

Evaluation of Approaches to Disability and Rehabilitation
in the context of Somali Refugees in Kenya

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ABSTRACT

There is international concern over the refugee increase in many parts of the world and the international community is bearing the responsibility of assisting refugees with relief, rehabilitation, integration and possible repatriation programs. This has created unprecedented challenges for the international community since the amount of assistance has had to increase and resources have had to be diverted from development programs in countries with serious economic and social problems.

The current study addressed important issues related to refugees with disabilities living in the Dadaab Refugee Camp Complexes in Kenya. After a pilot study to investigate the feasibility of the major study, 200 individuals with a disability were interviewed, and focus group discussions were held with individuals and groups supporting people with disabilities.

The study was guided by the following research objectives:

1. To determine the prevalence of disability among Somali refugees and clarify the concept of disability as it relates to the Somali community;
2. To identify and discuss the nature and the causes of disability among the Somali refugees in Kenya;
3. To gain a picture of the basic needs, aspirations, and challenges of Somali refugees with a disability;
4. To examine and evaluate the prevailing educational and rehabilitation approaches to disability in the context of Somali refugees in Kenya; and
5. To develop a framework for a comprehensive approach to community rehabilitation relevant to refugees with a disability in Kenya.

The research found that, while war in Somalia and related factors have contributed significantly to disability amongst members of the Somali community, cultural mindsets perpetuate disability and undermine the existing efforts to alleviate the conditions that people experience. Education and rehabilitation, which would be viable means of addressing the issues associated with disability, are inadequate in the refugee camps. The study acknowledges the efforts made by international agencies to help and support people with disabilities. However, it notes that more needs to be

done if the Somali refugees with disability are to live dignified and functional human lives.

This study draws the following conclusions:

- Although war in Somalia is, reportedly, the main actual cause of disability among the Somali refugees in the Dadaab camps in Kenya, culturally, curses are considered to have led to disabilities by major sections of the Somali community.
- The concept of disability as culturally and socially constructed is inadequate. Consequently, in order to address disability effectively, these cultural constructions need to be carefully evaluated and transformed.
- The current efforts aimed at assisting refugees with disability are commendable but there is a need to improve the educational and rehabilitation approaches used to provide services to refugees with disability. The community rehabilitation approach would seem to offer the best opportunities for assisting to engage and support the empowerment and acceptance of refugees with disabilities.

DECLARATION

I certify that this thesis does not incorporate without acknowledgement any material previously submitted for a degree, diploma, or other award in any university; and that to the best of my knowledge and belief it does not contain any material previously published or written by another person except where due reference is made in the text.



Siyat Hillow Abdi

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ACKNOWLEDGEMENTS

This thesis emanates from an intense interest and research in the areas of disability and refugee stimulated by my life experiences and familiarity with the plight of refugees and persons with disability. The study has provided me with the opportunity to meet and work with institutions as well as people who inspired and supported me enormously.

I would like to express my deepest gratitude to the Ford Foundation (International Fellowship Program) for giving me a scholarship to study in Australia and for funding my research. I am also grateful to Flinders University for waiving the portion of my fees that were not covered by the Ford Foundation Grant, and for the support I received in my studies from the Department of Disability Studies and the University Disability Liaison Officer.

I would like to thank CARE International, Nairobi Country office, for granting my request to conduct research. I am also thankful to Muhammad Qazilbash, from CARE Refugee Assistance Program (RAP) Dadaab Regional Office, for spending much of his time in order to organize the logistics available at the camps.

My gratefulness also goes to all the Staff at the CDS and CBR Offices. I enormously appreciate the efforts of Mr. Mohammed Hillow (CBR Coordinator) and Mr. Idris Atosh (Special Education Coordinator) in organizing groups of interviewees and making them ready for my research and for being so thoughtful and understanding with regard to my research needs. This facilitated my stay and research activities in the Dadaab Refugee Camps. In a special way, I am equally grateful to Ms. Ann and miss Ebla Farah and the staff at the kitchen team for their politeness and caring which made me feel at home! I would also like to thank CARE drivers, Mr. Gabow, Mr. Kioko and Mr. Abdirashid for their availability and readiness to help as well as working overtime to accommodate my needs.

I would like to thank my research assistants. Without Francis Wokabi, Abdullahi Madowe, Abdi Khalif and Mohammed Hillow, it would have been impossible to collect the data that grounds this research. Their presence also brought matters to attention that would have otherwise escaped my own.

My thankfulness and admiration go to my interviewees who waited for long hours to be interviewed. They shared with me their most intimate sufferings and trusted me to use it professionally in my research. My deep gratitude goes out to all those people with disability who shared their stories, points-of-view, and opinions with me and my research assistants. These stories and the valuable discussions from parents and community leaders provided the data for this research, but they also transformed my worldview. In order to respect their privacy, I do not thank my respondents by name, yet it is my hope that some directly or indirectly will recognize themselves in this piece of work. Actually, I wanted this thesis to be about them. I wanted it to tell their feelings, aspirations and hopes. I wanted it to portray the life they experience in the refugee camps. I wanted it to capture the challenges they face, their resilience and optimism. It is my deep contention that this research depicts a side of the story that is rarely told, though very much in need of telling.

Last, but not least, this thesis could not be in this beautiful shape without the firm guidance and commitment of my supervisors. I will never forget the numerous meetings I had with Dr Brian Matthews, Assoc. Prof Verity Bottroff and Dr Jerry Ford. From them, I learned so much, both about scientific research and academic writing. Brian Matthews was always at my side. I deeply appreciate their expertise, professionalism, and encouragement. Together, they helped me process raw ideas and experiences into a coherent work.

DEDICATION

This thesis is dedicated to the refugees with disabilities in the Dadaab Refugee Complex who were willing to share their stories with me. I wanted this thesis to be about them. I wanted it to tell the world about their feelings, aspirations, challenges, and dreams and, in particular, their resilience and optimism.

PROLOGUE

For generations and generations my great ancestors and forefathers pursued a nomadic life wandering from place to place with their livestock between the North Eastern parts of Kenya and Southern regions of Somalia. Their nomadic movement had been governed by the availability of water and pasture. Thus, in time of a prolonged drought, they would move into areas where they could obtain water and pasture, either within their locality or outside neighbouring regions.

In order to cope with the harsh climatic conditions in this part of the country during a prolonged dry season they traditionally used a herding system known as *Jilei* (the shifting system) to cope with diseases in their animals and manage extreme weather conditions. This meant that both cattle and camel owners moved away with the main stock establishing *Jil* (nomadic hamlets) and left behind the calves and milking cows with the rest of the family. Sometimes they had to be away from their families for long periods depending on the prevailing weather conditions and availability of water and pasture to graze their animals.

The Story of my birth is still fresh in the minds of the community elders. I asked my father-in-law who was then in his 101st year to explain the circumstances leading to my blindness: “I think the family was not prepared to receive a blind child at that time”. He said, “we had experienced prolonged *Xagaai* seasons (a dry and windy period from June to September) and your father had gone to look for a good place to move our livestock - centres where water was available from wells or any other watering points, to stay until the next Deer season.” However, he said, “the Deer season did not come until two months later and your father had just returned from a *Saahan* (survey trip) to determine good pastoral land for the livestock and to settle the family, when he was told the news of your birth. He was told the news that his wife had given birth to a baby boy who was not ‘normal’ and was born with red eyes.”

“Traditionally, this presented a mixed signal in the community” the old man explained. However, he continued, “your father went into the delivery hut anxiously to observe the newly born baby and was heard to say: ‘yes, this is Siyat - additional blessings in the family.’ My father-in-law said, “That night marked the beginning of the Deer season, generally known by the community as the season of plenty of water

[but] unfortunately, three months later your father died of a chest infection [most probably from chronic pneumonia].”

After the death of my father we also lost all our animals in drought and famine that hit the region and we moved from the border of Kenya-Somalia to settle in the slums of Garissa. My two elder brothers were given an opportunity in Boys Town Boarding Primary School, Garissa - a catholic sponsored school that catered for orphans who had lost their parents in the Shifta wars of 1967-1969 or were left destitute as a result of drought and famines which hit the province. My eldest brother, unemployed and out of school, was left with my paternal uncle at the Kenya-Somalia border. My sister (13 years old) and my mother were lucky, working as casual farmers also at the catholic primary school farm. So I wondered why I was left behind and out of school.

No one could better explain to me what happened during my birth and the family history in general, than my mother who is now in her 73rd year. Therefore, it was a matter of concern for me to get the first hand memories from her as soon as possible, as to what happened to me and why I became blind in my early childhood. Thus, from my early childhood, only about seven years old, I became very inquisitive to members of the family, and especially to my mother, to know more about myself, the family and the environment. I viewed my vision impairment or disability not as a defect in my person (a sensory or medical condition) but as a complex relationship between society and people who function differently.

My questions as a child would sometimes spark anger from my mother or at times she would intentionally ignore and change the subject. But I didn't give up. I was so curious to learn and this became, and continues to be, a major aspect of my personality. At times in my youth I would sit outside our home to kill boredom, pretending to bask in the sun but actually observing the village boys and girls of my age go to school.

But when I asked my mother in one of the evenings after she returned from work at the catholic farm, why I was not in school like other boys and girls in the village, she told me that, she wanted me to “grow big” to take care of myself against harassment from the village boys and girls and then she would take me to school. Then I asked her to explain the cause of my blindness. She told me that such questions are hard to explain but that she thought I must have been “passed over” by the evil bird

(*geedkorrah*) when I was in the womb. Traditionally, our local people strongly believe that the shadow of the *geedkorrah* causes illnesses and disabilities in children less than five years old.

The following year at the age of eight years, my sister and mother were able to raise a few shillings to buy me a uniform and some stationery and took me to nearby Jaribu Primary school, some two kilometres from the village. This marked my first experience of school life. I was very happy to have started a new life and for a time felt the same as any other child in the community, but ultimately, I realised that I was being treated differently by village children on the streets and in the classroom. I became scared to walk to school because of the village children who regularly threw stones at me and there was also frequent harassment in class.

I began to ask myself questions such as: Who am I? What have I done? What do these children want and expect? Why do they treat me badly and behave that way? Why do all these things happen to me? My poor treatment by the village children constantly circulated in my mind. It was a difficult period for me as I attempted to resolve these questions and to assign meaning to the stressful and disruptive series of events which I encountered.

I guess my presence at school and the fact that I was the only child with vision impairment caused conflicts which drastically affected community interaction patterns and impacted negatively on me and my family members. This was obvious at times, especially when I travelled between home and school and there were many instances when my sister cried because she was unable to restrain me from extreme anger caused by my frustrations at school and in the community. Schooling was getting tough and being a person with vision impairment, in the context of the Somali nomadic community, was very difficult.

Ultimately, one morning I hit a young boy in the classroom who was pinching me from behind to 'test' my vision impairment. I was serious and never entertained that kind of joke which was growing more common among the Somali boys at school. The class master punished me for that matter, without proper investigation, leading to the event forcing me to drop out from school altogether.

Two weeks after that incident, I went to Garissa town one afternoon to look for my eldest brother who, after returning from the Kenya-Somalia border, was working as a porter in one of the wholesalers in the town. I went to see him to give him a message from my mother. Unfortunately, at this time, the government had its own program and operation to arrest minors loitering in the streets - the so called “street children” - and I was arrested by the police operation. My mother was subsequently taken to court and accused of negligence. I knew she was not to blame. The majority of the villagers were poor and could not afford to take their children to school and my family was no different. She explained to the court what happened and why I was not in school.

Then the Provincial Children’s Officer, whose name I still remember (Sulub - well known for his active role in the Children’s Department), was instructed by the court to secure a special school for me. This marked a turning point in my search for education. In the next year, January 1978 at almost the age of 11, I was admitted to the Likoni Primary School - a missionary sponsored school for the blind. Although I was advanced in age compared to other children, I started from class 3 but performed exceptionally well, and led at class until when I completed my Certificate in Primary Education and attained high points.

In 1983, I pursued my secondary Kenya Certificate of Education (KCE, ordinary level) at Thika School for the Blind - another missionary sponsored school near Nairobi. Then I took my Kenya Advanced Certificate of Education (KACE) level in my home district Garissa, in 1989, where I attained even better results than the sighted students. This was a great achievement considering that I was the only visually disadvantaged student in the entire class of 64 pupils.

Finally, in 1990, I joined Kenyatta University Nairobi for a Bachelor of Education degree and completed in 1994. I was first posted to a girl’s secondary school in North Eastern Province Kenya and taught History and Islamic Religious Education for many years.

