How qualitative information helped to shape quantitative research instruments in Rwanda

Femke Verduin, Willem F. Scholte, Theoneste Rutayisire & Annemiek Richters

Rwanda experienced extreme violence and genocide during a three month period starting in April 1994. In the northern regions, there had been ongoing violence since 1990. Many inhabitants still suffer emotionally from the consequences of this era. We performed a quantitative study to measure the effectiveness of sociotherapy; a community based psychosocial intervention carried out in northern Rwanda. This article describes qualitative research methods used to enable and improve this quantitative study, and more specifically how the authors adapted and validated three main outcome measures for use within the local context. Psychological wellbeing was measured by use of the Self Reporting Questionnaire (SRQ-20), social functioning by use of a locally designed questionnaire, and social capital by use of a short, adapted version of the Social Capital Assessment Tool (Short A-SCAT).

The collection of context related, qualitative information was essential to create applicable and context appropriate instruments. The authors' experiences underline that for any mental health or psychosocial study, a substantial contribution from qualitative research is essential. In spite of the authors' efforts, it still proved to be very difficult to quantitatively assess issues related to social relations.

Keywords: instruments, qualitative research, quantitative research, Rwanda, validity

Introduction

The study described here was carried out in northern Rwanda, in and around the city of Byumba. A war had been raging there since 1990, when militias of the Front Patriotique Rwandais (FPR), mostly composed of Rwandan Tutsi refugees living in Uganda, began a series of repeated attacks upon the population in northern Rwanda. In the south, periodic violent eruptions against Tutsis took place at the same time. The assassination of the Rwandan president, Habyarimana, in April 1994 sparked the mass killings of Tutsis and moderate Hutus. During a three month period of genocide approximately 800.000 people were killed. Roughly two million refugees left the country, and around one million people were internally displaced.

Many inhabitants of the region still suffer emotionally from the consequences of this era, especially as, for centuries, the Hutus and Tutsis had lived together peacefully. Since the genocide, people are hesitant to speak openly about whether they are Hutu or Tutsi. To outsiders, it may seem that such ethnic differentiation is no longer made. The reality, however, is that people are still very much aware of the issue of ethnicity, and its role during the war and the genocide. Some informants told us they feel like they live in a country where the fighting could begin again tomorrow (Richters et al., 2005). Since September 2005, a psychosocial intervention programme has been implemented in and around the city of Byumba in Rwanda

by the Byumba Diocese of the Episcopal Church of Rwanda (now called the Anglican Church of Rwanda). Over the first three years it was technically supported by Equator Foundation, and was funded by the Dutch development organisation Cordaid. Sociotherapy is a group approach that aims at the restoration of mutual respect, safety, trust, and care, and sets democratic rule at the community level. From this base, individual recovery from the mental health consequences of past traumatic experiences is expected (Richters, Dekker & Scholte, 2008).

During 2007 and 2008 the authors carried out a quantitative study of the impact of the sociotherapy programme. Its design was based on the experiences and lessons learned during a pilot study the authors conducted over 2006 and 2007. A quasi-experimental design (Scholte et al., 2010a) was used. Data taken from respondents who had participated in sociotherapy groups (the experimental group) was compared to data which, over the same period of time, were taken from comparable others living in the same region who had not participated in sociotherapy groups (the control group). Trained Rwandan staff carried out interviews with the same respondents at three different points in time: at the start of the intervention, immediately following the intervention, and eight months after completion. It was assumed that the intervention would impact on people's mental state, their daily functioning, the way they interact, undertake common actions and the way they feel connected to each other. Therefore, the areas of interest for this study were defined as mental health, social functioning and social capital.

In general, as for any scientific study, qualitative methods can help to generate hypotheses and research questions, construct an adequate design and feasible working methods, choose and validate measures, and interpret findings. In this article, some general explanation and theoretical background for using qualitative methods within a quantitative study design are provided, and the practical elaborations are described. Several qualitative research methods, such as in depth individual and focus group interviews, free listing and ranking of items were used.[1] A structured multi step method for translating instruments was also used.

