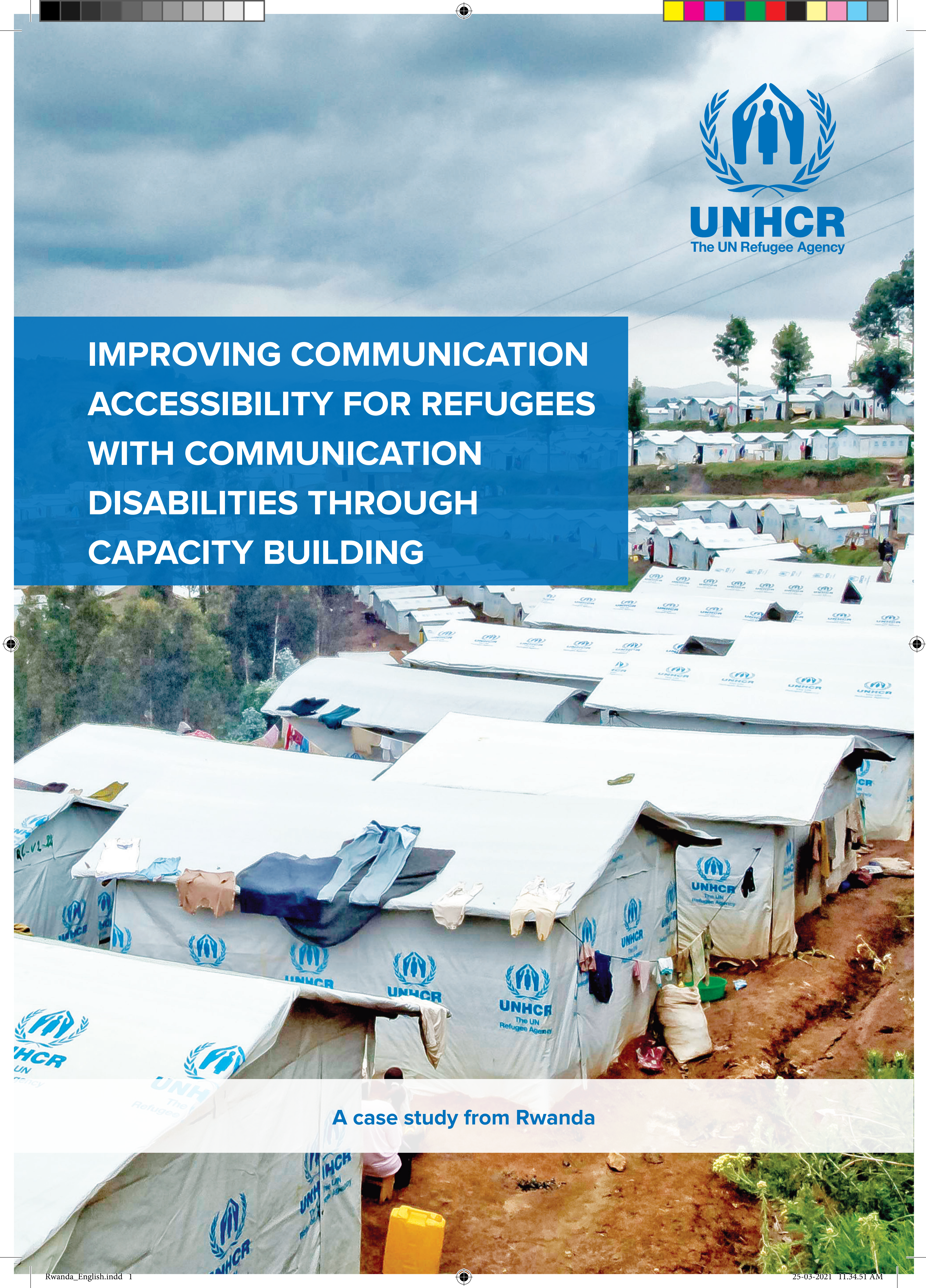

IMPROVING COMMUNICATION ACCESSIBILITY FOR REFUGEES WITH COMMUNICATION DISABILITIES THROUGH CAPACITY BUILDING

A case study from Rwanda

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Cover photo: Congolese refugees in Kigeme camp in Rwanda.

