

# **Training and Utilization of Refugees as Community Health Workers in Protracted Displacement Situations**

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Policy Brief

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## **List of Abbreviations**

CHW	Community Health Worker
CR	Community Researcher
FGD	Focus group discussion
FGM	Female genital mutilation
MOH	Ministry of Health
NGO	Nongovernmental Organization
UNHCR	United Nations High Commission for Refugees

## Executive Summary

The use of community health workers (CHWs) to provide primary health care, especially in rural settings and in low- and middle-income countries, has been previously documented. In Africa, CHWs mainly work in rural settings under the supervision of community extension workers who are usually trained professionals. The Daadab refugee camps in Kenya represent a protracted displacement situation in an extreme resource limited setting with an acute shortage of health workers. Here, refugees trained as CHWs play an important role in extending primary health care services. And yet, their training is quite limited and therefore may not adequately prepare them to deal with the challenges arising in this context. We investigated CHWs' current training, their scope of responsibilities, their challenges and whether they would be interested in a university degree program in community health. The overall goal was to inform an education model for building health care capacity in disadvantaged communities in Kenya (and ultimately, Somalia, where most of the refugees originated).

Trained community researchers (CRs) conducted four focus group discussions (FGDs) with CHWs in Daadab. In addition, they conducted 12 individual interviews with various professional health staff from humanitarian nongovernmental organizations (NGOs) and the Ministry of Health (MOH) who work in hospitals and health posts and who train and supervise CHWs. The results indicate that refugees receive limited training (mostly one or two weeks), which varies in length and content of across the camps. The CHWs work closely with health staff from various NGOs providing healthcare in the camps. The main populations served were young children (5 and under), elderly people, pregnant women and nursing mothers, people with disabilities and chronic illness, and people with mental illness. The CHWs provide a range of services including home based care, disease surveillance, and community education and awareness campaigns, among others. They also provide a link between the local health facility and the community. Both the CHWs and the NGO/MOH health staff identified gaps in the training programs that could best be bridged through formal higher education. All of the CHWs expressed interest in a community health degree program although some did not have the necessary secondary education.

In conclusion, refugee incentive workers provide a range of key primary health care services to the refugee population and should therefore receive the necessary education and training to obtain essential knowledge and skills. This brief highlights the challenges of health care capacity building in protracted refugee situations like Dadaab and points to the education and training needed by CHWs to provide quality community health services in such contexts.

## Introduction

Community health workers (CHWs) are used in many countries, especially in rural settings and in low- and middle-income countries, to assist with delivery of primary health care (Bhutta, Lassi, Pariyo, & Huicho, 2010). Usually members of the community without formal training, CHWs are trained and assigned to specific primary health centres or small populations. In Africa, CHWs mainly work under the supervision of community extension workers who are usually trained professionals. Research aimed at evaluating the utilization of CHWs, globally, suggests that the impact on health outcomes varies depending on how CHWs are trained, supervised, and utilized and the status of the respective countries' health and economic systems (Bhutta et al., 2010). However, there has been limited research on the capacity of refugees and internally displaced persons living in camps to provide health services to others living in the camps (Ehiri et al. 2014). In this research we investigated the utilization of refugee CHWs to provide basic health care services in Dadaab, Kenya, including current training and gaps in training. The larger goal of the project was to inform the creation of an education model for building health care capacity in disadvantaged communities in Kenya (and ultimately, Somalia) by utilizing the cross-sector experience and expertise of Canadian and Kenyan universities and NGOs (Pilkington, Mbai, Mangeni & Abuelaish, 2016).

The Dadaab refugee camps represent a protracted displacement situation<sup>1</sup>. The first camp was established in the early 90s after the outbreak of war in Somalia and there are now five camps: Hagadera, Dagahaley, Ifo, Ifo 2, and Kambioos (UNHCR, n.d). The refugees are mostly of Somali origin, and some of them have been in Dadaab for over 20 years (British Broadcasting Corporation, 2016). While the numbers have fluctuated over time, around 322,000 refugees lived there as of August 2016 (UNHCR, n.d.). Dadaab is one of the poorest areas in Kenya, with limited local resources (De Montclos & Kagwanja, 2000). In the camps, basic health services are provided by humanitarian NGOs aided by refugees trained as CHWs. The dense population living in confined spaces with limited access to clean water and poor sanitation conditions results in serious health challenges, including communicable diseases, excess maternal-child morbidity and mortality, and gender-based violence (UNHCR 2010, 2012; Nasrullah, 2015; Murray & Achieng 2011).

The research findings indicate that the training of CHWs in Dadaab varies considerably across the camps. Also, there are significant gaps in training related to key job responsibilities. It was concluded that the training should provide a better theory base as well as opportunities to practice newly learned skills. This would enable CHWs to improve their job satisfaction while improving the health of communities (Mbai, Mangeni, Abuelaish, & Pilkington, in press). This brief highlights the challenges of health care capacity building in protracted refugee situations like Dadaab and points to the education and training needed by CHWs to provide quality community health services in such contexts.

