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Don't let the suffering make you fade away: An ethnographic study of resilience among survivors of genocide-rape in southern Rwanda☆

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ABSTRACT

Rape has been used in contemporary armed conflicts to inflict physical, psychological, cultural and social damage. In endeavoring to address the psychological damage of collective violence, some researchers and global health practitioners are turning toward post-conflict mental health promotion approaches that centrally feature resilience. Though previous findings from resilience and coping research are robust, few studies have actually investigated resilience among genocide-rape survivors in cultural context in non-Western settings. This paper presents ethnographic data gathered over 14 months (September 2005 to November 2006) in southern Rwanda on resilience among genocide-rape survivors who were members of two women's genocide survivor associations. Study methods included a content analysis of a stratified purposive sample of 44 semi-structured interviews, as well as participant-, and non-participant-observation. Resilience among genocide-rape survivors in this context was found to be shaped by the cultural-linguistic specific concepts of *kwihangana* (withstanding), *kwongera kubaho* (living again), and *gukomeza ubuzima* (continuing life/health), and comprised of multiple sociocultural processes that enabled ongoing social connection with like others in order to make meaning, establish normalcy, and endure suffering in daily life. The results of this research show that the process of resilience among genocide-rape survivors was the same regardless of whether genocide survivor association membership was organized around the identity of genocide-rape survivorship or the identity of widowhood. However, the genocide-rape survivors' association members were more involved with directing resilience specifically toward addressing problems associated with genocide-rape compared to the members of the genocide widows' association. The findings from this research suggest that ethnographic methods can be employed to support resilience-based post-conflict mental health promotion efforts through facilitating collective sexual violence survivors to safely socially connect around their shared experiences of rape, neutralizing social threats of stigma and marginalization.

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Introduction

Rape is a violation of the social body as well as a violation of the self (Cahill, 2001). When perpetrated on a massive scale, rape provokes maximum terror by damaging and destroying multiple aspects of human life including social bonds, cultural practices, bodies, and psyches (Robben & Suarez-Orozco, 2000). According to the World Health Organization's (2002) typology of violence, rape

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employed in armed conflict, war or genocide can be understood as both collective and sexual violence (CSV). CSV has been used in contemporary genocide and warfare to create widespread fear and demoralization, to deliberately subvert community relationships, and to degrade and humiliate targeted groups of people (Gingerich & Leaning, 2004; Reid-Cunningham, 2008).

Current academic debates on the issue of war- and genocide-rape have questioned whether the international criminalization of rape signals true progress in the struggle to eradicate all forms of CSV or deeper entrenchment of problematic assumptions regarding women's agencies and identities (Barnes, 2005; Farwell, 2004). Scholars have argued that "sexual violence as a deliberate strategy in war and political repression by the state is connected in a range of ways to sexual violence in all other contexts," (Kelly, 2000: 45), and that the roots of violence against women pattern social order during both peace time and war time (Olujic, 1998). Re-visitation of the 2000 "Landmark" Resolution 1325 on Women, Peace and Security, the United Nations Security Council (2005) noted that sexual gender-based violence is a persistent obstacle for achieving women's peace, well-being and security, especially in post-conflict settings.

Though women and girls comprise the overwhelming majority of CSV victims/survivors, women and girls also inhabit multiple and overlapping identities and roles during and after violent conflict. These social positions include warriors, soldiers, mothers and wives socializing men for war and/or against war, political leaders, feminists, heroes, war reporters, spies, and the dead (Elshtain & Tobias, 1988; Enloe, 2000; Lorentzen & Turpin, 1998; Saywell, 1986). For example, women were both "agents and objects" in the 1994 Rwandan genocide (Sharlach, 1999: 387), during which rape, gang rape, sexual torture, sexual slavery, and forced "marriage" were used systematically against an estimated 200,000 to 350,000 women and girls (African Rights, 2004; Amnesty International, 2004; Bijleveld, Morssinkhof, & Smeulers, 2009). Though grassroots networks of women coalesced to provide care for the twenty- to fifty-thousand women and girls who survived genocide-rape (Cohen, d'Adesky, & Anastos, 2005; Turshen, 2002), observers have noted the threat of severe stigmatization and marginalization if their status was or became known by their families or the public community (Amnesty International, 2004; Mukamana & Brysiewicz, 2008). Moreover, women and girls who were already known in their communities to have survived rape have been suspected of harboring sexually transmitted infections (especially human immunodeficiency virus (HIV)), accused of having collaborated with genocide perpetrators in order to survive, deemed unable to marry, abandoned by their husbands, or affected by ostracizing medical problems such as obstetric fistula (Amnesty International, 2004).