Exploration and overall orientation

The quantitative study started after a phase of qualitative exploration. A scientific study addressing psychosocial issues among human subjects can only be conducted successfully if those who design the study familiarise themselves with the subjects' living context beforehand. First of all, local inhabitants of the area may be involved in, or their lives impacted by, the research activities. Therefore, they need to agree with the study's objectives and practical consequences. This requires attention and time, for introductions with counterparts and local leaders, and communicating the ideas behind the study. Additionally, consultation with local inhabitants may provide information crucial to determining how to collaborate with different partners, and go about organising research activities. For example: within this study it was essential to know which local leaders should be informed and visited, the state of the roads in different areas, information about public holidays and the period(s) of the rainy season(s). Finally, information gained from within the target population may also inform the researchers who are the most suitable and possibly available study subjects or respondents, and where and how these people could be found and approached.

The authors' understanding of the local context and living situation of the people in the region of Byumba was informed by in depth interviews with local key informants. Before setting up this pilot study, it was discussed extensively with three key informants, in particular, who had been deeply engaged with the intervention programme since it started and could oversee the practical implications of the study at a population level (e.g. which areas could be reached, how many people could be found there, how to inform people about the research, how to organise meetings with them, and how to arrange transport and food for the researchers and interviewers). Also, they helped choose a representative sample of sociotherapy groups to interview the participants, in order to help ensure the numbers of men and women, and of urban and rural settings, were well balanced. They connected the researchers to the facilitators of the groups, so arrangements could be made for visits to conduct the interviews. Additionally, they indicated where to find possible respondents for our control group. The authors recruited students of the recently established Sociology Department of the local university ('*Institut Polytechnique de Byumba*') as interviewers. There were six men and four women, aged between 20 and 45 years.

Theoretical background

Validity Validity refers to the extent in which a measure really does measure what it sets out to measure (Prince et al., 2003). It is essential that instruments have validity within the context they are used. There are various aspects to validity, and many terms to refer to these aspects. *Psychometric* validity is an umbrella term used when statistical analysis of data previously collected shows that certain criteria are fulfilled. It is validity as demonstrated through calculations performed on numbers. *Cognitive* validity is shown by qualitative information, demonstrating that concepts and words used in instruments have a similar meaning for study participants and researchers.

Often research instruments measuring subjective wellbeing assume that mental illnesses, and their underlying processes, are more or less similar throughout the world and that psychiatric taxonomies and measurements are globally applicable. This is called an '*etic*' approach. Others assume that illnesses are concepts relative to the culture. This implies that research instruments must reflect indigenous classifications of health and illness, and new instruments have to be designed for each separate context. This is called an '*emic*' approach. In this study, an attempt was made to balance these approaches, so that the results would be comparable to other studies in this field, while still applicable, relevant, and acceptable within the local context.

Translation and adaptation Apparently trivial questions eliciting simple information may be sensitive to phrasing or interpretation. Research instruments have to be evaluated scrupulously, even when they have been used countless times in various other contexts and languages. Every item's comprehensibility, acceptability, relevance and completeness need to be assessed systematically (van Ommeren et al., 1999). This is often done in the following seven steps:

(a) establishment of a bilingual group of experts;
(b) examination of the conceptual structure of the instruments by the experts;
(c) translation;
(d) examination of the translation by the experts;

(e) examination of the translation by a monolingual group;
(f) blind back-translation; and
(g) examination of the blind back-translation by the experts (Sartorius & Janca, 1996).

Constraints of quantitative methods One constraint to quantitative methods applied in research on psychosocial issues is the fact that even if rules for adaptation, translation and validation of instruments are complied with, only a reduced image of reality can ever be reflected. Quantitative instruments cannot reproduce personal opinions and appraisals, and nuances are lost. Often, possible responses to questionnaires are limited to a restricted set of choices. The more complicated the study subject is, the higher the risk of quantitative methods yielding data that provide a reduced or skewed picture of reality.

