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Cultural Diversity and Non-formal Health Education in Dzaleka Refugee Camp

A Master's Project Presented

by

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Abstract

Malawi is one of the African countries that hosts thousands of refugees mostly from Democratic Republic of Congo, Rwanda, Burundi, Somalia and other African countries. These refugees come from various cultural backgrounds. Their cultural diversity is visible in languages, tribes, spiritual beliefs, food, dances and etiquette. Even though these refugees are all around the country, their concentration at Dzaleka Refugee Camp is usually over 10, 000 at any given period of the year.

Amidst the refugees finding a relatively safe place in Dzaleka Refugee Camp, they however face community health challenges as any other reasonably stable community. In worst cases, health challenges in the camp are worse than the surrounding communities. In response to these health challenges, the need for a hygienic environment and health community members, various organizations provide non-formal health education in the camp. These organizations come from within and outside the camp. Non-formal health education in the camp strives to help the community use the information for sanitary living as a preventative measure to illnesses.

However, non-formal health education finds itself taking place in this culturally diverse community. This project interviewed 40 non-formal health education participants in the community to inquire about their views on cultural diversity's interaction with non-formal health education. This project finds that communication, personal value judgment and lack of non-formal health education resources are the main perceived challenges that cultural diversity poses in non-formal health education in the camp. Finally, the project finds that creating a support system through recruiting local staff and making use of community relationships are key strategies in adapting non-formal health education in such a culturally diverse community.

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Acronyms

BLM	Banja La Mtsogolo
CMHS	Center of Mental Health Services
DRC	Democratic Republic of Congo
FPAM	Family Planning Association of Malawi
HIV/AIDS	Human immunodeficiency virus infection/acquired immune deficiency syndrome
HSA	Health Surveillance Assistant
HTC	HIV Testing and Counseling
IEC	Information Education and Communication
IPs	Implementing Partners
JC-G-HEM	Jesuit Commons: Higher Education at the Margins
JRS	Jesuit Refugee Service
MACRO	Malawi AIDS Counseling and Resource Organization
MoH	Ministry of Health
NAC	National Aids Commission
PMTCT	Prevention of Mother-to-Child Transmission
PRDO	Participatory Rural Development Organization
PSI	Populations Services International
RSD	Refugee Status Determination
STDs	Sexually Transmitted Diseases
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
VCT	Voluntary Counseling and Testing
WFP	World Food Program

Introduction

This project explores the role that cultural diversity plays in non-formal health education activities in Dzaleka Refugee Camp in Malawi. Specifically, it examines the opportunities and challenges that cultural diversity offers to non-formal health education in the camp. The purpose of this paper is to provide information that can deepen our understanding of cultural diversity in refugee camps and discuss implications of such diversity for providing non formal health education to refugees.

Statement of the Issue

Malawi, the country where Dzaleka Refugee Camp was established, is located in Southern Africa. This is despite other people contesting that it is slightly located toward the east and others suggest more of central Africa. Malawi borders Tanzania in the North and Zambia in the west. Mozambique borders Malawi in the east, south and west. Malawi has approximately 17 million people as of June, 2014 (CIA, 2014). Malawi got its independence from Britain in 1964. Up until 1994, Malawi was led by an autocratic government. The country depends mainly on agriculture for its economy and it is land locked with a fast growing population. Tobacco and tea have been the sole exports for decades. This implies that any influx of refugees come to settle into a land locked country that depends on farming on its already overpopulated land.

Even though Malawi has had minor scenarios of internal violence, it is one of the countries in Africa that have never experienced civil war or external attacks. Such environment has provided a conducive atmosphere for people fleeing their home countries to take refuge in Malawi. Nkhoma (2010) says, “Since the Mozambican refugee influx into Malawi in the 1980s, Malawi has continued to host diverse populations of refugees.” In 1994, the government noticed Somalian refugees overcrowded in Malawi cities. “By as early as 1990, refugees from Somalia

had already started arriving in the country, fleeing from indiscriminate violence arising out of the Hawiye/Darod ethnic strife, lawlessness and banditry”, (Nkhoma, 2010 p. 98). “The genocide in Rwanda, civil wars in DRC and Burundi, the closed door policy to bar entry of more refugees into Tanzania all triggered the mass exodus of refugees into Malawi”, (Nkhoma, 2010). In response, the government set up Dzaleka Refugee Camp to accommodate refugees from countries such as DRC, Somalia, Burundi, Rwanda and Ethiopia among others.

Dzaleka Refugee Camp is located in the rural part of Dowa district, approximately 45 kilometers north of the capital, Lilongwe. At any given time, Dzaleka Camp has over 10 thousand refugees. According to recent records in deputy camp administrator’s office, as of June, 2014 there were 19,232 refugees. Before Dzaleka Refugee Camp was established, Malawi used to have many refugee camps including the recently closed, Luwani Refugee Camp in Mwanza district. These camps provided shelter for millions of refugees who had fled a 15-year-old Mozambican civil war that ended in 1992. Soon after Mozambican refugees started repatriating to Mozambique, another wave of refugees emerged. This new wave of refugees was Somalis. The number of Somalis fleeing into Malawi became so alarming that in 1994 the Malawi government established Dzaleka Refugee Camp on the land where Dzaleka maximum prison once existed. As of June 2014, Dzaleka Refugee Camp had slightly over 19,000 refugees. Countries represented in the camp include Democratic Republic of Congo (DRC), Rwanda, Burundi, Ethiopia, Somalia and Sudan among others. DRC, Burundi, Rwanda have a lot of people represented in the camp. While Somalia, Ethiopia, Sudan and others are less represented.

Dzaleka Refugee Camp in Malawi faces many challenges. These challenges include shortages of food, hygiene, housing, domestic violence and lack of quality health care. I have discussed these challenges in details in the “Dzaleka profile” section of this paper. In response to

these challenges, over the years, the government of Malawi and humanitarian organizations have partnered in various ways to provide and sustain various social services among refugees in the camp. The UN Agency, UNHCR plays the leadership role for other humanitarian organizations in ensuring the quality maintenance of the welfare of the refugees through various services that other organizations offer in the camp. In Malawi, UNHCR also supports voluntary repatriation, particularly to Burundi and Rwanda, whenever conditions are conducive for return (UNHCR 2009). The agency supports the Malawi government in the Refugee status determination (RSD). Along with WFP and Malawi Red Cross Society, UNHCR further endeavors to ensure that basic needs of refugees living in Dzaleka Camp are met including food, education and health care (WFP 2010). The rest of the other local and international organizations take part in offering allied social services along with the UN Agency, UNHCR. These services include education, health, sexual and gender based violence prevention, micro-business loans, nutrition education and counseling among others. For instance, Plan International provides services to curb sexual and gender based violence (SGBV). Malawi AIDS Counseling and Resource Organizations (MACRO) work in Malawi and have been to Dzaleka Camp to provide HIV/AIDS education and HIV Testing and Counseling (HTC). World Food Program (WFP) in collaboration with Malawi Red Cross Society provides food and nutrition services usually every fortnight. They provide fixed food ratios to the refugees depending on family sizes. National Aids Commission (NAC) is committed to providing HIV/AIDS response services such as health education, counseling, and testing. Jesuit Commons: Higher Education at the Margins (JC: HEM) is an initiative of the Society of Jesus that brings Jesuit higher education to those at the margins of society. It draws on the rich and centuries long Jesuit tradition of higher education and mobilizes the resources of the Jesuit worldwide network of educational institutions (JC-HEM).

One of the social services that some agencies provide to refugees in the camp is non-formal health education. The organizations that offer non-formal health education include most of those mentioned above as well as *Banja La Mtsogolo* (BLM), Population Services International (PSI), Youth Alert, a special program of PSI, Family Planning Association of Malawi (FPAM), Dzaleka Health Center and other non-formal health education providers.

These organizations are both locally and internationally based and funded. This implies that there is a convergence of various cultures in Dzaleka Camp. The cultures of places where individuals working with these organizations usually come from countries with the culture different from that of Dzaleka Refugee Camp. Even staff members who offer and coordinate non-formal health education in the camp sometimes come from subcultures within their own countries of origin. The more diverse the origins of these organizations, the more culturally diverse are the people who work for them and with them.

On the other hand, Dzaleka Refugee Camp itself has people from various countries of origin, tribes, and ethnic groups. All these groups bring into the camp unique traditions, beliefs, languages, music, etiquette, perceptions and leadership styles among others. Combining both the external culture that comes from non-formal health educators along with the culturally diverse refugee community, it forms even an advanced level of cultural diversity. This likely becomes even more complex in non-formal health education sessions. Since culture is very influential in people's lives, human development, and daily habits, I assert that culture also influences people's approach to health education, behaviors and allied beliefs about health.

Consequently, with such cultural diversity in these non-formal health education sessions, it is possible that that the process, outcome and content of sessions are affected by the different

cultural perspectives and beliefs about health that health educators bring with them to the refugees in Dzaleka Refugee Camp.

