

# **An Education Model for Building Health Care Capacity in Protracted Refugee Contexts**

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Policy Brief

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## **List of Abbreviations**

BHER	Borderless Higher Education for Refugees
BSc	Bachelor of Science
CHE	Community Health Education
CHW	Community Health Worker
CR	Community Researcher
FGD	Focus group discussion
FGM	Female genital mutilation
IRC	International Rescue Committee
KRC	Kenya Red Cross
MOH	Ministry of Health
NGO	Nongovernmental Organization
UNHCR	United Nations High Commission for Refugees

## Executive Summary

The refugee population in Africa continues to grow as more and more people destabilized by wars and conflicts within their own countries are forced to flee to neighboring countries. The Dadaab refugee camp located in Garissa County, Kenya is one of the oldest and largest camps in Africa hosting around 326,600 refugees mainly of Somali origin. Given that the population is much larger than intended for these camps, access to social services, education and health is a huge challenge. Humanitarian nongovernmental organizations (NGOs) provide basic health care services with the aid of the refugee community health workers (CHWs); however, these workers receive only brief training. Meanwhile, the refugees face numerous health related challenges including outbreaks of communicable diseases which are preventable. Reliance on humanitarian NGOs for health care in protracted displacement situations like Dadaab is not sustainable. There is a need to equip refugees to play a greater role in meeting the primary health care needs of their communities. A qualitative study was conducted to collect the views of the main stakeholders including NGOs involved in training CHWs, the Ministry of Health (MOH), CHWs, and prospective candidates for training in community health regarding the education needs for health workers in Dadaab. Findings clearly indicated overwhelming support for the development of a health-related degree, with most of the prospective students and CHWs expressing interest in taking the degree. The knowledge obtained was used for the development of a BSc degree in Community Health Education that is ready for implementation. This policy brief highlights the importance of developing education models aimed at addressing health and higher education equity issues in protracted refugee situations.

## Introduction

The refugee population in Africa continues to grow as people destabilized by wars and conflicts are forced to flee to neighboring countries, where they may stay for years. The Dadaab camps located in Garissa County, Kenya, represent one such protracted displacement situation.<sup>1</sup> Approximately 326,600 refugees, mostly of Somali origin, were living there as of July 2016 (UNHCR, n.d.). These camps started in the early 90s in response to humanitarian disasters posed by conflict and famine, and they remain due to the ongoing conflict in Somalia (Bradbury & Healy, 2010). The population is much larger than intended for these camps, and the host community of Dadaab is one of the poorest areas in Kenya (De Montclos & Kagwanja, 2000). The crowded conditions, limited access to clean water, and poor sanitation result in significant health challenges (UNHCR, 2010, 2012). Basic health services are provided by various humanitarian nongovernmental organizations (NGOs) assisted by refugees who receive brief training as community health workers (CHWs). While the good work being done must be recognized, it is nonetheless insufficient to meet the health needs of the population. Furthermore, reliance on expatriate health workers to provide health care in refugee camps “raises concerns about the long-term sustainability, cost effectiveness, and cultural appropriateness of programs and services” (Ehiri et al., 2014, 2014, para. 1). In order to meet the Sustainable Development Goal (SDG) of good health and well-being for all ages (United Nations, 2015), people in Dadaab need access to quality primary health care—that is, community-based approaches to health promotion and disease prevention that address the broad determinants of health (WHO, 1978, 1986). With appropriate education, the refugees and the host community could generate a more sustainable health workforce to provide comprehensive primary health in Dadaab.

The goal of this research was to inform an education model for building health care capacity in the Dadaab refugee camps, host community, and ultimately, Somalia. The research built upon another project in Dadaab called “Borderless Higher Education for Refugees” (BHER), which is a partnership of universities in Canada and Kenya that are collaborating to make educational programs available where refugees reside (see <http://www.bher.org/>). The research findings reflect perspectives obtained from three sources: a) BHER students (representing prospective candidates for training in community health), b) NGO-trained CHWs, and c) health staff from Kenya’s Ministry of Health (MOH) and NGOs who train and supervise CHWs. The findings identified gaps in CHW training in multiple areas including mental health, disease surveillance and control, and Kenya’s community health strategy. Findings informed the development of a new BSc degree in Community Health Education (CHE) at Moi University (U) that is accessible to Dadaab refugees and the host community. This policy brief highlights the importance of higher education as one solution aimed at addressing health equity issues in protracted refugee situations.

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<sup>1</sup> UNHCR has defined a protracted situation as one where more than 25,000 people are displaced and in a camp setting for more than five years (Crawford, Cosgrove, Haysome, & Walicki, 2015, p. 15).

