



**Reinforcing community capacity for social cohesion through societal trauma healing in Bugesera pilot programme**

# **End-line Programme Evaluation Report**

**Kigali, April 2023**

**Evaluators: Shyaka Mugabe Aggée & Interayamahanga Révérien**



Funded by the European Union through its Instrument contributing to Stability and Peace





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## List of Acronyms

<b>AVEGA</b>	Association des Veuves du Génocide-Agahozo
<b>CDF</b>	Community dialogue facilitators
<b>CNLG</b>	Commission Nationale de Lutte contre le Génocide
<b>CO-LIVE</b>	Collaborative livelihoods
<b>CSO</b>	Civil society organisation
<b>DMEL</b>	Design, monitoring, evaluation and learning
<b>EU</b>	European Union
<b>FGD</b>	Focus group discussion
<b>GAERG</b>	Groupe des Anciens Etudiants Rescapés du Génocide
<b>JADF</b>	Joint Action Development Forum
<b>KII</b>	Key informant interview
<b>MFH</b>	Multifamily healing spaces
<b>MHPSS</b>	Mental health and psychosocial support
<b>MINUBUMWE</b>	Ministry of National Unity and Civic Engagement
<b>NISR</b>	National Institute of Statistics of Rwanda
<b>OECD</b>	Organisation for Economic Cooperation and Development
<b>PFR</b>	Prison Fellowship Rwanda
<b>RBC</b>	Rwanda Biomedical Centre
<b>RCS</b>	Rwanda Correctional Service
<b>ROT</b>	Resilience-oriented therapy
<b>RWW</b>	Rwanda We Want
<b>TVET</b>	Technical and vocational education and training

# Executive Summary

From October 2020 to September 2022, in association with Prison Fellowship Rwanda (PFR) and in partnership with the Government of Rwanda through the former National Unity and Reconciliation Commission (NURC), now the Ministry of National Unity and Civic Engagement (MINUBUMWE), Interpeace implemented a Programme funded by the European Union (EU), titled **‘Reinforcing community capacity for social cohesion and reconciliation through societal trauma healing’** in Bugesera District, in the Eastern Province of Rwanda. The overall goal of the Programme was “to reinforce social cohesion and sustainable peace through scaling up community-based healing initiatives”. A total of 6,770 people, including 3,385 men and 3,385 women<sup>1</sup> participated in the Programme, including survivors of the 1994 Genocide against the Tutsi and their offspring, former Genocide perpetrators and their offspring, and prisoners currently detained in Bugesera Prison.

This end-line evaluation report is an integral part of the Programme plan. Its purpose is to assess the Programme’s outcomes, achievements, challenges, and lessons learned. More specifically, it evaluates the Programme’s relevance, effectiveness and impact, sustainability, coherence, efficiency, and what has been learned, as well as gender and youth inclusion.

The evaluation methodology combined several strategies, including post-intervention screening (endline-survey), and outcome harvesting. Through a mixed quantitative and qualitative approach, the evaluation applied four data collection methods: desk review; a questionnaire survey; focus group discussions (FGDs); and key informant interviews (KIIs). The desk review focused on Programme documents, monitoring reports and relevant literature. The questionnaire was administered to a total of 1,298 people, including 1,257 individuals from all 15 sectors of Bugesera District (576 men and 681 women), plus 41 men from Bugesera Prison. All had graduated from sociotherapy groups. The FGDs targeted three categories of Programme participant: sociotherapy graduates; multi-family healing space graduates; and participants in collaborative livelihood initiatives (CO-LIVE). A total of 26 FGDs were organised with a range of Programme participants, including prisoners from Bugesera Prison. KIIs were organised with Programme stakeholders from the MINUBUMWE, Rwanda Biomedical Center (RBC) and District of Bugesera. A dozen KIIs were conducted.

One overall finding is that the Programme achieved its initial goal: it increased social cohesion and sustainable peace by providing better access to mental health services, improved livelihoods as well as community dialogue and therapy in the district of Bugesera. The main beneficiaries were genocide survivors and former genocide perpetrators and their relatives.

More specifically, the end-line evaluation found that:

- The Programme responded to real and pressing needs for mental health support, social cohesion, and economic livelihoods. The Programme’s interventions made a direct contribution to Rwanda’s efforts to address the legacy of the Genocide against the Tutsi, including the country’s mental health issues as documented by the 2018 Rwanda Mental Health Survey. Moreover, one of MINUBUMWE’s core mandates is to enhance societal healing and social cohesion in the post-Genocide context. The Programme was perceived to have added value to the government’s efforts to boost social cohesion and livelihoods. In substance, the Programme was said to have “added real value” by participants, officials in Bugesera District, mental health experts, and central government partners.
- In terms of effectiveness, the evaluation found that, to a very large extent, the Programme has achieved its targets. A calculation of the differences between endline achievements and Programme targets suggests

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<sup>1</sup> Programme quarterly progressive report, July-September 2022, p. 2.



that, cumulatively, 86.7% of targets were fully achieved (100% or more), and 6.7% of the targets were substantially achieved (between 75% and 99%). With regard to outcome indicators, the Programme contributed to positive changes according to nine out of ten indicators.

- With regard to impact, the Programme led to remarkable changes at individual, family, community and institutional level. The impacts reported include: reduced trauma/psychological wounds; an increased sense of safety among Programme participants; better communication and engagement between spouses and parents and children; a decline in marital conflict; improved trust between the Programme core target groups (Genocide survivors and Genocide perpetrators and their respective relatives); improved livelihoods; increased knowledge and stronger socio-emotional skills. Unintended effects included: the formation of informal, inclusive financial schemes by members of the healing spaces, that contributed to cementing social relations among group members, particularly youth from different family backgrounds. In a similar vein, the Programme yielded some unintended positive gendered impacts. These include exposing men's vulnerability and hence triggering a sense of healing and communion, impact on reversed gender roles in post-genocide context, mitigating effects of negative masculinities among some male participants, building women's confidence and increased awareness about sexual abuses.
- At institutional level, government officials praised the Programme for building institutional capacity both at local and national level. For instance, Programme interventions have improved the country's mental health facilities by strengthening the mental health capacity of Nyamata Hospital and the district's health centres, as well as the resources of therapists and facilitators. The Programme also provided Bugesera District with a mobile clinic and other context-relevant mental health tools and health equipment necessary to provide services of appropriate quality. In addition, the Programme helped to create trauma-informed leadership in the district. This was achieved thanks to organisation and facilitation of a psychoeducation initiative for local leaders and relevant opinion leaders. Moreover, the Programme outputs, including the baseline survey report and MHPSS actor mapping report, are important assets that district authorities can use to inform the district planning process. Nationally, the Programme has made available important tools for societal healing, namely protocols for mental health and psychosocial support (MHPSS) that are relevant to Rwanda's context. The MHPSS protocols not only helped to implement the Programme, they promoted a comprehensive approach to peacebuilding in Rwanda (evidenced by the Programme's results).
- The evaluation suggests that Programme resources have largely been used efficiently. This can be attributed to the design of the Programme, but also to the adaptability and flexibility of Programme interventions on the ground, and readiness to adapt to contextual issues and challenges. Three key factors have contributed to efficiency: the involvement of national and local authorities from the Programme's inception; reliance on local/community-based human resources; and collaboration between health structures.
- By design, the pilot programme for "reinforcing community capacity for social cohesion and reconciliation through societal trauma healing in Bugesera District" was gender and youth sensitive. The language of the Programme document, for example, was gender and youth sensitive and key gender-related words are evident. Gender and related terms are used 37 times, while youth and related terms are used 70 times. Furthermore, the Programme document dedicated an important section to gender and youth inclusion. As a result, the selection of participants in Programme spaces, as well as community facilitators and therapists, and the facilitation content and the spaces used for facilitation were all gender and youth responsive.
- Several factors supported the Programme's sustainability. The district is committed to mainstreaming mental health in its annual planning, and to lifetime acquisition of knowledge and skills, including TVET. Health structures have bought into the development of socio-emotional skills. There is commitment to the protocols and income-generating initiatives that bring together people from different backgrounds. We can also mention the collaborative efforts spearheaded by the MINUBUMWE.

- Programme good practices include flexibility in activity implementation; healthy collaboration with national and district authorities; and empowerment of community-based facilitators and therapists. The multi-family approach has empowered family members to engage constructively while promoting inter-family reconciliation. The evaluation also found that CO-LIVE is primarily driven by the desire of people to stay together in order to build and strengthen community cohesion.

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## Recommendations

Despite significant achievements and the impacts summarised above, the Programme faced a number of challenges and limitations that should be taken into account if similar Programmes are developed, or this Programme is scaled up in the future. Major intervention issues included: lack of baseline and post-intervention data on multi-family healing spaces (MFHS) and resilience-oriented therapy (ROT); inadequate oversight of Programme implementation and supervision of therapists and CDFs; lack of a Programme advocacy strategy; and the limited reach of Programme healing spaces relative to needs. Based on the challenges identified, the evaluation's recommendations can be summarised as follows:

- Integrate disasters such as COVID-19 in implementation risks and prepare a contingency plan to mitigate their effects on the Programme (or the Programme's scale-up and extension).
- Adjust the protocols based on lessons learnt, and continue advocacy efforts to institutionalise them at the centre and locally.
- Set up a local joint monitoring and evaluation (M&E) committee to ensure that all parties are on track to fulfil their commitments, and that needed technical support is identified and provided promptly.
- Develop and operationalise a Programme advocacy strategy.
- Coordinate the CO-LIVE pillar across all Programme healing spaces to ensure that all the variables of the theory of change are connected.
- Increase funding to enable the Programme to achieve a wider coverage.
- Collaborate with local MHPSS partners and assist them to extend Programme protocols to community members who are not currently reached by Programme interventions.
- Increase the number of youth skills hubs to make them more accessible to youth.
- Revise the Programme's logframe and M&E framework to integrate expected outcomes from life skills, mediation, and psychoeducation training.
- Review the age range criteria for inclusion in the Programme in light of lessons learned, and align it with Rwanda's national youth policy (16-30).

# 1

## Introduction

# I. Introduction

The Programme ‘Reinforcing community capacity for social cohesion and reconciliation through societal trauma healing in Bugesera District’ is a contribution to Rwanda’s efforts to promote mental health, socioeconomic development and social cohesion. The pilot phase ran from October 2020 to September 2022. It targeted a total of 6,770 people, including 3,385 men and 3,385 women.<sup>2</sup> This section presents the background to, the goal and objectives of the Programme, and the Programme’s theory of change (ToC) and evaluation methodology.

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## 1.1 Background to the Programme

From October 2020 to September 2022, in partnership with Prison Fellowship Rwanda (PFR) and the Government of Rwanda, through the former National Unity and Reconciliation Commission (NURC), now the new Ministry of National Unity and Citizen Engagement (MINUBUMWE), Interpeace implemented a pilot programme funded by the European Union (EU), titled ‘Reinforcing community capacity for social cohesion and reconciliation through societal trauma healing’ in Bugesera District, in the Eastern Province.

Programme participants included survivors of the Genocide against the Tutsi and their families; former Genocide prisoners living in Bugesera District (including some who may have been held in other districts); current prisoners from Bugesera Prison and their families; and youth, particularly the children of Genocide survivors and Genocide perpetrators who are likely to have experienced the effects of intergenerational transmission of trauma.

Targeting Genocide survivors and perpetrators was therefore deliberate, in order to:

- Promote social cohesion between these two groups.
- Assist the reintegration of former Genocide prisoners, lessen the impact that their release might have on survivors and their own families, and reduce incentives for former Genocide prisoners to join extremist groups in neighbouring countries;
- Promote societal trauma healing for survivors and former Genocide prisoners.
- Address intergenerational transmission of trauma from victims and perpetrators of the Genocide to younger generations.

Geographically, the Programme focused on Bugesera District (including selected schools in the district and Bugesera prison), a region just over 40 kilometres south of Kigali. Bugesera was selected because of its particular experience during the 1994 Genocide against the Tutsi. Because it was among the worst affected districts, its need for mental health services and social cohesion is particularly high. Many of the Tutsi killed in Bugesera in 1994 had been deported from other regions (such as Bufundu, Bunyambiriri, Gitarama, and Ruhengeri) in the early 1960s (Commission Nationale de Lutte contre le Génocide [CNLG], n.d). Some authors consider that Bugesera was used to pilot the Genocide. According to Muse (2021), State-run radio broadcasts incited militias in March 1992 to murder Tutsi civilians and political opponents of Habyarimana’s government in Bugesera. This would later be referred to as a “dress rehearsal” for the Genocide (p. 572). Currently, Bugesera District hosts two of six national memorial sites in Rwanda (National Commission for the Fight against the Genocide, n.d.).

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<sup>2</sup> Programme quarterly progressive report, July-September 2022, p.2

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## 1.2 The Programme's goal and objectives

As defined in the Programme document, the overall goal of the Programme was “to reinforce social cohesion and sustainable peace through scaling up community-based healing initiatives”. From this goal, four specific objectives were derived:

1. To integrate into mental health and prisoner reintegration protocols and community-based methods for addressing past wounds and promoting social cohesion, in 15 sectors of Bugesera District.
2. To increase social cohesion in target communities by collective healing and socio-economic development activities.
3. To provide youth with skills and spaces to manage past trauma, and develop a shared understanding for building a peaceful and inclusive future, including through joint income-generating initiatives.
4. To draw lessons from this pilot phase that might inform national policies and programmes on mental health and social cohesion.

A mixed approach to implementation was adopted, which combined: the development or strengthening of protocols to support infrastructure for the provision of mental health services; facilitation of community healing dialogues; socio-emotional skills training; technical and vocational skills training (for youth and prisoners); livelihood and financial skills capacity building; and provision of start-up capital for community-based collaborative livelihood projects for graduates from youth TVET and healing spaces.

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## 1.3 The Programme's theory of change (ToC)

A theory of change “explains how a given intervention, or set of interventions, is expected to lead to specific development change, drawing on a causal analysis based on available evidence”.<sup>3</sup> The Programme's theory of change ran as follows:

**IF** evidence-based, Rwandan-context appropriate protocols for assessment and group-based interventions are developed **AND IF** a comprehensive training programme on how to deliver such interventions is offered to specialists **AND IF** epidemiological research and individualised assessments take place and the intervention priorities at the macro and micro level are established, **THEN** there will be an infrastructure for the provision of on-going mental health, livelihood and social cohesion building support in the district of Bugesera **BECAUSE** there will be an established and coordinated framework to deploy and capacitate therapists and trainers to conduct effective interventions with Genocide survivors and released Genocide perpetrators, and with youth in Bugesera District.

**IF** therapists and trainers support current and former Genocide prisoners through life skills training, basic livelihood skills training, cultural sensitivity training, multi-family group therapy, and diagnosis-specific clinical groups **AND IF** therapists and trainers also support Genocide survivors through life skills training, basic livelihood skills training, and group-based trauma healing, **THEN** there will be a reduction of tensions and risk of violence within families and between community members **BECAUSE** members of vulnerable groups will have enhanced skills and capacities to engage in dialogue with those of different backgrounds and experiences and trust, understanding and tolerance to engage in collective livelihood initiative will also improve.

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3 United Nations Development Group, 'Theory of change: UNDAF companion guidance', p. 4, <https://unsdg.un.org/sites/default/files/UNDG-UNDAF-Companion-Pieces-7-Theory-of-Change.pdf>.

**IF** therapists and trainers support young people through life skills training, group-based counselling, and dialogue **AND IF** younger people constructively engage with older community members in the context of inter-generational healing spaces, **THEN** youth will be less motivated to engage in violence **BECAUSE** young people will have reduced their traumas and acquired a positive sense of personal and common purpose while being empowered to meaningfully contribute to community-wide healing and collaborative livelihoods (CO-LIVE) initiatives.

**IF** this Programme is diligently monitored for impact through a baseline and endline epidemiological survey, randomised clinical trials and outcome harvesting **AND IF** evidence of Programme impact is captured through policy reports and documentaries which are appropriately disseminated to policy stakeholders and the general public, **THEN** there will be increased interest and motivation by national and international policy stakeholders to integrate lessons learned into national policies and practices and scale up the Programme to other districts of Rwanda **BECAUSE** stakeholders will have built consensus on key recommendations for improving mental health and social cohesion policy based on the evidence generated and lessons learnt from the programming and there will be finalised and validated tools for replicating the intervention across Rwanda.

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## 1.4 Purpose of the evaluation

The aim of the evaluation was to assess the outcomes, achievements, challenges, and lessons learned from the Programme using a combination of strategies, including post-intervention screening (endline survey) and outcome harvesting. The evaluation examined the impact of the Programme to inform future strategies for Rwanda societal healing and peacebuilding Programmes and similar Programmes that Interpeace and partners might implement.

The Programme design relied on an outcome mapping approach, and its theory of change guided the evaluation's methodology. The evaluation was guided by eight criteria, namely (1) relevance; (2) effectiveness and impact; (3) sustainability; (4) coherence; (5) efficiency; (6) learning; (7) gender and inclusion; and (8) project design improvement. Each of these criteria raised key questions that guided the process. A list of evaluation questions is appended to this report (See appendix 1).

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## 1.5 Evaluation methodology

The evaluation has used a **mixed methods approach**. It collected both quantitative and qualitative data, using four principal methods: a post-intervention screening questionnaire, a desk review, focus group discussions (FGDs) and key informant interviews (KIIs).

Quantitatively, the screening questionnaire was used to gather data from project boundary partners (participants). A total of 1,298 questionnaires were distributed, including to 1,257 individuals (576 men and 681 women) from all 15 sectors of Bugesera District, plus 41 men from Bugesera Prison. All had graduated from sociotherapy groups. All the participants in the first and second intakes participated in the endline survey (with the exception of people who were not available during the data collection period). Because it enabled endline evaluation results to be compared with the results of pre-intervention screening and baseline data, this method helped to clarify the pilot programme's progress and achievements.

Qualitatively, the evaluation relied on a desk review, FGDs and KIIs to collect feedback. The desk review assessed the Programme documents (particularly the results framework and the baseline report) as well as implementation progress reports issued during the pilot phase. This information enabled the evaluator to understand the Programme goals, objectives, and expected outputs and outcomes, and to document success stories, challenges and lessons learned.

FGDs collected evidence of change (from the perspective of participants) and helped to document participants' change stories, programme areas that needed improvement, and gaps and challenges that future phases of the Programme will need to address. FGDs targeted three groups of participants: sociotherapy graduates, multi-family healing graduates, and participants in CO-LIVE initiatives. A total of 26 FGDs were organised for selected community members and prisoners.

With respect to sociotherapy graduates (Genocide survivors, former Genocide prisoners and current prisoners as well as their respective relatives), FGDs focused on Programme outcomes that addressed safety, trust, tolerance, mutual care and compassion, and forgiveness traits. They also explored how individuals had discussed and overcome past conflicts and trauma, and progressed towards adoption of new life goals. With respect to multi-family healing graduates, FGDs assessed how interventions had helped to reduce intergenerational transmission of trauma, and improved family solidarity, intra-family communication, and social (inter-family) interactions.

With respect to graduates of CO-LIVE initiatives, FGDs explored whether the support the Programme had provided had helped to build participants' confidence, sense of purpose and hope for the future.

KIIs were conducted with selected government stakeholders, CSO representatives, and experts, who had witnessed or experienced the Programme's interventions in Bugesera District. (See Appendix 2 for FGD guides, Appendix 3 for KIIs main themes. Also see Appendix 4 for the list of key informants)

## Data collection and data analysis

Quantitative data was collected by skilled and trained enumerators, recruited from among the technicians who participated in data collection for the baseline or pre-intervention screening. To take account of gender sensitivity, efforts were made, wherever feasible, to ensure that male enumerators interviewed male respondents and female enumerators interviewed female respondents. To speed up data collection and ensure its quality, a tablet-based questionnaire was used, supported by Kobo Toolbox software. For qualitative data, FGDs and KIIs were facilitated by skilled and experienced researchers, who were supported by the Programme's psychotherapists to ensure that potential psychological crises were properly managed. Given the tight timeframe of the evaluation, skilled note-takers supported the FGDs and KIIs facilitation team. Notes and daily summaries were used in qualitative data analysis. A note-taking template was developed and shared with note-takers, who were trained to use it.

With respect to data analysis, the statistician/data analyst imported data from the server. It was then cleaned and analysed by running frequencies, cross tabulations and relevant statistical tests. The evaluation used SPSS software.

To analyse the qualitative data, the meeting notes and daily discussion summaries were analysed using a thematic analysis method. This considered the eight evaluation criteria and related questions as well as the Programme's theory of change.

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## 1.6 Gender and youth inclusion analysis

To be successful, societal healing programmes in post-conflict contexts need to take into consideration sensitivities associated with gender, age and the historical context. A gender and youth inclusion analysis was carried out for the purpose of this endline evaluation. Appendix 5 presents key elements that were considered for the gender analysis in the Programme endline evaluation.

# 2

## Evaluation Findings



## II. Evaluation Findings

This chapter presents the findings of the end-term evaluation. The findings are aligned with the seven evaluation criteria, namely: (1) relevance, (2) effectiveness and impact, (3) sustainability, (4) coherence, (5) efficiency, (6) gender and youth inclusion and (7) learning. The chapter also examines major challenges and gaps faced by the programme, while recommendations to address them in the design of future similar initiatives or the extension of the programme are formulated in a separate chapter

### 2.1 Respondents' demographics

Before presenting the evaluation results, this section describes some socio-demographic characteristics of the respondents.<sup>4</sup> Respondents were selected from pilot Programme participants who graduated from multifamily healing spaces, sociotherapy groups and collaborative livelihood (Co-Live) initiatives. They completed a questionnaire that was designed to enable the Programme to measure its effectiveness by comparing post-intervention data with pre-intervention data. Key variables of the respondents included sex, marital status, level of education, occupation, and historical background. See Table 3.

**Table 1. Respondents' demographics**

Variable	Count	%	Variable	Count	%
<b>Sex</b>			<b>Occupation</b>		
Male	576	45.8	Government employee	4	0.3
Female	681	54.2	Non-government employee	31	2.5
<b>Total</b>	<b>1257</b>	<b>100.0</b>	Self-employed	37	2.9
<b>Marital status</b>			Non-paid	23	1.8
Married	514	40.9	Student	59	4.7
Cohabitation	241	19.2	Unemployed	136	10.8
Polygamous union	3	0.2	Retired	25	2.0
Separated	38	3.0	Incapacitated	34	2.7
Widow(er)	133	10.6	Farmer	841	66.9
Divorced	5	0.4	Casual labourers	67	5.3
Single	323	25.7	<b>Total</b>	<b>1257</b>	<b>100.0</b>
<b>Total</b>	<b>1257</b>	<b>100.0</b>	<b>Historical background</b>		
<b>Level of education</b>			Youth born of Genocide survivor	227	18.1
No formal schooling	226	18.0	Youth born of rape	3	0.2
Primary school	701	55.8	Youth born of perpetrators	221	17.6
Catch-up	22	1.8	Youth born of ex-combatants	9	0.7
Ordinary level	167	13.3	Youth born of returnees (old and new cases)	25	2.0

<sup>4</sup> These were selected from pilot Programme participants who graduated from sociotherapy groups and collaborative livelihood groups/initiatives

Variable	Count	%	Variable	Count	%
Advanced level	105	8.4	Genocide survivor	414	32.9
Vocational training	20	1.6	Former Genocide prisoner	221	17.6
College/University	7	0.6	Genocide survivor - victim of rape	8	0.6
Postgraduate	7	0.6	Spouse of former Genocide prisoner	60	4.8
Masters	2	0.2	Returnee	18	1.4
<b>Total</b>	<b>1257</b>	<b>100.0</b>	Subtotal	1206	95.9
			General population	51	4.1
			<b>Total</b>	<b>1257</b>	<b>100.0</b>

#### Prisoners from Bugesera Prison

Sex	Count	Percent	Education	Frequency	Percent
Male	41	100.0	No formal schooling	21	51.2
<b>Total</b>	<b>41</b>	<b>100</b>	Primary school	16	39.0
			Secondary school-0 Level	3	7.3
<b>Marital Status</b>	<b>Frequency</b>	<b>Percent</b>	Secondary school-A Level	1	2.4
Married	21	51.2	<b>Total</b>	<b>41</b>	<b>100.0</b>
Cohabitation	10	24.4			
Separated	1	2.4			
Widower	7	17.1			
Divorced	1	2.4			
Single	1	2.4			
<b>Total</b>	<b>41</b>	<b>100.0</b>			

Slightly over half of respondents were female (54%). The majority (6 in 10) were married (of whom 40.9% were legally married and 19.2% in cohabitation). One in ten respondents were widows or widowers; one quarter of the respondents (25.7%) were single, most of whom are likely to be youth.