Under the guidance of the WHO directive to address the psychological damage of war and conflict, the global health community is in the midst of learning how best to respond to various forms of collective violence (WHO, 2002). The extent of short- and long-term negative health consequences from CSV is extremely difficult to estimate. Furthermore, the challenges of meeting the myriad health needs of survivors of CSV are complicated by the absence of adequate health care in many conflict-affected settings (Ward & Marsh, 2006; Zraly, Betancourt, & Rubin-Smith, in press). Health-related consequences of CSV are unwanted pregnancy, gynecological complications and injuries, sexually transmitted infections (including HIV/acquired immunodeficiency syndrome (AIDS)), post-traumatic stress disorder (PTSD), common mental disorders, and suicidal thoughts and behaviors (WHO, 2002). Reports have documented disproportionally high rates of HIV/AIDS among genocide-rape survivors in Rwanda (African Rights, 2004; Nduwimana, 2004), as well as persistent psychiatric suffering (Amnesty International, 2004).

Survivors of rape in war and genocide often experience trauma and other forms of mental health distress (Gingerich & Leaning, 2004; Mercy, Butchart, Dahlberg, Zwi, & Krug, 2003; Ward & Marsh, 2006). However, war-related trauma is a complex and controversial concept and there is "no agreement on the appropriate type of mental health care" (Kienzler, 2008: 218) that should be provided following collective violence. While some researchers have suggested that the trauma of political violence be approached as a normal psychosocial response (Bracken, Giller, & Summerfield, 1997; Pedersen, 2002; Summerfield, 1999), others have endeavored to "determine and verify the effects of violent conflicts on the mental health of those affected by focusing on war trauma, PTSD, and other trauma-related disorder," (Kienzler, 2008: 218). To move beyond this impasse, Miller and Rasmussen (2010) have suggested bridging the conceptual frameworks of psychosocially oriented and clinically focused approaches to post-conflict mental health.

The resilience way

Increasingly, researchers and practitioners are exploring the applicability of salutogenic (health-centered) post-conflict mental health promotion approaches (Almedom, 2004; Betancourt & Khan, 2008; Ghosh, Mohit, & Murthy, 2004). Mental health promotion is a public health strategy that seeks to protect and strengthen existing mental health, to prevent future threats to mental health at the group (e.g. community or population) level, and to specifically and historically addresses issues of power and inequalities (Friedli, 2009). Rooted in the field of developmental psychopathology, the concept of resilience generally "refers to positive patterns of functioning or development during or following exposure to adversity, or, more simply, to good adaptation in a context of risk," (Masten, 2006:4). This process is comprised of "overcoming the negative effects of risk exposure, coping successfully with traumatic experiences, and avoiding the negative trajectories associated with risks,"(Fergus & Zimmerman, 2005: 399).

The interdisciplinary mental health promotion movement and the discipline of public mental health are converging around the knowledge that mental health and mental illness are not mutually exclusive states (Payton, 2009) and that resilience is a pivotal concept for improving mental health (Friedli, 2009; Panter-Brick, 2010). Since the mid-1990s, the notion of resilience has been applied to communities and groups under the broad definition of a process that promotes social relationships, social structures, and community functioning amidst adversity or violent situations (Ahmed, Seedat, van Niekerk, & Bulbulia, 2004; Clauss-Ehlers & Levi, 2002; Hernández, 2002). Emotional integrity despite the experience of extreme human horror has also been suggested as a definition of post-trauma resilience (Jenkins, 1996). Foregrounding the link between emotion and resilience allows for inquiries that treat resilience as "cultural — and culturally specific — without ontologizing either the individual or social," (Beoellstorff & Lindquist, 2004: 438).

Though research investigating actual post-conflict resilience processes and resilience in non-Western ethnographic context is sparse (for exceptions see Fernando, 2006; Lothe & Heggen, 2003; Ungar et al., 2007), research concerning the impact of political violence and trauma on mental health, especially among children, has expanded in the past decade (Betancourt & Khan, 2008; Murthy & Lakshminarayana, 2006). For example, researchers have examined trajectories of trauma-related mental illness following exposure to political violence among refugee children and youth in North America (Beiser, Turner, & Ganesan, 1989; Rousseau, Drapeau, & Rahimi, 2003) and compared youth resilience across cultures (Ungar et al., 2007). The results of these studies illuminate the notion that across different populations, context and culture play a defining role in determining what constitutes risk, protection, and resilience

(Rousseau, Taher, Gagne, & Bibeau, 1998). Among conflict-affected populations, elevated risk for psychopathology may not interfere with or preclude social functioning in certain cultural contexts (Johnson et al., 2009; Tousignant et al., 1999).

Resilience has been directly related to the process of coping with the experience of rape in previous research publications (Burt & Katz, 1987; Fine, 1992; Firehammer, 2001; Littleton & Breitkopf, 2008). One resilience framework that may be of particular importance for understanding the response of genocide-rape survivors to the adversity characterizing their experience is the stress accumulation theory. This theory suggests that repeated and prolonged exposure to severe traumatic experience, such as genocide-rape, may exceed an individual's threshold level of stress and may result in compromised individual capacity to readjust (Dohrenwend & Dohrenwend, 1974; Panter-Brick & Worthman, 1999). In light of the existing literature, the purpose of this study was to empirically examine how persons live with and endure the unbearable pain and trauma of genocide-rape and have the capacity to readjust to everyday life in the context of post-genocide Rwanda.

