Annual Outcome Report

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Tackling Trauma and other Common Mental Disorders through the Community-based Social Healing Model

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EXECUTIVE SUMMARY

"…. My life was like in hell, I had lost hope in life……. I can (now) testify that my life has positively changed. I am now a role model in my community, which has driven the village members to vote for me as a social community worker at the village level"
The 2020/2021 annual outcome report highlights key outcomes from the implementation of pilot project phase 2 of the community-based social healing model to tackle trauma and other common mental disorders. The highlights are based on findings from quantitative data analysis comparing the pre-and post-intervention as well as stories and testimonials collected from program beneficiaries. The report suggests that the Ubuntu Center for Peace's community-based social healing program met expectations by successfully:

- Empowering 120 Community Healing Assistants to serve over 2258 people with ill-mental health
- Reducing trauma (PTSD), anxiety disorders and depressive symptoms respectively in 64%, 56% and 58.5% intervention participants and improving significantly their quality of life.
- Assuming that the lost to follow up had remained in the program without any improvement, the effect of the intervention would still be statistically significant reducing depression in 680 (49.5%) participants, anxiety disorders in 664 (47.5%) and PTSD in 174 (54.7%) participants and improving their quality of life.
- Participants' work productivity has improved significantly by increasing the number of people who have not experienced illness-related difficulties by 41 %, and decreasing those who were totally unable to work over 5 days within a month by 22% and those who had their daily activities disrupted over 5 days in a month by 30%.
- Participants' domestic violence/intimate partner violence has decreased in 59% cases
- Children school attendance improved by 30.6%, despite various challenges and Covid-19 related disruptions.
- The per capita cost of the program is currently estimated at US$44,5

To successfully expand the community-based social healing model, Ubuntu Center for Peace is committed to strengthen its Monitoring and Evaluation system including shifting the digitalized data collection task to the Community Healing Assistants, creating ID for all participants to facilitate their follow up and reviewing the monitoring and data collection calendar.

I. Introduction

I.1. Context

The Rwanda Ministry of Health recently published a report on the prevalence of mental health disorders in Rwanda, which suggests that over 2 million Rwandans i.e. 1 in 5 people in the general population are affected by ill-mental health, predominantly depression, anxiety disorders and Post-Traumatic Stress Disorders. Unfortunately, only one in six people access mental health services and care they need. The government's only individualized and medicalized approach to address the situation, is good but not sufficient. Ubuntu Center for Peace has developed a scalable, low cost and integrated community-based social healing model to compliment the government's approach in tackling trauma and other common mental health disorders and creating healthier and more productive communities. The model was initially tested starting in July 2017 in Kamonyi District, Southern Province, Rwanda. This report showcases the results of the second phase of the pilot, which was implemented between July 1st, 2020- June 30th, 2021.

I. 2. The community-based social healing model

- The community-based social healing model integrates mind-body practices including Qigong, Tai chi, slow breathing with storytelling/collective narrative practices and rituals.
- Healing practices are delivered through healing groups by lay Community Healing Assistants (CHAs) whom we recruit in the community, train, mentor and incentivise.
- Healing groups of 20 people each actively participate in 3-hour sessions of healing practices every week for 16 weeks,
- They then transition to long-term support or self-help groups and create new activities including solidarity work, loans circles, cooperatives etc., which sustain the healing process and lead people to a healthier, happier and more productive life.

II. 2020-2021 Year program goals

While the phase one of the pilot project which started in June 2017 explored the improvement of some trauma-related symptoms, social cohesion and reconciliation with success, the phase two of the pilot project implemented in the Year July 2020- June 2021 focused on the improvement of mental health syndromes including Post-Traumatic Stress Disorders, depressive syndrome and anxiety disorder as well as secondary effects-social functioning. Therefore, the Year 2020-2021 program goals included:

- Reduction of PTSD, Depression and Anxiety disorders in at least 50% of the targeted population of at least 2300 participants through the medium of a trained and supervised 120 Community Healing Assistants network.
- Improve work productivity in the program beneficiaries and their children's school attendance by 20%, and reduce family conflicts along with domestic violence in 50% beneficiaries as a secondary effect of mental health outcomes improvement.