Purpose of this paper

The goal of this study is to identify the role of cultural diversity in non-formal health education in the Dzaleka Refugee Camp, from the perspective of key stakeholders in the camp. The study documents the perceived and experienced challenges (and opportunities, if any) of cultural diversity in offering non-formal health education programs. The study also describes how non-formal health educators adapt to the cultural diversity in order to effectively pass along health information inside and outside the learning sessions, including ways that these health educators respect and value the culture of various cultural groups. The cultural diversity's complexity existing in Dzaleka Refugee Camp prompted the following research questions for this study:

- *What were the perceived and experienced challenges of cultural diversity for non-formal health educators and those who participate in health education classes?*
- *How well do stakeholders feel that non-formal health education classes respect and value the culture of all cultural groups represented?*
- *How did non-formal health educators report adapting to the diversity in order to effectively help participants learn health information?*

Significance of this Study

Few scholars, according to my literature review, have investigated the positive and negative role of cultural diversity on non-formal health education in diverse refugee camps. However, the power of culture in shaping people's health beliefs, practices and values argues for education practitioners, policy makers and researchers to understand the role of cultural diversity

in order to design the most effective approach to non-formal health education and development. And also to train health educators about how to facilitate health education activities in culturally diverse settings, such as multicultural refugee camps.

This study gives voice to different stakeholders participating in and offering non-formal health education in one refugee camp, Dzaleka. It also provides new and different insights into challenges and opportunities of cultural diversity for non-formal health education. As such, this study provides findings and implications that may lead to better learning for refugees needing health information in this refugee camp. Even though the study's participants will not experience immediate benefits from the findings herein, the study brings attention to the topic for future health education program designing and implementation that may improve the health knowledge, attitudes, skills and practices of refugees from a wide range of cultures.

Literature Review

In this section, I review the knowledge base about the health needs of refugees and the potential of non-formal health education to help meet those needs. I also present information about the cultural diversity of the refugees, as well as the concept of cultural competency and the potential role it plays in providing a lens through which health educators can navigate this cultural diversity to help refugees acquire knowledge and skills to meet their health needs.

Health Needs among Refugees

Refugees have a range of poor health conditions. Kumar et al (1990) assert that people who live in the slums, tribal areas and rural areas are affected with malnutrition, and the poverty experienced by refugees places them in this category. Population displacement is associated with

low nutritional status, inadequate water and food supply, lack of shelter, and overcrowding (Shears et al. 1987; Tool et al. 1988). Klause et al. (2000) assert that most people have less than optimal access to quality reproductive health services, but refugees often live in circumstances of extraordinary instability that further hinder their access. As the number of those who are war-affected grows, so too does our awareness of their reproductive health needs (Burns et al., 2000). This further calls for non-formal health education which is vital in meeting reproductive and general health needs.

Economically, the people in the camp community have various ways of surviving. Individuals run small-scale businesses, sell farm produce, groceries, beverages and clothes among other items. Other community members run businesses such as repairing electronics, bicycles and running restaurants. One community member expressed she does not do anything industrious due to lack of opportunities. Such opportunities include access to financial capital for business and inaccessibility of work permits for employment. As refugees, the host country Malawi does not allow them to take private or public employment even if they are qualified.

The camp is surrounded by villages that rely on subsistence farming for food crops and partially for income. While the opportunity to access a piece of land for planting basic food crops is sought after, it is not easy to access land. Rending land comes with an unaffordable cost. States News Service (2014) expressed the same concern that refugees at Dzaleka have limited access to arable land or any means of earning a living, rendering them largely dependent on assistance from WFP, the UN refugee agency, non-governmental organizations and the government of Malawi. Therefore, if refugees run out of food, the only option is to starve until the next food ration day. A guard at a food reserve manned by World Food Program expressed sympathy on the shortage of food refugees run into. He expressed that, “refugees’ food rations are not enough

to meet each family's needs even though it is portioned based on family size. Unfortunately, in the first months of 2014, WFP reduced food rations by more than half due to lack of funding (State News Service, 2014).

Poverty and economic hardships do not only put refugee lives at health risk but also pose a threat on the youths and vulnerable women. Poverty as justification, the youths and vulnerable women resort into prostitution. A few secondary school students expressed a concern on the increase of prostitution in the camp attributed to poverty and need to survive. Apart from the consensual sexual work, sexual exploitation of girls is also common. In a report, (UNHCR, 2005) recounted that girls have sex with older men in exchange for clothes and money, which is encouraged, by parents or foster parents. Girls describe that it is sometimes difficult to say no to sexual advances from boys as the boys use physical strength. Girls also said that sexual exploitation is related to food distribution. Rape, forced marriages, trafficking of girls and unaccompanied/separated children are further challenges the camp faces on regular basis (UNHCR, 2005).

Despite all these challenges, the clinic and hospital services are a challenge among the refugees. The camp has a clinic that offers immediate level of clinical services at a community health center before proceeding to district or central hospital. The need for district or Central [regional] hospital medical services depends of the seriousness of the illness. The health center is also the main provider of the community's non-formal health education. People from villages surrounding the camp also come to Dzaleka Refugee Camp's health center for medical services. Unfortunately, the health center does not meet the needs of the people. UNHCR (2005), reports of a group of children who made their statements about the health center.

“There is inadequate medicine ...and the types of medicine being provided are no more than three types, no matter how serious a disease one has, the same medicine is

administered, but we do not know why. We can complain about the problem in the health sector but there is no change. The common medicines are Panadol [pain killer], aspirins and ORS [Oral Rehydration Salts]. Apart from these medicine there are no others being provided at our clinic. (boys 14-17)” [UNHCR, 2005].

In relation to corruption, the children also made a statement.

That is at the hospital and you might be very sick and you need medicine but when you come then they don't have medicine, but surprisingly another will come and they will give them medicine. This is at the clinic in the camp. If I have to corrupt a nurse or a doctor I will get the medicine I am looking for. But if I have no money then I will not get medicine. (Girls 10-13) [UNHCR, 2005]

Finally one of the older girls in an older girls group had recently lost her father because of negligence in the hospital.

“I just forgot to say one thing. The way my father died. He wasn't sick or anything. He just fell down. He called me, that day I was eating. He told my sister to go call the doctor. When we go there, the doctor said he needs to come by himself because he is the one who is sick. We asked them to give us something to carry him and they refused. We took a door and carried him to the hospital. We wanted an ambulance to take him to Dowa [District level Hospital (bigger facility)] but they refused to phone the driver. We looked for transport to take him to Dowa and when we reached there they tested him and said he lost blood. He died in the hospital”. (Girls 14-19) [UNHCR, 2005]

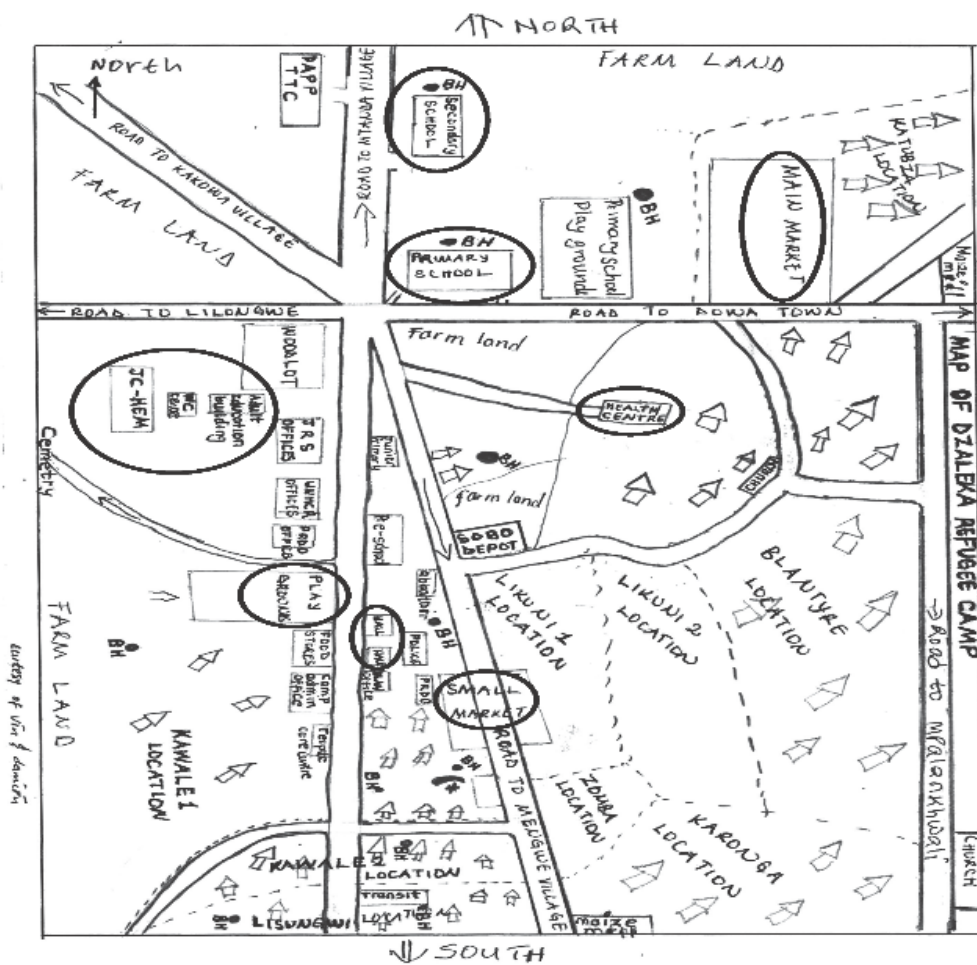
The challenges of medical services in Dzaleka Refugee Camp are not unique. Millions of people in the host Malawi face similar challenges. However, the community members in the camp are in a vulnerable and restricted situation. In other words, this is a place without opportunities if we compare with the host local communities. The health challenges of health delivery expressed by the girls above clearly align a report that came out four later. UNHCR and WFP (2009, p. 4), reports that, “there is a serious lack of qualified personal at the health center. Currently (2009), problems exist at the level of diagnoses and in the distribution of drugs. Hence both and training and recruiting of professional staff is necessary.”

