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Perceptions Toward Trauma Problems and Crises during the Genocide against the Tutsi Commemoration Period

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ABSTRACT

Introduction: Following the Genocide against the Tutsi in 1994, Rwandan society was severely impaired and could not function optimally, with an exceptionally large burden of mental health disorders. Therefore, this study aimed to evaluate the perceptions of trauma victims, family/friends of the victims, and health service professionals toward trauma problems and crises they face during the genocide against the Tutsi commemoration period.
Methods: This was a qualitative study using a focused group discussion approach (FGD) involving trauma victims who had trauma crises during the period of Kwibuka 24, their family/friends, and health service professionals, and using An FGD guide was used to guide the discussions.
Results: The results from the focus group discussions show increased trauma, especially among post-genocide children and the elderly and widowed survivors. Poverty, flashbacks, and the commemoration period are common key triggers of trauma crises. The main challenges include HIV/AIDS, stigmatization from within the community, poverty, inadequate service providers, lack of follow-ups, genocide ideology within the communities, and unprofessional service providers. Common strategies to cope with trauma include solitude, approaching service providers, joining support groups, and engaging in different activities.
Conclusion: This study showed the rising trauma crises among descendants of genocide survivors. The findings also highlight the need for targeted measures, including financial, emotional, and health support for survivors tackling the identified triggers.

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INTRODUCTION

In 1994, Rwanda experienced genocide against the Tutsi, which led to an extensive loss of human life, talents, and resources. Consequently, Rwandan society was severely impaired and could not function optimally [1]. Rwanda faces an exceptionally large burden of mental health disorders, and much of the country's burden of mental disorders can be linked to the genocide against the Tutsi [2].

In addition, the genocide survivors are devastated by the loss of all they had known, resulting in massive, unspeakable suffering (MoH, 2012). The Genocide against the Tutsi generated multiple and massive stressors that may lead to severe and long-lasting Post Traumatic Stress Disorders (PTSD) among its survivors. PTSD is among the most serious mental health disorders affecting the Rwandan population. Its prevalence ranges from 26% among adults to 41% among women survivors [3,4], and there is strong evidence for the transgenerational transmission of PTSD [5]. Evidence of mental health consequences of the genocide is consistently observed throughout the year, but the manifestation of traumatic memories appears to be particularly acute during periods of genocide commemoration [6].

Each year, for a period of 100 days, Rwanda commemorates the genocide against the Tutsi. According to the Ministry of Health, during the commemoration period of the genocide against the Tutsi, there is a large number of people experiencing emotional crises [7]. These emotional crises are often collective and create distress among the people who are participating in the events. They are accompanied by extreme emotional episodes, which create a resurgence of memories from the genocide itself [1]. As a result, there arises re-traumatization that requires intervention by mental health professionals and hospitalization when severe. When such crises are not managed properly or when there is a lack of effective interventions, they may create extreme anxiety and panic among genocide survivors and different individuals participating in commemorative events.

In light of the challenges posed by the above-mentioned issues, Rwanda emphasizes providing care to individuals experiencing trauma during the commemoration. Current practices include the organization and coordination of mental healthcare each year during the commemoration of the 1994 Genocide against the Tutsi, all over the country [1] This response framework portrays a Mental Health Care Delivery Model where healthcare professionals implement a chain of communication and a plan for mass interventions throughout the commemoration at each level of the health system in Rwanda [8]. According to the Rwanda Ministry of Health, trauma-related crises remain a national public health concern. During Kwibuka 24, 4,363 cases were handled at commemoration sites, health centers, district, and provincial hospitals [8]. Only a few studies have been conducted on the emotional crisis and trauma cases identified during the commemoration period. Reports from MoH and other studies have also recently reported some complex trauma cases with new symptomatology and possible recurrent cases [8,9]. In addition, the lack of a proper follow-up system for people who present repetitive crises during commemoration was reported [9]. All of these highlight the need for more research on this burden to inform strategies designed to mitigate the crises and improve genocide survivors' well-being. Therefore, this study aimed to evaluate the perceptions of trauma victims, family/friends of the victims, and health service professionals toward trauma problems in their communities, trauma trigger events, how they react when victims experience trauma symptoms, challenges faced by victims and services that need to be strengthened in order for victims to cope with trauma.

