Urban Webinar #21 - Responding to marginalised people in urban crises

(85 mins)

Leah Campbell: Hello everyone and welcome to the latest edition of ALNAP's Urban Webinar series. My name is Leah Campbell, I'm a Senior Research Officer at ALNAP, and I lead our urban work that this webinar falls within. This is our 21st urban webinar, so we do a few of these a year and try to bring together practitioners who are working on really interesting humanitarian response in urban areas around the world to share the experiences that they're having on different topics, and this webinar we're focusing on how to find and respond to the needs of hidden or marginalised people in urban areas.

I'll mention just to get started that the idea for this webinar, the theme of this webinar was really informed by ALNAP's Annual Meeting which we had last October. We just actually published the meeting paper relating to that meeting so you can find that on the ALNAP website, in case you're interested in this theme more broadly and in particular thinking about the relevance of aid that gets provided and questions around who decides about relevance.

So today's webinar, we have two speakers who I am going to introduce to you in a moment, and while I tell you a little bit about them, we'd also be really interested to find out a bit more about all of you, so we're going to put up a quick poll just for you to tell us a bit more about who's listening to the webinar today. There's only a couple of responses, so just pick the one that fits you best and while you do that I will tell you a bit more about our two speakers for today.

So our first speaker is going to be Valerie Rowles. Valerie became Relief International's Country Director in Lebanon in 2015, having previously served as the Regional Programme Development Manager in the Middle East for four years, also at Relief International. She was also Country Director for Jordan in 2018, and then moved back to Lebanon in December 2019, so very experienced in that region. Valerie also played a lead role in setting up Relief International's response at the onset of the Syria crises across the region, and has subsequently provided leadership in carrying forward both the Lebanon and Jordan country programmes. Previously Valier worked for Internews in senior roles including Business Manager for the Middle East and North Africa. She holds a master's degree in Arab and Middle Eastern Studies from the American University of Beirut, and Valerie is going to be our first speaker today talking about support for those with mental health needs in Lebanon.

Then we're going to have our other speaker, Katie Susman. Katie is the Technical Lead for IRC's Northern Central American Protection Programming. Katie has over ten years' experience working in Latin America in international development, education and humanitarian response.

Particularly focusing on violence prevention and response, child protection and gender equity programming from a feminist perspective. She has experience in Brazil, Honduras, Guatemala, Bolivia, Ecuador, Columbia, Venezuela, Mexico, US border response, and is now working in El Salvador. She has a double master's degree in Social Work and International Development from the University of Denver, and specialised in gender based violence and human trafficking at the Institute of Judicial Studies from the Judicial Power of Nicaragua. She has particular experience working with vulnerable populations affected by violence, forced displacement, trafficking, gender based violence survivors and rights-based programming in Central American and is particularly interested in how technology and non-traditional approaches can be used to reach hidden populations, as well as how trauma-informed care in secondary and tertiary violence response and prevention can be effective.

So those are our excellent speakers who are going to be telling you more about their work with marginalised populations in just a minute. So to get back to who you are, we always have quite a variety, although far and away, most of you listening on the webinar today have had some experience with marginalised populations, perhaps in urban, perhaps not, though not very much. Only a few of you think that you should have been asked to be presenters on this webinar, and a couple of you have never responded with urban marginalised groups.

So the good news is if you've got some experience, you will be able to follow along with the presentations we have for you today, and also hopefully it will be interesting for you to learn a bit about these particular projects.

So I am going to hand over to our first speaker who will be Valerie to tell us more about Relief International's work in Lebanon. Over to you Valerie.

Valerie Rowles: Thank you for the introduction and thank you for your participation and your interest on this topic. So I will just go ahead and jump right in, and I want to kick this off with a poll. So the poll is, in Lebanon, approximately what percentage of Syrian refugees live in formal refugee camps? And while you are answering that, I will just go into a little bit of background about Lebanon. So as many of you are probably aware, Lebanon has been consumed by the Syrian refugee crisis since 2012 and currently there are an estimated 1.5 million Syrian refugees in Lebanon, in addition to other refugee populations, most notably the Palestinians who are an estimated 300,000 in the country. And this is in a country that had an estimated population of only 4.5 million Lebanese before the influx. So this makes Lebanon the country with the highest number of refugees compared to the host population in the world.

So it seems that many of you will then be surprised to know that in Lebanon there are actually no formally established refugee camps for Syrians, which means that 100% actually live in urban settings. So I see that not everyone was aware of that, and it really means that the context for Syrian refugees in Lebanon is a bit challenging. Approximately 70% of Syrian refugees live in buildings, which can include apartments but also collective shelters, substandard buildings and other arrangements, such as within garages, construction sites, shops, you name it. And then there's the other 30% who reside in what we call informal settlements, which are groupings of tents, some are

large groupings with hundreds of tents and some are much smaller with just a few, but there are on private lands, which are dotted across the country, and they have absolutely no formal status.

So regardless of the structures in which they reside, Syrian refugees are part of the urban fabric of the country. They live in both large cities and in villages, and they live side by side with Lebanese and mostly in areas of the country where Lebanese suffer from higher levels of poverty than others. So in the map here on the slide, you can see that the larger circles actually indicate the higher concentrations of Syrian refugees, and in these areas, these are also the more highly impoverished ones within Lebanon.

As such, as humanitarian actors, we consistently strive to ensure services are provided to both vulnerable Syrian refugees and vulnerable Lebanese communities to the extent possible. And so this also applies to our mental health programming.

Relief International has been active in Lebanon since 2006, and we've evolved our programming over time to meet the changing needs of the most vulnerable communities. Currently we work in four sectors. Health, education, cash and livelihoods, and similar to our global portfolio, it's our health programme that makes up approximately half of our country programme, and we are seen as significant actors in the health sector here.

Our approach to mental health is ensuring it is integrated with healthcare, and we have been doing this since 2017, when we began to build our mental health programming unit. In addition, we do link our mental health services to the programming we implement across all the sectors, and we ensure that we are working in full coordination with the Ministry of Public Health.