Most of the respondents did not have basic education (primary and lower secondary education). While nearly 2 in 10 had no formal education, nearly 9 in 10 had not achieved secondary education. In other words, only 1 in 10 respondents had at least basic education. With respect to occupation, the majority of respondents (close to 7 in 10) were farmers (in most cases small landholders), while 1 in 10 of all respondents was able to work but currently unemployed. The data collected also suggest that an important share of respondents (16.5%) held low-earning or non-productive positions (for example, were students, or were incapacitated, or in unpaid or casual work). Including the unemployed, at least one fifth of all respondents were not generating any income at the time data were collected for the evaluation.

With respect to historical background, half of the respondents (51%) were either Genocide survivors (32.9%, almost one third) or the offspring of Genocide survivors (18.1%, nearly 2 in 10). Former Genocide prisoners and their relatives (children and spouses) together accounted for 4 in 10 respondents. Overall, at least 9 of every 10 respondents were either Genocide survivors or former Genocide prisoners. This makes sense in that these were the core target populations of the pilot programme.

With respect to the participants in Bugesera Prison, all were male because the prison hosts only male inmates. Half were married, while about a quarter were in *de facto* unions, and close to two in ten were widowers. With re-

spect to education, a very large majority of the current prisoners interviewed had no basic education. Nine in ten had not achieved more than primary education.

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## 2.2 Relevance of the pilot programme

In project evaluation, relevance criteria measure the extent to which an intervention is doing the right things (OECD, 2019, p. 7). The general objective of the pilot programme under review reads: “the approach to mental health and trauma healing in Rwanda reinforces social cohesion through the scaling up of evidence-based community-based healing and development methods” (Interpeace, n.d., p. 9). The Programme was therefore assessed for its relevance to: (1) the national context; (2) Bugesera District; (3) its leaders and staff; and (4) the Programme’s participants. Those who contributed to the evaluation agreed unanimously that the pilot Programme was relevant.

### 2.2.1 Relevance for the national context

Twenty-eight years after the Genocide against the Tutsi, Rwanda has made significant progress in rebuilding the State as well as reconciliation and national unity (National Unity and Reconciliation Commission [NURC], Rwanda Reconciliation Barometer, 2020). Despite this, the country still faces issues of mental health, which are a legacy of the Genocide against the Tutsi and other episodes of socio-political violence that Rwandans have experienced (persecution mainly of Tutsi since 1959, wars, etc. ). The 2018 Rwanda Mental Health Survey found a high prevalence of different mental disorders both in the general population and among Genocide survivors, and also found that the available mental health services were under-used (Rwanda Biomedical Centre [RBC], 2019).

Figures from the same survey showed that 20.49% of people aged 14 to 65 living in Rwanda suffered from one or more mental disorders (Kayiteshonga et al., 2022, p. 4). The main disorders included: major depressive episode (12%); panic disorders (8.1%); posttraumatic stress disorder (3.6%); obsessive-compulsive disorder (3.6%); and also epilepsy (2.9%) (RBC, 2019, p. 25). The survey found that less than 1% of the population suffered from anti-social personality disorder, suicidal behaviour disorder, substance use disorder, or bipolar disorder. It found that “psychotic disorder and social phobia have similar prevalence of 1.3% while major depressive disorder with psychotic features and alcohol use disorder present similar prevalence of 1.6% as well” (p. 25).

From a gender perspective, the study found that “major depressive episode affects women more (14.4%) than men (8.2%)” (p. 26). The occurrence of major depressive episodes was the most prevalent disorder among Genocide survivors. It accounted for 35% of mental disorders, and was followed by post-traumatic stress disorder (28%), and panic disorder (27%) (pp. 49-50).

These mental disorders and other unhealed emotional wounds are still major hindrances to social cohesion in Rwanda. In this context, it is evident that a pilot programme to reinforce “community capacity for social cohesion and reconciliation through societal trauma healing in Bugesera District” was relevant to national efforts to consolidate peace in post-Genocide Rwanda. Efforts to address mental disorders and heal psychological wounds inherited from the Genocide and its aftermath on one hand, and to promote social cohesion and reconciliation on the other, are definitely relevant for the national context. Some participants in the evaluation affirmed this point.

“Enhancing societal healing and social cohesion in the post-Genocide context is part of our ministry’s mandate [MINUBUMWE]. This Programme, which also focused on healing societal wounds, boosting social cohesion and livelihoods, has helped to achieve this mission. It complemented existing efforts and has therefore added real value.” (KII with a community engagement analyst, MINUBUMWE)

Furthermore, despite on-going efforts aimed to alleviate poverty and boost economic development, many Rwandans still experience socioeconomic vulnerabilities that jeopardise their livelihoods. According to the National Institute of Statistics of Rwanda (NISR, 2018a), the proportion of Rwanda's population that faced multiple deprivations (the incidence of poverty) fell from 44% in 2010/11 to 29% in 2016/17, but is "higher in rural areas than in urban areas, 32.1% and 13.4% respectively. At province level, the highest proportion of multidimensional poor people [...] is observed in Southern Province (36.0%) followed by the Eastern Province (32.2%), while the lowest deprived is City of Kigali (13.3%)" (p. xii). With respect to Bugesera District, the Integrated Survey for Household Living Conditions 5 (EICV 5) revealed that 40.3% of households in the district are poor and that 17.8% live in extreme poverty (NISR, 2018b).

The socioeconomic component of the pilot programme (Co-Live) also made the Programme relevant at national level, because much socioeconomic vulnerabilities is due to the effects of the Genocide against the Tutsi and its aftermath, as well as the COVID-19 outbreak, and Rwanda's longstanding poverty.

Last but not least, the pilot programme in Bugesera was implemented when many Genocide convicts were ending their prison sentences and returning to their communities and families. Yet evidence revealed ex-prisoners, community members (particularly Genocide survivors) and ex-prisoners' families were not well-prepared psychosocially or economically to reintegrate ex-prisoners effectively. There is a need to mitigate social tensions in both families and the community.

"The Programme of Interpeace and its partners' in Bugesera was implemented when many Genocide convicts are completing their sentences, so they have returned to their communities to be reintegrated, while others continue to be released. The Programme, with its sociotherapy and multifamily protocols, has therefore come in at the right time, when the country really needs synergies from a range of peace-building actors to support the effective reintegration of ex-prisoners." (KII with the Mayor of Bugesera District)



## 2.2.2 Relevance for Bugesera District

Bugesera District has a specific history in relation to the 1994 Genocide. Firstly, evidence suggests that, before it occurred, the region was home to many Tutsi who had been deported in the early 1960s from various other regions of Rwanda, such as former Bufundu, Bunyambiriri, Gitarama, Ruhengeri (Commission Nationale de Lutte contre le Génocide [CNLG], n.d.). Second, over 300 Tutsi were massacred in Bugesera in 1992, and some authors have suggested that the Bugesera killings were a test run for the Genocide that followed some months later (Muse, 2021; Des Forges, 1999). Last but not least, the Genocide led to the death of so many Tutsi in Bugesera (largely killed by their neighbours) that it currently hosts two of Rwanda's six national Genocide memorial sites (Ntarama and Nyamata, CNLG, n.d.). According to the District Mayor,<sup>5</sup> over 65% of the Tutsi dwelling in Bugesera were killed during the Genocide. The population is psychologically traumatised and the district is characterised by tense relationships between Genocide survivors and their families and former perpetrators and their families.

In this regard, a baseline survey conducted at the beginning of the pilot phase indicated that the people in Bugesera District who were screened had a variety of mental health issues. They included “PTSD, depression, anxiety, anger, identity disturbance, substance abuse, youth delinquency, and antisocial personality”, which are direct or indirect effects of the Genocide against the Tutsi (Interpeace, PFR and MINUBUMWE, 2021, p. 23). The survey found that: “34% of respondents had personally experienced (3%), directly witnessed (11%), or learned about the violent death of a child (20%); 36% had experienced the violent death of a parent; 35% had experienced the violent death of a family member”. In addition, “12 % of respondents had directly witnessed family members or friends being killed, while 23% had learned of such deaths” while “5% of respondents had been raped or tortured; 3% said their private parts had been harmed or penetrated by harmful objects; 7% had received physical injuries from attacks; and 13% reported that their houses and properties had been destroyed or that they had witnessed such destruction during the Genocide” (Interpeace, PFR and MINUBUMWE, 2021, p. 24).

From a livelihoods perspective, Bugesera District has striven to reduce poverty among its population. The Fifth Integrated Household Living Conditions Survey (EICV 5) revealed that 40.3% of households in the district were poor, and that 17.8% lived in extreme poverty (NISR, 2018b). According to the Mayor of Bugesera District<sup>6</sup>, as it has been throughout Rwanda, the COVID-19 outbreak worsened poverty in Bugesera.

Peacebuilding actors have made some interventions in Bugesera District to promote peace, reconciliation and livelihoods; nevertheless, psychological wounds, identity stereotyping and distrust persist, mainly between Genocide survivors and their relatives and Genocide perpetrators and their relatives. The pilot programme of Interpeace and its partners reinforced previous efforts to mitigate and reduce unhealed trauma, mend the social fabric, and improve economic resilience. Participants in the evaluation consistently mentioned the Programme's relevance for Bugesera District, as the following quote illustrates:

“Bugesera District has a special place in Genocide history in that it not only witnessed the test run for the Genocide but was also host to Tutsi deported from other regions of Rwanda in the early 1960s. The majority of Tutsi, at least 65%, were killed during the Genocide in 1994. In addition, it should be remembered that a significant proportion of our population is still poor. The pilot Programme implemented by Interpeace and its partners was therefore relevant for our district, because the Programme's core pillars involved tackling Genocide-related mental health issues, enhancing social cohesion, and livelihoods. This fits well in the district context.” (KII with the Mayor of Bugesera District)

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<sup>5</sup> Interview with the Mayor of Bugesera District, Kigali, 15 December, 2022.

<sup>6</sup> Ibidem

### 2.2.3 Relevance for local leaders

A core role of local government leaders and their staff (at village, cell, sector and district level) is obviously to deliver services to community members. The evaluation revealed not only that many leaders and staff were as wounded as other members of the communities to which they belong, but that they were not aware of the mental health problems (including trauma and psychological wounds) of the community they serve. Consequently, local leaders/staff were not able to consider the mental health condition of citizens when addressing their problems. Similarly, when they engaged with the community, local leaders/staff sometimes acted in ways that traumatised people or worsened their wounds.

The Programme's psychoeducation approach has therefore been relevant for local authorities/staff. The Programme raised their awareness of mental health issues, which had implications for service delivery, and equipped officials to deal more appropriately with people who have been traumatised. The quotes below indicate that some participants appreciated the Programme's relevance in this regard.

"Imagine a situation where some citizens ask for houses and you build the houses and hand them to the recipients, but they don't live in them! It's not easy to figure out what is driving such behaviour. Or you keep witnessing persistent conflicts in some families and, as a leader; you are expected to help handle them. But, instead of addressing the root causes, you focus on the symptoms. Most of us were not aware of the magnitude of society's wounds and trauma and their implication for our work with and for citizens. The psychoeducation approach used by the Programme was instrumental in equipping us [local leaders] with both awareness and basic skills to apply a trauma-sensitive approach in our service delivery and our interactions with the public." (KII with the Mayor, Bugesera District)

"Local leaders were not aware of the mental health issues experienced by many people in the community. Some simply assumed that some people were subversive or negative, they had no capacity to interpret them rightly and take mental health into account when addressing citizens' problems. The psychoeducation component of the Programme brought local leaders to take up this challenge." (KII with the Programme Coordinator, Prison Fellowship Rwanda)

The sociotherapy, multifamily, and socio-economic components of the Programme were also relevant for local leaders. These three components helped to heal trauma, enhance intra-family and social relationships (in the post-Genocide context), and improve the livelihoods of community members. Local leaders considered that these Programmes were of great relevance not only to Programme participants but also to themselves, because their work is likely to become easier and have more impact if the citizens they serve are less wounded, more cohesive and better-off. In the words of a KII participant:

"The Programme was also of great interest to us [local leaders] because it really addressed the wounds of our citizens, increased social cohesion and improved livelihoods. These are part of our core responsibilities. The Programme therefore was designed and implemented not just to complement our efforts as leaders, it also improved our service delivery environment, since serving mentally stable citizens makes our work easier." (KII with the Mayor, Bugesera District)

### 2.2.4 Relevance for Programme boundary partners (participants)

In spite of government policies and programmes and the actions of non-governmental actors, efforts to promote reconciliation, heal trauma and alleviate poverty in the post-Genocide context clearly have a long way to go. The Programme was clearly also helpful to the target population of communities and local actors in Bugesera District. Participants in the evaluation claimed that, when the Programme kicked off, there were still unhealed wounds among community members from various backgrounds, many intra-family conflicts were occurring, and



distrust and negative identity stereotyping were evident, particularly between Genocide survivors and their children and Genocide perpetrators and their spouses and children. Similarly, livelihood problems due to the general level of poverty were worsened by the low levels of income-generating activity, which in turn was mainly due to high rates of trauma.

In these terms, the Programme's interventions in mental health, social cohesion and livelihoods in Bugesera District were relevant for the public at large and to direct participants in particular. The Programme provided safe spaces for Genocide survivors and Genocide perpetrators to dialogue on their painful past.

“There was distrust between Genocide survivors and perpetrators; the MFHS space dispelled our fears and enabled a genuine dialogue between the two groups, which eventually led to forgiveness.” (FGD participant, MFHS, Shyara Sector)

The Programme also provided a space for dialogue between the children of Genocide perpetrators and Genocide survivors.

“As Genocide survivors we were angry when we saw the sons and daughters of perpetrators. I would imagine meeting with them and their relatives .... When I looked at the child of a perpetrator I immediately saw his father in him. I was angry with them, but on their side they were ashamed and frustrated. The multifamily healing space approach used by the Programme helped bring us together, to heal together, and reconcile.” (FGD participant, MFHS, Shyara Sector)

“I was extremely affected by the Genocide against the Tutsi. My family was exterminated and their bodies were eaten by dogs. After the Genocide I was like an animal; I had no desire to talk to people, no desire to work on my farm, I felt like my heart was cancerous. I would not even give drinking water or salt to anyone in need. Sociotherapy came to set me free and join public spaces.” (Female participant in an FGD for an adult sociotherapy group, Mareba Sector)

“Before joining this space, I used to stay on my own, I was afraid to meet other young people from Genocide survivors’ families. I thought they’d have a grudge against us because my father killed their family. The Programme offered us a chance to connect with them. Today, we have shared space and discuss lots of shared interests, which was not the case before.” (Female participant in a youth sociotherapy group, Ntarama sector )

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## 2.3 Effectiveness and impact

This section addresses the effectiveness and impact of the pilot Programme. It is sensible to combine these evaluation criteria because the Programme’s impact is closely tied to its achievements.

### 2.3.1. Effectiveness

The 18 month pilot programme on “Reinforcing community capacity for social cohesion and reconciliation through societal trauma healing in Bugesera District” made several interventions that contributed to inducing substantial changes in the district. The Programme’s core activities included: (1) a community screening, (2) a mapping of MHPSS actors, (3) a Programme baseline survey; (4) development of intervention protocols based on the findings of the baseline survey; (5) recruitment and training of community dialogue facilitators (CDFs) and therapists; (6) setting up and facilitating mental healing spaces (ROT, MFHS), social cohesion spaces (sociotherapy both in the community and in Bugesera Prison) and CO-LIVE initiatives; and (7) training local leaders and opinion leaders in trauma-sensitive leadership, and training community members in life skills (especially socio-emotional skills).

The developed protocols were validated prior to their application. They provide guidance/information on community screening, sociotherapy, ROT, MFHS, CO-LIVE, socio-emotional skills, and prisoners’ rehabilitation and re-integration. There have been two intakes of sociotherapy groups, two intakes of MFHS groups and one intake of ROT groups. The first sociotherapy intake ran from August to December 2021, and the second from January to April 2022. The first MFHS intake ran from January to April 2022, and the second from April to September 2022. ROT groups (facilitated by AVEGA and GAERG) began in May and ended in November 2022. CO-LIVE initiatives commenced after the graduation of the first sociotherapy intake. However, two CO-LIVE initiatives that did not originate from sociotherapy groups (the beekeeping project in Rweru and the irrigation project in Mbyo) started in October 2021 and February 2022 respectively.

It is worth highlighting that, by the time the Programme ended in September 2022, ROT spaces (facilitated by AVEGA and GAERG) were still running, and that ROT at the district hospital were not facilitated. As a result, this end-term evaluation has not been able to assess ROT impact. Nor was the evaluation able to assess the impact of TVETs and youth skill hubs embedded in the CO-LIVE pillar because they are still at an early stage and are expected to make an impact in the medium and long term. Table 2 outlines the status of Programme outcomes and indicators. Overall, the programme interventions directly benefitted 7313 individuals, of whom 3323 (i.e. 45.4%) were male and 3990 (i.e. 54.6%) female (see Table 8).



**Table 2. Status of Programme indicators.**

Result Chain	Performance Indicators	Indicator status	Status
<p><b>Overall objective.</b> The approach to mental health and trauma healing in Rwanda reinforces social cohesion through the scaling up of evidence-based community-based healing and development methods.</p>	<p>1. Number of districts to which the expansion of the Programme is planned and budgeted by the Government of Rwanda (GoR).</p>	<p>The target was one more district. However, with the financial support of Sida, Interpeace expanded the Programme to another five districts (Musanze, Ngoma, Nyabihu, Nyagatare and Nyamagabe). No expansion Programme component was financially supported by the Government of Rwanda, except for mental health services in health centres and TVET in Bugesera Prison. Here, human resource-related costs were supported by Bugesera District and RCS respectively.</p>	500%
	<p>2. Finalised epidemiological survey tool is validated for use across Rwanda.</p>	<p>The epidemiological survey was conducted in 2021 across the 15 sectors of Bugesera district. The survey report is available.</p>	100%
<p><b>Specific Objective 1.</b> Community based methods for addressing past wounds and promoting social cohesion are integrated into mental health and prisoner reintegration procedures and piloted in 15 sectors of Bugesera district.</p>	<p>1.1. Number of trained therapists (practitioners) scoring 80% or above in post-training tests.</p>	<p>The target was to develop and validate six protocols. A total of seven protocols and curricula were validated: screening, ROT, multifamily, Co-LIVE, socio-therapy, socio-emotional skills, the prisoners' rehabilitation and reintegration curriculum.</p>	116.7%
	<p>1.2. Number of community trainers scoring 80% or above in post-training tests.</p>	<p>The target was 20 therapists. After the training, 19 therapists (93%) scored above 80%. Two were male and 17 were female.</p>	95%
	<p>1.3. Number of prisoners who report satisfaction with the therapy and training services</p>	<p>The target was 20. However, 104 community trainers (community dialogue facilitators and CDFs) scored at least 87%, having trained in both the sociotherapy and MFHS protocols. 51 were male and 53 female. In the first intake the Programme established 31 sociotherapy groups<sup>7</sup> and in the second 31.<sup>8</sup> It also created 22 MFHSs across all sectors of Bugesera District. The initial target was 20 facilitators, but these healing spaces required an important number of facilitators. Each group was facilitated by 2 CDFs including a man and a woman.</p>	520%
	<p>1.4. Evidence that diagnostic screenings have been effective in identifying those most in need of psycho-social services</p>	<p>The target was 56 prisoners. A total of 56 including 8 prisoners trained as facilitators and 46 graduated from sociotherapy training. All were male.<sup>9</sup></p> <p>The target was 1,275 community members in need of psycho-social support. 1,914 people (894 men and 1,020 women) were identified and eventually supported through Programme healing spaces. Participants were allocated to their respective healing spaces based on the screening outcomes.</p>	100%

7 A cohort of sociotherapy groups set up and facilitated from August to December 2021

8 A cohort of sociotherapy groups set up and facilitated from April to September 2022.

9 Ririmu Prison hosts only male inmates.

Result Chain	Performance Indicators	Indicator status	Status
Output 1.1. Protocols are developed and adapted for the integration of community-based healing and social cohesion methodologies into mental health approaches	<p>1. Protocols were developed/adapted, translated and made available for ongoing use to: provide training to prisoners and Genocide survivors; create and facilitate group-based trauma healing, for community members of diverse backgrounds; and to create livelihood initiative groups, to bond community members of diverse backgrounds.</p> <p>IcSP:<sup>10</sup> a number of learning tools on reconciliation/mediation/conflict management/conflict transformation/ stabilisation were developed.</p>	<p>The target was 2 protocols and 7 were eventually developed and validated. as a process of integrating them, Consultations with Government institutions (name-ly: MINUBUMWE, MoH, RCS..) on the institutionalisation of societal healing approaches and the developed protocols are ongoing. Those protocols were translated from English into Kinyarwanda and culturally contextualised.</p>	350%
Output 1.2. An infrastructure for the provision of healing for social cohesion services is established, capacitated and functional in the district of Bugesera	<p>3. Number of prison officials, opinion leaders and local leaders who have participated in group psychoeducation activities (M/W).</p> <p>2. Number of therapists trained and deployed to Bugesera (M/W).</p>	<p>A total of 5 documentary learning tools were targeted; 16 learning tools were eventually produced. They included 12 documentaries,<sup>11</sup> 3 policy briefs (drafted but still under review),<sup>12</sup> and 2 research reports.<sup>13</sup></p> <p>The target was 255 people. A total of 256 people, including 166 men and 90 women, participated in psychoeducation activities. They included 4 prison officials, 96 local leaders and 156 opinion leaders.</p> <p>The target was 20 therapists. 2 male and 20 female therapists were trained on ROT, including 19 from the District Hospital, Bugesera Prison, and health centres, and 3 from local partners' health centres (AVEGA, GAERG).</p>	320%
			100.4%
			95%

<sup>10</sup> Instrument contributing to sustainability and peace.

<sup>11</sup> The documentaries covered: (1) youth sociotherapy; (2) adult sociotherapy; (3) MFHS; (4) ROT; (5) strengthening local organisations' capacities; (6) the Programme and its implementation process (long video); (7) key achievements of the Programme (long video); (8) CO-LIVE - Visit of the High Representative of EU Foreign Affairs and Security Policy; (9) the handover of a mental health mobile clinic; (10) the handover of TVET materials in Bugesera Prison; (11) Monica's Story from the sociotherapy programme; and 12 Programme Success Stories.

<sup>12</sup> One on mental health, one on CO-LIVE, and one on beliefs

<sup>13</sup> One baseline report and one endline report.