Luckily, in 1995, two months after marrying, I was awarded a government of Kenya Ministry of Education scholarship to undertake a Masters Course in Religious studies at Kenyatta University. I also received considerable financial assistance and support from the Young Muslim Association. In 1999, I graduated with an M. A. in Islamic Religious Studies at Kenyatta University and wrote my Masters Thesis on:

The Response of the Somali Muslim Community to Modern Family Planning Practices in Garissa District

In my later academic and even professional life, financial problems and my physical condition have been my greatest challenges. The lack of adequate educational facilities and frequent discrimination have been major hurdles for me to overcome. However, I still found life exciting. I learnt to be diligent, assertive, patient and disciplined. Consequently, these qualities have enabled me to manage and achieve my desired goals despite the odds.

I remember that I was never satisfied with the answer given by my mother explaining the cause of my blindness. I lost two of my brothers and sister in a road accident in 1992 and suffered depression and stress. I also had experienced worsening eye problems which ultimately led to my blindness.

I had to see an ophthalmologist who diagnosed that my vision loss probably resulted from congenital glaucoma caused by the improper development of the drainage channels (trabecular meshwork) in the eye. He explained that this led to a continuous production of fluid (aqueous humor) which could not be drained because of the improperly functioning drainage channels. Therefore, the amount of fluid increase inside my eyes raised intraocular pressure causing the optic nerves in the eyes to be damaged.

In 1991 when civil war was first reported and Somali refugees flowed into Kenya, I remember accompanying my late sister one afternoon from Liboi to see the situation at the Kenya-Somalia border. I was in my first year of university education by then at Kenyatta University. My sister was involved in charity activities distributing food to the displaced Somali people. I met some of the refugees who had disabilities and they told me horrible stories about life in Somalia in general, even before the civil war. These stories influenced me greatly and motivated me to start actively participating in the 'disability movement'.

These refugees told me that the educational needs of people with a disability were never catered for in Somalia, even prior to the civil war. They also told me how the civil war had resulted in many more Somali civilians losing their sight and/or suffering horrific injuries often caused by land-mines or other explosives. They

explained that they had no schools for people with a disability and no rehabilitation programs. There was also no social support or welfare system in Somalia and no work suitable for people who were blind or had other disabilities. Thus, they described a horrible situation of isolation, poverty and unemployment - a system that automatically excluded people with a disability in Somalia. Such horrible stories from fellow Somali people with disabilities influenced me to be more proactive and to identify the level of need within the Somali disabled community in the North Eastern Province, as well as to increase the awareness of the plight of Somali Refugees with a disability, hoping that this would help to improve social integration, encourage active, creative, and more educated and independent members of the community.

To this effect, in 1998, I launched my own organisation Nomadic Child Education and Environment Support Program – Kenya (NOCEESP - K) a community based Educational and Environment Welfare Society which aimed to achieve these goals. Our first mission was to conduct research in one of the suburbs in the Garissa District and we identified a number of children who were disabled and destitute, and who had no educational opportunities. Since we had limited financial resources, we managed to sponsor 30 children and came up with the idea of raising funds. Therefore, in August 2001, I walked a distance of 380 kilometres from Garissa to Nairobi in a charity walk dubbed as a “charity camel walk” which was very successful in raising funds. I was also involved in consultancy activities at the Dadaab refugee camps training special education teachers who were providing services for children with disabilities, during which time I learned much more about the plight of refugees with a disability.

It was from within the context of my involvement with people with a disability in this marginalised region, and my desire and energy to empathise with the plight of people with a disability, that the Kenyatta University employed me as a disability liaison officer at the student directorate, to assist students with a disability. However, the present study resulted from my active community based work and my scholarly interest to further study issues of social justice affecting people with a disability, especially those who were refugees and those in conflict situations.

I am greatly indebted to the Ford Foundation International Fellowships Program for providing me with a scholarship and an opportunity to study in Australia where I am

also committed as a volunteer to assist the Ogaden/Somali community settle as new arrivals in a new country – Australia, given that I am one of the very few members of the community with the ability to assist with issues such as language, community mobilisation/coordination, re-settlement and integration. My very good education and ability to speak and read other languages has given me an opportunity to negotiate with service providers for programs and services on their behalf. I am also grateful to Flinders University for waiving the portion of my fees that were not covered by the Ford Foundation Grant, and for the support I received in my studies from the Department of Disability Studies and the University Disability Liaison Officer.

As for my PhD studies, I have undertaken most of my academic work in Australia but travelled to the three major Kenyan refugee camps in Dadaab to conduct 251 interviews to gather the research data.

I am married with seven children and have a strong sense of commitment and responsibility to my family who I dearly love as they were the ultimate sense of my strength and spirit that harnessed the challenges of being a parent with a disability and a student. It is my belief, however, that the dignity of all human beings and their quality of life is important. The future of Humankind can only depend on all men and women being able to participate actively in building a rich global society without excluding anyone because of their circumstances or abilities. In a sense, there are two communities (those with disabilities and those without) who often do not understand each other and yet there is incredible value in struggling to make sense of the journey they share and the differences in perceptions that are fostered by their different life experiences. Over the years there has been a conscious effort in many parts of the world to integrate all people into community life but these changes have been very slow in underprivileged areas. My dream is to promote people with disability to actively participate and contribute as full citizens of their own communities and thus contribute their potential wealth. What is needed is a welcoming community attitude that acknowledges that all people including “differently abled” people have gifts, talents and abilities which they can use to contribute to and benefit the whole community.

Finally, in a special way, I am concerned about the number of people becoming disabled as a result of unnecessary wars in Africa and in particular, in Somalia. The

infrastructure and facilities in the African continent are neither there nor sufficiently adapted to meet the special needs of those with disabilities. Disability and the concerns of people with disabilities are usually the least prioritised and many people with a disability still grapple with basic issues of survival.

While many other factors that increase the disability toll in Africa are a matter of concern, disability caused by conflict can no longer be tolerated and must be condemned because it is preventable. The international community do hear of conflicts in Somalia but even the international media is silent about the untold suffering people with a disability in Somalia have to endure. There is little information on how many people have become disabled in the conflicts, the lives they are leading, and where they have been able to get into refugee camps, what life is like for them there and what is their future.

I have considerable energy and dedication to this research because of the experiences I have outlined. My own visual disadvantage has not prevented me from conducting this research and I think this demonstrates that a person with a disability is able, with the appropriate support and with his/her own motivation, to develop his/her talents to his/her full potential. I hope that this research will enlighten and bring greater understanding and awareness amongst the international community of the plight of Somali refugees with disabilities and of the situation of those living in the Dadaab camps in particular.

Siyat Hillow Abdi

September, 2008

CHAPTER ONE

1. GENERAL INTRODUCTION

1.1. BACKGROUND TO THE STUDY

There is international concern over the refugee increase in many parts of the world and the international community is bearing the responsibility of assisting refugees with relief, rehabilitation, integration and possible repatriation programs. This has created unprecedented challenges for the international community since the amount of assistance has had to increase and resources have had to be diverted from development programs in countries with serious economic and social problems (Cohen & Deng, 1998; Harding, 2002; Kibreab, 1985).

1.1.1 Refugee Numbers

The world's refugee population stands at nineteen million (UNHCR, 2006), down from twenty three million in 2004. However, due to the deteriorating situation in Iraq and continued armed conflicts in many parts of the world, the number of refugees may increase markedly again.

Africa contributes significantly to the refugee problem with an estimate of seven and a half million refugees and a population of twenty million internally displaced people (UN 1995 & 2006). Almost half of all African refugees are from the Horn of Africa mainly due to political turmoil in Ethiopia, the war of independence in Eritrea, the Ethiopian Somalia wars, civil wars in Sudan and civil wars in Somalia which have contributed to refugee movements across the borders of each country (Bariagaber, 1997).

Situated within a region known as The Horn of Africa, Somalia borders Kenya, Ethiopia, and Djibouti with a population of approximately eight to ten million. During the civil wars of the late 1980's and the subsequent years, more than 1.3 million Somalis were internally displaced and one fifth of the total population were forced to flee their country in search of security and sustenance. These people ended up in refugee camps in the neighbouring countries of Djibouti, Ethiopia, Kenya and Yemen as well as seeking asylum in the western nations of Canada, the United Kingdom, the Netherlands, Italy, Sweden, Norway, Denmark, Germany, USA and Australia

(Keynan 1995, USCRI 2007). The prolonged civil war in Somalia has also resulted in a growing number of persons with disabilities in the refugee Groups.

1.1.2 The Dadaab Camp Complex

While many Somali have subsequently sought asylum in a third country, many refugees with a disability continue to remain in the three main refugee camps in Kenya depending almost entirely on relief and rehabilitation from various international and local non-government organisations. The Dadaab Camps Complex consists of the Ifo, Dagahaley, and Hagadera camps. They cover a total area of fifty square kilometres and hold nearly two thirds of Kenya's total refugee population. The vast majority (92%) of the refugees are Somalis and the rest are refugees from Sudan, Ethiopia, Eritrea and Uganda (CARE, 2006; UNHCR, 2002, 2004).

Ifo refugee camp was established in September 1991. It lies six kilometres north of Dadaab town. It is divided into fifty-seven sections. Dagahaley Camp was established in May 1992 after the capacity of Ifo was exhausted. It is located seventeen kilometres north of Dadaab town. It is divided into seventy-seven sections for ease of administration (Gathungu, 1999). Hagadera Camp was established in June 1992 to take refugees transferred from Liboi. It is located ten kilometres south east of Dadaab town.

The services provided in the above camps include:

1. Protection. Refugees are provided with asylum.
2. Material assistance including food, shelter, water, sanitation and non-food items.
3. Healthcare and counselling.
4. Security. Efforts are made to prevent crime, civil disorder, violence, rape and abuse of women and children, domestic violence, clan violence, violent robbery and destruction of private property.
5. Legal guidance to ensure fair treatment under national laws of the host country, and
6. Educational and vocational training aimed at facilitating preparation for resettlement and repatriation (CARE RAP, 2006; Gathungu, 1999; Riungu, 1999; UNHCR, 2004, p. 217; US Refugee Program, 2006).

In addition to this, the African News Service (ANS, 2004) reports that there are insufficient social workers to cope with an enormous caseload of hundreds of people - all with severe problems of hunger, disability, sickness, family worries, resettlement problems and fear. Life in the Dadaab camps is not without difficulties. According to Horst (2003), the food rations are insufficient and insecurity in and around the camps is worrying. Instances of rape, armed conflicts and personal intimidation are regular. The level of dependency is also quite high because “whereas international assistance is focused on care for the refugees, far less attention is paid to providing them with opportunities to become self sufficient” (Horst, 2003, p. 85).

1.1.3 Attitudes toward refugees

Refugees are conceptualised as vulnerable, powerless and strangers, and are thus alienated by both the public and the media. “Refugees stop being persons, but are reduced to pure victims of the worst type in mankind. They are stripped of the particular characteristics of their person, place and history; left only with humanness of the most basic sense.”(Horst, 2003, p. 11). Thus labelled, refugees are excluded from the normal life of the host communities. This adversely affects their dignity, worth, rights, and self esteem.

Kenya is party to all international conventions relating to the rights of refugees. However, the conventions and protocols are not incorporated into Kenya’s domestic law (Kimathi, 2001). Kenya’s concern regarding the influx of Somali refugees was determined by the following factors: shortage of arable land, fear of Somalis due to the ideology of the extension of the Greater Somalia into Kenya in the 1960s and 70s, the spread of firearms, increased crime and social unrest. Kenya, therefore, sought to limit the number of refugees settling on a long-term basis in Kenya (Crisp, 1999). There was an explicit determination to resist the integration of refugees into the economic and social life of the country. The refugee policy of the Kenya government led to the establishment and maintenance of large-scale camps in remote areas close to the refugees’ place of origin. The assumption behind this approach was that the United Nations High Commissioner for Refugees (UNHCR) and the international community should take responsibility for the refugees in the camps. It is clear, therefore, that the Kenya refugee policy does not manifest any attempt to address the needs and challenges of Somali refugees with a disability by the Kenya government.

1.1.4 The Clan System

The Somali Community is organised into six main clan families of Issaq (in the North), Dirr (in the North West), Darood (in the north east) and the Hawiye, Digil and Rahanween (in the Central and South of Somalia.) There are also many sub Clans. The Clan system forms the basis for traditional, social and political organisation and power rests with the clan elders. Many conflicts arise between rival sub-clans competing for power, land, pasture and even watering points for livestock (Tomlinson & Osman, 2003).

Among the Somali community, there are a number of minority clans traditionally labelled as Low Caste and people with a disability from this group suffer double discrimination. Generally, the Somali think that people with a disability are “good for nothing” (Helander, 1995; Tomlinson & Osman, 2003).