METHODS

Study design and site: This study used a cross-sectional design with the qualitative approach using Focus Group Discussions (FGD). The study was conducted countrywide across all hospitals that report on mental health interventions provided to people experiencing an emotional crisis and trauma cases during Kwibuka 24 in 2018.

Study population: The study population included all individuals who presented emotional crisis and/or trauma (new cases or recurrent cases) during the 2018 commemoration period of the genocide against the Tutsi and who have been managed or treated at commemoration sites, Health Centers, District or Referral hospitals, and who were able to communicate are involved. We also included

mental health care providers who have provided an intervention at least once during the commemoration period, relatives and/or friends of people experiencing emotional crises and traumatic events during the commemoration of the 1994 Genocide against the Tutsi in Rwanda. In this study, we will refer to the participants as discussants.

Sample size and sampling techniques: A purposive sampling technique was used to select Discussants for the qualitative study. Daniels's 1999 formula was used to calculate the sample size during the quantitative data collection. Whereby;

n=z2 *p(1-p)
n is the sample size, z is the statistic for a level of confidence (for a level of confidence of 95%, which is conventional, the z value is 1.96) p is the expected prevalence or proportion (considered as 0.5), d is the precision (considered as 0.05 to produce good precision and smaller error of the estimate. With a Continuous Interval at 95%, the non-response rate of 3% and design effect of 1.5 was considered using Daniels's formula.
Therefore, from the formula above;
n=1.962 * (0.5(1-0.5)) =384.16
Sample size when response rate is considered:
=384 / (1-0.03 none response rate) = 384/0.97= 395.87= 396
Sample size when Design effect (Deff) is considered:
= 396*1.5= 594
Therefore, the final minimum sample size was 594, and 611 participants were included in this study.

Study instruments: For qualitative data, FGDs were used for three categories of Discussants namely; trauma victims, health care providers, and family and friends of the trauma victims. Five FGDs each composed of 8 participants are conducted for each category of Discussants. An FGD guide was used to guide the discussions.

Data collection process: Data was collected through Focus Group Discussions (FGDs) with three groups of Discussants namely: victims of trauma during the 2018 commemoration period of the Genocide against Tutsi; relatives or friends of the trauma victims and health service providers. Participants for the 3 categories of focus groups were identified considering their gender, age and their place of residence. An FGD guide facilitated the discussions and all proceedings were recorded using a voice recorder.

Data management and analysis: The data collected for the qualitative study are recorded and transcribed. This information was collected in Kinyarwanda. All transcripts/narratives were validated and translated to English for analysis. The software package used for qualitative analysis was Max QDA. The FGD transcripts were analyzed using scissors and sort techniques and content analysis. The steps included the following techniques:

1. The transcripts were read through and the sections of it that are relevant to the research question(s) were identified. Based on this initial reading, a classification system for major topics and issues was developed, and material related to each topic was identified in the transcript.
2. Color-coded brackets or symbols were then used to mark different topics within the text with colors. The amount of material coded for any one topic depended on the importance of that topic to the overall research question and the amount of variation in the discussion. The coded materials were phrases, sentences, or long exchanges between individual Discussants.
3. Once the coding process was complete, the coded copy of the transcribed interview was cut apart (the scissors part of the technique). Each piece of coded material was cut out and sorted so that all material relevant to a particular topic was placed together. This cutting and sorting process was readily carried out on a computer with a word-processing program.
4. Each topic was treated in turn with a brief introduction. The various pieces of transcribed text were used as supporting materials and incorporated into an interpretative analysis. Important segments of the transcript were categorized for the topics discussed by the group; representative statements regarding these topics from the transcript were selected and interpreted. Findings in an engaging narrative were written down to describe the themes and the quotations.
2. Most of the data was coded, and Max QDA

was used to develop the different narratives for each topic.

