Are we reaching refugees and internally displaced persons?

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Introduction

Public health communication is the production and exchange of information to inform, influence or motivate the target audience to enable desirable, sustainable health practices at individual, community and institutional levels. This paper explores key issues relating to health communication in refugees and other displaced populations, i.e. the "hardly reached".[1] Though there are several challenges there are also many opportunities and lessons learned that can be applied to existing programmes.

In 2007, the number of "people of concern" to the Office of the United Nation's High Commissioner for Refugees (UNHCR) included 9.9 million refugees and 12.8 million internally displaced persons. A refugee is a person who is outside his/her country of origin owing to a well-founded fear of persecution and is unable to avail himself/herself of the protection of that country. Internally displaced persons often leave their homes for the same reasons as refugees, including avoiding armed conflict or generalized violence but also natural or human-made disasters; unlike refugees, internally displaced persons have not crossed an internationally recognized national border.

Displacement is often assumed to be short-term but refugees can remain within host countries for many years, during which there is a need for effective health communication. In any well-planned communication intervention the approach must be appropriate to the target audience. While this applies to all populations, challenges and opportunities in health communication targeting displaced populations vary depending on, but not limited to, the stage of displacement, physical environment and location (urban, rural and camp-based settings), the sociocultural context and the degree of diversity within the displaced population.

Phases of displacement

Health communication is a necessary – but often overlooked – aspect of the emergency response. The aim is to ensure that the most vulnerable have access to essential and accurate information about key practices, available services and relief supplies to prevent the main causes of morbidity and mortality and to prevent abuse and exploitation.[2] Low cost, low-technology communication systems are often the most practical and effective during the initial phases. Megaphones, battery-operated public address systems, billboards and community radio can quickly and widely disseminate messages as well as provide opportunities to promote participation. Large gatherings for distribution of relief items provide further opportunities for information dissemination.

As the situation stabilizes, efforts should be expanded to promote sustained behaviour change and create a supportive environment. Areas of focus will depend on the local epidemiology and pre-existing knowledge and practices. Messages, activities and materials should be planned, implemented and monitored with the affected communities. Participation in all phases allows community input in decision-making, promotes ownership and community capacity and helps affected communities achieve a sense of normality. Participation begins with formative assessment or audience research conducted before the start of an intervention to gauge the needs, challenges and opportunities within the target population to guide programme activities; influential community members, leaders, women's and youth representatives are essential partners in this process.

During the repatriation phase, health communication must be targeted towards the most immediate needs, including information on availability and location of essential services on return. Communication should begin pre-departure; messages should be short and focused as periods of contact with returning refugees are limited and returnees are often preoccupied with other issues. Reception centres in Afghanistan promote landmine awareness to returnees through well-designed and clearly marked visual displays and a film. Using existing capacity in the returnee community is essential in maintaining communication activities for the longer term; in areas of return in Angola, returnees trained as community educators during the period of asylum are supported to continue HIV prevention activities.

Challenges and opportunities

The delivery of health communication for refugees and internally displaced persons can be influenced – both positively and negatively – by several factors. Identification of these factors will assist communication practitioners to develop an appropriate communication strategy and execute effective health communication interventions.

Values, attitudes and cultural practices must be considered in health communication in any setting. This is particularly relevant in conflict-affected populations that may adhere to cultural norms more strongly or adopt new ones in an effort to enforce identity and culture. Conversely, health communication that recognizes and reinforces cultural norms and values (where appropriate) and incorporates community traditions may be more readily accepted.

Emotional trauma from conflict, displacement and loss and a general feeling of hopelessness common to many long-term refugee settings may hinder access and reduce receptiveness to behaviour change communication. A sense of fatalism associated with recent loss and more immediate threats to life presents many challenges in promoting preventive behaviours. Integrating behaviour change communication activities with initiatives designed to

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improve psychosocial well-being (sport, competitions, cultural events) may reach more people and also associate messages with more positive aspects of life, thus motivating behaviour change.[3] Motivation and morale of community educators and other displaced staff can be enhanced through training, supportive supervision and creative competitions.

Geographical isolation and poor telecommunication infrastructure mean that mass communication, using radio, television and mobile telephones, often fails to reach displaced people. Although emerging communication avenues – such as the Internet – can be very cost effective, these options are usually not available in resource-poor settings. Conversely, the confinement of displaced populations in camp settings, the camp layout and social organization may mean that these populations are often more accessible and easier to reach using locally produced mass media, community art forms and interpersonal communication modes, such as community health workers and peer educators. Conversely, in urban settings, displaced populations are often widely dispersed and poorly organized; interpersonal channels, mobile telephones and use of communal meeting points to disseminate information and promote dialogue are more effective in these settings.