1.2 STATEMENT OF THE PROBLEM

Since the civil wars in Somalia there has been a regular flow of Somali refugees into the neighbouring countries of Djibouti, Ethiopia, Kenya, and Yemen. While many of the refugees have sought asylum in a third country of the western world, a considerable number of Somali refugees, particularly those with a disability, continue to remain in the major refugee camps without adequate rehabilitation.

In the case of people with disabilities, it has traditionally been expected that family members would support them. However, some families continue to hide children with disabilities away from the local community because members of the general community discriminate against them. People with disabilities are called names leading to stigma and isolation. As Helander (1995) observes, stigma and severe maltreatment of persons with disability is likely to be a product of lack of understanding of fundamental social and psychological processes that shapes the life of a person with a disability. It seems that this applies to many in the general Somali community.

Generally there is considerable ignorance and lack of awareness of the nature and causes of impairment and about the needs of people with a disability amongst the Somali refugee community. Even the international non-government organisations and governments providing social service programs are strongly influenced by the belief that people with a disability only need to be cared and provided for, without them

actively participating in their own programs; hence denying them the opportunity to realise their full potential as community members (Helander, 1995; Tomlinson & Osman, 2002).

Considering this problem, the focus of the study was to examine the situation of Somali refugees with a disability in Kenya. The aim was to clarify and describe the concept of disability as it relates to the Somali community in the refugee camps, as well as to develop a comprehensive plan for community rehabilitation. In view of this subject, a number of specific research questions guided this study:

- How do the Somali community define disability?
- What are the major causes of disability among the Somali community?
- How does the quality of life of people with a disability compare with that of non-disabled refugees within the camps?
- What are the basic needs, aspirations, and challenges of people with a disability in the refugee camps? and
- How can we develop a comprehensive approach to community rehabilitation relevant to the Somali refugees with a disability in Kenya?

The current research, therefore, sought to address all of the above questions.

1.3 RATIONALE FOR STUDYING THE DADAAB REFUGEE COMPLEX

Dadaab is the second biggest camp complex in Kenya consisting of three camps (Ifo, Dagahaley, and Hagadera) and with the largest single group of Somali refugees numbering 175,000 with around 35,000 children under five years old according to the latest statistics from UNHCR (2007) and CARE RAP (2006). The camps are located in very remote, dry and hot parts of the Garissa District in the North Eastern Province of Kenya. Menkhaus (2003) observes that refugees in these camps face a range of problems: living conditions are harsh, violent crime is endemic both in and around the camps, and the incidence of rape is very high. The food ratio is also below minimum caloric intake and refugees are not permitted to farm or do business and local militia (known as Shifta) and Kenyan police victimise refugees.

Therefore, destitute refugees including those with a disability and the aged, totally depend on external assistance for their security and survival. Refugees with a disability are victims amongst victims of the conflicts and wars in Somalia and as the

African News Service (2004) reported, there are insufficient social workers to cope with the enormous case load of hundreds of people all with severe problems of hunger, disability, sickness, family worries, resettlement problems, and fear. However, no one knows how many Somali refugees suffer physical or mental disability as a result of the prolonged civil wars in their country. Community involvement in the collection of data on disability was therefore the first step towards addressing this problem and the Dadaab complex seemed to be a useful area of study.

The Dadaab complex was also chosen because most of the six-clan families of the Somali community are represented in these camps. Therefore, a sample collection of data in these camps was representative of the Somali community in other camps and the results of the study would provide information that can generalise to a range of other refugee camps.

Finally, this study is justified because it complements international and local efforts to address the position of refugees in general and refugees with a disability in particular. The researcher anticipates that international organisations, UN agencies, CARE International and local NGOs will also find the outcomes of this study useful in planning how they address the needs of these vulnerable communities.

1.4 RESEARCH OBJECTIVES

The study was guided by the following research objectives:

1. To determine the prevalence of disability among Somali refugees and clarify the concept of disability as it relates to the Somali community;
2. To identify and discuss the nature and the causes of disability among the Somali refugees in Kenya;
3. To gain a picture of the basic needs, aspirations, and challenges of Somali refugees with a disability;
4. To examine and evaluate the prevailing educational and rehabilitation approaches to disability in the context of Somali refugees in Kenya; and
5. To develop a framework for a comprehensive approach to community rehabilitation relevant to refugees with a disability in Kenya.

1.5 RESEARCH PREMISES

1. War, poverty and disease are major factors contributing to disability among the Somali refugees in Kenya.
2. Negligence on the part of the international community and lack of clear understanding of the concept of disability among the Somali community determines disability prevalence in the Dadaab refugee camps.
3. The educational and rehabilitation approaches available to Somali refugees with a disability in Kenya are inadequate.
4. A comprehensive approach to community rehabilitation would have to focus on community participation, incorporate relevant traditional beliefs and be responsive to the socio-economic needs of people with a disability in the refugee camps.

1.6 SIGNIFICANCE OF THE STUDY.

This study is important for the following reasons:

1. It will contribute valuable information about refugees with a disability in Kenya. Such information is currently very scarce. The paucity of such data is the situation internationally as no one knows how many of the world's refugee population have physical or mental disability (Boylan, 1991). Even the United Nations' High Commission for Refugees (UNHCR, 2000) is unable to give figures for the number of refugees with special needs who have been resettled under its program. By making such information available, the assessment of refugee needs will be made more accurate and rehabilitation efforts will be enhanced.
2. The current efforts to bring peace and social tranquillity in Somalia are commendable. However, the task of social reconstruction is a difficult task. This study attempted to make a contribution towards these efforts.
3. This study will hopefully be instrumental in raising awareness about the plight of refugees with a disability. Such awareness is vital in guiding efforts to alleviate the problems that these refugees face. Significant differences exist between Western understanding of disability and that of the Somali African community. The perception and understanding of disability by the Somali community is a significant factor that needed to be investigated. While the

rehabilitation needs of the refugees cannot be ignored, traditional beliefs, cultural practices and community attitudes have to be understood before implementing any kind of community based rehabilitation program. Information on this issue is scarce and the findings of this study will help to create a basis for dialogue between the service providers, people with disabilities, and the community in general.

4. This study is important because it provides persons with disability and other people involved in rehabilitation efforts an opportunity to express themselves with regard to their aspirations, challenges, and prospects for the education and rehabilitation of refugees with a disability.

1.7.0 THEORETICAL FRAMEWORK

This study was informed by two theories, namely the Conflict theory and the theory of Social Reconstructionism. The Conflict theory is useful in developing an explanation of the problems identified in the study. This enables an analysis of the refugee problem and also facilitates an explanation of the social implications of disability among the Somali refugees. The theory of Social Reconstructionism also assisted efforts to resolve the problems caused by disability among Somali Refugees through exploration of a possible suitable community rehabilitation process.

1.7.1 Conflict Theory

The conflict paradigm emerged from the work of such thinkers as Hegel, Karl Marx and George Simmel (Abraham, 1982). Other advocates of the perspective included C. Wright Mills, Ralf Dahrendorf, Irvin Harowitz, Lewis Coser, Herbert Marcuse, Randall Collins and Andre Frank (Abraham, 1982). The theory asserts that social reality does not flow from consensus but from antagonistic yet interrelated needs and designs of people; that conflict, not harmony is the dominant form of social relationship. The theory emerged as an antithesis to the Functionalist perspective, which emphasises social stability, conformity and harmony (Abraham, 1982)

Karl Marx perceived society as divided into social classes. These social classes have distinct interests, which are often antagonistic. Unequal distribution of wealth, power, prestige, status, and other goods and services as well as unequal structures in society become the sources of conflict in society. A dominant class emerges and strives to

monopolise social arrangements and benefits. This leads to intensification of conflict in society (Bilton, Bonnet, & Jones, 1987).

The dominated class is made to conform and feel powerless, limited, neglected, discriminated and marginalised (Kimathi, 2001). This leads to a feeling of hopelessness, pessimism, defeatism, and resignation. The tools of analysis of this perspective include: racial, ethnic and political tension, class war, religious conflict, strikes and protests, revolutions and, recently, gender and disability inequalities.

According to Abrahams (1982, pp. 111-114), Conflict theory is based on the following assumptions:

- Conflicts emanate from the nature of the structure of the society. There are, therefore, seeds of conflict in every social structure;
- Every part of society is constantly changing;
- Conflict is not always violent or manifest. It can be latent, regulated or controlled;
- Social conflicts cannot be absolutely eliminated but their expression in specific contexts can be resolved or modified;
- Society and organisations are held together by constraint and coercion rather than consensus; and
- Every element in society contributes to social change.

Conflict theory is suitable for this study because of its potency in analyzing the refugee situation in Africa in general and Kenya in particular. The Somali refugee situation can be seen as a product of intense social antagonism in Somalia. According to Zartman (1995), the main causes of the presence of Somali refugees in Kenya include political turmoil caused by dictatorial regimes, ethnic tensions, and natural calamities. These tensions took a violent nature leading to the collapse of the Somali state. The consequences of these conflicts included disablement of many Somali people, and the displacement and subsequent influx of Somali refugees into Kenya in the 1990s.

Within the refugee camps, the forces of conflict have not been resolved. The refugees with a disability appear to continue to be marginalised and dominated by the rest of the community. Though the antagonism is not always explicit, this study plans to

identify the issues more clearly so that productive steps may be taken to reduce conflict and marginalisation.

1.7.2 Social Reconstructionism

According to McNergney and Herbert (2001), Social Reconstructionism is an educational theory advocated by such thinkers as Theodore Brameld (1904-1987), George Counts (1889-1974), and Saul Alinsky (1909-1972). The theory asserts that people are responsible for social conditions, and can improve the quality of life by improving the social order. It calls for rapid sweeping changes throughout the society to affect a new social order. It views education as a means of preparing people to create a new society.

The tools of analysis for this theory include: governance, decision-making, representation, participation, justice, opportunities, empowerment, curriculum design, and professionalism in teaching. Key concepts used in the theory include: inclusive education, participation, rehabilitation, equal opportunity, and democratic governance.

The theory is based on optimism about people's capacity to change their condition, the potency of quality and courageous leadership and the power of modern science to solve human problems. It views human problems and solutions as interconnected and locates the responsibility to change society in societal membership. The goal of education is taken to be the creation of a better world through sustainable processes of solving social, political, economic, and environmental problems. The theory emphasises the importance of social studies, social problems, global education and environmental issues in education (McNergney & Herbert, 2001, p. 136).

Social Reconstructionism embraces other approaches that are important in tackling the problem of disability, for instance, Community Based Rehabilitation (CBR). CBR was promoted by international organisations as a strategy for tackling the problem of disability in developing countries that face constraints arising from poverty, illiteracy and inadequate access to services (UN, 1983; WHO, 1981).

Initially, CBR followed the medical model, which emphasised the need to rehabilitate the functional abilities of individuals with a disability while leaving the social context unattended. The initiative was top-down in origin. However, this approach has been improved to suit the changing realities in rehabilitation efforts. Currently, the initiative emphasises a bottom up approach that facilitates autonomy, empowerment,

and inclusiveness. It is a rights and development based process that enables the persons with a disability to access equal opportunities and own the programs that are meant to benefit them. Through participation, involvement and decision-making, people with a disability and their families are enabled to control their lives, identify their needs and find solutions for them (Asindua, 2002; Thomas, 2002).

Social Reconstructionism as a theoretical framework was useful in providing a comprehensive background upon which the challenge of disability among the Somali refugees will be studied. The emphasis on education as a tool for societal change, as well as the related theoretical tools of analysis, facilitated the current researcher's efforts to evaluate the suitability of the existing educational programs within the refugee camps. Since the theory aims at social reconstruction and betterment, it is suitable as a guide in seeking appropriate rehabilitation approaches for refugees with a disability.

1.8 CONCLUSION

This chapter has introduced the study by outlining the nature, purpose, objectives, premises and significance of this study. It has also presented the theoretical framework that guided the study. The chapter provides the foundation for the following chapters. The next chapter provides a review of literature that informed this study.

CHAPTER TWO

2.0 THE CONTEXT OF SOMALI REFUGEES WITH DISABILITY

2.1 INTRODUCTION

The previous chapter introduced the problem addressed by this study, namely disability among the Somali refugee community in the Dadaab refugee camps in Kenya. The study focuses on the situation of Somali refugees with a disability. It examines the concept of disability as it relates to the Somali community in the refugee camps and attempts to develop a comprehensive plan for community rehabilitation. The purpose of the present chapter is to review the main literature that informed this study. The review is done in a thematic manner. The themes that reflect the entire study and which provide a framework for this review include:

- *Somalia and the Somali Community:* This provides background information about the Somali people. This is useful in introducing the wider context of the problem that this study addresses.
- *Refugees Issues in General:* This theme enlightens the refugee crisis in general and highlights key challenges that refugees face.
- *The Somali Refugees in the Dadaab Refugee Camps in Kenya:* This theme enlightens the specific physical and social context of the study. The field study was carried out at the Dadaab refugee camps in Kenya.
- *Disability and Educational Issues:* This theme addresses the two distinctive aspects of the study. Disability defines the nature of the refugees who are the focus of this study. Educational issues and principles provide the key criteria for evaluation in this study.
- *Community Based Rehabilitation:* This theme also explores the rehabilitation approaches used to address disability.
- *The Theories of social conflict and social reconstruction:* These provide the theoretical framework that informs this study.

