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# Capacity Building of Health Workforce: Investigation of Training Process for Community Health Volunteers (CHVs) Serving Refugee Populations in Host Communities, as Perceived by Participants and Trainers

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*Capacity Building of Health Workforce:*  
Investigation of Training Process for Community Health Volunteers  
(CHVs) Serving Refugee Populations in Host Communities, as  
Perceived by Participants and Trainers

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### **Key Words:**

Public Health

### **List of Acronyms**

CBO	Community Based Organization
CHV	Community Health Volunteer
NGO	Non-Governmental Organization
UNHCR	United Nations High Commissioner for Refugees

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Firstly, I would like to thank my family for raising me to view myself as a global citizen and thus supporting my decision to travel to Jordan in order to explore academic and personal interests.

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Sincerest thanks to Dr. Bayan Abdulhaq, the Academic Director for the SIT Jordan: Refugees, Health, and Humanitarian Action program, for guidance throughout this project and for connecting me with organizations and resources used to do this research. As well as Dr. Ayat Nashwan, who served as my advisor for this independent study project and provided immense feedback throughout the process. I would like to thank Leena Jumah, the SIT Program Assistant, for translating my questionnaires and written consent forms. Thanks to Ms. Maha Ghatasheh, a Training Coordinator, and Ms. Ayat Abed Al-Khatatneh, an Outreach Officer, at the Institute for Family Health for their help in data collection logistics, as well as translating as I distributed the questionnaires and explained the instructions. Additionally, I would like to express my appreciation to the following organizations whose assisted me in recruiting participants, helped with gathering material culture, and allowed me to interview their representatives: Institute for Family Health, International Rescue Committee (IRC), CDC Karak.

I would like to thank the community health volunteers who participated in my study by completing the questionnaire and the aid workers who I interviewed.

## ABSTRACT:

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The health system in the Hashemite Kingdom of Jordan, which hosts 1.4 million refugees from the Syrian Arab Republic—more than 636,000 of whom are registered with UNHCR—is over-extended (UNHCR, 2016). Non-governmental organizations fill gaps in service delivery by injecting health personnel to deliver care, however, nationals and refugees must be integrated in the response to ensure sustainable health care delivery (UNHCR Handbook for Emergencies, 2007). Leveraging the capacities of lay citizens and refugees by task shifting and training CHVs can alleviate the increased health burden. Research into training programs is significant because the quality of training is directly related to the effectiveness of CHVs.

This research project investigated the training of CHVs serving refugee communities, as perceived by the trainees and the trainers. The objectives of the study were to characterize the process of training CHVs, assess the extent to which the training programs build their capacities and prepare them to fulfill their responsibilities, and identify the perceived areas of improvement for the training process. The researcher formed a relationship with Noor Al-Hussein Foundation Institute of Family Health in Amman to administered questionnaires to CHVs as well as conducted interviews with trainers. The findings indicate that the trainings adhere to standards and manuals developed by donors that operate under the same mandates concerning training CHVs. However, participants and trainers reported that a wider array of topics, longer trainings to cover more in-depth information, and increased resources to allow for use of effective techniques would improve the quality of the trainings and build the capacity of CHVs. This study can inform process improvement if applied by training institutions. Additionally, research field is important to policy makers who can apply findings to advocate for scale-up of CHV programs and increased investment in the capacities of human resources.

## INTRODUCTION:

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The researcher has an academic background in Global Affairs, with a focus on International Development, and Global Health. This research project was pursued in order to learn more about health response during complex emergencies, and more specifically efforts to strengthening health systems through capacity building of human resources. This is an area of academic and research interest to the researcher due to previous studies; field visits to community based organizations (CBOs) and refugee camps in Jordan solidified this interest. The researcher's personal observations on the resiliency of communities impacted by the refugee situation and the integration of lay citizens and refugees in the response inspired this study.

This topic is extremely relevant in the context of Jordan and the MENA region given refugee flows due to the political instability and violence in Syria have significant regional impacts. Neighboring countries absorb the spillover social and economic costs. Jordan has provided significant assistance, expended limited resources, and incurred debt to accommodate the influx of refugees as well as assist vulnerable Jordanians. The conflict is protracted and the response has shifted from emergency to sustained so, looking forward, more investment in the health sector and health workforce is important. One strategy is to recruit and train community health volunteers to contribute to health care delivery. This topic is relevant not only to refugees, health, and humanitarian action in Jordan but many other settings where CHVs can be useful i.e. in refugee camps, in rural settings, etc. To assess if this is a beneficial investment, the researcher conducted this study to investigate the trainings conducted by nongovernmental organizations that build capacity of community health volunteers. Qualitative and quantitative data was collected to describe and evaluate the training process. The study population was lay citizens and

refugees serving refugee populations in host communities in Jordan, as well as aid workers who train CHVs.

*Research Objectives:*

- Characterize the process used by non-governmental organizations to train lay citizens and refugees to serve refugee populations as community health volunteers (CHVs)
- Assess the extent to which the training programs build their capacities and prepare CHVs to fulfill their responsibilities.
- Identify strengths and areas of improvement for the training process.

*Hypotheses/Expected Outcomes:*

The researcher hypothesized that there would be differences in the documented and lived experiences of trainers and trainees. I expect that participants will express many positive aspects of the training as the organizations have robust protocols and qualified trainers; however, the study will probe participants to think critically about the experience and identify areas of improvement and inefficiency. Since this research project will aim to illuminate information on training programs, not comparing two topics or suggesting correlation, no a priori hypothesis about perceptions will be made. The expected outcomes are a better understanding of the training topics that increase the health knowledge and “soft skills” of CHVs, the techniques utilized, the thoroughness using the length as a proxy, and the influence of the trainer’s teaching style.