Ethnographic study of resilience among Rwandan genocide-rape survivors

Methods – phase one

As previously described (Zraly et al., in press), the first author conducted fieldwork from September 2005 to November 2006 in the university town of Butare, Rwanda as well as the four contiguous Huye, Mukura, Ngoma, and Tumba Sectors of Huye District, Southern Province, Rwanda. The first eight months of ethnographic fieldwork was largely comprised of developing relationships with genocide-rape survivors who were members of two distinct survivors' associations. The first was *Abasa*, a district–level association of Rwandan genocide-rape survivors who publicly identified as such. *Abasa* was selected as a "revelatory" case (Teddlie & Yu, 2007) as the sociocultural phenomenon of a collectivity of Rwandan genocide-rape survivors who publicly identify as such had not been investigated previously. The second association was AVEGA-*Agahozo*, a national–level association of genocide widows among whom many were genocide-rape survivors.

Relationships with *Abasa* and AVEGA members generated culturally specific data on resilience. Upon invitation, the first author accompanied AVEGA and *Abasa* members at *icyunamo* (annual mourning period for remembering the genocide) events, *gacaca* (reinvented Rwandan institution used for community-level communal resolution of genocide crimes), *Umunsi wa Intwari* (Hero's Day), the national court trial of 10 men accused of genocide crimes, including rape, a gender-based violence conference at the National University of Rwanda, a ceremonial visit by the First Lady Janette Kagame to officially launch a *umudugudu* (planned resettlement village) with new houses exclusively for *Abasa* members, group meetings, mental health and economic situation assessments conducted by foreign NGO volunteers, the home of newly orphaned children due to the death of a member, Catholic church ceremonies, workplaces (e.g. the fields, the market, the hospital, the income-generation projects), and homes. The first author also conducted informal, unstructured interviews (i.e. conversations) with two Rwandan psychologists, two Rwandan psychology students, two Rwandan nurse counselors, five Rwandan genocide survivor association leaders, and two non-Rwandan women's and human rights organization directors. Basic ethnographic mapping of the two associations was also conducted.

Fieldnotes were transcribed into Microsoft Word usually the same day that they were recorded and included inductive preliminary coding (LeCompte & Schensul, 1999). At the end of this research phase, interim, in-field data analysis of the recoded fieldnotes and preliminary codes was conducted to identify culturally-specific resilience-related concepts. Through this analysis, the first author identified three resilience-related concepts and incorporated them into the Resilience Narrative Instrument (RNI), a semi-structured interview designed by the first author that included elements from the Rwandan Panic Disorder Survey (Hagengimana, Hinton, Bird, Pollack, & Pitman, 2003). The RNI gathered 'life experience' data (e.g. age, marital status, occupation, and number of children) and 'cultural data' on resilience among Rwandan genocide-rape survivors. Piloted with three *Abasa* members and three AVEGA members, the RNI was found to consistently generate narrative data on resilience.

Methods – phase two

The first author used the RNI to guide interviews with 57 study participants over a six month period (April–November 2006). All study participants were members of *Abasa* or AVEGA and had experienced rape during the 1994 genocide. During the second phase of the study, observation and participant-observation in homes, fields, and workplaces focused attention on emotion, social interaction, and everyday problem management in the daily lives of the study participants. Participant-observation was engaged in at social occasions, such as being a guest at a Mukura Sector group wedding were seven of the 164 couples married were *Abasa* members.

From the pool of 57 semi-structured RNI interviews, a quota sample of 22 *Abasa* members and 22 AVEGA members was drawn, optimizing sample variability and representativeness. Ethnographic mapping revealed three meaningful variables and quotas for sample stratification 1) sector of residence, 2) HIV status, and 3) lifecourse at the time of the genocide (Table 1).

Data analysis

The 44 interview narratives and their accompanying fieldnotes were uploaded into Atlas.ti (Scientific Software, 1997). Both inductive and deductive analyses were used to code the texts and to develop a codelist, guided by the model of grounded theory

Table 1
Stratified purposive sample ($N = 44$).[a]

Sector:	Huye		Mukura		Ngoma		Tumba		Total		
HIV Status:	+	−	+	−	+	−	+	−	+	−	ALL
Young Girls (18–24 yrs)	0	1	0	1	0	0	0	1	0	3	3
Girls (27–42 yrs)	0	0	2	8	0	0	1	2	3	10	13
Women (34–46 yrs)	2	3	6	2	3	1	2	2	13	8	21
Old Women (46–59 yrs)	0	0	2	1	1	0	1	2	4	3	7
Total (18–59 yrs)	2	4	10	12	4	1	4	7	20	24	44
TOTAL	6		22		5		11		44		

[a] One study participant in this sample reported not yet having tested for HIV infection. She was counted in the HIV- strata, which should be interpreted as including those who had tested negative for HIV or never tested.

described by Kearney (1998), which provided a template for developing a formalized Resilience Codebook (MacQueen, McLellan, Milstein, & Milstein, 1998). The finalized Resilience Codebook was comprised of 33 codes and applied systematically to all 44 interview texts. Calculations to test intercoder reliability would have been possible, however only one coder coded texts in this study. Following coding, a content analysis was conducted to quantify the presence or absence of each code for each study participant. Chi-square tests were used to show whether any apparent differences in each code frequency across the associations were likely to have been found by chance.

