAR then sought guidance from an international expert in healing and reconciliation research who is the author of this baseline report. The questionnaire was vetted through a working group meeting of Rwandan experts in psychosocial healing and representatives of the National Unity and Reconciliation Commission and the National Commission for the Fight Against Genocide. This working group provided valuable inputs to adjust and update the questionnaire. The questionnaire was then translated in Kinyarwanda, a native language, to facilitate data collection. Finally, prior to data collection, the questionnaire was pilot tested and adjusted considering pilot study recommendations.

Baseline and End line Survey Data collection

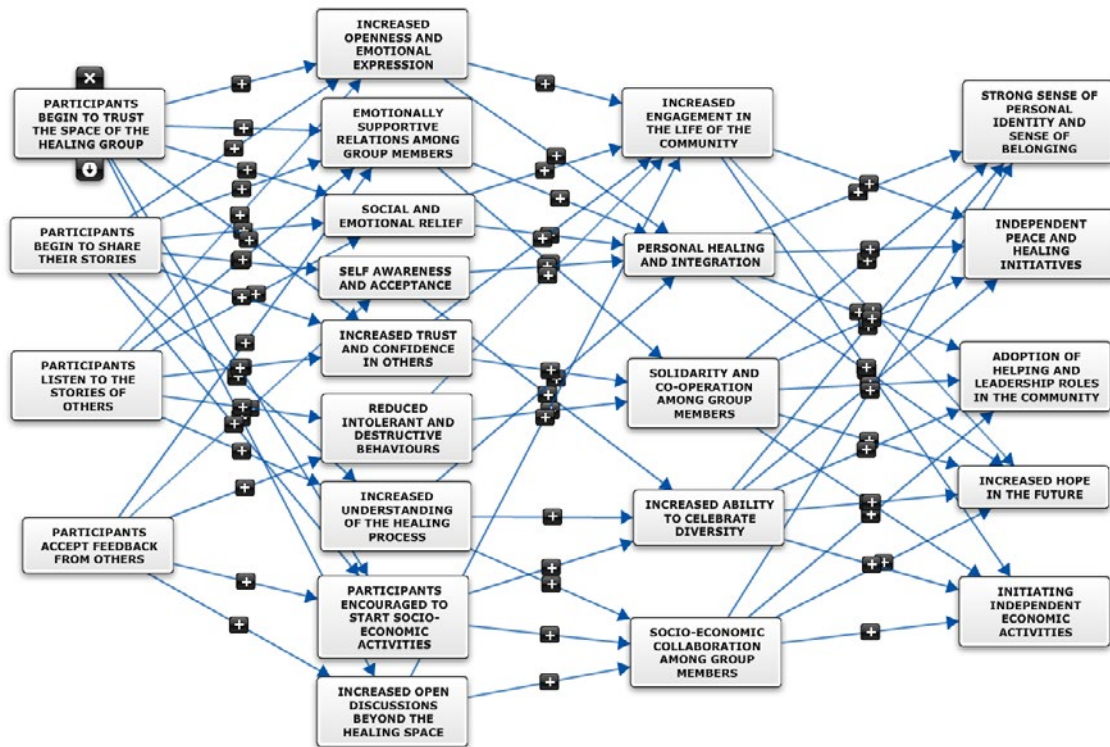
NAR and Interpeace decided to administer the baseline survey to 14 of the 15 groups that would be established during the programme in order to have a significant enough sample at end line that would enable statistical analysis. As mentioned above, many of the youth who participated in the baseline assessment were not able to be contacted for the end line. Table 3 shows a list of the groups surveyed and the number of people surveyed from each group both during the baseline and end line.