Another challenge that potentially hinders the progress of improving health is health related decision making process. Even though there is a special place on health education among

the youths, adults have a great role in making decisions for their lives. Youth health education happens in order to keep them away from contracting HIV/AIDS and other Sexually Transmitted Diseases (STDs). Parents/adults are a significant part of the interviews because of their significant role in the camp. Men lead in decision making in this patriarchal community. For some men, such decisions include those at health, the household and community levels. On the other hand women (mothers) take a leading role in household chores. These chores are significant to the health of the community and families. Women chores such as preparing meals, watching and nursing small babies and looking after children play a big role on the families' health.

All these challenges together pose a threat on Dzaleka Refugee Camp. It faces poverty that leads to malnutrition, prostitution and other sicknesses. Lack of adequate and quality health services denies people the treatment when they get sick. All these challenges altogether put people's lives in the camp at risk. This is why non-formal health education is one of the ways of achieving a health community through the use of health information disseminated in health education sessions.

Below is the map of Dzaleka Refugee Camp:



Map: Courtesy of Vin and Damien, secondary school students in Dzaleka Refugee Camp.

Figure 3: Map of Dzaleka Camp depicting places (circled) where health education takes place

MAP OF DZALEKA REFUGEE CAMP

KEY.

JRS	: Jesuits Refugee Service
WC	: JRS Women's Centre
BH	: Water borehole
TTC	: Teachers Training college
🏠	: Residential houses
==	: Main road
---	: Locations' boundaries
~~~~	: foot paths
☾★	: Mosque
PRDO	: Participatory Rural Development Organisation (PRDO™)
PLAN	: Plan Malawi™.
JC:HEM	: Higher education institution (Jesuit commons: Higher education at the Margins).
▭	: Main buildings / offices / churches
UNHCR	: United Nations High Commissioner for Refugees

Approximate distances on Map;  
① From North to South = 2KM  
② From East to West = 1KM

*courtesy of Vin and Damien.*

### Health Education in Dzaleka Refugee Camp

Due to the enormous health needs among refugee populations, various stakeholders have responded by offering non-formal health education programs. Research findings point to the need for interventions that address HIV-behaviors in the younger age groups especially refugee

population (Rowley et al. 2008 p. 13). Health Education in the camp provides health information that provide health literacy understanding and acting on disease care, prevention and treatment. Health education taking place in and out of school is a great tool that provides an opportunity for underprivileged communities to live with well informed and proper health life styles. The system of formal education caters only to a small percentage of the population and it is not relevant to the majority of the people. This is very true for rural and disadvantaged populations, including refugees. In this context an alternative, non-formal education enables people to increasingly control situations that affect their lives. With non-formal education, health education can be given equal importance (Kumar et al., 1990). Non-formal health education is one particular intervention addressing various health challenges in Dzaleka Refugee Camp.

Previously, UNHCR has partnered with the Malawian Red Cross to provide health and HIV activities in the Dzaleka Camp. UNHCR works with the refugee committee on HIV/AIDS at Dzaleka, called DAHACO. DAHACO has been able to strengthen activities, mainly in the areas of promoting VCT (Voluntary Counseling and testing) among refugees and locals, supporting sports and youth activities, taking care of HIV orphans through foster families. Locals and refugees work together with the DAHACO committee to scale up HIV prevention activities (MERCK, 2009). One of the activities associated with the prevention activities, VCT is providing health education and training to various committees on teaching other community members on prevention, care and counseling. UNHCR (2004) report states that through it (UNHCR) and Implementing Partners (IPs), Dzaleka receives support to build a strong basic information education and communication (IEC) development, training and mobilization of peer educators, and the development of a mobile video program. In Financial support from Family Health International (now fhi360) has previously funded UNHCR'S IP, the Malawi Red Cross

Society to carry out its health activities. “Access to prevention of mother-to-child transmission (PMTCT) programs at local health facilities also improved with the assistance of UNICEF and district level health authorities”, (UNHCR, 2004 p. 9). Other implementing partners in the health education programs include BLM, MACRO, PSI-Youth Alert, NAC, Ministry of Health (MoH), Dzaleka Health Center and Local Health Committees in the camp.

These IPs and organizations can be described as follows due to the nature and structure of their health education delivery:

- a. Irregular health education delivery: These organizations usually visit the market area, sport grounds (i.e. soccer field), community center (indoor meeting hall), schools and any other viable public areas. These organizations normally bring with them public address system. They bring promotion such as T-shirts, caps, condoms, pamphlets, mosquito nets and other important materials to distribute to target audience. Their education sessions happen once in a while. These organizations include Banja La Mtsogolo, MACRO, PSI-Youth Alert. These organizations come to the refugee camp from Malawi’s cities and districts. I think these programs happen irregularly because they are expensive due to need for transportation, hiring music artists or celebrities and the needs to tour a vast catchment area. Sometimes they are work under the banner campaign.
- b. Regular/consistent health education delivery: These are organizations work in refugee camp constantly. These health education programs have a very visible presents through one or more of the following: representatives, employees, local committees, and clubs among trained volunteers among others. For example Dzaleka health center holds health education sessions every morning before the day’s work begins patients and guardians are encouraged to attend these sessions. Topics such as reproductive health, malaria,

malnutrition and outbreaks are covered. People from various tribes and national origins attend these sessions. An interpreter provides help in order to convey the message to a wide range of audience with various linguistic barriers. EDZI TOTO (NO TO AIDS) Club one of the school and students' owned organizations provides health education. These clubs spread all over Malawi. Even though they sometimes lack sponsorship and decline, they provide a great forum through which primary and secondary school students get health education. Main topics covered through EDZI TOTO Clubs include AIDS and reproductive health. Dzaleka secondary and primary school students become members of the club regardless of their backgrounds.

- c. Local and outside health education providers: As indicated above, various organizations come from outside the camp to offer health education sessions. They come from either Malawian based or Western based organizations.

Attendance of health education varies from the provider's targeted audience. For example PSI's youth alert goes to secondary schools and youth gathering places to teaching about HIV/AIDS, abstinence, safe use of condoms and VCT among other topics. Apart from the secondary school education tours, the project also airs a radio show covering similar topics for the youths. Radios are aired in English and Chichewa. This poses no communication barrier for foreign students immersed in English language at a secondary school level in Malawi.

Health education sessions that use an open-air ground for venue have no control over specifying of the audience. All people regardless of age, tribe, language or country of origin attend these meetings. This is very true for organizations like BLM and PSI.

While Dzaleka Health Center holds morning health education sessions, it also has other kinds of health education sessions by specific staff for specific audience.

## Cultural Diversity

Many refugee camps in Africa are made up of various cultural groups that present cultural diversity altogether. Center for Cultural Competence in 2000 ( U.S. & CMHS, 2003), defines culture as “an integrated pattern of human behavior that includes thoughts, communications, languages, practices, beliefs, values, customs, courtesies, rituals, manners of interacting and roles, relationships and expected behaviors of a racial, ethnic, religious or social group; and the ability to transmit the above to succeeding generations.” Looking further, we find that “diversity is an inclusion based on respect for cultures, beliefs, values and individual differences of all kinds... “Just as cultures share many universal elements, they also differ on many dimensions” (Perez, 2014, p. 24, 30). People including those in culturally diverse communities, learn from their own culture how to be healthy, recognizing illness and how they become ill. Meaning attached to the notions of health and illness are cultural-bound creating health beliefs (Spector 2004). Taking non-formal health education into diverse communities such as Dzaleka Refugee Camp means confronting various cultural-bound understanding of health beliefs, behaviors and practices among various tribes.

Dzaleka Refugee Camp is made up of people from various countries as shown in the table below:

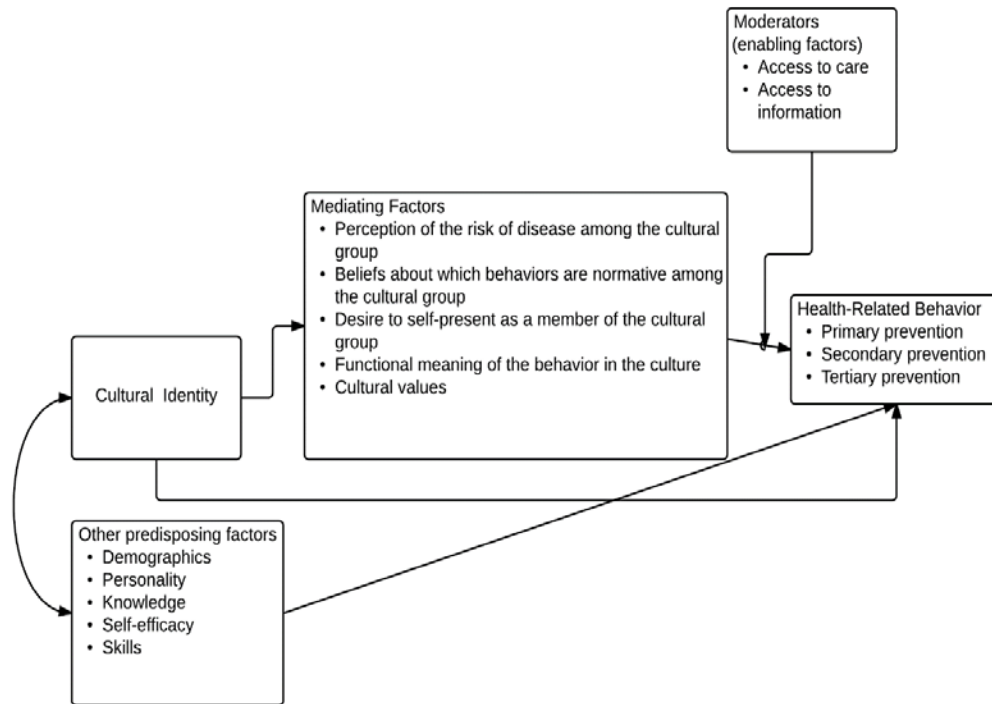
NATIONALITY	AGE GROUP										TOTAL
	0-4		5-11		12-17		18-59		60+		
	M	F	M	F	M	F	M	F	M	F	
Somalis	8	7	6	2	3	2	19	15	0	2	<b>64</b>
Congolese	995	958	1115	1035	815	653	2112	1650	19	28	<b>9380</b>
Burundi	476	457	597	580	410	345	1146	940	22	37	<b>5010</b>

Rwandese	284	309	531	530	369	438	1112	1059	56	48	<b>4736</b>
Sudanese	0	0	0	0	0	0	4	0	0	0	<b>4</b>
Ethiopians	0	0	0	0	0	0	22	0	0	0	<b>22</b>
Bel	0	1	0	1	0	0	2	0	0	0	<b>4</b>
Kenyans	0	0	0	0	0	0	1	0	0	0	<b>1</b>
Zambians	0	0	1	1	1	0	1	2	0	0	<b>6</b>
Brazil	0	0	0	1	0	0	1	0	0	0	<b>2</b>
Tanzania	0	0	0	0	0	0	0	1	0	0	<b>1</b>
Angola	0	0	0	0	0	0	2	0	0	0	<b>2</b>
<b>TOTAL</b>	<b>1763</b>	<b>1732</b>	<b>2250</b>	<b>2150</b>	<b>1598</b>	<b>1438</b>	<b>4422</b>	<b>3667</b>	<b>97</b>	<b>115</b>	<b>19232</b>

**Table 1: Dzaleka Refugee Camp population, June 2014 (Deputy Camp administrator’s Population Statistics, June, 2014)**

Unger (Schwartz et al. 2011), has proposed a theoretical model of the role of cultural identity in people’s decisions in engaging in specific health behaviors. This theory asserts that “cultural identity influences these decisions and that there are mediators and moderators of these effects” (2011, p. 814). Cultural identity can be dynamic in diverse cultural communities such Dzaleka Refugee Camp. Figure 2 below shows the role of cultural identity theoretical model.

**Figure 2: Cultural identity theoretical model (Unger, 2011, p. 815) in Schwartz et al, 2011.**



### Dzaleka Refugee Camp Profile: Beliefs, Culture, Health and Economic Welfare

Cultural identity in Dzaleka Refugee Camp plays a big role on health and allied life