The above themes reflect the key aspects of this study.

2.2 SOMALIA AND THE SOMALI COMMUNITY

Studies by Van Notten (1993), Ahuja (1993) and Adelman (2004) provide a history of modern Somalia, the Somali civil wars, clan composition, detailed description of the conditions in refugee camps and explored the three most used durable solutions for refugees: a resettlement program, a possible integration process, and repatriation in the event that the Somali peace process succeeded. These documents reveal that in the pre-colonial era, Somali people lived in five regions namely: Djibouti French Somali, Ethiopian Ogaden Somali region, Kenyan British Northern Frontier Districts (NFD), the British Northern Somaliland and Italian Southern Somalia.

The Somali people speak a common language (afsoomaali) and practice the same religion, namely Islam. The Somali community is organised in a patrilineal, social and political clan system except for the coastal people (reer Banadir and reer Barwaani) who are of mixed Arab, Somali and Persian heritage. There are also occupational castes such as the Tumaal, Yibeer, Migaan, and Eyle; Bantu riverine agriculturalists; the Swahili speaking Bajuni fishing communities and Arabs of Yemen, Oman, and Zanzibar descent. Even though division exists within their clan system, intermarriage is common, especially among Somali ethnic groups, who share grazing land and water resources. The traditional law (xeer) is instrumental in solving violence and conflicts (Siyat, 1999 and Adelman, 2004).

Studies presented by Keynan (1995) and Menkhaus (2003) demonstrate that, before the civil wars of the late 1980s, Somalia had a population of 8 to 10 million people and the country was ranked amongst the poorest in the world on key indicators of human development such as life expectancy, per capita income, malnutrition, and infant mortality, making much of its population highly vulnerable. The conclusion presented, is that a high level of vulnerability existed in Somalia even before the civil wars of the 1990s, the 1991-92 famine, and the refugee situation in the neighboring countries of Kenya, Ethiopia and Djibouti.

Menkhaus (2004) stated that, because the Somali community is a lineage-based society, clanism is always a central factor in politics, conflicts, and allocation of resources. The Clan is the main source of personal protection for individual households in the absence of public security; the main source of customary law, and

conflict management; the principle source of identity; and the basis for proportional representation and power sharing. However, these factors can easily be manipulated by any dominating clan in order to marginalise the minority groups and low status clans. Horst (2002) argues that before the civil war the Somali community had a particular way of dealing with insecurity. This was based on social networks, mobility and dispersing investment. In addition, the extended family households maintained close links to reduce vulnerability to crisis by diversifying their investment in people and economic activities such as mixed herding, nomadism and the use of various crops, which minimised ecological risk. However, in situations of extreme scarcity of resources, alternative means of survival were sought through minor trade activities and reliance on international aid.

Somalia gained independence after many years of British and Italian colonisation in 1960 and the British Northern Somaliland region and Italian Somaliland joined to form the Somali Democratic Republic in 1961. But on 21st October 1969, Mohamed Siad Barre assumed control over the country in a military coup, overthrew the civilian government, suspended the state constitution, banned all the political parties and declared Somalia a socialist state. However, in 1990, opposition forces deposed Siad Barre and his style of dictatorship crumbled. Then, bloody civil war erupted as various clan-based military factions competed for control with consequent devastation of a scale never before witnessed in the history of Somalia. Civil wars left Somalia in chaos and Van Notten (1993), Ahuja (1993) and Adelman (2004) make the assertion that Somali culture and literature were among the areas most profoundly affected by the military regime. Theft, lying, hypocrisy and rape became indicators of *Ragannimo* (manhood) contrary to Somali culture and civilisation.

The country witnessed many self-proclaimed independent entities. In 1991 the Northern region declared its independence as “Somaliland”. Secession took place temporarily in the North Eastern region and it was proclaimed as the “state of Puntland” in 1998 and also “Jubaland”, although its status was unclear. In June 2006, after months of intense fighting, a new force, the Union of the Islamic Courts (UIC) succeeded in capturing the capital Mogadishu, from a loose alliance of different warlords under the Alliance for the Restoration of Peace and Counter-Terrorism (ARPCT).

However, it was reported that, in December 2006, the transitional Federal Government (TFG) backed by Ethiopian forces defeated the Union of Islamic Courts (UIC) and imposed a state of emergency (BBC News 2006). The situation in Somalia still remains very complex and uncertain. Consequently, insecurity in Somalia has precipitated an influx of refugees into the neighbouring countries, especially Kenya. In response to the emerging situation, the Kenyan Government also closed the border with Somalia denying refugees fleeing from conflicts access to refugee camps. Therefore, order in Somalia still has not been restored despite the attempts by the international community to establish and support the Transitional Federal Government (TFG). But the international community has attempted to help in the establishment of a functioning administration in Somalia. However, most of these endeavors to end perpetual anarchy (and the Somali refugee problem) have failed so far due to the Somali leadership's lack of focus, vision and patriotism. All the previous peace and reconciliation initiatives were undermined by the Somali people's love for the clan more than for the nation.

2.3 REFUGEE ISSUES IN GENERAL

Studies on refugees by Kibreab (1985), Cohen and Deng (1998) and Harding (2002) indicated that the international community is concerned over the increase of refugee numbers and the mismatch of this with the limited availability of resources in assisting them with relief, rehabilitation, integration and repatriation programs.

Bariagaber (1997) also observed that refugees leave their country of origin against their will, stay in their new environment reluctantly, and keep their lives on hold temporarily or even sometimes permanently, depending on whether a solution to the problem that has caused refugeeism is found. Therefore, he argued that refugees are part of a mass of fleeing individuals primarily interested in safety and, therefore, their departure and survival at their destination is not orderly and they need help from the international community. However, as pointed out by Harding (2002), many countries of the developed world are reluctant to accommodate people in distress, particularly refugees from less developed countries, and have imposed strict immigration laws because they consider them economic opportunists rather than genuine refugees.

Banki (2004) asserted that wars have increasingly become complicated after the cold war conflicts and the refugee situation has become ever more prolonged. Therefore, the protracted refugee situation challenges the international community's refugee policies and the essence of the 'durable solutions' framework embraced by the UNHCR, which recommended one of three solutions for the refugee crisis, namely: local integration in the country to which the refugee has fled, a return to the country of origin (repatriation) or resettlement in a third country.

Although durable solutions have long been used as means to solve the refugee crisis, the prolonged refugee stays in the host countries (without the implementation of any of the tripartite solutions above) suggests that they require solutions in the intermediate term such as education, health, sustenance, housing and security. But Banki (2004), while acknowledging that some intermediate solutions have allowed refugees to integrate better than others and these more successful refugees have been able to pursue livelihood strategies in urban rural settings amongst local populations, the Somali refugees experience restricted camp situations where the opportunity for self-determination and self-reliance is virtually non-existent. There has been, up to this point, an inadequate intermediate solution for refugees with disabilities.

2.4 THE SOMALI REFUGEES IN THE DADAAB REFUGEE CAMPS IN KENYA

The UN (1995) estimates show that Africa contributes significantly to the refugee problem with an estimate of 7.5 million refugees. Bariagaber (1997) confirmed that almost half of all African refugees were from the horn of Africa, mainly due to political turmoil, wars of independence and civil wars, contributing to mass refugee movement across the borders of each country. One of the countries most affected by this mass movement of people has been Somalia.

The Dadaab Main Office (DMO) consists of a central compound for all agencies located in the three camps which are 6 to 17 kilometres apart. This main administrative compound is surrounded by an outer fence, with double fencing and a separate compound for each agency. Each organisation's compound is well gated and surrounded by thick barbed wire fencing. But the refugees' dwelling area only has fencing covered by thorn bushes and looks more like a military camp. Their shelter

mainly consists of *tukuls* (huts made with sticks) and covered with plastic sheeting distributed by the UNHCR. Many share one room making privacy non-existent for couples. The washrooms are also made of sticks and you observe from outside, worn out sacks hanging on the makeshift washroom, often making visible whoever is inside. This is very embarrassing for the Somalis who are Muslims and consider all bodily-related functions and sexuality very private. Thus, the camp habitation itself is a source of loss of dignity as refugees forego an integral part of their religious obligations. In these camps, living is not an easy way of life. The refugees have lived for as long as 17 years in withering semi-arid heat, confined in overcrowded camps and dilapidated shelters. They often do not get the minimal number of calories required to remain healthy, are not engaged in positive activities, and often face recurrent reduced levels of donor funding which have a negative impact on the provision of essential levels of support to refugees.

Zarman (1995), Kimathi (2001) and Menkhaus (2003) have identified and outlined the causes of the high number of Somali refugees as follows: Underdevelopment, militarisation, clanism, a dictatorial government, ecological conditions causing drought and famine, use of a 'divide and rule' approach by Siyyad Barre (ruler of Somalia from 1969-1991), armed loyal clans waging war against rebel clans, and political conflict and opposition from the region where Siyyad Barre originated.

At the beginning of the Somali conflict, there was lack of external diplomatic engagement due to the fact that, at the time of the collapse of the Barre regime, the world was preoccupied with the dramatic events surrounding the end of the 'Cold War' and the 'Gulf War'. Ultimately, there was a complete collapse of the government with little international attention.

Despite these factors outlined above, studies by Laitin (1997) argued that the sources of the spiraling civil war in Somalia after president Siad Barre was deposed, were not found in the specifics of the Somali lineage system or in the general security dilemma. They are best explained by the war of attrition set off by the declining resources made available to coup winners in most African countries after the end of the cold war. It is important to appreciate the social, political and economic situation in Somalia that has

given rise to the refugee crisis, as well as disability among the Somali people, due to the consequences of war and natural disasters.

Farah (2006) documented that, in what was the latest in a succession of savage tribal wars, coupled with the worst drought in memory, Somalia became a massive killing field, with some half a million dead before the carnage was done. Another two million Somalis were internally displaced persons (IDPs), and 800,000 fled the country, landing in refugee centres, and then diffusing throughout Africa and the world. However, this article falls short of providing reliable information regarding Somali refugees with a disability in transit or those in refugee camps in Kenya.

As documented by UNHCR (1993), from 1991 to 1993, approximately 300,000 Somalis who fled across the 800 mile Kenya-Somali border walked miles over Somalia's desolate savanna into Kenya's North Eastern Province. Somali refugees had few choices. The civil war destroyed their livelihood and took away their dignity. The war forced them to surrender their beloved motherland to warlords who had no sense of fair and transparent governance. The actions of the warlords against the people meant that they had to travel to foreign lands in search of safety and sustenance.

Human Rights Watch: Africa Watch (1993) reported that, at that point, hundreds of Somali women in the refugee camps had been raped in Somalia and in Kenya. Throughout the Somali conflict, rape has been used as a weapon of war to punish rival ethnic factions. Targeting women in socially weak and vulnerable groups posed little or no threat of retaliation. This has been identified as a particular human rights crisis for female 'Internally Displaced Persons' - IDPs, vulnerable groups such as people with disabilities, and Somali refugees in the Kenyan refugee camps at Dadaab, according to Kenya Human Rights Commission (1999, p. 13). Of 300 rape cases involving Somali women in the 1993 report, one hundred had occurred in Somalia, while the remainder took place in the Dadaab refugee camps. Although these figures are profoundly disturbing, Menkhaus (2003) stated that these figures represent only the cases actually reported to the UNHCR and, thus, are likely to be an under-representation of the scale of the problem.

The evidence expressed in the above sources clearly indicates the magnitude of the difficulties at the camps. The dominant group of refugees may make the vulnerable groups (for instance the refugees with a disability) feel powerless, neglected, discriminated and marginalised. This leads to a feeling of hopelessness, pessimism, defeatism, and resignation among the Somali refugees and specifically, the refugees with a disability.

Zartman (1995) and Kimathi (2001) described Kenya's North Eastern Province (where Dadaab camps are located) as an arid, barren area sparsely populated by nomadic pastoralist groups such as the Somali, Boran, Rendilles, and Turkana. Because of the artificially constructed colonial border between Kenya and Somalia, the area is inhabited almost exclusively by ethnic Somalis who are classified as Kenyan citizens but retain strong cultural, political and economic ties to Somalia. Kimathi (2001) further described the rise of a secessionist movement to unite Somalia between 1963-1967, which resulted in the Kenyan government committing widespread human rights abuses against large numbers of Somali Kenyans. Indiscriminate government killings, arrests, and security crackdowns in turn generated widespread suspicion and hatred of the government among the area's inhabitants. As a result, the government of Kenya continued to use the colonial legacy of 'emergency powers' in the North Eastern Province and these remained fully operational until 1993 when they were finally repealed.