Result Chain	Performance Indicators	Indicator status	Status
<b>Specific Objective 2.</b> Collective healing and socio-economic development activities increase social cohesion in target communities.	1. Score on trauma index among members of healing spaces (M/W).	The baseline score stood at 3.0. The post-intervention score was 1.0. In other words, the trauma score fell by 2.0.	-2.0
	2. Score on tolerance index of those of diverse backgrounds among members of healing spaces (M/W).	The baseline score was 1.1. The post-intervention score was 2.4. The tolerance score rose by 1.3.	1.3
	3. Score on trust index among members of healing spaces (M/W).	The baseline score was 8.4. The post-intervention score was 9.4. The trust index score rose by 1.0.	1.0
	4. Proportion of members of livelihood groups reporting an improvement in socio-economic status.	The baseline data were respectively 33% and 30% for the first and second intake. Post-intervention data showed an increase in both intakes: 70% and 39% respectively. The larger impact in the first intake was mainly due to the fact that it included both a sociotherapy and a collaborative livelihoods intervention (Co-LIVE).	+37% (intake 1); +9% (intake 2)
	5. Score on trust index among community members vis-à-vis former Genocide prisoners and their families (M/W).	The baseline data (trust index score) was 8.4. The post-intervention score was 9.4, an increase of 1.0.	1
	6. Score on trust index among former Genocide prisoners vis-à-vis community members (M/W).	The baseline score was 3.6. The post-intervention score was 6.1, an increase in the trust index of 2.5.	+2.5

Result Chain	Performance Indicators	Indicator status	Status
Output 2.1. Spaces for collective healing are established and functional.	<p>IcSP. The number of collective healing spaces/dialogue platforms set up</p> <ol style="list-style-type: none"> <li>The number of men and women participating in community healing spaces across the 15 targeted sectors of Bugesera District (M/W).</li> <li>The number of collective healing dialogue sessions facilitated.</li> </ol>	<p>The Programme targeted 30 collective healing spaces/dialogue platforms and 128 were eventually established: 62 Sociotherapy groups; 22 MFHS; 10 ROT groups; and 4 sociotherapy groups in Bugesera Prison. The indicator was therefore exceeded.</p> <p>The target was 1,275 people. The Programme reached 1,974 members of collective healing spaces, including 954 men and 1,020 women. The indicator was exceeded.</p> <p>A total of 62 sociotherapy groups were set up and facilitated (each group completed 15 sessions, one per week). 22 MFHS groups were facilitated (each group completed 18 bi-weekly sessions), 10 ROT were facilitated (each group completed 24 sessions, two per week). The sessions were guided by the respective protocols and all of them were completed.</p>	413%
<b>Output 2.2.</b> Current and former Genocide prisoners and Genocide survivors in 15 sectors of Bugesera district are equipped with relevant life and cultural sensitivity skills, to effectively participate in family and community life.	<ol style="list-style-type: none"> <li>The number of current and former Genocide prisoners and Genocide survivors (disaggregated by gender and age) participating in life skills and financial and vocational skills training (M/W).</li> <li>The number of men and women participating in MFHS groups and diagnosis-specific clinical groups (M/W).</li> </ol> <p>The number of people trained in reconciliation/mediation/conflict management/conflict transformation/ stabilisation (M/W).</p>	<p>The target was 1,080 current and former Genocide prisoners and Genocide survivors. 2,390 individuals (935 male and 1,455 female) were trained in socio-emotional skills (life skills), 725 people (339 male and 386 female) were trained in financial and vocational skills. All were graduates of sociotherapy groups. During follow-up sessions, the participants said that the socio-emotional sessions met an important community need, and that the livelihood initiatives (which require negotiation, collaboration and communication skills) did so too. The target was exceeded.</p> <p>680 people were targeted and 434 participated (including 186 men and 248 women). This target was only partially achieved. The MFHS protocol was finalised late (in January 2022). It was therefore not easy to enrol more than one intake before the Programme ended, given that training is spread over 24 weekly sessions, and under the protocol includes six monthly follow-up sessions.</p> <p>A total of 900 community members were targeted. 900 people (449 men and 451 women) were trained on reconciliation/mediation/conflict management/ conflict transformation/ stabilisation.</p>	288%
			63%
			100%

Result Chain	Performance Indicators	Indicator status	Status
<p><b>Output 2.3.</b> Community groups inclusive of former Genocide prisoners, Genocide survivors and other key members of communities, undertake collaborative livelihood activities.</p> <p><b>Specific Objective 3.</b> Youth have the skills and spaces to manage past trauma and develop a shared understanding for building a peaceful and inclusive future.</p>	<p>1. The number of people participating in financial skills training.</p> <p>2. The number of group socio-economic initiatives supported by the project that participated in training in life skills, financial and vocational skills, and livelihood skills (M/W).</p>	<p>600 people were targeted and eventually participated, including former Genocide prisoners, Genocide survivors, and other key members of communities. 259 men and 341 women took part.</p> <p>30 initiatives were targeted and 37 were reached. The target was exceeded. 31 were created by sociotherapy graduates, 4 were TVET youth hubs and 2 were associations from reconciliation villages. The rise in the initial target followed a recommendation by former NURC to strengthen existing community-based initiatives.</p>	<p>100%</p> <p>+123.3%</p>
	<p>1. Score on trauma index among youth participants of healing and intergenerational dialogue spaces (M/W).</p> <p>2. Score on tolerance index among youth participants of healing and intergenerational dialogue spaces (M/W).</p> <p>4. Evidence that older members of the community provided mentorship and assisted youth to actualise their initiatives, particularly initiatives to advance social cohesion.</p> <p>5. Evidence of young men and women participating in the Programme playing a more positive role in their communities.</p>	<p>The baseline trauma index score was 3.5. The post-intervention score was 2.3, a fall of 1.2 on the trauma index.</p> <p>The baseline score was 4.4. The post-intervention score was 5.7, an increase of 1.2 on the tolerance index.</p> <p>The Programme set up no mechanisms to enable older community members to mentor and assist youth to realise their initiatives, particularly initiatives to advance social cohesion. However, with respect to mentoring youth, after setting up the business hubs the Programme contracted TVETS schools for an additional 3 months of follow-up and coaching. Two national consultants were hired to assist youth to envision and plan businesses.</p> <p>Some young people who went through Programme spaces have played positive roles in their communities. For instance, in Ruhuha Sector, Jean Claude, a young Genocide survivor who graduated from a MFHS group, successfully mediated a conflict between two siblings (Epiphanie and Simon) whose parents killed Jean Claude's parents.</p> <p>Another case concerned the young son of a Genocide perpetrator in Ngeruka Sector, who also graduated from a youth sociotherapy group. He went to Bugesera Prison to look for prisoner N (a former neighbour) who he believed could be aware of people that his father had killed during the Genocide. After obtaining this information (which his mother had consistently refused to give him), he approached the family whose relatives his father had killed and begged their pardon. The family in question granted forgiveness. The son went on to reconcile the two families.</p>	<p>-1.2</p> <p>+1.2</p> <p>N/A</p> <p>N/A</p>

Result Chain	Performance Indicators	Indicator status	Status
<p><b>Output 3.1.1.</b> Youth in 15 sectors of Bugesera district are equipped with life skills and an infrastructure to support their ability to think critically, actively participate in community life and build a common future.</p>	<p>1. The number of young men and young women (disaggregated by gender and age) who received life skills training (M/W).</p>	<p>1,600 youth were targeted. However, only 1,400 were trained (557 male and 843 female). The target was not achieved because the Programme closed just after the graduation of sociotherapy groups.</p>	<p>87.5%</p>
<p><b>Output 3.1.2.</b> Healing spaces and intergenerational dialogue spaces to support youth healing and personal development are established.</p>	<p>1. The number of people participating in healing spaces and in intergenerational healing spaces across the 15 targeted sectors of Bugesera District (M/W).</p>	<p>800 people were targeted. The target was exceeded. 904 eventually participated (including 361 men and 543 women).</p>	<p>113%</p>
<p><b>Specific Objective 4.</b> National policies and Programmes on mental health and social cohesion are informed by lessons learnt from the monitoring and evaluation of the piloting of community-based methods for trauma healing for social cohesion.</p>	<p>1. Policy recommendations are formulated through a participatory multi-stakeholder engagement.</p>	<p>In August 2021, Interpeace and partners organised a national conference to present the findings of the Programme baseline survey. A number of recommendations were formulated, including: (1) harmonisation of healing approaches; (2) sector coordination (considered because Interpeace and MINUBUMWE jointly lead sector coordination meetings); (3) three policy orientation papers. The policy papers addressed decentralisation of mental health services; social cohesion and prisoner rehabilitation and reintegration; and the integration of collaborative livelihoods in social protection Programmes (specifically in <i>ubudehe</i> and integrated model villages).</p>	<p>100%</p>
	<p>2. The Ministry of Health plans to scale up the Bugesera Programme to other districts.</p>	<p>The target was to expand the Programme to one other district. This target was exceeded because, in partnership with MoH, through RBC and with financial support from Sida, Interpeace extended the Programme to another five districts (Musanze, Nyabihu, Nyamagabe, Nyagatare and Ngoma).</p>	<p>+500%</p>

Result Chain	Performance Indicators	Indicator status	Status
<p><b>Output 4.1.1.</b> A tool for assessing life skills, cultural sensitivity and clinical symptoms based on lessons learned from interventions with current and former Genocide prisoners, Genocide survivors and youth is finalised for national use in Rwanda.</p>	<p>1. An epidemiological survey to assess life skills, cultural sensitivity and clinical symptoms is validated for use in Bugesera District.</p> <p>2. A report on the findings of the randomised control trials is finalised.</p> <p>3. An outcome harvesting report presents key results and lessons learned that have not been captured in quantitative measurements.</p>	<p>The survey report was validated. (It was conducted from January to June 2021 and its findings were validated in August 2021).</p> <p>The Programme completed both a baseline and an endline survey (on psychotherapy groups). However, a randomised clinical trial was not conducted because its rigorous methodology would have taken time and affected the achievement of other Programme targets. The survey was postponed and will take place when the Programme expands into five districts.</p> <p>An outcome harvesting was conducted and its report was drafted.</p>	<p>100%</p> <p>0%</p> <p>100%</p>
	<p>1. The number of policy reports drafted to present the results of the implementation, lessons learnt and policy recommendations for scaling up the intervention</p> <p>2. The number of video documentaries produced to highlight lesson learned from the implementation of the intervention.</p> <p>3. The number of Programme stakeholders participating in policy dialogue groups (M/W).</p> <p>The number of advocacy initiatives targeting policy makers.</p>	<p>Two reports were targeted and 3 were drafted.</p> <p>Four documentary videos were targeted. 11 documentaries were produced. The target was exceeded.</p> <p>30 stakeholders were targeted. 60 stakeholders participated (including 33 men and 27 women). The target was exceeded.</p> <p>The target was one initiative. Five initiatives were eventually implemented: a community resilience framework study in partnership with MINUBUMWE; a civic education curriculum; a positive masculinity curriculum; a national stakeholder workshop on societal healing; and the RCS Curriculum on Prisoner reintegration and rehabilitation.</p>	<p>150%</p> <p>275%</p> <p>+200%</p> <p>+500%</p>
	<p><b>Output 4.1.2.</b> Key mental health and social cohesion stakeholders are aware of the lessons learned from the Programme interventions.</p>		

Table 2 indicates that, to a very large extent, the Programme has achieved its targets. (See the expected outputs highlighted in blue in Table 2.) The difference between endline achievements and Programme targets suggests that, cumulatively, 86.7% of targets were fully achieved (at a minimum of 100%), while 6.7% of the targets were very largely achieved (at between 75% and 99%). The figures are set out in Table 3.

**Table 3. Programme targets achieved (outputs).**

Performance range	Targets (number)	% achieved
100 % and above	26	86.7%
75%-99%	2	6.7%
50%-74%	1	3.3%
Below 50%	1	3.3%
<b>Total</b>	<b>30</b>	<b>100</b>

With regard to outcome indicators (highlighted in green in Table 2), Table 3 reveals that the Programme contributed to positive changes on nine out of ten indicators (see Objectives 2 and 3). Indicators were both quantitative and qualitative. With respect to quantitative indicators, the assessment basically considered differences between baseline and endline values (for the sociotherapy approach). Qualitative indicators were evaluated qualitatively. The impact of the Programme interventions is discussed in the section below.

## 2.3.2. Programme impact

The pilot Programme in Bugesera contributed to substantive changes at the level of the individual, the family, the community, and institutions. Participants' narratives and the post-intervention survey concur with respect to this claim.

### 2.3.2.1. Impact at individual level

The Programme had various impacts at individual level. The main benefits involved: healing trauma and psychological wounds; increased sense of safety; help to define new life orientations; and increased interest in acquiring skills.





## Healing trauma/psychological wounds

The Programme's interventions helped individuals to overcome psychological wounds or trauma inherited from the Genocide and from other episodes of violence in Rwanda. Both quantitative data and qualitative insights point to significant changes in this area: see Tables 4 and 5 and Figures 1 and 2 as well as the quotes below.

**Table 4. Mental health issues: symptoms disaggregated by intake.**

First Intake						Second Intake				
Indicator	Base	End	Change	Cohen's d <sup>14</sup>	Effect size	Base	End	Change	Cohen's d	Effect size
Depression	2.7	1.2	-1.5	0.6	<b>Medium</b>	1.6	1.3	-0.4	0.2	Tiny
Suicidality	1.4	0.5	-0.8	0.4	Small	0.4	0.3	-0.1	0.0	No
Anxiety	<b>3.2</b>	1.3	-1.9	0.8	<b>Medium</b>	1.8	1.3	-0.5	0.2	Small
Psychosis	0.8	0.5	-0.3	0.2	No	0.5	0.4	-0.1	0.1	No
OCD	1.0	0.6	-0.4	0.3	Small	0.8	0.5	-0.3	0.2	Tiny
Dissociation	1.0	0.5	-0.4	0.2	Small	0.5	0.3	-0.2	0.1	Tiny
Borderline Traits	1.7	0.7	-1.0	0.5	Small	0.9	0.5	-0.3	0.2	Tiny
Substance abuse	0.2	0.3	0.0	0.0	No	0.2	0.2	0.0	0.1	No
Lying	0.3	0.0	-0.3	0.4	Small	0.2	0.1	-0.1	0.2	Tiny
Anger	0.5	0.2	-0.3	0.3	Small	0.2	0.1	-0.1	0.1	No
Trauma	1.3	0.9	-0.4	0.2	Small	1.1	0.7	-0.4	0.2	Small
Emotion dysregulation	1.7	0.8	-0.9	0.5	Small	1.0	0.7	-0.2	0.2	Tiny
Rumination	1.6	0.7	-0.9	0.5	Small	1.2	0.5	-0.7	0.4	Small
Impulsivity	1.2	0.4	-0.8	0.5	<b>Medium</b>	0.5	0.4	-0.1	0.1	Tiny
Grandiosity	0.2	0.2	0.0	0.0	No	0.1	0.2	0.1	0.1	No
Somatisation	1.1	0.9	-0.2	0.1	No	0.8	0.8	0.0	0.0	No

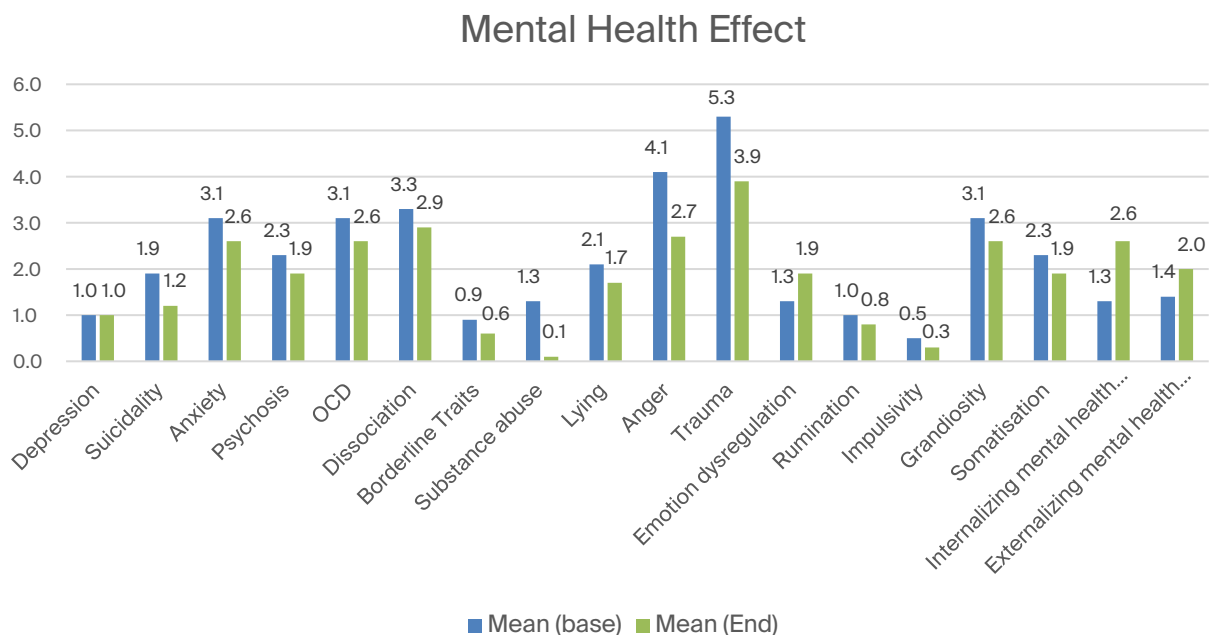
Table 4 suggests that both intakes showed signs of healing. The baseline/endline comparison showed a stronger effect in the first intake because the first intake displayed higher levels of trauma and psychological wounds than the second intake.

<sup>14</sup> Cohen's D is a standardised effect size for measuring the difference between two group means. It is generally used to compare a treatment to a control group.

**Table 5. Mental health symptoms (baseline vs endline).**

Indicator	FIRST INTAKE					SECOND INTAKE				
	Base	End	Change	Cohen's d	Effect Size	Base	End	Change	Cohen's d	Effect Size
Depression	2.7	1.2	-1.5	0.6	Medium	1.6	1.3	-0.4	0.2	Tiny
Suicidality	1.4	0.5	-0.8	0.4	Small	0.4	0.3	-0.1	0.0	No
Anxiety	3.2	1.3	-1.9	0.8	Medium	1.8	1.3	-0.5	0.2	Small
Psychosis	0.8	0.5	-0.3	0.2	No	0.5	0.4	-0.1	0.1	No
OCD	1.0	0.6	-0.4	0.3	Small	0.8	0.5	-0.3	0.2	Tiny
Dissociation	1.0	0.5	-0.4	0.2	Small	0.5	0.3	-0.2	0.1	Tiny
Borderline Traits	1.7	0.7	-1.0	0.5	Small	0.9	0.5	-0.3	0.2	Tiny
Substance abuse	0.2	0.3	0.0	0.0	No	0.2	0.2	0.0	0.1	No
Lying	0.3	0.0	-0.3	0.4	Small	0.2	0.1	-0.1	0.2	Tiny
Anger	0.5	0.2	-0.3	0.3	Small	0.2	0.1	-0.1	0.1	No
Tauma	1.3	0.9	-0.4	0.2	Small	1.1	0.7	-0.4	0.2	Small
Emotion dysregulation	1.7	0.8	-0.9	0.5	Small	1.0	0.7	-0.2	0.2	Tiny
Rumination	1.6	0.7	-0.9	0.5	Small	1.2	0.5	-0.7	0.4	Small
Impulsivity	1.2	0.4	-0.8	0.5	Medium	0.5	0.4	-0.1	0.1	Tiny
Grandiosity	0.2	0.2	0.0	0.0	No	0.1	0.2	0.1	0.1	No
Somatisation	1.1	0.9	-0.2	0.1	No	0.8	0.8	0.0	0.0	No

**Figure 1. Effects on mental health symptoms among prisoners (baseline vs endline)**



Source: Endline Survey Data, October 2022

Table 5 and Figure 1 show that the incidence of mental disorders fell for sociotherapy group participants from both the first and second intakes. For the first intake, the Programme effect size is small; and it is smaller still for the second intake. The first intake's improvement in mental health was larger because the group's baseline scores were lower. The first intake had a higher (worse) baseline than the second intake, but their endline was the same. Both are healing, but the first intake needed healing more.

**Table 6: Impact on mental health of sociohistorical background categories**

Program's impact on mental health - disaggregated by social historical background														
Historical Background Social Category	Depression		Suicidality		Anxiety		OCD		Substances abuse		Anger		Trauma	
	Baseline	Endline	Baseline	Endline	Baseline	Endline	Baseline	Endline	Baseline	Endline	Baseline	Endline	Baseline	Endline
Youth - Descendant of Survivor	15.2	13.2	3.9	3.4	16.3	17.8	4.4	4.9	0.2	1.0	1.0	3.2	5.6	4.4
Youth - Descendant of Perpetrator	11.3	8.7	2.3	4.0	15.3	10.4	3.7	2.3	0.7	1.1	1.3	0.8	5.8	2.8
Genocide Survivor	21.3	14.6	6.2	3.9	23.7	15.1	13.3	6.7	2.4	1.4	2.7	1.6	15.1	10.8
Ex-perpetrator	9.5	10.7	1.6	1.4	10.1	8.4	4.3	3.5	4.3	3.0	2.0	0.6	11.3	7.5
Other groups too small to analyse	18.3	13.2	3.3	3.9	17.5	14.5	4.7	5.0	0.7	1.2	1.6	0.9	9.0	5.3
Total	16.4	12.6	3.9	3.4	17.8	13.2	7.5	5.0	2.0	1.6	2.0	1.3	10.9	7.3

Source: Endline survey data , October 2022.

Table 6 depicts the programme impact on the mental health of selected socio-historical background categories (survivor-related categories, perpetrator-related categories and other groups). Overall, it emerges that the programme contributed to reducing mental health problems among all sociohistorical categories (covered by the Programme). Nonetheless, the impact appears to be greater among genocide survivors than ex-perpetrators. The former group had initially shown higher levels of mental health problems than other groups with respect to nearly all assessed mental health symptoms. This implies that more significant programme impact is observed among the group with higher symptoms of mental health issues. However, the programme impact on mental health problems of youth descendants of survivors proves to be mixed. In fact, the programme reduced levels of depression, suicidality and trauma, it did not do the same for anxiety, OCD, substance abuse and anger whose levels increased instead. A nearly same situation is observed among youth descendants of perpetrators. While the programme contributed to reducing levels of depression, anxiety, OCD, anger and trauma, levels of suicidality and substance rather rose. An increase of levels of mental health symptoms is also observed among ex-perpetrators with regard to depression. However, all other symptoms were positively impacted by the programme.

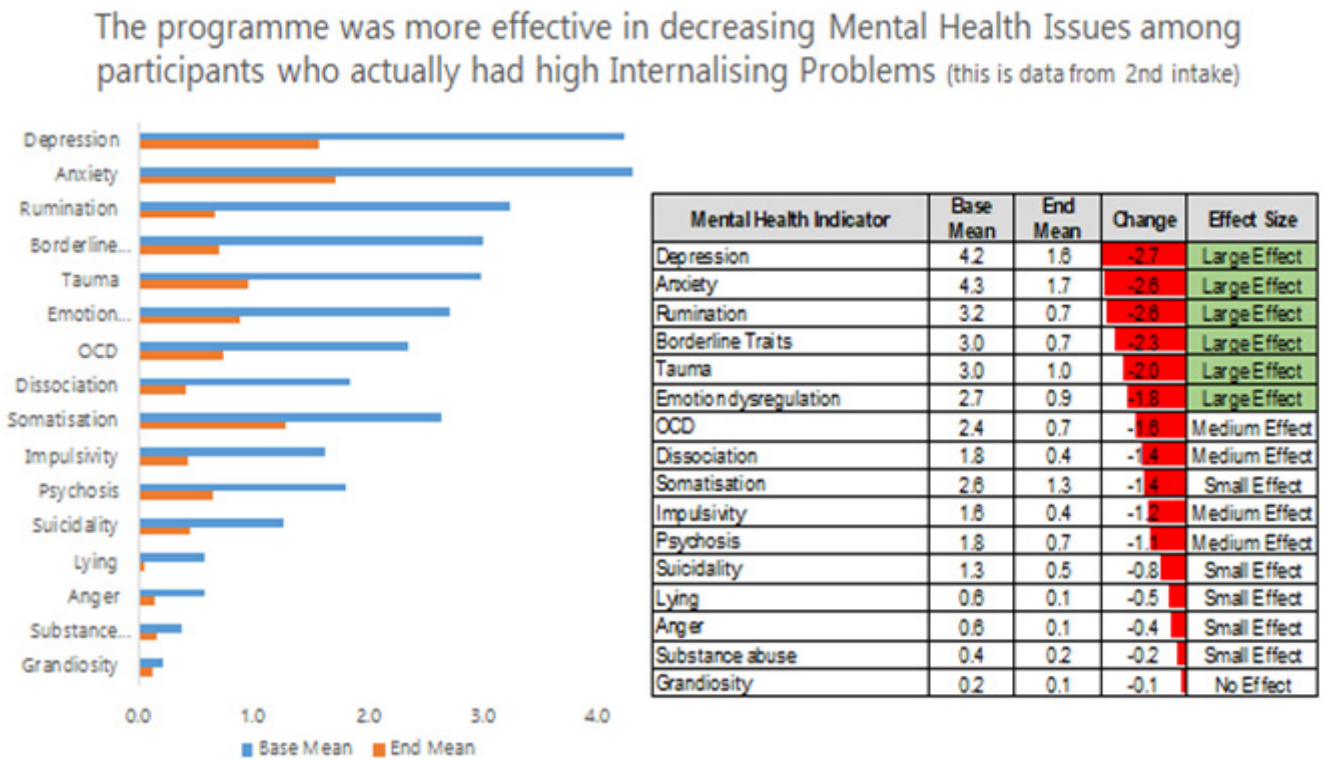
Qualitative insights match quantitative data on the Programme's impact, as the quotes below illustrate:

"I grew up seeing people coming home to ask my mother for forgiveness for killing her family. I would sit next to her each time they would be there and that is when I learned what our neighbours had done. I could see how my mother was hurt and that deeply traumatised me. One couple came home with money, they counted out three hundred thousand Rwandan francs and told her that they were asking her to go to Bugesera Prison to say that she had forgiven their son who had been convicted of killing my mother's brother and other relatives. I inherited my mother's trauma to the extent that I also started to have severe headaches and insomnia. It got so bad that I dropped out of school because of my depression and trauma. Later, my mother got recruited into sociotherapy and she started to heal. Interestingly, when she started to feel better, I also felt a bit better. She started telling me positive things, she even pleaded with me to join sociotherapy if I was ever given the chance. So I liked sociotherapy even before joining because of all it did for my mother. When I joined, I was ready to heal myself and move forward with my life, and I did that. I no longer have headaches and I have regained my smile." (Female participant in FGD for a youth sociotherapy group, Nyarugenge Sector).