issues in the camp. It is very relevant in this study to note that, “cultural identity represents an individual’s identity as a member of a group with shared characteristics, which often (but not always) include racial, ethnic, or geographical origins. Cultural identity influences multiple life domains, including ways in which people make decisions about performing behaviors that ultimately influence their health” (Schwartz, p. 811, 2011). Cultural identity has been associated with various aspects of health including people’s understanding of their vulnerability to various illnesses and their likelihood of performing health-risk and health-protective behaviors as well as health education (ibid p. 812). Cultural identity formation is continuous and dynamic process (Weinreich, 2009) and it influences people’s perceptions and beliefs about health, disease, how they use health information and allied actions to avoid disease (Mechanic, 1986).



Cultural identity in Dzaleka Refugee Camp affects people's understanding on the causes, cure and prevention of certain diseases. For example some people may understand witchcraft (bewitchment) as the cause of some of the conventional illnesses. Some believe that certain illnesses come as a result of anger from God or gods. In many cases, these understandings of disease etiology are contradictory to the western understanding of medicine and diseases.

It is vital to continue noting that one of the ultimate purposes of the non-formal health education is to facilitate behavior change for personal/community hygiene, disease prevention and/or care. This is done through people's use of the health information they get through non-formal health education. However, with cultural identity and diversity coming into play, non-formal health education can face either a tough or easy task towards behavioral change process. As in figure 2 above, cultural identity can influence primary, secondary and tertiary preventive health behaviors through the pathways shown (Schwartz, ed, 2011). Unger in (Schwartz, ed. 2011) further asserts that the key assumption of this model is that people are motivated to maintain consistency between their self-image and their behaviors. People are most comfortable when they act in ways that affirm their self-images created within their cultural identity roots.

As addressed somewhere else in this paper, Dzaleka Refugee Camp is made up of people of various cultural values, traditions and beliefs. These challenges pose a threat to how people adhere to health information that people get through health education sessions. In circumstances where religion and culture have heavily intertwined it is a challenge to pull them apart. For example, many Somalis in the camp associate themselves with Islamic religion. As a result, teaching them to incorporate pork for protein is an offense. Pork is not an acceptable part of their meal. One focus group highlighted specific nutrition traditional differences that exist in the camp. This is what he had to say:

*...in the camp there are people Somalis, and nearly all are Muslims. Telling them to eat pork for protein is an insult and offensive. In education where educators are not sensitive enough, they make such remarks without awareness of any offense -- Focus Group Male member.*

On the other hand, some members in the camp, especially some groups from Congo in particular value children as wealth. Those people tend to have children without proper child spacing and this puts the women's life at risk. This poses a challenge to the general health of families that are related to those who hold this belief. Having many children in Dzaleka Refugee Camp further puts pressure on nutrition in the family. The monthly food rations that people get in the camp are not enough to sustain families from month to month.

The other cultural belief barrier further goes on to the dependency traditional medicine for disease treatment. Belief and use of traditional medicine is widely relied in Africa. Dzaleka refugee camp is no exception. One nurse at Dzaleka Health Center expressed the awareness of the use of strings of traditional medicine tied around the children necks.

*One other thing...I get to see children with strings made from indigenous materials around the necks of children. Yes, they come here to get medical treatment, but they also believe the stuff on the child for healing. Sometimes it works...a lot of times people visit the traditional doctor first, if it doesn't work, they come here. Or if they start seeking medical treatment here, and if it does not work, they go to the traditional doctor [herbalist]. (Nurse, Health Center)*

These beliefs happen with various illnesses. In line with the information given by the personnel at the health center, refugees listed HIV/AIDS, sexually transmitted infections, cold and diarrhea as some of the communicable diseases affecting adults at the camp. In addition, many refugees suffer from non-communicable diseases, especially malaria, ulcers and hypertension. Refugees found malaria to be the most common diseases among children, followed by cold and roundworms. Also ringworms and pneumonia have been among the common illnesses. In the rainy season between January and March, cases of cholera can also be

confirmed, (UNHCR and WFP, 2009). Apart from the belief in choices of where to get medical treatment from, there is also a rich of worldview as to where diseases come from.

There are also beliefs in connection to spirituality and disease etiology. Some believe that some diseases come from gods, spirits, bewitchment, God as punishment, revenge, and spiritual discipline. Such beliefs as source of diseases can also contradict with the environmental factors in Dzaleka Refugee Camp. For example, “sanitation and drainage at the camp are poor. The number of boreholes is below standards and the existing ones have not been properly maintained. Water stagnates around boreholes and the need for proper drainage is event across the camp. Communal toilets are provided but they are few in number in many cases built too close to either housing or water sources, increasing the problem of sanitation. There are no areas for washing and maintaining personal hygiene that would also allow for privacy during these activities,” (UNHCR and WFP, 2009 p. 4). My interview raised that sanitation committees have been set to look into issues related to sanitation in the camp; hence, they are popularly known as sanitation committees.

Having a population that harbors a belief in traditional or spiritual causes of diseases besides the environment in turn seeks treatment in allied traditional source other than the clinics with western conventional medicine. Getting people stop using indigenous medicine they take pride in and have seen working to treat various ailments is a challenge. Providing non-formal health education that addresses the issue is not only provocative to the community members, but also likely to face resistance. The nurse further expressed that sometimes, women remove the stuff if visible and put it back on when they get back home. Indigenous medicine come in the form of roots, ground burnt roots, leaves, stem (tree bark), water with soaked leaves, root among many forms. Even though the challenges are the use of the proper dose, safety and sanitation, it

is still widely used. Interestingly, health education in Dzaleka Refugee Camp finds itself within a cultural element of using indigenous medicine.

## Theoretical framework for Analysis

My study stands on some theoretical assumptions. Firstly, I assume that cultural diversity in non-formal health education classrooms or open air sessions can pose various challenges, potentially influence its effectiveness. Secondly, I hypothesize that culturally competent education programs and educators may or may not deliver non-formal health education lessons effectively in a culturally diverse classroom/session, depending upon the competency of the health educator. Third, I assume that people's cultural beliefs, traditions, and values have a significant role in the way community members perceive, receive and respond to non-formal health education lessons.

This paper will use a theoretical concepts to understand data collected during the project and its relation to non-formal health education. *Cultural competency* is a “framework that allows us to design research and provide services uniquely tailored to reach communities and individuals by integrating and being responsive to the spectrum of factors that influence attitudes, behavior and experience”, (Rankow, p. 135, 1998). Rankow also asserts that these factors, or “cultural indicators,” include a complex interweaving of race/ethnicity, socioeconomic class, gender, age, religion, language, nationality, and degree of acculturation. Usually people enjoy living and working where culture is congruent to theirs. “Cultural competence is an ongoing process of organizational and individual development that includes learning more about our own and other cultures; altering our thinking about culture on the basis of what we learn; and changing the ways in which we interact with other to reflect an awareness and sensitivity to diverse cultures” (United States & CMHS, p. 12, 2003).

## Methodology

This section reviews the research questions and the process of inquiry. It also includes the researcher's position within this study. It further discusses the limitation of the study.

### Data Collection Methods

I approached the study through the use of qualitative interviews, focus group discussions, document review, and participant observations to gather data. I did this research in the Malawian winter. Winter season in Malawi runs from May through early August. This time of the year is ideal for research because there are no serious weather interruptions such as rain. On the other hand my target interviewees were aged 18 and older. In the months of May through July, classes are in session and this provided me with the opportunity to coordinate and interview the select students.

### Document review

I reviewed documents from various sources such the refugee camp administrator, UNHCR website and other online documents. I intentionally looked into documents addressing issues concerning Dzaleka Refugee Camp.

### Interviews

I conducted interviews with 40 people (20 students, 10 parents and 10 health educators). To get these people for interviews I used snowball (referral/chain) sampling. I chose sampling strategy in order to identify and have the people that specifically met the ideal candidates meeting particular criterion. In order to qualify for interviews, students were required attended at least twice health education programs in the camp. And they were required to be 18 years old or above. I chose this age because most ages around 18 are at a critical stage of life in the camp. If they went to secondary school, at this stage they have graduated. Unfortunately, after finishing

secondary school their academic dreams come to the end for a few reasons. Firstly, they cannot pay for college and do not qualify Malawi government loans as foreign students. They can work in Malawi except within the camp on voluntary basis. World University Services of Canada (WUSC) provides a few scholarships to handful secondary school graduates for tertiary education in Canada. Unfortunately the scholarship can only take so few that many qualified candidates are disappointed. Taking a “school leavers” status in the camp puts their lives at risky health behaviors such drug abuse, risky sexual relations and ultimately HIV/AIDS. For this reason, health education providers target such young people. Even though there is no exact number (statistics) of youths in Dzaleka camp, it is evident that the youths make up the majority of the population. This is why I chose a significant amount of the youths for interviews. These youths included those who were either in the final two years of secondary school or graduated but were attending post-secondary vocational training. Eventually, I noted this as a perfect audience for the purpose of the study. Each of these categories is very significant to participate in this study in Dzaleka Refugee Camp. Additionally, I also conducted a focus group discussion of 6 men and 6 women. I chose to gather data through focus group in order to get an advantage to have my research to be guided and informed by the target population. This reduces reliance upon researcher’s assumptions. I chose these categories because these are the key players in non-formal health education in Dzaleka Refugee Camp.