Throughout this period, the government deliberately invested little or nothing in the infrastructure of the North Eastern Province, with the result that the region was undeveloped and isolated, and its population was politically marginalised. Much of the nomadic population has increasingly resorted to cattle rustling, banditry, and poaching. These local bandits, known as 'shiftas', make a living from robbing local inhabitants. Zartman (1995) and Kimathi (2001) addressed historical and political issues such as the rise of a secessionist movement in the North Eastern Province, the Shifta menace, marginalisation of the Kenyan Somali, and the relationship between the Kenya Somali and Somali people in Somalia. They also provided useful background on how the outbreak of the Somali civil war in 1991 dramatically increased the activities of these Shiftas, causing insecurity among the refugees in the North Eastern Province.

The UNHCR (1993) stated that approximately 200,000 Somali refugees were housed in the three main camps of Ifo, Dagahaley and Hagadera. Refugees in these camps were housed in appalling conditions in squalid 'igloo'-type hovels made of branches covered with patches of plastic, burlap or cloth. In addition to this, it further stated that the location of these camps exposed refugees to attacks from Somali fighters. Former Somali government soldiers or combatants with the warring factions routinely staged raids into North Eastern Kenya and then retreated across the border, eluding capture by Kenyan security forces, since it is difficult to distinguish the Somali shiftas from those of Kenyan origin.

Gradually the area turned into a virtual 'free-for-all' zone because of the mounting insecurity and an increasing number of weapons. Shiftas regularly terrorised the relief community, the refugees, and even the Kenyan police, forcing the Kenyan government to require relief workers to travel with an armed escort for protection until the situation improved in 2002.

Although Kenya is party to all principle international conventions relating to the rights of refugees, as argued by Kimathi (2001, p. 70), the conventions and protocols are not incorporated into Kenya's domestic laws. Kenyan refugee policy is based on a general recognition of the principles of asylum and 'non-refoulement' (not sending someone into a situation of persecution) but is characterised by a number of other hidden features. Namely, Kenya's concerns regarding the influx of Somali refugees which are related to the shortage of arable land, fear of Somalis reclaiming land for the 'Greater Somalia', the Shifta menace, the spread of firearms, and increased crime and social unrest.

Kenya has, therefore, sought to limit the number of Somali refugees settling on a long-term basis. In addition to these issues, Crisp (1999, p. 72) noted other factors such as the determination to resist the integration of refugees into the economic and social life of the country, maintenance of large scale camps in remote areas close to the refugee's place of origin, and the assumption that the UNHCR and the international community should take responsibility for the refugees. In reality, however, as observed by Kimathi (2002, p. 85), the majority of the refugee host

countries are in the developing world and are unable to provide sufficient educational and other opportunities even for their own nationals. Thus, refugees receive little consideration.

The UNHCR (2002) reported that Kenya has 190,000 registered refugees, most of them living in the two designated camp complexes of Kakuma and Dadaab, as required by Kenyan law. Up to another 100,000 are thought to be living outside of the law, either aspiring to be recognised as refugees or having already been rejected. Out of the many who apply to be recognised as refugees in Nairobi each month, about half are rejected because many refugees run away from their home country but they do not know, due to their low levels of literacy, the criteria for being a refugee according to the definition of the 1951 United Nations Convention on refugees and, subsequently, may not meet the criteria required.

Adequate literature exists on the diasporic life of the Somali refugees (being forced to leave their homeland and then dispersed through other parts of Africa and the world). Al Sharmani (1998) discussed issues of survival, culture and identity among the Somali refugees in Cairo while Berns (1999) considered the livelihood of Somali refugees in London and Toronto and provided a detailed account of their coping strategies as they resettled in different cultures. Kroner (2000) observed a number of factors, which led to the migration of Somali refugees to Western countries. He also made a comparative study of their experiences in East Africa and Western countries and documented various problems encountered such as health, culture and integration. Similar studies were also presented by Kuhlman (1991) in which a research model on economic integration of the refugees in the developing countries was assessed. Although these sources are important because they provide information on the general experience of Somali refugees, little information has been gathered about the experience of refugees with a disability.

2.5.0 DISABILITY AND EDUCATIONAL ISSUES

2.5.1 Disability

According to Mpagi (2002), disability refers to a form of restriction that hinders one from performing an activity in a way that is considered 'normal' for a human being. A person who has a disability is easily recognised as such by the society due to

differences in physical appearance, behaviour, or other functional limitations. Disability is temporary or permanent, reversible or irreversible.

Disability is not merely the result of impairment. Disability has to do with limited participation and empowerment of an individual. Rather than merely being a physical condition, it is a state of being that permeates the entire personhood. The person with disability is excluded from resources, opportunities and rights that characterise dignified human life.

According to the WHO (2004), persons with a disability do not receive adequate rehabilitation services. They do not participate meaningfully in education, training, employment, recreation and other social activities. As such, these people are discriminated against in society. The more severe the form of disability one has, the greater the extent of discrimination that the person is likely to receive from society. Women, people with multiple disabilities, people suffering from HIV/AIDS and persons with disabilities who are poor, are among the people who have least access to social resources. Disability, therefore, is an ethical issue. It leads to significant questions regarding social justice.

The UN Millennium Project (2005) discusses the Millennium Development Goals, namely, eradicating extreme poverty and hunger, achieving universal primary education, promoting gender equity and empowering women, reducing child mortality, improving maternal health, combating HIV/AIDS, malaria and other diseases, ensuring environmental sustainability and developing global partnerships for development. These goals are relevant to disability. The goals related to eradication of poverty, achieving universal primary education, promotion of gender equality and combating diseases like malaria and HIV/AIDS are especially relevant to persons with a disability who are refugees in Africa.

Disability, especially in developing countries, is not very well understood. Social cultural myths surrounding disability limit proper awareness about disability, leading to isolation of persons with a disability and underestimation of certain forms of disability. Mental disability is given as an example of a form of disability, which is difficult to detect. Therefore, there is a need to study and assess disability levels in

society, in order to examine the challenges posed by different forms of disability. This facilitates the formulation and implementation of relevant disability policies.

It would seem that mobility and physical rehabilitation are only the beginning of relevant disability interventions. Interventions should also include training, employment and credit facilities that empower persons with a disability to determine their own future autonomously. Social and economic integration strategies must form part of the disability intervention approaches. Adequate legislation should ensure that persons with disability have equal access to food, shelter, health, education, skills training, employment and recreation.

Bazna and Hatab (2005) discussed disability from the perspective of Islam. They concluded that “the concept of disability, in the conventional sense, is not found in the Qur’an” (p. 22). Furthermore, they stressed that “the Qur’an concentrates on the notion of *disadvantage* that is created by society and imposed on those individuals who might not possess the social, economic, or physical attributes that people happen to value at a certain time and place.” (p. 22). Thus, Bazna and Hatab concluded that the Qur’an emphasises a social responsibility toward improving the “condition and status” of people who are disadvantaged (p. 25). They also perceived claims that Islam teaches that disability is divinely ordained as misplaced and incorrect, and that such claims reflect a view of religion that is tainted by culture. “The practices of the current day Muslims have been tainted by their local cultures and influenced by outside factors, and their understanding of Islam has been calcified by the accretions of centuries of decay and the stagnation of the scholarship and industry that mark the early period of Islam” (Bazna & Hatab, p. 7). Islam teaches that all people regardless of their status in society should be treated with dignity as ends in themselves and not as mere means. Persons with a disability are subjects who deserve respect and consideration as equal persons.

2.5.2. Education

Bogonko (1992) and Eshiwani (1993) provided a historical account of the development of Kenya’s system of education from pre-colonial past (before 1963) to the post independent period (after 1963 when Kenya achieved independence from Britain). Racial discrimination predominated pre-independence education policy in Kenya. After independence, gender based discrimination replaced racial

discrimination. Poor people were also significantly excluded from having access to quality education available in high schools. Persons with disability were not given any significant attention in the educational policies discussed in the two sources.

Kenya Institute of Education - KIE (1994a, 1994b, 2002) discussed the goals of education in Kenya. These included: fostering national unity and patriotism, facilitating personal and national development by developing desirable skills, knowledge and attitudes, preserving cultural heritage and fostering international consciousness co-operation. These goals are lofty and admirable. However, the Republic of Kenya (1988 & 1999) revealed that the goals have not been met and there exists a likelihood that they may not be met unless the government and the people of Kenya change their attitude towards education and become committed to reforming their system of education. Problems of wastage, unequal access to education, poor educational infrastructure, and lack of commitment to excellence inhibit learning in Kenya. Persons with disability are greatly disadvantaged. Though special schools exist in Kenya, they are not adequately equipped and staffed, and facilities in mainstream schools are not suitably adapted to the needs of persons with disability. Thus, persons with disability are stigmatised in society and this de-motivates and demoralises them.

Paul (1995) and Paul and Elder (2001) asserted that education must develop the inherent human capacity to think critically and creatively as well as develop dispositions that facilitate effective human relationships. Such an education assumes that every individual learner regardless of his/her status has an innate ability to learn which needs to be developed. It is argued that the development of these critical faculties need a conducive environment characterised by mutual respect, participation and recognition. Also, that dispositions like tolerance, intellectual honesty and empathy facilitate learning and self-fulfillment.

Wambari (1999, 2002) outlined the complaints raised against Kenya's education system. Relevant to this study is the inability of the system to produce graduates who can think autonomously and be self-reliant. There is too much emphasis on examination and certification at the expense of understanding and transformation of

intellectual and moral dispositions. If this is true of non-disabled learners, it must be worse for persons with disability who are refugees residing in Kenya and who are equally exposed to the same system of education.

2.6 COMMUNITY BASED REHABILITATION

Finkenflugel (2004) defined rehabilitation as all types of interventions aimed at improving the functioning and participation of people with a disability. The interventions include counselling, special education, vocational training and different types of medical rehabilitation such as physiotherapy and occupational therapy. Rehabilitation, therefore, enhances the capacity of people with a disability to be better integrated into the life of the community by improving their physical, social, emotional and economic well-being. Rehabilitation has for a long time, especially in developing countries, been institution-based. Specialised institutions have provided rehabilitation services for specific types of disabilities. However, this approach has been found to have the following shortcomings in Africa: it is costly, inaccessible to people with a disability in rural areas and is heavily dependent on foreign material and human resources.

According to the WHO (1981), forty million people with a disability in developing countries needed rehabilitation and this figure has obviously grown since that time. This is because the quality of life of people with a disability is much lower than that of an average person without disability. People with a disability are more prone to poverty, disease, illiteracy and exclusion from leadership. The institutions that may exist for addressing the needs of people with a disability are mostly located in towns and are therefore inaccessible to people living in rural areas. There is, therefore, a need to localise rehabilitation so that people with a disability and their families and community can participate in the rehabilitation efforts. This would enable people to develop their abilities and skills. At the same time, the attitudes of the community towards disability would be influenced and transformed. This leads to a discussion of the importance of an approach to rehabilitation referred to as community based rehabilitation (CBR).

CBR, as first promoted by the World Health Organisation, was designed to be integrated into the Primary Health Care system. The WHO model of CBR has had an

‘impairment’ bias, focusing largely on the transference of basic rehabilitation techniques to community level workers and to people with disabilities and their families. However, over time definitions of CBR have shifted away from an impairment focus towards ‘community development’.

The WHO (1994) defined CBR as a strategy within community development for the rehabilitation, equalisation of opportunities and social integration of people with a disability. Its implementation involves combined efforts of people with a disability, their families, communities and appropriate government and private sectors. It aims at improving the quality of life of people with a disability using locally available material and human resources. People with a disability are seen as active partners in the planning, implementation, monitoring and evaluation of measures affecting their civil, political, economic, social and cultural aspects of life.

To strengthen a CBR strategy and to make it more effective, the WHO (2005) made the following recommendations that can be useful in enhancing CBR programs:

- Community involvement and ownership
- Multi-sectoral collaboration in implementing CBR
- Involvement of Disabled People’s Organisations in CBR
- Scaling up CBR
- A CBR strategy to be used as an effective tool for poverty reduction, and
- Evidenced based practice to promote CBR.

