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Community approaches to trauma

MCC's mission and work have always included responding to human suffering caused by violence, displacement and disaster. Responding "in the name of Christ" goes beyond physical, material aid and takes seriously psychological, social and spiritual needs. Trauma response work broadly defined encompasses efforts to prevent, mitigate and heal the impacts of traumatic exposure on individuals and communities. While MCC has worked with people exposed to trauma since the 1920s, an explicit focus on responding to trauma has been growing since the 1990s. These trauma projects have emerged organically out of specific contexts rather than from centralized planning. The result is a wide diversity of community approaches to trauma in use across MCC.

In 2018 and 2019, I conducted a multi-project evaluation to assess this wide continuum of trauma response projects across MCC programs. The goals of the study were to better understand the scope of MCC's global trauma response programing, to develop a clear framework for categorizing and evaluating these diverse approaches and to provide recommendations and resources to inform future work. The evaluation used a mixed-method design, including desk audits of 18 project case studies in eight countries (Afghanistan, Egypt, Haiti, Lebanon, Nepal, Syria, Tanzania and Ukraine), field visits to 11 of these projects, a literature review and semi-structured interviews with 22 disciplinary experts among MCC staff and active partners. Field visits included focus groups and semi-structured interviews with project participants, partner staff and MCC program staff. In this article, I outline a framework for understanding the diversity of MCC-supported trauma responses that emerged from this study, along with recommendations for strengthening how MCC and its partners deploy different strategies to address trauma. The other articles in this issue, in turn, reflect on some of the different approaches to trauma embedded in MCC-supported trauma work in Nepal, Haiti, Colombia, DR Congo, Ukraine and Afghanistan.

Understanding of trauma has grown rapidly in the past 50 years, following the U.S.-led war in Vietnam. Prior to that point, no formal clinical diagnosis of Post-Traumatic Stress Disorder (PTSD) as currently understood existed, with little awareness that non-physical impacts of extremely stressful events can create long-term impairment or require professional intervention.

Kolo Adamu holds a photo of her daughter Naomi who was abducted by an extremist group and held for three years. Adamu is a participant in an MCC-supported trauma healing program at Chibok Church of the Brethren in Chibok, Nigeria. (MCC photo/Matthew Lester)

Growing evidence shows that the public health consequences of untreated severe traumatic exposures include higher rates of depression, anxiety, substance use, suicide, early death, autoimmune disorders, cardiovascular disease, diabetes, obesity, criminal justice involvement, medical complications, psychosomatic illnesses, homelessness, unemployment, sexual-risk-taking behaviors, domestic violence and second-generation mental and physical health problems in children of parents with untreated PTSD.

Much early research on trauma was limited to the United States, Canada and Europe, with clinical approaches then exported to other regions with little attention to different cultural and religious contexts, divergent

	Community Building	Community Healing	Rights-Based	Public Health	Clinical Health
Frame	Violence, conflict, and trauma are the result of, and a major contributor towards, social divisions and inequality.	Violence creates trauma at the individual and community level; unaddressed, this trauma leads to recurring cycles of violence against self and others.	Traumatic exposure results from a violation of rights, and the unwillingness of those in power to protect vulnerable populations and uphold rights.	Unaddressed traumatic exposure can serve as a driver of population ill health and suffering, particularly in vulnerable groups.	Traumatic exposure increases risk of death and specific clinical diagnoses (PTSD, addictions, depression, anxiety, hypertension, etc.)
Framing of Response	Prevention and response through bridging division and bringing separated groups together in shared spaces and for shared work.	Trauma can be healed, violence prevented and people reconciled by mutual sharing, awareness raising and skills training.	Raise awareness of and mobilize people to demand human rights and advocate for changes to laws and policies.	Targeted evidence-based efforts to prevent traumatic exposure and mitigate downstream health effects	Trauma-linked clinical diagnoses should be addressed through specific evidence-based clinical interventions at the individual level.
Community Building	• Youth clubs and activities to bring participants from different sides of a conflict together. • Economic development initiatives for marginalized groups. • Shared safe spaces for relationship building.	• Strategies for Trauma Awareness and Resilience (STAR) • Healing and Rebuilding our Communities (HROC) • Singing to the Lions (Catholic Relief Services) • Alternatives to Violence Project (AVP)	• Advocacy efforts to change policy/law. • Education and empowerment of survivors to stop future violations and demand justice from perpetrators. • Legal efforts to secure protections or compensation.	• Developing treatment for trauma-linked conditions. • Early mitigation interventions for most at-risk sub-populations. • Targeted violence reduction efforts for populations at risk of violence.	• Provision of evidence-based clinical treatments for trauma-linked conditions, including PTSD, addictions, depression, anxiety, hypertension, heart disease and physical injuries.

conceptions of what is considered traumatizing, traditional resilience and coping strategies and the potential damage of imposing inappropriate and poorly contextualized labels of disease, suffering and victimhood across cultural contexts. Thankfully, more recent work has made progress in using culturally adapted approaches, validating methods and tools in local languages, developing more refined diagnostic definitions and demanding a stronger and contextually relevant evidence base.