So I think we all understand that mental health is important for all of us, but why is it especially important for vulnerable populations? So not surprising, vulnerable populations, they face challenges that increase the risk of suffering from mental health issues, and they are generally factors that most of us take for granted in our daily lives. They suffer from poor health, hygiene and living conditions which are interlinked and raise anxiety and stress. They often have a deficiency meeting their basic needs, which includes challenges with paying rent, affording food, lacking access to education to livelihoods and income generating opportunities, which also exacerbates anxiety and leads to depression.

And then many of the populations we serve face insecurity. Both external linked to authorities or crime and internal, for example, with higher levels of domestic abuse. And then for refugees specifically, they do face challenges with lack of rights, and there's issue of social cohesion within the host community, that can also present stresses. And I think it goes without saying that many Syrian refugees have also survived truly traumatic experiences during the war in Syria, and then not to mention being displaced in itself is quite traumatic.

And then finally, which is something we will touch on a bit more as well, there is a lack of awareness among vulnerable communities about the importance of protecting mental health and the services that are available to support them.

At the time we started our mental health programming in 2017, the landscape for mental health services was quite bleak. In Lebanon, private psychotherapists and psychiatrists charge high fees

and they're mostly reserved for the well-off, who can afford the services. And in addition, most are not trying to deal with extremely vulnerable groups such as refugees. Given this context, while there was a very high number of agencies providing psychosocial support through various types of programming, the specialised one-to-one services were extremely limited. And it wasn't until 2016 when the Ministry of Public Health began to focus on mental health for more vulnerable populations in the country by introducing MH gap to the Ministry's network of primary healthcare centres, and RI was one of those agencies that were at the forefront and we were playing a significant role in supporting the ministry to ensure primary healthcare centres were adopting this new approach.

At the same time, there was a general lack of awareness about the importance of mental health and a severe stigma attached to those who sought such services. So in this slide, you can see Relief International's approach to the mental health in Lebanon. So first we identify the need and how we are doing this. So because we are working in an urban setting and not for example in a formal refugee camp setting, identification of those in need of mental health is actually a distinct challenge. We address it through door-to-door visits by trained community health workers within the neighbourhoods and informal settlements where we implement. And as you can imagine, this requires manpower and time.

Through these visits our community health workers provide awareness and identify individuals to refer to our social workers for follow up. In parallel, they are also taught about the pathways to access our mental health services, by also going directly into the primary healthcare centres.

When an individual is individual is identified as in need of services, our social worker will assess each case and determine the level of mental healthcare required. This could be provision of one to one psychosocial support sessions through social workers at home, could be specialised one to one psychotherapy with our psychologist or it could be psychiatric care to be provided by our psychiatrist. And then the patient is subsequently enrolled in our mental health programme which is our step three, and of course during step three, we're also setting the schedule for the service provision with each patient.

And then this leads us to step four, which is the provision and continuity of the service, until we can consider the case to be closed. There's actually no formula for how many sessions will be provided to each patient. It's very much dependant on the needs of each individual and on a case by case basis. But we can say it usually ranges from between five to ten sessions.

The supervision by the psychologist and the psychiatrist is done at the primary healthcare centre in a safe and private environment, and we are also therefore working with the government public healthcare centre in coordination with the Ministry of Public Health and I just want to highlight here that through our approach, we really are not only coordinating with the Ministry, but we are also ultimately helping to strengthen the Ministry's approach.

In exceptional cases, we do provide sessions at home in the case where a patient's mobility is limited. So here you can see the most common mental health issues that we're seeing through appointments which I am sure have a lot of similarities with other humanitarian context. Post-traumatic stress disorder, depression, anxiety, sexual abuse, threats of suicide. And in our caseload

in particular we're seeing about 48% experiencing anxiety, about 37% experiencing depression, and so that's the majority of the symptoms that we are seeing. But just to highlight here that most of what we're finding with our patients, the conditions do not come alone. So there's often compounded issues and of course, again, each case is quite unique.

So through our several years working directly with patients, we've just come up with some lessons learned, specifically when we're dealing with patients. And just mentioning three here. So first the brief psychotherapy. We learned that it's important to keep the sessions as focused as possible and minimise the number of sessions so that the problem can be addressed quickly and to mitigate the risk of the patients discontinuation from the programme. Secondly, which I know is quite obvious, but it's building a good rapport with the patient. And it's just important to highlight because the patient really needs to feel comfortable with the mental health worker, so that there can be an honest communication channel in order to have the best results.

And then finally we learned that sessions should include a focus on tailored plans to enhance the patient's ability to stay as resilient as possible, and to build their coping strategies for the future with the cards and tools available to them, with support of a psychologist. So people can better cope in the future challenges they face, and it also will help because they can contribute with the knowledge and tools that they've learned to cope and impart that to their family and their neighbours.

So I am just highlighting here some of the key challenges that we face in implementing our programming in an urban context, which I think has its own set of unique challenges. So firstly, there's the stigma which we have mentioned before, and we believe that actually operating in an urban context will exacerbate this issue of stigma, because going to the centre to seek services can not easily be hidden. Through the awareness sessions by RI and efforts of other actors, we have seen some of the stigma improve, especially for refugees, but we're having a more challenging time with Lebanese.

Secondly, because one to one specialised support from psychologists and psychiatrists is offered at primary healthcare centres in communities, for many this can pose challenges that would not be faced in a formal refugee camp setting with staff in the homes to help facility when the refugee camp is clear.

So in the urban setting, individuals must pay for transportation to reach the centre, and in many cases this is really an additional burden for the extremely poor households that we're working with. Also patients may have difficulty getting to the centre when there are extreme weather conditions, or there's protests that block the road, and in Lebanon this actually happens more frequently then you might expect.

So we do mitigate these access challenges by ensuring that the primary healthcare centres where our psychologists and psychiatrists work are in relative proximity to areas where we're providing awareness and the link between the community health workers and the centres is clear. However, there are some cases in some areas of the country where this is more challenging, and in those cases we will do our best to refer to other providers if available.

A third challenge is the lack of availability for clinical psychologists and psychiatrists, especially living outside of the capital Beirut. Especially as most vulnerable populations are living in other parts of the country. So for RI with our mental health programming, it's currently focused mostly in Beqaa in the North, and this is a minimum of a two hour drive from the capital. Often it's actually longer depending on the location, and to manage this challenge we actually don't have a one size fits all approach, and we try to be flexible, and it depends very much on the individual that we're trying to hire.