“What caused my outbursts of anger was that I was imprisoned for the 1994 Genocide against the Tutsi when I was 20 years old. I was severely depressed and didn’t like those who accused me. After my release, I couldn’t talk properly because of depression and I was alone since my parents and siblings were dead. In addition, as if it was not enough, I was asked to repair the properties of survivors that my older brother destroyed in 1994 when it wasn’t my fault. I looked for the plaintiffs and begged them to allow me to repay in instalments until the full amount was covered. Joining this healing group, I was able to forgive them. Particularly, I loved it that the healing group reconnected us with the youth, our children, who learned about our history.” (Male participant, FGD with an adult MFHS, Kamabuye Sector)

The Programme particularly helped participants who had difficulty internalising their mental health problems as depicted in Figure 2.

**Figure 2. Programme effects on internalising versus externalising mental health issues**



Source: Endline survey data , October 2022.

Figure 2 shows that the Programme particularly helped participants who had reported during the pre-screening assessment that they found it very difficult to internalise their mental health problems. Significant changes were observed in rates of depression, anxiety, rumination, borderline traits, trauma and emotional dysregulation. Qualitative data supported this finding.

“... Sociotherapy saved my life. After I confronted Genocide perpetrators, towards whom I felt deep resentment, which kept worsening my emotional pain, I felt profound relief. I was also helped by hearing the confession of perpetrators who killed my relatives and who the group helped to seek my forgiveness. It was hard to digest the truth at first, but after he confessed, I opened up, I expressed all my anger and re-

sentment, it was like the lump in my heart blew out. Gradually I started feeling better. The migraines disappeared, my blood pressure normalised, and I no longer have heart attacks.” (Female Genocide survivor, participant in a FGD of sociotherapy graduates, Juru Sector).

## Increased sense of safety

In addition to reducing mental health problems, the Programme made participants feel safer. Sociotherapy sessions were principally responsible for this. The quotes below indicate the improvement.

“I was picked on because of my background. In primary school, some kids used to call me a killer’s child and that really made me insecure, I remember wishing I could go back and be born different. I have battled that my whole life... We have youth clubs for unity and reconciliation but I have always felt like an imposter participating in those clubs because, if I was really a “killer’s child” what was I doing there? Sociotherapy reminded me that I am not the one who killed, I am not my father. I slowly developed some sense of safety. Honestly, I have learnt a lot from sociotherapy - but the fact I can now show up at any event without shame or guilt, with that sense of peace, that sense of belonging and safety, is just unmatched.” (Participant in an FGD for a youth sociotherapy group, Nyarugenge Sector)

“I was raped during the 1994 Genocide against the Tutsi. The man who raped me also kept me hostage in his house until I gave birth to three children with him before he later died. After his death all the community members blamed me. Whenever I came to a meeting, people avoided me because my husband had wronged almost every survivor’s family in the community. Even after the 1994 Genocide against the Tutsi, people feared him. He was an angry man. My family members were also killed during the 1994 Genocide. But whenever I got trauma during the commemoration period, people could not understand me because I got married to that man when I was a Genocide survivor. I lost hope and chose to isolate myself from everyone in the community. I became an offensive person, but since joining the sociotherapy healing space I feel safe because I found people who made me feel valued. I reconnected with people who I used to avoid, especially people who rejected me. I now feel healthy. I sleep easily, interact with others. Due to this step that I made, I even joined a savings group with members of the healing, where I save and borrow some money to help me improve my standard of living.” (Female participant in an FGD for a sociotherapy group, Ririma Sector).

## Help to define new life orientation

It was expected that the Programme would help participants to give their lives a new direction - to feel less hopeless and look forward again. The evaluation suggested that the Programme contributed to this outcome. The words below speak for themselves:

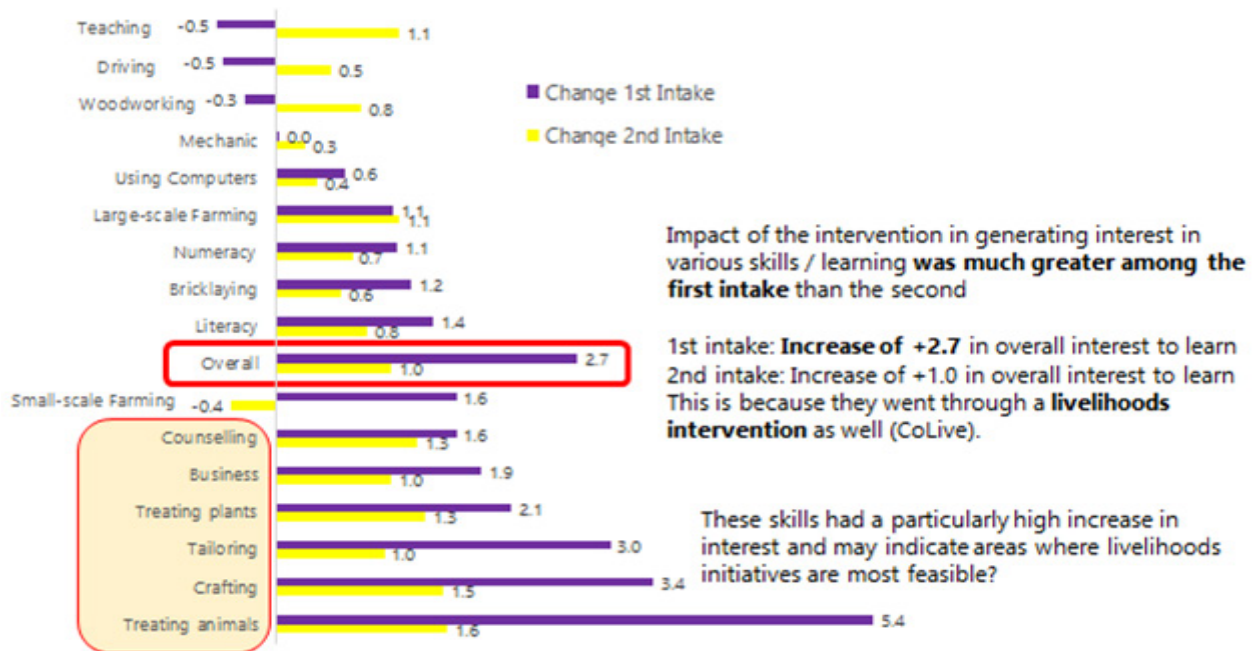
“Sociotherapy has enlightened us. It not only healed us but gave us self-confidence and a new direction in life, to develop through small income generating activities.” (Female participant in an FGD for a sociotherapy group, Shyara Sector)

Prisoners from Bugesera Prison made similar statements. FGD participants consistently said that they had acquired social and emotional skills that in the future would enable them to reintegrate their respective communities.

## Increased interest in acquiring skills

The Programme had another impact at individual level in that it increased participants' interest in acquiring skills. Figure 3 provides more detail.

Figure 3. The Programme's impact on skills acquisition



Source: Endline survey data, October 2022.

Figure 3 shows that Programme participants became more interested in acquiring skills. It appears that interest was higher in intake one (+2.7) than intake two (+1). The skills that attracted Programme participants included treating animals, craftwork, tailoring, growing plants, and business.

**Table 7. Interest in livelihood skills among prisoners (baseline versus endline).**

No	Interest to learn ...	Mean (base)	Mean (end)	Mean Change (end vs base)	Sample size
1	Small-scale farming	2.1	1.7	-0.4	41
2	Large-scale farming	3.3	3.5	0.2	41
3	Treating plants	1.9	1.6	-0.3	41
4	Treating animals	3.6	3.2	-0.4	41
5	Bricklaying	5.3	6.8	1.5	41
6	Woodworking	5.7	7.4	1.7	41
7	Tailoring	3.3	3.7	0.4	41
8	Teaching	2.2	2.2	0.0	41
9	Counselling	2.3	2.6	0.3	41
10	Crafting	1.1	1.0	-0.1	41
11	Using computers	1.5	1.6	0.1	41
12	To be a mechanic	3.7	5.3	1.6	41
13	Driving	3.9	4.3	0.4	41
14	Business	2.1	2.9	0.8	41
15	Literacy	1.0	1.1	0.1	41
16	Numeracy	2.1	2.9	0.8	41

Source: Endline survey data, October 2022,

The endline survey showed that the Programme increased the interest of prisoners as well as community members in livelihood skills. Prisoners' interest in farm-related skills fell, but they wanted to train to be carpenters, mechanics or bricklayers. This trend suggests that prisoners may be adopting more positive attitudes and becoming readier to actively participate in socioeconomic life, at family and community level, when they complete their sentences.

### 2.3.2.2. Impact at family level

The Programme's impacts on the family were similar to its impacts on individuals. Participants reported that the Programme's interventions had improved communication and relations between parents and their children, reduced marital conflicts, strengthened intergenerational dialogue on sensitive topics, and supported livelihoods.

## Better communications and relations between parents and children

Improvements in communications between parents and children, and in their relationships, were reported in several sectors of Bugesera District, especially by participants who attended MFHS groups.

I grew up in very difficult conditions, raised by my mother because my father was in prison. I grew up isolated, I was angry when I saw other children of my age talking to their father, it caused me to hate the Tutsi who I thought were responsible for my father's imprisonment. At home, I fought with my mother, and was in such pain that I became a delinquent. Since joining the group, I respect my mother and I am no longer that insolent girl." (Female participant in FGD for an MFHS, Mwogo Sector)

“Before joining the healing group, my family was always in conflict. My mother was always leaving home. Our father did not listen to us or our mother. Everyone fended for themselves. These days, us children play an active role in our households and our parents listen to us; we are at peace. What pained me most was the fact that after tensions with our dad, our mum would leave home with my younger brothers and sisters. I was ashamed of my family’s behaviour. Joining the healing group helped our parents. Whenever our father wants to do something, he asks for advice, and we all participate in the discussion.” (Female participant in an FGD for an MFHS, Kamabuye Sector)

## Less marital and family conflict, improved family cohesion

Improved communication at family level lowers marital conflicts and improves family cohesion. In almost every single one of the FGDs that were held, the participants mentioned that marital conflicts had eased and family cohesion had improved as a result of the Programme. Here are a few examples:

“Where the healing group helped most was that I learned how to remain in my marital home, I always left home leaving my children alone without even showering them or taking them to school. Before, we would stay silent and never took time to discuss our marital problems or find a solution. After joining the healing group, we learned to discuss with each other and with our children. I was the person who left everything to my husband even when my child asked me for a pen. After the healing group, we have a talk and find solutions together.” (Female participant in FGD for an MFHS, Kamabuye Sector)

“My husband was imprisoned for having killed Tutsi during the Genocide. He completed his sentence and returned home. Family conflicts started after he came back. He was the first one to join the healing space. As he went through sociotherapy, he changed completely, he stopped beating me, he started greeting me whenever he arrived home. I said wow! The group my husband is attending is very constructive. He started calling me sweetheart, when he used to say I was just useless. [...] Later on, I joined a sociotherapy group too. As a result of the dialogue and healing, my husband and I sit together and plan the develop-





ment of our family; we even share the little money we have at home. I was able to buy a phone, he sometimes buys airtime for me, I sometimes give him money to buy a bottle of beer.” (Female participant, FGD for an adult sociotherapy group, Mareba Sector)

“Before joining the group (multi-family), there were endless tensions in our home. Our father used to come home too late in the evening. He was often aggressive to our mother and he verbally harassed her almost every day, particularly when he was under the influence of alcohol. After joining this *Mvura nkuvure* group, he started to change, he became kind, he preferred dialogue and consensus (...). Today, the situation in our home has significantly improved. We discuss things in a very friendly way. In short, we respect each other.” (A female participant, FGD for an MFHS, Ntarama Sector)

## Improved intergenerational dialogue on history and the Genocide

Programme interventions contributed to promoting dialogue between generations, including on sensitive topics such as the Genocide against the Tutsi. Platforms established by the Programme supported these, especially MFHS. These spaces brought together all members of participating families (aged 13 and above) and taught them practical skills for holding intra-family and inter-family dialogues on family and Genocide-related matters. Similarly, sociotherapy groups equipped participants with dialogue skills on sensitive issues. In the words of two participants:

“Before joining this healing space, we [Genocide perpetrators] felt ashamed to tell our children what we did during the Genocide. The space empowered us to open up on our crimes and eventually we were able to discuss them with our children. Now, our children are aware.” (Male participant in an FGD for an MFHS, Shyara Sector)

“Our mother never told us the real reason why our father was in prison for many years. After joining a youth sociotherapy group, we had sessions that empowered us to openly discuss our family stories. With the skills I had learned, I approached my mother and gently asked her about my father’s imprisonment. She was reluctant at the beginning, but my mother ended up admitting that my father had been involved in committing the Genocide.” (A male participant in an FGD for a youth sociotherapy group, Ntarama Sector).

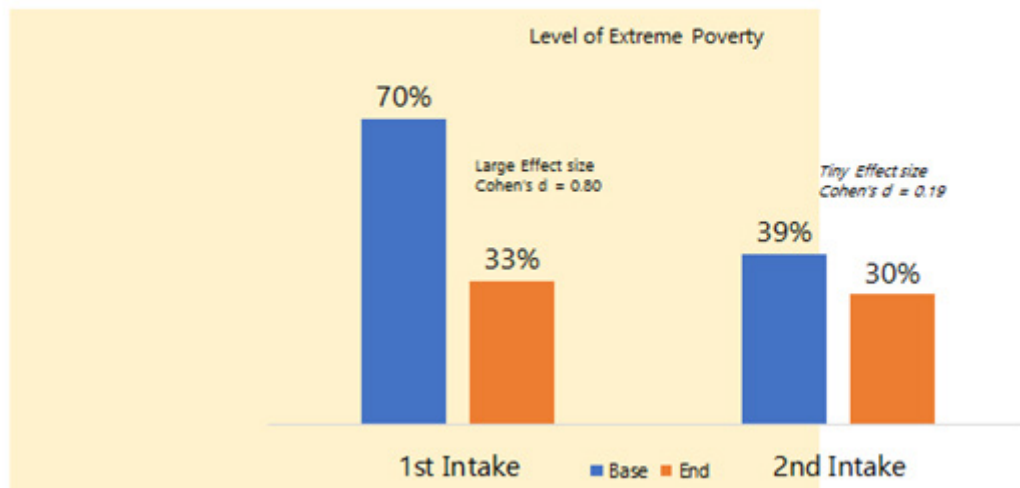
## Improved livelihoods

As noted earlier, the Programme’s theory of change connected mental health, social cohesion, and livelihoods. In addition to ROT, sociotherapy and MFHS, Programme interventions also provided financial support to livelihood initiatives. The aim was to enhance economic resilience as a way to strengthen social cohesion. The support went to graduates of selected sociotherapy groups and to other selected initiatives that did not go through Programme healing spaces. The evaluation showed that this financial support improved the socioeconomic condition of recipients (see Figure 4).



**Figure 4. Programme impact on family poverty**

**Reduction in Extreme Poverty was seen in the 1st intake but not in the 2nd intake**



Source: Endline survey data , October 2022.

The survey suggests that “poverty” fell significantly among members of the first intake (from 70% to 33%), but that the fall was much smaller for members of the second intake (from 39% to 30%). One reason may be that the first intake received both sociotherapy and CO-LIVE while the second intake only received CO-LIVE. This implies that healed and reconciled groups may be more successful at working together to alleviate poverty than groups that formed for economic reasons.

Insights from qualitative data did not reveal much on the programme impact on the livelihoods of participants. However, some narratives echoed a certain indication that programme-based collaborative initiatives could lead to improved livelihoods in the future as in the following quotes.

"I am grateful to be a member of Tuzamurane [a CO-LIVE initiative]. We used to rely on watering cans to irrigate our crops and would get too tired spending the whole day working. Now we use a watering engine that we acquired through Interpeace’s Programme support. The engine has significantly reduced our physical labour, saves us time, and increases productivity. CO-LIVE activities have enabled us to pay health insurance for my family, I’m not on my own since I work together with group participants, we sell our agriculture products for self-development, and all our children get plenty to eat.” (Female participant in an FGD for a CO-LIVE initiative, Mayange Sector).

"I am one of the perpetrators of the 1994 Genocide against the Tutsi. It is good being a part of this group. Before, everyone was alone. You ask yourself 'How is it that people against whom I committed these crimes trust me and appoint me as their leader?' But I am leading them, they never judge me, and we work as a team. Before being given a watering machine, we used to use manual watering cans, which was tiresome. Now we can water 3 hectares a day. [...] We've been asked by local leaders to water the entire area to help our neighbours. Before we had the irrigation engine, I used to get FRW 100,000 per season, but now I get around FRW 300,000. We hope to have a brighter future. We are still harvesting despite the hot weather. Returns on our family livelihoods are significant. For instance, there is a big demand for our services. We supply small companies, schools, and some investors from Kigali. The group helps the members to pay five health insurances per family, we meet together at Christmas and New Year events, and we sometimes eat together socially. We keep a crop store to avoid running out of seeds for the next season." (Male participant in an FGD for a CO-LIVE initiative, Mayange Sector).

It is important to highlight that given the short timeframe of the pilot Programme, it may be too soon to document the impact of CO-LIVE initiatives on households. Realistically, returns from such initiatives can be expected in the medium and long term.

In addition, from a peace and conflict perspective, CO-LIVE initiatives are more likely to be impactful and sustainable if they create a sense of togetherness, of belonging, while improving livelihoods, rather than simply improving livelihoods. Many participants reported that attending healing spaces had been valuable in itself but was also an important preparation for running CO-LIVE initiatives. This link is likely to be significant, particularly in the post-Genocide context. It does appear that CO-LIVE initiatives that originated in psychotherapy tended to become more productive and more sustainable than initiatives that had no prior healing experience. For instance, the Programme financially supported Rweru Bee Hiving Project under the CO-LIVE pillar, whose members had no prior healing experience. It was implemented as a stand-alone project, without links to healing and social cohesion endeavours. The initiative did not yield the expected results. Members of the group became entangled in self-interested conflicts that led to its disintegration rather than social cohesion.<sup>15</sup>

## Unintended positive gendered impacts at individual and family levels

The evaluation revealed a set of unintended positive impacts of the Programme from a gender perspective. These include exposing men's vulnerability and hence triggering a sense of healing and communion, impact on reversed gender roles in post-genocide context, mitigating effects of negative masculinities among some male participants, building women's confidence and increased awareness about sexual abuses.

**Exposing men's vulnerability and hence triggering a sense of healing and communion:** Traditionally, men are socially expected to be strong, resilient and never show signs of weakness like crying or asking for help. As a Rwandan proverb goes "*amarira y'umugabo atemba ajya mu nda*" (Man's tears flow inside his body". The healing spaces established by the Programme in Bugesera District exposed some men's vulnerability that triggered a sense of healing and communion beyond the gendered expectations. The evaluation found that some men in healing spaces went back home different from their previous versions, more inclined to listening, paying attention and getting involved in house chores. Neighbours attest this to be a great impact of belonging to a space that allowed them to express their grievances without being judged. This progressive transformation mainly resulted from the fact that healing spaces not only instilled skills/attitudes of effective listening, empathy and expression of one's feelings/emotions among participants.

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<sup>15</sup> Interview with the Programme Senior Psychotherapist (Prison Fellowship Rwanda) and the DMEL Advisor (Interpeace Rwanda and Great Lakes Region)

“During the different meetings we were having, I got to know that I was not a- good parent and husband to my wife and children, I learnt for family harmony to be there, I needed to involve my family in different dialogues and to plan our future together unlike before where I would take all the decisions without consulting them. I also got to realise that my anger was stemming from historical background coz I was a genocide perpetrator and my harshness towards them prevented me from being asked many questions which made me feel guilty and therefore transferred that anger inform of non-communication” [ a male ex-genocide perpetrator that took part in the Multifamily healing groups in Ntarama]

**Impact on reversed gender roles in post-genocide context:** The evaluation showed that the programme positively impacted on the reversed gendered roles of women brought about by the genocide. As a matter of fact, many men were killed during the genocide, while others were imprisoned over their roles in the same genocide. This left most women widowed, orphaned and mostly households’ heads. This pushed most of women who previously were illiterate, unempowered in public spaces where they had to take up leadership roles to sustain their families and households. Women survivors and wives to genocide perpetrators had to take their households’ headship, and actively be involved in educating their children and take up land ownership and usage since most are fundamentally agriculturalists. The following quote substantiates the claimed change.

“When my parents were killed during the Genocide, I had to grow up so fast even when I was 13 years old;I had to take care of my young siblings as well as myself, I had to find ways of cultivating and selling crops from our family land and it also pushed me to get married earlier at 18. To add salt to the wound, my husband who I thought was going to help me look after my family and my children also passed on and left me on top of being orphaned, widowed! I had to learn to vend for my children as well as siblings and that’s how I started a butchery business which I initially thought was a male only business” [ A female CDF in Musenyi Sector]

Furthermore, the programme contributed in **mitigating effects of negative masculinities among some male participants**. Traditionally, the husband had the right of correction towards his wife and his children (including beating), but the wife did not enjoy such a right toward the former<sup>16</sup>. While the post-genocide legislation abolished the so-called right which was a driver of negative masculinities, some cases of related attitudes and behaviours are still observed in Rwanda and are extended to husband’s mismanagement of family income and properties. The following quote illustrates the change that the programme induced in this regard.

Don’t be surprised as you see my wife crying! She’s emotionally shaken by the positive outcome of this space. In fact, multi-family healing space has not only restored harmony and cohesion in our family but also challenged me on my role and responsibilities as a husband. I used to beat her a token of correction, mismanage our income and let her deal with all chores as I believed that was real men’s style. Since my joining the MFHS, I learned about constructive intra-family dialogue, caring for the family as well as participatory decision-making through involvement of my spouse and children. Now, I am a new husband in our family. Our family is at peace now because as I stopped mismanaging family income and assets, and consult with household members on most of family matters (Participant in a FGD with MFHS graduates, Juru Sector).

**Building women’s confidence:** The programme has also built confidence in female participants with respect to gender roles. Through dialogue in their spaces, women who used to shy away saw the fears dispelled by sharing their stories but also listening to those of their fellow participants. The dialogue process eventually enabled them to speak in public. In a similar vein, some women saw a positive change in their attitudes with respect to the labour division.

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16 Association pour la défense des droits de la femme et de l’enfant [Haguruka] (2001). La femme rwandaise et l’accès à la justice, p.27

In the words of a female community dialogue facilitator (CDF):

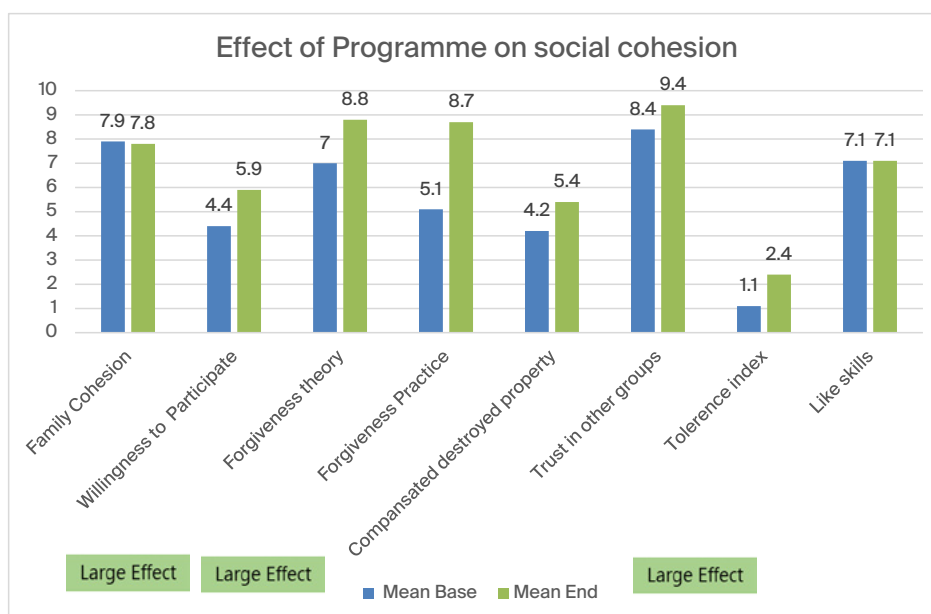
“I used to think that certain activities were meant for men and no woman was able to do them. Nonetheless, as a result of socio-therapy, I was able to open and run butchery business, while I initially thought that those kinds of businesses were for men. I also feel like am no longer afraid to express myself in public. I also tend to engage even other opinion leaders like me about socio-therapy and I sense that my advice helps them. (female CDF, participant in a FGD with facilitator, Musenyi Sector)

**Increased awareness about sexual abuses:** The same facilitator acknowledged having increased her knowledge around sexual abuse. Before embarking on sociotherapy youth group facilitation, she thought that most of teen young mothers were reckless and got impregnated due to their negligence. However, during the facilitation of several youth groups, it opened her eyes to more parameters. She says that “I learnt that some teens got impregnated not because of carelessness but some factors beyond their control such as being an orphan and related vulnerabilities which expose them to being tricked. This eventually changed my attitudes towards and judgement of teen mothers (female CDF, participant in a FGD with facilitator, Musenyi Sector)“.