Table 3. Groups surveyed, gender disaggregated

District	Group code and Name	Male	Female	Total
Huye	A1	8	24	32
Gisagara	B1	0	26	26
Muhanga	C1	0	29	29
Gicumbi	D1	8	23	31
Gasabo	E1	18	9	27
Gasabo	E2	4	31	35
Nyarugenge	F1	10	18	28
Ngoma	G1	16	11	27
	Total	64	171	235

To ensure that high quality data was collected, a strong supervision of the data collection process was ensured by the NAR M&E expert. After the completion of questionnaires, each data enumerator handed them over to the M&E expert who checked the data collected. Any inconsistent data and empty spaces in questionnaires were directly filled or corrected by the data enumerators with the guidance of the M&E expert before leaving the field. After each day, a reflection meeting between data enumerators and the M&E expert was conducted to discuss challenges met and together find solutions, and plan, for the following day. The data was entered into a database by six trained data entry clerks over a period of five days. The process of data entry was supervised by the NAR M&E expert to ensure the quality of data. The data was then cleaned and validated to remove data anomalies before advancing with the data analysis.

Figure 19. Process of trust and healing theory of change



Annex 3. Effect Size Results

To calculate targets from baseline to end line indicators, the ‘effect size’ method was used. To estimate the effect size, one must start with calculating the mean and standard deviation of the index to be assessed. In the case of trauma, trust and tolerance indices, the relevant means and standard deviations, also disaggregated by type of group and gender in this case, are shown below. Similar principles were utilized to calculate targets for peace activism initiatives. According to these statistics, we can denote a small effect size as a change of 0.2 standard deviations; a moderate effect size as a change of 0.5 standard deviations; and a large effect size as a change of 0.8 standard deviations. Effect sizes that are greater than 1.0 are in scientific literature typically describes as ‘huge’.

Table 4. Indices and their sub components, mean baseline scores out of 10 compared to end line and effect size

Key	Indicator	Mean Baseline	Mean Endline	Std. Deviation Baseline	Std. Deviation Endline	Cohen's d (Effect Size)	Classification of Effect Size
1	Index: Impact of Trauma	3.20	2.39	2.10	1.84	0.41	medium effect
	Trauma Index (experience and effect)						
2	Index: Victim of violence	1.98	1.48	2.36	2.08	0.22	small effect
3	Index: Victim of property crimes	3.18	2.37	3.62	3.04	0.24	small effect
4	Index: Exposure of violence against others	4.53	3.62	4.40	3.86	0.22	small effect
5	Index: Victimization in the community	2.69	1.76	2.52	1.99	0.41	medium effect
	Psychological Distress and Resilience						
6	Index: Post traumatic distress	4.18	2.66	3.05	2.26	0.57	medium effect
7	Index: Poor self-esteem and guilt	2.44	1.45	2.69	1.85	0.43	medium effect
8	Index: Anger	2.07	1.18	2.58	1.78	0.40	medium effect
9	Index: Psychological resilience	6.88	8.57	2.13	1.18	0.98	large effect
	Forgiveness and Revenge						
10	Index: Forgiveness in practice	5.52	6.26	2.45	1.66	0.35	small effect
11	Index: Forgiveness in theory	3.87	4.64	2.52	2.21	0.32	small effect
12	Index: Revenge tendency	0.54	0.12	1.14	0.48	0.48	medium effect
13	Index: Trust	4.81	7.56	2.26	1.31	1.49	huge effect
	Healing Spaces Index						
14	Index: Readiness for social interaction	5.72	8.42	2.44	1.27	1.39	very large effect
15	Index: Readiness for personal sharing	4.43	7.80	2.80	1.64	1.47	huge effect
16	Index: Readiness for trauma expression	4.87	6.67	2.43	1.81	0.84	large effect
17	Index: Readiness for daily life partnerships	4.21	7.36	2.78	1.81	1.35	very large effect