So in some cases it could be that we're supporting their relocation to be based in other areas of the country, and in other cases it could be that we're just providing daily transportation from Beirut to the field locations. But in both cases, it does require additional financial resources.

A fourth challenge which I think is felt by all, is really just the sheer volume of need compared to the capacities available. So it's really a nationwide issue experienced by all mental health providers, and a good example is with RI's programme, currently we have over 200 patients on our waiting list, and we know that this number could actually go higher relatively quickly.

So a final challenge I just want to highlight within this presentation is the difficulty for NGOs to secure reliable funding and support of mental health. I think in some cases donors still see this intervention as an add-on, or something that we can integrate within other programming. And of course we agree that mental health should be included to the extent feasible within any humanitarian intervention. We do also want to advocate for really a well thought out approach to ensure that the provision of the specialised care that is needed is actually available. And this of course requires resources. So there was the cost of the highly specialised staff, cost for the transportation, the cost of supplies to work with our patients, and in addition, we find the support for mental heath so far is mostly linked to humanitarian donors, which really provide more than one year of support at a time, and often it's less, and the short nature of the programming does pose challenges for the timelines of our caseloads, and it can also complicate our relationship with donors, because we don't have assurance of a more long-term presence.

So just to wrap up, I just wanted to leave with a few key takeaways. The first point is really just highlighting and underscoring the importance of mental health in humanitarian response. Having a foundation in mental health really does underpin the success of all other aspects of an individual's life, including feeling well and physical health relationships with family and community, success in the classroom, ability to earn income, and other needs of course, and as such mental health is truly a component of primary health and it should be prioritised as a key humanitarian intervention provided to vulnerable populations which will also support the success of other programmatic interventions across other sectors.

So it's not only good for individuals, it's also important for building healthy societies with performing economies and communal security, because a significant portion of the population is suffering from mental health issues, it will have a ripple effect on the society at large.

The second point I would like it highlight is that mental health should support existing systems and structures for sustainability. Especially in urban contexts, mental health programming should

not be implemented in a vacuum, and it should be linked to and in support of existing health structures within the country.

So in the example of Lebanon, the Ministry of Public Health opened a mental health department in 2015 and our programming is designed to fit in and also support the strategies and policies being put in place by this new department and ensuring the needs of vulnerable communities are being addressed. We believe that it is the responsibility of international NGOs operating in urban context to contribute to strengthening the national systems in order to support the overall sustainability of mental health service provision within the confines where we're working.

And finally, I just want to I guess reiterate about the resources required to implement mental health. Of course it can be implemented in any context including urban settings, but to do it thoroughly, we really need the resources to support it, and because the outcome of mental health programming is not as visible for lack of a better word as some of the other interventions in the humanitarian space, we can often be overlooked for donor support. I will say there have definitely been huge strides in the right direction within the humanitarian community within this regard, but I do think we have a way to go.

Thank you all.

Leah Campbell: Great, thanks so much Valerie. That was really interesting and we already have a bunch of questions coming in. So I wanted to ask you one specific one about your presentation before we go to something more general. We had a couple of questions about the relationship you just mentioned in your takeaways again there with the public health ministry or department in Lebanon, so the question in particular if you could elaborate maybe a bit more on two parts.

What sort of capacity building support do public health authorities in Lebanon need, basically what are the gaps that you've identified in terms of capacity building support required by those authorities, and how did you go about building the relationship with Public Health and did you have any challenges in doing that and how did you address those?

Valerie Rowles: Thank you, that's a very good question. If I may just-, a little bit of additional context for the Lebanon-specific. In Lebanon the public health system, when it comes to primary healthcare, the primary healthcare centres are actually, for the most part, there are a few exceptions, but for the most part they are actually privately owned. And they are enrolled in what's called the primary healthcare network. The primary healthcare network is for those centres that meet the criteria to be enrolled and from that, then they benefit from the services and the support of the national ministry.

So of those that are enrolled, there has been a movement from the Ministry of Public Health, with the creation of this new department for mental health support, to integrate mental health within those centres that are enrolled within the network. I mentioned that they're rolling out-, they have already rolled out the MH gap, and by doing that, they're actually training the medical care workers within the centres on safe identification and referral for those who might need additional mental health services.

Ideally, each primary healthcare centre actually would have the psychologist on staff, and what we find is a major challenge is that many centres cannot afford this, and so for example, the psychologists and the psychiatrists that we have on staff as RI, we've threaded them in the centres but they are actually RI staff. So I think that one of the main challenges is honestly just a lack of resources to staff, appropriately those primary healthcare centres that are within the network.

In terms of relationship building, to be honest, the Ministry of Public Health within Lebanon has actually-, they've been quite welcome to working with NGOs where it can support any gaps, so it's really just been a matter of direct coordination, specifically in the case of mental health, with the national mental health department, and we've actually had some just really good, open dialogue and understanding about the direction that they want to go and how we can support that.

Leah Campbell: Great, thanks. And I wanted to ask you one of the other questions that's come in that's a bit more broad in terms of relating to all different sorts of marginalised groups, one of the questions that's come in is is there a different between hidden groups in an urban context or any humanitarian context even, hidden groups who maybe don't want to be seen and invisible groups or individuals, people who are unseen by external actors, but perhaps very much hoping that their needs might be seen and met, and is there a difference between them and how you can support each of them? Do you have any thoughts on that one?

Valerie Rowles: Sure. So I will say that there can be a difference, but not always. So it depends on the case. So we do have people in need that are invisible within the urban context, and not always easy to locate. In the refugee context, they may or may-, these would probably be the Syrian refugees that are not registered with UNHCR, so they're less easy to locate. But that doesn't mean that they don't necessarily want services.

There are some however that do not want services, and they choose to remain hidden. I think that as humanitarian community, for those who choose to be hidden and they do not want to benefit from services, that's their right, but I think we need to make sure that they are aware of what is available, so that they do have access to them in case they would like to. So I would say that the approach for both within the context of our mental health programming is actually similar because what we do in terms of outreach is on a door to door basis. So we are talking with communities at large. Those who want assistance and those who don't.