Growing academic, clinical and humanitarian interest in trauma in recent decades has gone hand-in-hand with the fragmentation of the trauma response field into disciplinary silos, each with its own definitions, theories,

“Good trauma work is highly contextualized, locally adapted and owned and based on a rigorous assessment of local needs, priorities and partner capacities.”

bodies of research and preferred approaches. MCC's trauma work has mirrored this wide diversity, with MCC partners in varied contexts using different language, conceptions of trauma, scales of analysis (e.g., assessing trauma at the individual or community level), understandings of the consequences of unaddressed trauma and types of interventions seen as most effective and appropriate. Working to improve MCC's trauma response efforts requires starting with a shared framework for defining and discussing this diversity of contextualized approaches.

"While raising awareness about the causes and impact of trauma on individuals and communities can be important, it is not an end in and of itself, but a means of pursing other types of change."

The framework developed during my evaluation identified five basic types of MCC-supported approaches to addressing trauma: *community building, community healing, rights-based, public health* and *clinical health*. The accompanying table describes how each approach understands what trauma is and why it originates, how it impacts individuals and communities and what types of interventions are likely to be successful in preventing traumatic exposure or mitigating its effects. The conceptual categories described here are not rigidly circumscribed but are presented as part of a flexible framework in which approaches to trauma response can overlap. In practice, many MCC-supported trauma response initiatives adopt multiple approaches. While most of the articles in the remainder of this issue examine a project using one of these approaches, the final article considers an integrated trauma response model in Afghanistan that includes all five approaches.

In addition to producing this typology of MCC's trauma response efforts, the evaluation also advanced several findings and recommendations to guide and strengthen MCC's use of different trauma approaches. These included the following:

1. MCC is well positioned to implement effective trauma response programming across the full spectrum of approaches due to its commitment to long-term relationships, contextualization and localization of work, a network of respected and experienced local partners and staff, strong fit with mission and flexible funding structure allowing for tailored programing.
2. MCC can use its strong and diverse network of local partners and experienced staff who are well placed to lead the type of rigorous grassroots situation assessments and contextualized project design that is critical to this work, rather than relying on outside experts and prepackaged project models.
3. Good trauma work is highly contextualized, locally adapted and owned and based on a rigorous assessment of local needs, priorities and partner capacities.
4. MCC and its partners must insist on high standards for situation assessments, project design, theories of change, justification of the specific approaches used, monitoring and evaluation and the qualifications and professional competencies of trauma practitioners. These elements are essential to minimizing the risk of harm and ensuring work is high quality, effective and appropriate.
5. Community building approaches to trauma should be considered in contexts where MCC lacks partners and staff with sufficient technical capacity to implement more specialized approaches.
6. MCC should not underestimate the complexity, risk and cost involved in implementing community healing approaches. While community healing approaches may feel less intimidating than public health or clinic health approaches, they should be approached with the same seriousness, professionalism and understanding of risks.

7. Rights-based approaches should be carefully assessed for appropriateness to the local context. The locally-directed advocacy critical to this approach (e.g., seeking change from local or national governments and local power brokers) can put MCC, its partners and project participants at risk in some contexts. However, when appropriate, advocacy-oriented rights-based programing can be a powerful pathway to longer-term systemic change.
8. Public health approaches to trauma response can be flexible to specific contexts and partner capacities, and easily integrated as a complement to other activities. This approach resonates with a wide spectrum of MCC partners, staff and participants as it prioritizes building on local capacities, cultural perspectives and existing resources.
9. While raising awareness about the causes and impact of trauma on individuals and communities can be important, it is not an end in and of itself, but a means of pursing other types of change (policy change, behavior change, de-stigmatization, etc.).
10. Even if trauma response projects do not have a clinical focus, they should at a minimum consider mental health issues in their project design to ensure people needing urgent clinical care are appropriately referred.

The articles throughout this issue of *Intersections* reflect many of these learnings about how communities can effectively respond to trauma.

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Clinical mental health: rehabilitation and community reintegration in Nepal

Mental health is a young field in Nepal, one in need of strengthening, particularly in rural areas. Mental health problems in Nepal are often treated simplistically and ineffectively with pharmaceuticals alone. Psychiatrists and primary care doctors in government hospitals are quick to prescribe medications but often lack a complementary approach that addresses patients' psychosocial needs for rehabilitation and caregivers' need for increased knowledge of how to better support patients.

KOSHISH is an MCC-supported Nepali organization that aims to fill this gap by receiving referrals of people who have been mistreated or abandoned by their families due to their mental health problems. KOSHISH works with these individuals by providing clinical mental health treatment and rehabilitative services, including psychiatric consultation, medication management, counseling, life skills training and wellness activities in a safe and nurturing environment. KOSHISH's model of care is based on the biopsychosocial model of mental health care, where an individual's biology, psychology and social-environmental factors are all considered in an individualized treatment and support plan. Once KOSHISH's multidisciplinary team determines that participants have successfully met the threshold for stabilization and recovery, staff work to reintegrate participants back into their home communities whenever possible and appropriate. Throughout the rehabilitation process, staff work with each participant's family and community, providing psychoeducation and information on caring for those with mental illness, including awareness and

> **"A purely medical approach to rehabilitation may allow for short-term improvements with medication, but it does not equip participants and caregivers with the skills they need to maintain recovery, increase engagement in daily activities or strategize about the future"**

Learn more

U.S. National Center for PTSD, U.S. Department of Veterans Affairs. Available at: https://www.ptsd.va.gov.