*Community Health Volunteers: Definition and Role*

In order to understand the role of CHVs, their importance, and thus the significance of the study, the following is a definition of CHVs and a brief explanation of their roles. CHVs are individuals trained to assist professional health personnel by engaging with beneficiaries in the community, assessing needs, and informing of the availability of health services; provide basic



public health services, they do not have professional health care certification, and CHVs are not compensated through a salary (Pallas, 2013). Individuals who do the similar activities are also commonly referred to as village health workers, health promoters, or community health workers in other settings—in Jordan they are exclusively referred to as community health volunteers. CHVs perform a number of tasks, including providing immediate care, doing health screenings, giving referrals, educating community members about health promotion, and conducting surveillance and disease control. CHVs are most effective when recruited from the community they serve, they use approaches in line with norms, they are adequately trained and supervised, and they are formally integrated into the health system hierarchy (Pallas, 2013). Refugees inherently have attributes of successful CHVs, like racial and ethnic concordance with the community, understanding of health issues and cultural factors that impact health behavior, and a sense of accountability to the community (Executive Committee of the High Commissioner's Programme, 1997; Pallas et al., 2013).

#### *Training Programs:*

This scope of the study is narrowed onto the training, which is a key intervention that improves performance of health workers (Rowe et al, 2005; WHO, 2010;). If sufficiently trained and supported CHVs, with or without prior medical knowledge, can fill the gaps in geographical coverage, quality, and the number of health workers (Pallas, 2013; Bhattacharyya et al., 2001; JSI Research and Training Institute, 2009; PATH, 2007). Many actors play a role in the training process and there is heterogeneity in the training experience. Nongovernmental organizations utilize standard protocols and manuals from leading agencies and their donors. Varying methods are utilized—some trainers give printed manuals to participants and facilitators, others use presentations and/or flip charts depending on setting (Partners in Health, 2013). Training

institutions generally produce protocols, including pictures to aid in identifying specific health conditions, checklists, cultural notes, case studies, and information for the trainers. Additionally different institutions and individual trainers amend the agenda based on the setting, target audience, and the techniques that lend well to the topic of the training. Research on this is critical before advocating for NGOs and governments to apply the CHV model and increase trainings programs. This policy-oriented report will be distributed to the training institutions and aid workers that were interviewed to insure organizations have access to the findings and may use them to improve their training process.

#### LITERATURE REVIEW:

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Task shifting by training CHWs, who serve populations that would otherwise lack access, can effectively address the unmet health needs in the absence of health providers (Swider, 2002). Organizations in Jordan are already training refugee CHVs for specific campaigns but a critical analysis of the training programs is necessary in order to ensure outcomes are achieved and refugee-delivered care can be scaled-up (UNICEF, 2013; WHO, 2011; Roenne et al., 2010; O'Brien, et al., 2009). One study conducted in Amman, Jordan found that community health workers who had no previous training in clinical care of sexual assault were able to effectively address health needs after going through a robust training with multimedia tools (Smith, 2013). Another compelling study examined the critical role that lay refugees trained to serve as CHVs play in providing reproductive health care in refugee camps in Guinea, where language barriers between Guinean health staff and Sierra Leonean and Liberian refugee patients hindered the ability to provide essential services (Roenne et al., 2010). However, few studies have assessed CHW utilization while conflict is

underway or with as great of health need as in host communities in Jordan. While this study reinforces the feasibility of training anyone to be a health worker, studies in the context of ongoing violence should be conducted, as there is more rationale for training if the CHVs will likely be in the home country for an extended period of time. Additional studies of the training conducted in the context of the refugee situation in Jordan are necessary.

Evaluating the training programs is an underemphasized but critical aspect of the success of CHV programs. Training programs increase skills and confidence among health workers, and have direct impacts on outcomes (USAID, 2015; Vichayanrat, Steckler, Tanasugarn, 2013). However, programs vary widely; researchers who coded literature examining the selection and training process of CHWs found significant heterogeneity in the quality and intensity of training programs (O'Brien, et al., 2009). While 60% of the papers reviewed discussed how CHWs were trained, the procedures were unstandardized: only three of the forty-four articles mentioned explicitly orienting CHWs to their roles and responsibilities; the length of the training, ranging from 5 hours to months, varied based on the complexity of the health condition and outcome type; and recruitment decisions based on CHW characteristics, like educational level or age, were inconsistent (O'Brien, et al., 2009). These findings emphasize the need for analysis of each training program to determine if the specific trainings adhere to best practices, before considering up-scale.

Evaluation should involve the trainees themselves since participant perspectives can increase understanding of the training and identify improvements. A cross-sectional survey conducted in Ghana examined community mental health workers' perceptions of the quality of the training, and compared them to views of other psychiatrists and health policy implementers who are generally in positions of evaluating programs. The researchers found

that the workers attended less trainings and reported few instances of receiving feedback from supervisors than expected by independent evaluators (Agyapong, et al. 2015). The participants also felt less confident in their ability to diagnose all disorders compared to psychiatrists and nurses who encounter similar mental health issues which was not expected (Agyapong, et al. 2015). The study concluded that a review of the curriculum used by training institutions and greater emphasis on participant feedback is necessary but under researched, which supports the rationale and methodology of this study.

Additionally, a balanced evaluation that includes the participants, trainers, and material culture has rarely been conducted. Researchers doing a study in Iran similar to this one coupled a review of existing documentation of the training with interviews of CHWs to capture participants' assessments (Javanparast, Labonte, & Sanders, 2011). They found compelling evidence of positive impacts of the training. However, this training program was conducted over months, the program was integrated in the health system through established Ministry health centers, and health workers participated in a two year pre-service training. Thus the program and findings of this study are incomparable to short-course training programs conducted by NGOs in Jordan that this project will investigate. This study does highlight that this methodology can provide important insight into the impact of the training on CHW activities as perceived by the workers.