This research protocol was approved by the Case Western Reserve University Institutional Review Board. Letters and/or stamps of approval were obtained from the National University of Rwanda School of Public Health, the Mayor of Huye District, the President of *Abasa*, the President of AVEGA at the national level, and the President of the AVEGA at the Butare level.

Results

Characteristics of the stratified sample

Abasa members often identified themselves by the categories of girlhood and womanhood that they occupied at the time of genocide-rape experience, emphasizing that the rape of unmarried girls disrupted the normative cultural pattern of gender identity by forcing girls them into a painful social space where they were neither girls nor women. Within the *Abasa* association, *abagore* (women) had been married and/or had at least one child during the time of the genocide, while *abakobwa* (girls) had not been married nor had any children. Furthermore, *abana* (children) was used to refer to *Abasa* members who were “young girls” between the ages of six and twelve during the genocide, and women nearing or over 50 years and/or grandmothers in the present were considered to be in the respect-bearing social category of *abakecuru* (old women). In the AVEGA association, members identified themselves simply as *abapfakazi* (widows). Because of the profound salience of gendered social experience and status in the context of post-genocide Rwanda, we used lifecourse instead of age to organize meaningful categories for sampling. Furthermore, in order to combine the two association quota samples, the *Abasa* lifecourse categories (described above) were applied to the AVEGA sample (Table 1).

Fifty percent of the participants in this sample ($n = 22$) resided in Mukura Sector, home to the *Abasa* headquarters. The most populated Lifecourse category for the total sample was Women, of which there were 21 (48%). However, the single most populated quota was that of Girls residing in Mukura Sector, of which there were 10 (23%). Among the 43 study participants who reported having tested for HIV infection, 20 (47%) reported being HIV-positive.

Demographic characteristics of the sample

The mean age of genocide-rape survivors participating in this study was 40 years old, and the mean number of living birth children reported by participants was just over two (Table 2). While the majority (70.5%) of study participants had no adopted children, the number of children adopted ranged from zero to five. Only 16% of the sample were currently married or living with a partner. Though some study participants reported never having attended school (11.6%), most had participated in at least some primary level education and beyond (88.6%), but none completed secondary school. The majority of study participants owned a home (65%), land (70%), and livestock (55%). The most common occupation among study participants was cultivating and/or raising livestock (64%). Half (50%) of the study participants were currently holding positions of community leadership, including serving as elected *inyangamugayo* judges (persons of integrity) in *gacaca*. The majority of study participants were Catholic (75%).

Table 2
Selected Characteristics of Two Quota Samples: *Abasa* (genocide-rape survivors' association members) and AVEGA (genocide widows' association members).

	Abasa $n = 22$	AVEGA $n = 22$	Total $N = 44$	*p*
t-test				
Mean Age	35.59 ± 8.65	43.91 ± 7.56	39.75 ± 9.06	***0.001
# of Own Children	1.86 ± 1.36	2.91 ± 2.07	2.35 ± 1.81	0.054
# of “Adopted” Children	0.41 ± 1.14	0.73 ± 1.08	0.56 ± 1.12	0.347
X^2-test				
Current relationship status				***0.000
Single, never married	12(54.5%)	0(0%)	12(27.3%)	
Married/living together	5(22.7%)	1(4.5%)	6(13.6%)	
Divorced/separated	1(4.5%)	1(4.5%)	2 (4.55%)	
Widowed (Single)	4(18.2%)	20(90.9%)	25(57%)	
Education attained				
None	1(5%)	4(18%)	5(11.5%)	
Primary	9(43%)	11(50%)	20(46.5%)	
Post-primary	11(52%)	7(32%)	18(42%)	
Completed secondary	0(0%)	0(0%)	0(0%)	0.238
Home ownership				
Homeowner	19(86%)	9(43%)	28(65%)	**0.003
Other (e.g. rent)	3(14%)	12(57%)	15(35%)	
Land ownership				
Own land	13(59%)	18(82%)	31(70%)	
No land/yard only	9(41%)	4(18%)	13(30%)	0.099
Livestock ownership				
Own animals	18(82%)	6(27%)	24(55%)	***0.000
Own cows	3(14%)	0(0%)	3(7%)	0.233
Leadership positions				
Any leadership	14(64%)	8(36%)	22(50%)	0.070
Inyangamugayo	12(55%)	4(20%)	16(38%)	*0.021
Religion				
Catholic	17(77%)	16(73%)	33(75%)	
Muslim	2(9%)	1(5%)	3(7%)	
Christian (non-Catholic)	3(14%)	5(23%)	8(18%)	0.649
Occupation				
Cultivator/livestock raiser	13(59%)	15(68%)	28(64%)	
Wage Earner/business	6(27%)	3(14%)	9(21%)	
Unemployed	2(9%)	4(18%)	6(14%)	
Student	1(5%)	0(0%)	1(2%)	0.422

$^{*}p \leq 0.05$, $^{**}p \leq 0.01$, $^{***}p \leq 0.001$.
Note: Continuous variables were examined with the independent *t*-test, and categorical variables were examined with Pearson's X^2-test. For 2×2 contingency tables that contained expected values ≤5, Fisher's exact test was used. For contingency Table $2 \times k$ contingency tables that contained expected values ≤5, *p* for Pearson's X^2 was reported.

