

## HUMANITARIAN INNOVATION FUND

### Large Grant Final Report

<b>Organisation Name</b>	INTERNATION RESCUE COMMITTEE, Democratic Republic of the Congo (DRC)
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<b>Project Title</b>	Embedding Cognitive Processing Therapy (CPT) in the DRC Health System- Pilot Project
<b>Partner(s)</b>	IRC Health Program/ DRC Ministry of Health/ Provincial Direction of Health (Kabare Health Zone and the South Kivu Coordination of Mental Health)
<b>Problem Addressed / Thematic Focus</b>	Post-traumatic stress symptoms resistant to usual psychosocial care, most notably individual counselling and case management.
<b>Location</b>	Kabare Health Zone, South Kivu, DRC
<b>Start Date</b>	January 1st 2014
<b>End Date</b>	January 31st 2015
<b>Reporting Period</b>	Entire Project Period

<b>Total Funding</b>	150,000 GBP
<b>Total Spent</b>	150,000 GBP

<b>Innovation Stage</b>	Identification and capacity building of individuals implementing the project, monitoring and supervision of activities, and evaluation meetings
<b>Type of Innovation</b>	Research has shown CPT to be effective in the DRC for survivors of sexual violence (SV) and this project tested a model that has the potential to make CPT widely available to women at low cost through a health needs system that has been unable to meet the mental health care needs of survivors.
<b>Project Impact Summary</b>	<ul style="list-style-type: none"> <li>117/120 or 98% beneficiaries with high and persistent trauma symptoms who were referred to</li> </ul>

	<p>CPT groups by local CBOs completed 12 sessions of CPT within 13 groups.</p> <ul style="list-style-type: none"> <li>• 100% of beneficiaries (117/117) who completed CPT reported significant improvement in their psychological well-being, as measured by a 20% or more decrease in trauma symptoms</li> <li>• 100% of 14 therapists and 6 supervisors received 70% or more on the post-training test.</li> <li>• 93% (13/14) of therapists achieved at least 80% in the quality criteria evaluation check lists at the end of the project.</li> <li>• 93 supervisory visits were completed by the Ministry of Health, the Coordination of Mental Health and the Central Office of the Kabare Health Zone (HZ) during CPT sessions for the two pilot series.</li> </ul>
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## PROJECT ACTIVITIES AND OUTPUTS

Please go to **Appendix 1** and attach the final workplan, showing all work that was actually completed.

### 1. With reference to the final workplan, what have been the key achievements of the project?

CPT was put into place from April 2014 to January 2015, with the following key achievements:

- With its clinical partners, including the Mental Health Coordination, the Kabare Health zone and the IRC health program, the IRC Women’s Empowerment and Protection (WPE) team adapted the CPT management tools (symptom checklists, individual and group monitoring tools and the supervisor form);
- Identification of CPT providers from existing health professionals;
- Capacity building and training of 21 service providers: seven APS<sup>1</sup>/Nurses ; six Head Nurses; one Director of Nursing in HGR MUKONGOLA ; two supervisors of the central office of the health zone ; two Mental Health Coordination supervisors; one supervisor from the IRC Health Program and two staff of the Provincial Health Direction;
- Identification of 120 sexual violence survivors with high and persistent trauma symptoms by case managers within community based organizations (CBOs) from their current and previous caseloads;
- Therapy sessions conducted for 13 groups of six to eight women (117 in total) in collaboration with the health structures;
- Organizing and carrying out the supervision of the care provided by the therapists;
- Post-action reviews held by all the CPT providers, the supervisors, and representatives of the collaborating partners;

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<sup>1</sup> APS- acronym in French meaning Psychosocial Assistant

- Production of a report on lessons learnt and recommendations for future implementation<sup>2</sup>.

## INNOVATION OUTCOMES

Whether this innovative project was successful, not successful, or a mix of both, the HIF would like you to report as much detail as possible, so that success can be built on and failures can be learned from. By 'success' we mean that the innovation has achieved the planned positive impact/outcome, or that it has performed better than the current process, product or system.