In addition, because we are ensuring that the populations that we work with are aware of access to the primary healthcare centres as one of the key avenues for just directly accessing mental health services, those who choose to be hidden, if they decide otherwise, they can always approach the centres as well directly.

Leah Campbell: Great, thanks for that. So we're going to turn now to our second speaker, Katie, who is going to tell us a bit more about IRC's work supporting LGBTQ individuals in El Salvador. Over to you Katie.

Katie Susman: Great, thank you so much. Thank you Valerie for that very interesting presentation and thank you all for being here. So today I am going to tell you guys a little bit about how we reach marginalised populations, specifically in El Salvador and how we can start where they are.

I want to set the scene a little bit. In El Salvador we have around 8 million people. El Salvador is about the size of Connecticut and it's a very small country. It borders Honduras and Guatemala and has a long coast with the Pacific Ocean, and it really has a very interesting history. In El Salvador it's gone through a civil war that lasted for 12 years, and really the population, especially the older generations, are very traumatised and there's a lot of intergenerational trauma that sort of is pervasive throughout. They've had quite an interesting turn in this past year, with a new president who is named Nayib Bukele and he has brought sort of a very progressive, young voice. He's a young president and has kind of shattered the typical bipartisan politics that were within the country for so many years.

Unfortunately, there still is prolonged violence and internal displacement, and it's not really seen as your typical humanitarian crisis, and this really goes for all of Latin America, but specifically in the Northern Triangle, or Northern Central America, as we are now calling it, and in El Salvador, you see this violence that's been occurring for years, that has gone from a civil war to armed groups, gang control and effects of long-term narcotrafficking on the population, and unfortunately up until just about two years ago, did even donors or academics start seeing this as a humanitarian crisis.

So what do we do in El Salvador as IRC? The International Rescue Committee in El Salvador sort of is an anomaly in the sense that we are pure protection programming. So we came into El Salvador and we really saw that there was a need for access to information and services. We run an access to information platform, which is called CuentaNos, and it's an area where we have georeferenced services and then have a space where we provide information three to four times a week and are constantly updating that. And then we also have a two-way messaging service in which people can talk in real-time via WhatsApp with a live moderator regarding their needs and that either then turns into some crisis referrals or into giving them the information about services that they need.

We do capacity building with local government, specifically in sort of applying this protection principles. There's a very rich history in Latin America and specifically in Central America about the local civil society. Lots of local organisations doing amazing things, and really a lot of them have come out of responding to natural disasters or responding to more of a development context. And so trying to sort of put a spin on what they're doing and apply some of the humanitarian principles and protection principles specifically and having them look beyond and sort of the surface and see that the violence is also a humanitarian need and crisis.

We do safe spaces specifically for the LGBTQI population and for women and girls. We also provide rapid support through humanitarian cash assistance in a sort of innovative way. Our focus here in El Salvador, specifically in the urban area San Salvador and some other cities is on returnees and particularly vulnerable populations and for us that means women and girls and LGBTQI population, and when we say returnees these are typically from the United States or from Mexico and they've been deported.

So I am going to tell you a little bit about CuentaNos, this is the homepage just so you get an idea of what it looks like, and what it has to do with the current situation and why we chose to come in

and not provide direct services, but rather fill a gap that we saw within the space in El Salvador. The current situation specifically in Northern Central America in this past year, there's been more than 712,000 internally displaced people in a very small geographical area. And when we say more than, it's because we know that the statistics and data that we have is very little. Unfortunately because it hasn't been considered a humanitarian crises, we have very little data to work with and just now are we getting sort of more involvement from the United Nations and UNHCR in trying to count that number. We are also just now in El Salvador getting support from the government in even recognising that there is an internally displaced population. In December, the president Bukele finally passed the internally displaced population protection law. Before the government would not recognise that there was this population, they just called them internally moving population, rather than recognising that they had this population within.

And then we see more than 500,000 people fleeing North a year. So if you think about a population of 8 million, which albeit hasn't been updated in several years, because they go by census numbers, but that's quite a large number going North a year. So this sort of complex needs and sort of mandate a transformation and creative rethinking in what a humanitarian response looks like, and we couldn't do the typical humanitarian response that we may do in other crises. And that's what brought us to setup this interactive user inputted information platform, because we found that in times of crisis, people are desperately in need of information about where to go and how to access those vital services. Up until now we've had over 208,000 page views, 7,017 users and 17,092 sessions.

So when we talk about the vulnerable population in El Salvador, we are particularly focused on LGBTQI population, especially trans women and we get this question a lot as to why do we focus on trans women. Trans women have an average live span of age of 33 in El Salvador. So the amount of people that are killed or die violent deaths within that population, 68% of them are homicides of trans women, and so we really know that they're the most vulnerable because they're the most obvious and they can't hide as well as other populations within the LGBTQI population, and that really makes them a target in a very machista society.

People living in gang controlled areas, now all of El Salvador is affected by gangs, and I'm going to talk a little bit further on about what that means, gang controlled versus gang affected. Women and girls. It's not a coincidence that trans women are the ones that are most vulnerable within the LGBTQI population. Women and girls are especially vulnerable within El Salvador as well. Unfortunately the rights of women and girls are also still very remedial in terms of being able to access sexual reproductive healthcare, really being able to have a full place in society, but if you would look at it from a superficial level, it wouldn't look like that, so it's something that's very normalised.

And then we look at returnees and their families. Returnees and deportees, even their families, are a special risk. These people are usually coming back not at their own will from the United States or from Mexico and they are specifically under threat because a lot of them left because of potential threat for their life. Many of them left because they were being forced out of their homes by gangs, or they were being extorted and if they didn't pay up they were going to get killed. So it really puts them at higher risk. And then there's also some very cultural interpretations around returnees and

deportees. Many people perceive them to be less than. They perceive them to have some sort of gang affiliation, and so then it's very hard for them to get reintegrated back into the urban society. Some of them come back after five years, some come back after 35 years, and with nothing but a backpack.

And then we look at the internally displaced population. We know that once a person or a family is internally displaced within El Salvador, they are exponentially at risk to be displaced again and again.