Translation, adaptation and validation of the three instruments Our local counterparts/ key informants were consulted as to whether they thought it was appropriate to define mental health, social functioning and social capital as the areas of interest for this study. The possible validity for the instruments in the specific context of Byumba region was demonstrated. Qualitative information was collected through the use of informal conversations and group discussions, in depth individual and focus group interviews, and free listing and ranking of items.

- *Socioeconomic status* The questionnaire had to contain items on respondents' sociodemographic characteristics. Usually, socioeconomic status (SES) is categorised by three or more scales of yearly income. In a low income country like Rwanda, however, people generally do not have a fixed yearly income. As a result of a group discussion with the interviewers, it was concluded that respondents should not be urged to rate their wealth or poverty, but rather have the interviewer check the state of the roof of the respondent's house, as this would provide an indication of the households' SES. Three categories were then defined for SES:

1) marginal (meaning extremely poor, living on the margin), indicated when the roof of the house was made of straw;
2) poor (meaning poor, but able to provide just enough for the family), indicated when the roof was made with roof tiles;
3) sufficient (having relatively more than most others), indicated when the roof was of corrugated iron and the walls were built with durable materials such as bricks.

Another sociodemographic characteristic, marital status, is usually represented by four options; being single, married, divorced or widowed. In this study, after consultations with key informants and interviewers, the option of being an orphan was added, as after the genocide a lot of children were orphaned. The concept of being an orphan provided a clear example of the need of qualitative information in even the simplest of issues. Rwandans do not only call a person an orphan if he or she has lost both parents, but also in the case of loss of one parent. Furthermore, the description '*orphan*' is applicable for such a person until he or she gets married. With this study's' interviewers, it was agreed that for unmarried orphans older than 21 years the term '*single*' instead of '*orphan*' should be used.

Instrument on mental health To measure mental health, the Self Reporting Questionnaire, 20 items version (SRQ-20) was chosen. This is a structured interview developed by the

World Health Organisation (WHO) as a screening tool for common mental disorders in primary health care settings, often used in developing countries (Beusenberg & Orly, 1994). When patients are literate, it can be self-administered, but in low income countries it is usually administered by lay interviewers who read the questions out loud. This instrument consists of 10 yes/no items about mood, thinking capacity, feelings of anxiety and physical wellbeing. Questions in any of these domains, answered with a yes result in a higher score on the SRQ-20. The 20 items in this instrument are phrased in simple and understandable English. For the translation, an adapted version of the WHO seven steps process (see above) was applied.

The questions were translated to Kinyarwanda by a bilingual co-researcher (TR), who was familiar with the intervention programme, and the (mental) health issues addressed by the instrument. Blind, back translation was done by another bilingual Rwandan, who was independent from, and not familiar with the intervention programme or the study. This back translation was examined by the first translator, together with two researchers (FV, WFS). This examination led to one minor change in the translation. The question; '*are you unable to play a useful part in life?*' proved difficult to translate. The concept of '*playing a useful part*' was hard to translate in a way that our respondents would understand it. It was decided to change the question to; '*are you unable or incapable of doing something visible/tangible in your life*?' Each separate item was then discussed with the future interviewers. For cognitive validation of the final version, the authors focused on each item, one by one. The group members were examined as to whether they interpreted the item the way it was meant, whether they thought that for respondents the issue and wording would be acceptable, whether they considered the item relevant for the subject of general mental health, and whether the items together fully covered the subject. Most of the discussion group members grew up in rural and remote areas, which, although they had been further educated since, made them suitable to judge the items on these criteria, in relation to the illiterate populations of their home communities. The discussion group members noted that the word '*digestion*' exists in Kinyarwanda, but is not often used. It was decided that the question; '*is your digestion poor?*' would not be changed, but that the interviewers would explain this word to the respondent during the interview. The discussion group thought that no further questions or words needed to be changed, and no items needed to be removed nor added. The translated SRQ-20 was then used in the pilot study, psychometrically validated (Scholte et al., 2010b), and used again in its exact same form in the longitudinal study over 2007 and 2008.