### 2.3.2.3 Impact at community level

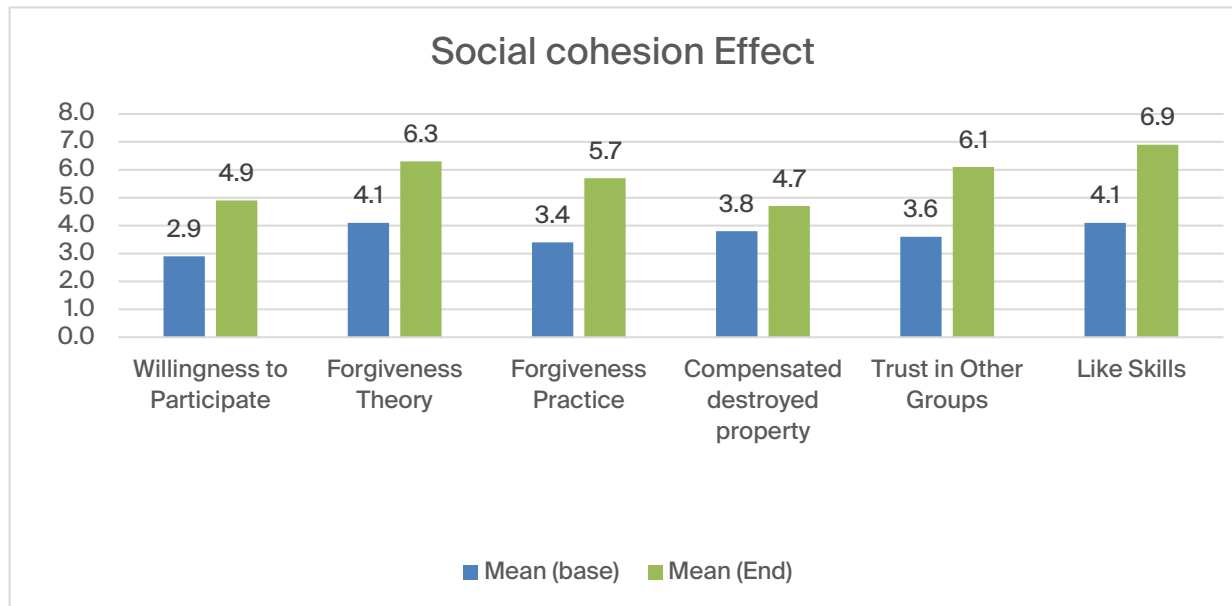
The Programme also had impacts on the communities it reached. Interventions primarily improved social cohesion in the post-Genocide context. Figure 5 and 6 show the impacts reported by participants in the community and by prisoners respectively.

**Figure 5. Programme impact on social cohesion - community participants**



Source: Endline Survey Data, October 2022.

**Figure 6. Programme impact on social cohesion - prisoners**



Figures 5 and 6 suggest that the Programme helped graduates from community sociotherapy groups and prison-based sociotherapy groups to improve social cohesion in several respects. They were more willing to participate; were more willing to seek pardon and forgive; actually forgave more; compensated more looted property; trusted others more; were more tolerant. The largest effects were observed in willingness to participate, forgiveness, and tolerance. However, the Programme’s interventions seem not to have enhanced family cohesion or life skills. With respect to family cohesion, participants in the evaluation (all sociotherapy graduates) said that this was an important limitation of sociotherapy as a healing approach. They argued that, while the approach had helped them to embark on a healing journey as individuals, some of their family members (who were usually not members of the same spaces) continued to wound them. When people in the healing process live in a wounding environment, they are unlikely to heal effectively. This implies that, to address this challenge, it would help to include all family members in healing processes, if resources are available to do so. This is actually what the MFHS approach did.

With respect to **forgiveness**, participants underscored the contribution of the Programme in this area. Quotes from two participants capture this:

“I was 4 years old during the 1994 Genocide. Right afterwards, my dad disappeared on us, my mother knew where he was, but I didn’t. So, a few years after, we received a letter from Ririma [prison] from my dad requesting that we bring him a few items. Since my mom did not know how to read, I had to read it, but because I was still young I couldn’t understand what it was all about. I tried to ask my mother, but she shut me down. I was not satisfied, so I went to my uncle, borrowed a bicycle, looked for some money and bought the items my father had requested. I started inquiring about other people who would visit their family members in Ririma prison and I followed them. When I got there, my dad was so shocked but he did not tell me anything. So, when I got back home, I told my mom that whatever her and dad were hiding I would eventually come to know. A year later, the perpetrators who were in Ririma Prison were taken to the community to testify, my dad too. That is when I got to know what my dad did and the magnitude of it. Let me tell you this, that’s when I decided that I will never forgive my dad because of his crimes which brought shame on our family. Can you imagine that I even got to the point of getting married and not inviting him? And yet I invited one of my dad’s victims. I took it on myself to inquire in the village and find out the victims of my dad’s crimes. I started with Musabeyezu and her family. I went there and sat with her dad and asked for forgiveness, for my dad’s crimes and for my whole family. That man looked me right in the eye and said

that because of my courage, he forgives me, and he forgives my dad. But I did not rest at that, I vowed that I would make sure that my dad got to face the people he offended and beg for their pardon, their forgiveness. God heard my prayer. Time came when my dad was recruited in sociotherapy, and he learned for himself the importance of repenting. He resolved to face the families he had offended, and he eventually begged pardon. I think that is the day I saw my father as my father and allowed him in my life again. Our relationship got even stronger when I also participated in sociotherapy and learned about the beauty of creating new life orientations.” (Male participant, FGD for a youth sociotherapy group, Nyarugenge Sector)

“Before joining this group, our relationship was characterised by suspicion and total silence. I didn’t dare face Françoise to confess and ask for pardon. However, everyone was suffering from the same situation. Meeting Françoise in a sociotherapy group helped me to open up. I confessed to her and asked for pardon. I was surprised it didn’t take her long to forgive me. We have become inseparable friends.” (Former Genocide prisoner, participating in an FGD with sociotherapy group members, Juru Sector )



With respect to the Programme’s impact on trust between groups, its interventions increased trust between Genocide survivors and Genocide perpetrators as well as their relatives. Programme participants claimed that the Programme’s facilitated spaces enabled them to meet together safely and openly to discuss their traumas and psychological wounds and gradually start healing themselves. The openness of the dialogue allowed some participants to discover that other people with the same historical background suffered the same wounds; but also that those on the other side during the Genocide were also wounded. This experience helped to increase forgiveness (both in theory and practice), and to increase trust across age groups, gender and between Genocide survivors and Genocide perpetrators and their relatives as well as across age groups and g (see Table 8 and 9).

**Table 8. The Programme’s impact on social cohesion disaggregated by age and gender**

<b>Age Groups</b>	under 28	29 - 50	over 51
Forgiveness Practice	5.6	3.8	2.6
<b>Genders</b>	Male	Female	
Trust in Other Groups	0.6	1.5	
Willingness to Participate	1.8	1.3	
Extreme Poverty	-0.1	-1.6	

Table 8 suggests that the Programme’s impact on social cohesion varied significantly between age groups and gender. With regard to age, participants under 28 reported a larger impact on forgiveness (5.6) than other age groups. It also seems that the impact on forgiveness practice is negatively correlated with age because the lower the age the greater the change. As regards gender, female participants reported a larger impact on trust, in other groups (1.5) and poverty reduction (-1.6).

**Table 9: Impact on social cohesion among sociohistorical categories**

Historical Background Social Category	Willingness to Participate			Forgiveness Theory			Forgiveness Practice			Trust in Other Groups		
	Baseline	Endline	Change	Baseline	Endline	Change	Baseline	Endline	Change	Baseline	Endline	Change
Youth - Descendant of Survivor	4.3	5.4	1.1	6.9	8.3	1.5	0.4	8.1	7.7	7.4	9.3	1.8
Youth - Descendant of Perpetrator	4.6	5.9	1.3	6.6	8.5	1.9	4.4	7.3	2.9	8.7	9.4	0.7
Genocide Survivor	4.3	6.1	1.8	7.1	8.9	1.9	6.2	9.1	2.9	7.7	9.2	1.5
Ex-perpetrator	4.6	5.8	1.2	7.3	9.0	1.7	5.5	9.4	3.8	9.6	9.9	0.3
Total	4.4	5.9	1.5	7.0	8.8	1.8	5.1	8.7	3.6	8.4	9.4	1.1

Table 9 shows that the Programme interventions contributed to improving social cohesion among sociohistorical background categories. Significant change is observed among youth descendants of survivors with respect to forgiveness theory (7.7) and trust in others (1.8). Similarly, genocide survivors saw significant change in terms of willingness to participate (1.8) and trust in other groups and forgiveness theory (1.9). The latter dimension equally applies to youth descendants of perpetrators.

Narratives from FGDs and KIIs concur with these quantitative findings on Programme impact on social cohesion as substantiated in the following quotes.

“I am a Genocide survivor but during the 1994 Genocide I had a Hutu identity card which at times saved me. I saw people digging holes, I saw them throwing Tutsi in those holes. I later married a Hutu woman but it was always hard because of Rwanda’s history, we kept living that struggle. After attending the healing space, I experienced many positive changes. I now feel safe, I share with Genocide perpetrators, even the conflict with them ended. The grief I had was over after I met both survivors and perpetrators in the healing space.” (Male participant, FGD for an adult sociotherapy group, Mareba Sector)

“I married a Tutsi woman before the 1994 Genocide. My brother used to come to my house disturbing us. During the Genocide he attempted to kill my wife. My wife and I were eventually able to flee to Gitarama. When we reached there, a neighbour came to know that my wife was a Tutsi and at the roadblock my wife was severely beaten. I was asked to pay some money to save my wife but they eventually killed her. I still remember that she told me: “My darling husband, you tried your best to protect me but unfortunately I am gone, take care of my children if you survive”. [...] Later, the man who killed my wife was imprisoned, long afterwards he told me that he was the one who gave my wife to be killed. The good thing is there are people in the community that stood up to tell the truth about the people who killed my wife. I never used to



greet the person who killed my wife but after attending the healing space I now greet him. I felt insecure to the point that I had stopped my children from going to school, but after attending the healing space I tried to think about my children's future and sent them back to school.” (Male participant, FGD for an adult sociotherapy group, Mareba Sector)

“The sociotherapy journey has given me so much. Being one of the perpetrators in the Genocide, we learned in prison to accept the crimes we had committed. Even though the government taught us to admit guilt, I did it just for the sake of being released. So I hastened to apologize to those I betrayed. But I couldn't forgive those who testified against me during Gacaca. Sociotherapy brought us back together and during the time we were together I realized my evil and asked for real forgiveness.” (Male participant in an FGD for a sociotherapy group, Ntarama Sector)

**Perpetrators' relatives are more rarely accused of being responsible for the Genocide**

In addition to increasing social cohesion, the Programme changed participants' views on responsibility for the Genocide against the Tutsi. In the post-Genocide context, some Rwandans have continued to assume that all Hutu were Genocide perpetrators. Some participants in the Programme, particularly Genocide survivors and their children, had held this view. A number of them said that dialogues in the healing spaces (notably in the sociotherapy and MFHS groups) had changed their attitudes. In the words of one participant:

“I used to study with a girl whose family was related to Habyarimana [the former president of Rwanda]. She looked like him and this terrified me more because of what my parents had told me. I used to feel that I could not have any interactions or do any business with her. However, thanks to the dialogue in sociotherapy, my attitudes and perception changed. I was set free from thinking that all Hutu were killers.” (Male participant in an FGD for an MFHS, Ntarama Sector).

#### 2.3.2.4. Impact at institutional level

The Programme also had impacts at institutional level. Government officials, including the Community Engagement Specialist at MINUBUMWE and the Mayor of Bugesera District, praised the Programme for helping to build institutional capacity both locally and nationally.

At local government level, Programme interventions improved mental health facilities by building the capacity of the district's mental health community, in Nyamata Hospital and in health centres, as well as therapists and facilitators. Similarly, the Programme provided Bugesera District with a mobile clinic and other context-relevant mental health tools and health equipment. The Programme also raised the trauma awareness of District leaders, by organising and facilitating a psychoeducation initiative for them.

In addition, according to the Mayor, outputs such as the baseline survey report and the MHPSS actor mapping report became important assets for district authorities, which supported their planning processes.

At national level, the Programme made tools available for societal healing. The Programme developed and tested several protocols adapted to the Rwandan context. According to two government officials, these will not only support the implementation of government programmes but can be used by other actors in the field.

In a nutshell, both the endline survey and Programme participants agreed that the Programme's interventions positively shaped capacity to cope with the effects of the Genocide against the Tutsi and other episodes of violence in Bugesera District. Nonetheless, neither claimed that Programme interventions had helped participants to fully resolve mental health problems, achieve healing and social cohesion, or adequately generate livelihoods. These objectives cannot be achieved in a period as short as the lifespan of the pilot programme. It would be better to say that the Programme took the first steps in a long process of mental, psychological, social and economic transformation for participants, their families and their community. While established CO-LIVE initiatives cre-

ated a platform for consolidating and leveraging the Programme's achievements, it is to be noted that graduates of the majority of healing spaces (Sociotherapy, MFHS and ROT groups) did not receive financial support from the Programme. This is a challenge for Programme implementers, with regard to both phase-out interventions and the Programme's expansion into another five districts.



## 2.4 Sustainability

This section argues that the pilot programme is currently sustainable. It discusses Programme strategies that increase the chance that the Programme's outcomes will be sustainable. These could be assessed in the future to see whether they have effectively worked. For the purpose of this evaluation, Programme sustainability was examined at three levels. (1) Has the Programme strengthened local leaders' capacities? (2) Are the Programme's achievements likely to be sustainable after the Programme ends? (3) To what extent has the Programme established processes and systems that are likely to support its continued implementation? One of the merits of the pilot programme under review is that it envisioned sustainability from the inception phase, when it was designed.

### The Programme strengthened the trauma awareness of local leaders

To ensure local ownership of the Programme and to increase the trauma awareness of the District's leaders, the Programme conducted a psychoeducation training for local leaders in Bugesera District. This was important because Programme implementers needed to ensure that stakeholders in leadership positions in the different areas of intervention were aware of the work being carried out, recognised its importance, and understood the trauma issues the Programme was targeting. For local leaders, capacity building was important for the service delivery and conflict management they do in the community. Trauma influences the needs of the population and service delivery, and officials need to be able to understand, interpret and respond appropriately to trauma-influ-

enced attitudes and behaviours in the community. The Programme initially targeted 255 local leaders, but eventually provided psychoeducation training to 294. According to a PFR official:

“Trained local leaders included the District Director of Governance, the JADF coordinator, the Director of Social Affairs, the Officer in charge of cooperatives, District Coordinators of the National Women’s Council, National Youth Council, National Council for Persons with Disability, Sector Executive Secretaries, Sector Staff in charge of Social Affairs, and Cell Executive Secretaries. Selected local opinion leaders, members of community-based conflict/dispute resolution such as *Abunzi* [mediators], members of *Umugoroba w’umuryango* [family evening forums], and *Inshuti z’umuryango* [friends of the family volunteers] were also included. The psychoeducation training with local leaders covered critical issues such as mental health, trauma and crisis management, conflict management, and the nexus between trauma healing, social cohesion and collaborative livelihoods, among other things.” (Interview, PRF Programme Coordinator, Kigali)

Participants in the evaluation were largely unanimous in saying that training to enhance the capacity of local leaders was a key strategy for the Programme’s sustainability. The quotes below substantiate this view.

“As local leaders, we acquired important human capital in terms of trauma-aware leadership and this will remain useful even after the Programme phases out. Local leaders at different levels and in different positions have benefited from this capacity building. It is an important human asset for our leadership and for our communities.” (Interview with the Mayor of Bugesera District)

“The psychoeducation component of the Programme strengthened the capacities of local leaders. This is a big asset, tied to the Programme’s sustainability because local leaders will still be applying the skills they acquired after the 18 month lifetime of the Programme.” (Interview, Community Engagement Analyst, MINUBUMWE)

Ultimately, strengthening the psychoeducation capacity of local leaders not only made them aware of the value of the pilot programme’s interventions but built a platform for sustainability because it targeted actors who work with community members daily and who will remain in the communities of Bugesera District.

## The District leadership is committed to include mental health in the district *imihigo* and action plans and budgets

Having recognised the value of psychoeducation training and the Programme’s overall effectiveness and impact, the leadership of Bugesera District have resolved to make mental health an important dimension of District planning. This commitment was highlighted by the Mayor:

“From the pilot Programme we have learnt that mental health is a precondition for the success of our efforts to enhance social cohesion and the economic development of our citizens. The district authority is therefore committed to integrate mental health in our planning and budgeting.” (Interview with the Mayor of Bugesera District, Kigali)

## Life-long knowledge and skills acquired

The evaluation found several human and technical assets that can enable the Programme’s achievements to endure after phase-out. Several participants and informants were optimistic about this. Major elements supporting this view include: (1) the establishment of collaborative livelihood initiatives; (2) the willingness of ROT groups and Multifamily Healing Spaces to stay together; (3) the presence of trained facilitators in the communities; (4) the

presence of an infrastructure to support mental health; (5) the presence of youth skills hubs in the communities; (6) the TVET in Bugesera Prison; (7) the increase of staff in local partner organisations and NGOs involved in implementing the pilot programme; and (8) the protocols on mental health, sociotherapy, collaborative livelihoods, ex-prisoners' reintegration and other subjects.

## The value of baseline data on mental health and the mapping report for Bugesera District

Before initiating any interventions, the Programme conducted a mental health baseline and social cohesion survey. This informed the Programme's activities but also established the initial conditions that provided a point of comparison for subsequent mid-term and endline evaluations. Concurrently, the Programme mapped initiatives and approaches in the District that were relevant to core pillars of the Programme. These outputs supported implementation of the pilot programme, but some participants also considered that they were assets for sustainability, because other actors are likely to use them in their own interventions.

"The baseline survey not only informed the Programme interventions, but also raised our awareness as local leaders of the mental health needs of our community. I have no doubt that the baseline report will continue to inform our district planning, and other stakeholders might refer to it when they design their interventions in our district. The same is likely to be true of the mapping report that was also produced by the Programme in its inception phase. Both are important assets for the pilot programme's sustainability." (Interview with the Mayor of Bugesera District, Kigali).

"At the Programme's inception, Interpeace and its partners made use of two important reference documents that should be useful to many actors even after the Programme phases out. I mean the mental health baseline survey and the mapping of actors. The RBC Mental Health Survey provides a national picture of mental health issues, but so far, except for the baseline report for Bugesera District, no research papers provide a picture of the districts." (Interview, community engagement analyst, MINUBUMWE)

## Protocols prepared by the Programme

The Programme developed protocols to guide the inception phase of several interventions. Relevant stakeholders tested and validated the protocols, which covered: community screening; ROT; MFHS; sociotherapy; CO-LIVE; prisoner's rehabilitation and reintegration; and socio-emotional skills. Participants in the evaluation agreed that the protocols were assets and that stakeholders involved in the pilot programme and other actors in Rwanda will continue to make use of them in the future.

## Income generating initiatives

Collaborative livelihoods was one of three pillars of the Programme. While the mental health and sociotherapy pillars were meant to last for a limited period without compromising their outcomes, because of their economic dimension the collaborative livelihood initiatives were expected to endure after the Programme finished. Participants in CO-LIVE initiatives consistently maintained that they wished to stay together, not only to sustain the outcomes of their sociotherapy but to improve their material well-being through collaboration.

"When we joined this sociotherapy group, we had no idea we would open a bank account. Today we have one. Having a bank account is a sign of our commitment to stay together and continue after the Programme is phased out. We are all committed. Interpeace also gave us Rwf 800,000 to support our initiative." (Female participant, in an FGD for youth graduates of a sociotherapy group, Ntarama Sector)

## Willingness of ROT groups and Multifamily Healing Spaces to stay together

During the healing and dialogue processes, members of ROT groups and MFHS discussed whether they might stay together after the Programme phased out. Nearly all spaces agreed to continue and established arrangements for doing so. Most started small-scale socioeconomic initiatives through which groups could help each other. In the words of a ROT facilitator:

“[ROT] groups have convened to carry on their meetings and exchange to support their healing and resilience. They want to keep reflecting on what they achieved through groups. The group I facilitated has started a small saving scheme. They contribute 500 Rwandan francs a week, and members have started buying poultry in rotation. So far, the indications are that they want to stay together as a group to sustain the ROT outcomes.” (Interview, psychotherapist at AVEGA and facilitator of ROT group, Bugesera District).

“I’ve noticed that members of spaces that graduated almost a year ago have stayed together and are involved in small-scale saving schemes and income generating activities that help them to leverage the outcomes of mental health, social cohesion and enhance livelihoods. This is evidence that achieved outcomes are likely to last.” (Interview, Senior Programme Psychotherapist, Kigali)

## The presence of trained facilitators in the communities

To implement its mental and sociotherapy pillars, the Programme selected and trained facilitators from the community. The following quotes indicate their value.

“[ROT] group members have established a small-scale saving group to keep connected and support each other. They asked me to make myself available whenever they need me and I am ready to do that and have no doubt that my employer will be equally supportive.” (Interview, psychotherapist at AVEGA and facilitator of ROT group, Bugesera District)

“The Programme outcomes stand a great chance of being sustainable because most of Programme interventions were driven by local actors, many of whom are themselves community members. I mean, for instance, the group and space facilitators and some psychotherapists, who are still willing to support these spaces after they are phased out.” (Interview, senior psychotherapist, Kigali).

## Stronger presence of staff from local partner organisation and local NGOs involved in implementing the pilot Programme

To implement the pilot, the Programme trained selected staff from some local NGOs, such as PFR, Rwanda We Want, GAERG, AVEGA and Nyamata District, as well as affiliated health centres. The training covered issues relevant to the Programme’s core pillars (mental health, sociotherapy, and CO-LIVE). Staff interviewed for the evaluation confirmed that they would continue to use the knowledge and skills they had learned to implement other interventions by their organisations both now and in the future.

## An infrastructure to support mental health

During its implementation, the pilot Programme created important elements of a mental health infrastructure, especially the ROT and CO-LIVE pillars.

The Programme established a mobile clinic to raise community awareness of mental health issues and deliver mental health screening. It also bought motorcycles to give psychotherapists mobility; psychotherapists were recruited and dispatched in all health centres in Bugesera district under the coordination and supervision of Nyamata District Hospital Mental Health Department. This infrastructure was designed to support the ROT pillar, but also to remain active after the Programme ended. Both the District Mayor and the head of the mental health department at Nyamata district hospital said that their institutions will continue to use these facilities to promote mental health in the District.

To support the CO-LIVE pillar, the pilot programme also equipped a TVET centre in Bugesera prison. The aim was to give Bugesera Prison inmates practical skills that would enable them to become economically useful and so minimise recidivism. The TVET functioned through the lifetime of the Programme lifetime and will remain available to prisoners after the Programme phases out. The evaluation found that Genocide convicts who recently graduated from the sociotherapy group in Bugesera Prison were interested in learning a wide range of livelihood skills, in the areas of farming, treating plants, treating animals, bricklaying, carpentry, tailoring, teaching, counselling, craftwork, computers/electronics, vehicle repair and maintenance, driving, business management, literacy, and numeracy. Ultimately, all these infrastructures support the sustainability of the Programme.



## Youth skill hubs in the community

To support the CO-LIVE pillar, the project established TVET centres in Bugesera District to give youth hands-on skills in masonry, tailoring, welding, hairdressing and other skills. The Programme also supported four youth skills hubs in Ruhuha, Mayange, Rweru and Juru sectors for youth from all parts of Bugesera District. Participants in the evaluation commended the creation of such hubs, which are meant to remain active and improve youth livelihoods after the Programme ends. It is also important to note that the youth skills hubs align with “Reconciliation in Action”, a growth-driven, forward-looking socio-economic initiative that aims to strengthen the links between psychosocial wellbeing, reconciliation, and economic development .



## Extension of the Programme into other districts

Following the phase-out of the pilot Programme in Bugesera, and based on lessons learnt from it, Interpeace and its partners, with financial support from Sida, have started to extend the Programme’s interventions into five additional districts (Nyagatare, Ngoma, Musanze, Nyabihu and Nyamagabe). This scale-up is a key element of the pilot Programme’s sustainability because the interventions in these districts will be informed by both the protocols tested in Bugesera District and lessons learned from the pilot phase.