Photo credit: UNHCR/Frederic Noy

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Title: Improving communication accessibility for refugees with communication disabilities through capacity building in Rwanda.

Project objective: to provide capacity building in communication accessibility to improve service access for persons with communication disabilities.

Dates: April 2019 - ongoing

Population groups: Refugees and asylum-seekers

Partners: Julie Marshall (Manchester Metropolitan University, UK), Helen Barrett (Communicability Global).

PROJECT OVERVIEW

This project is a unique collaboration between UNHCR and Manchester Metropolitan University (MMU), to strengthen the capacity of refugee communities and service providers in Rwanda to improve communication accessibility and bolster service access for refugees with communication disabilities.

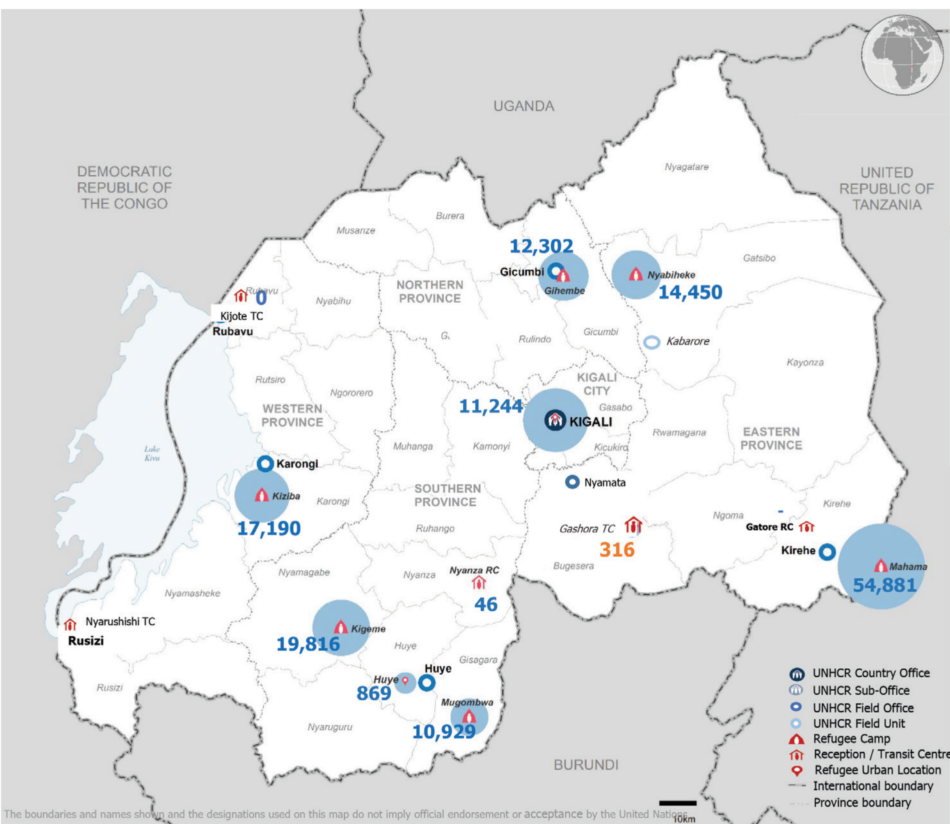
CONTEXT

Rwanda has continued generously to host refugees for over two decades. As of March 2020, there were some 148,268 persons of concern in the country, mainly from the neighbouring Democratic Republic of the Congo and Burundi. Most refugees and asylum seekers reside in six camps and there is a smaller number in urban settlements, where UNHCR delivers basic services and protection assistance. In 2019, Rwanda opened its doors once more to refugees and asylum seekers from Eritrea, Somalia, Sudan, Ethiopia and South Sudan, who were held in detention centres in Libya. In addition, since 1994, nearly 3.5 million Rwandans have voluntarily repatriated to Rwanda where they have received assistance to facilitate their return and re-integration.