III. Key Program Outcomes of the Year 2020-2021

III.1. Methods used for the program outcomes evaluation

- The phase 2 of the community-based social healing pilot program was implemented in Nyarubaka, Musambira and Rukoma sectors of Kamonyi District, Southern Province of Rwanda. 120 CHAs were recruited, trained and supervised in delivering healing practices to 2258 participants recorded in the program. The latter formed 120 healing groups of 18-20 persons each. They were split in 2 cohorts, the first one starting in October 2020T and the second one starting in April 2021. They met every week for a 3-hour session of healing practices, each group facilitated by 2 CHAs for 16 weeks. When they completed 16 weeks of formal healing practices, they made their plans and commitments for long term support groups, creating additional activities including solidarity work, loan circles and/or cooperatives.
- Quantitative data was collected before and after the intervention by clinical psychologists whom we recruited and trained in the data collection tool, which we had set up in Kobo Toolbox. The data collection tool comprised the adapted MINI (Mini International Neuropsychiatric Interview) based on the DSM-IV[1], validated by the Geneva University Hospital previously used in the Rwandan context, PHQ-9[2] for depression screening, GAD-7[3] for anxiety, PCL5[4] for PTSD, the WHO Quality of Life-BREF and the WHO Disability Assessment Schedule (WHODAS 2.0), 12-item version. The screening and diagnostic tool was translated in Kinyarwanda and back translated in English by a team of 3 people.
- Data was analyzed by an independent consultant using STATA 14.2. Baseline and end line data was descriptively analyzed and specific indicators were compared using a z-test. The Wilcoxon matched-pairs signed-ranks test was used to analyze the difference between medians values of the compared pairs. Given the nature of the analysis which compares the same individuals in the pre- and post-intervention—only complete pairs of data were included. By a complete pair, we mean a pair that has no missing values or discordant values between pairs. Discordance refers to the situation when there is one response and one missing or N/A value. 1889 participants had complete pairs for data analysis, i.e. 83.6% of the total participants recorded in the program
- Qualitatively, we collected testimonials and healing stories from beneficiaries either in their healing groups or through individual interviews during home visits
- Evaluation limitations: data collection by external professionals all the time is very resource intense and expensive. In addition, there is a high likelihood for some clients to miss their rendez-vous on the data collection days, when they have conflict priorities. In addition, organizing and analysing the sizeable amount of data is associated with logistical and time constraints. The social desirability bias in the Rwandan cultural context is likely for some questions where participants want to say what they think is acceptable. Due to Covid-19 disruptions, some participants had to suspend group healing practices for some weeks. This certainly had an impact on the outcomes. This also led to the prolongation of the implementation for 2 months.

1 DSM-IV: DSM-IV: Diagnostic and Statistical Manual of Mental Disorders, fourth edition, the official source on definitions related to mental illness.
2 The Patient Health Questionnaire (PHQ) is a self-administered version of the PRIME-MD diagnostic instrument for common mental disorders. The PHQ-9 is the depression module, which scores each of the 9 DSM-IV criteria as "0" (not at all) to "3" (nearly every day).
3 The Generalized Anxiety Disorder scale (GAD-7) is one of the most frequently used diagnostic self-report scales for screening, diagnosis and severity assessment of anxiety disorder
4 PCL5 is the Posttraumatic Stress Disorder Checklist (PCL), a widely used DSM-correspondent self-report measure of PTSD symptoms. The PCL5 is the final product from a recently revised PCL to reflect DSM-5 changes to the PTSD criteria.

III.2. Key program outcomes of the Year 2020-2021

Empowered 120 CHAs to deliver healing practices in the community

The CHAs training is not a mere training in the program healing practices but also the opportunity of CHAs for healing and empowerment. Our 120 CHAs including 53 males and 66 females, witnessed experiences of healing, transformation and empowerment as a few powerful stories suggest.

Healing to help others heal: a moving story of a CHA

Grace is a 30-year-old woman. She's been married for the last 12 years to a very loving man. She has 2 children. In her past, she was raped when she was 12 years old. When the project started, she was selected to be one of our Community Healing Assistants (CHAs) who is now supporting her traumatized community members to heal from trauma. During the CHAs' training, she shared her story of rape about which she felt deeply ashamed. She had never felt sexual pleasure (sexual anhedonia) during intercourse. She experienced dissociation related to her traumatic experience of rape. She felt that her life had become miserable, unworthy and unhappy. We worked together, practicing meditative bodywork and exercises for freedom of her emotional memory. Before the training ended, her life had completely changed. She had a more radiating face and appeared more confident and integrated in the group. While she was shy at the beginning of the training, she even volunteered to lead morning bodywork exercises at the end of the training. "I can't be more grateful to God for the miracle that happened this morning," she told me. "For the first time in my sex life, I felt something great that I cannot describe, I feel very happy that I had the chance to be selected as the CHA and benefit from the training," she said with a big smile. It was magical! Her body has now freed itself from the traumatic information that it had memorized for years. Grace is now the role model for her community, many married couples in conflict seek her support and insight in helping them heal and reconcile.