So I want to do a quick poll with you all and I want to find out what you think about the access to internet and technology, and you're going to see why I am asking this question later on. How many people do you think have consistent and reliable access to internet in El Salvador? And it should be interesting what you all come up with here. Okay, so the majority of you think 15%, and then 60%. Those 60 percenters, you got it right. Yes, 60% of people have consistent and reliable access to internet in El Salvador. This is quite a dichotomy because we do see that the average El Salvadorian only has 6.8 years of education, so we know that people are connected and we know that people have the technology to be able to get connected. 95% of people that answered a recent needs assessment that we did have smartphones. 95%. And so that's very abundant in a population that has a relatively low education rate. That just kind of shows us how much they rely on technology to create their community.

And then we specifically found that discrimination, exclusion and poor treatment really dissuades population to seek services, especially the LGBTQI population. This community is very closed and it's closed because they are protecting themselves, and so if they feel like there is any threat or any risk to their safety or wellbeing, they chose just not to seek those services.

And then we also found that social media is actually the first place for hidden populations to turn to for information. So this is quite interesting, because even in some of the more rural areas, we know that urban settings that make a little more sense, but this is in general in El Salvador we found that Facebook is one of the biggest resources that people use to find their information. And then we also found that safety is absolutely key for people to seek information and services, and we're not just talking about physical safety. Yes, that's a very real need in El Salvador, but also emotional safety. Feeling safe.

So I want to talk a little bit about what are the barriers. So we know the needs, but what do we have to do to get across these obstacles that we have? And some of these barriers are just very rooted within a society that has normalised violence. Violence has existed since people were born and maybe for the older generations it existed in the form of the civil war and now it's turned into gang-related violence, but it's a part of daily life. People have figured out how to manage within those restrictions of normalised violence, and if that means that they are restricted to invisible borders within their community and they can only go within a few blocks radius because they know if they cross that invisible border they could be potentially killed, that's what they do, if that means not going out after 7:00pm or not taking transportation after a certain hour, or just knowing that whatever you're carrying at any time could get held up by gunpoint, that's just something you life with. That causes a lot of fear that builds up, that really builds up in the population, and a lot

of mistrust. And so in El Salvador you will find that people will be very hesitant to share information with you. And that's because they're protecting themselves and they are protecting their families, because that's one of the main ways that gang affiliated groups get their targets in terms of extortion particularly.

There's a lot of stigma and that stigma is strong. There doesn't need to be a physical barrier for returnees and deportees specifically. That stigma is strong enough for people to be confined to their house and not leave to seek services, to seek psychosocial support, to seek employment. There's a lack of resources, right? El Salvador still has very high levels of poverty. So that is a real issue that sort of comes across with the high levels of violence, and the lack of knowledge of services.

Finally this population in particular is a moving target. We know that our population, our target population is always moving, and that means because they're consistently displaced, they're consistently having to move locations, and so it's a harder population to be able to reach for purely logistical reasons beyond all of the more emotional security reasons and trust.

So I wanted to just show you an example of what we're talking about when we say invisible barriers. Here you see a map just of San Salvador and this is just showing the control that the armed groups or gangs have within the city. You can see that all of the coloured in areas are gang controlled, and the areas that just have a coloured border are gang presence. So when you have a gang controlled area, the people living in these areas have very tight norms, and restrictions. They know who is the leader and they're not your typical community leaders. Their leaders are the leaders of the gang within that area. And you have to work within the confines of whatever they setup as the norms within the community.

And that becomes quite complex when you're talking about internally displaced people. If somebody is being threatened in a green area, they may not be able to go to an orange area, and if they're being threatened in a blue area, then they can't go to a green area. Because then they could become a larger target for that other gang. And this is just very representative of many municipalities within El Salvador.

So what is our conclusion? Our conclusion is that we cannot fit a circle in a box. It's just not going to happen, so we need to really reimagine what our interventions as humanitarian responders are going to look like. So that brings us to the conclusion that we need to start where people are. We aren't going to have the luxury to be able to have the people there and have them trust you to provide them services day *una* as we say in Spanish, right away.

So what does this mean to start where people are? Starting where people are means that we need to start where they are physically and also emotionally, and give them the space to be at the centre of the intervention, to really lead it and to give us the idea of what's the pace we should go at and where do they want to receive services.

And how do we do that? Sort of what have been our lessons learned in doing that, how have we been able to achieve that and how are we continuing to do so? For IRC El Salvador we have utilised diverse entry points, so that means that we really have supported ourselves on trusted partnerships

and the first thing you have to do is listen. You listen to those partners and they may not be your typical partners, you may need to talk with the women that work in the local pupuseria, or the people that are doing sort of work within that particular community, rather than just organisations and know that particular marginalised groups have trust in others that may not be your go-to CBOs. So really listen to who they are and what their experiences are to learn what works for them in terms of providing services.

And that brings us to mobile programming. So we know that static programming specifically for this population, it has a lot of challenges. One is being able to really reach scale, reach the amount of people that you would like to be able to reach, given all of the security challenges and movement, free movement challenges that we experience in El Salvador. And so really looking at innovative ways of how can we bring the programming to them and that is quite difficult at times, because you have to balance that with also taking into account safety and security for staff, for volunteers and for your own personnel.

And we do that through some unconventional programming. Really focused on places where people already go. Where do people already go on a day to day basis? A lot of women in El Salvador may go to their beauty salon and they may not go there because they're getting their hair done, but they go there because they want to share with other women. They may go to the local pupuseria or local eating joint and many of them still go to remittance agencies to pick up remittances so that's something that we used as a lesson learned for our cash programming specifically, rather than providing cards or putting people at risk by providing cash, we used a mechanism that was already there that people were already using, already knew, already felt comfortable with and really just used that and so we provide our cash support through remittance agencies where they can go and just pick up the money.

And then we also have to look at sort of really diving into strong while safe social media outreach. We know that this particular population especially the LGBTQI population, they are very insular and the way to reach them is through social media first. I recently was peaking with a trans woman and she said, "We find our friends online, we find our partners online. It's only natural when we are in crisis that we seek support online," and so that really resonated with me and I think that's something that we are continuing to always do now.

And then we have to provide communication mechanisms that are not sort of programme driven in terms of our idea of who is it, we want to know about them, what's the demographic, but providing anonymous communication mechanisms that really puts the needs of that population first, rather than the needs of us wanting to collect information about that population first. So we do that via WhatsApp, a lot of other ways that that can be done as well. That's just the platform that Salvadorians tend to use.