Hughes, Karen, et al. "The Effect of Multiple Adverse Childhood Experiences on Health: A Systematic Review and Meta-Analysis." *The Lancet: Public Health*. 2/8 (August 2017): E356-E366. Available at: https://www.thelancet.com/journals/lanpub/article/PIIS2468-2667(17)30118-4/fulltext.

sensitization campaigns on stigma reduction and how to avoid additional traumatic exposures, supporting treatment adherence and encouraging active participation in community activities and household tasks.

KOSHISH has found that a biopsychosocial clinical mental health approach to trauma and mental health is beneficial and appropriate for our participants for several reasons. KOSHISH works with severe cases of mental illness, such as schizophrenia and bipolar disorder, and these disorders require comprehensive intervention to be successful. Left untreated, these disorders can severely limit daily functioning and make it extremely challenging for caregivers to support loved ones appropriately. Participants and their caregivers need long-term treatment and coping strategies to maintain recovery and this approach focuses on wellness and thriving beyond the stabilization of symptoms. A purely medical approach to rehabilitation may allow for short-term improvements with medication, but it does not equip participants and caregivers with the skills they need to maintain recovery, increase engagement in daily activities or strategize about the future. Through community-based trainings and follow up, KOSHISH staff counsel participants' families and communities about mental health disorders and how to engage participants in ways that promote healing and increase their involvement in livelihood and economic activities. Through psychosocial therapies, such as traditional talk therapy, music, dance, games, bead-making and group counseling, participants experience increased social skills and the ability to engage in daily household tasks and community activities. KOSHISH also works with reintegrated participants to equip them with livelihood opportunities, such as livestock raising and agricultural production, which engages them in meaningful work, provides income and assists in creating a better future for themselves and their families.

Over 12 years of operation, KOSHISH has experienced impressive success in the rehabilitation and long-term outcomes of project participants, including those with difficult histories of severe trauma and serious mental illness. At KOSHISH's MCC-supported transit home, 96% of those who received treatment experienced recovery. Of those, about 89% were able to reintegrate back into their home communities successfully. While rehabilitation and reintegration are important to the long-term well-being of people with mental illness, KOSHISH has learned that follow-up post-reintegration is key to maintaining patient recovery. Recent post-reintegration data gathered from people treated by KOSHISH indicates that 85% are maintaining good mental health and 93% continue to take their medication as prescribed. KOSHISH is working even harder in its new phase of programming to connect reintegrated participants to local government health posts and hospitals where they may continue to receive pharmacological and psychosocial support. Another indicator of success is the Government of Nepal's desire to replicate and support KOSHISH's model. The government is a primary source of referrals for KOSHISH's program and has offered support to help sustain and expand the work.

"While rehabilitation and reintegration are important to the long-term well-being of people with mental illness, KOSHISH has learned that follow-up post-reintegration is key to maintaining patient recovery."

The context and culture of Nepal drives the design and implementation of KOSHISH's model. In Nepali culture, mental health stigma is still very high. The real barrier to social inclusion and support is most often community members' mindsets regarding mental health. This has led KOSHISH to incorporate mental health awareness and advocacy into all aspects of programming. This process begins with psychoeducation with participants and their families from intake to reintegration. It also includes educating the local community and government agency staff where the participant will

be reintegrated. KOSHISH has been actively securing commitments from local government officials to care for reintegrated participants, as there is not a robust social support system currently in place in Nepal. This education and advocacy extend to the national level, where KOSHISH has successfully advocated for the inclusion of mental illness into Nepal's Disability Act and for greater sensitivity to people living with mental illness in government policies. The relationships built with the Ministry of Health over many years and KOSHISH's innovative and successful model of care have given the organization a national platform to advocate for people affected by mental illness and international recognition as a service provider and advocate.

KOSHISH's work serves as an example of effective clinical mental health work and trauma response. KOSHISH advises those interested in engaging in clinical mental health care to begin with the community rather than the individual. Most of our participants' primary problems stem from the community and the stigma they face in those relationships. At KOSHISH, rather than treating individuals and viewing them as sick anomalies, we treat communities, because it helps us get at the root causes of why people struggle with mental health and at the barriers to receiving treatment. It also roots our approach deeply in the local context and culture, rather than simply importing foreign models. In Nepal, we see people and communities struggling to know how to interact with and care for those living with mental illness, to the point where some people with mental illness are locked up or abandoned by their families. Our context shapes the way we provide treatment and care and helps us know how to make that treatment more sustainable by encouraging families and communities to become more active in providing care and post-reintegration support for those living with mental illness and recovering from trauma.

Matrika Devkota is the founder and executive director of KOSHISH National Mental Health Self-Help Organization. Ryan Fowler was MCC Nepal representative from 2017 to 2020.

“We all have a responsibility to protect children, teenagers and other vulnerable people.”

Public health: church as sanctuary for the prevention of child sexual abuse in Colombia

At the Educational Foundation for Peace and Conflict Resolution (Edupaz), a ministry of the Mennonite Brethren Church in Cali, Colombia, we believe that children and adolescents deserve protection from abuse and traumatic exposure. We work for the protection of minors by developing workshops and training for adults (focused on appropriate and inappropriate touch) and on strengthening the self-esteem and identity of children so that they can better express themselves. We also explore the origins of abusive behavior and how to respond to cases of abuse appropriately.