Healing from trauma inherited from parents' wrongdoing

Pascasie is a 33 years old woman. She was 9 when the 1994 genocide occurred in Rwanda. Her father was involved in killings during genocide and was jailed afterwards. Pascasie had been suffering terribly from a sense of shame for being born from a genocide perpetrator. She didn't have a chance to go to college as all family resources were diverted to taking care of her father who was then in jail. For her, life was meaningless. She had been feeling isolated and disconnected, as if she was a foreigner in her own community. She never dared to get involved in any activity that required her to take a leadership role. 2 weeks after the CHA training, she was surprised to be identified one of the best leaders we had in the group, very engaging, with a sense of command. The healing has disinhibited her. She managed to let go her sense of shame, felt more integrated and accepted, worthy and with zest for life as she shared with other CHAs at the end of the training.

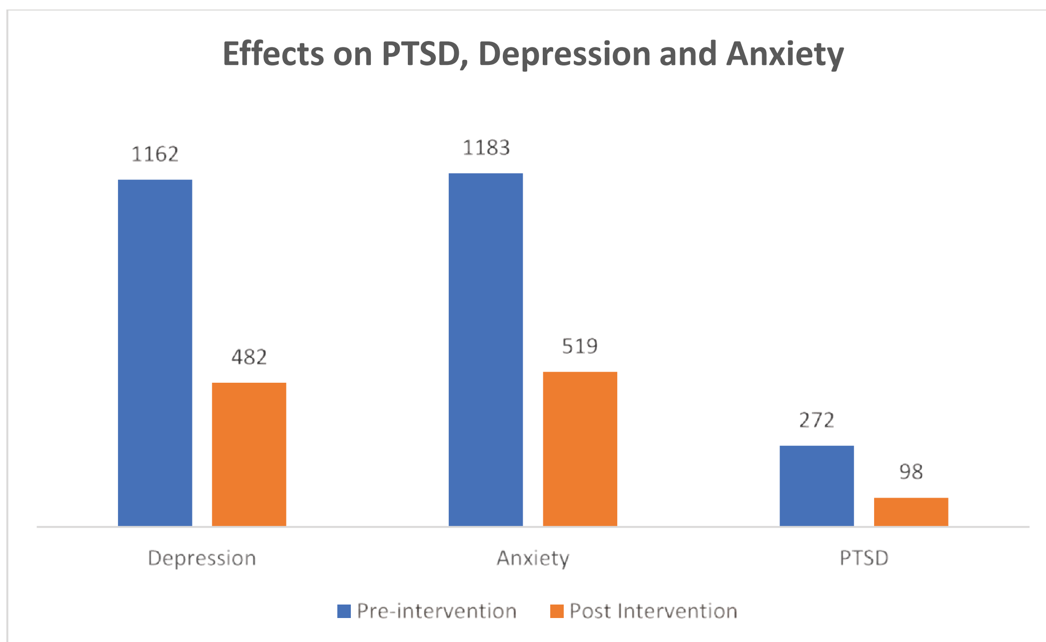
Intervention effects on PTSD, depression and anxiety disorders' symptoms

We analyzed 1889 people including 1436 (76%) females and 453 (24%) males with complete pairs of data. Most participants have finished primary school (60%) and live from subsistence agriculture (91%) with no paid salary (99.7%). The table below suggests statistically significant effects on mental disorders and quality of life.

Table 1: Population with all complete pairs of data.

Variables	Baseline(n=1889)		Endline (n=1889)		Difference	95%CI	P value
	n	%	n	%			
With depression	1162	61.5%	482	25.5%	-36.0%	[-38.7%, -33.3%]	<0.001
With Anxiety	1183	62.6%	519	27.5%	-35.2%	[-37.9%, -32.4%]	<0.001
With PTSD	272	14.4%	98	5.2%	-9.2%	[-11.0%, - 7.4%]	<0.001
With Very good/Good Quality of life	1063	56.3%	1338	70.8%	14.6%	[12.0%, 17.1%]	<0.001
Very satisfied/Satisfied with their life	1186	62.8%	1400	74.1%	11.3%	[8.8%, 13.9%]	<0.001

As the table and figure suggest, of 1162, 1183 and 272 participants who respectively had depression, anxiety disorders and PTSD, 680 (58.5%), 664 (56%) and 174 (64%) became symptoms free respectively from depression, anxiety disorder and PTSD after the intervention. The 2 tables below show the improvement of severity of symptoms respectively in depression and anxiety cases.