AVEGA and *Abasa* members in this sample differed significantly with respect to a number of characteristics. The mean age of AVEGA members (44 years old) was significantly higher than the mean age of Abasa members (36 years old) ($p = 0.001$). The pattern of relationship status was also highly significantly different between the two samples ($p < 0.001$). All but two AVEGA members were currently widows, while ten *Abasa* members had never been married. The percentage of home ownership among *Abasa* members was significantly higher than percentage home ownership among AVEGA members ($p = 0.003$), with *Abasa* members owning homes at double the rate (86%) compared to AVEGA members. Likewise, the percentage of livestock ownership among *Abasa* members was significantly higher than percentage livestock ownership among AVEGA members ($p < 0.001$), and the three study participants who owned cows were all *Abasa* members. Furthermore, *Abasa* members were significantly more likely to be *inyangamugayo* (54.5%) than AVEGA members (18.2%) ($p = 0.027$).

Culturally specific concepts of resilience

Three cultural-linguistic specific concepts of resilience emerged from the fieldwork and were incorporated into the RNI. First, *kwihangana*, to withstand, was the most directly accessible way to express and talk about resilience in Rwanda. It involved strengthening oneself in the face of suffering the tragedies of life. *Kwihangana* was used liberally in post-genocide Rwandan society to encourage patience in response to circumstances ranging from irritating annoyances, to painful hardships, to the death of loved ones.

> To strengthen yourself, you feel that you don't let the suffering make you fade away; otherwise, you could die. You hurry up and go through it. You do not linger in that pain. But, as it goes, *kwihangana* causes you to feel that you brought force inside yourself…

> *Kwihangana* simply means to withstand something you have experienced that has hurt your heart. You withstand it to avoid committing suicide … You feel as if it were the end of life but you eventually realize you are not the only one who has suffered because there are other people with whom you share problems. This then makes you withstand and you no longer experience these feelings …

Second, for the genocide survivor community in general, *kwongera kubaho* was a reaffirmation of life after death, referring to the process of finding and living a life after the humanitarian catastrophe that intended to destroy Tutsis, their families, and their humanity. It can literally reference a return to life from after the "death sentence" of the genocide, or having survived among dead bodies. *Kwongera kubaho* was often expressed in public forums, particularly in political speeches during *icyunamo*.

> *Kwongera kubaho* is the first thing. At least one should believe that they are alive, that no one is hurting them, no one is violating their rights; thus, you take what you deserve, at the very least feeling that no one is behind you, which would make you feel that you are going to be killed or raped.

> *Kwongera kubaho* now, it is to have a life similar to the one you had before … you feel there is peace in you, on your body and inside in your heart you feel there is peace and you have means to develop yourself in order to live.

Third, *gukomeza ubuzima*, to continue living, conveyed a sense of willingness, effort making, or participation in one's own life. It included aspects of finding the motivation to live and adhering to the imperative to keep oneself alive and to strive for a decent life, especially following genocide survival.

> *Gukomeza ubuzima* is to accept your everyday problems and not to despair as if you were no longer alive; you rather believe that you still on your way forward like others.

> I personally feel that I must *gukomeza ubuzima* and I'm happy I'm still alive … so I feel I have to fight for survival and therefore work hard to gain a living.

Resilience content analysis

There was no significant difference found between the AVEGA and *Abasa* associations in terms of the overall frequency of any of the 33 individual codes in the Resilience Codebook (Table 3). Ten of the 33 resilience codes were found to have a frequency of >90% for both of the *Abasa* and AVEGA samples (Table 4). The 44 individual resilience narratives in the sample were coded with a mean of 24.9 codes each (Min = 18, Max = 33). Because this study approached resilience as a process as opposed to a quality or set of qualities, theses code counts do not measure degrees of resilience; rather, these results speak to differences in the breadth of variety in resilience practices.

For example, the resilience narrative of *Abasa* member, Fiona, a 19 year old, HIV-negative, secondary school student, whose mother was also an *Abasa* member, had the highest code count. All 33 codes were applied to her narrative. On the other end of the spectrum, eighteen codes were applied to the resilience narrative AVEGA member, Laverne, a 43-year old HIV-positive woman who had one child at the time of the genocide and had not formally married the father of that child. Laverne owned her own business and held a leadership position in AVEGA. This difference in code counts reveal that Fiona is engaging in a wider array of resilience techniques compared to Laverne. This illustration suggests that demographic factors may configure patterns of resilience engagement. For instance, being a single, HIV-positive, head of household and mother may locate Rwandan women's association members in a social environment that constrains their opportunities for engagement in a broad spectrum of culturally-relevant resilience processes. Alternately, being a HIV-free, youth and student, with a family member in the same women's association, may expand opportunities for elaborating a wider set of resilience engagements.