Edupaz carries out its child sexual abuse (CSA) prevention work in a context that too often dehumanizes children and ignores their rights. Statistics on CSA globally show that about 90% of cases of abuse are perpetuated by a family member or someone known and trusted by the child: our Colombian context is no exception. Cultural norms have hypersexualized children through clothing and music, along with normalizing inappropriate relationships and behaviors between peers and even between adults and minors. Colombian children, young people and women have been treated as

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“spoils of war” by both legal and illegal armed groups during Colombia’s armed conflict, leading to all kinds of abuse and trauma. Within this context that violates the rights of children in multiple ways, Edupaz seeks to promote a culture that protects and defends children’s rights to live free from abuse.

“Pastors and church leaders have an important role in creating communities that foster a healthy, respectful environment and in facilitating abuse prevention and healing from the trauma of abuse.”

We all have a responsibility to protect children, teenagers and other vulnerable people. It is not easy to work in a culture in which few are working for the protection of children and adolescents. At the same time, we see the culture shifting, new laws emerging and values changing in ways that could better protect children. We chose to focus on CSA prevention in evangelical churches, which have historically been reluctant to openly address abuse. As the culture shifts, we have witnessed increased engagement and commitment from churches to address child abuse and protect children’s rights.

Our CSA prevention program aims to prevent abuse and traumatic exposure by creating awareness of the factors that increase the risk of abuse. This public health approach works to reduce risk factors and increase protective factors for children and adolescents as well as their families and church communities. Together we can help to ensure all actors have the awareness, skills and support needed to create a society with greater equity and social responsibility for guaranteeing children and adolescents a better future.

In our CSA program, we organize accessible educational activities focused on personal safety and risk reduction. We have developed a manual to educate communities about CSA. Drawing on this manual, Edupaz’s training raises children’s awareness of their rights and of what to do about sexual abuse they witness, hear about or experience. The training also equips church leaders to know how to deal with the disclosure of abuse and how to facilitate the healing process for victims and their families. Edupaz programs empower community and church volunteers by equipping them with child protection skills, as they are crucial to the success of sustainable child-centered programs.

Edupaz’s training covers a variety of topics, but the main learning objectives are for children to acquire knowledge about body ownership, the difference between good touch and bad touch and the distinction between appropriate and inappropriate secrets. We also prioritize equipping children with self-protection strategies, such as leaving dangerous situations, trusting their intuition and saying no if they experience something that crosses boundaries. We teach children about support systems, where to get help (even anonymously) and how to disclose to a trusted adult if they experience or fear abuse.

Pastors and church leaders have an important role in creating communities that foster a healthy, respectful environment and in facilitating abuse prevention and healing from the trauma of abuse. Leaders should be self-aware and maintain healthy personal boundaries. Edupaz not only teaches children abuse prevention skills, but also adults, so that they can detect when children may feel uncomfortable with touches, looks or other unwanted attention. Edupaz’s pedagogical structure uses experiential learning modules that prepare church leaders to approach children in these situations in appropriate, non-alarmist and preventative ways, so that children in their congregations can feel safe and be safe.

Rodolfo Sánchez of Edupaz describes the organization's youth curriculum about healthy sexuality in 2017. MCC supports Edupaz's peacebuilding, child protection and trauma response work in Cali, Colombia. (Photo by Colin Vandenberg).

Churches must ensure that they function as places of refuge and safety, places where children and adolescents feel protected and healthy and can fully enjoy and express their spirituality. Just as Jesus taught in his ministry, the church should be the first to watch over the well-being of children. Parallel to a growing awareness in the broader Colombian society regarding the need to protect children and provide a comprehensive response to children who suffer violence, evangelical churches are also beginning to address this issue. Our churches are taking small steps to create spaces for talking about and acting for the protection of children. Many now have comprehensive child protection policies in their churches. They are

Learn more

Harris, Nadine. *The Deepest Well: Healing the Long-Term Effects of Childhood Adversity*. New York: Mariner Books, 2018.

"Adverse Childhood Experiences." U.S. Centers for Disease Control and Prevention. Available at: https://www.cdc.gov/violenceprevention/aces.

slowly changing some of the harmful paradigms and myths among their congregants.

From our experience with the broader Colombia society and the evangelical churches with which we work, strengths within our Colombian context that we can build on to promote child protection include:

- Growing awareness within society regarding the problem of child abuse, stronger national laws about children's rights and government-provided services to defend those rights.
- High degree of passion and commitment, particularly among Sunday School teachers, to improve congregational child protection practices and responses to abuse.
- Parents' strong desire to learn how better to talk about, address and prevent child abuse in their homes.
- Increasing openness in churches to acknowledge the trauma caused by abuse.

Our model of community intervention and prevention seeks both to prevent new traumas and to respond in a trauma-informed way after abuse has occurred. After an intervention, we accompany professionals, families and victims of sexual abuse in a process of fostering resilience and redirecting their pain into self-care and a focus on their life goals, so that they may begin to heal.

Our greatest challenge is to sensitize the church to its calling as moral guardians, as agents of peace and as light and salt. Jesus showed concern and special respect for children and warned of the terrible consequences for those who harm them (Matthew 18:1-7). Understanding the roles and practices of church communities is a fundamental step in determining approaches to be used in church-based abuse prevention programs. Edupaz therefore seeks to promote creative initiatives to accompany church members in defending the rights of children to live in peace and free from violence, mistreatment and abuse. Our deep desire is that the church, along with other sectors of civil society, can affirm and act for the dignity of children.