Instrument on social functioning Standard instruments to assess function are often developed in Western countries and contain culture bound questions that are difficult to adapt to other situations. For example in the SF-36, a widely used instrument for assessing social functioning, respondents are asked about activities such as walking a block, pushing a vacuum cleaner, or playing golf. Another constraint of the standard instruments is that none of these acknowledges possible differences in the roles of men and women in low income countries (Bolton & Tang, 2002). Therefore, to measure social functioning, we chose an instrument that was designed and validated for use in Rwanda and Uganda (Bolton & Tang, 2002). This instrument lists tasks and activities that adults in these particular cultures are expected to perform, on a daily basis.

There are separate lists for men and women. Respondents are asked to rate how much difficulty they experience in completing these tasks. Using a Likert scale (where respondents are asked to rate their answers) may be problematic for illiterate people, therefore, illustrative drawings may help indicate the various degrees of difficulty in performing a task.

During a discussion on these two lists within our group of future interviewers, the instrument was adapted to the context of Byumba. The adequacy of the existing items was valued, alternative items were free listed, and finally all items were ranked. This led to significant changes. For example, it was decided that participating in folklore evenings would be added as a common task for both men and women, as well as taking care of cattle and participating in burial ceremonies for men and growing food for women. In this way, the group compiled and listed 10 activities for men and 10 for women. This instrument was called the Byumba Social Functioning Questionnaire. Data from the pilot study revealed that the instrument's psychometric properties were acceptable. It was then used in the exact same form in the actual study in 2007–2008.

Instrument on social capital Social capital is a concept based on the idea that social networks provide a basis for social cohesion and cooperation. It has been characterised as; *'the glue that holds societies together.'* Social capital may play a role in the incidence and prevalence of mental illness (McKenzie et al., 2002). There are many definitions of social capital. By general agreement it is divided into two components, *'structural social capital'* and *'cognitive social capital'*. *Structural social capital* refers to the relationships, networks, and associations that link members together. It can be split up in horizontal and vertical relationships, networks or associations. Horizontal relationships are those that exist among equals or near equals, like between family, friends and work colleagues. Vertical relationships stem from hierarchical or unequal relationships due to differences in power or resource base, e.g. relationships between common citizens and local leaders, tax officials, or government representatives. *Cognitive social capital* is the *'driving force'* and it includes values, norms, civic responsibility, expected reciprocity, charity, altruism, and trust. These two components can be respectively characterised as what people *'do'* and what people *'feel'* in terms of social relationships (Harpham et al., 2002).

No consensus has yet been reached on how to measure social capital, therefore resulting in a large number of different tools available. The Social Capital Assessment Tool, short adapted version (Short A-SCAT; Harpham et al., 2002) was chosen. This version was further shortened and validated in the Young Lives research project (an international study of childhood poverty, that includes quantitative measures of caregivers' social capital) (Tuan et al., 2005) (De Silva et al., 2007). This particular instrument was chosen because of its limited length and the presumed relevance of the various items for the Byumba context. Questions in the Short A-SCAT ask about support received from groups or individuals, whether and how people connect with their leaders, how they feel connected to others in their area, and how they get along. The questions can be categorised in three sections; support, citizenship and cognitive social capital.

The Short A-SCAT has been extensively validated in two resource poor settings (Vietnam and Peru) (Tuan et al., 2005). Due to time and financial constraints however, the Rwandan version could not be validated in the same scrupulous way.