## Approaches

The research was launched with a workshop held at Moi U in Eldoret, Kenya, in September, 2014, at which the research plan and interview guides were finalized. The workshop was attended by academic researchers from Moi University (U) and York U, representatives from stakeholder groups including Kenya's MOH and several NGOs (Kenya Red Cross [KRC], International Rescue Committee [IRC]), and Windle Trust Kenya); and refugee community researchers (CRs) from Dadaab hired for the project. Between October and December, the CRs (three men, one woman) conducted fieldwork at four sites (Dadaab town and three refugee camps: Hagadera, Dagahaley, and Ifo).

Data were collected using semi-structured interview guides for focus group discussions (FGDs) and individual interviews, which were audio-recorded and transcribed by the CRs in January 2015. Four FGDs were held with BHER students (31 in total) who were untrained refugee teachers enrolled in a Certificate or Diploma in Education program. Participants were asked about their interest in the community health degree program, their questions/concerns about the concept, and their suggestions concerning development of the program. In addition, four FGDs were conducted with NGO- certified CHWs (31 in total) regarding their job responsibilities, the knowledge and skills required, and gaps in their education and training. Finally, individual interviews were conducted with various MOH and NGO health staff (12 in total) regarding health issues and priorities in the camps and the training and education needs of CHWs.

The transcripts of the FGDs and interviews were first analyzed separately by the Kenyan and Canadian researchers using thematic and content analysis approaches. The preliminary analysis was circulated for review and feedback. The findings and their implications for the development of a new community health degree program were discussed at a second workshop held in Nairobi in early June, 2015.

## Results

The findings identified significant health challenges and key health priorities in Dadaab as well as gaps in the education and training of refugee CHWs with respect to addressing these challenges and priorities (Mangeni, Pilkington, Mbai & Abuelaish, 2016; Mbai, Mangeni, Abuelaish, & Pilkington, in press). Also, BHER students and CHWs expressed strong interest in the concept of a community health degree program.

The harsh environmental conditions were among the identified challenges in Dadaab. The area experiences water scarcity with flooding in the rainy season which, along with poor drainage and waste management, contributes to disease outbreaks. People moving between the camps and Somalia and children arriving malnourished and without immunization also leads to disease outbreaks. Another challenge is poor health-seeking behavior among the population. This is related to low literacy levels, language barriers and certain cultural practices. The key health issues identified were maternal, infant, and 'under-five' mortality; female genital mutilation

(FGM); and the quality of care at the health facilities. Accordingly, the main health priorities were maternal-child health, nutrition, preventive and health promotive services, water, sanitation and hygiene (WASH), and clinical care (Mangeni et al., 2016; Mbai et al., in press).

Health services in the five camps are provided by different NGOs. Fiscal constraints and high turnover result in a significant shortage of health personnel and reduced services, especially in the area of primary health care. Security issues also limit access to services. Reportedly, Al-Shabaab (a Somali terrorist organization) operates within the camps. At times government and NGO personnel have to withdraw due to security issues, leaving CHWs to run health posts. These CHWs are ‘incentive’ workers<sup>2</sup> trained by NGOs help extend service capacity. Some of them have low motivation to work. Moreover, there aren’t enough of them and it is difficult to find people who can be trained in English. In the rest of Kenya CHWs typically cover 20 households, but in Dadaab they cover from 120 to 200 households (Mangeni et al., 2016; Mbai et al., in press).

The populations served by CHWs are young children (5 and under), elderly people, pregnant women and nursing mothers, people with disabilities and chronic illness, and people with mental illness. The main services provided are disease surveillance, community education and awareness campaigns, and home based care. They also provide a link between the local health facility and the community. The length and content of their training appeared to vary across the camps and did not include formal practical attachments, although trainees receive some on-the-job training. At the end of basic training CHWs only receive a certificate of participation and because of this, and the fact that they are incentive workers, they often feel that the importance of their work is not recognized (Mangeni et al., 2016; Mbai et al., in press).

Health staff and CHW participants identified similar gaps in CHW education and training in areas ranging from general health knowledge, to disease surveillance and control and Kenya’s community health strategy. Other areas where CHWs would like further knowledge and training included HIV/AIDS, FGM, family planning, drugs and drug abuse, crisis management, strategic management, and environmental health. Interestingly, the majority of CHWs indicated that they did not receive training on mental health but this was not identified as an area for further knowledge and training. Overall, CHWs thought that their education should provide a better theoretical foundation and opportunities to practice their newly learned skills. Health staff agreed that CHWs need better training. Access to post-secondary education would increase their community involvement while enabling individuals to improve their qualifications and quality of life (Mangeni et al., 2016; Mbai et al., in press).

Almost unanimously, CHWs said they would pursue further education if they got the opportunity, although some didn’t have the necessary educational background (Mangeni et al., 2016).

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<sup>2</sup> An “incentive” payment is “generally lower than a wage and is intended to acknowledge the volunteer’s efforts but not provide full compensation for their labour” (Morris & Voon, 2014, p. 3). Refugees receive a small incentive payment rather than wages because the government’s policy is not to permit employment of refugees.