As a result of forced displacement, refugees with disabilities are more likely to experience isolation and social exclusion and remain at heightened risk of exposure to exploitation, violence and abuse. They also face multiple and intersecting barriers to accessing services, due to compound discrimination on the grounds of both their disability and their refugee status. The barriers that persons with disabilities face in accessing humanitarian assistance include physical obstacles and inaccessible communication, as well as discriminatory policies and practices. All too frequently, persons with disabilities are under identified because refugees with 'visible' disabilities are more easily identified, resulting in the needs of those with 'less visible' disabilities being overlooked[1]. For example, in May 2020, 3.3 per cent of the refugees in Rwanda were registered as having a disability; however, since it has been estimated that persons with disabilities make up an estimated 15 per cent[2] of the world's population, the real figure is likely to be much higher, especially given the forced displacement context[3].

Communication disabilities are frequently invisible and poorly understood by humanitarian actors and the community. Communication disabilities are recognised to be a risk factor for exclusion from services for refugees in Rwanda and there has been a growing recognition of the need to increase awareness, knowledge and skills among service providers, in order to identify persons with communication disabilities and ensure that their protection concerns are adequately addressed[4].

[1] Barrett, H., Marshall, J. and Goldbart, G. (2019). Refugee children with communication disability in Rwanda: providing the educational services they need. Forced Migration Review (March).36-38
[2] In Syria, a 2019 household survey indicated that 27 per cent of the population has a disability. https://www.globalprotectioncluster.org/wp-content/uploads/Disability_Prevalence-and-Impact_FINAL-2.pdf
In Jordan, a 2019 population study revealed that 21 per cent of the refugee population has a disability. https://reliefweb.int/sites/reliefweb.int/files/resources/68856.pdf
In Afghanistan, a 2019 disability survey showed that 80 per cent of the adult population has a disability. https://reliefweb.int/report/afghanistan/model-disability-survey-afghanistan-2019
[3] World Health Organization, World Report on Disability (Geneva: WHO, 2011).
[4] Marshall & Barrett (2018)



[6]

Map of Rwanda indicating the location of refugee camps and transit centers, the estimated number of displaced people, as well as where UNHCR has a presence as of Jan 2021.

Communication disability

Refers to the barriers to participation experienced by people who have difficulty expressing themselves or understanding what others communicate to them. It is not widely recognized and persons with communication disabilities often experience stigma. Persons with communication disabilities may use a wide range of means to communicate, including words, signs, gestures, photographs, symbols and objects, or other types of Augmentative and Alternative communication. Their communication disabilities may be caused by or associated with a wide range of underlying conditions: intellectual and/or hearing impairments; specific language impairment; physical or health conditions such as cerebral palsy, Down's syndrome, cleft palate, autism, stroke or head injury. Communication disability can affect educational outcomes, mental health, employment, relationships and vulnerability to gender based violence (GBV).

In Rwanda, many refugees with communication disabilities are not identified and do not receive formal support. While it is not known how many people have a communication disability, it is estimated that up to 20 per cent of the world's population may experience a communication disability at some point in their life.[5]

[5] Hussain, N., Jagoe, C., Mullen, R., O'Shea, A., Sutherland, D., Williams, C., & Wright, M. (2018). The Importance of Speech, Language and Communication to the United Nations Sustainable Development Goals: A Summary of Evidence. Melbourne, Vic: International Communication Project.
[6] Population of Concern to UNHCR, Rwanda, as of 31 January 2021 https://reporting.unhcr.org/rwanda

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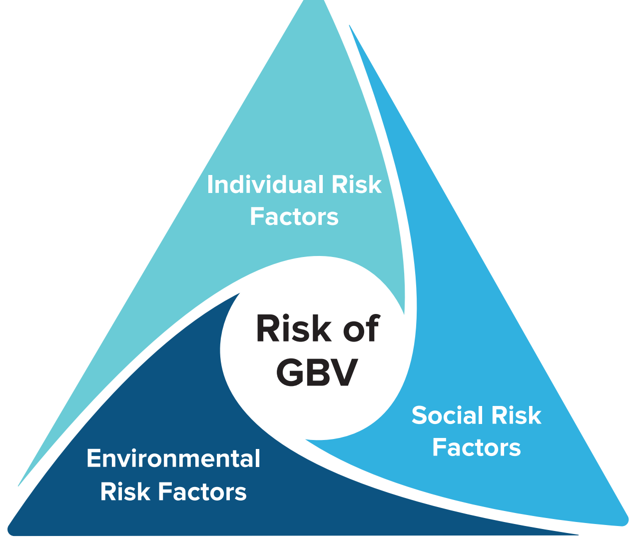
Photo credit: UNHCR/Frederic Noy

Two female refugees looking at Kigeme camp in Rwanda.