And then bringing information and services to their fingertips and taking out that middle man. So typically Salvadorians to be able to get information or services they would have to go to an organisation, ask, or go to a government entity and ask and just to be able to go there and ask creates a lot of barriers for them. So really bringing that to their fingertips, online, they can go and look and allowing it to be directed by current events, needs and available services. So constantly

changing, constantly updating and validated. So not just a typical sort of service directory, but something we have gone and visited over 120 service providers, 1,200 points of service, and really knowing that where you're looking, it's trustworthy services, and then allowing them to also participate in creating information. So we do three to four articles a week on the CuentaNos platform specifically regarding current needs for the population, and that's absolutely dependant on what kind of questions we're getting via our two-way communication mechanism, as well as what we're seeing on our social media that are their needs at this moment.

So that's what I wanted to share with you today and I really just want to emphasis the need to start where the population is within urban settings with particularly marginalised groups, and starting where they are is the way to be effective. Thank you so much.

Leah Campbell: Thanks so much Katie, and I have a couple of questions to follow up with you and then we'll kind of evolve the rest of the session into a Q&A and bring back Valerie's thoughts as well.

The first question that I have following your presentation that someone has submitted is can you talk a little bit about any partnerships that IRC have built with the local authorities in El Salvador and how helpful those may or may not have been for you.

Katie Susman: Absolutely. Yeah, partnerships particularly with the local authorities have been key. And that's because we know outside of San Salvador, we know that the local authorities are those that have the power and have the word. So if we get them on our side, and when we're talking about local authorities, we're talking about municipal level, we have worked at the country level in each department and with municipal actors hand in hand, and so everything that we do particularly with CuentaNos and with some of the communication campaigns and things, are really led by them. And really pushing them to involve these more hidden populations and recognise that they exist and building up their capacity to be able to provide services and response to them in a safe and differential manner.

Leah Campbell: Thanks, and then another question going back to the context you described around El Salvador and the conflictual context that it is, we have a question around kind of coexisting in an environment which is gang-controlled or gang-accessed, and how do you kind of maintain that coexistence without getting into conflict with the gangs?

Katie Susman: That's a good question. So coexisting, it's a very fine line. Typically people that have grown up in these areas, they know each other, they know the gang members, they may have grown up with some of them. And so a lot of them don't see them necessarily as a threat, which is quite interesting. Some of them even see them as a leader within their community, or somebody that's brought some sort of positive change within their community, and that's how gangs really gain control by also gaining buy-in from people within.

But it's a fine line because you have to know what you can do and what you can't do. You have to know where you can go and where you can't go. And you have to follow the rules. If you don't follow the rules, then you are subject to being ousted or to violence. And one of the most common sort of techniques is threats, right. And those threats are definitely made real and using people

close to you and surveillance of movement, etc. So, you know, I think people get by by being quiet, not looking, making sure that they keep to themselves as much as possible, and that definitely does have long term mental health implications.

So coexistence, while it sounds not so harmful, it really is, because it's a forced coexistence. And this is particularly damaging to small business owners, or people that are working in informal trades, because if you work within that territory you have to give a percent of what you make to the gang. If you don't pay then you are in potential risk of being hurt or your family being hurt or killed.

Leah Campbell: Thanks Katie. One more specific question about the particular marginalised group that you've talked about, before we get into the more general questions. Someone's asked if you could talk a bit more about what the housing situation is like for LGBTQI people in El Salvador because from their own work, they found that this is a particularly concerning area for this vulnerable population. Do you have any thoughts about that in particular?

Katie Susman: Absolutely. That is a very good question. The housing situation for this particular group is not good. People, if they have the ability and courage to be able to feel safe enough to come out to their families, many of them are ousted and that means being ousted from whatever home they live in, which may not be the most comfortable or affluent place, but they have a roof over their head.

Unfortunately, this puts this particular population, especially trans women again because of just the notoriety of being able to know that they are a distinct population at risk. Many trans women particular start working in sex work, they start working on the streets. They start trying to make money for themselves in what they can, and that might mean going through some really negative coping mechanisms to do so.

And then we also just see a lack of reliable shelter here. Because of the urban population and also because of the lack of trust, most of the shelters that do exist are very closed and they're not accessible after 5:00pm until 9:00am the next day, and if it's a weekend, well you're out of luck. So you tend to see a lot of this population on the streets as well, if they do get kicked out of their homes and they're not taken in by a friend, and it just puts them at more risk for potential exploitation.

Yeah, unfortunately we have the same problem here and there is not an easy answer. I know many organisations have been interested in doing a specifically trans sort of targeted shelter and what a lot of them have come to start doing is just giving out subsidies and that's something that some of our cash programming is also supports with, where because there is so little amount of shelters that are really accessible for this population, they're not-, a lot of trans women are not allowed in the general shelters because people don't consider them men or women, and so they sort of are ousted from both specialised areas and so what some organisations have started doing, and we have done is same, is giving out cash transfers specifically for supporting with shelter or housing, and that typically looks like a motel or something of that sort.

Leah Campbell: Okay great, thank you. So we will move now to some of the questions that have been asked both when people registered and those coming in now that talk about this kind of topic overall, because obviously each of your presentations have addressed a different marginalised population, but I think there are a lot of similarities of the experiences of marginalised people and there are obviously other marginalised groups that we haven't talked specifically about in the webinar today.

So the first question I will ask each of you and maybe I will turn to Valerie first and then get your thoughts afterwards Katie is how do you find who is representative of a marginalised group, especially if these individuals are hidden and not necessarily easy to identify, how do you know if you find someone who belongs to that group if they might be representative of that group, or if you've just found a one-off opinion, especially considering how much it's important to try and engage affected people throughout the humanitarian programming cycle, how do we find representatives of marginalised groups? Over to you Valerie.

Valerie Rowles: Sure, so just in general, how we find somebody who would represent a vulnerable group, I mean the first tier of vulnerability or marginalisation we can look at economic vulnerability. So when we're targeting those locations, we can know by location, which would either be by neighbourhood or by the settlement in which they are living, if they have economic vulnerability, and of course then there's other layers that add to that vulnerability based on the group that they're a part of. So it could be that they're elderly, it could be that they're children, it could be that they're disabled, it could be a number of factors.