### 2. Has the project demonstrated the success of the innovation? (Please choose only one answer.)

- Completely successful  
 Significantly successful  
 Partially successful  
 Completely unsuccessful

#### 2b. Please select the successes that your project have achieved:

(You may choose more than one)

- There is real evidence that the project achieved the planned outcome(s)  
 There were perceived contributions or improvements to the planned outcome(s)  
 Learning was achieved within the project cycle  
 'Lessons learned' were gathered and circulated to humanitarian stakeholders and actors  
 The completion of this project has led to another innovation  
 Other (please comment) \_\_\_\_\_
- 

#### 2c. Please select the challenges your project has encountered:

(You may choose more than one)

- The project did not complete its planned activities  
 There is no real evidence that the project achieved the planned outcome(s)  
 There were few perceived contributions or improvements to the planned outcome(s)  
 Learning was not achieved within the project cycle  
 'Lessons learned' were not circulated to humanitarian stakeholders and actors  
 Other (please comment)

Ownership of the activity by the health authorities remains a major challenge, the project has proven it is possible for health authorities to use CPT but a successful scale up requires not only a huge financial and human resource investment to ensure the quality of CPT in DRC but also a lead from the Ministry of Health which at this stage is not guaranteed.

#### 2d. If there is any evidence for the successful performance of the innovation, please describe it further:

- The presence of trained therapists in seven CPT development sites;
- 117 CPT beneficiaries were able to heal and begin to function and participate again within their communities;

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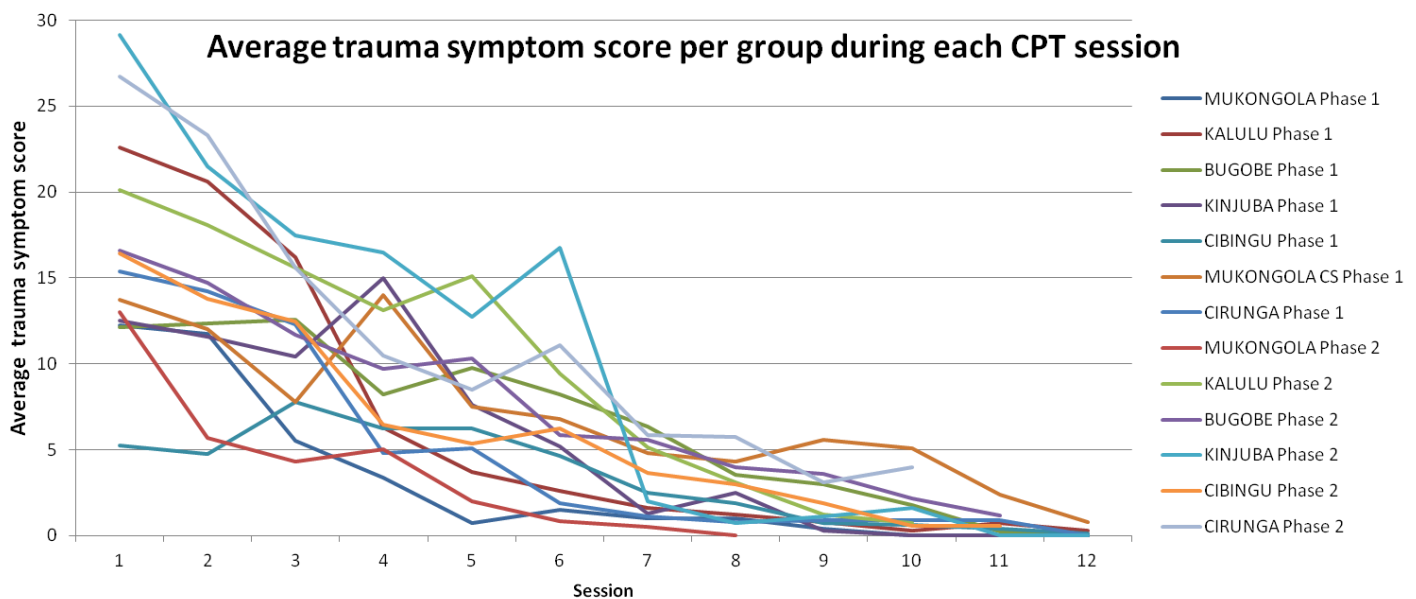
<sup>2</sup> Draft version of the report in French can be shared with HIF. The report needs to be finalized with the head of Mental Health Department within the Ministry of Health in South Kivu who has not been available to meet in February and March. The meeting has been programmed for second week of April 2015. The current draft version is available in French.