Table 3
Resilience codelist.

Code	Brief definition
Accepting	Acknowledging problems regarding the self or reality
Calm & quiet	Calming down and/or being quiet in the face of problems
Cultivating inner peace	Giving oneself peace in the mind and/or heart
Enduring	Enduring problems as a last resort
Getting rid of	Getting rid of painful or unwanted things from the self
Good crying	Crying with a positive spin, for emotional relief
(Never) forgetting	Trying to forget something that one can never forget
Praying	Being involved in prayer, imploring a spiritual power
Reflecting	Wonder about the self, reflecting on one's life
Resting	Decreasing activity for the purposes of rejuvenation
Self-seclusion	Ushering oneself to a place to be more alone
Thought control	Controlling thoughts in order not to be so affected by them
Being a resource	Being someone that can offer assistance in some form
Being with	Being together with others, especially emotionally present
Caring connecting	Relating empathetically with care, comforting
Conduct concerns	Imparting or receiving advice about problems
Expressing problems	Letting someone else know that you have a problem
Humoring	Laughing and joking with others, even about problems
Incorporation	Becoming part of a group and staying in association
Meaning making	Interpreting and making sense of life experiences
Microcomparison	Comparing oneself to like others
Normal human being	Normalizing experiences, problems, and adversities
Sharing the same problem	Knowing others who have the same problems as you
Ending distress	Having the experience of problems coming to an end
Fortifying positive affect	Boosting morale, lifting mood, mustering courage
Gaining benefits	Acquiring material, social, or other resources
Maintaining dignity	Being proud of identity, not feeling shame
Protecting health	Abstaining from certain behaviors to prevent illness
Rejecting death	Refusing death, dying, or suicide as an option
Returning to living life	Coming back from a state of (extreme) distress
Struggling for lifechance	Fighting for survival, doing whatever is possible to live
Valuing self-sufficiency	Wanting to be responsible for oneself
Wanting lifetime	Valuing life itself, as well as the extension of days alive

Table 4
Resilience codes applied to at least 90% of each sample.

Code	*Abasa n* (%)	AVEGA *n* (%)	*Exemplar quote*
Being with	21 (95.5%)	21 (95.5%)	*As members, we're almost always together.*
Caring connecting	22 (100%)	22 (100%)	*Only when I meet a friend who experienced war problems do we discuss and they comfort me.*
Conduct concerns	20 (90.9%)	22 (100%)	*The Sister is the one who used to give us advice and talk to us, and said that the headache is caused by thoughts … she told us that whenever we felt unable to deal with it, that we would go to someone we trust and talk.*
Expressing problems	21 (95.5%)	21 (95.5%)	*When I joined Abasa, I had to say all I went through, no secrets.*
Fortifying positive affect	22 (100%)	20 (90.9%)	*I never have a day full of problems because I always give myself morale. So, if you are annoyed in addition to the life you have, you can die quickly, so you withstand.*
Incorporation	22 (100%)	22 (100%)	*… we made a group and created positions that enabled us to meet and talk together in the group. We talked about our problems and the life we live.*
Meaning making	22 (100%)	22 (100%)	*If those three or four people raped you and you survived, He [God] has another thing that He wants from us.*
Human being	21 (95.5%)	20 (90.9%)	*Earlier, we took shake and trauma as head sicknesses, but we finally realized that it is like a sign from a given wound … and this helps us avoid going mad and thinking that you are no longer a human being.*
Sharing the same problem	21 (95.5%)	22 (100%)	*We all share that, we talk about it of course, we talk about it, all of us, because we all were raped.*
Thought control	20 (90.9%)	20 (90.9%)	*When you come across a serious problem in life, that's when you think about it [genocide]. But, because you can meet other people, you just talk with them and try not to think too much*

Revealing genocide-rape experience

This study of resilience among genocide-rape survivors who were members of either the AVEGA or *Abasa* associations included women and girls in southern Rwanda ranging from 18 to 59 years in age, with diverse marital, birthing, and childcare-giving backgrounds. *Abasa* included significantly more members who had been unmarried girls when they experienced genocide-rape compared to AVEGA. Between *Abasa* and AVEGA, there was a difference in the expression of genocide-rape experience among girls. From the AVEGA widow point of view, girls who experienced genocide-rape had reasons to conceal that fact, such as to avoid shame and unmarriagability.

> We [women] reveal it as we have already given birth to children and hence it is not a shame … However, many girls remain private and hence say nothing about it. This would make them not get married.

In contrast, the perspective of *Abasa* members who experienced rape during the genocide as girls was that they had been advised by their fellow members not to hide it.

> They've advised me not to hide it, because it happened to all of us, but you can't talk about it with someone who was not concerned, for them they think it's shameful. But when we talk about it, be it with my sister, be with it anyone else from the association or any other survivors outside of the association, we feel it's normal.