Though this literature provides important guiding information, the knowledge gap persists. There is limited research on CHVs in current-conflict settings. These studies in post-conflict settings inform hypotheses, but commensurate data on lay citizen and refugee CHVs in Jordan has yet to be gathered. Additionally, there is a lack of published information on the exact process through which CHVs are being trained. A study that documents the process as

described by participants will bolster the analysis of any existing documentation and identify deviations from the manuals. This information would provide insight into the strengths and areas of improvement in the training, to improve CHWs' abilities and confidence. Thus this study addressed these gaps in the literature and knowledge of the training process, through illuminating CHV and trainer perceptions of the quality of training.

#### METHODOLOGY:

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##### **Study Population:**

The study population is individuals who have been trained by non-governmental organizations to serve refugee populations in host communities as community health volunteers. This study population was chosen because CHVs play a critical role in the work that health providers play, in terms of referral, raising awareness through educational campaigns, and validating the health concerns of refugees. Both nationals and refugees were included in the study as they undergo the same trainings. Additionally, trainers are included in the study population. They were included because they offer data on the other side of the experience and offer critical insight into the training process.

Originally the researcher sought to survey CHVs trained and working in northern Jordan in host communities and camps, to isolate refugee CHVs serving their own communities. However, the researcher had obstacles with gaining time access permission to refugee camps especially with time constraints. For the purpose of feasibility, the researcher adjusted the study population to CHVs in host communities in Jordan. The Noor Al-Hussein Foundation Institute for Family Health (IFH) in Amman trains and supervises CHVs. IFH was established in 1986 with the support of Save the Children and is a non-governmental organization that offers comprehensive services to refugees and vulnerable Jordanians. These services include family

health, gender-based violence, reproductive health, child development, specialized rehabilitation for trauma victims, as well as psychological and legal counseling (Noor Al Hussein Foundation). Additionally, IFH is a national training center for CBOs and NGOs, and partners with universities to provide practical training. The organization focuses on health education to inform behavior changes, which CHVs play an integral role in (Interview #1). This change in study population affected the depth of the data and the ability to make comparisons between trainings in the camp vs. host community settings. However, this adjustment allows for higher participation rate of the full population and robust data analysis.

Making the questionnaires anonymous protected the participants' identities and the responses were only linked to a participant number. Demographic information including age range, gender, and nationality were collected. In a small sample at the same organization this could pose concerns about identifying information being linked back to participants. However, the demographic information was analyzed at the aggregate level and not connected to analysis of the actual responses to minimize this.

### **Methods:**

Mixed methods were selected to best capture the different types of data that the research sought from CHVs (evaluation) v. trainers (description).

### CHV Perspective:

Quantitative data was collected to capture perspectives on the training process of the CHVs who participated in them. Convenience sampling was employed to recruit participants; the researcher developed a relationship with the NGO that trained and supervises CHVs in order to identify the full population of prospective participants. The researcher visited IFH on the same day as a scheduled monthly meeting with all CHVs, to reduce inconvenience of participating and

work around their shifts. Participants were informed about the project and of their right to decline to participate to minimize feeling coerced to participate or provide certain information, as well as ensure no fear of implications if they decided not to participate. A self-administered survey translated into Arabic was distributed, after obtaining consent, and then collected by the researcher. A translator was present to aid in explaining the consent form, answer any questions the participants had about the survey, and allow for the participants to ask questions of the researcher.

#### Trainer Perspective:

Qualitative data was collected to capture the views of trainers. Convenience sampling and snowball sampling was utilized; the researcher and SIT Academic Director contacted numerous organizations that run CHV programs to inquire about if they train CHVs and identify trainers. The researcher scheduled meetings in their offices, to reduce inconvenience of participating. After receiving consent, the researcher conducted semi-structured interviews in English and took handwritten notes; additionally, audio recordings were taken to insure all the information they provided was captured, when participants agreed to be recorded. Subsequent interviewees were contacted based on their referral.

These methods were strategically selected to also accommodate for the language barrier. The researcher created numerous drafts of both the questionnaire and interview guide; they received feedback from their advisor on the content, wording, and translation of the questionnaire, and adjusted the interview questions as each interview revealed relevant questions not originally considered by the researcher.

#### ETHICAL CONSIDERATIONS:

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*Participation of Members of a Vulnerable Group*

The greatest ethical consideration for this study is participation of a vulnerable group: refugees. While the focus of this study is not to address the care the health workers provide, the nature of the questions will require participants who are also refugees to reflect on health issues faced by fellow refugees, which may be disheartening or even traumatic. The questionnaire was carefully designed to insure each question that is asked is intentional and the participant just speaks to their role as a CHW.

The data and findings will directly benefit the training institution, however participants will benefit from efforts to improve the training that they must going through. Additionally, findings may support scale-up of training programs for refugee CHWs, which increases job prospects and job security for refugees in the camp.

#### *Social Identities and Implications*

The presumed social identities of the research participants are that they may be refugees, predominately female, adults of working age, and not former health professionals. My role was as an independent research, not directly affiliated with the organization that recruits, trains, and supervises them. My relevant social identities that influenced my role as an interviewer and researcher are that I am American of Ethiopian descent, female, English-speaking, college-educated, and a young-adult with no prior training in conducting interviews and approaching the study with an academic lens. My nationality and ethnicity makes me an outsider to their community and required me to focus on building rapport; my gender will impact how I interact with CHVs of either gender—potentially earning me quicker trust with female CHVs and required me to be very cognizant of social norms with male CHVs; being English speaking limited conversation deviating from the survey and introduced another person (the translator) into the process of distributing the surveys; my education and academic aims aided in gaining



trust from the partnering organization wanting to support rigorous and ethical research but also distanced me from participants if they do not value this research. All these factors affected responses to my questions, so I was conscientious of asking direct and simplified questions and maintaining professionalism with all participants.