Here is the breakdown of all interviewees:

<b>Category &amp; Total</b>	<b>Gender</b>		<b>Country of origin</b>	<b>Health Education Attendance (sessions)</b>	<b>Length of stay in the camp</b>
	<b>Male</b>	<b>Female</b>			
20 Students	10	10	DRC: 7, Rwanda: 5, Burundi: 6, Somalia: 1	2-5+	2-13years

10 Parents	4	6	DRC: 5, Burundi: 3, Rwanda: 2	2 – 6+	2-15
Health Educators	5	6	Malawi: 7, Rwanda: 2, DRC: 1.		

**Table 3: Breakdown of participants.**

The interviews with all the participants were structured and took about 30minutes to one hour each. Regardless of category they were all 18 years old and higher. From the table above, you notice that some countries represented in the camp are represented in my interview participants. They are not represented because of their failure to fit into the criteria. Another reason is that there population is much less and it is difficult to locate them and assess their eligibility. With funding and time constraints, I was limited to follow up with such course of action.

**Focus Group Discussions**

My focus group discussions took about one hour. One other helpful connection in the camp that supported my research was a longtime friend who has a refugee friend, who is a pastor in the Dzaleka Refugee Camp. Through the pastor, I was able to identify community members who best fit the criterion for a focus group. This included men and women who have attended at least two health education sessions.

**Participant Observation**

In addition to interviews, I also used observation to collect additional data. I was introduced to the camp with the help of a native high school graduate from the camp. After getting familiarity with the camp, I did observations on my own. I spent some days going around the camp with the help of high school students. I developed great friendship with many students

who expressed their view of me as a role model. Our walk through the camp was two-fold purpose. Firstly, I toured to become more familiar and learn more about the camp. The second purpose was to observe people's daily lives purposefully look for ways people make use of health information they learn. At the same time I purposeful look for ways people fail to live up to health information they get from non-formal health education sessions. Observation as data collection tool helped me by getting to the bottom of everyday activities in the camp. For example, I attended morning sessions of health education for patients at Dzaleka Health Center. Every morning, Dzaleka health center hold morning health education sessions. Patients, clinical officer(s), nurses and health educators gather for health education before work starts. Malnutrition, HIV/AIDS, breastfeeding, Malaria and STDs are a few of many health topics that morning sessions cover. Going through the households that are highly congested, I saw how people take care of their water source, trash, and drainage systems. I observed their nutrition habits through interaction with families and individuals.

In order to get more details about the camp that otherwise I could not, I identified key people in the camp, such as two guards in the camp. First, I spoke with a guard on the premises of Jesuit Refugee Service (JRS), a key organization that provides vocational and higher education services to communities on the margins. I chose this guard because he is at a strategic place where visitors (foreign and local) do not miss visit. This place lies along one of the main entry roads to the camp. This road further goes to the sport facilities, camp administrator's office, and food reserve facility. In short, this guard is very much exposed to life of the camp. The second guard I chose watches over the premises of World Food Program where food is reserved. I found him to be at a critical place where the food for the community members in the camp is distributed. The pre-school, camp administrator's office, Plan International office that addresses



gender-based violence cases and the soccer field, surrounds his spot. The soccer field is where youths converge for soccer training and games. This sport is vital, as other stakeholders have used it as a tool for keeping the youths busy in the fight against the spread of HIV/AIDS and STDs. For the guard this place gives him the opportunity to get familiarity on food issues and regular happenings in the camp. Due to year-round fair weather, life in Malawi is general spent outdoors during the day. In Dzaleka Refugee Camp, people are always wondering everything engaged in business, sports, chatting in a communal way. Therefore life is very exposed, easy for observe and this why the guard were some of the key people in my study. In my interaction with the guards, I used semi-structures interviews. I noted their responses in my book after each informal conversation. I visited each guard three times on different days and the unstructured interview flew within our conversations.

The other key people I interacted with are the secondary school teachers. I have known the teacher more 10 years when he taught at alma mater. He currently teaches at secondary school in the camp. He helped me identify ideal students for my interviews at the secondary school. I also had an unstructured interview with him throughout my research in the camp.

The health center director, camp health services coordinator and deputy camp administrator were key to proving vital information on demography of the camp, health issues orally and written documents. They were all key persons providing vital data help to identify key interview participants, getting consent forms done and finally linking me up with the Malawi's Ministry of Health in getting the permission to do research in the camp.

### Data analysis Strategy

At the end of data collection, I divided my data into categories. These categories included interview data, focus group data, document data, and finally data from the observations and interactions with people and Dzaleka Refugee Camp literature. For data that I collected through observations, I used relational data analysis. In this analysis, I identified concepts and explored relationship between these concepts. In the process, I used three basic procedures including noticing the concepts, collecting examples of these concepts and analyzing these concepts in order to find the commonalities, difference, patterns or structures among them.

For both semi-structured and structured interviews, I used an inductive approach to analyze data. An inductive approach involved making specific observations to break the written data (notes, questionnaire responses) into words phrases, sentences and paragraphs. Then I gave one or two words summary or code for each chunk/line of data. I then looked at the list of the codes and reduced them to a smaller list easy to manage and compare. I categorized overarching codes into major themes that reflect the purpose of the research and its major question/s. Finally, I constructed a narrative from themes descriptions quotes from my interviews to support the ideas captured in the themes. This further includes a discussion of the interrelationships between these ideas.

## Stance of the Researcher

My position as a Malawian had a significant impact on this research project. I was born and raised in Malawi. I have worked and schooled in Malawi from kindergarten through my college. Due to a large population of refugees that has incorporated itself into various parts of Malawi cities and towns, I have interacted with them. This has given me the familiarity of refugees' life (challenges and opportunities) found at Dzaleka, Dowa where the refugee camp exists. This further provides me with the privilege of Chichewa language fluency for interacting

with a few refugees who have lived in Malawi long enough to speak the language. Those refugees that have integrated into the general Malawi population look for various opportunities to survive. They do business and have access to various social services just like any other local individuals. Their presence in ordinary neighborhoods has given me an opportunity to interact and learn more about them way before this research.

Culturally, I found it easy to integrate into the Dzaleka community because of my background as a Bantu, which is similar to most of the refugees in the camp. This cultural similarity gave me an opportunity to immerse myself into the camp without fear of critical identity challenge. However, I faced the language challenge, which at many levels posed a hitch on communication. It is clear and acknowledgeable that my position can affect the study at various levels. However, I have done all to eradicate any associated challenges by upholding professional conduct with all participants. I shared my background and answered questions, provided information related to the study.

### Limitations

This study has limitations due to its nature as a short-term and small-scale study. Summer alone for the study time in Dzaleka Refugee Camp was not enough. Limited time means that the number of participants was also small. This limited time did not allow me to attend various health education sessions that happen during some other parts of the year. Limited funding influenced my time allocation for the study to summer only. My studentship also influenced my choice of the summer to do the study in the summer only.

Another challenge was tracking down health educators who have worked in the camp in the past. Some educators are no longer working with the organizations that offer health education in the camp. These were not easy to find and do interview, especially when organizations have

not kept where-about records of their previous employees. This limitation influenced me to interview new health educators even those without much experience.

One other limitation during this study was language. Dzaleka Refugee Camp is has over seven widely spoken languages. Of all the languages, I was fluent in English and Chichewa. My research participants fell under various categories on language fluency. I did not have a problem with participant spoke English and Chichewa well. For participants fluent in other languages other than Chichewa and English, I needed a translator for help. Some high school students and one man volunteered to offer translation for me. The man who translated for me had worse challenge in providing translations than the students. As result, the process was so slow that I had to delay or reschedule some other interviews of the day.

This is my first entire qualitative research endeavor and, as such, has been a learning experience. Conducting interviews, collecting data, analyzing and presenting my own data has given me the opportunity to learn. To encounter this limitation, I have sought support from professors and fellow students. Through their support, I have made use of best practices in order to stay within the standards of the field.

## Findings and Analysis

In this section, I present the findings of this study along with its analysis. There were three major questions that guided the study.

*What were the perceived and experienced challenges of cultural diversity for non-formal health educators and those who participate in health education classes?*

