# Support systems among urban IDPs in Georgia

Namrita Singh and Courtland Robinson

**Given the population density and diversity of peoples in urban contexts, it might be expected that urban displaced communities would have strong social networks and support – but a recent study carried out with IDPs in Tbilisi, Georgia, suggested the opposite.**

Social support refers to the perceived or actual psychological benefits from social contacts, such as trust, cohesion and intimacy, as well as to the exchange of information and material goods. Social networks provide the connections which allow for the exchange of such support and resources (as well as the transmission of disease). While refugees and migrants may come into contact with numerous social networks in urban settings, the connections they develop with them may be too weak to be meaningful. Rebuilding strong social support systems is hindered by the disruption produced by displacement and the felt or real impermanence of living situations.

UNHCR's Policy on Refugee Protection and Solutions in Urban Areas notes that a lack of social support limits the potential for self-reliance among refugee populations. However, this is the only mention of social support in the document. More attention needs to be given to the effects of social support mechanisms (or the lack thereof) on livelihoods, health and overall well-being. A small qualitative study was carried out during July and August of 2009 in Tbilisi by researchers at the Johns Hopkins Bloomberg School of Public Health and the Institute for Policy Studies (IPS) in Tbilisi.[1]

## Preliminary findings

The IDPs we interviewed reported that they did not interact frequently with the local community. While their adult children and grandchildren were regularly involved in work and school activities, older IDPs had no form of regular engagement with non-IDPs. Further, their limited mobility – often due to health problems and the layout of the collective centre in which they lived – made interaction with each other more difficult. One woman had not left the collective centre in two years.

Some of the IDPs lived alone, and the rest lived with their spouses, relatives or their adult children and grandchildren. IDPs described spending the majority of their time in their individual rooms, cooking and watching television on small sets given by local charities. Social interaction tended to take place in the shared hallways but there were no regular social activities within the collective centre in which IDPs could take part. One woman reflected on our interview with her by saying that it was nice to have company and someone to talk to. Despite living at very close quarters for a number of years, the individuals we spoke with described feeling isolated and alone.

## Programming implications

Collective centres in urban spaces are often former hotels, hostels, schools or unfinished buildings. These types of spaces do not promote social interaction within the local urban community, as they are spaces closed off from the outer environment, both symbolically and literally. In our study, the only collective spaces inside were the hallways and stairwells, and groups of IDPs were separated by the different floors on which they lived. It is difficult to imagine how any meaningful space for social interaction could develop. The physical space of collective centres needs to be considered in interventions that address refugees' social and psychosocial health.

Collective centres tend to be dispersed within urban environ-


IDP collective centre in former hospital building, Tbilisi, Georgia. An estimated 148 families live in this hospital complex which suffers from widespread rat and insect infestation and falling masonry.

ments and also to be isolated from each other, so building social networks and social capital among urban displaced communities is difficult. One strategy might be to develop relationships between collective centres so that individuals and groups can share resources, information and social ties.[2] For example, retired teachers in one collective centre might provide tutoring services for children in other centres. One IDP we spoke with was a trained nurse who was unable to work. Interventions that build social capital would attempt to utilise her knowledge by connecting her with those who need medical services.

Psychosocial interventions with displaced communities need to move beyond targeting wellbeing at the individual level to also considering the health of social relationships. Existing self-help groups or community support mechanisms should be identified and strengthened as a part of psychosocial interventions. Researchers in the field of forced migration and public health need to understand the role of social support systems in refugees' psychological, physical and social health. Doing so is key to developing community resources, as well as culturally appropriate and innovative psychosocial interventions.

Namrita Singh (nasingh@jhsph.edu) received her MSc in Forced Migration from the Refugee Studies Centre, University of Oxford, in 2007 and is currently a doctoral student in international health at the Johns Hopkins Bloomberg School of Public Health. Courtland Robinson (crobinso@jhsph.edu) is Assistant Professor at the Center for Refugee and Disaster Response at the Johns Hopkins Bloomberg School of Public Health in Baltimore, Maryland.

See mini-feature on collective centres in FMR33 pp62-6. http://www.fmreview.org/protracted.htm

1. 21 IDPs were interviewed who were residing in one collective centre in the city, which housed long-term IDPs displaced from Abkhazia in the 1992 conflict. These IDPs were all ethnic Georgians aged 60 years and above.

2. The Global Initiative on Psychiatry's (GIP) Tbilisi branch used this approach in their interventions with Georgians displaced during the 2008 crisis. Interview with Jana Javakhishvili, Mental Health and HIV/AIDS Projects Coordinator for the South Caucasus and Central Asia, Global Initiative on Psychiatry (GIP), Tbilisi, 30 July 2009.