Rodolfo Sánchez is coordinator of the Church as Sanctuary for the Prevention of Child Sexual Abuse program with MCC partner EDUPAZ (Educational Foundation for Peace and Conflict Resolution) in Colombia. Translation by Elizabeth Miller, MCC representative for Colombia and Ecuador, living in Bogotá.

Rights-based: Preventing and responding to sexual and gender-based violence in Haiti

"Every time SOFA successfully advocates for a change in law or policy and every time SOFA changes a community's understanding of the rights of women and girls, we have made another small step of progress on the path toward justice."

SOFA (Solidarity of Haitian Women) is one of the oldest and most respected women's rights organizations in Haiti and is an MCC partner in the field of sexual and gender-based violence (SGBV) prevention and response. SOFA's current project with MCC, based in the southern town of Bomon, is built on a foundation of solidarity between women and respect for human rights. SOFA staff and volunteers accompany women and girls who have suffered SGBV through a wrap-around response that is both wholistic

Learn more

UN Practitioners' Portal on Human Rights Based Approaches to Programming. UN Development Group's Human Rights Working Group. Available at: https://hrbaportal.undg.org/.

"The Lancet Commission on the Legal Determinants of Health: Harnessing the Power of Law for Global Health and Sustainable Development." *The Lancet.* Vol. 393 (May 4, 2019): 1857-1910. Available at: https://www.thelancet.com/commissions/legal-determinants-of-health.

Emma Themistoc, program coordinator with MCC partner, SOFA (acronym for Solidarity with Haitian Women in Haitian Kreyol), in Beaumont, Haiti. SOFA operates Daybreak Centers that support women who have suffered gender-based violence by accompanying them through legal and medical processes, providing microcredit and offering psychological and social support. (MCC photo/ Annalee Giesebrecht)

and supportive. Wholistic support means that that we consider the whole circumstances of the women or girls who have survived violence, the services and support they need and what is required to reduce barriers to them getting the help they need in that moment. For example, the moment a woman or girl takes the courageous step to ask for help after sexual violence, we must be ready and resourced to move quickly to ensure that she gets medical care within 72 hours, as this is vital for providing appropriate medical care. We must be responsive to each person's wholistic needs, whether those are physical, psychological, social or legal.

To be effective, our work must also include mobilizing the community and advocating for change. SOFA works to educate and change community

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attitudes so that the whole community can understand the realities of SGBV and work to prevent it. SOFA also works at local, regional and national advocacy to help change policies and ensure that decision-makers have accurate information on the rates of SGBV in their jurisdictions and understand the measures that need to be undertaken to respond to and prevent SGBV, along with the consequences of continued inaction.

In this struggle, SOFA understands that women and girls suffer SGBV because of their place in society and the way their rights are understood and upheld (or violated) by those with power. The work of addressing and preventing SGBV is rooted in commitment to human rights because each time a woman or girl suffers SGBV, their fundamental rights are violated. For SOFA, violence against women and girls is understood as a manifestation of social inequity and patriarchal power structures. To respond to the pain of individual cases of violence without addressing the deeper social, cultural and legal drivers behind it is to be complicit in these self-perpetuating systems of violence, domination and patriarchy. On the other hand, in every case in which we support a survivor of violence and bring legal action against the perpetrator, we score a victory in this systemic fight for justice. Every time SOFA successfully advocates for a change in law or policy and every time SOFA changes a community’s understanding of the rights of women and girls, we have made another small step of progress on the path toward justice. Signs of success in this work include:

- The percentage of women and girl survivors who receive timely and appropriate medical care, psychological care, social support, legal assistance and economic livelihood aid.
- Mobilization of youth in a community on the issues of women’s rights and SGBV.
- The extent of community acceptance of SOFA, the services SOFA provides and the rights framing around issues of SGBV and women’s rights.
- The extent of support from key decision makers (police, judges, medical staff, elected officials and more) for SOFA, its programs and the rights of women and girls.

The work of SOFA is only effective because of how it embeds within the local community and culture. SOFA is a democratic membership organization run by and for the women of Haiti. The ‘daybreak victim support centers’ that SOFA runs are staffed and supported by volunteers from the community. These local members and volunteers are trained and provide the accompaniment and support for women and girls suffering violence within their own community. SOFA’s approach builds upon local knowledge, mobilizes volunteerism and builds community solidarity. Local SOFA members know and are known and respected within their communities. Because they are rooted within their communities, they comprehend complex community dynamics and thus understand the impact and chances of success different initiatives will have. Too often, the SGBV response field has been dominated by well-meaning outsiders who misunderstand local contexts. SOFA demonstrates the effectiveness of an alternative model based on the solidarity of local women with one another, giving them the resources, training and connections to operate as agents of locally-led change.

The experience of MCC Haiti and SOFA suggests the following learnings for others considering similar SGBV response work in other contexts:

- The mental health needs of survivors of SGBV cannot be understated. These needs, however, are not merely individual psychological challenges, but must be addressed within a wholistic context of social support and accompaniment. SOFA has found great value in peer-led social support groups, in which women and girls who have had similar experiences can find solidarity and belonging, moving from a position of victim to one of empowered survivor.
- This work is challenging and requires a high level of organizational and technical competence. For example, one must be able to respond rapidly and effectively in cases of sexual violence to get medical care within 72 hours to protect the health of the survivor. It is easy to do harm in this field: all staff and volunteers must be well trained, supported and supervised.
- True recovery and prevention require the whole community. All sectors of society must be involved to end impunity for perpetrators, protect and empower vulnerable members of society and tear down the systems of oppression that perpetuate violence and injustice. This in turn requires advocacy and community mobilization to call for change.