> And we discussed it a lot … We didn't hide anything from each other because we realized that we had the same problem. And we advise anyone who still hides it, that it is not a good idea.

Public expression of genocide-rape experience

Abasa members also spoke publicly about their experiences of genocide-rape. An AVEGA member who survived genocide-rape identified with the *Abasa* girls' experience upon encountering its public expression.

> How can I be like those *Abasa* children who speak it out in the stadium? They spoke it out in the stadium, and a woman who was their representative added: all the children you can see there have been raped. As she had said it, many people got traumatized and mad, but an old woman like me, the same situation happened to me, and I experienced it.

Similarly, in April 2006, *Abasa* members were visited by First Lady Janette Kagame in a highly visible public ceremony. Crowds of community members watched as the President of *Abasa*, accompanied by a well-dressed *Abasa* membership, spoke about how *Abasa* was comprised entirely of genocide-rape survivors. Afterwards, the First Lady spoke about the courage that *Abasa* members had demonstrated by speaking out about the issue of rape, indicating that they were an example to follow in the struggle to address the problem of sexual violence in Rwandan society. After the First Lady's speech, the entire *Abasa* membership rose from their seats to sing and dance for the First Lady, performing with voices, claps, and swaying bodies in the ceremonial space. Again, Madame Kagame responded with respect by joining in the dance with an open-faced smile. During this ceremony, *Abasa* was officially granted 15 new houses and two goats for every member.

The practice of speaking out about genocide-rape experiences in Rwanda was influenced by context and history. Though there were dramatic differences between the 1959 massacres and the 1994 genocide, certain parallels have been drawn between the two episodes of collective violence primarily targeting Tutsis inside Rwanda. In this study, a single, home-owning *Abasa* leader, who had been a girl during the genocide, referenced the events of 1959 in her resilience narrative while explaining the meaning of *kwongera kubaho* (living again):

> Normally, our parents used to tell us what happened in the year 59 … They said that in the 59 war my mother's family house was burnt down, and they were helped to flee by a Hutu man who was their neighbor … We used to ask her, "but Mom is there a person who can kill another one like that, who can hunt you that way?" She told us that this is what happened. I couldn't believe it. But she told us because she survived. As for me now, I survived and I saw it. I feel I should tell, and as soon as I'm able to shout about it, I would tell anyone who doesn't know about it so that they know it, and it will not happen again.

Kwongera kubaho (living again) was a reason to strive to speak out about the events of the 1994 genocide, thus linking survivors' resilience and CSV prevention.

However, speaking out about genocide experience and genocide-rape among genocide-rape survivors was a powerful act

of emotional expression that took courage. In the quote above, the *Abasa* leader alludes to a moral obligation to develop her capacity to speak out. Understanding how patterns of courageous emotional expression among CSV survivors are supported or constrained by social and structural forces in post-conflict and post-genocide settings is critical, especially considering the potential impact of survivor voices on the prevention of future collective sexual violence and genocide-rape. Furthermore, courage may be a particularly important emotional aspect of resilience to focus on with regard to mental health promotion among CSV survivors, since both CSV itself and the memory of it can be profound sources of discouragement and indescribable pain:

> … when I think back and remember how I was raped, I of course realize that it is something very discouraging to me. When I remember how I was raped, sometimes you could be raped by one man, and this was not very problematic, but when you imagine a number of people, you really feel [*pause here*], it is the way I was raped which disturbs me…

Discussion

Rwandan genocide-rape survivors suffered *in extremis* during the genocide, and each of their genocide-rape experiences is unique. Yet, among genocide-rape survivors located in women's associations in southern Rwanda, the process of resilience appeared to be patterned by the culturally specific concepts of *kwihangana, kwongera kubaho*, and *gukomeza ubuzima. Kwihangana* was found to be an intrapsychic creative process of drawing strength from within the self in order to withstand suffering. *Kwongera kubaho* was found to reference the re-establishment of the fundamental existential conditions of being; in other words, that living life is still possible after many terrorizing experiences of rape and torture. *Gukomeza ubuzima* was found to be a sense of moving forward in life and living on despite the ongoing struggles of accepting myriad problems and fighting for survival. These findings reveal that fourteen years after experiencing genocide-rape the everyday life of survivors was imbued with an emotional ethos of refusing to linger in pain, standing firm in the face of problems, and struggling for survival and health.

From the perspective of genocide-rape survivors, coping strategies and resilience processes were tightly integrated. *Kwihangana, kwongera kubaho*, and *gukomeza ubuzima* in the context of Rwandan genocide-rape survivors' everyday life was found to be comprised of a set of multiple elemental sociocultural processes that did not differ across association membership. Ten of these processes appeared in at least 90% of the *Abasa* and AVEGA resilience narratives. Taken together, they describe an orientation to the world that involved being socially connected to like others in order to make meaning, establish normalcy, and endure suffering in daily life. Taken in isolation, each of the processes may be considered a coping strategy, such as "thought control" and "fortifying positive affect".