When it comes to representatives in sort of the group setting, in terms of who would represent as a group, it really will vary based on the setting. So in sort of more of the informal settlements, you will find usually in Lebanon what they call a *shoesh*, which is basically a representative that's nominated or appointed by the community itself that might represent themselves to the humanitarian community, and we do work with those individuals to ensure that they have an awareness about the importance of what our programming is, although we actually do work directly with the individuals within those communities, and not just with representative.

In other circumstances, it will be, for example, the nominated representative of the collective shelter, or it could be a prominent person within a neighbourhood, if we're talking about, for example, an apartment building or a neighbourhood. And then of course you also have potentially, again, depending on the specific context, a local religious leader or a *makhta*, a local authority but on a very local level, so it really will just depend. And we do think that working with these people as well is really important. It really helps in terms of ensuring that we're addressing the reduction of stigma, and basically facilitating the need and access to primary healthcare centres where it's relevant.

Leah Campbell: Thanks Valerie. Do you have any thoughts on that one, Katie?

Katie Susman: Yeah, I would just say particularly for the LGBTQI population here in El Salvador, we have to dig deep and go beyond sort of the big names of people that we know work within the field, or organisations that we know work within the field and really talk to people on

the ground, and I think that's where you'll find out how-, if somebody's voice is really representative of the majority of the population.

There's a lot of layers of complexity within that. We found that a lesbian woman in El Salvador may not feel comfortable with a trans man, and they may not have a lot in common, so their community representative may not be the same, so don't assume. And really try to talk to a diverse set of people within the group and know that experiences can't be prescribed. One person's experience can be very different from another's, depending on what their sort of social support network looks like and particular experiences have looked like.

And I would just say, typically in El Salvador with other populations, you would be able to rely a lot on the religious, on the Catholic church, the evangelical church, because they have a very strong presence in the community. Unfortunately with this particular population, that's not a community representative that you can really trust, particularly because of a lot of the marginalisation that they themselves have done. It's not an actor that the community really sees themselves in.

So I would say it's not going to be just one community representative and I think we need to be okay with that.

Leah Campbell: Great thanks. Going back to you Valerie, I wanted to ask you one of these questions that was submitted by someone who registered for the webinar. Do you know of any sharable examples where crisis response has been linked to sustainable solutions for particular marginalised groups?

Valerie Rowles: Sure. So I think actually Lebanon provides a good example of where there is a direct link between humanitarian assistance and sustainability. In many circumstances, again to the extent possible, and that's because all of the refugees, and again, speaking specifically about the Syrian refugee context, are living within the communities within Lebanese communities, and so the services that they access are also services that are available to Lebanese, whether that be in mental health, also education, also when it's possible work, so the informal economy for refugees.

So by the engagement that we have as humanitarian actors with the government, we are actually in a process where we're supporting humanitarian needs, but simultaneously actually building the capacity of the government to respond and also win and if the Syrian refugees do leave, they will be at a more strong position to serve their own people which also have vulnerability.

So there's actually a number of examples. When it comes to mental health, since we are focusing on mental health with RI's presentation, I think similar to what we were mentioning with one of the earlier questions, because we are working actually within the primary healthcare centres for our psychologists and our psychiatrists, although we're doing the community health outreach, we're also finding as our programming has gone on, we're actually finding an increased number of patients that are coming without having received outreach or awareness from us, seeking mental health services. So we believe that this actually is demonstrating that what we're doing is actually having a sustainable impact beyond just directly with the patients that we're directly targeting.

Leah Campbell: Great, thank you. And Katie, especially given you already mentioned about your work, engaging with local authorities and also things like religious authorities, do you have any

thoughts about the role that humanitarians might be able to play in advocating or engaging with these authorities who, in the case of, for example, LGBTQ individuals, may actually be taking actions that exacerbate marginalisation rather than addressing it? Is there a role for humanitarians in this?

Katie Susman: Yeah, I think there is and I think there has to be, especially in Latin America. You can't do this work without doing advocacy at the same time, and it's a bit of a sort of non-traditional marriage, because humanitarian work, you don't necessarily think of advocacy and policy sort of influencing at the same time. But I think specifically in the Latin American context, you have to. And you have to do that in a very subtle relationship-based way.

So I think finding that person within the particular institution that you know is very committed or interested in a particular topic, and they may not be, for example, in agreement with trans people having access to an ID that has a new name on it, and says a different gender, but they may be open to dialogue, and I think it's finding that right person within the institution or governmental organisation with who you can start that dialogue and relationship, because it's particularly in Northern Central America, relationships are everything. If you can make a relationship with somebody, then any sort of advocacy or a change that you would like to do on behalf of a population or involve them in being a champion on a particular issue is much easier and feasible and they'll consider it because they have a good relationship with you or your organisation.

Leah Campbell: Great, thanks. I know we're trying not to focus on coronavirus here today, but we have inevitably had a few questions submitted about the relevance of this topic, you know, with this unprecedented pandemic that the world is now experiencing. So there is a couple different angles to this and I am going to combine them together and then ask each of you your thoughts.

So in a situation like this where so many individuals in each country that's affected by coronavirus will be visibly in need, how do we meet the hidden need of the marginalised in this situation, and is there a risk that marginalised people can be left further behind as a result of something like the COVID-19 pandemic, and what can we do about it?

So I will turn first to Valerie and then I will go over to Katie for your thoughts on this one.

Valerie Rowles: So COVID-19, it's the hot topic. Just to say in the context of Lebanon, and I know it's sort of happening worldwide, but we in Lebanon, we actually had our first case on February 21st and we've been experiencing progressive shutdown, and basically since mid-March we have been sort of in a lockdown mode, and that includes lockdowns within municipalities which does mean that access to refugee populations is becoming more difficult. And that's for vulnerable populations in need.

In addition, because of the lockdown, we know very much that the economy which is already suffering will also be taking an extra blow, and again I know that is happening worldwide, but in Lebanon we know that that's going to be impacting the level of vulnerability, is going to be spreading. And certainly, those who are already vulnerable will become even more vulnerable.