“The Programme interventions are being expanded in five other districts of Rwanda because we are confident that the protocols fit the Rwandan context. Similarly, from the pilot Programme, we [Programme implementers] have learned lessons that helped us fine-tune our strategies and approaches. This shows the sustainability of the pilot programme.” (Interview, DMEL Advisor, Interpeace Rwanda and Great Lakes Region)

“The Programme’s sustainability lies partly in the fact that the protocols developed and tested in the pilot phase are now being used in the Programme expansion in five other districts. I would say it is a more informed continuation of the Programme out of the initial district, based on lessons drawn from the pilot Programme.” (Interview, PFR Programme Manager, Kigali)

## Partnership with relevant public institutions

Last but not least, from the design stage of the pilot Programme, Interpeace and PFR worked closely with selected government institutions. Government partners of the pilot Programme included the former NURC (merged with three other public institutions to form MINUBUMWE), the RBC, the Ministry of Justice and the RCS. The evaluation found that the partnerships with most of these institutions took shape during the implementation phase. In the words of the DMEL Advisor, Interpeace Rwanda and Great Lakes Region:

“Throughout implementation of the pilot Programme, we [Programme implementers] were in constant dialogue and exchange with most of the local and national government institutions that were involved. This strengthened the partnership and increased trust between us. This trust is a vital social and political capital for both sides. I have no doubt that it will remain and deepen as the Programme scales up in other districts.” (Interview, Kigali)

MINUBUMWE is committed to establishing networks of peacebuilding actors across the country. One of the unintended positive impacts of the pilot phase was the formation of a mental health and psychosocial support (MH-PSS) network in Bugesera District. This occurred after the Programme mapped peacebuilding actors/initiatives and approaches in Bugesera District during the inception stage. The network is a critical avenue “to connect and support community-based actors and local government in delivering and developing mental health and psychosocial support services for individuals and communities affected by the Genocide against Tutsi and its legacies”.<sup>17</sup> Largely inspired by this Programme achievement, since October 2022 MINUBUMWE has undertaken to work with other peacebuilding organisations to set up networks of peacebuilding initiatives and structures at district level. The Community Engagement Specialist at MINUBUMWE described this commitment :

“The pilot Programme in Bugesera has made a good job of facilitating the establishment of an MHPSS network in Bugesera. This has partly inspired our ministry’s commitment to support the formation of such networks to improve coordination of and collaboration between existing initiatives and structures at district level. In fact, this is in line with MINUBUMWE’s mandate. In this regard, since October 2022 we have selected ten relevant peacebuilding organisations to coordinate setting up such networks. Each organisation received a grant of FRW 30,000,000 and will be responsible of setting up networks in three districts.” (Interview, Kigali)



From the above, it is clear that several sustainability strategies for the pilot Programme and its outcomes are in place. At this stage (the end-term evaluation), it is possible to say with some confidence that the Programme funding was justified and delivered value for money. However, only future assessment can judge whether the Programme’s outcomes will have been sustained.

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<sup>17</sup> Interpeace, PFR and NURC (2021), ‘District Follow-Up and MHPSS Coordination Meeting’, La Palise Hotel, Nyamata, June 10, p. 2.



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## 2.5 Coherence

In Programme evaluation, the coherence criterion<sup>18</sup> assesses “how well the intervention fits” (OECD, 2019, p.8). The pilot programme has been coherent both internally and externally.

### 2.5.1 Internal coherence

The Programme is interconnected with other interventions by the implementers (Interpeace and PFR). First and foremost, both Interpeace (the lead implementing organisation) and PFR (the implementing local partner) are peacebuilding organisations. Interpeace has long experience of international peacebuilding initiatives in Rwanda, where, in partnership with local NGOs, it has run societal healing, reconciliation and participatory governance projects for the past two decades. The Programme under review was the pilot phase of a wider societal healing programme which is currently being extended to five other districts (Musanze, Nyabihu, Nyamagabe, Nyagatare and Ngoma).

According to the Design, Monitoring, Evaluation & Learning (DMEL) Advisor for Interpeace’s Rwanda and Great Lakes Region Programme:

“The pilot Programme was in line with Interpeace and partners’ four year Programme which was designed to complement completed initiatives, particularly in Rwanda, that had focused on societal healing and social cohesion. Societal healing and reconciliation have been at the centre of the interventions of Interpeace and its partners in Rwanda for the past two decades. It is no wonder that the pilot programme implemented in Bugesera District is coherent with Interpeace’s mission at large and its experience in Rwanda in particular.” (Interview, Kigali)

As for the implementing local partner, since its inception PFR has worked on peace building and psychosocial support in both the community and in prisons. Sociotherapy has been among its core strategies of action, which are designed to contribute to societal healing and social cohesion in Rwanda. According to PFR’s societal healing coordinator:

“The pilot programme in Bugesera District came in to support PFR to realise its mission and objectives. Supporting efforts to effectively reintegrate ex-Genocide convicts in their families and communities has been a core focus of our interventions. We have other projects that work with children, on prisoners’ re-integration, and on prisoners’ spiritual transformation, and one on restorative justice through enhancement of practical reconciliation between prisoners and Genocide survivors.” (Interview, Kigali)

From the foregoing, it is clear that the Programme’s interventions were coherent with the missions and other interventions of Interpeace and PFR, and added value to them.

### 2.5.2 External coherence

External coherence was assessed by examining the degree to which the Programme’s interventions were consistent with the interventions of other actors, both in Bugesera District and nationally.

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<sup>18</sup> Internal coherence addresses the synergies and interlinkages between an intervention and other interventions by the same institution/government, as well as the consistency of an intervention with international norms and standards to which that institution/government adheres. External coherence considers the consistency of the intervention with other actors’ interventions in the same context. It considers complementarity, harmonisation and co-ordination with others, and the extent to which the intervention adds value while avoiding duplication of effort (OECD, 2019, p. 8).

It is worth noting that at the implementation stage, Interpeace collaborated with several other relevant actors in Bugesera District. They include Nyamata District, through Nyamata District Hospital and affiliated health centres, and three local NGOs working in the same district: the Association des Veuves du Génocide (AVEGA, Genocide Widows Association), the Groupe des Anciens Etudiants Rescapés du Génocide (GAERG, Student survivors of the Rwandan Genocide), and Rwanda WE Want (RWW). Nyamata Hospital, AVEGA, and GAERG collaborated in providing resilience oriented therapy (ROT); RWW was involved in providing multi-family dialogue spaces with a focus on youth. It emerged that the pilot programme was equally coherent with the missions and some interventions of both the hospitals and the three NGOs. Nyamata District Hospital has a mental health department that has largely relied on individual approaches to trauma healing, including Genocide-related traumas. Despite its newness, ROT aligns with the mental health mission of the hospital, especially in its resilience component and group dimension.

“Basically, we have been relying on an individual approach to deal with mental health issues among our service seekers. The ROT approach complements that approach and innovates.” (Interview with the Head of the Mental Health Department, Nyamata District Hospital)

Officials from the three NGOs also confirmed the Programme’s external coherence. For instance, AVEGA had been providing trauma management services to the general public, and particularly to Genocide widows and their dependents, children born as a result of rape, GBV victims, teen mothers, and drug abuse victims. A pillar of GAERG’s work was the provision of psychosocial support to Genocide survivors by building “members’ capacity in terms of skills, tools, and techniques to provide a response to the unique psychosocial needs of members and participants”. According to the Executive Director of Rwanda We Want:

“Helping youth learn about the history of their country, and the Genocide against the Tutsi, and fostering a healthy intergenerational dialogue, have been our organisation’s concerns. They are coherent with Interpeace’s pilot programme in Bugesera, particularly its multifamily healing space approach. In this district, Rwanda We Want has been implementing a project that harnesses intergenerational dialogue to teach history, but two major aspects were missing: number one was societal healing, and number two was engaging the entire family in the dialogue.” (Interview, Kigali)

At national level, the pilot Programme in Bugesera was also consistent with national policies and interventions. In this regard, the newly established Ministry of National Unity and Civic Engagement (MINUBUMWE) was mandated, among other things, to “preserve and share with others, methods used by survivors of the Genocide against the Tutsi for recovery and resilience after the Genocide against the Tutsi” and “to elaborate, disseminate, and implement strategies related to: (a) social cohesion to heal the wounds caused by the distortion of the history of Rwandans...”<sup>19</sup>

The pilot Programme’s interventions were consistent with this mandate, which the Ministry, in collaboration with its stakeholders, is endeavouring to translate into action. As the Community Engagement Analyst at MINUBUMWE put it:

“The Programme’s interventions not only contribute to but are highly consistent with the Ministry’s mandate to enhance social cohesion, resilience and heal historical wounds as core ingredients of achieving national unity. Similarly, our Ministry [MINUBUMWE] has an entire department in charge of community resilience. Interpeace’s pilot Programme was therefore closely connected to our work.” (Interview, Kigali)

The pilot programme also aligned with the national programme to reintegrate ex-Genocide convicts. As an im-

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19 Article 3 of Prime Minister Order No 021/03 of 21/10/2021 determining mission, responsibilities, and organisational structure of the Ministry of National Unity and Civic Engagement.

portant proportion of the Genocide convicts who were sentenced to ten or more years in prison<sup>20</sup> complete their sentences and return to their families and communities, initiatives are needed to support that process by boosting and cementing social cohesion and healing trauma. The Programme's focus on sociotherapy, skills development, and rehabilitation and reintegration of prisoners in Bugesera Prison mirrored that agenda. The partnership of Interpeace, PFR and Rwanda Correctional Service (RCS) through the life of the Programme again shows the Programme's relevance and coherence.

The pilot programme also aligned with the mental health work of the Rwanda Biomedical Centre (RBC). The Rwanda Mental Health Survey (RBC, 2019) highlighted the scale of mental illness in the general population, and the high prevalence of mental disorders among Genocide survivors. Under its mandate as an implementation agency of the Ministry of Health, the RBC "manages mental health during commemoration of 1994 Genocide against the Tutsi and conducts follow ups of trauma cases ... advocates for mental health programs ... and [provides a] helpline for trauma cases".<sup>21</sup>

The mental health pillar of the pilot programme was therefore consistent with current government efforts, through RBC's mental health department, to heal traumas and other mental health issues among Rwandans, including mental problems inherited from the Genocide against the Tutsi. The following quote from a mental health expert who supported implementation of the pilot programme underscored this.

"The Genocide adversely impacted the bodies and the minds of Rwandans but also the social fabric at large. Through its mental health pillar, the Programme was consistent with on-going national efforts to address mental health issues that are mainly a legacy of the Genocide. Initiatives to promote social cohesion, reconciliation and livelihoods are likely to be unsustainable if they do not address mental health impediment." (Interview, mental health expert, Kigali)

It is equally important to note that, to the best of our knowledge, the pilot programme has complemented and added value to existing peacebuilding initiatives and has not duplicated the latter. By design, the Programme relied on a theory of change that applied a holistic approach. The theory addressed mental health as a starting point towards achieving sustainable social cohesion and socioeconomic stability for people and communities that had experienced severe mass violence, notably the 1994 Genocide against the Tutsi and its aftermath. Few other organisations have undertaken or are currently undertaking substantial work in societal healing and social cohesion in Rwanda, particularly in Bugesera. Some organisations have developed sociotherapy or psychosocial support groups. They include Community Based Sociotherapy (CBS), Never Again Rwanda, and Interpeace, GAERG, AVEGA and International Alert. However, to the best of our knowledge, none of those initiatives had applied such a holistic strategy. Additionally, the pilot programme's adoption of the ROT approach and pre-intervention screening appears to be unprecedented, certainly in Bugesera and probably in Rwanda.

## Provision of complementary support to other local healing and peacebuilding initiatives

In addition, the pilot Programme supported other healing and peacebuilding efforts in Bugesera. This aspect of the Programme has been discussed in relation to the sustainability criterion, but it is just as relevant to consistency. The evaluation showed that the Programme's strategy to support the work of other initiatives not only helped it to achieve expected results but increased its sustainability. As earlier discussed, through the pilot Programme, Interpeace provided support to Nyamata District (as an administrative entity), to RCS, and to three local NGOs (AVEGA, GAERG and Rwanda We Want).

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<sup>20</sup> Gacaca courts officially closed their proceedings in June 2012.

<sup>21</sup> See for details <https://www.rbc.gov.rw/index.php?id=631>

In a nutshell, the internal and external coherence of the pilot Programme in Bugesera is demonstrated not only by its mission and related interventions but through its cooperation with local and national actors.

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## 2.6 Efficiency

This section examines how well the Programme used its resources, taking achieved results into account. For the purpose of this evaluation, efficiency was qualitatively assessed. Based on the Programme's theory of change (see the introductory chapter), the pilot Programme was built on three core pillars: mental health (to be achieved through ROT and MFHS); social cohesion (to be achieved through sociotherapy groups for youth, adults and prisoners as well as MFHS); and CO-LIVE (to be achieved through livelihood initiatives, youth-oriented TVETs, youth skills hubs, training in life skills, and prisoner-oriented TVET).

To implement these interventions, the Programme mainly relied on group facilitators who were locally recruited and trained by local organisations focused on peacebuilding and mental health or by Nyamata District Hospital and affiliated health centres. Psychotherapists were equally trained. To implement ROT under the mental health pillar, the Programme supported the local health infrastructure by providing a mobile clinic, and supplying motorcycles to the psychotherapists attached to public health centres and Nyamata District Hospital. For the CO-LIVE pillar, the Programme offered financial support to graduates of sociotherapy groups to enable them to start socioeconomic initiatives that would cement social cohesion and livelihoods.

The evaluation concluded that the Programme's use of resources was largely efficient, due to the design of the Programme but also to the adaptable and flexible way it managed its interventions and contextual issues and challenges. Key points substantiating the Programme's efficiency are discussed below.

### Involvement of national and local leaders from the Programme inception phase

From the outset, Interpeace and PFR involved government actors at national and local level. At national level, they strategically engaged officials from line ministries, such as the Ministry of Health and the Ministry of Justice, as well as public implementing agencies, such as the RBC, RCS and the former NURC. This engagement was a core strategy for managing the political space but also obtained technical support and built partnerships for programme implementation.

At local level, the Programme engaged with the district leadership, not only to increase awareness and solicit support for the Programme but to create conditions for a more citizen- and context-oriented process. The Programme strengthened local leaders' trauma-awareness leadership. In doing so, it made local leaders more aware of mental health issues in the community, and appropriate responses to them, but made local leaders more receptive and supportive to the Programme. This increased ownership of Programme interventions.

These engagements gave both sides avenues into discussion of the Programme's objectives and expected outcomes. Further, they created opportunities for government institutions to express their interests and their concerns.

As a result, the relationships and partnerships with national and local leaders have been highly advantageous. They smoothed implementation and reduced the time needed to negotiate and obtain political approval for the Programme and its implementation.

It is also worth noting that, due to the quality of its relationships and partnerships, RCS agreed to co-fund the construction of a TVET in Bugesera Prison to facilitate the CO-LIVE pillar for prisoners who were beginning their re-

integration process. The co-funder covered the cost of labour (carpenters, teachers, psychologists) and the purchase of land and bricks, while the Programme provided cement, iron sheets, paint and school equipment.

## Reliance on local human resources (such as community-based facilitators)

The Programme aimed to rely primarily on community-based human resources. This aim was largely achieved by recruiting group facilitators from the community. The strategy paid off because it reduced the amounts spent on outside facilitators and their accommodation, transport and communications. In addition, because the local facilitators were generally people of integrity who were well-known in their communities, the strategy increased public trust in the project and community members were more willing to speak about sensitive aspects of their private and social life.

## Strengthening local health infrastructures (mobile clinic, transport for psychotherapists)

While it did not initially plan to do so, the Programme strengthened local health facilities. The initial plan was to recruit and train psychologists and assign them to health centres in Bugesera District. However, consultations with local and national officials suggested that this strategy would not be sustainable because the psychologists would not reach enough people. In addition, after the Programme ended, recruited psychologists would leave and mental health support in the District would return to its previous state. This was an important sustainability issue.

The Project therefore provided a mobile clinic, attached to Nyamata District Hospital. The budget included six months of salary for the mobile clinic driver, seventeen psychotherapists to be based in all public health centres (15 sectors), and 17 motorcycles to enable the psychotherapists to move around. According to the District Mayor and Programme managers, this was a superior strategy because it allowed psychotherapists to reach much larger numbers of people in their communities. It also made the Programme more sustainable because all the acquired facilities (mobile clinic, motorcycles) were taken over in good condition by the district authority when the Programme ended.

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## 2.7 Gender and youth inclusion

Gender and youth inclusion are critical dimensions of both development and peacebuilding interventions and are increasingly key elements for Interpeace and its partners.<sup>22</sup>

The evaluation assessed gender and youth inclusion at two levels: (1) design (drawing on the pilot programme document); and (2) implementation. With respect to design, the assessment examined the extent to which the Programme document provided roles and responsibilities to men, women and youth across Programme interventions and how specific gender and youth needs would be addressed. With respect to implementation, the evaluation examined the extent to which the Programme considered gender and youth inclusion when selecting participants, community group facilitators and therapists, as well as inclusion in spaces facilitation, Programme protocols and related-Programme interventions.

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<sup>22</sup> Highlighted by the Interpeace's Senior Programme Manager and Gender and Inclusion Advisor.

## 2.7.1 Gender and youth inclusion at the Programme design level

To address gender blindness, the Programme document took care to employ gender related terms. It mentioned 'gender' 18 times, 'women' 14 times, 'female' 3 times, 'men' 2 times, 'male' once, 'youth' 49 times, and 'young' 21 times. Cumulatively, gender and related terms figure 37 times and youth and related terms figure 70 times. It can be said that the Programme document used gender and youth sensitive language.

The Programme also hired a gender expert, who oversaw gender mainstreaming throughout the Programme's design. With other colleagues, the expert was closely involved in designing and formulating the Programme's interventions and approaches.

Further, the Programme document contains a section on gender and youth inclusion.<sup>23</sup> It affirmed that gender and youth inclusion would be promoted in two ways. From a gender perspective, the Programme would run screening and group-based therapy protocols, including multi-family group sessions, that would address gender-based violence, family conflict and the economic empowerment of women (among other issues).<sup>24</sup> Specific group therapy protocols would also address traumas relating to experience of sexual violence. In every sector, both male and female therapists would be present to ensure that female survivors could talk about their experiences with a female therapist. To achieve this, the Programme decided to create safe spaces in which survivors of sexual violence and persons from the LGBTI community could share their experiences. These would be co-facilitated with a national or local women's organisation.

In its cultural sensitivity trainings, furthermore, the Programme included sessions on the evolution of gender equality in Rwanda in the last 25 years as well as changes in gender norms and expectations. To deliver this session, the Programme chose to work with an organisation with expertise in promoting positive masculinities, which helped to develop and deliver training protocols on that theme.<sup>25</sup>

With respect to youth inclusion, the Programme planned to focus on youth who are at risk of experiencing developmental and intergenerational transmitted trauma, youth who were very young during the Genocide, and the offspring of survivors and perpetrators born after the Genocide.<sup>26</sup> Youth specific protocols were to be developed; these were to be gender sensitive and to include same-sex and possibly LGBTI sessions.

Last but not least, the Programme determined that its monitoring and evaluation methods should be age and sex-disaggregated, and should include gender and youth specific indicators for tracking progress and identifying lessons.<sup>27</sup>

The Programme was also inclusive with regard to historical backgrounds. Considering the post-Genocide context, the Programme elected to focus on two key categories of Rwandans, on opposite sides of the Genocide: Genocide survivors and Genocide perpetrators, and their relatives.

There is clear evidence that the design of the pilot Programme in Bugesera was highly gender and youth sensitive and inclusive of major historical categories in relation to the Genocide (survivors and perpetrators and their relatives).

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23 Interpeace (n.d.), 'Reinforcing community capacity for social cohesion and reconciliation through societal trauma healing in Bugesera District', Programme Document, p. 21.

24 Ibid.

25 Ibid.

26 Ibid.

27 Ibid.

## 2.7.2 Gender inclusion during implementation

The Programme's sensitivity to gender was largely continued during implementation. Evaluation participants, and monitoring and evaluation data, largely agreed with this claim,.

### Hiring a gender expert

Staffing was gender sensitive. In June 2021, Interpeace hired a "local expert on gender mainstreaming in trauma healing and social cohesion programming in Rwanda". Acting as a consultant, this expert provided technical support and advice on integration of gender in the design and implementation of various activities related to trauma-healing, social cohesion, prisoner reintegration and collective livelihoods in Bugesera District. Her specific tasks included: (1) providing inputs on the protocols in mental health, social cohesion, and collective livelihoods, focusing on gender responsiveness and sensitivity; and (2) helping to analyse data from the Programme's baseline and community mapping surveys of all 15 Sectors of Bugesera District.<sup>28</sup> Towards the end of the pilot programme, the gender expert's position was upgraded to a full-time post as "Gender and Inclusion Advisor". The post will continue to provide technical support and advice on gender mainstreaming as the Programme extends into five additional districts of Rwanda.

### Taking gender into account when selecting participants in Programme spaces

The recruitment of participants for Programme spaces (socio-therapy, MFHS, ROT) was essentially informed by screening outcomes rather than gender considerations. Based on the results of the screening exercise, men and women, girls and boys were allocated to different healing spaces. The selection had little to do with balancing the number of men, women, boys and girls in a given space.

"The screening protocol was instrumental in assigning Programme participants to appropriate healing spaces. Based on the screening result, an individual is allocated to either ROT, sociotherapy or multifamily. This process therefore has little to do with group composition from a gender perspective." (Gender and Inclusion Advisor, Interpeace-Rwanda)

However, in CO-LIVE initiatives and groups, gender sensitivity was a funding requirement. According to the DMEL Advisor of Interpeace Rwanda and Great Lakes Region:

Core criteria [for CO-LIVE] included: (1) they had social cohesion as the end-goal; (2) they have gone through a healing process; (3) they were inclusive of different historical and social backgrounds (survivors, ex-perpetrators, returnees., and their offspring). Of course [this applied to] ongoing livelihood initiatives (not a start-up). And (3) gender inclusiveness, not only in terms of membership but also in terms of governance and management structures." (Interview, Kigali).

More important, the Programme included vulnerable single mothers who participated in youth skills development through TVETs and later skills hubs.

### Gender considerations in selection of community group facilitators and therapists

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<sup>28</sup> Job description of the local expert on gender mainstreaming in trauma healing and social cohesion programming in Rwanda.

As mentioned earlier, the Programme initially planned to have a gender balance between group therapists dispatched to different sectors of Bugesera District. In practice, therapists led in ROT spaces and community dialogue facilitators (CDFs) facilitated sociotherapy and MFHS. The Programme recruited CDFs from their communities. In most of the sociotherapy and MFHS spaces, the facilitation team was composed of a man and a woman.

“The rule of thumb is that sociotherapy groups have both male and female facilitators. For instance, I and a male fellow facilitator led the dialogue in our group. In other groups it was the same.” (Interview with a female sociotherapy group facilitator, Nyarugenge Sector)

Group co-facilitation with a man and a woman was seen to be beneficial because it increased the likelihood that both male and female participants could speak about sensitive issues. It also helped to ensure that the floor was not dominated or monopolised by one gender.

Unlike the facilitators of sociotherapy and MFHS, ROT facilitators had expertise in psychology rather than gender. It was also much harder to achieve gender balance when recruiting therapists, compared to facilitators. Some participants explained this.

“ROT groups required special skills in mental health. Their roles went far beyond those of CDFs. That is why we turned to psychotherapists. During the recruitment, there were more female than male candidates. And some of the few males who showed up were not excited about the remuneration. Consequently, of ten therapists we involved, one was a man and nine were women.” (Interview with a psychotherapist at AVEGA and a ROT group facilitator, Bugesera District)

“For ROT groups, the facilitators were qualified psychologists, and gender balance was hard to ensure because we are talking about the available qualified personnel in a certain profession.” (Interview, Gen-



der and Inclusion Advisor, Interpeace Rwanda )

## Gender considerations in group facilitation

For group facilitation, gender-balance is essential but it is not an end in itself. Gender sensitive facilitation is important to ensure that no gender monopolises the floor, that participants feel safe to open up on gender sensitive issues, and that topics of dialogue are not gender blind. The evaluation showed that the facilitation of community spaces was largely gender sensitive. MFHS and sociotherapy group facilitators endeavoured to ensure that male and female participants were equally active in the dialogue, and that no-one felt forced to take the floor.

“In our sociotherapy group, there was much gender inclusiveness. Not only did we have gender parity in the facilitation team, but they [the facilitators] made all of us feel safe and men did not dominate the dia-



logue as they often tend to do.” (Participant, FGD for a sociotherapy group, Bugesera District)

“It is enshrined in the sociotherapy protocol that the facilitation should be gender sensitive. We [facilitators] respected that requirement and made sure that no-one was left behind. It was our responsibility to encourage all participants to open up. At the same time, we respected everybody’s privacy and freedom to speak when he or she wanted and felt safe to speak. That is how it is mainly in the healing process.” (Interview, MFHS and sociotherapy group facilitator, Bugesera District).