However, though the resilience patterns among both *Abasa* and AVEGA members were the same, the fact that they associated around distinct problem-based identities differentiated the groups according to their potential to overcome the specific problem of genocide-rape. *Abasa* was able to transform rape survival identity from a stigmatized, marginalization-inducing social position to one occupied by courageous, justice-deserving, publicly valorized women and girls. This was accomplished by collectively "going public" as genocide-rape survivors in a political environment growing increasingly supportive of the struggle to end sexual gender-based violence. This "going public" expanded the safe social space for *Abasa* members in particular, and to some extent for genocide-rape survivors in the Butare area in general. *Abasa* may be following a universal pattern of taking on a "survivor mission" after traumatic experience that allows them to "speak the unspeakable" (Herman, 1997). By being out with their rape survival status, the *Abasa* membership was able to gain significantly more access to housing and livestock resources during the study period compared to AVEGA, and may have been more prepared to serve as leaders in post-genocide truth and reconciliation projects, such as being *inyangamugayo* in *gacaca*. In light of the stress accumulation theory, the process of resilience among genocide-rape survivors may be differently complex for widows, who carry the added stress from the social problem of losing their husband in a culture context with almost no opportunities for re-marriage, than for girls who faced the excruciating social dilemma of not fitting into the social role of either a girl or a woman after genocide-rape. Age may also be an important demographic factor to consider, as the older group of AVEGA members have had nearly an extra decade of life exposed to the lethal social conditions of racism, authoritarianism, and structural violence that fueled the genocide (Uvin, 1998).

Including genocide-rape survivors from two different survivors' organizations rendered different results from previously reported findings on the issue of Rwandan women and girls revealing their rape experiences publicly. For example, Mukamana and Brysiewicz (2008) interviewed seven women from AVEGA who were raped during the 1994 genocide in Rwanda and concluded that "[w]omen who were raped did not reveal their experience publicly, fearing that their family and community would reject them and they would never be able to reintegrate or to marry," (383). However, in light of our findings, Mukamana and Brysiewicz's results can be reinterpreted as a particular view from the world of genocide widow association membership, which does not represent the entire scope of genocide-rape survivors who were members of post-genocide survivor associations.

The findings from this study have implications for post-conflict mental health programs and policy-making in settings where populations have experienced CSV. In terms of mental health services, the results from this study suggest that post-conflict women's associations should be considered a significant site of "informal community mental health services" where CSV survivors seek help and discuss and manage emotional problems (WHO, 2007). Therefore, these associations ought to be recognized as fertile ground for understanding and promoting war- or genocide-rape resilience in cultural context. The findings from this study also support the argument to incorporate ethnography in the design, implementation, and evaluation of post-conflict mental health programs and policies (Gozdziak, 2004). Based on our experience with the RNI, we recommend an adaptation to Bolton and Tang's (2004) ethnographic methods to understand local concepts of resilience for effective mental health programs intended to serve CSV survivors. Specifically, we suggest the free listing of problems among CSV survivors, descriptions of those problems, ways that CSV survivors handle those problems, identification of local people who support CSV survivors in handling those problems in those ways, then key informant interviews with the identified people about all aspects of the resilience tactics including how people can engage in it.

Conclusions

In field of global mental health, resilience-centered mental health programs hold promising potential for application in the humanitarian, health, and development sectors as responses to the needs of CSV survivors. Parallel to discussions of the trauma/PTSD debates in psychiatric anthropology, a resilience debate is coming to the fore. While some resilience researchers attempt to establish

resilience as a universal and cross-culturally valid psychological response to traumatic distress based on the criteria of not meeting diagnostic criteria for psychopathology (e.g. Connor & Davidson, 2003), others conceptualize resilience as a process that trends toward mental health, on a distinct axis from mental illness (Friedli, 2009), and unhinged from dependence on criteria for psychopathology (Almedom & Glandon, 2007). The position that this paper has taken supports the latter view that resilience is a fundamental and ordinary human adaptation system (Masten, 2001) that involves the inextricable domains of self, emotion, and sociality, which are mediated by culture and context (Jenkins, 2004).

Given the global patterning of inequality, populations most vulnerable to the deleterious health effects of collective violence are often the very same as those are most impacted by the erosion of lifechances and social suffering rooted in structural and symbolic violence (Rylko-Bauer, Whiteford, & Farmer, 2009). Rwandan genocide-rape survivors have been able to begin to forge pathways toward ameliorating the pain, suffering, and injustice of collective violence amidst considerable constraints, hence exceeding expectations of "functionality" in the wake of the extreme, pervasive social and personal violence of genocide-rape. Therefore, mental health promotion activities in post-conflict states should look for opportunities to seamlessly interface with the potentially powerful informal health care systems used and comprised by CSV survivors. Furthermore, the results of the research demonstrate that given the right program and policy conditions, it is possible for CSV survivors in Africa south of the Sahara to safely connect around their shared experiences of genocide-rape despite threats of stigma and marginalization. In turn, these social connections provide the cultural milieu for CSV survivors to authorize, stabilize, and catalyze culturally-specific resilience processes (see Cole, 2004).

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