Early education as a path to long term health in refugee and displaced populations

By Osefame Ewaleifoh

THE GLOBAL REFUGEE CRISIS IN HISTORICAL CONTEXT

In the last 30 years there have almost constantly been at least 8 million refugees adrift every year.¹ This trend peaked in 1990 at which point there were 17.4 million refugees globally (1/350 people).¹ Over the following decade the number of global refugees and internally displaced populations declined significantly to a record low of 8.6 million people in 2005. Sadly this steady decline in global refugee populations was short lived, interrupted by a new wave of natural disasters and geopolitical conflicts culminating in the Arab Spring by early 2011.¹ Thus, whereas only 8.6 million people were identified as refugees in 2005, by 2015 this number had increased to 15.6 million people—once again approaching the 2-decade high of 17.4 million globally displaced.

According to a recent UNHCR report, if the current displaced populations around the world were a country, they would form the 21st largest country in

Tent camp for refugees on the outskirts of Jordan's northern city of Mafraq
What role if any does education play in promoting health outcomes in refugee and displaced populations?

The growing trends in refugees and displaced population have been driven by geopolitical forces such as wars, but also by climate change, a factor that promises to become an even bigger driver of migration and displacement in the years ahead. Even more distressing, recent data suggests a growing population of refugees are stuck suspended in a state of “protracted displacement” that extends over 20 years in camps—neither returning home nor getting absorbed into new communities. Together these realities raise the question: what happens to health needs of refugees stuck in camps for months or years? More specifically, what interventions might be employed to promote short- and long-term health outcomes among refugees and displaced populations? The answers to these questions might provide insight on how to both manage the current crises and prepare for future need.

The refugee experience is changing. Increased volume of refugees and duration of their displacement has revealed the inadequacy of existing health access frameworks, which were designed primarily to meet short-term settlement health requirements. Here, I examine the potential role of an education-centered model in promoting access to health and improving long-term health outcomes in refugee and displaced populations around the world. I ask three central questions: first, what role if any does education play in promoting health outcomes in refugee and displaced populations? Second, what institutions and infrastructures currently exist to promote health outcomes in refugee and displaced populations? Finally, looking forward in the light of current and predicated migration trends, I examine the role of education in innovatively promoting health access and outcomes in refugee and displaced populations.

“According to a recent UNHCR report, if the current displaced populations around the world were a country, they would form the 21st largest country in the world.”
A person is designated a refugee when he or she "is outside the country of his or her nationality, and is unable to or...is unwilling to avail himself of the protection of that country" due to a "well-founded fear" of persecution, but not all forcibly displaced persons are refugees.

According to the UNHCR, a protracted refugee situation is one in which 25,000 or more refugees from the same nationality have been in exile for five or more years in a given asylum country. The estimates of this definition are conservative, because irrespective of how long a group has been in exile it will not be counted as "protracted" if the group size is fragmented in different regions and thus less than 25,000. Still, by this conservative estimate in 2015, the UNHCR estimated that some 6.7 million refugees, 41% of those under UNHCR's mandate, were in a protracted situation. Specifically, this report suggested that of the 32 protracted refugee situations at the end of 2015, 23 have lasted for more than 20 years. The conflict in the Syrian Arab Republic, which entered its sixth year in 2016, has been the single biggest driver of global refugee populations in the last three decades. Concurrent with a growing wave of global nationalism and resistance to the refugee resettlement effort, the proportion of protracted refugees is expected to grow.