So as a humanitarian community, we are doing our best to look at alternative modalities to reach those in need. When it comes to our mental health programming specifically, we are continuing

with our patients via telephone, and we're ensuring that we're having regular follow up with each of them, and one of the things that we're doing in addition, is we're making sure that we actually will not be closing any cases during this period.

So the mental health support will be ongoing until the lockdown is removed. This is because we do recognise the additional stress that's being caused and we don't want to leave any of our patients, even if their initial issue that they're seeking support with has been addressed, we want to make sure that we are continuing that support.

There are other modalities that are being looked at in other sectors. Of course again, the issue of access is very difficult because NGOs do not have permission to go around the country unless they have specific mandates specifically for example related to health, and WASH. So there are a lot of challenges that are being faced in terms of remote implementation. So it is something that is evolving and it is fully recognised that we expect the level of vulnerability to increase quite significantly over the coming months.

Leah Campbell: Thanks Valerie. It's really interesting to hear what specifically is happening in Lebanon and your thoughts on this. Over to Katie for any further thoughts you might have.

Katie Susman: Yeah, so specifically in El Salvador, it's been an interesting progression in that Nayib Bukele the current President really responded cautiously, which I think he's being praised for internationally. He put very strict measures in early before cases came out and similar to what Valerie said, we've also been on lockdown, except for essential services since middle of March.

And I am going to focus particularly on the deported population. So many may not know this, but the deportation flights of Salvadorians to El Salvador to the United States have not stopped. Mexico has stopped deportations temporarily. But particularly the United States has not stopped them. And so this is creating quite the conundrum within the country as quarantine centres grow, there are now over 80 quarantine centres in the country with over 4,000 people in them and there are six of those quarantine centres that are specifically for deportees, or returnees, to El Salvador.

So a very different demographic that you are seeing in other quarantine centres, where maybe they had travelled by will outside of the country and came back. And so essentially many of these people are going from one confinement situation to another. They may have flied El Salvador because of confinement within their own home because of threats and violence, then went to the States, got put into a detention centre and then come back into a quarantine centre.

Obviously for public health reasons, it has its advantages. Unfortunately these deportation flights are sort of now being used to bypass due process for asylum seekers. And we also know that particularly because of these restrictions that the government has put into place, 95% of services have been closed. So those that are particularly vulnerable people, women, girls, the LGBTQI population that may need particular services may not be able to get them right now.

We have continued our CuentaNos platform, we've continued our cash provision, we're also doing some support within the quarantine centres that are dedicated to deportees, but we know that this further complicates things and is kind of importing still the virus back to the country, and not necessarily considering the ramifications it could have for El Salvador and I think it's going to

continue to get more complex, and we're going to have to look at how we can reach that particular population as well once they leave quarantine centres.

If they were already a population that was hidden and difficult to reach I think this puts another layer. We also don't have permission to mobilise within the country, given that we're not a health responder particularly. So we're looking at sort of different solutions and really building upon the use of technology and two-way communication mechanisms to provide support to our partners, as well as to the population in need.

Leah Campbell: Great, thanks so much to you both. Because we only have five minutes and I know some people have to head off to go to their next meetings, I will just say that when you leave the webinar a survey will come up. It's only a few questions. If you don't answer it you will get a reminder by email tomorrow. Please do share your thoughts and tell us what you thought of the webinar, because we find this feedback really valuable in planning future webinars, and thank you all for joining us.

We still have a couple more minutes so I am going to turn back to each of our speakers to hear any final thoughts you might have, perhaps if you can think of maybe one thing that you would want people to take away when they maybe go forward and consider working with the marginalised population that you work with in an urban area, is there one thing that they should definitely not forget.

I'll turn first to Valerie for any closing thoughts you might have.

Valerie Rowles: Sure, so thank you. I think my closing thought is rather basic and maybe obvious, but it's just something I really want to stress, and that is the importance of mental health. It really, really should not be overlooked in the interventions that we're doing and with the populations that we're working with. They're really under high levels of stress, many of them again have experienced traumatic issues. So I think it's really important for us to, while at the same time us as humanitarians are obviously meeting their basic needs when it comes to other primary healthcare support, when it comes to for example cash assistance, so meeting some of their basic needs, education provision, all of the other things, WASH, food, really mental health needs to be also on the top of that list. So I would just like to highlight that.

And I think that with the COVID-19 situation that is happening, the mental health needs will grow considerably, not only with those who already have been identified as in need of mental health services, but a growing population because it has put all of us under stress and particularly those that have less financial resources or find themselves within a more vulnerable situation, are going to be under a great deal more of mental health issues. So that would be my closing message.

Leah Campbell: Great, thanks very much Valerie. Over to you Katie.

Katie Susman: Yeah, I think I would just emphasis to start where they are. Don't assume that we know best or that we know what the needs are for particular populations. Don't group them together and really do your due diligence and ask and speak to diverse sects of the population before even designing programming and I think that really sort of hits home something that we talk a lot about in the humanitarian sector, as well as the development sector, that things need to

be co-led or co-designed and feedback mechanisms are so important. But I think that it's really a time to put that into action, and let some of these projects and programming be really led by the person of interest.

And then finally, I would just emphasis, build programming around these rather than trying to fit our programming into a specific context, go into the context, explore the context and see what it tells you, and that might mean being uncomfortable at times, that might mean having to try out new technology or new ways of doing things, but I think that's where we see the breaking point, I think that's where we see learning and I think that's where we really can create new evidence in terms of what can work for urban populations, especially marginalised groups.

Leah Campbell: Great, well thanks again to both Valerie and Katie for really interesting presentations and discussion and answers to those questions. Thanks to all of your who have listened to the webinar and stuck it out until the end with us. Thanks to my colleagues behind the scenes, Danny and Maria, who have been making sure that the webinar happens smoothly. A couple final reminders from me, the webinar was recorded and will be available in a couple of weeks. The link will be sent out to you as you've registered for the webinar, so you are welcome to share it with anyone who couldn't make it today, or refer back to it as a resource. Please do answer that survey, it's really helpful for us to continue to improve these urban webinars, and most importantly, especially in these very challenging times, stay safe, take care of yourselves, and we hope to see you at the next ALNAP urban webinar in a few months.

Thanks again, have a great day.