Maya and Thomas (2004) have strongly argued that CBR is somehow a form of ‘community therapy’ and it is perfectly possible for services to move their geographical location to the community, and to retain identical practice to that which is used in a ‘clinical setting’. They have suggested that such activity can be considered a community-based therapy especially when there is empowerment and active involvement of people with a disability and their families. The professional, though part of the community, retains a degree of control. However, one can differentiate those services, which move to the community and revise their practice by listening to people with a disability and their families’ needs, assessing perceived needs rather than the observed needs of the rehabilitation professionals and actively working in partnership with people with disabilities. This method, the authors suggested, is the

community disability service that is desired. CBR should also include thinking about life issues of people with disabilities at all times, and not exclusively about rehabilitation. People with disabilities should also equally have access to all services, which are available to other people in the community, such as community health services, child health programs, social welfare and education.

Finkenflugel (2004) emphasised that CBR is a bottom up approach, which addresses the needs of the people in the community by harnessing the resources available in the community. It brings together the following stakeholders: the people with a disability, family members, community rehabilitation workers and officers as well as other relevant specialists. CBR has the strength of addressing local problems by empowering local persons to address the issue of disability. This encourages the community to own the initiatives, enhances capacity building, self-reliance and respect for human rights.

According to the World Bank, Disability and Development website (2007), CBR has been received well in some developing countries. In India, for instance, community driven development programs have been initiated. These programs employ the principles of *participation*, *voice* and *agency*. People with a disability are organised into self-help groups and federations and linked to the wider community and other stakeholders. The aim of CBR is to empower and build the social capital of people with a disability, so that they can demand and articulate their needs, interests and challenges. Banks are approached and persuaded to offer loans and employ people with a disability.

The WHO (2004) argued that rehabilitation services should not be imposed on persons with disability. Instead the consent and participation of persons with disability should be sought. Adequate and relevant information should be given to the consumers of rehabilitation services to facilitate the making of informed decisions. CBR therefore seeks to make persons with disability live as equal citizens within the community.

2.7 THEORIES: SOCIAL CONFLICT AND SOCIAL RECONSTRUCTION

Bilton et al. (1987) and Haralambos (1980) discussed the conflict theory of society. According to this perspective, society is pervaded by the dynamics of control, power and constraint. The conflict paradigm emerged from the work of such thinkers as Hegel, Karl Marx and George Simmel. Other advocates of the perspective included C. Wright Mills, Ralf Dahrendorf, Irvin Harowitz, Lewis Coser, Herbert Marcuse, Randall Collins and Andre Frank (Abraham, 1982). The theory asserts that social reality does not flow from consensus but from antagonistic, yet interrelated needs and designs of people, and that conflict as opposed to harmony, is the dominant form of social relationship. The theory emerged as an antithesis to the Functionalist perspective, which emphasises social stability, conformity and harmony. Social change is seen as a product of social tensions and antagonisms. This theory enlightens the problems identified in the study; the social, political and economic situation in Somalia that has given rise to the refugee crisis as well as disability among the Somali people. It forms the framework that guided the concepts and the interpretation of the data.

According to McNergney and Herbert (2001), Social Reconstructionism is an educational theory advocated by such thinkers as Theodore Brameld (1904-1987), George Counts (1889-1974), and Saul Alinsky (1909-1972). In respect to this theory, people are responsible for social conditions, and can improve the quality of life by improving the social order. The theory prescribes rapid sweeping changes throughout the society to affect a new social order. It views education as a means of preparing people to create a new society. The tools of analysis for this theory include: governance, decision-making, representation, participation, justice, opportunities, empowerment, curriculum design, and professionalism in teaching. Key concepts used in the theory include: inclusive education, participation, rehabilitation, equal opportunity, and democratic governance.

Social Reconstructionism is optimistic about people's capacity to change their condition as well as the potency of quality and courageous leadership and the power of modern science to solve human problems. It views human problems and solutions as interconnected and locates the responsibility to change society in societal

membership. The goal of education is regarded as the creation of a better world through sustainable processes of solving social, political, economic, and environmental problems. The theory emphasises the importance of social studies, social problems, global education and environmental issues in education (McNergney & Herbert, 2001). This research will apply the theory of Social Reconstructionism and other approaches that are important in tackling the problem of disability, for instance, Community Based Rehabilitation (CBR).

2.8 CONCLUSION

This chapter has reviewed the literature that reflects the themes characterising this study. It has provided information that enlightens the specific and general contexts of the study. The core issues in this study, namely disability, education, refugee life and rehabilitation approaches have also been reviewed. The theoretical framework that guides the entire study has also been considered. The chapter has made explicit key issues that are addressed in this study. These issues can be summarized in the form of research questions as follows:

- How do the Somali community define disability?
- What are the major causes of disability among the Somali community?
- How does the quality of life of people with a disability compare with that of non-disabled refugees within the camps?
- What are the basic needs, aspirations, and challenges of people with a disability in the refugee camps? and
- How can we develop a comprehensive approach to community rehabilitation relevant to the Somali refugees with a disability in Kenya?

The questions above guided the collection and analysis of data. The next chapter discusses the methodology of this study.

CHAPTER THREE

3.0 METHODOLOGY

3.1 INTRODUCTION

Fitzgerald and Buchanan (2003) define methodology as the principles underlying the use of specific techniques or methods of research. This chapter describes the methodology employed in this study. Generally, the study had both conceptual and field components. The conceptual part involved a library search, which yielded the literature review, that is documented in chapter two. This conceptual aspect enabled the researcher to clarify the problem and formulate the objectives of this study. The field component involved the collection of primary data from the Dadaab refugee camps in Kenya. Qualitative methods were used in data collection, but both qualitative and quantitative methods were used to present, interpret and analyze the collected data. This chapter explains how the researcher collected and processed raw data from the field using the quantitative and qualitative methods. It begins by explaining the relationship between quantitative and qualitative methods of social research.

3.2 QUANTITATIVE VERSUS QUALITATIVE APPROACHES TO SOCIAL RESEARCH

Mugenda and Mugenda (1999, p. 204) contrast quantitative and qualitative approaches to research. Quantitative research aims at prediction and control of the causes and effects of human behaviour. It is based on the assumption that reality is stable and made up of facts that do not change. It seeks a value free and objective perspective of the facts and focuses on particular selected and predefined variables. After data are collected, they are measured in the form of numbers. Data analysis is conducted using statistical packages that may yield both descriptive and inferential statistics.

Qualitative social research, on the other hand, aims at understanding people's interpretations and perceptions. It assumes that reality is dynamic and socially constructed. People's perceptions of reality, which are value bound, are therefore

important in qualitative research. Qualitative research focuses on obtaining a holistic picture of reality. It therefore employs multiple methods for data collection. Data are analysed by coding, organising into themes and concepts from which generalisations are formulated.

Quantitative and qualitative approaches to research are founded on positivistic and phenomenological worldviews respectively (Abraham, 1982; Easterby-Smith, Thorpe, & Lowe, 2002; Fitzgerald & Buchanan, 2003; Mugenda & Mugenda, 1999). The positivistic worldview, which is the basis of quantitative research, is based on metaphysical (ontological) and epistemological assumptions. Metaphysical assumptions have to do with the nature of social reality. Epistemological assumptions have to do with the nature of social data and knowledge. Since the nature of reality determines the nature of the knowledge of that reality, the ontological and epistemological assumptions are discussed together. With regard to the quantitative/positivistic approach, the assumptions are that:

- Man and society are governed by invariable laws, which are discernible empirically. Cause-effect relationships are therefore observable in society.
- Social reality is made up of facts that do not change.
- Social data is stable because social activities, norms and institutions are repetitive.
- The purpose of social research is prediction and control of human behaviour.
- Society is like a natural object therefore social data can be studied scientifically using scientific indicators.
- Human beings react to external stimuli and their behaviour can be objectively explained by this reaction.
- Social data is objective and value free since values can be controlled using appropriate methodological procedures; and
- The results of social research should be reliable and valid.

However, the phenomenological worldview, which is the basis of qualitative research, is based on the following metaphysical and epistemological assumptions:

- Social reality is dynamic and relative and therefore social data is relative to time, place and situation.

- Human beings are cultural and not merely natural objects. They have awareness and freedom that sets them apart from material objects.
- The purpose of social research is to understand and interpret human behaviour.
- Humans are socialized beings. Social data are qualitatively different from other scientific data. Human beings have meanings and purposes expressed through thought, feelings, intentions and actions.
- As conscious and free beings, humans create and modify meanings. They evaluate their own activities and situations and act in a goal oriented way. As such, they are actively self determining and therefore significantly unpredictable. They act rather than merely reacting to external stimuli, and
- Quantitative measurement of social data is either impossible or difficult because social data are complex and subjective. Reliability and validity of social data is difficult to achieve since determinants and results of human action are varied and dynamic.

Despite the differences discussed above, quantitative and qualitative approaches can be complementary. Quantitative approaches can sometimes yield qualitative data and vice-versa depending on the objectives of the study, data collection procedures and the kind of questions asked (Mugenda & Mugenda, 1999, p. 202). Qualitative researchers can therefore, where appropriate, use quantitative instruments (Silverman, 2000, p. 185). Emphasising the complementarity between the two approaches, Kirk and Miller (1986, p. 10) assert: “By our pragmatic view, qualitative research does imply a commitment to field activities. It does not imply a commitment to innumeracy”.

The methodology of this study was both qualitative and quantitative. While quantitative research employs numerical indicators that ascertain relative size of a particular research phenomenon, qualitative methods employ greater descriptive information to indicate the presence or absence of a particular research phenomenon. Thus, the researcher applied both quantitative and qualitative methods because both have an important complementary role and the choice of this approach was made due to their distinctive advantages that seemed to suit this study. The qualitative research

excels at ‘telling the story’ from the participant's viewpoint, providing the rich descriptive detail that sets quantitative results into their human context.

Mack, Woodson, MacQueen, Guest, and Namey (2005) suggested qualitative research advantages that include:

- Qualitative research yields culturally specific and contextually rich data. Since this study focuses on Somali refugees with a disability who share a common cultural and social context, qualitative methods were found suitable.
- The qualitative methods reveal and attempt to explain the dynamics of socio-behavioural factors like cultural norms, ethnic identities, gender norms, stigma and socio-economic status. These factors are active in disability affairs hence the suitability of the qualitative approach.
- The qualitative approach has been credited with facilitating the development of relevant, cost-effective, and efficient interventions whose formulation involves the contributions of the respondents in the research. This study hoped to develop recommendations for such interventions.

Morgan and Smircich (1980), Smith, (1988) and Cassell and Symon (1994) suggested that the quantitative mode of inquiry is guided by the functional or positivist paradigm based assumption that social reality has an objective ontological structure and that individuals are responding agents to this objective environment. Since this study focuses on Somali refugees with a disability, quantitative methods were found suitable for assessing the responses of people with disabilities to their environment at the refugee camps.

Quantitative research involves performing the statistical analysis of a body of numerical data and summarising large amounts of data and reaching generalisations based on statistical projections. While the raw details in the qualitative research data were not simple to organise, the researcher was able to use the qualitative research to describe the phenomena of interest (issues of refugees with a disability) in great detail. Thus, in the results chapter (see chapter four) some quantitative methods of analysing data, namely SPSS generated tabulations and percentages, were used to facilitate a vivid display of relationships among the qualitatively collected data.

3.3 LOCATION OF THE FIELD STUDY

The Dadaab Refugee Complex (DRC) consists of Ifo, Dagahaley and Hagadera camps, which are situated 110 kilometres from Garissa town and only 80 kilometres from the Kenya Somalia border. Dadaab town is a division of the Garissa District of North Eastern Province (NEP) Kenya. The three camps cover a total area of 50 square kilometres and hold nearly two thirds of Kenya's total refugee population.

Ifo is located 6 kilometres north of Dadaab town. Dagahaley 17 kilometres north of Dadaab and Hagadera is located 10 kilometres south east of Dadaab town. Each of these camps is divided into blocks and sections labelled alphabetically for easy administration.

This study was carried out among the Somali refugees in Kenya and limited to Somali refugees under the protection of the UNHCR in Dadaab Refugee Camps. Other Somali refugees living in urban centres of Garissa and Nairobi were excluded due to time and resource limitations.

3.4 PRELIMINARY RESEARCH (PILOT STUDY)

Information concerning people with disabilities in refugee populations is very limited. This lack of data means that these refugees constitute a largely ignored population whose social needs and circumstances need to be investigated. The researcher therefore, considered it important to conduct a pilot study to:

- Assess the validity of the research topic
- Find out any terms of reference required by stakeholders before the main research
- Determine the level of community support for the identified research topic, and
- Evaluate the suitability of the questions used in obtaining the information required.

Based on approval from the Social and Behavioural Research Ethics Committee of Flinders University and, the permission of the government of Kenya, and acceptance from CARE International Country (Kenya) office, the researcher was able to collect

preliminary data from the 13th December 2004 to 25th February 2005 (10 weeks) at the Dadaab refugee camps.