Ethical considerations: Ethical approval from Rwanda National Ethics Committee (RNEC) was obtained prior to the conduct of the study. Informed consent was obtained from the participants by signing consent forms. Participation in the survey was voluntary, and all necessary logistics to facilitate the study were provided. The transcripts were kept in a password-protected computer to ensure the confidentiality and anonymity of the discussants. Focus groups gathered in a safe, comfortable, and private location.

RESULTS

Perception of victims of trauma

Trauma victims indicated increased trauma, especially among postgenocide children and the elderly and widowed survivors around the places where they live. Discussants indicated that postgenocide children get to learn about the atrocities committed during the genocide against the Tutsi in school and during the commemoration period, thereby getting traumatized.

"I am a small child, but there are problems we have as children from families of survivors of Genocide, and you find your parent doesn't have a family when he/she tells you the Genocide history, it hurts you, and you fail to manage it or when you see the kind of life your parent live you get trauma, other young people around us say that we are acting because we didn't see what happened during the Genocide, but you find that many children have trauma because of their families, there is a time you find a child's thoughts are beyond his/her age," Discussant D from Group 2, 20 years old noted.

The old widows and the elderly are also traumatized because they are lonely, and have scars and traumatic memories from the 1994 Genocide against the Tutsi. An elderly discussant was quoted saying: *"I go to the hospital for treatment and have nobody to take care of me and the trauma cannot end. Most of the time trauma is due to loneliness and also when I look at the scars on my body."*

The victims of trauma also further noted that there is stigmatization and genocide ideology in the communities. This stigmatization has made many people get discouraged from seeking help hence resulting in chronic trauma. *"The problem I share with my fellow Discussants is that people in the neighborhood don't understand what trauma is. They only attach value to us in April. Even if I may be telling the truth, people will say I am mad. Even when you invited me for this discussion, they started gossiping that I was taken to Neuro-Psychiatric Hospital in Ndera to have my madness screened,"* V5, aged 31, Group 5.

Perception of friends and family of victims of trauma

Friends and family of victims of trauma also indicated that there are increased trauma cases within their neighborhoods. Discussants noted that there is increased trauma amongst, especially postgenocide children and the elderly. F8 from Group 3 noted: *"I would also like to corroborate my fellow Discussants and say that trauma is in both groups. Elderly survivors and young people who didn't experience the horrors of the genocide against the Tutsi. This is true because we currently find young people getting traumatized, yet they were born in the postgenocide period. On both sides, the children born of survivors and those born of genocide convicts get traumatized. As for elderly survivors, they get traumatized due to lacking people to support or render service, yet they had children who were killed in the genocide."*

Friends and family also noted, however that there is reduced trauma in their communities because the government has continuously supported survivors, and counselors have helped many survivors cope with trauma. Most people only witness trauma during commemoration and whenever they go to the memorial sites. Discussant F2 from Group 5, a 40-year-old male, notes: "*Comparing to what happened last year, we may say that trauma cases are abating, as my fellow Discussant has said. This is true because long ago, one could get traumatized by the fact that they stayed alone in the family, but with the support being rendered to survivors, victims all end up braving the odds."*

Perception of health service providers

The service providers observed that trauma cases

around the places where service is offered is complex. They noted that there is increased trauma amongst the elderly and from the post-genocide generation, as earlier asserted by the other group of discussants. The elderly have traumatic memories, PTSD, scars, poor standard of living, diseases, and are lonely hence making their trauma issue complex, while amongst the youths, most of the children born of genocide convicts get traumatized once they find out what their parents did in the past, they find it hard to accept why they took part in the genocide and the ones born of genocide survivors get traumatized because they lack closure of what happened. *"Trauma is at the highest rate to the extent that it is not only found among elderly people but also among postgenocide generations. People wonder how possible this can be. For example, we sometimes join schools to commemorate the genocide against the Tutsi and find young men and ladies being traumatized because of originating from families affected by the genocide,"* noted PBA from Group 3.