Sensitivity analysis

As above-mentioned, 2258 participants were recorded in our program. However only 1889 (84%) had complete pairs of data. Assuming that the lost to follow up had remined in the program without any improvement, the effect of the intervention would still be statistically significant reducing depression in 680 (49.5%) participants, anxiety disorders in 664 (47.5%) and PTSD in 174 (54.7%) participants and improving their quality of life.

Table 2: the lost-to-follow-up have remained the same as the baseline

Variables	Baseline (n=2258)		Endline (n=2258)		Difference	95%CI	P value
	n	%	n	%			
With depression	1371	60.7%	691	0.3	-30.1%	[-32.5%, -27.8%]	<0.001
With Anxiety	1399	62.0%	735	0.3	-29.4%	[-31.8%, - 27.0%]	<0.001
With PTSD	318	14.1%	144	0.1	-7.7%	[-9.2%, -6.2%]	<0.001
With Very good/Good Quality of life	1289	57.1%	1564	0.7	12.2%	[10.1%, 14.3%]	<0.001
Very satisfied/Satisfied with their life	1430	63.3%	1644	0.7	9.5%	[7.4%, 11.6%]	<0.001

Healing depression and/or other mental disorders along with Psychosomatic Disorders:

Theresa's story

"Theresa is 36 years old and single mother. Her son is 16 years old. In 2004 I she pregnant by a young man who later denied his fatherhood responsibility and rejected her. Her family rejected her as well. Her heart became heavy with sadness and from 2008 to 2011 her legs got paralyzed. She could not walk anymore. She spent one year in the hospital. When she started recovering, she suffered much from her spine. In addition, she was morally suffering for not being able to struggle for her son who was also rejected by her family members. That led to her self-rejection and to hating her whose father was not assisting the family even in those challenging times. The intention of killing her son rose in Theresa's thoughts, but she failed to do it. Instead, she decided to end her life through suicide. She tried to swallow tablets used to kill mice, but she didn't die. When I started to attend the healing group, she shared her story and she was listened to with empathy. She felt as if she belonged to a new family. From the time she started feeling care from the group, her spine started getting better. Her endless headaches and isolation feeling subsided. She felt reintegrated in a family. She had lost her weight from 64kgs to 58kgs. As she gets better, she regains her weigh up to 60kgs. She said that she loves her son now and she feels motivated to fight for his best and she managed to forgive her son's father. "I am so grateful for this program that made me smile again" said Theresa!

Effects on social functioning (socio-economic)

Healing Group Participants sharing stories in Nyarubaka

Effects on work productivity

We evaluated the work productivity by looking at the reduction of lost days due to illnesses in our participants. The table below gives us a better picture of improvement in work productivity in our participants in terms of percentages.

Lost days due to disability

Variables	Categories	Baseline		Endline	
		n	%	n	%
Overall, in the past 30 days, how many days were these difficulties present?	None	374	19.80	637	33.72
	Between 1-5	691	36.58	746	39.49
	Above 5	824	43.62	506	26.79
In the past 30 days, for how many days were you totally unable to carry out your usual activities or work because of any health condition?	None	730	38.64	855	45.26
	Between 1-5	590	31.23	590	31.23
	Above 5	569	30.12	444	23.50
In the past 30 days, not counting the days that you were totally unable, for how many days did you cut back or reduce your usual activities or work because of any health condition?	None	606	32.08	877	46.43

As we can see, the table suggests that people who could not experience difficulties for the last 30 days increased from 374 to 637, i.e. by 41 %, those who were totally unable to work more than 5 days within a month decreased from 569 to 444, i.e. by 22% and those who had their daily activities disrupted over 5 days in a month decreased from 529 to 371, i.e. by 30%.

Domestic Violence
Intimate Partner Violence

Based on participants' testimonials and data collected by Community Healing Assistants, of 1889 participants, there were 595 cases (31.5%) of intimate partner violence before the intervention. After the 16 week-long journey of healing practices in groups, cases had dropped to 246 (13%). That means Intimate Partner Violence reduced by 349 (59%). When parents' mental health outcomes improve or intimate partner violence reduce, their children feel safe and are empowered to go back or regularly attend the school.