Muriel Chaperon is program manager for MCC Haiti. Marie Eveline Larrieux is a founding member of SOFA and a current board member. Both live in Port-au-Prince.

Community healing: using the Healing and Rebuilding our Communities approach in DR Congo

Traumatic exposure is very common for people like me from DR Congo and other war-effected countries. I experienced armed violence as a child, lost loved ones to violence and was forced to flee my home as a refugee. I came to understand trauma as something we could and should respond to by studying at the Africa Peacebuilding Institute, and later learning trauma healing methodologies like Strategies for Trauma Awareness and Resilience (STAR), developed by Eastern Mennonite University, and Healing and Rebuilding our Communities (HROC), an approach pioneered by Rwandan and Burundian Friends. Trauma healing focuses on the wounds of the heart, the wounds inside us that not only hurt us but can damage our relationships with others. If we do not share healing with the wounded, the wounded will share their wounds with us. The need for this work is great: organizations like MCC need to support community-led strategies, rather than relying heavily on outside specialists who can never fully address the need.

HROC is a model of community trauma healing developed in Rwanda and adapted to our contexts here in DR Congo. HROC trainings help people understand the river of life, the journeys that people go through with many ups and downs to lead them to where they are today, supporting them in charting a more positive path forward after exposure to traumatic events. MCC and its partners use HROC in North and South Kivu in eastern DR Congo to help people name and understand how they have been impacted by different traumatizing events, how they can cope with trauma and pain and how as a community they can overcome difficult experiences and move forward in lifegiving ways. The HROC approach mobilizes the

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Learn more

Healing and Rebuilding Our Communities website. Available at: https://healingandrebuildingourcommunities.org/.

larger community to heal together, rather than only working with people as isolated individuals. The program is built on a series of intensive workshops tailored to the resources and needs of each community. The first workshop introduces trauma healing as a concept and connects it to their experiences and culture. The second begins to help them care for themselves. The third prepares them to help others go through a similar process of healing and transformation.

The HROC approach is valuable because it works at both the individual and community levels. HROC applies the *ubuntu* principle: I am because you are. One cannot be fully healed alone. Everyone has a unique story and learns to understand their own river of life and how to cope with the ups and downs they face. However, the community must be activated for deeper healing and resilience to support others who have been through similar situations. Resilience builds on the resources available in the community and local culture. In some cases, HROC workshops can contribute toward reconciliation by bringing together groups of people who have been in conflict to restore their relations.

Success from the HROC approach is seen most clearly through individual stories. In 2018, we introduced HROC workshops in Tshikapa alongside humanitarian aid distributions. I remember a female participant who was always visibly down when she came to distributions. One could read stress on her face, in her eyes and in her body language. After the first workshop, she began to markedly change. She began to smile again. She found a constructive way to tell her story. Before she would just break into tears, but now she could tell her story positively and help mobilize others. HROC's success in this woman's case was her transformation from someone who was down, angry and crying now to someone who now has hope, is smiling and can tell her story and help others.

"We must avoid saying that everyone from a war-torn country is traumatized. Such claims are not true and can in fact be damaging."

I also see success when reconciliation takes place. After workshops, I see people once again able to eat, interact and work together. Not every workshop is a success for every participant right away. Healing from exposure to traumatic events takes time. We do not want to rush to say that trauma response has failed because we do not see immediate transformation. It takes time for some people to deal with their past. The intensity and duration of the trauma people have undergone can impact how long healing takes: healing can also take longer when people are still living in a context of unending violence. Some argue that Post-Traumatic Stress Disorder is not an appropriate construct in contexts in which one can never truly be post exposure.

Adapting trauma healing models to the culture and context is essential. I have seen examples of outside experts who do not understand the culture and context and who in turn make things worse, leading to re-traumatization and conflict. The basic principles may be universal, but we cannot copy and paste strategies between countries or cultures, even within the same region. Every culture has existing ways of helping people heal and cope. These local resilience strategies are often not documented or known outside the community. For example, women in some rural areas spend time at the river sharing stories of what they go through in life and supporting each other as they share painful stories. If you bring a trauma healing model from outside without taking local cultural and other contextual factors into consideration you can override resources people already have and make things worse. For example, if a health project tells women to no

longer collect water at the river, this may unknowingly eliminate a source of community resilience. We must start by seeing what has been unique and helpful in each context for addressing trauma before we bring something from the outside. HROC was developed in neighboring Rwanda, but Rwanda is a different context from DR Congo, and DR Congo has a wide variety of diverse contexts: trauma healing approaches must be adapted and appropriately contextualized for each community.

My advice to people interested in trauma healing work is to be careful. Do not promise healing if all you are doing is raising awareness. Do not come into a new context you do not understand and start facilitating workshops based on some supposedly 'universal' model. You must spend significant time in a context and culture to learn before you can be helpful: trauma healing trainers coming from outside the context should co-facilitate with someone from the context who can help with adaptation and cultural translation. We must also avoid generalizing people's experiences. For example, we must avoid saying that everyone from a war-torn country is traumatized. Such claims are not true and can in fact be damaging. Everyone responds to trauma differently: we should respect this. We also need to take religion and religious values seriously in trauma healing work. In many communities we work in, Christianity can be a resource for hope and for coping with trauma. We must build on people's sources of strength and resilience: religious commitment, practice and community are often such essential sources. HROC has been useful in DR Congo because it can be adapted to each local context and helps both individuals and communities understand themselves and move forward positively together.