Trigger events indicated by victims of trauma

A couple of trigger events lead to the manifestation of the trauma symptoms by the people who experienced trauma during Kwibuka 24. Participants indicated that flashbacks, poverty, the commemoration period, lack of closure from released genocide perpetrators, testimonies from other genocide survivors, domestic violence and visible wounds like scars and other diseases are key triggers to their trauma crises.

"When the commemoration date arrives, one remembers a lot of things, the mood changes, you remember so many things. On the commemoration date, when I go to the stadium, I have a problem. The crowd of many people causes me trauma, and the noisy place also causes me trauma. When something makes a loud noise abruptly, I lose my mind." Discussant B from Group 2, a 40-year-old woman, noted with deep sorrow.

Trigger events indicated by family and friends of victims of trauma

Victims' Family and friends cited many events, which trigger trauma symptoms in the victims. They indicated that poverty contributes heavily to the trauma of their friends or family member. Other triggers cited include the commemoration period, testimonies from other genocide survivors of how they suffered and lost their family members, commemoration songs and poems that are mainly sung during the commemoration, lack of closure because most of them are surrounded by people who took part in the genocide. Hence, they get traumatized every single day by being in contact with the perpetrators, diseases like HIV/AIDS that they have to live with, memories most especially about their deceased victims and genocide ideology amongst some members of the community.

Discussant B from Group 4, a 27-year-old man, noted: *"Another thing causing trauma is seeing bodies of other people, and you have not yet seen yours and buried them in dignity. In addition, the punishments of most genocide perpetrators are coming to an end, and they are being released, yet survivors are not prepared to deal with this."*

Trigger events indicated by health service providers

Health service providers observed that poverty is one of the root causes of trauma since it has resulted in poor living conditions like hunger, lack of shelter and lack of income, making many people remember what the genocide took from them. They also further noted that most of the victims claim that there was injustice in Gacaca courts; hence some perpetrators are living freely in the communities.

Other trigger events cited by the health service providers also include the commemoration period itself through activities like testimonies, songs, and poems that bring back bad memories of what happened during the 1994 Genocide against Tutsi; insults, hurtful/insensitive words, and mocking by neighbors; diseases like HIV/AIDS brings depression and bad memories; scars and disabilities got from the genocide also brings back bad memories; attending burials of the dead reminds them of their loved ones that they did not get to bury; and loneliness most especially amongst the elderly and widows who have no one to take care of them when in trouble or sick are the biggest trigger events amongst trauma victims during the commemoration period and beyond.

Discussant No. VIII from Group 2, a 27-year-old lady, noted: *"One of the factors is seeing your*

tormentor being released without your knowledge. Survivors are sometimes surprised with the release of those who killed their relatives, this shocks them and contributes to their trauma crisis."

Reaction of neighbors as indicated by victims of trauma

From the discussions, victims noted that most of their neighbors are not supportive because they don't understand that one can have trauma. Some of the neighbors mock, insult, laugh at the victims, others get scared and flee away from the victims. These neighbors keep saying hurtful statements and falsely accuse the victims by saying that the symptoms demonstrated are staged, making the victims feel much stigmatized. Discussant M4 from Group 3 noted: *"Neighbors consider us to be mad. You will find them warning one another when the commemoration period is near-keep away from M4; her madness is now terrible. Instead of comforting us, they consider us mad; whenever they call us mad, our trauma worsens." M4 further says that some neighbors have bad attitudes toward survivors. "They graze their animals in the survivor's crops, and some of them remove our house doors."*

Although the majority of discussants indicated that their neighbors were not supportive, some indicated that their neighbors were very supportive and comforted victims, consoled them, talked to them, they helped change the environment of the victims by taking them to less noisy places, and some even took trauma victims for further help like counseling including seeking medical help.
"I got trauma during the holidays. I remember just finding myself at Masaka hospital, the person I was with did not know me, but he made a lot of sacrifices and took care of me and kept my things, and when we went back, he took me to his home saying I still haven't recovered energy, that I will go back after full recovery, after he organized my transport back to my home," V8 from Group 3.