Augustin's story reconciling with his wife is one of the examples

Augustin is a 40 years old male, married, with five children. He is working in the mines sector. Before attending our healing group, he told us that it was very hard for him to live in harmony with his family. "I was abusing my family without knowing. My wife couldn't know how much I was earning, and even any time she wanted to ask about it, it leads us into quarrels and fights. Administrative authorities attempted many times to reconcile us but it was in vain", he said. Their children's rights were also violated by poor schooling, lack of school materials and even occasionally lack of food as Augustin chose to take all the money to the bar and come back drunk. His wife was not happy, always angry at him as he would come back home drunk. Quarrelling and/or fighting. When the healing program started, the Community Healing Assistants approached and invited them to attend 16 weeks healing sessions. His wife refused to join the group healing practices while Augustin did with passion. "…Breathing exercises were helpful because every day I practiced them, I could feel calmer than before", he said. After week five of the healing practices, Augustin took time to share his story with the group and his concern that his family had lost confidence in him. The group members shared some insights with him to help him re-assert himself as a father of his children and a husband of his wife so that he could regain trust from his family.

A few days after Augustin received insights from the healing group, he apologized to his wife and children for all his wrongdoing that had hurt them many years. They forgave him and let him know that they had also started noticing positive change in his behaviors. "I am now a happy Husband and Father; my family is happy too. Thanks to the organization that brought the healing groups, I am resurrected"! said Augustin.

Children school attendance

Variables	Impact on children school attendance (N=1889)			
	Baseline		Endline	
	n	%	n	%
Absenteeism or child dropped out of school	816	43	566	30

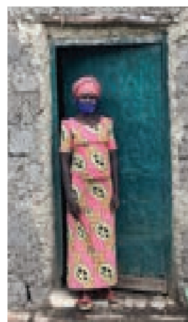
As the table above suggests, children who either dropped out of school or didn't regularly attend school due to their parents' illness decreased significantly from 816 to 566, i.e. children school attendance improved by 30.6%, despite the Covid-19 pandemic stress and restrictions.

IV. From formal therapeutic to long-term support groups

Grace's story of healing and resilience

Grace is married to a second husband who is now in prison. They had together 4 children. Unfortunately, 2 of them died during the 1994 genocide. Four of her five siblings died as well. Because of all those losses, Grace was always sad, lonely and crying almost every day. She used to wonder why she didn't die. “My life was like in hell, I had lost hope in life” she said.
During the healing practices in her group, she shared her story and listened to other group members' experiences. Meeting others motivated her as she realized that she was not alone to be suffering. The group helped her feel better and she started sleeping well. Her weight has increased. She has now regained the interest and energy to work.

After the formal 16 week-long healing practices, she and her group members decided to join their hands in order to support one another and increase their economic capabilities. They started cultivating their land supporting one another, which significantly helped her increase her rice production.



“Working together made our solidarity stronger as after the activity we seat and share again on new life experiences”, she said. Grace's long support group decided that each member should contribute 250 rwfs (25p) each week with the goal to buy a chicken for each member. Currently, Grace has received a chicken whose eggs are sold to help her children eat better and have enough school materials. She took that opportunity to renew her family house. “I can testify that my life has positively changed. I am now a role model in my community, which has driven the village members to vote for me as a social community worker at the village level”.
There are many inspiring stories of healing and resilience initiated in the formal healing groups which is cemented in the long-term support groups.

V. Involved cost

All the community-based social healing program outcomes to be reached, we have estimated the per capita cost at US$44.5 factoring into human resources, program expenses including CHAs training, supervision and incentives, Monitoring and Evaluation, Equipment and supplies as well as administrative. Given that the program is still at a relatively small scale, we hope that the per capita cost will reduce as we expand.

VI. Conclusion and recommendations

The Year 2020/2021 annual outcome report indicates that the community-based social healing program met well our expectations by successfully reducing trauma, anxiety and depressive symptoms respectively in 64%, 56% and 58.5% patients and improved significantly the quality of life. The results suggest that the improvement in trauma and other common mental health work productivity by 30%, children school attendance by 30.6% and reduced domestic violence by 59%. Given that the evaluation is human resource intense and that some participants miss the appointments for data collection and/or their names don't match due to wrong spelling at either baseline or endline, our top priority is to Strengthen the Monitoring and Evaluation system:

- Train Community Healing Assistants in data collection, and conduct a validation study for them to collect all data
- Use of smart phones by the Community Healing Assistants
- Give IDs to all participants to allow follow up
- Review the data collection calendar: before the intervention, at week 8 (during the intervention), week 16 right after the intervention, 6 months and 24 months after the intervention to see if the improvement has been sustained and the impact of the long-term support groups on the healing process.

VII. Acknowledgement

Heartfelt thanks for all your support and collaboration:

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