This question was directed at the 42 interview and focus group participants, which included the educators, students (youths), and parents. The study's focus group also discussed this question. To stir relevant responses from the participants, aligning with the study, sub-questions were developed. These were the questions that inquired to find out if participants had found non-formal health education beneficial. Whether they found them beneficial, the study probed more to the reason behind their "Yes or No". The study further inquired on why interviewees found non-formal health education either beneficial or not.

From the responses, the participants split between the "yes and no" response on whether they found the sessions beneficial or not. Finally, the question was to inquire the difficulties associated with the cultural diversity in the sessions.

Details of participants				Found health education beneficial	
# of students	Nationality	# of sessions attended	Length of Stay in the camp (years)	Yes	No
20 Students	DRC: 7, Rwanda: 5, Burundi: 6, Somalia: 1	2 -- 5+	2-13	17	3
10 Parents	DRC: 5, Burundi: 3, Rwanda: 2	2 – 6+	2-15	10	0
12-member Focus Group.	Rwanda: 2, DRC: 10.	2 -- 7+	1 – 15	9	3

### **Table 3. Participants' Perception on the benefits of Non-formal Health**

Out of 42 participants, 6 participants said “no”. They did not find health education beneficial. With this in mind and upon analysis, themes came up that might have contributed to the “yes” – “No” answers in the question above. These included relevance and communication.

**Relevancy:** This came up as a theme, more especially around three facets of “relevance” perception. I was surprised that relevance emerged as both positive and negative among various interview members. Firstly, some participants expressed cultural diversity made non-formal health education interesting through involving traditional activities into the program; hence, making cultural diversity relevant to non-formal health education. Having people of various nationalities bring music and traditional dances carrying health education messages made the program or sessions very interesting and fun to participants. Study participants provided the following thoughts:

*...on World AIDS Day many people from the community we gather together for various activities. Poem recitals, traditional dances, music all incorporate health information for all people present. I think that including cultural art shows value and respect of our culture. **Female community member - Focus group***

*... people do not seem to come for the real education but to enjoy watching Amahoro dancers. **HSA, Malawian Male***

While it is very significant that including traditional and cultural activities is one way of appealing to people's participation, if their inclusion achieves the purpose of non-formal health education. It is unclear whether or not the core aim of including these activities is to use them as a media for health messages to participants. Nevertheless, I believe that these cultural activities become appealing because of the opportunity available to community members to watch other people's cultural life apart from their own. I also that this aspect of relevance happens in two ways. Cultural diversity has been relevant on non-formal health education. On the other way

round, non-formal health has also become relevant for diverse cultural groups to express their diversity in constructive and educational way.

Contrary to this positive aspect of cultural diversity relevance, a few participants expressed concern of perceiving cultural diversity as irrelevant on non-formal health education. I believe that this did not come up to discredit the value of cultural diversity in the camp, but as a concern on challenges it raises on some community members.

*I feel that my neighbors do not feel welcome to be here when we discuss issues of HIV/AIDS and polygamy. Polygamy is bad because it promotes the spread of the virus. I don't know how teachers can teach in their presence. In our program we talk about it as a bad habit that needs to stop. – **Parent (female), Rwanda***

*You [interviewer] have seen today, women celebrating around the new born baby and the mother. That is the tradition. Children are highly valued among them [Congolese]. As such bearing children without proper spacing is common for the most I have worked with. The challenge is that not all men are interested to come and learn about reproductive health. Now even we teach the woman alone. She is not strong enough to convince the husband on the effects of this kind of children bearing. **Health educator, Malawian***

In responding beliefs and traditions of other community members of the camp. One interview participant highlighted specific nutrition differences that exist in the camp. This is what he had to say:

*...in the camp there are people Somalis, and nearly all are Muslims. Telling them to eat pork for protein is an insult and offensive. In education where educators are not sensitive enough, they make such remarks without awareness of any offense. **Male focus group member, Congo***

It is evident from the sentiments that there is lack cultural competence in the process of running non-formal health education classes. By thinking through the cultural competence continuum, the scenario failing to find means to address someone's valued cultural belief could also mean failure to perceive the smallest differences that exist in diversity. This could further be classified on the negative stage on the continuum called cultural blindness. There the educators

might to believe that culture makes no difference and that all the non-formal health education participants are the same. On the hand I consider the educators might still consider themselves unbiased and meeting all cultural while failing to address cultural sensitive spots.

Finally and surprisingly, relevance also emerged from the community and not from a health education classroom setting. This relevance emerged from perception of people attitudes towards non-formal health education. Attitudes seem to disregard non-formal health education not because necessarily for cultural diversity reason, but attributed to lack of basic needs and competing values. One student, narrated how she noted many students and out of school youths never adhered to health education messages:

*...I have heard girls say that HIV/AIDS came for people. These girls go around to prostitute, yet they have participated in health education. The question I have is, what is the reason of attending health education session? To me it is a waste.* **Male Focus group member**

Likewise one student expressed how she feels it disconnected on using some of the things she learns and her reality of the basic needs in the home.

*...we also learn about nutrition in some programs and they recommend to us the right diet. Unfortunately, I and my parents struggle to just find paraffin or candles to give me light for studying at night. And we cannot afford that kind of food.* **Female Secondary school student**

The student's expression is not unfamiliar among many camp community members. I think this challenge has worsened due to the demand on funding for food in other conflict settings around the world. Humanitarian organizations that provide food assistance such as the WFP has also extended its help in other regions such among the Syrian refugees.

The relevance raised here does not exactly relate to cultural diversity in the classroom only, but in the community where the learners are coming from. Therefore the health educators' understanding of the community's needs and factors that could hinder the applicability of health information is important.



**Communication:** Non-formal health education students who reported “No” when asked if they had found non-formal health education beneficial its reported language as one of the contributing factors. Linguistic issues barred the communication of the teacher to the student as well as the student to the teacher. One parent expressed:

*...we don't have single language in the camp and that makes it hard for me when my language is not used for learning about HIV/AIDS, Malaria and other diseases. **Parent, Rwanda***

*...sometimes you find participants from various countries in one session. If you are not the majority of the group, sometimes you have no translator for your language in order to get what is happening and being taught. **Student, From 4: Rwanda***

Despite communication being an issue in the classroom, I found it natural for people to associate with who and be where they fell comfortable. During my observations in the camp I noticed that other characteristics of the camp vindicated this parent's statement. This happens usually in two ways. Firstly, I noticed that religious associations such as churches have membership usually of similar culture. If it is not the one cultural group represented, then it is usually the majority. The other minority could also be attributed to intermarriages. It was clear that people love to associate with people who share cultural similarities. This provides a comfortable feel to communicate and interact on daily basis.

Secondly, there was association in the pattern of housing. In some parts of the camp, people of cultural similarities live together. And you also still find some other places where there is a great mix of housing. I believe that the reason for the mixture could be the lack of choices for the people who came late into the camp. They might had little or no freedom of choice in the land sharing process. These streamed associations have the impact to maintain people's inability to learn each other's languages and culture.

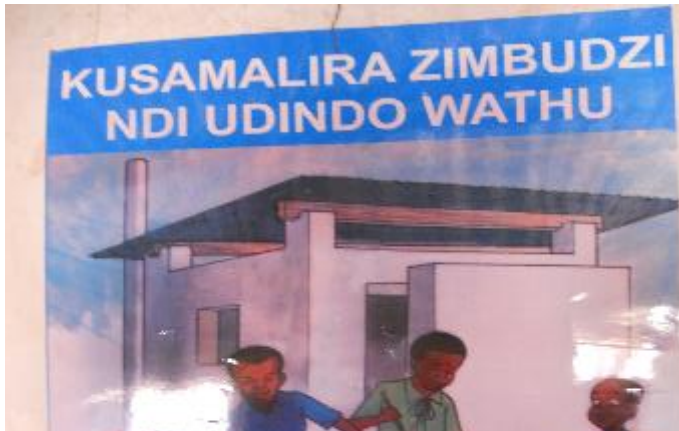
Regardless, I observed that youths tended to take advantage of cultural diversity to learn other languages. For example:

*I came here young and as I live here, I speak a few more languages. My mum speaks well one language only.. Heath education is one of many ways I interact with friends from other countries and learn from them. **Male High School Student, Form 3***

Using the interaction with students from other linguistic backgrounds, their peers start learning new languages. This tendency helps them bridge their communication gaps with other people from other cultural groups.

Communication was not only a challenge in the spoken words but also through the written words. These written includes those that appear on learning materials such health education posters found in the camp (see below). The challenge also includes handing out instructional manuals on how to use chlorine for treating water, proper use of condoms and contraceptives. All these come in languages that most refugees find themselves illiterate.

Usually English, Swahili and Chichewa dominated on health education posters in the camp. This left other tribes and nationalities left out. Here are some examples:



These are some of the pictures that display health information messages in public places in Dzaleka Refugee Camp public places as well areas around where health education takes place. However, the messages in the pictures are in the language that are not squarely representing the linguistic part of the camp.

In reflecting on the realities of camp, organizations that provide health education in the camp are falling short of meeting the three positive stages of the cultural competence continuum. As we see in the pictures above, they were designed to be accompanied by a script with them. Therefore, it is unlikely if the pictures alone can convey the intended messages. However, messages written in the language people cannot read are not helpful. As discussed above, organizations and individuals participate in continuing self-assessment of culture. They strive to expand their cultural knowledge and resources and adopt service models that better meet the needs of minority populations, and in this case, minority languages.