The reaction of neighbors as indicated byfamily and friends of victims of trauma

All family members and friends are very supportive of the victims of trauma. Much as the trauma problems bring frustration to them because they cannot change history and time, they try to comfort victims, get closer to them, take them for counseling and call people with similar problems to share their experiences with their loved ones. Victims are given emotional support while others make them change the environment when traumatized. This is done by treating them as if they were in their shoes, listening to them, giving them touch therapy like hugging them, taking them to a less noisy environment, and comforting them.

However, when the family members/friends were asked about the neighbor's reaction towards a person in a trauma crisis, all discussants indicated that the neighbors don't support trauma victims since they insult them and falsely accuse victims of pretending to have trauma. The neighbors are not supportive because they don't understand that one can have trauma even after 24 years since the genocide against the Tutsi. They mock, insult, laugh at the victims, and others get scared and flee away from the victims. They keep saying hurtful statements and falsely accuse the victims by saying that the symptoms demonstrated are staged, making the victims feel more stigmatized.

"When there is a trauma incident, some neighbors flee the scene, even those you consider your friends run away from the victim. Most people in society think that trauma is meant for one group of society. Again, when neighbors see victims battling trauma, they will start gossiping, asking one another whether such a victim can be traumatized." Discussant F4 from Group 3 noted.

Challenges in victim's daily life indicated by victims of trauma

From the discussions, the biggest challenge highlighted for the trauma victims is the lack of support, insults and hurtful statements from the public, which makes them feel stigmatized. Other challenges include poverty, the lack of shelter, food, and other basic needs; inadequate service providers to handle the many trauma cases; lack of follow-ups of the trauma victims after the commemoration period; and lack of closure from the genocide perpetrators. Discussants also noted that there is a challenge of unprofessional service providers who don't ensure confidentiality of testimonies. Some also run away when they see a patient in crisis.

"Our daily lives are complicated. We have nowhere to get a living from. We only depend on support, and whenever we think about those who would be there for us, we feel shocked, and our head starts paining while our trauma stirs up. Again, we take medicines, which weaken us to the extent that we need something to eat and drink so as to regain energy, yet we are broke, and some of us receive no allowances. Only childless families are prioritized in giving allowances, with the rest of us being left aside." Noted Discussant M2 from Group 3.

Challenges indicated by family and friends of victims of trauma

Family and friends of trauma victims corroborated the challenges identified by the victims of trauma. These discussants indicated that poverty is the biggest challenge to the victims. This has led to poor living conditions like hunger, lack of shelter, and lack of income, and also increased trauma since the thought that they cannot have a good standard of living makes them remember how the genocide destroyed their property and took their loved ones. Other challenges mentioned include genocide ideology amongst community members, diseases like HIV/AIDS from sexual assaults during the genocide that victims have to deal with daily; and lack of health insurance preventing them from afford medical treatment in case of trauma crisis.

Challenges indicated by health service providers

Health service providers also indicated that poverty is the biggest challenge to trauma victims. This has led to poor living conditions, including hunger, lack of shelter, and lack of income. Other challenges raised by the health service providers include loneliness amongst the elderly and widows as a serious challenge; stigmatization and injustice have also made very many people feel unworthy of living in society; mistrust has left many people lonely and made them live in fear since they cannot trust anyone, and this has made them not to ask for help once traumatized. Health service providers also cited intermarriages and insults as posing the greatest challenge for victims in their everyday life since some of them are married to people from different ethnic groups. Most of these marriages have resulted in violence hence causing trauma.

Services received during the commemoration period that should be strengthened

There were a couple of suggestions of the services offered during the commemoration that should be strengthened in order to improve response to trauma cases. Discussants suggested an increment in a number of service providers to be able to attend to all the patients with trauma, especially during the commemoration period. Follow-ups of trauma victims to curb the trauma cases; training of service providers to improve their skills and so that the people can get professional and confidential help; need to use fellow survivors as service providers so that they can feel comfortable sharing with them since they believe that the fellow survivors will be able to understand them and help them better; and sensitization of the public about trauma to reduce on the stigmatization of the victims were some of the other services suggested to be improved.