Mulanda Jimmy Juma is MCC representative for DR Congo and Angola, living in Goma.

Community building: finding a home in Nikopol, Ukraine

New Life Nikopol, an MCC partner organization in Ukraine, has developed a wholistic community-building approach to support the most vulnerable and traumatized people of Nikopol town, including prisoners, ex-prisoners, persons experiencing homelessness, people living with HIV/AIDS or tuberculosis, families with many children, single mothers and internally displaced persons. New Life provides food and clothing, medical care, psychological and spiritual support, legal accompaniment, temporary housing and sustainable livelihoods. Thanks to New Life's services, participants can eat, take a shower, get a haircut, receive a new set of clothes, obtain help with the restoration of legal documents, find a place to live and access medical care. They also receive psychological and spiritual support from caring people. Through its programs, New Life builds community one person at a time, as the most vulnerable receive dignity and begin to believe their lives can change.

"New Life staff receive people discarded by society, take time to listen to their stories and find ways to restore them to life and dignity."

In Ukraine, people who experience setbacks in their lives find it difficult to get back on track, especially if they have fallen more than once. In the Ukrainian context, problems tend to spiral out of control. If no one will help, it becomes increasingly hard for a struggling person to turn that story around. People referred to New Life come from different traumatic situations, such as addictions in the family, homelessness, HIV/AIDS

Lubov Yarchuk and Natalia Mezentseva at the women's rehabilitation centre run by New Life in Nikopol, Ukraine. (MCC photo/Matthew Sawatzky)

infections, poverty due to old age and small pensions, no access to social benefits or medical care due to stolen or lost documents, being released from prison and having no family or property to which to return and more. The situations are countless.

The government lacks resources to help all these vulnerable people who have experienced traumatizing events and some of their interventions are imperfect at best. Government social service agencies, for example, routinely separate struggling families so that children are physically safe in orphanages. However, the orphanage system is imperfect and then the story of traumatized parents is often repeated by their children. As in the story of the Good Samaritan, it takes at least one caring person who will take time to help her neighbor. New Life offers such care. New Life staff receive people discarded by society, take time to listen to their stories and find ways to restore them to life and dignity. Women and men assisted by New Life live in separate Mercy Houses (houses where a few people with similar life stories live together) where they can get back on track with the help of one another and New Life staff. This kind of intervention has proven to be effective to support traumatized people in the Ukrainian context recover their lives.

The success of New Life's efforts can be seen in testimonies about how New Life has changed lives. New Life is well-known in Nikopol: governmental

and non-governmental social service organizations routinely refer traumatized people to New Life for assistance. The transformational changes in individual lives are the ultimate measures of New Life's success in overcoming traumatizing circumstances. Success is visible in the lives of people who have their legal documents restored so they can access services, who have received medical care they needed for so long, who can now live independently and with dignity and who have found a job. Each life is precious to God, each story of a transformed life in and of itself represents success.

New Life focuses on addressing gaps in services not filled by government agencies or by other community-based actors. The Nikopol municipality knows it cannot fill these gaps alone, so they have built a trusting relationship with New Life. Local hospitals and social services refer people to New Life when they know they cannot assist. For example, when a person who is homeless arrives at the hospital without identification documents, regulations prevent them from receiving medical treatment: in these instances, New Life staff step in to accompany the person to obtain legal documents and then literally walk with the person to the doctor in the hospital to ensure they receive care.

New Life builds its wholistic approach on the positive elements of Ukrainian culture and character. Many Ukrainian people are compassionate, open and hospitable, but often feel like they cannot help. They know that at times the government does not have enough resources to help: as a result, compassionate Ukrainians banded together to build and support New Life to serve these needs. Some people donate clothes, others refer people experiencing homelessness to New Life and others volunteer their time and skills with New Life. People want to come together to do what they can. New Life staff draw their motivation for service from their faith in God and God's love. When New Life staff face hardships and its workers feel like giving up, New Life's director, Natalia Mezentseva, reports that she goes to church and asks her brothers and sisters to pray for her: God's Spirit, moving through the prayers of the church, gives Mezentseva and her colleagues the strength to continue on. God's love is what gives us our desire and motivation to persevere. Mezentseva observes that in working with traumatized people, if one is motivated by something other than love, one will soon burn out. If, in contrast, one is motivated by love of God and neighbor, God will give the strength to press on until one sees results.

Olga Litvinenko is MCC Ukraine project coordinator, living in Zaporizhzhia.

“Success is visible in the lives of people who have their legal documents restored so they can access services, who have received medical care they needed for so long, who can now live independently and with dignity and who have found a job.”

An integrative approach: peacebuilding and mental health in Afghanistan

The 2018 National Mental Health Survey of Afghanistan showed that over half of Afghans are experiencing mental health distress—for 24% of respondents, this distress affected daily functioning. The survey found that 85% of Afghans have experienced at least three traumatic events, with many reporting symptoms that meet the criteria for post-traumatic stress disorder (PTSD). These high levels of mental distress and trauma flow from prolonged decades of military, social and interpersonal violence, high rates of poverty, stark gender inequality and low rates of mental health recovery due to lack of access to mental health services and family and community support.

