FACILITATING DATA-DRIVEN STIGMA REDUCTION IN HUMANITARIAN SETTINGS

1. MAIN DETAILS

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War Child Holland undertakes research and development to demonstrate the effectiveness of all our interventions. Our in-house R&D team is working to develop a holistic Care System made up of evidence-based intervention models. This Care System will increase access to integrated education, protection and psychosocial support for conflict-affected children and their communities. This challenge brief outlines and contributes to the development of one specific element of this Care System.

2. PROBLEM STATEMENT

"How to improve approaches to addressing social/gender norms (harmful) & power structures in humanitarian settings?"

3. CURRENT CHALLENGE

Imagine that you are lying in a hospital bed - and you're told to vacate it to make space for another patient. Or that when you pass other women on the street they spit on the floor. Consider a situation where you might want to leave the boundaries of your community – and you have to request a permit to do so while other members of the community don't[1].

These real-life incidents are all manifestations of **stigmatisation** - the social process of labelling, stereotyping and prejudice that results in separation, devaluation and discrimination[2] - because you're *outside* the boundaries of locally proscribed norms. Stigmatisation functions to keep people (1) *out* by enforcing social norms; (2) *away* to avoid disease; and (3) *down* by exploitation/domination[3]. It has a profound negative impact on psychosocial wellbeing, quality of life and social and economic participation[4].

The prevalence and burden of stigmatisation will be aggravated in each humanitarian or protracted crisis - be it in Colombia, Burundi, Sri Lanka, Uganda or elsewhere. The example of differential treatment, the obligation to request a permit while other don't have to, mentioned above, is a daily reality for youth formerly associated with armed groups in South Kivu, DR Congo, and hampers their opportunity to earn their own livelihood.

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[1] *Testimonies derived from qualitative data of a practice run phase 1, in DRC, 2018*

[2] *Link, Bruce G, and Jo C Phelan. 2001. "Conceptualizing Tigma," no. Lewis 1998: 363–85*

[3] *Bos, Arjan E. R. Aer, John B. Jb Pryor, Gd Glenn D. Reeder, and Sarah E. Se Stutterheim. 2013. "Stigma: Advances in Theory and Research." Basic and Applied Social Psychology 35 (March): 1–9*

[4] *Mak, Winnie W.S., Phoenix K.H. Mo, Gloria Y.K. Ma, and Maggie Y.Y. Lam. 2017. "Meta-Analysis and Systematic Review of Studies on the Effectiveness of HIV Stigma Reduction Programs.", Kaddumukasa, Mark, Martin N Kaddumukasa, William Buwembo, Ian G Munabi, Carol Blixen, Samden Lhatoo, Nelson Sewankambo, Elly Katabira, and Martha Sajatovic. 2018. "Epilepsy Misconceptions and Stigma Reduction Interventions in Sub-Saharan Africa, a Systematic Review.", Sengupta, Sohini, Bahby Banks, Dan Jonas, Margaret Shandor Miles, and Giselle Corbie Smith. 2011. "HIV Interventions to Reduce HIV/AIDS Stigma: A Systematic Review."*

The pervasiveness of stigma within all contexts of humanitarian and protracted crisis worldwide presents us with a challenge - particularly in light of the commitment within the Sustainable Development Goals to 'leave no-one behind'. We are therefore compelled to find ways to address this social phenomenon - particularly in contexts of humanitarian crisis – while knowing that current practices to boost inclusion are insufficient and even potentially harmful. However, while being globally experienced, stigma is socially constructed, and its drivers contextually influenced.

War Child therefore has made it an overall objective to **develop an evidence-based stigma reduction approach that can effectively be implemented in all humanitarian and protracted crises to tackle the stigmatisation of any group.** This approach is developed in *three phases*: (1) data gathering on drivers and facilitators, stigma practices and experiences, and local (in) formal leaders; (2) data analysis and strategy adaptation, training and commitment of (in) formal leaders; and (3) parallel implementation of strategies.

Building on systematic literature reviews, qualitative research and the work of others, we have indications that drivers of stigmatisation, such as fear, blame and misconception, are globally comparable[5], and can be conceptualized into a single intervention framework[6]. We hypothesise that each driver can be targeted through a combination of strategies - such as social contact, experience, dialogue and cooperation. Within the larger picture of the development and evaluation of a generic, customizable stigma reduction approach, we anticipate **cost-effective, rapid and accurate data analysis to be a key challenge**. Robust data analysis will ensure stigma practices, experiences and testimonies are properly filtered and that drivers and facilitators of stigmatisation are accurately identified and understood.