## RESULTS & ANALYSIS:

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### **Data Analysis Process:**

#### Quantitative—Questionnaires

The researcher created an Excel spreadsheet in order to compile the data; the rows correspond to each question on the survey and the columns to each respondent. First, numerical data was entered, including yes/no questions, multiple choice questions, and Likert scale questions. The researcher coded the Likert scale questions so Strongly Agree is 4, Agree is 3, Disagree is 2, and Strongly Disagree is 1. Frequencies and percentages were calculated by hand, given the small sample size, and presented using pie charts. Then, the researcher and a translator translated the responses to the open ended questions. The researcher reviewed the comments and identified themes and outlying responses to inform the conclusions.

#### Qualitative—Interviews

After each interview, the researcher listened to the recordings of the interviews and typed a transcript. Then, added in comments from handwritten notes taken during the interview. Given few interviews were conducted and the interviews were the secondary focus, the researcher did not employ a full coding process as is normally done when analyzing qualitative data. A similar process, of creating buckets for the topics the interviewees brought up, and noting reoccurring concepts as well as comments only made by one interviewee was employed. The results

provided background information about the training process and informed the recommendations at the end of this paper.

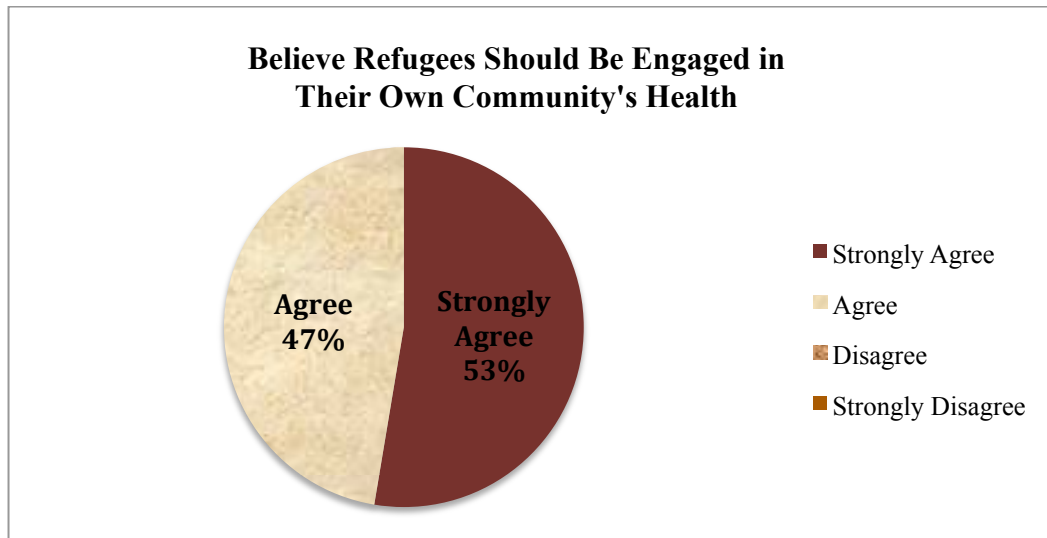
### **Findings:**

#### Quantitative—Questionnaires:

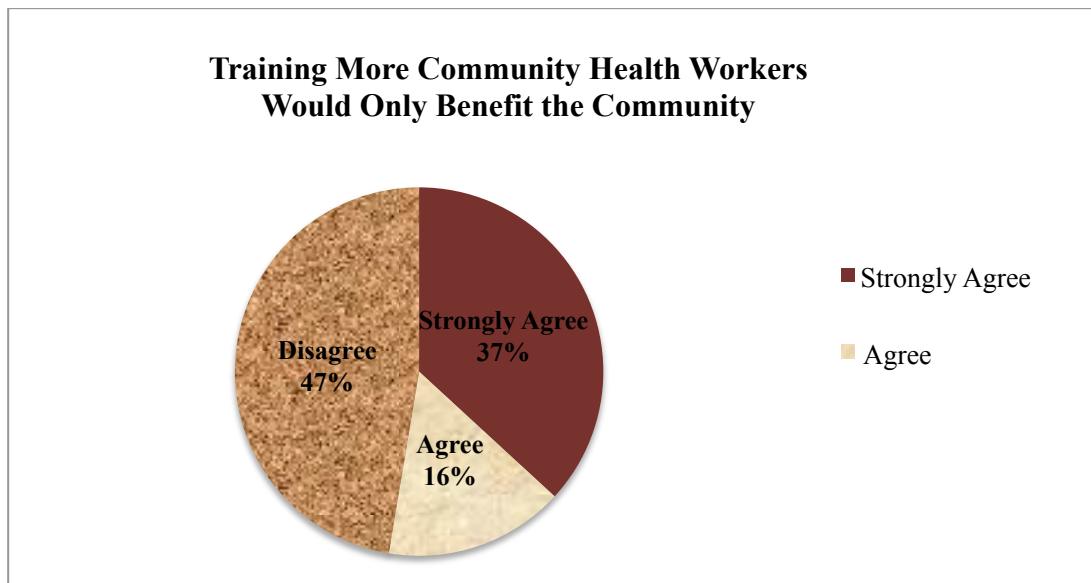
##### *CHV Responsibilities and Role:*

All respondents were CHVs trained by the Queen Noor Hussein Foundation Institute for Family Health. 19 of the 20 CHVs in the entire population responded. 14 were female and five were male. Six were Syrian refugees, nine were Iraqi refugees, and four reported they were Jordanian nationals. When asked to describe their responsibilities, all respondents mentioned that their main activities include visiting refugee families, gathering information about their needs, and guiding them to the institute to receive the services it provides. Of the 19 respondents, 17 said they are tasked with reporting health information, 15 said they do referral, and 11 said they provide educational information. No respondents said they examine patients or provide medical care. When asked if they gained an accurate understanding of their daily tasks as a CHV through the training, 14 strongly agreed, four agreed, and one respondent disagreed. When asked if the training program they participated in prepared them to serve as a CHV, all participants responded positively: 79% strongly agreed and 21% agreed.