- The different community actions that the beneficiaries have taken following the therapy including social funds, savings, etc.;
- The regular harmonization meetings between all stakeholders (IRC WPE and Health program, health authorities of Kabare, provincial representatives of National Program of Mental Health) with documentation and recommendations ;
- The participation of key health services, from the Mental Health Coordination up to the National Director, in the closing meeting and drawing up of recommendations.

CPT was overall very beneficial for SV survivors and served as a valuable tool to help survivors where standard case management was not successful. Following the intervention, survivors showed significant improvements in mental health, with substantial decreases in trauma symptoms.

At the start of each session, therapists assessed trauma symptoms of each participant using a simple, standardized symptom checklist that had been adapted to the local context. The checklist contains 11 questions, each with a possible score of 0 to 3, with 3 indicating major difficulty with that symptom. Therapists recorded the sum of the scores of all 11 questions for each client, with 33 being the maximum score (indicating major difficulty with all 11 symptoms).

The graph below shows that the average total score for most groups was between five and nearly 30 at the beginning of CPT (that is, ranging from ‘a small problem’ to ‘a major problem’ for the 11 symptoms), and that the average for most groups dropped to nearly zero by the end of CPT, showing significant improvement in mental health and healing from lasting trauma.



Many CPT participants experienced a small increase in symptoms between sessions four and six, after an initial decline during sessions one to three. At this stage of CPT, the sessions focus on learning how to identify rather than repress harmful thoughts and feelings related to the trauma experienced, with the remaining sessions focusing on working through these thoughts and feelings. As a result, some may experience an increase in trauma symptoms during this phase of CPT. This trend is consistent with previous CPT groups in DRC in 2012-2013.

Feedback from CPT participants and therapists indicated that CPT helped survivors identify deeply hidden feelings related to trauma, improve decision-making and problem-solving power for survivors, and facilitate social reintegration.

**3. Please show the components of the project which contributed the most to any successes:**  
(where 1 = most influence 3 = least influence)

<b>Component</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>N/A</b>
Design and placement of the innovation	X	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The methodology or approach to collecting evidence	X	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Context	<input type="checkbox"/>	X	<input type="checkbox"/>	<input type="checkbox"/>
The availability of resources and capacities (financial, human, technical etc.)	<input type="checkbox"/>	X	<input type="checkbox"/>	<input type="checkbox"/>
Success in identifying and responding to different project and innovation risks	<input type="checkbox"/>	X	<input type="checkbox"/>	<input type="checkbox"/>
Strength of relationships and collaborations within the team and with other stakeholders	X	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The process was flexible and responsive to emerging results	X	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ability to draw on experience and expertise of existing practice, codes and standards	X	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**4. Please show the components of the project which contributed the most to any unsuccessful elements of the project**

<b>Component</b>	<b>Yes-contributed to failures</b>
Weaknesses in the design and placement of the innovation	<input type="checkbox"/>
The methodology or approach to collecting evidence	<input type="checkbox"/>
Context	X
The problem here was that the beneficiaries had been provided case management services by community based organization (CBO) psychosocial assistants and the CPT continued the care through health providers who were not familiar with the case management. IRC staff were involved in identifying clients with high trauma symptoms which in other circumstances would be a responsibility of the CBO offering psychosocial support. This weakness is linked to the potential of scaling up and sustainability of this intervention, which would be very challenging without IRC involvement.	
A lack of access to resources and capacities (financial, human, technical etc.)	<input type="checkbox"/>
Difficulty in identifying and responding to different risks	X
In the implementation of CPT, the program faced an unexpected risk where one of two therapists was accused of raping a community member in the health structure in late 2014. The resolution of the problem created controversy between implementing partners and the WPE program (some people did not believe the accusations were true while the WPE program supported the survivor and asked for prosecution of the therapist, who was later removed from the health structure).The remaining activities at that site were carried out	