The growth in protracted refugees raises new demands for long-term health services. Currently, the overwhelming majority of health services provided during refugee crises focus on emergency and short term care. These services concentrate almost exclusively on infectious diseases, malnutrition, and sanitation and, to a limited degree, child and maternal health. The goal of these services is simple—to reduce "refugee emergency kills" that result from the sudden mass exodus of refugees, such as those that occurred following Rwanda in 1994 and most recently Syria. However, while reducing refugee emergency kills remains important, the growing trend in protracted displacement raises new "long-term health challenges" much beyond simply preventing infections or treating war injuries among refugees. Although the full impact of protracted displacement on refugee health outcome remains to be carefully examined, a recent global burden of disease multination analysis of the 22 countries in the Mediterranean implicated in the Arab spring and related conflicts observed that since 2013, there has been a clear shift in main causes of death from communicable to non-communicable diseases in the region. This study notes an increase in mental health disorders including addictions. Most noteworthy, this study documents a steady decline in life expectancy in the region (by 6 years for males and 5 years for females) perhaps attributable to the continuing war and protracted regional instability. In light of the reality that most refugees will experience protracted displacement before resettlement (if and when that occurs), perhaps it is time to re-think our approach to refugee health. Future health priorities must go beyond simply emergency care and infection control in search of new strategies to promote long-term health and wellness among refugees.

"The conflict in the Syrian Arab Republic, which entered its sixth year in 2016, has been the single biggest driver of global refugee populations in the last three decades."

**RECOMMENDED READINGS**

**A Hope More Powerful Than the Sea**
by Melissa Fleming

The story of Doaa, a Syrian refugee, and her plight as she voyages from her native Syria. Fleming is the director of communications for the UN Refugee Agency, recently spotlighted by Humans of New York in her efforts to put a face to the refugee crisis.

**Aging with Grace**
by David Snowdon

This book follows the landmark "Nun Study" which was one of the first studies to draw a link between education and healthy longevity.
Conflicts and natural disasters frequently lead to some degree of health concern, and beyond this, forced displacement and the refugee experience are highly associated with trauma and other health-related conditions. The health-related needs of refugees are often complex and multi-factorial, and these factors might be further complicated by genetic, socio-economic, and geopolitical factors. To better understand the individual factors that might influence health outcomes in displaced populations the health experience continuum of displaced populations can be categorized into three temporal divisions: pre-flight, in-flight, and post-flight phases of displacement. Pre-flight factors are pre-existing factors in the community such as poverty, unemployment, infectious disease outbreaks, or lack of preventive services that existed before the migration occurred. Pre-flight factors might or might not be of significant impact depending on their duration, how precipitously living conditions changed, and what event precipitated flight. In cases where wars and civil unrest led to flight, the pre-flight phase might be hallmarked by significant physical and psychological trauma. Next, the actual process of relocation can lead to health challenges, particularly among vulnerable groups such as children, the elderly or otherwise infirm. The health challenges associated with refugee relocation can stem from the mode, duration, or specific context of transport. The impact of relocation process has been most studied for the refugees from Vietnam who escaped the fall of Saigon on boat, some of whom continue to suffer significant psychological struggles related to their escape decades later. Finally, post-flight factors that determine health outcomes can range from access to basic initial needs such as housing, food, water, and sanitation to more complex factors like asylum status, permission to work, and access to local health resources. Collectively, factors from each of these three phases affect the physical and mental health outcomes of refugees.

Psychosocial evaluations of displaced populations around the world show that refugees consistently exhibit significantly higher rates of mental health impairments than non-refugee populations. Mental health impairments in refugees have been specifically associated with severe anxiety, post-traumatic stress disorder (PTSD), depression, and
It is important to note that not all refugees present with mental health impairments and that some presentations take time to manifest. A longitudinal study estimating the prevalence of mental illness among Guatemalan refugee communities in Mexico 20 years after the resolution of initial conflict and relocation showed that 12% fulfilled the criteria for PTSD, over half (54%) had anxiety symptoms, and more than a third (39%) had symptoms of depression. This study is among others in suggesting that mental distress among refugees might present immediately or might occur years after the initial flight experience.