Key	Indicator	Mean Baseline	Mean Endline	Std. Deviation Baseline	Std. Deviation Endline	Cohen's d (Effect Size)	Classification of Effect Size
	Readiness for trauma expression beyond groups						
18	Index: Social Tolerance	6.20	7.43	1.57	1.47	0.81	large effect
19	Social Tolerance Index: Socially disadvantaged group	6.26	7.48	1.79	1.70	0.70	medium effect
20	Social Proximity Index: Inflowing populations	5.64	6.94	1.93	1.82	0.70	medium effect
21	Social Proximity Index: Social ingroups	7.38	8.45	1.41	1.23	0.81	large effect
22	Social Proximity Index: Ex-genocide perpetrators	4.57	6.02	2.64	2.45	0.57	medium effect
23	Social Proximity Index: Genocide Survivors	7.15	8.27	1.86	1.43	0.67	medium effect
	Index: Peace Activism and Community Participation						
	Peace Activism Index						
24	Index: Peace Activism of Healing Spaces	0.94	1.33	1.31	1.54	0.28	small effect
25	Index: Peace Activism of Youth Peace Dialogues	1.01	1.25	1.43	1.53	0.16	small effect
26	Index: Contact Quality – Socially disadvantaged groups	6.68	7.24	1.08	1.23	0.49	medium effect
27	Index: Contact Quality - Social Outgroups	6.61	7.03	0.84	0.93	0.48	medium effect
28	Index: Contact Quality – Ex-genocide perpetrators	6.24	6.68	0.81	0.99	0.48	medium effect
29	Index: Contact Quality – Genocide survivors	7.09	7.51	1.44	1.45	0.30	small effect
30	Index: Contact Quantity – Socially disadvantaged groups	5.98	6.11	2.25	2.20	0.06	negligible effect
31	Index: Contact Quantity - Social outgroups	4.40	4.71	2.02	1.90	0.16	small effect
32	Index: Contact Quantity – Ex-genocide perpetrators	3.05	3.17	2.64	2.64	0.05	negligible effect
33	Index: Contact Quantity - Genocide Survivors	6.70	6.81	2.84	2.43	0.04	negligible effect
34	Index: Sharing Story with socially disadvantaged groups	5.12	6.28	2.77	2.68	0.43	medium effect
35	Index: Sharing Story with social outgroups	3.54	4.43	2.44	2.48	0.36	small effect
36	Index: Sharing Story with ex-genocide perpetrators	3.17	4.16	2.83	2.91	0.35	small effect
37	Index: Sharing Story with Genocide survivors	6.19	7.04	2.77	2.48	0.33	small effect
38	Index: Community Development Participation	3.55	4.92	2.39	2.66	0.54	medium effect
39	Index: Comfort in Community Participation	5.80	8.22	2.74	1.79	1.05	large effect

Trauma Index (experience and effect)
Index: Victim of violence
Torture
Permanent Disability
Being a Victim of Physical Assault
Sexual Violence from Someone outside your family
Index: Victim of property crimes
Destruction/vandalisation of house
Destruction/vandalisation of crops
Eviction from land/house
Index: Exposure of violence against others
Have learned of extreme violence suffered by a close relative or his/her death
Witnessing violence or the death of someone, Witnessed atrocities, e.g. mass killings
Index: Victimization in the community
Forced to do things you do not want to do
False imprisonment
Lack of adequate justice
Experiencing Maltreatment by other people in the community (i.e. school, work, neighbors, ...)

Psychological Distress and Resilience
Index: Post Traumatic Distress
I have really bad memories or dreams
I worry a lot about bad things that could happen
I feel depressed or very sad
Experienced Avoidance
I feel like I am ready to explode due to grief
Experiencing Anxiety
Experienced Somatic illness
I lack peace in my heart
Experienced isolation/restriction of relationship
Experienced constant headaches
Index: Poor self-esteem & guilt
I feel worthless

I think about death or suicide
I feel that my life is unfair compared to the lives of others
I feel bad about things that I have done
Index: Anger
I become so mad that I may break things
I become so mad that I may hit people
I have trouble controlling my temper
Index: Psychological resilience
I usually manage one way or another
I feel proud that I have accomplished things in my life
I usually take things in stride
I am friends with myself
I feel that I can handle many things at a time
I am determined
I can get through difficult times because I've experienced difficulty before
I have self-discipline
I keep interested in things
I can usually find something to laugh about
My belief in myself gets me through hard times
In an emergency, I'm someone people generally can rely
My life has meaning
When I'm in a difficult situation I can usually find my way out of

Forgiveness and Revenge
If happened, I feel that I can forgive someone who raped me/my relatives
If happened, I feel that I can forgive someone who poisoned my child/relative
If happened, I feel I can forgive someone who did other bad things to me or to my family
If happened, I feel that I can forgive someone who killed my parents/children/ relatives
If happened, I feel that I can forgive someone who make my child pregnant before the adult age
If happened, I feel that I can forgive someone who destroyed my properties



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