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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

A community based approach was used to obtain the perspectives of refugee CHWs and professional health staff in Dadaab concerning the training and education need of CHWs. The research team comprised academics and graduate students from Moi University (U) in Kenya, and York U and the University of Toronto, Canada, as well as four community researchers (CRs) (three men and one woman) from Dadaab. Ethics approval was obtained from Moi U and York U Institutional Research Boards. Prior to the fieldwork, the CRs participated in a workshop where the research plan and semi-structured interview guides were finalized. The CRs gathered data in four sites (Dadaab town, and three of the camps: Hagadera, Dagahaley, and Ifo) in October-November 2014 using focus group discussions (FGDs) and individual interviews. Volunteers who could speak English were recruited through word of mouth.

Four FGDs (7-8 participants in each) were held with NGO-certified CHWs. In addition, 12 individual interviews were conducted with various professional health staff from NGOs and the Ministry of Health (MOH) who work in hospitals and health posts and who train and supervise CHWs. The FGDs and interviews sought to obtain participants' perspective on CHWs' job responsibilities, current training, gaps in training, and education needs, as well as health issues and priorities in the camps. The FGDs and interviews were audio-recorded and transcribed by the CRs in January 2015. Transcripts from the FGDs and interviews were jointly analyzed by the Kenyan and Canadian researchers using content and thematic analysis approaches. The findings and their implications were discussed at a second workshop held in Nairobi in June, 2015.

## Results: What did we learn?

Findings from CHWs concerning their role and training and education needs are presented first, followed by the perspectives obtained from NGO and MOH health staff.

### Perspectives of CHWs

A total of 31 CHWs, mostly of Somali origin, participated in FGDs. (Some participants from Dadaab town were Kenyan nationals.) The length of time they had worked as a CHW ranged from one to 23 years (mean = 6.2 years). They worked closely with health staff from various humanitarian NGOs. The populations mainly served were young children (5 and under), elderly people, pregnant women and nursing mothers, people with disabilities and chronic illness, and people with mental illness. CHWs provide home based care, conduct disease surveillance, and provide a link between the local health facility and the community. In addition, they provide community education and awareness campaigns on issues including immunization, basic hygiene measures, gender based violence, and female genital mutilation (FGM).

The training participants received ranged in length from 3-4 days up to 6 months (mostly one or two weeks). Specific courses taken during training also varied considerably, as did opportunities for on-the-job training. Participants reported they were not well trained in prevention of disease

outbreaks, disease surveillance, chronic disease management, reproductive health, maternal-child health, nutrition, health promotion, general nursing skills, quality assurance, laboratory skills, conflict management, gender based violence, and health management and administration. Other areas where participants said additional knowledge and training would be helpful included HIV/AIDS, FGM, family planning, drugs and drug abuse, First Aid, crisis management, strategic management, community health, and environmental health. Interestingly, the majority said that they had not received training in mental health but they did not identify this as an area for further knowledge and training.

Participants indicated that overall, their training should provide a better theory base and opportunities to practice newly learned skills. Almost unanimously, they agreed that they would pursue a university degree in community health if given the opportunity, although some didn't have the necessary secondary education. Some participants identified issues with supervisors related to unequal power dynamics and negative views of "incentive workers"<sup>2</sup> (e.g., "people who don't know what they are doing, they consider us inferior"). Obtaining a degree was seen as a means to personal satisfaction, providing for their family, and giving back to and being better advocates for their community.

## Perspectives of Health Staff

Twelve health staff members from different NGOs and the MOH were interviewed. Participants explained that health services in the five camps in Dadaab are provided by different NGOs. Preventive services are provided at health posts and curative services are provided at the main hospital. There is a significant shortage of health personnel due to budgetary constraints and high turnover, which results in reduced services, especially in the area of primary health care. Utilization of refugee CHWs helps to extend health service capacity but supervision presents a challenge when government and NGO personnel withdraw due to security issues. CHWs are then left to run health posts on their own. The main health priorities were identified as preventive and health promotive services, including immunization; WASH (water sanitation and hygiene); maternal-child health; nutrition; and clinical care. In general, the health needs of the community exceed the service capacity of health facilities. More CHWs are needed but it is difficult to find people who can be trained in English. Also, some participants indicated that CHWs lack motivation to work.

CHW training in the camps is provided by the MOH in partnership with several international agencies (UNHCR and UNICEF) and national and international NGOs. Descriptions of CHW training reflected the government's basic training modules for CHWs but training seemed to vary based on whether trainees were Kenyan nationals or refugee incentive workers. Participants noted that the education level of CHWs ranges from little or no education to secondary education. It was also mentioned that refugee CHWs are not at the same level as the Kenyans. Upon completion of basic training, CHWs receive on-the-job training. Identified gaps in the training and education of CHWs included, among others, general health knowledge, Kenya's

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<sup>2</sup> Refugees receive a small 'incentive payment' rather than wages because the government does not allow employment of refugees. 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).

community health strategy, nutrition, communicable diseases, water and sanitation issues, and disease surveillance.