4. IMPACT GOAL

Evidencing a scaleable, generic, customizable stigma reduction approach in contexts of humanitarian or protracted crisis can contribute positively to enhanced psychosocial wellbeing, access to services, participation and social cohesion within disaster- and conflict-affected communities. Responders in humanitarian and protracted crises, such as governmental and non-governmental organisations, can use such an evidence-based approach not only as a strategy to better identify and reach excluded communities but also to contribute to their social acceptance, with them perceived as worthy of support. Linking to the experiences mentioned earlier, this could manifest itself in affected individuals continuing to receive medical treatment even if someone else is brought in; in their being positively greeted when they walk by; and in their enjoying freedom of mobility to increase their opportunities in life.

An additional important function of such an approach could be to support the work that organisations are undertaking to address harmful social norms, such as female genital mutilation, forced feeding or early marriage. Tackling these locally accepted practices requires pioneers to take the first step in (publicly) denouncing the practice in question - which essentially means that they will have to deviate from socially accepted norms. This makes them prone to stigmatization, and an accompanying process to safeguard this may be advisable.

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[5] *Jones, Edward E., Amerigo Farina, Albert H. Hastorf, Hazel Markus, Dale T. Miller, and Robert A. Scott. 1984. Social Stigma: The Psychology of Marked Relationships.*

[6] *Stangl, Anne L, Valerie A Earnshaw, Carmen H Logie, Wim van Brakel, Leickness C. Simbayi, Iman Barré, and John F Dovidio. 2019. "The Health Stigma and Discrimination Framework: A Global, Crosscutting Framework to Inform Research, Intervention Development, and Policy on Health-Related Stigmas."*

The Dutch Relief Alliance provides urgent humanitarian assistance and responds to major international crises, aiming to do so in a timely and effective manner. To be able to do this and ensure that vulnerable and marginalised populations (1) become less vulnerable; (2) have increased agency, and; (3) perceive positive impact, supporting research into the feasibility of a scaleable, generic customizable stigma reduction approach for humanitarian and protracted context is potentially indispensable - not least to enable other organisations to use and contextualize the approach without needing to invest in research.

5. ASSUMPTIONS MADE

The success of testing the feasibility, and effectiveness, of an approach to reduce stigmatisation is based on a number of assumptions, namely that:

- Country context(s) stable enough to conduct intervention research can be identified;
- Drivers of stigmatisation, such as fear, or morality, responsibility or blame, are globally comparable and can be addressed using generic change mechanisms such as experience, contact and dialogue, while still able to be adapted with local content and to the context;
- **The analysis of sensitive information can be facilitated easily, potentially through artificial intelligence or other (technological) solutions;**
- Based upon the notion of positive deviance, there are local (in)formal leaders within the community who commit themselves to contribute and undertake an active role to bring about positive change;
- It is possible to develop and positively evaluate an approach which is generic in phases (phase 1, 2 and 3), and customizable because of the content that is derived from the implementation of these phases.

6. RISKS IN PURSUING THIS CHALLENGE

- Risk: Actively addressing stigmatisation is a sensitive issue and should be treated that way, as discussing the status of certain groups might aggravate their stigmatized position instead of reducing it.
- Mitigation: Integration of this risk in each phase of the research, through non-intrusive data gathering intervention exercises; the training of implementers as well as research assistants to monitor potential manifestations of harm; diffuse tension where necessary/possible, and report adverse events for follow up.
- Risk: Power structures are crucial in upholding social norms - and within stigma reduction approaches these structures are often challenged. This can be seen as a threat by local power holders.
- Mitigation: The current intervention flow foresees an active role of identified and committed local (in)formal leaders in data discussion, strategies' adaptation and co-facilitation of the strategies, to advocate for and facilitate positive change.
- Risk: Local, national and international people and organizational entities are not immune to stigma practices themselves. People come with their own biases, stereotypes, attitudes and behaviour, either consciously or unconsciously, and this can impact upon their programmatic operations and policies.
- Mitigation: Individuals involved in the intervention research, whether local organisations, research assistants or others, will go through a training to reflect on their own bias, attitudes and behaviour.

7. NEXT STEPS

- (Literature) research, including **discussions with interested stigma or social change practitioners and researchers**, will continue be conducted to identify and select drivers and change mechanisms for further development of the intervention manual;
- On the possibilities for **cost-effective, rapid and accurate data analysis** based on raw data, we would like to invite **actors working within and outside of the humanitarian sector**, to share their expertise and jointly brainstorm on out of the box, scaleable solutions that can be tested in unstable, humanitarian contexts. For parties to **indicate their interest the deadline is May 9**. Depending on availability of the interested parties, the brainstorm session is planned on 20, 21 or 22 May, 3-5pm, at the War Child office in Amsterdam;
- Identification of stable enough country context(s) to carry out the intervention research;
- Finalisation of the intervention manual;
- Practice run, adaptation, piloting and evaluation of the stigma reduction approach in the coming years, including potential cooperation in tackling this challenge;
- Dissemination on e.g. War Child's Learning Platform to promote use by other organisations;
- If you want to know more about War Child and stigma reduction, please scan the QR-code or visit https://www.warchildholland.org/stigmatisation/, and watch the short video.