Suppose, all the visual learning/teaching materials were available in all languages found in the camp, would people be able to read? Obviously not. Making learning material to ease communication does not achieve communication itself. This is because on the other we encounter issues of literacy. I think the communication issue could also focusing on pictures that are self-explanatory to the audience in a culturally diversity.

*How well do stakeholders feel that non-formal health education classes respect and value the culture of all cultural groups represented?*

In this question, I wanted to find out how non-formal health education classes/sessions handle cultural diversity that exists in the sessions. To draw in the required response, sub-questions sought to an explanation on how welcome participants felt in the setting, methods of delivery of the health education lessons. These questions also sought to probe factors that helped

health education students to learn more effectively in the classroom. Even though questions were directed to all participants of non-formal health education. In the end of analyzing data, themes such cultural arts delegation.

**Culturally Embedded Education:** Most participants from both educators and learners expressed the use of cultural arts (drama, painting, music) and activities as one way non-formal health education valued and respected the cultural among various cultural groups in the camp. They expressed that cultural activity and materials to aid conveying health information during the education.

In the actual sense interview data from these participants indicates that the cultural embedded education emerges in two ways. Firstly, are the activities and secondly are the tangible materials. Participants expressed that they had experienced and perceived the presence of learning tools incorporated in the education programs. For instance talking of Population Services International (PSI) and Banja La Mtsogolo (BLM), one participant said:

*...usually when they [BLM and PSI] come to teach about HIV/AIDS, they usually bring live music, drama and distribute poster. The only challenge is that most posters are in Chichewa and English languages. Not all people in the camp are fluent in either language. The music and drama attract people to come and attend health education sessions.* **Female Secondary School Student: Burundi**

The interview participants also expressed that cultural inclusive activities in health education programs were able to cover most of the represented groups in the camp.

*When you come and watch all camp education days such world AIDS day, you will be amazed. It is a very exciting moment. Nearly every represented country showcase their traditional talent and riches to teach others on specific health topic.* **Security guard, JRS**

In my personal observations as an interviewer and observer, I noted that every art was actively inclusive. Another example is that of the camp health center that holds non-formal

health education sessions before work to see patients begins. In these sessions, music with messages is included in the program. However, the challenge remains. Some people do not understand some languages in music or other cultural activities. However, with the use of translators and the fun accompanied appeals to the community members for participation.

Interestingly, a Malawian security guard noticed the positive impact that comes with cultural inclusive non-formal health education:

*Yes in the camp those from Congo tend to live together. Those people Rwanda, they tend to live together and so forth. While this tendency brings them apart, education programs in the camp bring them together regardless of origin.* **Malawian, IRS Compound Guard in the Camp**

My question that came up in the data analysis process is how this togetherness flows into the community. Do health education committees facilitate and reinforce unity in the camp?

While I do not know the answer, it is very evident that these health committees are made up of a diverse membership.

I think that the use of local committees in the health education programs is a vital way of bridging the gap between ordinary community members and educators from outside the camp. There is one major outstanding problem that I think comes in the way of non-formal health education program by involving the committees. This comes in two ways. Firstly, as a patriarchy community, gender disparities in the issues of addressing health issues at family or community level. As addressing somewhere else in this paper, there are more women than men who actively participate in non-formal health education. Therefore this is likely to bring challenges in a patriarchy community where men dominate in decisions on various issues. Secondly, addressing own cultural beliefs that are detrimental to the community's and family's health. I have also addressed in this that some cultural values such bearing more children with minimal spacing puts women's health at risk.

*How did non-formal health educators report adapting to the diversity in order to effectively help participants learn health information?*

This question was primarily directed to health educators; however, I also considered the perception of the interviewed health education participants. To inquire some of the methods that they use in order to adapt their lessons in a culturally diverse classroom or sessions. Adapting in this context, means being able to improvise teaching methods, content, aids, and any other means in order to convey health education information effectively to every participant regardless cultural background in the education program. In analyzing their data two major themes emerged, and these are support system and lack of resources. The support system emerged as a positive and optimistic element incorporated in the health education classrooms, while lack of resources a recurrent theme that made health educators very pessimistic on the success in adapting health education classes to the culturally diverse classrooms.

**Support System:** The support system emerged as a positive theme that that help health educator easily contextualize health education to the needs, characteristics of the various cultural values and beliefs. For example one educator expressed how the recruiting and training local staff members provides needed help to address issues of language barrier. Similarly, other participants also expressed the availability of local groups, organized by health educators to carry follow ups outside the classroom.

*...with the support of the health center, community organizations and local leaders, we have committees that help coordinate taking care of the community water sources. These committees enforce sweeping and making sure that people are washing clothes away from the water pump to avoid contamination. -Congolese-male focus group member*

*...we also have a few fellow Health Surveillance Assistants (HSAs) who are of different nationalities in the camp. They are instrumental in working well across cultural barriers in the camp. -HSA, Malawian*

In my observations and interaction with some of the health educators, I came across HSAs who have been recruitment based on country of origin and some related qualification to teach health education. One Rwandese HSA I interviewed has the role to providing support to students outside the classroom reinforce the use of knowledge that they have acquired. The camp also has a network of volunteers who provide translations services during health education sessions. For selected morning pregnant and nursing women come to the clinic to get vaccine. But before they get the vaccine they gather and learn various topics on health education. Due to the fact that not everyone understands English, Swahili and Chichewa the volunteers or assigned staff member help in interpreting for others. One educator put it this way:

*...as a Malawian nurse, there are times when I also struggle to interact with patients, guardians to interact as I teach health. But he (the Congolese gentleman) helps us with understanding the language and also helps me to understand their frustrations. We also have other qualified educators in the health center who are not Malawians but come from Congo and Burundi. They bridge the cultural gap between learners and us. You see, sometimes it is tough to get respond to what I am saying to them as my as clients. However, when the fellow educators who coming from the same countries with the clients, it becomes easy.* -**Malawian nurse-maternal health educator and counselor**

Looking deeply at the sentiment above, we can also conclude the camp has lack of culturally competent staff. However, it is very interesting that educators use local people to overcome this deficit both within and outside the classroom. One secondary school student further narrated that:

*...in the camp we have a sanitation committee that teaches other people how to keep our boreholes, wells and taps clean. They make sure they enforce that community members are keeping our water sources clean:* **Secondary school student, Female**

In my observations, I learned that sanitation committees are made of local people that have been closely trained in a special area of health education expertise in order either teacher or reinforce other to practice or a combinational of both. However, some participants indicated



dissatisfaction on the provision of social support. While the support is present, it fails to reach out to all communities with who are the most minorities culturally. Talking of Somalis, one participant said,

*...they (Somalis) speak a language that is tough to read and write [I suppose because of its alphabet characters]. At the same time they are not as many as others. Finding someone who can translate for them is not simple.* **Focus Group Member DRC**

It is very true the Somalis were once the majority, but now they are one of the most minority groups in the camp. This implies that most of the time they do not enjoy some privileges due to their minority status.

On the hand, I found that some health education topics surrounding sexual or reproductive health have a tough interaction among local members or with the educators in the community. People consider talking publicly sexual issues as an embarrassment and for privacy talk. However, to deal with this challenge, the health educator and a student expressed the following points respectively:

*...these days we encourage families to discuss issues related their health. Discussing on HIV/AIDS, and reproductive health. Family involvement helps every family member participate. We especially encourage husbands to accompany their wives to the clinic during pregnancy. This helps the husbands learn together what other the only the wife would have learned.* **Health Educator, Malawian**

*...here in our school we have various clubs open to students. Through these clubs, students go through guided sharing and discussions in various topics. HIV/AIDS [also known as EDZI TOTO in host Malawi] Club is one of these clubs. The club is also extended to upper primary school.* **Male Secondary School Student: Rwanda**

Health educators make use of social groups in the camp to make sure that they are able to adapt health information into the camp. It is evident from their observations that these social groups are not only conducive for health education channel, but also the means through which relative or peers can be free of each other and tackle health issues with a greater freedom.