While mental health in displaced populations have been more extensively studied due to the traumatic nature of forced displacement, a retrospective Lancet study in 2002 showed that “displacement increases the Crude Mortality Rate (CMR) to at least double normal baseline rates in the population before any displacement activity.” Specifically, this study showed that camps that were close to the border or region of conflict, or had longer travel times to referral hospitals had higher CMRs than those located further away or with shorter travel times. Additionally, camps with less water per person and high rates of diarrhea had higher CMRs. The displacement-associated increase in CMR has been attributed to malnutrition, measles, a lack of sanitation, malaria, diarrhea, and acute respiratory infections. Beyond these acute increases in CMRs, sustained conflicts, forced migration, and protracted displacements have also led to an increase in the incidence of chronic diseases, one example being diabetes.

To be clear, much success has been achieved in providing emergency care to internally displaced communities by such organizations as the UNHCR; however, much of this work has centered on “Band-Aid” relief. This current emergency health care strategy might be ill-suited for the challenge posed by the growing displaced populations’ shift towards protracted displacement. Given the growing interest of education as a social determinant of health outcome, I propose a role for education in delivering and improving health outcomes among displaced and refugee populations. If education is indeed a core social determinant of health outcome, it could prove invaluable in delivering positive health benefits to the displaced and dispossessed victims of forced migration.

THE CASE FOR EDUCATION AS A PROTECTIVE SOCIAL DETERMINANT OF HEALTH

In 1973, Kitagawa and Hauser published a cross-sectional study focused on understanding how mortality outcomes are driven by differential measures of socioeconomic status such as education in the United States. This landmark study found substantial differences in mortality by education level for both white men and women showing that overall, persons with less education had higher levels of mortality. Follow-up longitudinal studies found that mortality differentials by educational attainment remained after controlling for other socioeconomic factors such as income, employment, and marital status. These studies provided the earliest empirical evidence for the relationship between education and health outcome, and were further confirmed by U.S census data in 1999 that showed the age adjusted mortality rate of high school dropouts ages 25 to 64 was more than twice as large as the mortality rate of those with some college education.

“If education is indeed a core social determinant of health outcome, it could prove invaluable in delivering positive health benefits to the displaced and dispossessed victims of forced migration.”
Extensive studies have been conducted to gain insight into the relationship between education and health outcome. In 1991, Snowdon and colleagues began following 680 nuns born before 1917 as part of the now famous “Nun Study”—a longitudinal study of aging and Alzheimer's disease. The goal of the experiment was to determine how early childhood factors influenced health outcomes later in life. Once admitted into sisterhood, all sisters had essentially the same meals, health insurance, and living conditions. Importantly, this allowed researchers to better control for later life exposures that might impact health outcome, and created room to study the impact of early life experiences. The most seminal finding of this study was that the greatest predictor of health outcome was earlier life education. Specifically, sisters who had received any education before entering the sisterhood had much better health outcomes later in life than those who had no education. This study indicated that the protective impact of education suggested by Kitagawa and Hauser was more complicated than simply the result of higher income or better access to health resources, and that it was more directly connected to elemental tenets of education such as numeracy and literacy.

Follow-up studies have reinforced the role of education in predicting and influencing health outcomes. These studies revealed that the 30% drop in lung cancer following the 1963 surgeon general’s pronouncement on cigarette and lung smoking was almost exclusively attributable to behavioral changes among those educated to at least high school levels. Parallel and analogous studies show that following widespread knowledge on the preventable nature of HIV with condoms, the greatest drop in new infection rates were among the educated.
Increasingly, it is evident that education improves long-term health, but how precisely does education improve health outcome? Two primary models have been proposed for how education can influence health outcome: the exogenous and endogenous models. The exogenous model for the impact of education posits that obtaining an education provides more income, places one in a higher socio-economic class, in a wealthier neighborhood, and different social settings which collectively serve to promote better healthy behaviors and outcomes. Still, the results from the Nun Study and other longitudinal health access study suggest the impact of education on health outcome might be significantly more complicated and interesting than the simple presence or absence of more resources. These studies support a role for the endogenous model, which posits that the knowledge gained through education is itself responsible for improved health outcomes.