Four focus group discussions took place with, respectively;

1) a group of six sociotherapy group facilitators: three men and three women, educated and uneducated, rural and urban residents;
2) a female group of widows and married women (educated and uneducated, rural and urban);
3) a group of teachers of primary and secondary school (women and men), and4)
4) a group of local leaders and health care workers.

The groups started with free listing examples of good social connectedness, free listing groups in the community available to actively participate in, and free listing individuals that, in ideal circumstances, are available to provide support. The concept of community was extensively discussed in order to find the right Kinyarwanda term for it. All social capital questions referred to relationships within the respondents' community, and not to those outside. The concept of '*community*' needed to be understood as a group of people who share a space that is demarcated by administrative boundaries. The next step in the discussion was the presentation of each Short A-SCAT question in Kinyarwanda to the groups. The groups were asked whether the question was easy or difficult to answer. In case the question was easy to answer, the groups were asked to explain what the question meant to them, illustrating the response, when appropriate, with examples. In case the question was difficult to answer, the facilitator asked the groups to explain why. Sub questions put to the groups were; '*can you explain what you thought of when you heard this question? Which word made it difficult to give an answer? When you heard that word, what did you think of?*' After the facilitator had explained the meaning of the question, as the developers of the questionnaire had intended it to be, the groups were asked; '*how should the question be phrased in order to enable you to answer it more easily?*' Finally, the respondents were asked whether they thought the Short A-SCAT questions covered the items they had free listed together. Each group gave suggestions for replacing some Kinyarwanda words by others, to rephrase a few questions and to clarify some of the questions by adding some examples. In the analysis, the results of the four discussion groups were compared. It was found that there was an overall agreement on the changes to be made in the Short A-SCAT in order to capture what the intended meaning of the questionnaire items was, and to phrase the questions in such a way that that meaning would be understood by future respondents. Some examples were: a change of the word '*community*' to '*area, neighbourhood or hill*'; a change of the word '*majority*' to '*many people*', because the term had been contaminated during ethnic polarisation; in the question '*are you an active member of any group?*' the word '*active*' was discarded because it appeared to be too ambiguous and would probably bias responders towards answering '*yes*'.

The '*readapted*' Short A-SCAT was tested by interviewing two middle aged people, a man and a woman, by asking them how well they understood each question, whether in their opinion people they knew would understand them, and whether people would be willing to answer the questions. They understood the questions and thought others would as well. After (back) translation of this '*readapted*' Short A-SCAT, each question was considered separately and elaborately discussed within the discussion group of interviewers. As with the other instruments, the questions'

comprehensibility, acceptability, relevance and the completeness of the set of items was addressed. Given the sensitivity of issues like trust and connectedness within the specific context of post genocide Rwanda, the acceptability of questions seemed to be of utter relevance here. However, the group of interviewers did not think any of the questions were inappropriate.

The *'readapted'* version of the Short A-SCAT was used in the pilot study. Analysis of the collected data yielded outcomes that were unexpected and hard to interpret. The experimental group (sociotherapy group participants) did not seem to significantly gain social capital, whereas, surprisingly, the control group (with no intervention) did. One possible explanation was that the instrument, in its current form, just did not work. Interestingly, qualitative information pointed out that there was a significant rise in social capital among sociotherapy group participants due to the intervention. Many stories of local leaders, group facilitators and participants drew a picture of growth in active citizenship, solidarity and collaboration. For example, citizens increasingly participated in communal programmes; exprisoners helped each other build houses; sociotherapy groups continued meeting and formed income generating associations (Richters, 2010).

It was decided to try to raise the Short A-SCAT's psychometric qualities after the pilot study, by adding a few new items, aiming to better distinguish between different types of giving and receiving support, and to provide more examples of citizenship. Also, the yes/no options were changed to Likert scales, which allow for more differentiation in responding (see Annex).