The initial part of the project involved visiting the refugee camps and obtaining basic data about refugees from Camp Administrators on history of the camps, prevalence of disabilities amongst refugees, main activities service agencies provide to people with disabilities as well as the educational facilities available at the refugee camps.

During data collection interviews and focus group discussions were also conducted with community leaders, persons with disabilities, staff and management of the refugee camps.

Two focus group discussions were conducted in each of the three camps after the researcher prepared the session's objectives, guideline questions and identified the target population in liaison with CARE management staff at the camps. During the sessions, participants were provided consent forms to sign, issued name tags to conceal their identity, reviewed ground rules for the session and participants were requested to introduce themselves using the name tags provided by the researcher. Each participant was given adequate time to answer the questions. A round table approach was used to prevent domination by respondents.

In addition, extensive consultations were held with International Agencies providing services to the refugees, NGOs, staff of the implementing agency CARE Kenya Chapter, the Somali Refugee Community (SRC), Community Based Rehabilitation (CBR) committees, persons with disabilities and Associations of Parents with Disabled Children (APDC).

The researcher also had the opportunity to visit schools and cultural festivals that were organised by CARE's Community Development Sector (CDS) as well as a number of visits to the Rehabilitation Centres and Learning Institutions for Children with Disability. Such visits were crucial for interaction and helped to develop a relationship with the community.

The findings of the pilot survey helped to establish the following:

- The research topic was viable and the specific problem under investigation had not been given any attention previously.
- There was need for a research assistant to help in data collection.
- Interviews took a long time and sufficient time needed to be set aside for them.
- The use of a tape recorder during interviews would enhance data collection by minimising interruptions and creating a reliable record of the interviews that could be played back if necessary. However, respondents would have to consent to the use of the same.
- One focus group discussion would be adequate for the main research since the respondents tended to offer similar information.

3.5 SAMPLE SELECTION AND SAMPLE SIZE

Data relating to the refugees with a disability receiving services at the refugee camps were collected from the CARE Refugee Assistance Program (RAP) Office through camp administrators. Official data on the refugees with a disability included information about their: age, gender, level of literacy, disability category, employment status and services received. Names and identities of individuals and carers were not recorded. These data provided a useful basis for the sampling of respondents.

Of the targeted 251 respondents, 200 of them were interviewed individually. Forty five of them participated in the focus group discussions and 6 of them provided information for case studies. More males were willing to participate in the study. Some women declined and were replaced by male respondents. This accounts for the lower percentage of the female respondents in the study sample. Of the 251 total respondents, 100 (39.8%) were women, distributed as follows: 72 in individual interviews, 25 in focus group discussions and 3 in case studies.

The 200 respondents who were interviewed individually were refugees with a disability. Administrative records were used to obtain the full list of refugees with a disability in the various camps and then individual respondents were randomly sampled. Members of focus group discussions were purposively sampled from official

records of APDCs (Associations for Parents of Disabled Children), special education teachers, camp administrators and community elders. Purposive sampling was used to identify potential respondents on the basis of gender, occupational class, and age differences in order to diversify the membership of focus groups. The six respondents whose information provided the case study material were purposively identified on the basis of the uniqueness of circumstances in which they became disabled. Camp administrators who were familiar with the biographical information of the refugees helped to identify the suitable respondents.

3.6 METHODS OF DATA COLLECTION IN THE FIELD

Mack et al. (2005, p. 2) identified participant observation, in-depth interviews and focus group discussions as the main methods used to collect qualitative data. In-depth interviews are very useful in collecting data on individual opinions, perspectives and experiences. Focus groups are effective in collecting comprehensive data on the cultural norms of a group of respondents. The data generated by these methods may take the form of field notes, audio recordings and transcripts of the recordings.

According to Easterby-Smith, Thorpe, and Lowe (2002, p. 85), “the most fundamental of all qualitative methods is that of in depth interviewing.” Other methods provide useful ways of supplementing interviews and help to generate insights into how respondents see their world. This study used qualitative methods of data collection namely, interviewing, focus group discussions and case studies. These methods aimed at enabling the researcher to understand how the respondents construct the reality of their situation. This reality is formed from the personal framework of beliefs, values and experiences, which the respondents have developed in order to explain and anticipate events in the world (Jones, 1985, p. 45 and Easterby-Smith et al. 2002, p. 87).

The methods of data collection used in this study have their unique advantages and disadvantages [Mugenda and Muegenda (1999); Krueger (1998); and Denzin, and Lincoln, eds. (2000)]. The advantages of interview include:

- The method facilitates provision of in-depth data.
- Accuracy and relevance of responses is enhanced since the interviewer can clarify questions to the respondent.

- Very honest and sensitive information can be provided by the respondent through a personal interaction with the interviewer,
- Probing questions can be used in order to obtain more complete information.
- The interviewer can get non-verbal information through face-to-face interaction with the respondent.
- Interviews yield higher response rates than questionnaires.

The disadvantages of interview include:

- Interviews are expensive since they involve traveling to meet the respondents.
- Interviews require high level of communication and interpersonal skills.
- Interviewers need to be trained to avoid bias.
- Interviews are time consuming. Consequently, they are suitable for small samples.
- Responses may be influenced by the respondent's attitude towards the interviewer.

Focus group discussions have the following advantages:

- The respondents are more relaxed since they discuss in a group rather than responding to the questions individually.
- Participants can explain in detail and justify their responses.
- A variety of views and opinions can be obtained, compared and explained.
- The method can supplement other methods like individual interviews.
- Concerns, attitudes, experiences and beliefs can be adequately investigated.

The disadvantages of focus groups are similar to those of interviews discussed above.

Case studies are useful in collecting detailed information about a subject, situation or area. The information can then be used to establish patterns, trends and relationships regarding the issue under study. A more systematic study of phenomena can therefore be accomplished especially if the cases selected are typical enough to allow generalization. The difficulty in case studies is to determine whether the cases selected are typical of others.

In line with the usual ethical guidelines for data collection, the researcher sought and received consent from the camp authorities and respondents before collecting any data. The respondents were verbally briefed about the nature of the study and assured

that the information gathered would be confidential (see Appendix 1 for written content of the briefing). Briefings were conducted verbally in the Somali language in order to ensure that respondents understood the requirements of the study as many refugees have low levels of literacy. Appointments were made with respondents who agreed to the process. Where consent was provided respondents were asked to sign a form indicating their consent to being interviewed and to having a tape recording made of the oral conversations (see Appendix 2). Notes were taken during interviews for all respondents as some declined to be recorded on tape. A sighted research assistant accompanied the researcher and assisted in data collection and transcription.

3.6.1 Individual Interviews.

These were both formal and informal interviews. The target group was the people with disabilities and people representing parents' groups. A semi-structured interview guide was used so as to provide flexibility for open conversation to enable the researcher to explore the major themes of the study and communicate effectively with the respondents (see Appendix 3 for a copy of the interview guide). The questions asked were open and respondents were free to provide detailed information. Such questions included: *How do other persons describe you within your community? What is your opinion regarding this description?* Questions that were closed such as: *Are you given any responsibilities in the camp?* were accompanied by a request for explanation. The questions covered three main areas. Questions on personal background sought information regarding the marital status, literacy level, employment status and gender of the respondents. The next group of questions sought information regarding disability and related beliefs among the Somali refugees. The last group of questions sought information regarding needs and challenges of Somali refugees with disability.

Content validity for the questions was established by providing copies of the interview guide to the researcher's academic supervisors and associates of the researcher and debating the questions that had been formulated. Changes were subsequently made to the interview guide on the basis of these discussions and the Pilot study established that the guide provided a useful framework for data collection.

Due to the low literacy level at the refugee camps, oral schedules were translated into the Somali dialect to reduce the possibility of misinterpretation from respondents who had no formal education. A research assistant skilled in the Somali language administered the oral schedules. The researcher and the research assistant took three days to discuss and agree on the following: the contract between the researcher and research assistant; the background, purpose and objectives of the study; the target population; and data collection procedures.

As mentioned previously, consent forms were provided to the respondents and at all times requested information relating to the research was provided freely with an acceptance that confidentiality would be maintained. Any person who did not wish to participate was excluded. A total of 200 people were interviewed (144 individuals with disabilities, and 56 people representing parent groups).

3.6.2 Focus Group Discussions

Bloor, Franklin, Thomas and Robson (2001) and Krueger and Casey (2000) define a focus group as a small group of individuals used to discuss a clearly defined topic. The members of a focus group share some similar characteristics. They are guided through a facilitated discussion, on a clearly defined topic, by a moderator with an aim of gathering information about the opinions of the group members. Since questions are asked to the group, dialogue is promoted as members contribute in answering the questions. The advantage is that the interviewer does not dominate the dialogue and comprehensive responses can be collected.

The researcher carried out three focus group discussions in each of the camps. The respondents included community Elders, members of groups representing parents of children with disabilities (Associations for Parents of Disabled Children/APDCs), special education teachers and camp administrators. Two discussions were held in the preliminary research and the third one was carried out during the main field research. Focus group discussions were a powerful means of evaluating services and testing new ideas. These discussions were used in this study as a qualitative method of data collection with the purpose of obtaining in-depth information on concepts, perceptions, beliefs and treatment of people with disabilities among the Somali refugees. As Morgan (1993) observed, it aims to be more than a question-answer interaction so that members discuss the topic freely among themselves with guidance

from the facilitator hence, becoming a powerful tool which provides valuable spontaneous information in a short period of time and at relatively low cost.

3.6.3 Case Studies

Two case studies were carried out in each camp in order to collect in-depth experiences and views of Somali refugees with a disability. The cases were recorded verbatim by the researcher and later transcribed into English for purposes of analysis. The camp administrators helped the researcher to identify persons in the camps who had significant disabilities.

3.6.4 Ethical Considerations

This study was guided by the following ethical principles as recommended by Nkwi, Nyamongo and Ryan (2001) and Denzin and Lincoln (2000):

- **Respect for persons.** This involves respecting the dignity and autonomy of the respondents. Consequently, the respondents participated in the research voluntarily. They also determined for themselves what questions to answer and how to answer them. Confidentiality was assured for all respondents. Written consent was also obtained for individual participation.
- **Transparency:** While seeking consent from the participants, the researcher explained the purpose of the research and what the respondents were expected to do. The researcher also informed the participants about the risk of re-living the trauma related to their disability. The benefits of contributing towards enhanced awareness about disability and recommendations for more appropriate interventions through the outcomes of the research were clearly explained to the respondents. The researcher promised to send a copy of the thesis to the camps and share the findings of the study with the parties involved in the field research. Once the study is successfully completed, the researcher plans to honour this promise.
- **Adherence to University Research Ethics Guidelines**
The researcher adhered to the research ethics guidelines of Flinders University and signed the Ethics commitment form (see appendix 2). Specifically, the following process was followed:
 1. Consent Forms were signed by all respondents. These were translated into Somali, where relevant, by the researcher who is also Somali.

These forms contained clear statements about anonymity and the right to discontinue involvement.

2. Permission was obtained from the District Commissioner from the Garissa District in Kenya. The District Commissioner was provided with the letter of introduction and a request to provide a written permit for the project.
3. The time frame of interviews and focus groups was mutually negotiated by the researcher and participants.
4. The Researcher was aware of cultural sensitivities about disability issues and was courteous and civil toward all community members.
5. All participants were offered the opportunity of accessing the findings of the research and this will be made available through the Camp administration.

3.7 ORGANISATION AND CODING OF DATA

After data collection, the responses from the individual interviews and focus group discussions were carefully studied to establish trends, relationships and patterns in line with the objectives of the study. The responses to the 33 questions in the interview schedule were categorised according to the common characteristics and patterns that were observed. The research assistant and the researcher discussed responses to each question individually until agreement was reached about how each response should be categorised. There was almost perfect agreement on the assignment of categories and the few disagreements that occurred were resolved easily, after brief discussion, as differences in interpretation were easy to clarify due to the apparent similarities in the experiences of people with disabilities and their carers or supporters. All the responses were therefore placed in agreed upon categories. The categories were assigned numbers or codes. Effort was made to ensure that code categories were as exhaustive and mutually exclusive as possible.

The researcher prepared a codebook (see Appendix 3 & 4) that described in specific details the coding scheme to be followed. In the codebook, the code assignment for each response category for each item in the interview schedule was described. The codebook was used to transfer information to a code sheet.

Examples of entries in the codebook are as follows:

	Question 1 Marital status	Question 2 Literacy	Question 3 Disability category	Question 4 Employment status
Respondent 1	Coded answer	Coded answer	Coded answer	Coded answer

Question 1. Mstatus (Marital status)

1. Single
2. Married
3. Widowed
4. Divorced
5. Other

Question 9. Bowncond (What do you believe about your own condition?)