by the second therapist and IRC staff. IRC staff continues to follow up on this accusation to ensure that the legal process is followed and the perpetrator is punished. Questions related to code of conduct have always been part of the training but will be further strengthened in all our interventions in the future.	
Lack of good relationships and collaboration within the team and with other stakeholders	<input type="checkbox"/>
Having a process that was not flexible or responsive to emerging results	<input type="checkbox"/>
No ability to draw on experience and expertise of existing practice, codes and standards	<input type="checkbox"/>
Other:	<b>X</b>
Working with multiple stakeholders without clearly defined roles for each of the different partners was very challenging at various stages of the project.	
An additional challenge was linked to the nature of this innovation and the full ownership of this project by some stakeholders. This is a new approach that was introduced by a NGO partner to the governmental health structures who are currently providing very few mental health interventions in DRC, for lack of resources and capacity. The intervention relies on local CBOs providing case management and screening for clients with high symptoms, an approach that is functioning only with NGO partner support. Scaling up and sustainability of this intervention would require a change of perception of how mental health services are provided and who is the leading party (a change from NGO to government) which will be costly and time consuming.	
Other:	<input type="checkbox"/>

**5. What are the top three, key lessons learnt relating to the innovation? This should relate to the innovation or the sector in which it operates, rather than project implementation.**

1. CPT is an effective tool for improving mental health in insecure settings, which can be carried out successfully by therapists without an extensive background in mental health and psychotherapy. CPT helps to heal persistent trauma, uncover hidden thoughts, but also creates a decision making power and facilitates social reinsertion of beneficiaries into their communities.

2. CPT requires that therapists have prior knowledge of case management so they understand what care has been provided to the beneficiaries by members of community based organizations (CBOs) before referral for CPT services. Furthermore if this approach was to be scaled up to sites where CBOs do not offer case management the therapists from the health structures would require training in case management to be able to apply CPT as case management is a way to identify beneficiaries with high symptoms of trauma that did not heal during case management treatment.

3. Joint supervisions between IRC and the representatives of the Ministry of Health were beneficial for the rich exchange of experiences and continued capacity strengthening of care providers as well as to reinforce the application of CPT in basic health care provision.

## 6. Do the final outcomes support the initial rationale for the innovation?

- Yes, completely
- Yes, significantly
- Partially
- No, not at all

*Please describe further:*

CPT has proven to be a successful therapy which can be used by paraprofessional therapists within the governmental health structure. Questions related to the scalability of this intervention remain but the results of the project created helpful recommendations for scale up in the future.

## 7. How has your understanding of the innovation changed through the project period?

The IRC's understanding of CPT changed in several ways over the course of the project period. The first change was the understanding that the implementation of innovation in health facilities requires staff that are able to provide psychosocial support including individual counseling and case management before CPT.

A second change in understanding is that in order to implement CPT in other sites it is crucial to increase the number of trained supervisors, which will require the training of trainers and structured supervision by a master trainer, a costly and time consuming process.

The IRC also learned that while CPT was welcomed by managers at all levels (operational/local, intermediate/provincial and structural/national), progress can be slow or difficult because of the lack of motivation and feeling of ownership experienced by state health workers. During the implementation of the project, the IRC also came to understand that although mental health is an integral part of primary health care, it is not sufficiently developed nor financially supported at the national level and needs substantial technical and financial support in order to expand and be implemented across DRC.

## 8. Did the innovation lead to any unexpected outcomes or results? How were these identified and managed?

As a result of CPT within several health structures, the IRC witnessed the self-identification of individuals for CPT. The psychosocial assistants encouraged them for the second series in certain sites while others had to wait for the second phase that we hope to run in the near future<sup>3</sup>.

Four CPT groups created solidarity groups, continuing weekly meetings and creating rotating credit to help one another with small enterprises that supported their families. The IRC also saw other beneficiaries creating a group to combat malnutrition of their children through the collection of funds and purchase of small animals in order to use their manure to fertilize the vegetables grown in their fields and increase food for their families. Groups also created solidarity funds in case individuals in a member's family experienced sickness, marriage or death.