**The endogenous model of education and its impact on health outcome**

The inadequacy of exogenous factors such as socio-economic status (SES) and income to fully explain the education–health correlation has led to the “endogenous model” for educational impact on health outcome. This model is anchored in the theory that health outcome is affected by the process and products of education. Specifically, this model proposes that education imparts essential life skills and learned effectiveness that enhances an individual's quality of life. Endogenous benefits of education include both cognitive benefits such as literacy and critical thinking, and non-cognitive benefits like self-control and impulse regulation. This is possible because education helps one develop the capacity to find out what needs to be done and how to do it, and develops habits and skills of self-direction. Furthermore, education improves health because it “increases an individual’s effective agency, enhancing a sense of personal control that encourages and enables a healthy lifestyle.”

Research suggests that the process of education “intentionally engages the receptive capacities of children imbuing them with knowledge, skills of reasoning, values, socio-emotional awareness and control, and social interaction that help them grow as engaged, productive, creative, and self-governing members of a society”. It is worth noting that this process of education occurs both within and outside the walls of a formal classroom educational process. Beyond thoroughly establishing that education has positive health outcomes, the health benefits of

---

**Spotlight: Education of Refugee Children**

Only 10% of refugee children are enrolled in primary education.

Sources: UNHCR, Education, UNESCO Global Education First initiative.

“the health benefits of education are even greater among the poor, minorities, and less privileged”
Given the documented health benefits, what can be done to promote access to education among refugees and displaced populations where potential constraints to education access exist? Specifically what legal frameworks, infrastructures, innovations, and policy tools have been used historically to promote education, and how can these tools be redeployed to promote long-term, education-based improvements in access to health in displaced populations?

Currently, the foundational framework driving the rights of displaced children to education include the Article 22 of the 1951 Convention relating to the Status of Refugees, which states that signatory states “shall accord to refugees the same treatment as is accorded to nationals with respect to elementary education…. [and accord] treatment as favorable as possible… with respect to education other than elementary education” (UNHCR, 2010c). Furthermore, in the UN Convention Rights of the child, Article 28, signatory States are directed to:

This article continues, outlining that discipline should occur in a “manner consistent with the child’s human dignity”, and that international cooperation should be encouraged to promote modern teaching methods in addition to scientific and technical rigor. Article 29 expounds upon the need for education to be of high quality, stating that “the education of the child shall be directed to: (a) The development of the child’s personality, talents and mental and physical abilities to their fullest potential”.

The UN conventions on the rights of the child provide an essential foundation for both the educational right of the child and the right to wholesome, healthy development. This convention is particularly important for refugees today because of its binding character, participation rights, and comprehensiveness, which collectively committed all signatories to protect the rights of children—including the right to education.

education are even greater among the poor, minorities, and less privileged. Thus, if education policy were to be re-interpreted as health policy, vulnerable and underprivileged communities could benefit the most from its equalizing impact. 24, 25, 27, 28

It is becoming increasingly evident that education improves long-term health not just by increasing wealth, but because it increases an individual’s effective agency; it enhances a sense of personal control by increasing the stock of one’s competencies, general and specific knowledge, and personal and social attributes. Education thus increases one’s ability to function successfully within market and nonmarket environments—a valuable attribute for effectively managing one’s health and accessing care—making it a particularly potent tool to empower vulnerable and high health risk communities like refugees and displaced populations. 23-25
A well-characterized hallmark of forced displacement is its corrosive impact on local education systems. The violence in Syria is a case in point: in 2009, before the current conflict began, 94 per cent of Syrian children attended primary and lower secondary education; by June 2016 only 60 per cent of children did so, leaving 2.1 million children and adolescents without access to education. The situation is not much better for Syrian refugees in neighboring countries. In Turkey, only 39% of school-age refugee children and adolescents were enrolled in primary and secondary education, 40% in Lebanon, and 70% in Jordan; this suggests nearly 900,000 Syrian school-age refugee children and adolescents are not in school. Globally it is harder to identify precisely how many refugee children are deprived of basic education. Still, estimates range upward from 1.7 million, and those who are receiving educational services find that the content and the quality vary drastically. Depending on their asylum status, displaced children might or might not receive education, as immigrants and undocumented refugees are often left unreached unless they are fortunate enough to find NGOs offering educational aid. Legal status matters a great deal as access to education is not universally guaranteed, especially for children with irregular status. Furthermore, migrants with irregular status may avoid formal schooling for fear of being identified, and detained or deported, a complication that further limits these children's access to education opportunities.