New services to be introduced as indicated by victims of trauma

From the discussions, all 34 Discussants agreed that new services need to be added to improve the services offered to people experiencing trauma crises. The services that need to be added are; the need for support groups within different communities, and advocate for financial support for example service providers should work for free during commemoration so that people can be encouraged to seek help, and there should be an increment in FARG assistance, follow-ups after commemoration period, increase medical assistance in the health centers so that all the trauma patients are attended to, increased government support so that; justice is served in the Gacaca courts and support projects with people with trauma, need for confidentiality amongst the service providers, for example, Red Cross, need for moral support from both the government and the public, review of the Ubudehe categories, sensitization of the public about trauma, need more service providers and training service providers at village level to curb down on trauma.

New services indicated by family and friends of victims of trauma

Discussants advocated for more counselors since the number of counselors is few. They feel that if the number is increased, many people will be able

to get help. Furthermore, these counselors should be trained to get better skills when working with the victims as some break down when the victims are traumatized. Family and friends also advocated for more financial and material support from the government in order to improve their standards of living like building shelters, paying school fees, and starting up small businesses; more follow-ups in that the counselors should not only help them during commemoration period but also after the commemoration period; government intervention most especially to fight corruption in the Gacaca courts; there should be training programs for parents with children experiencing trauma so that the parents can be able to help their children.

Techniques used by health service providers to handle trauma victims

The results for the FGD show that service providers use counseling, which involves talking, listening, and advising the victims. They also lay victims in calm and secure places, and this is mainly done by keeping the victims away from the crowd, listening to him/her, helping them come back to normal life, providing basic needs like water, and checking vital signs in case there are any disease symptoms. Other service providers also monitor and counsel victims, and they keep records of their patients in order to see how they are coping with their services; while others use support groups, these groups are formed by people with similar problems so that they can share their testimonies and the solutions to their trauma.

Service providers also further indicated that they follow up with victims and give them appointments. This involves door-to-door visits and making sure the patient attends their appointments; they also give different treatments to victims, like medicine in order to reduce symptoms like headache and stomachache. Other providers use touch therapy, which involves massage and hugs; whereas others use exercises as a means of helping victims deal with trauma during commemoration.

Considerations for referring a trauma case to a higher service level

Service providers observed that a patient is referred to a higher service level when his/her health has deteriorated, for example, when an individual is in a coma or when there is no improvement after half an hour. Other patients are referred when there are disease symptoms that cannot be treated by the service provider's post. The referral also depends on the information got from the escort for example if the person has had chronic trauma and is very suicidal then they have to be referred to a higher service level. In addition, service providers indicated that referral also depends on the period spent when one has been traumatized, especially when a person is unresponsive to medicine and has failed to get better. Discussant PBA from Group 3 said: *"When their health keeps on deteriorating, we transfer them to the health center, especially when someone has fallen in a coma, or after an hour and a half has elapsed with no significant improvement."*

Prevention techniques to avoid relapse and new trauma cases and enhance a follow-up framework

There were a couple of prevention techniques that were suggested by the service providers in order to avoid relapse and enhance a follow up framework and they include the following; need for follow ups through giving appointments and visiting the patients at home to see how they are coping with life; training service providers so that they can professionally help the victims; recruiting service providers so as to increase on their number; sensitization of the public about trauma so as to reduce on stigmatization and enable those with trauma crisis to seek help from professionals; supervising service providers so as to make sure that they are providing a professional service; introducing a policy regarding trauma victims so as to also help them access services even after the commemoration period and conducting a census and close monitoring of the numbers of the trauma victims using a data base, which will help to see whether the techniques applied to curb down on the number of patients with trauma is reducing or not.

