USAID'S HEALTH EVALUATION AND APPLIED RESEARCH DEVELOPMENT (HEARD) PROJECT

RESEARCH BRIEF:

A Mixed-Method Study of a Community-Based Psychosocial Support Intervention for survivors of the armed conflict in the Colombian Pacific

KEY FINDINGS

- In a pilot study, participants community support groups (CSGs) conducted in remote, in-person, and hybrid modalities showed significant improvement in wellbeing and reduction in distress from pre to post intervention, although coping results varied by modality.
- In an RCT, CSGs were effective in reducing symptoms of anxiety and depression among participants who attended 4+ sessions (trend level effects on PTSD, functional impairment, and community resilience). By modality analyses revealed significant reduction in anxiety, depression, and PTSD for in-person participants, but not for remote participants.
- Qualitative data across both studies highlights unique challenges and opportunities in each modality, including potential explanations contributing to lack of effectiveness for remote groups:
  - In-person:
    - Key opportunities: Inclusion of traditional practices and cultural codes; assurance of confidentiality and safety; strong social cohesion and exchange of peer support
    - Key challenge: Attendance issues due to conflicting activities.
  - Remote
    - Key opportunity: Flexible scheduling
    - Key challenges: Privacy, internet connectivity, social cohesion, and managing distractions.

BACKGROUND

Since 2010, Heartland Alliance International (HAI) has provided mental health and psychosocial support (MHPSS) services to marginalized populations affected by violence by armed actors in Colombia. HAI employs a community-based task-shifting approach, in which community members are trained to provide a group psychosocial support intervention which integrates collaborative problem-solving and culturally based expressive activities to improve participant wellbeing.

HAI partnered with Universidad de los Andes to test HAI's Community Support Group (CSG) intervention with support from the United States Agency for International Development (USAID), through the University Research Co. (URC) Health Evaluation and Applied Research Development (HEARD) project. The team conducted a pilot study and a randomized controlled trial (RCT) with survivors of the armed conflict in the municipality of Quibdó on Colombia's Pacific Coast.

INTERVENTION DESIGN

CSGs consist of eight weekly two-hour sessions, including one introductory session, four sessions of bodily and artistic expression, and three sessions of collaborative problem-solving, drawing from the World Health Organization Problem Management Plus methodology. Each group consists of 7-10 participants, and is facilitated by two Community Psychosocial Agents (CPAs) with supervision by mental health professionals. The CPAs are community members who have experienced violence associated with the armed conflict. They enrich the intervention with their knowledge of the context, culture, language, customs, beliefs, and understanding of community needs. In response to the Covid-19 pandemic, CSGs were conducted in remote, hybrid, and in-person modalities.

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STUDY DESIGN

Pilot Phase Methods

The pilot study was conducted with remote, hybrid, and in-person modalities. Participants were recruited by CPAs using a non-probabilistic snowball sampling approach, targeting adults from Quibdó affected by violence (N = 39) who were randomly assigned to modalities. Participants completed pre- and post-intervention quantitative interviews and a subset of 17 participants also completed qualitative interviews exploring implementation science themes. A focus group discussion (FGD) was conducted with staff.

RCT Phase Methods

In the RCT phase, 268 participants from Quibdó municipality were asked to choose if they preferred to participate in-person or remotely, then were randomized to experimental and waitlist control groups (accounting for modality). Participants completed quantitative interviews before and after the experimental group intervention. Treatment effects were estimated using an intent-to-treat (ITT) approach (in which all participants were included) and a per-protocol (PP) approach (including only participants who attended at least 4 sessions. A subset of 25 participants also completed qualitative interviews and a focus group discussion (FGD) was conducted with staff.

FINDINGS

Pilot Phase Results

The pilot's quantitative results showed significant reduction of distress and improved wellbeing on pre-post measures for the combined sample **(Table 1)**. Results did not differ by modality; There were no significant main effects of modality or modality by time interactions for any outcome variables (all $p > .05$).

In regards to coping, participants in in-person and hybrid modalities had higher scores in social support and religion subscales of the Brief COPE in comparison with remote modality. Participants in the remote modality showed decreased emotional support, social support, positive reappraisal and venting from pre- to post-intervention.

Qualitative data

revealed that remote sessions allowed for flexible scheduling, less exposure to community violence, and more feasible participation when transport was interrupted by strikes or street violence. Remote sessions were generally preferred by tech-saavy younger participants. However, participants shared that the remote

Qualitative results

highlighted general barriers and opportunities as well as those specific to each modality. Participant attendance was compromised by a range of factors, including the Covid-19 pandemic and country-wide protests and police violence, as well as competing work and family priorities. Remote groups faced challenges in reducing distractions and ensuring participant confidentiality due to potential to be overheard when participating from home or workplaces, and also struggled with poor connectivity. However, data revealed significant opportunities stemming from CPAs roles as community members. Incorporating of traditional practices such as the comadreo (informal community talks) proved critical in understanding and capitalizing on ways that communities naturally comprehend and face their problems, especially in in-person groups.

Table 1 outlines recommendations for policy makers and practitioners based on these results.

Key recommendations and implications for policymakers and practitioners

- Consider integration of task-shifting approaches to expand service provision where the health system does not have adequate coverage. Integrate community-based PSS group interventions into Colombia's National Health Service to complement the traditional mental health services.
- Cultural practices and traditions such as "comadreo" can be effectively integrated into evidence-based modalities, especially with facilitation by non-professional community members.
- Ensure equitable access to internet and mobile data services to increase the viability of remote MHPSS interventions for all communities, including in rural and low-income areas. Remote modalities represent a promising option for increasing access to MHPSS services during a pandemic, in contexts of community violence, and when there is need for flexible scheduling.
- Establish funding opportunities and dissemination spaces to encourage and share research on strategies and programs for MHPSS group interventions for those affected by violence and displacement.
- A participatory approach in which community agents advise on methodological and intervention adaptations is key to ensuring feasibility and uptake