Another possible explanation for the confusing pilot study outcome was that it might have been caused by nonvalid responses to questions on very sensitive issues. Our key informants and discussion group were asked for their views. One of their comments was that many levels and different kinds of trust exist. They gave the examples of people trusting their neighbours with their children, which enabled them to go to the market while leaving their child behind, but at the same time not being sure if these neighbours would take advantage of them by taking their land if they had the opportunity, or if they would be on their side if a new round of political aggression started. However, because of time constraints, it was decided not to change the content of the cognitive social capital questions.

During the actual study, a systematic cognitive validation of the *'readapted'* Short A-SCAT was performed, according to the method described by De Silva et al. (2006). In the end the researchers wanted to find out whether respondents appropriately interpreted the questions. For this purpose, respondents were interviewed with the aid of a translator by two of the researchers (FV, WFS), immediately after they had been taken through this version of the Short A-SCAT by one of our interviewers. Eighteen interviews were conducted, two in each area visited, nine with men and nine with women. Each person was asked probing questions about the Short A-SCAT, in order to provide examples illustrating their view, and finally to inform us if they thought others would feel free to answer these questions, and answer them truthfully.

Our findings, in short, were as follows: when asked about support given or received, people gave different responses to Western interviewers than to fellow Rwandans. Apparently, being *'white'* and considered a potential benefactor biased the interview. Also, responders did not seem to differentiate between the various kinds of support

mentioned in the questions (comforting, encouraging, economic support); in this very poor region, all support seemed to be expressed in material forms. If no goods were received nor given, no comfort nor encouragement was experienced nor provided. We also discovered that the word *'group'* was actually translated and thus understood by respondents as *'association'*, meaning people would only think of groups that carried out income generating activities. This was different from our intended meaning of the word *'group'*, which could refer to any kind of group, such as a football team or a church choir. For citizenship and cognitive social capital there appeared to be no interpretation differences from the intended meaning.

Conclusion

Applied research may contribute to programme design, implementation, monitoring and evaluation (Bolton, Tol & Bass, 2009). This article describes in detail how qualitative information was collected and how these were used to inform three quantitative research instruments, and the results. The cognitive validation of the Short A-SCAT gave an indication of how, in a complex sociocultural setting, seemingly straightforward and clear concepts can be quite ambiguous and understood in a variety of ways. It showed that studying the level of social capital in any population by use of a structured interview can be extremely complicated, and requires the collection of extensive qualitative information beforehand. Also, evaluation and monitoring at different intervals would be relevant. This study was conducted in Rwanda, a country that, in many aspects, still can be characterised as a post civil war area and therefore highly complex in terms of the Rwandan sociocultural setting. Respondents may have been willing to open up and provide valid answers if they were not asked about issues directly linked to social relations. Questions addressing the build up of one's social environment and one's position in it may not have elicited a reliable picture of reality. Before entering the field, the authors had been told repeatedly that people in Rwanda do not easily show their true face nor speak explicitly on topics in these domains. This study confirmed that. Therefore, whereas, in general, the picture evoked in a quantitative study is already constrained by the structured way of interviewing and the use of closed questions and restricted response options, there were even more constraints in Rwanda. The ongoing close and comradely collaboration with our counterparts and interviewers, and our efforts to feed valid qualitative information into our study at all stages, may have helped to overcome some of these constraints. Yet, it is our impression that in a context so complex, the value of quantitative data is relative. Our experiences underline that for any mental health or psychosocial study, a substantial contribution from qualitative research is an unconditional requirement.

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[1] Clear descriptions of these methods can be found in the *'Applied Health Research Manual'* (Hardon et al., 2001) and in the online training manual by W. Weiss and P. Bolton http://www.jhsph.edu/refugee/publications.tools/publications/qualresearchtrain.html.

Femke Verduin is a psychiatrist with Equator Foundation in Diemen .
email: femkeverduin@hotmail.com
Willem F. Scholte is a psychiatrist and director of Equator Foundation in Diemen.
Rutayisire Theoneste, is a theologian and a medical anthropologist in Byumba, Rwanda.
Annemiek Richters is professor of culture, health and illness at Leiden University Medical Center (LUMC).