PROJECT BACKGROUND

In 2015, UNHCR Rwanda identified the need to improve access to gender-based violence (GBV) response services for persons with communication disabilities and, in collaboration with two communication disability experts from Manchester Metropolitan University and Communicability Global, launched an initial project aimed at examining the scale and nature of the challenges of supporting refugee survivors of gender-based violence who have communication disabilities. A literature review was carried out and, using a human-centred design approach, data was collected from stakeholders, including survivors, family members and the multisectoral workforce. Consultations were held, which documented responses to GBV and also identified good practice. The literature review[7] and briefing paper/project report[8] were shared widely.



Findings from the first literature review: vulnerability of refugees with communication disabilities to GBV: interconnected individual, environmental and social risk factors.

[7] https://www.elrha.org/wp-content/uploads/2017/03/sgbv-literature-review-2.pdf
[8] https://www.elrha.org/researchdatabase/final-report-supporting-refugee-survivors-gbv-communication-disability/

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During this project, it became apparent that survivors faced barriers to inclusion in prevention programming, including access to sexual and reproductive health education (SRHE) and GBV prevention programming.

Building on this iterative process, a second project was launched to collect data that would facilitate the planning of inclusive GBV prevention and SRHE services. A second literature review on SRHE was carried out. Focus groups were held with service providers and government providers and interviews were conducted with persons with communication disabilities and their carers.

A workshop was then held with stakeholders to identify possible solutions. This second project provided a better understanding of GBV and SRHE services, the vulnerabilities of refugees who experience communication disabilities, the challenges to providing services that are inclusive of persons with communication disabilities and some understanding of existing good practice. It also revealed a need for cross-sectoral and community understanding and awareness of communication disabilities and for more skills and knowledge in the field.

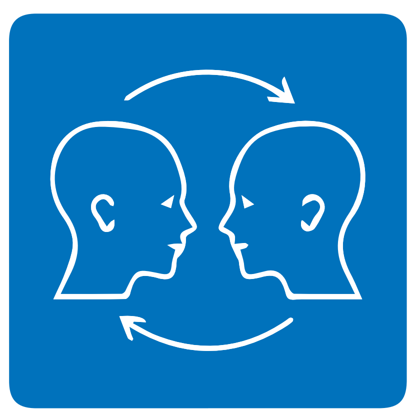
Concurrently, a project that made use of the biannual refugee verification process to increase identification of persons experiencing communication disability also helped to identify persons with communication disabilities and raise awareness of the issue.

The two projects above led to a third project, funded by Manchester Metropolitan University[9], aimed at 'mainstreaming' understanding of refugees with communication disabilities and responses to their needs across various sectors.

Guided by the human-centred design approach, this third project sought to learn directly from service providers about their needs, as regards delivering more inclusive services and tailored training on communication accessibility. The process of seeking feedback from participants as co-designers of the training was crucial to building capacity to ensure the project's long-term success and sustainability.

- Meetings were held with service providers (UNHCR, partner organizations, camp-based staff, community mobilizers, refugee groups, persons with communication disabilities and their carers), to understand their needs in relation to providing inclusive services. The MMU team offered stakeholders a selection of feasible communication accessibility solutions and training.
- A training package, originally designed by Communication Access UK[10] was, with permission, adapted to fit the Rwandan context and translated into Kinyarwanda. The training sought to enhance the skills, knowledge and attitudes of community members and the workforce in supporting the needs of persons with communication disabilities. The training uses a combination of direct teaching, discussion and practical exercises designed to challenge thinking, develop skills, increase understanding and enhance positive attitudes.
- It uses the acronym 'TALK' - to remind trainees about helpful strategies when communicating with a person who experiences communication disability:

Take Time | **Listen**
Ask what helps | **Keep trying**



The Communication Access UK symbol

[9] Manchester Metropolitan University https://www.mmu.ac.uk/
[10] https://www.rcslt.org/home/policy/communication-access-uk

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Congolese refugees strengthening their tents in the Kigeme camp in Rwanda.