In addition feedback from therapists and others within the health structures pointed to the potential effectiveness of CPT for other people suffering trauma besides SV survivors which were the main target for this project. This is very much in line with the use of CPT in other contexts to treat a variety of traumas.

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<sup>3</sup> IRC plans to continue supporting CPT implementation in the 7 sites with other funding.

## METHODOLOGY

### 9. Was the methodology successful in producing credible evidence on the performance of the innovation?

- Yes, completely
- Yes, significantly
- Partially
- No, not at all

*Please describe further:*

The results from this project in terms of improvement of the psychological well-being of survivors of sexual violence (see graph on page 4), as well as stakeholder feedback on the implementation process, were dramatic in terms of improving trauma symptoms, and were consistent with studies among survivors of sexual violence in high-income countries of cognitive behavioural interventions generally (Olatunji, 2010) and of CPT specifically (Resick, 2002;Chard, 2005, Resick et al, 2012).

Such positive results show that CPT is an effective tool for improving mental health in insecure settings, which can be carried out successfully by therapists without an extensive background in mental health and psychotherapy. This pilot also shows that, with effective support and supervision, CPT could be successfully integrated into existing structures in DRC, which has great implications for making this therapy widely available in DRC.

## PARTNERSHIPS AND COLLABORATION

### 10. How and why did the partnership change during the course of the project?

Though there were sometimes absences in monitoring or coordination meetings, the partnership did not change during the course of the project. Project partners included the Mental Health Coordination, the Provincial Health Direction, the Kabare Health Zone, the IRC Health Program and the CBOs that referred survivors for CPT.

### 11. Are there plans to continue your partnership, either while scaling up this innovation or on other projects?

- Yes, with this innovation
- Yes, with another project
- Maybe
- No

*Please describe further:*

In the immediate future IRC plans to continue supporting the seven health structures targeted through this project to offer CPT to survivors identified by the CBOs. In the longer term and providing that the Ministry of Health expresses interest and there is sufficient funding to support it, IRC would like to participate in the scale up of this innovation to other geographical areas and the extension of the use of CPT to other types of trauma.



## DISSEMINATION

### 12. Please describe any steps taken to disseminate the outcomes of the project.

*Please include all completed and forthcoming, as well as all planned and unplanned products (for example, research and policy reports, journal articles, video blogs, evaluations)*

- In order to disseminate the outcome of the project, the IRC produced monthly blogs during the thirteen months of the project. The IRC also involved other health system professionals in the project evaluation including the South Kivu Mental Health Coordination and the Director National of the Health Coordination. The IRC also advocated at the Ministry of Health and at the National Direction of Mental Health for the integration of CPT into basic primary health care.
- In coordination with the Ministry of Health and at the National Direction of Mental Health, the IRC organized two separate after-action review meetings after each CPT cycle, where results of the activities were shared with therapists, supervisors and other stakeholders, and participants discussed the learning from these results, the successes and challenges of the project overall, and its potential future in the DRC based on the experiences of those involved.
- The results of the report will be used to create a policy paper in the form of fact sheets to share with donors and other stakeholders so they are aware of the success of this approach and that their support for the scaling up can be discussed. This activity will be supported by other funding and is now planned for mid 2015.
- The IRC has discussed the results of the project with Debra Kaysen from the University of Washington who supported the implementation of this project and has agreed to support Debra to write an academic paper and/or present the results at academic events - the details of such dissemination are being discussed at the time of writing this report.

### 13. Has the project received any third party coverage during the project (from news media, third party blogs, researchers or academics etc.)?

The IRC has discussed the possibility of collaborating with the CPT trainer at the University of Washington on a paper to be submitted for publication to an academic journal (see last point on dissemination).