Participants were asked questions regarding their beliefs about the role of CHVs and refugee involvement. In response to if CHVs are important actors in health care delivery, 58% strongly agreed and 42% agreed. Furthermore, when asked if they believe that refugees should be engaged in their own community's healthcare 53% strongly agreed and 47% agreed.



When asked if training more CHVs would only benefit the community, 37% strongly agreed, 16% agreed, and 47% disagreed.



#### *Motivation for Training and Serving as a CHV*

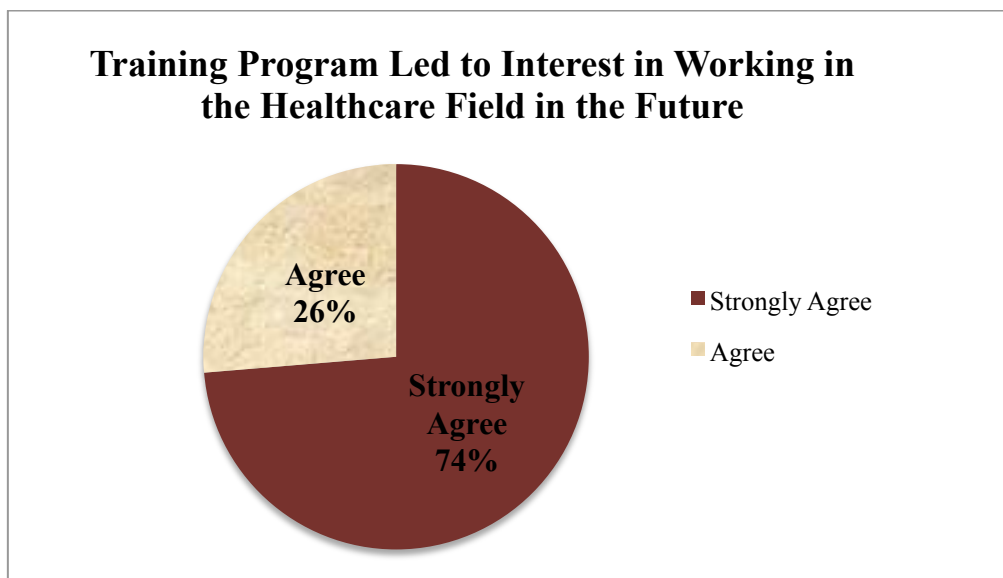
Participants stated a variety of reasons for wanting to go through the training program in order to serve refugee communities as CHVs. The most common response, which nine respondents mentioned, was the desire to offer help to refugees by liaising them to services they need which existing organizations offer. Several CHVs said that they met with many refugee families that suffer from trauma and illness, and through engagement with the community before

and after their training they felt that this vulnerable community needed to be connected to entities that provide aid. Participant #3 said they decided to become a CHV in order to “offer any help no matter how simple and advice and information that people need because the refugees are not aware of someone to guide them”.

Many CHVs mentioned their love for humanitarian work, which pushed them to become a CHV and continues to motivate them. Participant #14 said that “this is the only job that made me feel valuable as a human being, that is able to help others and I am proud of my humanitarian work”. Serving refugee populations is especially rewarding for CHVs like Participant #7 who felt as though they were “improving society” through their volunteering and “standing with refugees in order for them to not become a burden on society”.

CHVs want to help in part because they can empathize with the community and thus want to contribute to improving the wellbeing of their own community. Some CHVs have a deep understanding of the experiences of refugees, for example Participant #2 who noted that they “went through very difficult circumstances that the current refugees go through and still are”. Several respondents viewed training to be a CHV as a way to “stand in solidarity with the rest of [their] people and help them in any means possible” (Participant #6). Going through the training and serving as a CHV made Participant #18 “feel like an effective person in the community” and Participant #3 felt “more involved with fellow citizens from [their] country [Syria]” in particular.

Additionally, CHVs decided to participate in these trainings in order to gain numerous skills. Participant #6 emphasized that they “can benefit from this field” with their new skills and outlook on health. All participants were asked if the training program made them interested in working in the health care field in the future; 74% strongly agreed and 26% agreed.



*Training Process: Length, Materials, Techniques, and Social Setting*

The length of the training ranged from 4 to 7+ days. The majority of CHVs said it was more than seven days (11 of 17), six respondents said five days, and two respondents reported four days. The most common response for the duration each day was six hours, and the average was 4.9 hours/day. When asked if the training program was the appropriate length, for learning what they needed to learn in order to fulfill their responsibilities, 58% of the CHVs strongly agreed and 42% agreed. Participants were asked if they asked questions throughout the training process; 42% strongly agreed and 58% agreed.

Varying materials and techniques were utilized in the training. All respondents indicated presentations were used, 14 said demonstrations, 13 said pamphlets, nine said role play was used, and six reported the use of videos. One participant added that group work was a technique used in the training they participated in. When asked if the training program uses effective methods and materials to educate CHVs, all respondents replied affirmatively as 58% strongly agreed and 42% agreed. When asked if the trainer(s) leading the program were prepared and knowledgeable, 58% strongly agreed, 32% agreed, and 10% disagreed.

All respondents estimated that 20 CHVs were trained at the same time as them. Four CHVs did not know any of the other trainees prior to the session, while 15 reported that they did know other CHVs who participated in the same training.