DISCUSSION

According to the Rwanda Ministry of Health, trauma-related crises are still a national public health concern, especially emotional crises and trauma cases identified during the commemoration period [10]. This study would help gain insights

into how the measures already in place tackling this problem might be performed according to victims, family and friends of victims, and care providers.

During the 1994 genocide against the Tutsi, more than 10% of the country's 7.8 million population and approximately 75% of the Tutsi were killed. This left many people widowed or orphaned [11]. Thus, some victims experience invisible trauma because most do not speak out for fear of being stigmatized. As highlighted by some discussants, some community members still consider survivors with trauma as mad people. "

Family members and friends of the trauma victims have observed increased trauma in their neighborhoods as a result of insults, the commemoration period itself, poverty, scars, diseases, and loneliness of survivors [12]. This also extends to young people born after genocide as they get traumatized even if they did not directly experience the killings. This is similar to what was reported in previous studies that the descendants of genocide survivors in Rwanda experience trauma symptoms [11]. It was found that descendants of genocide survivors with PTSD had more secondary trauma symptoms than descendants of parents without PTSD [11] and former prisoners ($p < 0.0001$) [11,13].

The service providers observed that trauma cases are still very complex, leading to other complexities like hypertension, diabetes, and cardiac diseases. Studies confirmed this and reported that 94% of people in Rwanda during the genocide experienced at least one genocide event, including witnessing the murder of family members, having their property and homes destroyed, and having their lives threatened [14]. These traumatizing events can contribute to several non-communicable diseases later in life [15,16], and trauma episodes also lead to stress, a risk factor for cardiovascular diseases and other chronic conditions [17,18].

These traumatic crises are quite contagious and can affect up to a hundred people at one commemoration site. For example, throughout the week of national mourning that ran from 7 to 13 April 2010, a total of 3193 people were reported to have developed these traumatic crises at different commemoration sites [6]. It has been established that attending the commemoration period may be a trigger of the crisis [6], in addition to other triggers reported by this study's participants. During seven days in April every year, Rwandans gather to mourn the victims of the genocide against Tutsis. Testimonies, songs, and documentary videos about the genocide are used to help people mourn by remembering their families and friends who perished during the genocide as a tool to build a violence-free country in the future and repair broken hearts. However, during these commemoration activities, survivors living with chronic PTSD manifest symptoms, such as flashbacks, agitation, self-mutilation, avoidance, anger, fear, crying, etc. [19]. Other symptoms are anxiety and bipolar disorder symptoms, uncoordinated statements, screaming, crying, hiding, running away, paranoia, depression, self-isolation, unconsciousness, hypertension, diabetes, headache, stomachache, and low self-esteem. A study conducted in Ngarama district hospital found that common mental health conditions were depression, anxiety, brief psychosis, drug (mainly cannabis) and alcohol misuse, and somatoform disorders [20].

This study revealed that some trauma victims' neighbors are not supportive of the trauma victims because of ignorance, and they falsely accuse victims of pretense. These add to other problems, like HIV/AIDS, stigmatization from within the community, poverty, lack of public support, inadequate service providers, lack of follow-ups, genocide ideology within the communities, and unprofessional service providers, worsening their symptoms [20]. However, previous interventions have focused primarily on the emergency period during the crisis. There has been inadequate follow-up intervention for individuals who experience repetitive crises during and after commemoration for those who do not regain their psychological health between crises and those who do not return for follow-up at health centers [9].

CONCLUSION

This study's findings highlight the need to increase the number of well-trained counselors and ensure follow-ups are undertaken to provide services to people at their doorsteps to curb trauma. To achieve this, the mental health authorities can engage fellow survivors and train them as counselors of their colleagues. The Ministry of health and its partners should introduce training programs for parents with children experiencing trauma so that they can easily be in a position to help their children when they get traumatized.

Support groups in different sectors should be emphasized and increased because through these, one can easily share their trauma with people who understand them, and solutions can easily be got. Through these groups, the communities can also be sensitized about trauma so as to stop the stigmatization.

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