- A Training of Trainers (ToT) group was established, comprising 12 members, to support the sustainability and scalability of the training. The refugee community identified 10 trainees from within the refugee community: UNHCR partners (community mobilizers), members of the Refugee Executive and Disability Committees and two UNHCR staff.
- The ToT group was trained by Dr. Julie Marshall (MMU), an experienced Speech and language therapist, researcher and trainer, and the participants received one extra day of advanced training to facilitate their role as future trainers. The ToT group also helped to evaluate the training which contributed to an iterative adaptation process.
- The ToT group then delivered the training to 14 participants, including refugees, one parent with a child with communication disabilities, UNHCR staff and partners. Dr. Marshall (MMU) and the two UNHCR ToT members also delivered the training to UNHCR and partner staff in Huye and in Kigali. Efforts were made to select a diverse and representative group and a total of 53 male and female participants were trained, including carers and people with disabilities.
- The work carried out in relation to persons with communication disabilities in Rwanda appears to have the potential to have a positive impact on the lives of people with communication disabilities and their care providers. Each training was evaluated by the participants and trainers and was also further adapted to fit the local context. While the project is still ongoing, the evaluation showed that all groups of trainees reported feeling more confident about interacting with persons with communication disabilities and their perceived abilities to support them. Anecdotal reports of trainees responding more positively to persons with communication disabilities were also noted.

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LESSONS LEARNED

- Collaboration between experts on communication, academia and UNHCR resulted in willingness among all stakeholders to learn and develop inclusive approaches to service provision. It fostered mutual learning about voluntary, informed consent, ethical practice, culturally appropriate training, research methods and writing publications for professional, service user and academic audiences.
- The projects have resulted in increased understanding of the needs of a previously unrecognized group and how improving communication accessibility has the potential to benefit not only persons with communication disabilities but also service providers and refugees who do not speak the same languages, persons with intellectual or literacy difficulties, older persons and persons with conditions such as acquired (or traumatic) brain injury or dementia.
- Iterative, co-designed, context-specific trainings ensure that the beneficiaries can participate actively through continuous feedback and increase the likelihood of contextually appropriate training.
- Ensuring that persons with communication disabilities and their carers are given the opportunity to provide input to the training would likely increase its impact.
- Obtaining consent from all participants before commencing training and meetings ensures the safety and dignity of persons with communication disabilities and their care providers during all phases of the project. This takes considerable time to do in a way that is familiar and inclusive of participants with a range of abilities and literacy skills. Time should be allowed for this.
- This simple, low-cost training can be delivered to a wide range of audiences in most indoor or outdoor locations, on paper or using computer projection. The ToT model increases the possibility of sustainability; it may be tested more widely once more data has been collected about the longer-term impact on service users and their carers and on the quality of services provided by those who have been trained. Impact evaluation, which was interrupted by the COVID-19 pandemic, is due to restart in mid- to late 2020. Furthermore, this intervention has the potential to be continuously adapted, provided that it has the oversight of a communication disability expert to ensure that ToT have adequate underpinning knowledge and the core messages are not altered.
- Time and funding constraints for the MMU and ToT trainers and participants limited the scale of achievements.

NEXT STEPS

- Impact evaluation is expected to begin in mid- to late 2020. This will initially involve discussions with trainees about whether/how the training has impacted their work, with reference to (anonymized) case studies. In Kigeme camp, persons with communication disabilities and their carers will also be asked to provide examples of impacts of the projects on their receipt of services. These findings may feed into further iterations of the training.