### *Best Aspects of the Training Process*

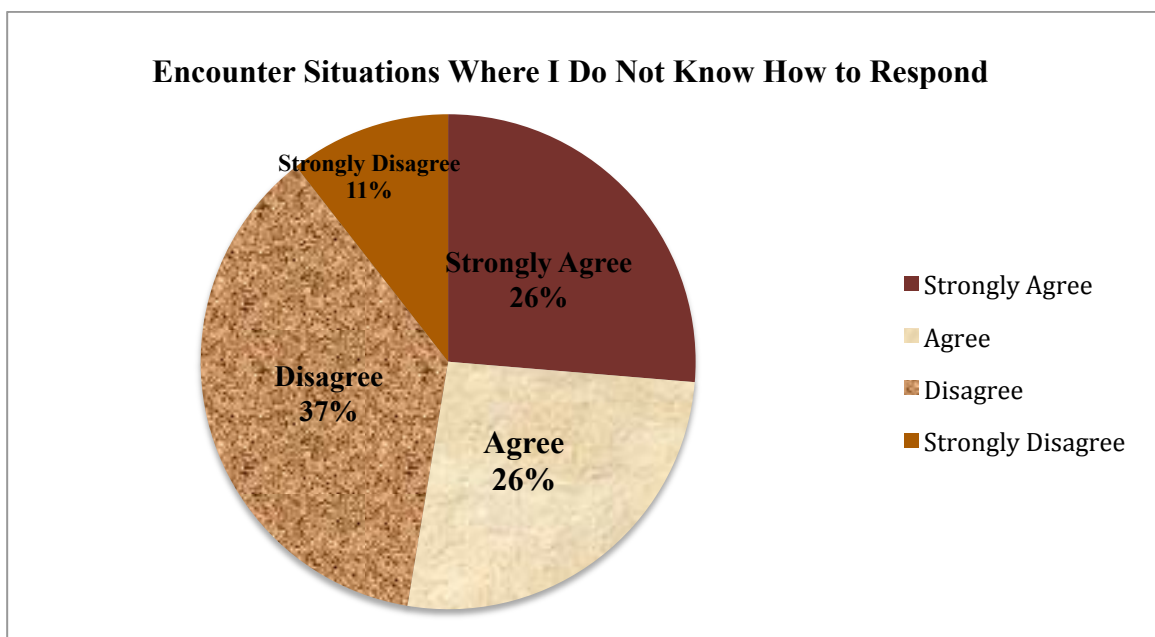
CHVs were asked about the best parts of the training process. Four CHVs explicitly mentioned acquiring new skills, namely communication skills, and educational information about specific health and wellbeing topics, like mental health and breast cancer. Again, respondents linked their favorite part of the training to their ability to serve the community through humanitarian work; three CHVs said that they enjoyed the training because they then knew how to help ease other people's psychological stress, especially when working with refugees with special needs, torture cases, and children with learning disabilities. Eight participants said that they valued the training because being a CHV facilitated them getting to know members of the community. The trainings made this especially valuable because after the program they had a better sense of the issues that the beneficiaries face on a daily basis (Participant #7). Participant #3 said that as trained CHVs they could communicate with refugee members of the community with more trust, and thus reach many refugees with the knowledge they acquired. Participant #14 highlighted that "the information covering the refugee situation from the training [gave them] the ability to improve the refugee situation". Another respondent, Participant #2, articulated the link between the trainings and ameliorating the lives of refugees since they "feel successful when applying what we learned in the training to these cases".

For many of the CHVs this training and position introduced them to the spirit of voluntary work and "increased [their] love for humanitarian work and the idea of volunteering" (Participant #18). Two respondents noted that they enjoyed the training process since they were

able to get to know other volunteers and form friendships with fellow CHVs. Another noteworthy aspect of participating in the training programs was building their own capacity. Participant #12 said that they had “information to work in other fields” and the trainings “makes us qualified to move on in our lives”. Additionally, one CHV said that one positive part is that they gain skills and knowledge that they “use within [their] field of work” (#8).

#### *Ability to Carry out Responsibilities due to the Training*

When asked if the CHVs encountered situations when working with beneficiaries where they did not know how to respond, 52% reported that they did (26% strongly agreed, 26% agreed) and 48% replied that did not (37% disagreed, and 11% strongly disagreed).



#### *Areas of Improvement*

The CHV respondents suggested areas of improvement for the training program. Regarding the actual trainings, three respondents said training could be improved if the program was intensified: longer duration, more periodic, includes more in-depth information, and covered more topics within mental health and psychological first aid. One participant said that more

materials, namely brochures for both the CHVs during the training and for the CHVs to take with them on house visits to help explain, would be useful. One participant also noted that the location where the trainings were held could be changed so that the volunteers would be in better moods and concentrate better.

CHV respondents also suggested ways to improve the experience related to approaches to give the trainees first-hand experience. Two participants said that involving people from the local community during the course would improve the training. Three participants mentioned group visits to refugees to gain a better understanding of what they learn in the trainings. Participant #8 reiterated this idea of hands on experience and suggested more “opportunities to apply what you learned in the training...attending, listening, applying”.

Another area of improvement is related to supporting the CHVs as they carry out their position through trainings. Three respondents suggested teaching CHVs how to cope with the stresses they harbor and offering entertainment programs. Participant #2 said this would “ease the pain and agony off the shoulders of the volunteer so he can be able to interact more positively with the community and refugees”. In regards to the aspects of the experience related to the cohort of CHVs training together, respondents mentioned that recruiting volunteers from a wider age spectrum and “getting volunteers from different nationalities and cultures to get their ideas and opinions and get to know their cultures (Participant #17) would richen the experience.