## SCALE UP AND DIFFUSION – WHAT NEXT?

### 14. Is the project or innovation to be replicated or scaled up?

- Yes, we will scale up in the same or similar context
- Yes, we will scale up within our organisation (including running more pilots or trials)
- Yes, we will replicate the innovation/project in another context or country
- Yes, the innovation/project will be replicated or scaled up by another organisation or stakeholder
- Yes, other
- No

If you answered *yes* to question 14, please answer 14b:

**14b. What model are you pursuing to scale up or sustain your innovation?**

- Applying for more donor funding
- Selling the innovation or patent
- Cost recovery (for example, selling your service or being paid as a consultant to implement the innovation)
- Innovation to be taken up by organisation or government as standard and included in standard planning and core funding by them
- Other \_\_\_\_\_

*Please describe further:*

In the immediate future IRC plans to continue supporting the seven health structures targeted through this project to offer CPT to survivors identified by the CBOs. In the longer term and providing that the Ministry of Health expresses interest and there is sufficient funding to support it, IRC would like to participate in the scale up of this innovation to other geographical areas and extending the use of CPT to other types of trauma.

**15. If the project or innovation could be replicated or scaled up, please list the three most important issues or actions that will need to be considered:**

*(where 1 = most important and 3 = least important)*

Suggestion/issue	<b>1</b>	<b>2</b>	<b>3</b>
1. Therapists need to be trained on other GBV strategies including individual counseling and case management.	<b>X</b>	<input type="checkbox"/>	<input type="checkbox"/>
2 The Ministry of Health (in general and in particular the National Program for Mental Health) need to take ownership and lead on the development of the scale up plans and their implementation, with IRC playing only a supporting role.	<b>X</b>	<input type="checkbox"/>	<input type="checkbox"/>
3 A pool of national DRC based master trainers should be established from among the best therapists trained so far with a very detailed plan of supervision from the CPT specialists at the University of Washington, so in the longer term the master trainers can scale up this project to all health zones in DRC.	<b>X</b>	<input type="checkbox"/>	<input type="checkbox"/>

## Appendix 1. Final Workplan

Below is a table that is the same as the workplan that you submitted with your original application. There are **three ways** to respond to this section.

1. If there have been no changes at all through the project you may cut and paste your original workplan here.
2. If there have been changes to the project but these changes **were previously reported to the HIF** in an *Agreement Amendment* form, please adjust your original workplan so that these changes are recorded in it here.
3. If there have been changes which were **not previously reported to the HIF**, please **also** fill in Table 2 (which is on the next page). In particular, please make sure to explain any budget various greater than 15% in Table 2.

Expected Results	Main Planned activities	Implementation period													Responsible party / person	Budget		
		Months														2014	2015	
		1	2	3	4	5	6	7	8	9	10	11	12	13				
Conditions for implementation of CPT respecting minimum standards and best practice are in place	Ensure confidential spaces and data security															IRC/MoPH	60,000 GBP	0
	Adaptation of tools															IRC/University Partner		
	Identification of CPT providers															IRC/MoPH		
	Training of CPT providers															IRC/University Partner		
Survivors of sexual violence meeting the criteria receive CPT safely and seamlessly	Referral of survivors from CBOs to health centres															CBOs/IRC	18,000GBP	2,000GBP
	Case management and psychosocial support															IRC		
	Cognitive Processing Therapy Implementation															MoPH		
CPT is implemented correctly following project objectives and clinical standards	Joint DPS/IRC Monitoring															IRC/MoPH	40,000GBP	20,000GBP
	Clinical monitoring															University Partner/IRC		
	Project monitoring															IRC		
	Peer review & supervision															MoPH		
Learning from the	Regular IRC-MoPH																3,000GBP	7,000GBP

pilot is collected, collated and analysed to inform viability of scale-up within health structures for the future	review meetings																	IRC/MoPH/University Partner		
	After-action review																			
	Lessons learned & recommendations documentation																			

**Table 2: Changes to Workplan**

For every change in the final workplan that is different to your original worktable AND that has not already been reported to the HIF, please add a record in this table. Changes can include alterations to the methodology, project process or innovation design, for example.

Change (as referenced in workplan above)	Reason for change	Overall impact of change
1.		
2.		
3.		
4.		

No change to the work plan took place besides the no cost extension already reported to the HIF and approved.