Beyond asylum status, language education policies also influence the education of refugees. Proficiency in the language of instruction profoundly affects educational outcomes. Studies show that migrants who speak the language of instruction at home perform better than those who do not, making appropriate language of instruction essential to improved refugee educational outcome. In addition to system-level drivers like asylum status and language policy, school-level factors like access to kindergarten and early childhood education enrollment have been observed to be essential for migrant student performance and positive outcome. Finally, the presence of migrant teachers and the responsiveness of curriculum to the migrant experience have been found to positively correlate with enhanced education outcomes for migrant children. Promoting access to health in refugee populations through education is a complex and multi-factorial challenge and will require a concerted coordinated interagency effort. Still, in light of the overwhelming need for a long-term strategy towards refugee access, an investment in education might be an ideal place to start.

### STRATEGIES TO PROMOTE REFUGEE HEALTH THROUGH EDUCATION

According to a recent UNHCR review by Sarah Dryden-Peterson, “while education is one of the highest priorities of refugee communities, at present there is little evidence of tangible organizational commitment or capacity by UNHCR to guaranteeing the right to education for refugee children and young people”. Even more, the UNHCR is not currently recognized as an actor in the education arena by other players in the field, including Non-Governmental Organizations (NGOs), scholars, and other UN agencies. An education-centered strategy to promote health outcomes among displaced populations must achieve a few objectives to be truly effective.

**OBJECTIVES**

1. **1st**, it must target young migrant children as early as possible to bring them into the education pipeline.
2. **2nd**, it must focus on developing core cognitive skill such as numeracy, literacy, critical thinking, and abstraction, as well as non-cognitive skills such as organization and self-regulation. The development of these skills must be prioritized over the acquisition of diplomas or other formal attainments, although the latter are not of themselves undesirable.
3. **3rd**, the school curriculum and administration must be innovative yet sensitive to the needs of students from displaced backgrounds.
Innovations to promote education among refugees must integrate refugees into national education systems, which will require optimizing current educational infrastructures. To achieve this aim, we must encourage investment in teacher training that cultivates high quality skills related to both pedagogy and content, and there must be a recognition of the connections between education and conflict in all education policy and planning. Since most local government and state actors are unlikely to have the capacity to pursue these aims, close partnerships between local Ministries of Education, Ministries of Health, and UNICEF must be prioritized to strengthen national education curricula for the benefit not only of refugees but also host communities. Promoting long-term refugee health outcomes through prioritizing refugee education can only be achieved through a concerted, interdisciplinary partnership, as no single agency or state alone possesses the capacity to meet this growing need.

**IN SUMMARY**

In “A Framework for Public Health Action: The Health Impact Pyramid,” Frieden writes, “Interventions that address social determinants of health have the greatest potential public health benefit”. Education is fundamental among social determinants because it is foundational to the development of new members of society—children and youth—and it bridges the gap across socio-economic inequity. In this context, effective teachers become facilitators of long-term health benefits and education policy becomes in itself a form of health policy. Thus, while education as a means of public health intervention might remain difficult to define and evaluate, its impact—particularly in high-need communities such as refugees and displaced populations—can be cumulative, formative, and transformative, both for the individuals who experience it and for the society it recreates.

---

**Osefame Ewaleifoh** is a PhD/MPH student at Northwestern University and a co Editor-in-chief of the NPHR.

---

**REFERENCES:**

1. project, T.r., 2015.
31. UNHCR, Missing out - refugee education in crises. 2015.