## Gender inclusion in the content of Programme spaces

With respect to the structure of MFHS meetings, it emerged that people are not always free to speak about some gender issues. The MFHS protocol provided for four types of meeting space: (1) intergenerational dialogue; (2) breakout sessions for family units; (3) parents-only healing; (4) youth only healing. Because some issues are very sensitive, neither men nor women were usually willing to talk about some matters in the presence of adults of the other gender, or children. It seems that women-only and men-only healing spaces were lacking.

“Space participants would not put it this way, but we’ve been observing symptoms of this problem across the facilitation. For instance, some women have experienced intimate partner sexual violence, young girls have faced rape perpetrated by close relatives. Such issues are often so sensitive that victims cannot disclose them in mixed sessions. Similarly, as you know, when some ex-Genocide convicts returned home, they found their wives with babies they had out of wedlock. In our [MFHS] spaces, affected men tend to claim that they forgave their wives, but in reality we sensed that some of them were not comfortable to say otherwise because of their criminal background and the nature or composition of the space. It is likely that they would have been more comfortable in men-only healing spaces, if these had been available.” (Interview, MFHS and sociotherapy group facilitator, Bugesera District)

“The structure of MFHS was not fully gender sensitive. Some highly sensitive issues women or girls are more comfortable to discuss in the presence of women, rather than when men or children are present. This is especially so when it comes to sexual violence or rape that occurs in a family setting. We noticed that the lack of men-only and women-only healing spaces in MFHS could be a gap in the MFHS protocol.” (Interview, Gender and Inclusion Advisor, Interpeace Rwanda)

**Table 10. Gender and youth inclusion in Programme protocols**

Protocol	Gender and youth inclusion considerations
1 Screening	<p>Considers gender and youth when referring individuals to healing spaces.</p> <p>Includes community members of all ages (including youth) that struggle with social cohesion, participation in community initiatives, and forgiveness.</p> <p>Youth under 30 who are wounded due to their historical background.</p> <p>Women who were victims of rape during the 1994 Genocide.</p>
2 ROT	Gender and youth blind. Resilience-oriented therapy does not consider gender.

Protocol	Gender and youth inclusion considerations
3 MFHS	<p>The approach considers inclusion in group activities.</p> <p>It affirms that all participants will be valued as persons with equal opportunities to speak and be heard, regardless of age, gender or social status.</p> <p>It expects facilitators to encourage participants to sit in a circle, because this allows them to see each other face to face and feel that in MFHS all are equal and that everyone's voice should be heard and respected regardless of differences in age, gender, and position in society.</p> <p>13 years as the minimum age for inclusion in MFHS.</p> <p>It provides youth-only, parent-only and intergenerational dialogue healing spaces</p> <p>It does not address gender-based violence within families, though this is the most common form of GBV.</p> <p>Meetings do not include women/girls-only or men/boys-only healing spaces.</p>
4 Sociotherapy	<p>The method affirms gender is a key element in stereotyping.</p> <p>It considers gender is an important aspect of respect (one of the six phases of sociotherapy).</p> <p>It pays attention to gender relations, including sexual and gender-based violence.</p> <p>It contains rules for setting boundaries for sexual abuse survivors.</p> <p>Groups are jointly facilitated by men and women.</p> <p>It accommodates mixed groups (male and female) and single sex groups, depending on needs and the targets to be achieved.</p>
5 Co-LIVE	<p>Gender equality is a guiding principle.</p> <p>To qualify for selection and funding, initiatives must be inclusive of gender and youth.</p> <p>To qualify for funding, the board and management must be gender inclusive.</p>
6 Prisoners' Re-integration & Rehabilitation Curriculum	<p>The training syllabus presents an overview of national gender policies.</p> <p>It includes a module on family dynamics and a complete unit on GBV and related penalties.</p> <p>It addresses positive masculinities.</p> <p>It defines gender equality and related terms.</p>
7 Socio-emotional skills curriculum	<p>The curriculum considers stereotyping as a gender issue.</p> <p>It considers that gender is a key aspect of respect.</p> <p>It considers age and gender are key elements of nurturing community relationships.</p> <p>It enumerates and defines age-specific competences.</p>

Overall, the Programme's protocols and curricula were gender and youth inclusive, save for the ROT protocol which appeared to be gender and youth-blind. However, a deeper and specific gender and youth inclusion analysis of these protocols should be conducted in order to recommend areas for adaptation and improvement.

The Programme proposal document stated that specific group therapy protocols were to be developed to address traumas associated with experience of sexual violence. Although a specific protocol was not in fact developed, it is important to say that experiences of sexual violence cut across several protocols that were developed, including the protocols on ROT, MFHS, and sociotherapy. In addition, as this report was being drafted, curricula on positive masculinities and positive parenting were being developed in collaboration with the Rwanda Men's Resource Centre (RWAMREC).

## 2.7.3 Youth inclusion in the Programme interventions.

The evaluation found that the Programme design's youth sensitivity was largely reflected in the Programme's implementation. Youth were selected for a range of interventions in the course of screening, and in addition the Programme allocated specific spaces for youth. Each of the three core pillars of the Programme paid special attention to youth. In mental health, six youth spaces were allocated under the MFHS protocol (by Rwanda We Want), and intergenerational dialogue was a key element of the dialogue process. As Table 8 shows, in sociotherapy, 33 youth-only sociotherapy groups were formed. They grouped 495 young adults, of whom 256 were male and 239 female. Under the CO-LIVE protocol, the Programme funded four youth TVET schools (in the domains of welding, tailoring, hairdressing and masonry) and four youth skills hubs across Bugesera District. The TVET schools accommodated 140 youths, of whom 53 were male and 87 were female (including some young single mothers). The four hubs were established in Mayange, Ruhuha, Mbyo and Juru sectors and trained 134 youth, of whom 45 were male and 89 female.

In addition, 1,130 young adults (529 male and 601 female) benefited from trainings in socio-emotional skills. Table 11 describes the numbers of male and female participants, facilitators/therapists, and youth in the key Programme interventions in Bugesera.

**Table 11. Participation in key Programme activities (disaggregated by gender and youth, plus some data on youth).**

BUGESERA PILOT PROGRAMME DATA					
ACTIVITY	Number of groups	Number of men	Number of women	Total	
<b>1</b>	<b>COMMUNITY SCREENING</b>				
1.1	Screened for ROT/ health centres	15 (health centres)	829	1,760	2,589
1.2	Screened for ROT/ GEARG, AVEGA	10	63	82	145
1.3	Screened for sociotherapy	92	883	941	1,824
1.4	Screened in prison	4	60	-	60
	<b>Total screened</b>		1,835	2,783	4,618
<b>2</b>	<b>PARTICIPANTS IN SOCIO THERAPY GROUPS</b>				
2.1	Groups and participants in adult sociotherapy	59	394	491	885
2.2	Groups and participants in youth sociotherapy	33	256	239	495
2.3	Groups and participants for sociotherapy in Bugesera prison	4	60	-	60
	<b>Total</b>	96	710	730	1,440
<b>3</b>	<b>PARTICIPANTS IN MULTI-FAMILY HEALING GROUPS</b>				
3.1	Groups and participants in multi-family healing, facilitated by PFR	16	156	168	324
3.2	Groups and participants in multi-family healing, facilitated by RWW	6	47	63	110
	<b>Total</b>	22	203	231	434

<b>4 PARTICIPANTS IN RESILIENCE-ORIENTED THERAPY</b>					
<b>4.1</b>	Groups and participants in ROT, facilitated by GEARG	5	16	34	50
<b>4.2</b>	Groups and participants in ROT, facilitated by AVEGA	5	25	25	50
	Total	10	41	59	100
	<b>Total of Participants in Healing Groups</b>	128	954	1,020	1,974
<b>5 COLLABORATIVE LIVELIHOODS (CO-LIVE)</b>					
<b>5.1</b>	Groups and participants in supported Co- Live initiatives	33	294	297	591
<b>5.3</b>	Youth attending TVET (in welding, tailoring, hairdressing, masonry)	4	53	87	140
<b>5.4</b>	Supported youth TVET/business hubs (Mayange, Ruhuha, Rweru & Juru)	4	45	89	134
	Total	41	392	473	865
<b>6 TRAINING PROGRAMMES</b>					
<b>6.1 Training of Community Facilitators</b>					
<b>6.1.1</b>	Community facilitators trained in sociotherapy protocol		31	31	62
<b>6.1.2</b>	Facilitators in Bugesera Prison trained in sociotherapy protocol		8	-	8
<b>6.1.4</b>	Community facilitators trained in multi-family healing protocol		21	21	42
	<b>Sub-Total</b>		60	52	112
<b>6.2 Training of Mental Health Professionals</b>					
<b>6.2.1</b>	Psychologists from health centres and district hospital, and local actors trained in resilience-oriented therapy		2	20	22
<b>6.2.2</b>	Partner organisations and staff trained in intervention protocols (ROT, multi-family, sociotherapy)		10	29	39
	<b>Sub-Total</b>		12	46	58
<b>6.3 Participants in Life Skills Training and Psychoeducation Programme</b>					
<b>6.3.1</b>	Inside mediators training on mediation and conflict resolution (TOT)		13	17	30
<b>6.3.2</b>	Youth participants in socio-emotional skills training		529	601	1,130
<b>6.3.3</b>	Adult participants in socio-emotional skills training		406	854	1,260
<b>6.3.4</b>	Local leaders in psychoeducation		166	90	256
<b>6.3.5</b>	Participants in mediation and conflict resolution training (all community)		452	448	900
<b>6.3.6</b>	Participants in financial and vocational training		339	386	725
	<b>Sub-Total</b>		1,905	2,396	4,301
	<b>TOTAL PARTICIPANTS (excluding screening)</b>		3323	3990	7313

In addition, as it had pledged in the design, the Programme collaborated with local youth and women's organisations to implement several gender and youth related activities. For example, Rwanda We Want (a local youth organisation that enables children born after the Genocide to discuss intergenerational legacies, among other topics) and AVEGA (a local organisation that supports widows, children, and families affected by the Genocide) helped to implement some MFHS and ROT groups. The former organisation has worked primarily with families (parents and children/youth), the latter primarily with Genocide survivors (women and men).

The Programme had planned to promote positive masculinities in association with a local organisation that had relevant capacity, and to develop and deliver a training protocol. During the mapping, RWAMREC was identified as an organisation that had successfully worked in this area. In the event, this partnership did not take shape in the pilot phase, but a collaboration framework has now been established, according to the Gender and Inclusion Advisor of Interpeace Rwanda, and work will be done on positive masculinities when the Programme extends to other districts.

## 2.7.4 The Programme's integration of historical backgrounds and Do No Harm Principles

The Programme was also inclusive with regard to historical backgrounds. In recognition of the post-Genocide context, it planned to focus on two key categories of Rwandans, on opposite sides of the Genocide: Genocide survivors and Genocide perpetrators, and their spouses and offspring.

According to the Programme staff (Interpeace Rwanda and PFR), although Programme spaces were allocated primarily on the basis of screening results, sociotherapy groups were mainly composed of Genocide survivors and Genocide perpetrators. As noted earlier (see the section on gender considerations when selecting participants for Programme spaces), historical background was a core criterion for selecting and funding CO-LIVE initiatives, and supporting youth TVETs and youth skills hubs. However, the DMEL department was not able to provide accurate statistical data on this aspect.

With respect to the Do No Harm principle, participants in the evaluation did not often refer to it. Nevertheless, some participants, mainly from MFHS and ROT, said that they felt they had been excluded from CO-LIVE support, from which some graduates of sociotherapy benefited. Data from DMEL (Interpeace Rwanda) suggested that only 31 out of 92 spaces received Programme funding in the framework of CO-LIVE.

“We heard that some Programme spaces resolved to stay together after graduation, to sustain their achievements, and that the Programme supported them financially. We [our group] are equally committed to do so. To that end, since last December we have started a small saving initiative to which each of us contributes one thousand Rwandan francs a month. We wish the Programme also supported us financially, to have a more substantial initiative.” (Interview, ROT group member, Bugesera District)

“Some group members told us that they heard that some sociotherapy groups got Programme funding to support their sustainability and livelihood initiatives. Those people asked whether their spaces would be funded as well, which they thought would be fair. It sounded like they were expecting the same funding, though their commitment to stay together does not necessarily depend on such financial support.” (Interview, sociotherapy and MFHS facilitator, Bugesera District)

Providing financial support to participants in one category of spaces and not providing the same support to other categories does not pass the Do No Harm test. Moreover, the Programme's theory of change specifically connected mental health, social cohesion and CO-LIVE aspects. The allocation of support implied that the theory of change applied only to participants in sociotherapy groups, because only they benefited from the interconnectedness of the Programme's theory of change.

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## 2.8 Challenges and gaps

In the course of implementing the pilot Programme several challenges and gaps were experienced.

- **Covid-19 outbreak and restriction on movement.** The first case of COVID-19 in Rwanda was officially reported on 14 February 2020. To curb its spread, in March the Government imposed confinement measures and at times a total lockdown. The pilot Programme in Bugesera was launched in this period, during October 2020. Lockdowns sometimes applied exclusively to the City of Kigali (where the majority of Interpeace and PFR staff, as well as the staff of AVEGA, GAERG and Rwanda We Want are based), and sometimes included Bugesera District, where all field Programme and boundary partners were based). On occasion, as a result, certain activities (such as community gatherings) could not be implemented. The anxiety caused by fear of contracting the illness and insufficient information about its effects made people insecure and forced changes of plan. These problems undoubtedly delayed some key Programme activities, including the baseline survey, the mapping of peacebuilding initiatives, mental health awareness campaigns, and community screening. To mitigate these challenges, the Programme hired a house in Nyamata City, which accommodated key staff and from which they worked. Similarly, teams doubled the frequency of the meetings of some sociotherapy groups (to twice a week) to enable them to return to schedule.
- **Programme protocols were validated but not institutionalised.** The pilot Programme validated seven protocols, which were then tested in Bugesera District by agreement and in partnership with key government institutions (the former NURC, MINUBUMWE, MoH/RBC, MoJ/RCS). To increase ownership and their use by other mental health, social cohesion and collaborative livelihood interventions in Rwanda, these protocols need to be adopted and institutionalised them and the lessons learned in Bugesera applied.
- **Lack of baseline data and post-intervention data on MFHS and ROT spaces respectively.** The multi-family healing approach was new to Rwanda. Practitioners therefore lacked baseline values against which to measure its impact. Baseline data are available for ROT, but groups had not graduated in time for this endline survey.
- **ROT spaces were not established in health centres.** Whereas AVEGA and GAERG facilitated ROT spaces in their operational zones, therapists in health centres were not able to do this. Having conducted mental health awareness campaigns, screening and referrals, therapists in health centres did not switch to ROT space facilitation before the Programme phased out in September 2023. The reason for this does not seem to be agreed. A source in Nyamata District Hospital claimed:

“Interpeace embarked on the Programme scale up in other districts before the pilot phase had completed. As a result, follow up stopped when we needed it most. Briefly, they phased out too early.” (Interview, Bugesera)

Interpeace’s view was that this issue “resulted from the delay on SEED’s side to share the screening report, on one hand, and ineffective follow-up by Nyamata District Hospital, on the other.” (Interview, DMEL Interpeace Rwanda and Great Lakes Region).

- **Inadequate follow-up and supervision of therapists and CDFs.** The evaluation found that the Programme did not follow up adequately in three respects. First, it did not sufficiently supervise therapists and CDFs or follow-up the graduates from healing spaces. Therapists and CDFs did not have enough sessions to follow up and reflect on the challenges they faced during facilitation. It was initially planned to establish a local follow-up and monitoring committee.<sup>29</sup> However, if it was established, it appears the committee did not play its

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<sup>29</sup> The Committee was to be set up at Bugesera District level, and was to include representatives of the District authorities, the Ministry of health representative at district level, community representatives delegated by their peers, and a

role effectively. Third, despite strong political support, technical accompaniment by the District was very limited due to lack of dedicated staff. One member of staff generally supported the Joint Action Development Forum that brought together the District and its partners, and this person had several other duties, leaving little time for project follow up.

- **Lack of an advocacy strategy.** Working with communities involves supporting them to define and analyse their problems and solutions to them. Solutions may also require action by decision-makers and other stakeholders. This is no less true for mental health, social cohesion and CO-LIVE issues. However, the Programme did not devise a clear advocacy strategy to resolve community issues that boundary partners and Programme implementers were unable to address successfully.
- **The Programme's progress depended on a research and development process that did not always produce results quickly.** The time required to complete the protocols delayed other processes, preventing the achievement of certain targets (including multi-family and Co-Live targets).
- **Limited support to livelihood initiatives compromised the theory of change.** The Programme theory of change assumed a linear causal link between mental health, social cohesion and CO-LIVE. In fact, the Programme was able to assist some CO-LIVE initiatives led by sociotherapy graduates (33 spaces) but did not assist other sociotherapy groups, or MFHS or ROT graduates. Similarly, some initiatives that received financial support under the CO-LIVE pillar did not pass through Programme-facilitated mental health and social cohesion spaces. As result, it is difficult to assess the extent to which Programme interventions were connected, as pre-supposed by the theory of change.
- **Limitations of the theory of change.** The Programme needs to review and perhaps adapt the ToC with respect to the connectedness of mental health, social cohesion and collaborative livelihood. The PoC presumed that a participant heals after passing through healing spaces and then improving his or her livelihood in collaboration with others. It is more accurate to say that the Programme initiates the healing journey, but that the journey is both longer and reiterative.
- **Limited reach of the Programme healing spaces.** Compared to the need for mental health services and skills, participants consistently noted that the Programme's effective reach was narrow. For instance, in Bugesera Prison, only 46 prisoners participated in the Programme (out of a total prison population of 3,300).<sup>30</sup> In addition, prisoners believed that *Mvura nkuvure* should be extended to prisoners' families since they were also affected by the imprisonment. Scaling up the Programme would better prepare the ground for prisoners' reintegration after their release. A similar point was made by participants in the sociotherapy and MFHS FGDs, who said that many more members of the community are in need of support than were included in the Programme.
- **The timeframe for implementing protocols was too short (especially sociotherapy, ROT and MFHS).** CDFs and participants in Programme healing spaces agreed that the Programme needs to allocate more sessions to each protocol. Staff who implemented the Programme did not seem to agree with this claim.
- **Dropout from youth skills hubs was high due to their distance from home.** The Programme set up four youth skills hubs for youth to receive TVET in a range of skills. Because the hubs are located in just four sectors (Mayange, Ruhuha, Mbyo, and Juru), youth who lived far from them could not easily attend. Because of their distance, some youth participants dropped out.

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representative from Interpeace and from Prison Fellowship Rwanda. It was to meet as often as required to ensure successful implementation of the project. It was mandated to reflect on challenges and opportunities associated with the Programme, provide troubleshooting support for Programme activities, gather data, and produce regular reports for the Technical Committee.

30 Visit to Bugesera Prison and FGD with prisoners, 15 November 2022.

- **Instances of conflict were mainly due to inadequate preparation.** Instances of distrust and some disputes were reported among some members of CO-LIVE initiatives (youth skills hubs) that did not go through sociotherapy. In some cases, disputes, especially among youth, had identity (historical background) ramifications. This highlighted that CO-LIVE initiatives need to be linked to social cohesion interventions, because no conflicts were recorded in CO-LIVE initiatives led by graduates of sociotherapy. This suggests that disputes and cases of distrust are likely to be driven by the unhealed wounds of some participants.
- **Some Programme interventions were implemented without a clear framework to measure their outcomes.** As part of its interventions, the Programme conducted community training on life skills (socio-emotional skills), mediation for community members, and psychoeducation for local leaders. However, the Programme did not define the outcomes to which those trainings would contribute, or provide a framework to assess outcomes.
- **Some log frame baseline data and targets were not sex- or age-disaggregated.** This made it difficult to track some project changes through the gender and youth lenses.
- **The Programme did not define the age range of ‘youth’ in youth-specific healing spaces.** Neither the Programme document nor the sociotherapy protocol defined the age limits of ‘youth’. The Republic of Rwanda defines a youth as a person aged between 16 and 30 years of age (Republic of Rwanda, 2015, p. 5). It was observed that participants in some youth specific spaces for example the youth sociotherapy group in Nyarugenge sector were aged beyond 30.

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## 2.9 Lessons learned

Lessons were learned from the Programme’s design and implementation, and the challenges that it confronted. Some have already led the Programme to make adjust its parameters or adapt to meet contextual changes and challenges. Others can inform relevant future interventions.

- **Involving local and national leaders in all Programme phases is key to Programme success.** From the start of the Programme, Interpeace and PFR engaged with government officials at both national (NURC, MoH, MoJ, RBC, RCS) and local (Bugesera District) level. On one hand, this was vital to enable Programme implementers to understand local and national priorities in MHPSS, social cohesion and livelihoods. On the other, local and national leaders were able to familiarise themselves with the Programme’s goals and expected outcomes, and to express their concerns and have them addressed. Engagement was profitable for both sides because it facilitated a continuous dialogue and a partnership that deepened trust throughout the Programme’s implementation. This assisted the Programme to achieve its goals.
- **Flexibility in Programme implementation is key to Programme success.** As noted above, Programme implementers designed and implemented the Programme with a range of stakeholders, including local and national leaders. When the Programme faced contextual challenges, these stakeholders made helpful and positive suggestions (for example, to support the District’s mental health facilities by providing a mobile clinic and motor cycles for psychologists).
- **Design and apply a sustainability plan from the start, not at the end.** Interpeace and PFR conceived key elements of the Programme’s sustainability strategy (see the section on Programme sustainability) during the design phase. The Programme continued to reflect on sustainability during the implementation phase, with both strategic and boundary partners. The participants in this assessment were almost unanimous in saying that early planning and local participation made it possible for the Programme outcomes to be sustainable. Some participants contrasted the Programme with others that began discussing sustainabili-



ty when interventions were coming to an end. Future assessments of this Programme will be able to judge whether or not the Programme's approach in fact made the Programme sustainable.

- **Community screening is key to Programme success.** The pilot programme demonstrated that, if community screening for healing groups is properly done, it is easier to identify individuals with critical needs that require support. Similarly, screening helped to determine what forms of intervention were appropriate. In other words, Programme implementers and boundary partners were able to “administer the right medicine for the right illness”.
- **Community dialogue facilitators are also wounded.** CDFs were responsible for facilitating dialogue in safe spaces, enabling participants to open up, share their wounds and experiences of trauma, and so heal and enhance social cohesion. At the same time, CDFs are members of these same communities and share the same history. Some CDFs pointed out that during the dialogue processes they came to understand that they too were wounded. CDFs should be accompanied and supported by clinical supervision and feedback sessions, to enable them to help others but also to deal with their own psychological wounds.
- **Local and national leaders are also wounded.** Because they are entrusted with legal powers, government officials may be perceived as strong (even psychologically and emotionally). However, government officials at all levels basically come from the same society and are therefore wounded too. Their wounds/traumas are likely to be worsened by their interaction with community members they serve. The local leaders who received psychoeducation training recognised their situation and requested adapted healing spaces.
- **A single family member in a group healing space may fail to heal if other family members are not included.** Some members of sociotherapy groups (both youth and adults) said that relatives who had not experienced a healing process sometimes obstructed the participant's efforts to heal. This suggests that healing processes which engage all family members may be more successful at reducing re-traumatisation in family settings. Participants in MFHS supported this point in that many praised the MFHS approach for bringing all eligible family members together to heal.

“We really need to involve parents and youth together because home is the source of information. If we are here alone and our parents, siblings, husbands or wives are not part of the healing group, then our wounds are re-opened when we return home. It would be much better if we could all be part of the healing group. We would be able to share and discuss on the same platform.” (Female participant, FGD for a youth sociotherapy group, Nyarugenge, Bugesera District)

- **Young children (aged 14 and younger) may not be old enough for MFHS.** Throughout the MFHS process, participants and facilitators observed that some very young participants could not understand some of the topics or issues raised by adults. Children under 14 or 15 may be too young to participate in MFHS. The suggested minimum age could be 16.
- **CO-LIVE initiatives are primarily driven by the wish to stay together (social cohesion) and prosper together.** They are likely to be more sustainable and fruitful than initiatives driven only by the desire for economic gain. One lesson was that CO-LIVE initiatives appeared to be more stable and impactful when their members had been through a healing process together beforehand.
- **Synergies of local and international experience may improve MHPSS and peacebuilding interventions.** In its design and implementation, the Programme relied on a combination of local and international experience and expertise. This was true, for example of research, protocol design, actor mapping, community screening, baseline survey, the post-intervention survey, etc. Combining perspectives made Programme interventions complementary, richer and more responsive.

# 3

## Conclusion and Recommendations

# III. Conclusion and Recommendations

The overall aim of this end-line evaluation was to assess the outcomes, achievements, challenges, and lessons learned from the pilot programme on "Reinforcing community capacity for social cohesion and reconciliation through societal trauma healing" in Bugesera District. The evaluation applied a number of criteria to examine project performance: they included relevance, effectiveness and impact, sustainability, efficiency, coherence, gender and youth inclusion and learning.