### **Conclusion: What does it mean?**

CHWs in Dadaab provide basic health services to vulnerable populations across the lifespan, sometimes running health posts on their own. However, despite similar job responsibilities across locations, the length and content of their training varies considerably. Also, there are gaps in CHWs' knowledge and training related to key health priorities and job responsibilities, including disease surveillance and prevention of disease outbreaks, chronic disease management, maternal-child health, nutrition, health promotion, mental health, gender based violence, and health administration. The brief training CHWs receive does not adequately equip them deal with the serious challenges faced in the camps. In addition, there are issues with morale and motivation to work. Better education and training would improve CHWs' job satisfaction while increasing health service capacity and improving the health of communities.

### **Implications**

Refugee CHWs are being utilized to extend health human resources in Dadaab. However, the variability in the length and content of their training across camps is probably reflected in the services provided. This, along with the poor living and environmental conditions in the camps, is likely to have a negative impact on health outcomes for vulnerable populations (i.e., young children, elderly people, pregnant women and nursing mothers, people with disabilities and chronic illness, and people with mental illness). This is a human rights issue because everyone has a right to adequate conditions for health (United Nations, 1948, Article 25). The impact of CHWs on health outcomes depends on how they are trained, utilized, and supervised and the status of countries' health and economic systems (Bhutta et al., 2010). Kenya is a lower-middle income country with a well-developed health sector strategic plan and community health strategy (Republic of Kenya, 2013); however, these do not appear to be in force in the refugee camps, where humanitarian NGOs provide health services and training of CHWs.

Challenges affecting recruitment, training and utilization of refugee CHWs include low literacy in the population, the incentive payment system for refugees, and low motivation to work. The issue of literacy is the result of generations of refugees growing up without access to a proper education. This, too, is a human rights issue (United Nations, 1948, Article 22; Anselme & Hands, 2010). Refugees living in protracted displacement situations such as Dadaab should have equitable opportunities for education and training. Regarding remuneration of CHWs, the expectation that CHWs work as volunteers is an issue for both refugee incentive workers and Kenyan nationals (Republic of Kenya, 2013). Thus, remuneration needs to be addressed for both groups in order to improve their recruitment and retention in the health workforce.

CHWs participants in this study expressed strong interest in pursuing higher education in community health (Pilkington et al., 2016); however, many of them would not qualify for a



university program because they have not completed secondary education and obtained the Kenya Certificate of Secondary Education (KCSE). Again, this indicates that refugees in protracted displacement situations need equitable access to education at all levels (Anselme & Hands, 2010; Dryden-Peterson, 2010). However, some individuals have obtained the KCSE and could pursue post-secondary education with the appropriate support. Higher education is a longer term strategy for increasing the health service capacity in protracted displacement situations. Meantime, improvements to the training and utilization of current CHWs would enhance their capacity to assist with the delivery of primary health care services in their communities. Well prepared health workers would contribute to the health and development of refugee communities within the camps and in Somalia, when they repatriate (Pilkington et al., 2016).

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

- 1) Refugees in protracted displacement situations must be provided with access to primary and secondary education. This education is foundational to the training required for CHWs. In addition, qualified individuals should be supported to pursue post-secondary education (Anselme & Hands, 2010; Dryden-Peterson, 2010; Pilkington et al., 2016).
- 2) CHWs in protracted refugee situations should be provided with training that is closely aligned with that provided to citizens of the host country. Thus, in Dadaab, the training of refugees as CHWs should reflect Kenya's Community Health Strategy.
- 3) CHW training programs should include not only a theory component but opportunities for supervised practice of newly learned skills.
- 4) CHW training programs, especially in protracted displacement situations, should address mental health (Jenkins et al., 2010).

In addition, the following "key messages" based on a systematic review of research on utilization of CHWs (Bhutta et al., 2010, pp. 13-14) are relevant to protracted refugee situations, although these were not included in the review:

- 5) CHWs should be included in health human resource strategic planning (Republic of Kenya, 2013; Bhutta et al., p. 13). In the context of Dadaab, UNHCR-Kenya should work closely with the Kenya MOH in planning and implementing health services in the camps.
- 6) Given the important role of CHWs in primary health care delivery, the curriculum in training programs:

*...must incorporate scientific knowledge about preventive and basic medical care, yet relate these ideas to local issues and cultural traditions. They should be trained, as required, on the promotive, preventive, curative and rehabilitative aspects of care related to maternal, newborn and child health, malaria, tuberculosis, HIV/AIDS as*

*well as other communicable and non-communicable diseases. Other training content and training duration may be added pertinent to the specific intervention that the CHW is expected to work on. (Bhutta et al., p. 13)*

- 7) CHWs should be provided with “opportunities for career mobility and professional development. These should include opportunities for continuing education, professional recognition, and career advancement” (Bhutta et al., p. 14).

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