**Lack of resources:** While lack of resources fits well as the challenges associated implement non-formal health education in the camp, it rather came as more of a challenge associated with adapting health education among the culturally diverse participants in the camp. Most non-formal health educators indicated and acknowledged knowingly and naively their inability to adapt their work to cultural diversity in the camp. However, I found regardless of either acknowledgement, they attributed failure of adaption to lack of resources. One HSA narrated:

*...we had official from the ministry of health promise us to provide health information/education posters in other languages. But as you see, it is now three years we have had no feedback. This means only people who can read in Chichewa language can stand the educative health information in these posters. **Nurse-health educator, Malawian***

I found it interesting that some women in the focus group expressed a similar concern: *...regardless of your sickness, it is not easy to get help one needs from the health center. They only say they do not have the right medicine. **Focus group female member, DRC.***

*...it is only those who are financially better who can afford health services outside the camp at a private clinic, as the rest of us struggle on the panado [type of drug]. **Focus group female member, Rwanda.***

*If the only ambulance we have is not available for critical sicknesses, we have to hire a car on our own and that is expensive. **Focus group member, male DRC***

While these expressions are focused on medical treatment, the challenge also flows into the need for appropriate health education materials. The Dzaleka Refugee Health Center is too small to address health needs of the population in Dzaleka Refugee Camp and the surrounding areas.

*...on average we have between 400-500 outpatients every day. From this number, about 60% percent are Malawians who come from the surrounding community. In the camp there is a small number of people considered upper class, those doing small scale businesses. This class goes to the private clinics to seek help....as you have noted, every morning we teach all out patients in morning as soon as they arrive. We have translators who help out...yes it is time consuming to the whole chain of translating into the need languages. **Clinical health officer, In charge of Dzaleka Health Center, Malawian.***

A degree holder in Agriculture works to assist the health education section of Dzaleka health center. He speaks Swahili, French and Chichewa.

*...sanitation, HIV/AIDS, safe water, childcare, family planning are some of the areas that I teach in groups or one on one depending on the situation. If someone comes but does not speak any of my languages, they have to come with a neighbor or friend to translate for them. This compromises the issues of privacy when discussing personal health issues mores especially HIV/AIDS. People do not easily want to publicize they are HIV positive to any person anyhow. Some issues such as reproductive health, wife inheritance, polygamy can be too personal to be discussed along with a third or fourth person. **Male health educator.***

With a situation like this, I agree that adapting health education programs can be challenging from various aspects. Firstly, relying on translators poses various threats to the effectiveness of the health education. For example, the messages can be distorted between the teacher and the final audience. Secondly, if the interaction is very cultural sensitive, people could resist contributing their thoughts, ideas or challenges. Now, the question could, how can this be solved? This is where the need for resources comes in. Training more educators from the same culture could offer a better platform. However, as indicated elsewhere in this book, involving people of the same culture has a bias threat. Confronting your cultural beliefs that promote ill health can be overlook or taken for granted.

One educator above indicated delayed support to solve lack of learning materials that are in one's own language. Producing such materials is possible and effective with the assumption people are literate in their own language. Therefore, a need for coming with more innovative ideas on relevant and accessible materials could be one of the solutions.

Surprisingly, I found it identical that as health educators' concern on lack of resources is also well expressed among learners. These learners do not usually have readily available food for nutrition all the time. There is no proper sanitary materials such as soap and other disinfectants to use in their community.

## Conclusion

Non-formal health education programs are very vital in needy and fragile communities. Dzaleka Refugee Camp is one of such places where non-formal health education programs take. While non-formal health education program can be challenging in culturally homogeneous communities, it is even more challenging in a fragile and culturally diverse community. I have learned that cultural diversity is not as easy as we verbalize it. Let alone in a refugee camp.

In this small exploratory study, I looked at the impact of cultural diversity of non-formal health education in Dzaleka Refugee Camp. I recognize that the sample was very small; therefore, hard to generalize the findings to the whole camp or replicating in similar contexts. However, a couple lessons emerged which undoubtedly can provide some insights to other people with academic and professional interests in the in the allied field.

Communication and resources are some of the majors challenges that non-formal health education programs encounter in Dzaleka Refugee Camp. Health educators strive to respect and value health education through incorporating cultural related activities in health education sessions and classes. In amidst of cultural diversity, health educators use the social-cultural ties (groups) that exist in the camp in order to adapt their content and methods. This further helps solve the cultural gap issues that exist normally among educators and learners of different cultures. Despite the attempt to provide a comprehensive non-formal health education in the camp, lack of resources remains one major challenge.

While this project focusses on non-formal health education and cultural diversity role for its success in Dzaleka Refugee Camp, fragility of the community also plays a big part. Even though it is true that cultural diversity brings dynamics on non-formal health education, fragility could also be a confounding factor in the challenges associated with the failure of non-formal

health education. This implies that in dealing with cultural diversity to address non-formal health education challenges, it is also very important to critically consider and appropriately address the fragility of the community.

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## Appendices

### Interviewees: Students and Parents

1. Demography (Optional but encouraged):
  - a. Age
  - b. Religion
  - c. Country of origin
  - d. Tribe
  - e. For How Long Have you been here?
  - f. what and how many language/s do you speak
  - g. Marital status
  - h. Occupation
  - i. Level of education
2. What are the non-formal health education programs you have attended, attend or plan to attend?
  - a. If yes, in what language did the instructor/educator teach?
  - b. How fluent are you in the language (understand, speak, don't speak, read and write, do not understand, do not read and write)
3. What other people participate in the health education programs?
  - a. What is the background of other participants (country of origin, language/s they speak, sex, and ages)?
4. What health issue/s does this health education program address and why those issue/s?
  - a. What tools did the educator bring for teaching (e.g. drawings, pictures,)
  - b. Are those tools acceptable to use in your in culture?
5. What is your motivation for participating in health education?
6. What is your experience attending non-formal health education?
  - a. Language fluency
  - b. Topic in relation culture
  - c. audience diversity (co-existence)
  - d. Dressing (make-up, attire)
  - e. Did you feel included or embraced in the course learning
7. Who offered/offers or will offer the health education you have attended or plan to attend?
  - a. Sex
  - b. Age (youth, adult, aged)
  - c. Country and tribe of origin
  - d. Language of the educator
  - e. Dressing
8. On a scale of 1 to 4 (1 means little and 4 means much) how much do you think you learned or learn in health education? Please provide the reasons that contribute to your learning of that much.  
1= Never, 2=Little, 3=Average, 4=Good, 5=Very good.
9. What are the cultural challenges you have experienced or experience during the health education?



10. How welcome do or did you feel in the setting, methods including delivery of the health education programs? Please explain.
11. What do you think are the factors from the health education providers that affect your health education learning?
12. What factors do you feel and think affect you from using what you learn or have learned from health education?
13. What are the community cultural practices that you know affect the practice of what you learn through health education? And Why?

**Interviewee: Students (youth) and parents**

1. Demographic (Optional but recommended):

- a. Age: _____
- b. Country of origin: _____
- c. Tribe and native language: _____
- d. For how long have you been living in the camp: _____
- e. What and how many language/s do you speak: _____
- f. Level of formal education: _____

2. What are the non-formal health education programs you have attended, attend or plan to attend?

- a. If yes, in what language did the instructor/educator teach?
- b. How fluent are you in that language (understand, speak, don't speak, read and write, do not understand, do not read and write)

3. What other tribal groups of people participate in the health education programs?

4. What is the background of other participants (country of origin, language/s they speak, sex, and ages)?

5. What health issue/s does this health education program address and why those issue/s?

- a. What tools did the educator bring for teaching (e.g. drawings, pictures,)
- b. Are those tools acceptable to use in your in culture?

6. What is your motivation for participating in health education?

7. What is your experience attending non-formal health education?

- a. Language fluency
- b. Topic in relation culture
- c. audience diversity (co-existence)

d. Dressing (make-up, attire)

e. Did you feel included or embraced in the course learning

8. Who offered/offers or will offer the health education you have attended or plan to attend?

a. Sex

b. Age (youth, adult, aged)

c. Country and tribe of origin

d. Language of the educator

e. Dressing

9. On a scale of 1 to 4 (1 means little and 4 means much) how much do you think you learned or learn in health education? Please provide the reasons that contribute to your learning of that much.

1= Never, 2=Little, 3=Average, 4=Good, 5=Very good.

10. What are the cultural challenges you have experienced or experience during the health education?

11. How welcome do or did you feel in the setting, methods including delivery of the health education programs? Please explain.

12. What do you think are the factors from the health education providers that affect your health education learning?

13. What factors do you feel and think affect you from using what you learn or have learned from health education?

14. What are the community cultural practices that you know affect the practice of what you learn through health education