Similarly, BHER students (currently pursuing teacher education) expressed strong interest in the concept of a community health degree, with 24 out of 31 participants (77%) indicating they would consider this option, if available. Their main reasons were opportunities for career development and to serve their community. Their questions and concerns related to the quality and credibility of the proposed program, admission criteria and access, location and mode of teaching and learning, relevance/marketability of the program, and cost/availability of sponsorship. Suggestions to those developing the program included that it should be a credible university program with a comprehensive curriculum, a practical focus, equitable access, and that there should be gender balance and sensitivity.

## Conclusion

Health service capacity in Dadaab is constrained by a significant shortage of health personnel, especially in the area of primary health care. Utilization of NGO-trained CHWs helps to extend health service capacity, but there are not enough of them and they appear to lack motivation. Furthermore, there are gaps in their training in multiple areas including mental health, disease surveillance and control, and Kenya's community health strategy. More advanced education and training in community health is needed to produce well prepared health workers. This preparation will benefit both individuals who obtain the credential as well as communities where they live and work, through better access to comprehensive primary health care.

## Implications

Protracted displacement situations like Dadaab pose enormous challenges to meeting the health and education needs of refugees (Anselme & Hands, 2010; Dryden-Peterson, 2010; Giles, 2012). Humanitarian NGOs are doing the best that they can to train refugees as CHWs, but this training is neither systematic nor equivalent to what is available to citizens within the host country. The knowledge produced through this research was used to inform the development of a new BSc degree in Community Health Education by the School of Nursing at Moi U, which will launch in September 2016. Created to address health and education inequities in Dadaab, the program curriculum addresses the areas of knowledge and skills needed by health workers in this low resource context.

In addition to program quality and credibility, education models for implementation within protracted refugee situations must take into consideration efficient use of the limited education resources. The blend of education and health disciplines in the CHE degree is highly relevant to the community-based health promotion and disease prevention work of primary health care. In addition, the program is resource efficient in that qualified applicants with an accredited Education diploma will receive advanced standing (i.e., credit) toward the degree, which they could then complete with as little as two additional years of study. In order for refugees and impoverished host communities to have access to the program, funding on a cost recovery



basis is required. Canadian government funding is in place for the first cohort of students (2016-2018), but new funding is needed for future cohorts.

Other key considerations in developing an education model for protracted refugee situations are student mobility and repatriation. For example, students in Dadaab are mobile within and between the camps and Somalia. Therefore, programs must be offered in ways that are flexible, accessible, and portable when students repatriate. Hence, the new CHE program will be delivered mainly online, allowing students to continue their studies wherever they go. However, practical learning experiences (practicums) require direct supervision. Thus, program administrators from Moi U must connect with responsible personnel in Dadaab (e.g., UNHCR Senior Health Officer, NGO representatives) in order to arrange for supervision by local health staff with support from university academics. The Kenyan government recently announced its intention to close the Dadaab camps within a year (Mutiga & Graham-Harrison, 2016). This development has stimulated the BHER consortium universities to develop new partnerships with Somali National University in Mogadishu, so that students can continue to access their program remotely when they resettle.

### **Recommendations: Call to Action**

To create conditions for health and wellbeing in protracted refugee situations, what is needed is a systematic, coordinated, and visionary approach to post-secondary education aimed at preparing health human resources to deliver comprehensive primary health care (WHO, 1978, 1986). Responsibility for preparing these health human resources must not fall entirely on host countries; rather, it should be equitably shared among actors responsible for health and education at different levels (from local to national and international). These actors include UNHCR, academic institutions, the host government's Ministry of Health, humanitarian health and education NGOs, and community representatives. As stakeholders, these groups should be involved in planning, developing, and implementing post-secondary programs aimed at educating and training the necessary health human resources.

As the principal actors in post-secondary education, academic institutions should take the lead in developing the required health programs; however, the above mentioned stakeholder groups should be consulted. The SDGs (United Nations, 2015) may fuel the vision to pursue this work but it needs to be supported by governments and other funders. To ensure equitable sharing of educational resources, academic partners in the host country where the refugees are located and higher income countries need to work collaboratively. Different education models are possible; for instance, programs could be offered entirely by the academic institution located in the host country, or jointly with partner universities located elsewhere, given access to the internet and online learning.

Regardless of the education model adopted, post-secondary community health programs should provide a strong theoretical foundation drawn from the health sciences, social sciences, and education. This will ensure that graduates have the breadth and depth of knowledge and competencies needed to function in various contexts with individuals, groups, and communities.

In addition, because refugees may relocate or repatriate during their studies, program delivery should be flexible and accessible, which means using online platforms and e-learning to deliver most of the program. However, opportunities for supervised practice must be provided, which requires collaboration and partnerships between academic institutions and community health agencies and facilities.

Finally, ongoing funding from governments and other donors is needed to enable all qualified students interested in completing post-secondary studies in health to do so.

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