In substance, the Programme's theory of change built on the following logic:

- Making available protocols appropriate for Rwanda's context as well as group-based interventions, with a comprehensive training programme on how to deliver such interventions, will create an infrastructure able to provide on-going mental health, livelihood and social cohesion building support in the district of Bugesera.
- Therapists and trainers' support to Genocide survivors, current and former Genocide prisoners and their descendants and families, including the provision of life skills, basic livelihood skills, cultural sensitivity trainings, multi-family group therapy, and diagnosis-specific groups, will reduce tensions and risk of violence in families and between community members because members of vulnerable groups will be equipped to dialogue with those of different backgrounds and experiences and will have more trust, understanding and tolerance to engage in collective livelihood initiatives.
- Diligent monitoring of evidence of impact, appropriately disseminated, will increase the interest and motivation of national and international policy stakeholders to integrate lessons learned from the Programme into national policies and practices, and extend the Programme to other districts of Rwanda.

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## 3.1 Summary evaluation findings

The end-line evaluation found that the Programme contributed to significant changes at individual, family, community and institutional level. At individual level, the principal changes included healing of trauma and psychological wounds among Programme participants (women reporting higher level of healing than men); improvements in mental health (particularly among the first intake); and increased feelings of safety, self-confidence, and new life orientation.

At family and community levels, similar findings were obtained. Major Programme impacts included: improved inter-spouse communication; improved engagement and relationships between parents and children; lower levels of intra-family conflict; improved family cohesion and intergenerational dialogue on issues such as history and the Genocide. Ex-prisoners reported improvements in family reintegration. Other participants said that their livelihoods had improved. Trust increased between Genocide survivors and Genocide perpetrators and their relatives. It was also noticeable that people more rarely held perpetrators' children responsible for the Genocide. These results provide a strong foundation for social harmony between groups of different backgrounds living in Bugesera District.

At institutional level, Programme interventions improved mental health infrastructures by building the capacity of the mental health community in the district (Nyamata hospital and health centres) as well as therapists and facilitators. Materially, the Programme provided Bugesera District with a mobile clinic and other context-relevant mental health tools and health equipment. Further, the Programme created trauma-informed leadership in the

district by organising and facilitating a psychoeducation training for local political and opinion leaders.

The Programme nevertheless faced a number of challenges that should be addressed by any similar Programme or if the Programme is scaled up. Major issues included: a lack of baseline and post-intervention data specifically on MFHS and ROT; ROT groups were not established and facilitated in health centres; the Programme did not adequately follow up or supervise therapists and CDFs; the Programme lacked an advocacy strategy; the healing spaces reached a limited number of people relative to the number of people in need of support.

## 3.2 Recommendations

Based on the challenges and issues identified, the evaluation makes several recommendations as outlined in Table 12.

**Table 12. Recommendations**

Identified issue	Recommended action	Responsible entity
The COVID-19 outbreak and related movement restriction.	Integrate disasters such as COVID-19 in implementation risks and prepare a contingency plan to mitigate their effects on the Programme (or the Programme's scale-up and extension).	Interpeace
Mental health and societal healing protocols are not institutionalised.	Adjust the protocols based on lessons learned from the pilot phase; popularise and institutionalise them for large-scale use by stakeholders in government institutions and civil society whose interventions focus on mental health, social cohesion, collaborative livelihoods and prisoner reintegration.	MINUBUMWE; Ministry of Health/RBC, Interpeace
Lack of baseline and post-intervention data on MFHS and ROT spaces respectively.	Prepare a strategy to build the local capacity (of Interpeace Rwanda and local implementing partners) to collect, analyse and manage data. The Programme generated a lot of data but largely depended on external support (outsourcing).	Interpeace, CSO partners
Add sessions to the protocols (especially Sociotherapeutic, ROT and MFHS)	Learn lessons from the pilot programme and review the content of healing spaces and the number of sessions allocated to them. This can be done in the context of the Programme's extension to five new districts.	Interpeace, partners
ROT spaces were not launched by trained psychologists in health centres.	Set up a local joint monitoring and evaluation (M&E) committee to ensure that all parties are on track to fulfil their commitments, and that needed technical support is identified and provided promptly.	Interpeace, Bugesera District, MINUBUMWE, RBC, RCS
Inadequate follow-up and supervision of therapists and CDFs.	Set up a local joint monitoring and evaluation (M&E) committee to ensure that all parties are on track to fulfil their commitments, and that needed technical support is identified and provided promptly.	Interpeace, Bugesera District, MINUBUMWE, RBC, RCS
	Build local capacity in data analysis because the Programme generates a lot of data and largely depends on external support.	Interpeace

Identified issue	Recommended action	Responsible entity
Gender blindness in the ROT protocol.	Revisit the ROT protocol and integrate gender considerations, particularly with regard to allocation of places.	Interpeace
Lack of a Programme advocacy strategy.	Develop and operationalise a programme advocacy strategy to ensure that critical issues emerging from Programme spaces, research, and evaluations and assessments are brought to relevant actors for action.	Interpeace
The Programme relied on research to guide interventions. The time it took to develop protocols delayed other processes.	Prepare a strategy to institutionalise the protocols tested by the pilot Programme.	MINUBUMWE, Interpeace
Not all livelihood initiatives received support, which compromised the theory of change.	Coordinate the CO-LIVE pillar across all Programme healing spaces to ensure that all the variables of the theory of change are connected.	Interpeace
Limited reach of the Programme healing spaces.	Increase funding to enable the Programme Programme to achieve wider coverage.  Collaborate with local MHPSS partners and assist them to extend Programme protocols to community members who are not currently reached by Programme interventions.	Sida, EU, other donors
Youth drop out from skills hubs because these are far from their homes	Increase the number of youth skills hubs to make them more accessible to youth.	Interpeace donors
Conflict cases are mainly due to inadequate preparation.	Coordinate the CO-LIVE pillar across all Programme healing spaces to ensure that all the variables of the theory of change are connected.	Interpeace & partners
Some Programme interventions were implemented without a clear framework to measure their outcomes.	Revise the Programme log frame and M&E framework to integrate expected outcomes from life skills, mediation, and psychoeducation training.	Interpeace
Some log frame baseline data and targets were not sex- or age-disaggregated.	Revise the log frame and M&E framework to enable sex and youth data to be disaggregated for all relevant indicators.	Interpeace
The age range for youth included in youth-specific healing spaces was undefined.	Review the age range criteria for inclusion in the Programme in light of lessons learned, and align it with Rwanda's national youth policy (16-30).	Interpeace

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# Appendices

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## Appendix 1: Key evaluation Questions:

### Relevance

- To what extent was the programme intervention logic/strategy relevant to the context of societal healing, social cohesion and livelihoods in Bugesera?
- To what extent was the programme responsive to the defined needs and priorities of targeted population and communities in Bugesera, and those of the local actors and stakeholders?

### Effectiveness and Impact

- To what extent did the programme meet its goal?
- What were the main factors that influenced the outcome of the programme, as to whether the programme reached its goal or not?
- To what extent has the programme contributed to changes in the context (peace, security, livelihoods), at the local level?
- Has the programme been implemented as designed?

### Sustainability

- To what extent has the programme strengthened local capacities?
- To what extent are the programme achievements sustainable beyond the programme period?
- To what extent are the programme's established processes and systems likely to support the continued implementation of the programme?

### Coherence

- To what extent has the programme been consistent with the national priorities?
- Has the programme been able to provide complementary support to other healing and peace building initiatives within Bugesera District?

### Efficiency

- To what extent were the programme's strategies and activities sufficient for meeting the programme's goal?
- Did the programme partners have adequate capacity to implement the programme?
- What other capacities do the programme partners need?

### Learning

- What challenges emerged during the various periods of programme implementation that affected the achievement of results?
- How did the programme adapt to changes in the context and emerging challenges during programme implementation?
- What best practices and key lessons learnt from the programme should inform the national policies and other stakeholders' practices?

## Gender and inclusion

- To what extent and how effective did the programme integrate gender into the programme's strategy?
- To what extent and how effective did the programme integrate the youth into the programme's strategy?
- To what extent and how effective did the programme ensure inclusion and do no harm principles?

## Project Design Improvement

- What best practices and lessons learnt from the programme should be incorporated into the next phase of the programme?
- What strategies should the next programme employ to be more relevant to the context and responsive to the needs and priorities defined by stakeholders?
- What mechanisms should the programme integrate to ensure continued monitoring and relevant adaptation of the programme to changes in the context?
- What should programme partners take into consideration to improve the overall design of the programme?

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## Appendix 2: Focus Group Discussion Guides

### Guiding questions- FGD with adult sociotherapy groups

*Objective:* The FGD on sociotherapy will focus on the programme's outcomes in terms of improving safety, trust, tolerance, mutual care and compassion, and forgiveness traits between genocide survivors, ex-perpetrators, and their families. It will also look at how the groups helped them to openly discuss and overcome their past conflicts and trauma, and their progress in terms of new life orientation.

#### Guiding questions:

On project relevance

**1) Ni ibihe bibazo mwari mufite mvura-nkuvure yaje kubafasha gukemura?**

**2) Referring to your personal experience with sociotherapy, why do you think it was important/ (or not important) for you to be part of this process?**

Mukurikije ubunanaribonye bwanyu ku rugendo rwa mvura-nkuvure, mwatubwira impamvu mwumva byari iby'agaciro (byari ngombwa) kuri mwe kuba mwarakoze uru rugendo?

**3) With concrete example, can you please describe how sociotherapy process improved the feeling of safety, tolerance, and trust among group members?**

Mwifashije ingero cg ubuhamya, mwatubwira uburyo mvura-nkuvure yabafashije kumva mutekanye, kwihanganirana, no kubaka ikizere hagati y'abagize itsinda?

**4) With concrete example, can you please describe how your participation in the sociotherapy process enabled you to openly discuss and overcome past conflicts and trauma, with your family and with people from different background, including those you had conflictual relationships related to the legacies of the genocide against Tutsi?**



Mwifashije ingero n'ubuhamya, mwatubwira uko mvura-nkuvure yafashije mu kuganira ku bikomere byatewe n'amateka ya jenocide yakorewe Abatutsi, kuganira no gukemura amakimbirane aturuka kuri ayo mateka, yaba hagati y'abagize itsinda ubwabo, ndetse no hagati y'abagize itsinda n'abandi bantu bari bafitanye ibibazo ariko bari hanze y'itsinda?

**5) With concrete example, can you please describe how your participation in the sociotherapy process helped you personally and the group to define new life orientation?**

Mwifashishije ingero zifatika cg ubuhamya, mwatubwira uburyo mvura-nkuvure yafashije mu kugena icyerekezo gishya cy'ubuzima, yaba umuntu ku giti cye cg itsinda?

**6) What were the shortcomings or challenges encountered, as individual or as a group, and what should you recommend for improvement?**

Ni izihe mbogamizi mwaba mwarahuye nazo, yaba umuntu ku giti cye cg nk'itsinda? Mubona ari iki cyakorwa mu rwego rwo gukuraho izo mbogamizi?

**7) Ese mubona ibyo Mvura-nkuvure yabagejejeho mu guhangana n'ibibazo mwari mufite bizakomeza nyuma y'isoza ry'iyi gahunda? Ni iki mushingiraho mwemeza ko bizakomeza cyangwa bitazakomeza?**

**8) Ni ayahe masomo mwigiyeye muri gahunda ya mvura-nkuvure mubona yakwitabwaho mw'itegura rya gahunda nk'iyi mu bihe biri imbere? Ni ibihe bintu byakozwe muri iyi gahunda ya mvura-nkuvure musanga bikwiye kwirindwa muri gahunda nk'iyi zizategurwa mu bihe biri imbere? Ni ibihe mwakunze musanga byakubakirwaho mu zindi gahunda nk'iyi?**

**9) Ni gute mubona itegurwa n'ishyirwa mu bikorwa rya gahunda ya mvura-nkuvure byitaye kw'ihame ry'uburinganire n'urubyiruko? Ese ibibazo byihariye by'abagore, abagabo n'urubyiruko byitaweho? Mutange ingero zibigaragaza. Ese itsinda ryanyu rya Mvura-Nkuvure ryitaye ku bikomere by'ibyiciro byose by'abanyarwanda?**

## Guiding questions- FGD with youth sociotherapy groups

### On project relevance

**1. Ni ibihe bibazo mwari mufite mvura-nkuvure yaje kubafasha gukemura?**

Referring to your personal experience with sociotherapy, why do you think it was important/ (or not important) for you to be part of this process?

Mukurikije ubunanaribonye bwanyu ku rugendo rwa mvura-nkuvure, mwatubwira impamvu mwumva byari iby'agaciro (byari ngombwa) kuri mwe kuba mwarakoze uru rugendo?

**2. With concrete example, can you please describe how sociotherapy have reduced your trauma (emotional pain, hatred, resentment, shame, guilt...)?**

Mwifashije ingero cg ubuhamya, mwatubwira uburyo mvura-nkuvure yabafashije gukira ibikomere?

**3. With concrete example, can you please describe how sociotherapy reduced stereotypes and enhanced tolerance and compassion towards others, including those from different backgrounds or with whom you had conflictual relationships related to the legacies of the genocide against Tutsi?**

Mwifashishije ingero cg ubuhamywa mwatubwira uburyo mvura-nkuvure yafashije mu kugabanya urwikekwe no kubaka ikizere hagati yanyu nk'itsinda, n'abandi bantu mwari mufitanye ibibazo cg amakimbirane ashingiye ku ngaruka za jenocide yakorewe Abatutsi?

- 4. What are the examples of evidence that your participation in sociotherapy process, enabled you to acquire a positive sense of personal and common purpose, and your contribution to community-wide healing and collective livelihoods?**

Mwaduha ingero zifatika z'uko urugendo rwa mvura-nkuvure rwabafashije mu kugira ikizere cyiza cy'ejo hazaza no guhuza icyerekezo mu gufasha abandi gukira ibikomere, no kongera uruhare rwanyu nk'urubwiruko mu bikorwa biteza imbere aho mutuye?

- 5. Ese mubona ibyo Mvura-nkuvure yabagejejeho mu guhangana n'ibibazo mwari mufite bizakomeza nyuma y'isoza ry'iyi gahunda? Ni iki mushingiraho mwemeza ko bizakomeza cyangwa bitazakomeza?**

- 6. Ni ayahe masomo mwigiyeye muri gahunda ya mvura-nkuvure mubona yakwitabwaho mw'itegura rya gahunda nk'iyi mu bihe biri imbere? Ni ibihe bintu byakozwe muri iyi gahunda ya mvura-nkuvure musanga bikwiye kwirindwa muri gahunda nk'iyi zizategurwa mu bihe biri imbere? Ni ibihe mwakunze musanga byakubakirwaho mu zindi gahunda nk'iyi?**

- 7. Ni gute mubona itegurwa n'ishyirwa mu bikorwa rya gahunda ya mvura-nkuvure byitaye kw'ihame ry'uburinganire n'urubwiruko? Ese ibibazo byihariye by'abagore, abagabo n'urubwiruko byitaweho? Mutange ingero zibigaragaza. Ese itsinda ryanyu rya Mvura-Nkuvure ryitaye ku bikomere by'ibyiciro byose by'abanyarwanda?**

- 8. What were the shortcomings or challenges encountered, as individual or as a group, and what should you recommend for improvement?**

Ni izihe mbogamizi mwaba mwarahuye nazo, yaba umuntu ku giti cye cg nk'itsinda? Mubona ari iki cyakorwa mu rwego rwo gukuraho izo mbogamizi?

## Guiding questions- FGD with youth Multi-family healing groups

FGD with multi-family healing graduates will assess how the interventions supported in reducing intergenerational transmission of trauma, as well as improving family solidarity, intra-family communication, as well as social (inter-family) interactions & relationships.

### Guiding questions:

On project relevance

- 1. Ni ibihe bibazo mwari mufite mvura-nkuvure ihuza imiryango yaje kubafasha gukemura?**
- 2. Referring to your personal experience with with multi-family healing group, why do you think it was important/ (or not important) for you to be part of this process?**

Mukurikije ubunanaribonye bwanyu ku rugendo rw'itsinda rya multi-family (mu rugendo rwo gukira ibikomere binyuze mu biganiriro hagati y'urubwiruko n'ababyeyi), mwatubwira impamvu mwumva byari iby'agaciro (byari ngombwa) kuri mwe kuba mwarakoze uru rugendo?

- 3. With concrete example, can you please describe how your participation in multi-family healing group improved intra-family discussion on the history of past conflicts and the genocide against Tutsi, and supported in reducing intergenerational transmission of trauma?**

Mwifashishije ingero cg ubuhamya mwatubwira uburyo ibiganiro byarafashije ababyeyi kuganiriza abana babo ku mateka ya jenocide yakorewe Abatutsi n'ingaruka zayo, ndetse no kugabanya ihererekana ry'ibikomere hagati y'ababyeyi n'abana?

- 4. With concrete example, can you please describe how your participation in multi-family healing group has improved your family solidarity and intra-family communication?**

Mwifashije ingero zifatika cg ubuhamya, mwatubwira uburyo ibiganiro byafashije mu kugabanya amakimbirane mu miryango no kubaka umubano mwiza hagati y'abashakanye no hagati y'ababyeyi n'abana?

- 5. With concrete example, can you please describe how your participation in multi-family healing group has improved the relationships between your families and other families in your community (neighbours, families with conflictual relationships)?**

Mwifashishije ingero cg ubuhamya, mwatubwira uburyo itsinda ryafashije gukemura amakimbirane hagati y'imiryango yari ifitanye ibibazo bishingiye ku ngaruka z'amateka ya jenocide no kubaka imibanire myiza n'abaturanyi?

- 6. Ese mubona ibyo Mvura-nkuvure yabagejejeho mu guhangana n'ibibazo mwari mufite bizakomeza nyuma y'isoza ry'iyi gahunda? Ni iki mushingiraho mwemeza ko bizakomeza cyangwa bitazakomeza?**

- 7. Ni ayahe masomo mwigiye muri gahunda ya mvura-nkuvure mubona yakwitabwaho mw'itegura rya gahunda nk'iyi mu bihe biri imbere? Ni ibihe bintu byakozwe muri iyi gahunda ya mvura-nkuvure musanga bikwiye kwirindwa muri gahunda nk'iyi zizategurwa mu bihe biri imbere? Ni ibihe mwakunze musanga byakubakirwaho mu zindi gahunda nk'iyi?**

- 8. Ni gute mubona itegurwa n'ishyirwa mu bikorwa rya gahunda ya mvura-nkuvure byitaye kw'ihame ry'uburinganire n'urubwiruko? Ese ibibazo byihariye by'abagore, abagabo n'urubwiruko byitaweho? Mutange ingero zibigaragaza. Ese itsinda ryanyu rya Mvura-Nkuvure ryitaye ku bikomere by'ibyciro byose by'abanyarwanda?**

- 9. What were the shortcomings or challenges encountered, as individual or as a group, and what should you recommend for improvement?**

Ni izihe mbogamizi mwaba mwarahuye nazo, yaba umuntu ku giti cye cg nk'itsinda? Mubona ari iki cyakorwa mu rwego rwo gukuraho izo mbogamizi?

## Guiding questions for TVET hubs/ Co-Live Initiatives

- 1. Ni ibihe bibazo mwari mufite mvura-nkuvure ihuza imiryango yaje kubafasha gukemura?**
- 2. Ni gute/ku buhe buryo kugira uruhare muri TVET/CO-LIVE byabafashije kwiyubakamo icyizere, kugira intego ndetse n'icyerekezo cy'ubuzima bushya?**

How participation in TVET/CO-LIVE training helped to build the confidence, sense of purpose and hope for the future?

**3. Mwifashishije ingero zifatika, mwatubwira uburyo CO-LIVE ibafasha kunoza imibereho myiza y'ejo hazaza no kubaka ubufatanya/imibanire myiza mu itsinda?**

Using concrete example, can you tell us how the Co-Live initiative you are participating in is helping/ is anticipated to improve your livelihoods and consolidate the group cohesion?

**4. Ese mubona ibyo Mvura-nkuvure yabagejejeho mu guhangana n'ibibazo mwari mufite bizakomeza nyuma y'isoza ry'iyi gahunda? Ni iki mushingiraho mwemeza ko bizakomeza cyangwa bitazakomeza?**

Ni ayahe masomo mwigiyeye muri gahunda ya mvura-nkuvure mubona yakwitabwaho mw'itegura rya gahunda nk'iyi mu bihe biri imbere? Ni ibihe bintu byakozwe muri iyi gahunda ya mvura-nkuvure musanga bikwiye kwirindwa muri gahunda nk'iyi zizategurwa mu bihe biri imbere? Ni ibihe mwakunze musanga byakubakirwaho mu zindi gahunda nk'iyi?

**5. What were the shortcomings or challenges encountered, as individual or as a group, and what should you recommend for improvement?**

Ni izihe mbogamizi mwaba mwarahuye nazo, yaba umuntu ku giti cye cy' nk'itsinda? Mubona ari iki cyakorwa mu rwego rwo gukuraho izo mbogamizi?

## Appendix 3: KIIs main themes

S/N	Category of key informants	Main themes discussed
<b>I. GOVERNMENT PARTNERS</b>		
1	MINUBUMWE	Overall programme relevance, and alignment to district priorities, progress achieved, lessons learnt, coherence, challenges, recommendations for future programming from central government perspective
2	Bugesera district	Overall programme relevance, and alignment to district priorities, progress achieved, lessons learnt, coherence, challenges, recommendations for future programming from local government perspective
3	Bugesera district hospital	Programme design and relevance, progress achieved, lessons learnt, impact, challenges, recommendations for future programming all from mental health perspective
<b>II. NATIONAL IMPLEMENTAING PARTNER</b>		
4	Prison Fellowship Rwanda (PFR)	Programme design and relevance, progress achieved, lessons learnt, impact, challenges, recommendations for future programming
<b>III. PROGRAMME CONSULTANT</b>		
5	AVEGA	Perceptions on the programme relevance and how it contributed to reinforcing local capacities, particularly with regard to ROT and MFH; impact, and what are the good practices and lessons from the programme that would be integrated in their institutional/organizational practices
6	Rwanda We Want (RWW)	Programme relevance and contribution with a particular focus on to multi-family healing approach, MHF, socioemotional skills and inter-generational dialogue; lessons learnt, impact and recommendations for future programming
<b>IV. NATIONAL EXPERT</b>		
7.	Prof Eugene Rutembesa	Project design and relevance; lessons learnt and recommendations for future programming with a focus on Mental Health
<b>V. INTERPEACE PROGRAMME TEAM</b>		
8	Gender and inclusion advisor	Relevance of the programme, effectiveness, sustainability, lessons learnt and challenges from a gender perspective and recommendations for future programming
9	Senior Programme Manager	Programme relevance, effectiveness, efficiency, impact, sustainability, coherence, lessons learnt, good practices, challenges and recommendations for future programming
10	DMEL	Programme relevance, effectiveness, efficiency, impact, sustainability, coherence, lessons learnt, good practices, challenges and recommendations for future programming
11	Finance and administration manager	Programme relevance, sustainability, lessons learnt, challenges and recommendations for future programming
<b>VI. COMMUNITY DIALOGUE FACILITATORS</b>		
12	Community dialogue facilitators	Programme relevance, effectiveness, efficiency, impact, sustainability, lessons learnt, good practices, challenges and recommendations for future programming

## Appendix 4: List of key informants

Name	Position	Institution
Adelite Mukamana	Programme senior psychotherapist	PFR
Benjamin Ndizeye	Programme manager	PFR
Colbert Rulinda	Executive director	Rwanda We Want
Ernest Dukuzumuremyi	DMEL	Advisor, Interpeace Rwanda and Great Lakes
Joanita Mwiza	Gender and inclusion adviser	Interpeace
John Shema	Finance and administration manager	Interpeace Rwanda
Joyce Batamuriza	Facilitator	Sociotherapy, Bugesera
Julienne Murorunkwere	Psychotherapist	AVEGA/Bugesera
Laurence Mukayiranga	Community engagement specialist	MINUBUMWE
Margret Mahoro	Senior programme manager	Interpeace Rwanda
Prof. Eugene Rutembesa	Mental health expert	Interpeace Consultant
Richard Mutabazi	Mayor	Bugesera District

## Appendix 5. Key considerations for gender analysis

Variable	Evaluation stage	Aspects for consideration
Gender sensitivity	Desk review	Check if the Programme document is (not) gender sensitive (e.g. problem statement, expected outcomes, result framework...)
	Design of data collection tools	Include gender sensitive questions
	Sampling (selection of participants)	Consider balancing men and women, boys and girls
	Recruitment of enumerators and FGD facilitators	Consider balancing men and women among evaluation team
	Data collection	Where possible let male enumerators deal with male respondents, and female ones with female respondents
	Data analysis	-Disaggregate data by sex and age -Analyse gender specific needs and gender Programme outcomes and implications





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