Annex: Short A-SCAT, readapted version for Rwanda

Scholte & Verduin (2007), adapted from Tuan, Harpham et al. (2005)

1. Are you a member of any group?
1. Yes 2. No

2. In the last 12 months did you receive from the group(s) any help in comforting/encouraging you?
1. No 2. Yes, once 3. Yes, a few times 4. Yes, often

3. In the last 12 months did you receive from the group(s) any help in improving your economic situation?
1. No 2. Yes, once 3. Yes, a few times 4. Yes, often

4. In the last 12 months did you receive from the group(s) any help in knowing and doing things?
1. No 2. Yes, once 3. Yes, a few times 4. Yes, often

The following questions have nothing to do with any group.

5a. In the last 12 months did you receive any help or support from any one, in the sense of comforting when something bad happened? (e.g.: losing a loved one)
1. No 2. Yes, once 3. Yes, a few times 4. Yes, often

If no go to question 6a.

5b. If yes, from whom? You can tick more than one option.
- ○ Family members
- ○ Neighbours
- ○ Friends
- ○ Religious people
- ○ Leaders
- ○ Others

6a. In the last 12 months did you receive any help or support from any one, in the sense of encouraging when something good happened? (e.g.: a wedding)
1. No 2. Yes, once 3. Yes, a few times 4. Yes, often

If no go to question 7a.

6b. If yes, from whom? You can tick more than one option.
- ○ Family members
- ○ Neighbours
- ○ Friends
- ○ Religious people
- ○ Leaders
- ○ Others

7a. In the last 12 months did you receive any help or support from any one, in the sense of improving your economic situation?
1. No 2. Yes, once 3. Yes, a few times 4. Yes, often

If no go to question 8a.

7b. If yes, from whom? You can tick more than one option.
- ○ Family members
- ○ Neighbours
- ○ Friends
- ○ Religious people
- ○ Leaders
- ○ Others

8a. In the last 12 months did you receive any help or support from any one, in the sense of any help in knowing and doing things?
1. No 2. Yes, once 3. Yes, a few times 4. Yes, often

If no go to question 9.

8b. If yes, from whom? You can tick more than one option.
- ◯ Family members
- ◯ Neighbours
- ◯ Friends
- ◯ Religious people
- ◯ Leaders
- ◯ Others

9. In the last 12 months have you joined together with other people of your area/neighbourhood to address a common problem/issue?
1. No 2. Yes, once 3. Yes, a few times 4. Yes, often

10. In the last 12 months have you talked with or informed leaders about problems in this area/ neighbourhood you live in?
1. No 2. Yes, once 3. Yes, a few times 4. Yes, often

11. In general, are many people in this area/ neighbourhood satisfied with local leaders?
1. Not at all 2. A little 3. Most of the time 4. Completely

12. In the last 12 months have you joined others in choosing your local leaders?
1. Not at all 2. A little 3. Most of the time 4. Completely

13. In general do you join others in attending meetings called by local leaders?
1. Not at all 2. A little 3. Most of the time 4. Completely

14. In general, can many people in this area/ neighbourhood be trusted?
1. Not at all 2. A little 3. Most of the time 4. Completely

15. In general, do many people in this area/ neighbourhood get along with each other?
1. Not at all 2. A little 3. Most of the time 4. Completely

16. Do you really feel part of this area/ neighbourhood?
1. Not at all 2. A little 3. Most of the time 4. Completely

17. In general, do you feel safe in this area?
1. Not at all 2. A little 3. Most of the time 4. Completely

18. In your area/neighbourhood do people have a culture of visiting each other?
1. Not at all/ no one 2. Only few people 3. Most of the people 4. Everyone/All

19. Do you think that many people in your area/ neighbourhood would try to take advantage of you if they got the chance?
1. No one 2. Only few people 3. Many people 4. Everyone