#### Qualitative—Interviews:

##### *Training Program Logistics*

Trainers and aid workers were interviewed to provide background information and offer insight into the experience from the other perspective. Interviewees #1 and #2 at the same institute informed the researcher that the location of the trainings are either at the training institute, in hotels, or at community based organizations depending on the number of



participants, the length, and the budget. The duration ranges from two to five days, and on average lasts six hours per day. Many health and wellbeing topics are covered including but not limited to: child protection, women empowerment, domestic violence, torture, and clinical management of rape. Trainings to build capacity of CHVs cover topics like community mobilization, case management, standard operating procedures, and code of conduct. A variety of techniques, like presentations and interactive role-play, are utilized given the range in the training topics and the target audience (i.e. Interviewee #1 gave the anecdote of training professionals vs. mothers in the community). The individual trainers have the agency to use their preferred methods based on the topic. The materials are created by the training institution and/or provided by the donors, and reflect international norms and standards for training programs. The implementation of the trainings is based on the project theme and demands of the partners and donors including UNHCR, UNFAP, or USAID. For example trainings on psychological first aid, the clinical management of rape, and the minimum initial service packages (MISPs) have varying components of the trainings. The budget for the trainings generally comprises of trainer fees, transportation fees and stationary. Additional budget items may be added, like tools and refreshments, as seen fit and based on the budget constraints.

Interviewee #3, who works at International Medical Corps (IMC) in Karak governance, explained their organization's utilization of CHVs. IMC has three sites with mental health clinics for Syrian and Iraqi refugees and focus on psychosocial health, case management, and outreach through their mobile medical unit. There are four female CHVs—two Syrian refugees and two Jordanians. The CHVs volunteer three days per week, six hours each day, serving a total of 30 children, both Syrian and Jordanian, with developmental disorders. The recruitment and training process takes six months and the CHVs were selected from a pool of over 40 individuals who

expressed interested based on their “activeness and education in a relevant area” (Interviewee #3). The trainers follow standards of international organizations and their produced agendas and techniques. Materials, including pamphlets, videos, and role-play, are used; and CHVs are instructed to then aid the children and teach them how to do daily tasks using materials that “accommodate the child’s learning style”.

The training also varies in host communities vs. refugee camp settings. Interviewee #2 works as a SGBV officer and trainer in Al Za’atari Camp and the institute has 30 CHVs (24 working on GBV and six working on protection campaigns). In addition to the type of trainings in host communities, there are other approaches like starting informal trainings on SGBV and protection and peer trainings. For peer trainings youth ambassadors are thoroughly trained for specific campaigns like personal hygiene, stress management, early marriage, healthy lifestyle, and legal rights, and then train other youth to spread the educational knowledge and reach.

*Impact of the Trainings on CHVs and the Community:*

Interviewees were asked about their beliefs towards CHV programs in general as well. All indicated that they believe refugees should be involved in the health of their communities. They play a role in delivering care to a population that trusts health providers who are more relatable. Interviewee #3 said that Syrian refugees are motivated to volunteer to engage with their community, gain experience and skills, maintain routine, and be compensated. Interviewee #3 emphasized that the trainings help the organizations in delivering care but more importantly build the CHVs’ skills. In the future “when they return to Syria they can provide psychosocial support. The number of NGOs in Syria will increase and they can be helpful to them” (Interviewee #3).

Overall, the trainers and aid workers advocated for more training as they benefit not only CHVs but the entire community. Interviewee # 1 explained that the trainings are a great

educational opportunity for the refugee CHVs, but they have far reaching effects since the campaigns that the trained CHVs work on then change the attitudes and behaviors of the whole community. They provided an example of successful campaigns to reduce HIV and STI prevalence through educating CHVs to deliver messages. Interviewee #3 noted that more training for refugee volunteers would have an adverse effect, of increasing complaints from qualified Jordanians who would also want the opportunity to volunteers.

### *Challenges & Areas of Improvement*

Firstly, interviewees identified that materials need to be updated to meet the needs of the community and incorporate new dialogue approaches. Interviewee #1 emphasized the need for “new and updated materials and techniques” and cited past experiences of trainings on taboo topics (in this case on preventative strategies for women regarding domestic violence) that met resistance at first by eventually this was “overcome when they have good manuals and supporting policies”. Beyond content, language barriers pose obstacles since many of the manuals are in English. Interviewee #1 and #2 both said that the manuals would be more helpful if translated into Arabic.

Regarding the budget, interviewees said that increased funding towards tools in order for the trainers to use known effective techniques would improve the trainings. For example, if the location facilities do not have the technology needed to support the techniques and there is no budget for supplying those then the trainers are limited. Interviewee #1 explained that in resource poor training sites trainers “can’t use data share or the computer, only flip charts, and certain trainings need more instruments to be able to have tools to put in their hands so they can fully understand”. Additionally, when certain tools are not within the budget the trainers have to be innovative and expend time to find creative solutions to try to mitigate this.

Capacity building for trainers and staff is another critical way to improve the trainings. Interviewee #1 explained that facilitating skills for trainers through refresher courses depends on the budget and certification programs, which are important for trainers so they may receive qualifications in new areas, but the burden is upon the trainer to bear the cost.

#### CONCLUSIONS:

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This research project did not have an a priori hypothesis to be confirmed or rejected; the data to be collected on the training experience was qualitative in nature. The researcher anticipated that CHV participants would illuminate information about their experiences that motivated them to volunteer, offer more insight into the details of the trainings in particular the differences between the documented and lived experiences, and be critical of the program to highlight shortcomings or areas of improvement. The researcher anticipated that the aid workers who participated would contribute in-depth information about the structure of the trainings and comment on the actors and factors that influence the experience. The results of this study brought to light information about the experience of CHVs and trainers beyond the trainings and the scope of this project. There was great heterogeneity in the experiences of participants and interviewees, which makes consolidating the findings difficult. However several conclusions emerge after analyzing the data.