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ACKNOWLEDGEMENTS

- HIF/ELHRA for funding projects 1 and 2
- Manchester Metropolitan University for funding the third project and Dr. Marshall and Ms Barrett's time
- Communication Access UK (CAUK) and the Royal College of Speech and Language Therapists UK for freely and generously sharing the CAUK materials and supporting this project
- The refugee community in Kigeme and Kigali who supported and took part in delivering and receiving training and consultations
- UNHCR and partner organizations

MORE INFORMATION

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ANNEX 1

DISTINCTION TABLE

Below you will find the categorization table for field practices. The practice above from Rwanda has been defined as a case study based on the criteria below:

	Case Study	Emerging Practice	Promising Practice
Rationale	Capture practices to provide information on process, insights and lessons that are of interest (topics, themes etc.), but there is no requirement to evidence the study. The purpose of case studies is to capture successful and/ or unsuccessful attempts to implement a project. These are considered valuable for learning and improving. There is a requirement that the study was designed to meet minimum criteria in design.	Identify and track practices which may have not yet produced sufficient results but there are indications that it could. The practice should not have been documented elsewhere with an exception of programme evaluations. There is a requirement to ensure that it meets the minimum criteria in design and results.	Document and share practices that are promising. The practice should not have been documented elsewhere with an exception of programme evaluations. There is a requirement to ensure that it meets the minimum criteria in design and results.
Definition	Descriptive and explanatory overview of a practice, or part of a practice, without requirement for provision of evidence or any judgement as to its value or sustainability. It can provide insights and lessons learned into future programming.	Practice that shows early indications of producing positive results to transform lives of individuals or communities.	Practice that is proven to work well and produce sustainable results, and has a protective and/or transformative potential for individuals or communities, as demonstrated by quality and reliable evidence. It can serve as a model to be replicated and scaled up.
Results (evidence level)	**No results are required.** It is a plain explanation of the process that does not have any results or may have very limited results such as quotes about the process.	The availability of indications can be **'showing signs of some aspects' to 'consider producing positive results along the way'.** Indications can be assessment (qualitative or quantitative) or monitoring results that do not have a comparison with a baseline. An emerging practice should be something that has the potential to become a promising practice	There should be some **existing results** of effectiveness of the practice demonstrated as positive changes that the practice is making. Baseline and midline or endline data (qualitative or quantitive) should be available as well as documented results before and after the practice is carried out. When results are not documented, the practice can be still considered if staff members or partners can provide a detailed account on observable changes.

[1]A demonstration of attempted adherence refers to those practices that attempted to apply the criteria and did not succeed for various reasons such as context/operational environment etc. It is recognised that all practice implementation must strive toward adhering to and achieving the criteria. It is acknowledged that there are lessons to be learned from challenges faced and unsuccessful attempts.

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	Case Study	Emerging Practice	Promising Practice
Inclusion	Can be a study that is inclusive of all groups or that is targeted.	Can be a practice that is inclusive of all groups or that is targeted.	Can be a practice that is inclusive of all groups or that is targeted.
Criteria *optional ®Should only be indication that these were considered in the design phase in order to allow for capturing all types of case studies.	Relevance® Participation® Age® Gender® Diversity® Do no harm® Innovation*	Relevance Participation Age Gender Diversity Do no harm Innovation* Results (indicated outputs/ outcomes/impacts)	Relevance Participation Age Gender Diversity Do no harm Innovation* Results (outputs/outcomes/ impacts) Sustainability Replicability Scalability
Timeline	No minimum requirement for implementation duration. Can be on-going or recently completed.	No minimum requirement for implementation duration. Should be on-going.	Implemented within the past 3 years, can be concluded or ongoing.
Submission	All submissions, regardless of a category, will be submitted using a common template to describe the practice briefly (not more than three pages) applying a self-rating tool		
Process ***clearance is only needed for documents for external publication**	Self-rating by the field operation Review by HQ to confirm self-rating Completion of documentation by field team Review of documentation by HQ + editing Publish on intranet	Self-rating by the field operation Review by HQ to confirm self-rating Completion of documentation by field team Review of documentation by HQ + editing Approval and clearance (for external publications) at field level (+Bureau) Clearance at HQ and publish	Self-rating by the field operation Review by HQ to confirm self-rating Completion of documentation by field team Review of documentation by HQ + editing Approval and clearance (for external publications) at field level (+Bureau) Clearance at HQ and publish
How it will be used	Can be hosted online (intranet) Incorporated into learning tools and materials Can be offered as examples in various reports	Can be hosted online (intranet) Can be published in print or online for external audiences Incorporated into learning tools and materials Can be offered as examples in various reports	Can be hosted online (intranet) Can be published in print or online for external audiences Incorporated into learning tools and materials Can be offered as examples in various reports

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