The diversity of nationalities, ethnic groups, religion and other dimensions is apparent in many refugee settings. Kakuma, a long-term camp in northern Kenya, has refugees of nine nationalities and 20 ethnic groups. Urban refugee populations often consist of persons from numerous national, ethnic and religious backgrounds. In these situations, target audience segmentation is challenging. One approach is to develop simple messages in language/s that are most common in that setting. Visual communication materials such as pamphlets and brochures featuring neutral images that are not specific to any particular groups are preferred. In some settings, neutral cartoon characters have been well received. It is important to ensure representation of all groups in formative assessment, pre-testing of materials and in interpersonal communication channels. During pre-testing, the target group's responses to draft communication materials are sought and materials revised to ensure comprehension, acceptability and promote effectiveness. Role plays, art competitions and creative writing can be used to involve children and young people from diverse backgrounds.

Differences between displaced and host communities also significantly affect access to effective communication. Host country communication channels and materials cannot be used among Myanmar refugees in Thailand due to language and cultural differences, requiring the development of context appropriate materials. Similarly, refugees and internally displaced persons often come from areas of long-standing conflict with interruptions in schooling resulting in low levels of basic education and literacy. More than 95% of Afghan refugees in the Islamic Republic of Iran live in urban or semi-urban areas among the host community. However, Afghans generally have a low level of education and so health communication aimed at the more literate Iranian population will not reach many refugees. Host country services need to be adapted to the particular needs of Afghans to ensure that they are reached. In addressing substance use, this will include training and recruiting Afghan service providers to improve interpersonal communication, face-to-face community consultation[4] and development of communication materials adapted to the needs of Afghans and the diversity within their community.

All of the above factors highlight the importance of participatory approaches and of communities being partners in the process and not passive recipients of information. A capacity building project, Community Conversations, among displaced populations in the Congo describes an innovative way of mobilizing individuals and communities so that they become the agents of change for effective responses to HIV.[5] Similarly the film, "Love in the time of AIDS", narrates the story of the first Burundian refugee in the camps in western United Republic of Tanzania to declare his HIV-positive status publicly, and then start a successful community-based HIV initiative. This highly personal account illustrates the strength and effectiveness of community-driven approaches.

Monitoring and evaluation of communication activities can be particularly challenging in resource-poor, displaced settings. Knowledge, attitude and practice surveys, together with qualitative and quantitative research and measurement of appropriate programme indicators, can assist in targeting activities, allocating scarce resources and assessing effectiveness. Lessons can be learned from experience with HIV-related behavioural surveillance surveys among displaced populations.[6] These include: engaging expertise where possible; use of standardized indicators, definitions and measurements; and incorporating interactions with the host community where relevant.

Communication in all its facets is an integral component of public health and HIV programming in displaced populations. Quality programmes that are designed, implemented and monitored using participatory approaches in partnership with the displaced community and in consideration of their particular needs will maximize impact. Humanitarian actors, including donors, must ensure the provision of adequate expertise and resources. ■

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References

1. Goodyear L. Reaching refugees and internally displaced persons. In: Murphy E, Hendrix-Jenkins A, eds. *Reproductive health and rights: reaching the hardly reached*. Washington, DC: Program for Appropriate Technology in Health (PATH); 2002.pp. 36-48.
2. Woods LN. *Behaviour change communication in emergencies: a toolkit*. Nepal: United Nations Children's Fund; 2006.
3. Benjamin J, De Buysscher R, Engel D. HIV/AIDS prevention and education for refugees: implementing effective emergency projects. In: Makinwa B and O'Grady, M, eds. *Best practices in HIV/AIDS prevention collection*. Arlington, VA: Family Health International and UNAIDS; 2001. pp. 7-23.
4. Abandokht Sarkarati. *Rapid assessment of substance use and HIV vulnerability among Afghan refugees in Tehran, Iran*. Berlin: Charité Universitätsmedizin, Freie Universität and Humboldt Universität; 2008.
5. *Community conversations in response to HIV/AIDS: a capacity building project with refugees and the host population*. Geneva: Office of the United Nations High Commission for Refugees; 2005.
6. Spiegel PB, Le PV. HIV behavioural surveillance surveys in conflict and post-conflict situations: a call for improvement. *Global Public Health* 2006; 1:147-56. PMID:19153903 doi:10.1080/17441690600679764