Overall the trainers and CHV participants reported positive experiences and emphasized the strengths of the training process, which reflects the fact that the process is relatively productive. The researcher expected the programs to be less developed so investigation of the actual process was much more straightforward and transparent than anticipated. The trainers interviewed were visibly passionate about their work and many of the participants used the opportunity to also emphasize their pleasure in serving as a CHV because “humanitarian work is

what pushes us to help people and families especially those in great need for that help” (Participant #19). Another benefit of training CHVs that emerged from the findings, but was not anticipated by the researcher, was the value of being a member of a community of fellow volunteers. Many CHVs said the highlight of the training was meeting other refugee volunteers and that this experience instilled in them a deep value in volunteering. CHVs reported that going through the training gave them more confidence in engaging with the community, with increased understanding and trust. This extends to the CHVs’ relationship with the trainers and training institutions as well. In observing interactions between one of the trainers and the CHVs, it was evident that their relationship was informal, respectful, and supportive. Another compelling reason to advocate for increased trainings is that CHVs derive fulfillment from contributing to the betterment of one’s community as a volunteer and learned soft skills from serving in this role.

However, limited resources explain the shortcomings of the trainings and the suggested improvements can be achieved with increased funding. This would allow for more topics to be covered, longer trainings in spaces with the adequate technology, the use of a wide variety of materials and techniques that enrich the experience, and more refresher trainings for the trainers. Likewise the increased health needs and endless educational campaigns that could benefit refugee communities call for more services and campaigns that need providers like CHVs. As Participant #4 said NGOs “need bigger places in order to be able to provide more services because of the increase number of refugees and need for services”. Additionally, more attention and funding towards supporting refugees by having trainings about coping mechanisms for the stresses associated with the position and entertainment programs would be valuable to the CHVs

and improve their effectiveness. The findings of this study suggest that CHV training programs, which are underemphasized, should be invested in but this is contingent on funding.

The impacts of going through the training program on CHVs are immeasurable. The findings show the CHVs gain knowledge that serves them in their role but also in the daily lives and develop communication and community mobilizations skills, which results in long-term capacity building. CHVs reported that the trainings aid them in their current work and expressed hopes that they will be able to translate the information and skills they gained in their future area of work, in their host country or in their country of origin. This is extremely important when devising response tactics that not only ameliorate the present circumstances but also contribute to the development and rebuilding of places where refugees will return.

#### STUDY LIMITATIONS:

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##### *Time Constraints*

One major limitation to the study is the relatively short period of time allotted to establish connections, acquire permissions, collect data, and do analysis. A slow start, which is expected when conducting independent research, coupled with the constraints to four weeks limited the amount of time to travel to collect data and complete the entire project. The researcher maximized the data collected at each visit to mitigate this however a longer study period would have allowed for

##### *Sample Size:*

Pre-data collection, the researcher intended to collect as many surveys as possible, in order to reach a significant sample size. However, time constraints and logistical challenges to gaining access to refugee camps, where many CHVs are, made achieving this target unrealistic

for this short-term research project. Upon reflection, the researcher decided to redefine the study population as CHVs at the Noor Al-Hussein Foundation Institute for Family Health, located in Sweileh, Amman, Jordan, for the purpose of this study because getting the full population to participate was more feasible. While this limits generalizability of this study when speculating about the entire population of CHVs trained by NGOs, this choice of methodology allows for a more in-depth evaluation of this specific program. The study could be richened with more interviewees of trainers since just three interviewees were conducted. Each interview provided a great deal of information that was not to the point of saturation but to the point of hearing reoccurring ideas. Furthermore, after interviewing trainers at various organizations it seems as though IFH's process is reflective of the overall standards of training and mirrors the process many other NGOs utilize.

*Language Barriers:*

Another limitation to this study is the implication of language barriers, as the researcher worked with a translator during data collection and data analysis, and thus indirectly interacted with the study participants. Competent translators aided in this project, but there was little way to be sure that they conveyed the project and instructions as intended; the researcher relied on their understanding of the project when translating to explain the project, instructions, and answer questions. Furthermore, some of the qualitative data that was written in Arabic and then translate into English maintained the sentiment but at times finding the most accurate terminology may have led to some responses not making sense in the context of the question asked.

*Biases:*

A major limitation, which was anticipated but nevertheless impacts the findings of this research project, is bias, including social desirability bias. While the results and discussion

sections illustrate that there was variety in the responses, overall responses were positive. One example of bias is responses to the belief that refugees should be involved in the health of their own communities. This question sought to gauge perceptions of the importance of refugee providers. Another question about the frequency of CHVs encountering situations where they are unsure of how to respond had interesting results, which illuminated some bias. The researcher anticipated this to be reported, as health providers often engage with patients or illnesses they are less familiar with, and especially because the trainings are shorter and refugee CHVs have been in this role for a relatively short period of time. The questionnaires asked CHVs to reflect on their experiences during and after the training they participated into to serve in the roles they currently hold, so there was anticipation of positive responses to prove competence.

#### RECOMMENDATIONS:

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I would recommend future studies on this research project that include CHVs from more organizations and different settings like refugee camps. This would add to understanding of the trainings and the role that CHVs play across the country. The researcher learned about different interesting training programs for community volunteers like an initiative in Za'atari to train youth to then train other youth, which facilitates dissemination of information effectively as youth may receive information better from their peers and follows the model of engaging volunteers from the same community. I would also advocate for future qualitative research on the participant experience as I used questionnaires, which limits the depth of the information.

Additionally, I would recommend further inquires into the psychological stress and pressures that refugee CHVs experience as a result of serving the community—from meeting with refugee families, assessing their needs, and being exposed to shared traumatic experiences.



A common call to action from participants was increased attention to this need and research on this is necessary before advocating for training and entertainment programs that directly aid the volunteers themselves.

Lastly, I would recommend investigations of the impacts of CHVs serving refugee communities, particularly refugee CHVs, to gather data on if their engagement results in behavior changes in the target populations. Ultimately donors want to know if the trainings lead to increased effectiveness and improved health and wellbeing outcomes. This research would be critical to gauging their effectiveness and advocating for increased attention towards trainings at the policy level.