IAM's programming builds on the strengths of Afghan culture, such as very strong family structures, respect for elders and reliance on God for strength in times of suffering."

After decades of violence, working to reduce trauma and increase peace in Afghanistan is a difficult task. International Assistance Mission (IAM) has been working since 1966 in Afghanistan to build capacity in the health and community development sectors. IAM's mental health work started over 25 years ago in response to women attempting suicide by immolation. IAM's programming has always integrated a clinical component (training health providers to provide high quality mental health and psychosocial services) with a community component (working to reduce the stigma faced by people with a psychosocial disability and improving the capacity of families and communities to support them).

IAM's mental health program, supported by MCC, focuses on developing integrated community-based mental health services and reducing social determinants of mental health and trauma in the Afghan context. After analyzing needs and mapping the efforts of other actors, IAM decided to address two social determinants through its programming: positive parenting methods and the emotional resilience of young people. Through interventions in schools and universities, IAM works with groups of young Afghans to overcome trauma and increase their emotional resilience. Through a multi-sectoral advocacy that aims to integrate the efforts of civil society and government agencies, IAM strives for the inclusion of peacebuilding and life skills in the national education curriculum, skills that help young Afghans heal from traumatizing events they have endured.

IAM recognizes that clinical and public health interventions cannot simply replicate so-called "best practices" from wealthy, urban and culturally distinct countries of the North and West. Instead, IAM adapts trauma response models to Afghan culture, regularly adjusting course as we learn more about what methods prove most effective in local contexts. Ways that IAM adapts its trauma response to Afghan realities include:

- *Getting to know and understand each community in which IAM operates, as local cultures vary widely even within the same region of the country.* This approach requires getting wide local involvement in developing trauma response resources and trainings to ensure cultural appropriateness and accessibility. Volunteers and staff should be carefully selected based on their abilities to understand local dynamics and generate trust.
- *Working with (not against) local culture whenever possible.* We want to be sure that our programming builds on the strengths of Afghan culture, such as very strong family structures, respect for elders and reliance on God for strength in times of suffering. These strengths encouraged us to focus on leveraging family support for traumatized people, integrating community and religious leaders into community-based trauma response and encouraging people to engage with faith in God as part of recovery. IAM works to involve local religious leaders, given the respect and attention they receive from the wider community. We have also found it essential to offer program options for male and female participants separately to increase women's comfort with and participation in IAM's programs. At the same time, IAM discerns when to push back against some cultural norms, such as norms that disempower women and young people: effective trauma response work that reaches Afghan women requires empowered leadership by women, so IAM thus aims to have 50% of its trauma response work led by women.

In developing and adapting its trauma programming, IAM gather input directly from people with psychosocial disabilities who say that "success" means being fully included in family and community life and the ability to access high quality local mental health services. IAM also sees success when the mental health, peacebuilding and trauma-sensitive approaches IAM promotes are adopted by other organizations and integrated into their work. We have seen indications that we are moving in the right direction. So, for example, in 2018 IAM successfully handed over the Mental Health Training Center it founded in Herat to the Government of Afghanistan. In 2019, 194 people with psychosocial disabilities supported by IAM were included for the first time into local livelihood projects run by other organizations after IAM's successful advocacy and peacebuilding activities that underscored the importance of including people with psychosocial disabilities within normal societal activities.

Over the course of implementing our wholistic trauma response program, IAM has identified multiple learnings.

- Initiatives that seek to shift attitudes and behaviors related to mental health and peace are complex and difficult to measure, especially within a short time horizon. While carrying out easily measured short-term trauma response activities, one must not lose sight of longer-term visionary goals, such as changing government policies related to mental health care.
- The impact of an organization's trauma interventions will be greater if other stakeholders can be encouraged to integrate mental health, psychosocial, peacebuilding and trauma response into their work. Influencing governmental actors and other non-governmental organizations requires investing in long-term relationships at all levels of government, earning technical credibility in mental health by hiring trained psychiatrists and clinical psychologists and building connections to global and local mental health networks, aligning when possible with government health plans, inviting stakeholders to see one's work firsthand and collecting good data and publicizing the results of one's work.
- Flexibility and adaptability are assets that organizations responding to trauma must cultivate. Being able to respond quickly to surprising challenges, such as new mental health needs associated with COVID-19 or a community group requesting parenting resources, can push forward an organization's long-term goals in unexpected ways. Having a monitoring and evaluation plan with both qualitative and quantitative indicators has helped IAM understand our impact better and make these adaptations swiftly and strategically.
- Trauma response work is only possible with passionate and capable staff, some of whom have personal experience of mental health problems or who strive to build peace in their communities outside of their IAM work. Investing in staff capacity is critical.

Other organizations seeking to develop wholistic, contextually adapted responses to large-scale societal trauma may find such lessons helpful.

Mohammad Tamim Ebrahimi, Abdul Fattah Najm and Sayed Javid Sadat are staff with IAM in Afghanistan. Emily Allan is a former IAM staff member.

Learn more

International Assistance Mission website. Available at: https://iam-afghanistan.org/.

A woman with psychosocial disability (PSD) meets in her house with an IAM mental health project community mobilizer. Names of the people pictured are withheld for security reasons. (IAM photo)

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