1. Reversible if better treated.
2. Accepted as God's will.
3. Hopeless and unbearable.
4. I am equally human
5. No response.

Question 10. Spercep (How does the Somali community perceive disability?)

1. Negatively
2. Indifferently
3. Positively
4. No response

In the code sheet, the respondent's number was entered in the first column and the numerical values representing the individual responses to each question were entered as shown in the table below (see Table 3-1). These data were then transferred to the SPSS data editor.

Table 3-1 An example of how data were recorded.

	Mstatus	Bowncond	Spercep
1	2	3	1
2	1	5	2
3	5	2	3

In Table 3-1 the first respondent was a married person (MStatus = 2) who believed that his own condition was hopeless (Bowncond = 3). The respondent also reported that he/she felt that the Somali community perceives disability negatively (Spercep = 1).

3.7.1 Clarification About Categorisation Of Responses

The categories in part one of the interview schedule (personal information) were structured by the researcher and guided by the official profiles of the refugees in the

camp. These categories were structured for the following variables: marital status (Mstatus), Level of literacy (Literacy), Disability category (Catdisab), and Employment Status (Emsatus) (see Appendices 3 & 4).

Categories of responses for open-ended questions (e.g., Question 9 and 10 above) were formulated after studying the trends and patterns in the various responses collected. The researcher and his assistant discussed each question and its corresponding responses and agreed on the categories that best distinguished the kind of responses that were provided. Every category of responses was given a numerical value. The numerical value was neutral. It merely identifies and sets apart a certain category of responses. For Question 9 for instance, Value 1 was given to all responses that portrayed hope that the disability condition was reversible if proper medical attention was provided. Value 2 was given to all responses that attributed the disability to God or a supreme being. Value 3 was given to responses that portrayed pessimism, fatalism and resignation. Value 4 was given to responses that asserted the humanity and dignity of the respondent while Value 5 was given to situations where the respondent declined to provide a response (as was their stated right according to the briefing they were given – see Appendix 1 for briefing outline).

Negative responses were those that portrayed pessimism and dehumanisation. For instance, responses for Question 10 that were given Value 1 (negative) included: disabled people are cursed, disabled people will not go to paradise, disability is inability, and similar responses. Positive responses (Value = 3) were optimistic and dignifying in depicting disability as follows: disability is not inability, disabled people are part of the community and they have their rights and duties, and similar responses. Indifferent responses (Value = 2) portrayed neither positive nor negative characteristics for instance the response that disability is a fact of life that need not be good or bad.

Responses categorised as ‘other’ (e.g., Question 1, Value = 5) seemed to deviate from the patterns and trends observable in most of the responses. They were categorised as such in order to preserve their uniqueness. The research assistant and the researcher did the organisation and coding of responses manually. They developed the codebook (see Appendices 3 & 4) using the interview schedule and the responses obtained from the interviews.

3.8 DATA ANALYSIS

The analytical objectives of qualitative research include: descriptions of variations, description and explanation of relationships among the data, descriptions of individual experiences, and description of group norms (Mack et al., 2005). This study was guided by these objectives. It also used tables and percentages to display in a clear manner the characteristics of the respondents as well as the relationships in the responses they gave.

This study analyzed the data collected from the field as suggested in Mugenda and Mugenda (1999, p. 203-205). The steps included the following:

- Data organisation: This involved transcribing the tape-recorded data and field notes made by the researcher and his research assistant.
- Guided by (but not restricted to) the questions and objectives of the study, categories, themes and patterns were identified. Relationships were established among categories.
- Codes were used to represent categories and themes identified in the data and by use of an SPSS text editor, tables and percentages were generated.
- The codes used are words or letters that represent a link between raw data from interview transcripts and the researcher's theoretical framework.

3.9 CONCLUSION

The present chapter has described the methodology used to collect, organise, analyse and interpret data. The next chapter presents the results of the data analysis.

CHAPTER FOUR

4.0 RESULTS

4.1 INTRODUCTION

This chapter deals with the analysis and presentation of data which were collected during field research in the Dadaab camps, located in the Garissa District, in the North Eastern province of Kenya. The data were collected from respondents who were interviewed individually or collectively through focus group discussions. This chapter provides the necessary background for the discussion of research results in the next chapter.

4.2 DATA RECEIVED FROM INTERVIEWS OF INDIVIDUAL RESPONDENTS

4.2.1 Characteristics of Respondents.

Information on the characteristics of respondents was collected in the following categories: age, gender, marital status, employment status, level of literacy, disability category and various concepts, beliefs, treatment and challenges facing Somali refugees with a disability in the Dadaab camps in the Garissa district.

The researcher developed a list of questions as a guideline for the interview schedule which was circulated to the supervisors for their approval. These interview schedules were then used during the pilot project as well as in the field research to collect data.

The target groups were either interviewed individually or collectively in the focus group discussions. The individual interviews had a sampled population of 200 respondents mainly from people with disabilities and parents of people with disabilities while the three focus group discussions in each of the camps had a sampled population of 45 respondents representing Associations of Parents with Disabled Children (APDCs), people with disabilities, Special Education Teachers and Section Leaders who were also Somali Community Leaders.

Table 4-1: Distribution of respondents according to camps

Camp name	Frequency	Percent
Ifo	67	33.5
Dagahaley	67	33.5
Hagadera	66	33.0
Total	200	100.0

The survey involved a total of 200 respondents; 67 from Ifo, 67 from Dagahaley and 66 from Hagadera camps. Individuals interviewed in these sampled populations were people with disabilities and parents of children with disabilities.

Table 4-2: Distribution of respondents according to age.

Age Group (Years)	Frequency	Percent
18 to 27	31	15.5%
28 to 37	51	25.5%
38 to 47	71	35.5%
48 to 57	37	18.5%
58 to 67	10	5%
Total	200	100%

Table 4-2 shows the age of the respondents which was organised into five age groups of 10s. This was done to simplify the data and to make it easier to summarise.

These results indicated that the respondents' ages ranged between 18 and 67 years. The information in the table shows that the largest group of the respondents ranged between the age of 38 to 47 years and represented 35.5% of the sample while only a small percentage (5%) of the respondents were in the oldest age group of 58 to 67 years.

Table 4-3: Distribution of respondents according to gender

Camp name	Gender		Total
	Male	Female	
Ifo	45	22	67
Dagahaley	43	24	67
Hagadera	40	26	66
Total	128	72	200

The information in Table 4-3 shows that 128 (64%) were male respondents and only 72 (36%) were female respondents. This gender imbalance is discussed in the next chapter.

Table 4-4: Marital status of respondents

	Frequency	Percent
Single	89	44.5
Married	89	44.5
Divorced	12	6.0
Widowed	10	5.0
Total	200	100.0

The information presented in Table 4-4 presents the marital status of the total respondents in the three camps. It reveals that majority of the respondents, 178 (89%) were either single or married and only 22 (11%) were widowed or divorced.

Table 4-5: Respondents' level of literacy

Level of Literacy	Frequency	Percent
None	97	48.5
Primary	70	35.0
Secondary	29	14.5
Tertiary	4	2.0
Total	200	100.0

Primary level of literacy refers to basic literacy and numeracy skills obtained in elementary grades of the schooling system. Secondary level of literacy refers to skills obtained in high school grades of the schooling system. Tertiary level of literacy refers to advanced knowledge and skills obtained at the college and university levels of education.

The findings in Table 4-5 indicate that the majority of the respondents were illiterate or had only a primary level of literacy (83.5%) and only 16.5% had secondary level of literacy or higher. Therefore, it can be concluded that the vast majority of people with disabilities in the refugee camps had little or no formal training in literacy.

Table 4-6: Comparison of level of literacy by gender

		Level of Literacy				Total
		None	Primary	Secondary	Tertiary	
Gender	Male	47	53	25	3	128
	Female	50	17	4	1	72
Total		97	70	29	4	200

Furthermore, a cross tabulation of respondents' level of literacy by gender suggests that Somali women with disabilities have even fewer opportunities than the men, with women having half the level of tertiary training (1% cf. 2%), less than a third of the secondary level training (6% cf. 20%), just over half the level of primary training (24% cf. 41%), and almost twice the level of illiteracy (69% cf. 37%).

Table 4-7: Comparison of marital status by gender

		Marital Status				Total
		Single	Married	Widowed	Divorced	
Gender	Male	61	67	0	0	128
	Female	28	22	10	12	72
Total		89	89	10	12	200

Respondents were asked to indicate their marital status based on five categories: Single, married, widowed, divorced and others. Surprisingly, given that polygamy and divorce is high among the Somali (Siyat, 1999), comparison of respondents' marital status in Table 4-7 shows that none of the males indicated that they had been divorced or that their partner had died. Of the males, 48% indicated they were single and 52% that they were married. Amongst the female respondents, all categories of marital status were indicated such that 39% indicated they were single, 31% that they were married, 14% that they were widowed, and 17% that they were divorced.

Table 4-8: Disability categories of the respondents

Disability Category	Frequency	Percent
Physical	133	66.5
Sensory	30	15.0
Multiple disabilities	17	8.5
Intellectual	11	5.5
Mental disorders	6	3.0
Chronic medical conditions	3	1.5
Total	200	100.0

The researcher provided the disability categories shown in Table 4-8 and the respondents chose from them. They are the categories used in the official camp records and the respondents were very familiar with these. Table 4-8 reveals that the majority of the respondents 133 (66.5 %) had a physical disability but that sensory disabilities were relatively common (15%) and that a range of disabilities was reported.

Table 4-9: Respondents' employment status

Employment Status	Frequency	Percent
Unemployed	156	78.0
self employed	27	13.5
Employed on Contract	11	5.5
Permanently employed	6	3.0
Total	200	100.0

The degree of respondents' employment status among the people with disabilities was considered important in this study because it was crucial in determining the level of income the respondents were receiving at the time of the interviews. The researcher therefore considered this view, and basically divided the respondents into unemployed, permanently employed, employed on contract or self employed and these results are indicated in Table 4-9.

The results show that the majority of respondents (78 %) were unemployed. The next highest category was those who were self employed (13.5 %) and those permanently employed or employed on contract constituted only 8.5 % of the sampled population. These data, therefore, indicate that a high percentage of people with disabilities had little or no source of income.

Table 4-10: Comparison of disability category by gender

Gender	Disability Category by Percentage					
	Physical	Sensory	Intellectual	Mental Disorders	Chronic Medical Conditions	Multiple Disabilities
Male (% of total males)	72	13	5	2	0	8
Female (% of total females)	56	18	7	6	4	10

The above table indicates that: (a) There is a higher level of physical disabilities amongst males which may be accounted for by the effects of war and violence, and (b) There are higher levels of mental health conditions and chronic medical conditions amongst women and these issues will be explored in the later discussion of the results.

Table 4-11: Comparison of employment status by disability category

Disability Category	Employment Status				Total
	Unemployed	Permanently Employed	Employed on Contract	Self employed	
Physical	101	5	9	18	133
Sensory	24	1	1	4	30
Multiple disabilities	13	0	1	3	17
Intellectual	10	0	0	1	11
Mental disorders	5	0	0	1	6
Chronic medical conditions	3	0	0	0	3
Total	156	6	11	27	200

The results in Table 4-11 indicated that the overall number of people with disabilities who were involved in gainful employment constituted 44 (22 %) out of which only 17 (8.5%) were either employed permanently or on contract basis. The remainder of the respondents, 27 (13.5%) were self employed. It also shows that those with intellectual disabilities, mental disorders and chronic medical conditions were not able to be employed permanently or even on contract. The table illustrates that, while the overall opportunities for employment are poor for people with disabilities, there is almost no likelihood of employment for those with particular disabilities

Table 4-12: Comparison of employment status by marital status

Marital Status	Employment Status				Total
	Unemployed	Permanently employed	Employed on contract	Self employed	
Single	80	3	1	5	89
Married	59	3	7	20	89
Divorced	8	0	2	2	12
Widowed	9	0	1	0	10
Total	156	6	11	27	200

A comparison of respondents' employment status by their marital status reveals that: Of those who were single, only 9 (4.5%) were employed permanently (with full-time job security) and on temporary contract (by agencies operating at the refugee camps) or self employed (engaged in business and micro-financing activities) at the time of the field research (2005).

Among the married respondents, 30 (15 %) were employed or self employed and among the widowed and the divorcees, only 5 (2.5 %) were employed or self employed. In the table above, we need to remember that widowed and divorced only

applies to women. This indicates that people who are married are more likely to have employment. This could mean that only people who have a job can afford to marry or that a married person is more motivated to get employment to look after the family.

Table 4-13: Comparison of employment status by level of literacy

Level of Literacy	Employment Status				Total
	Unemployed	Permanently employed	Employed on Contract	Self employed	
None	78	0	2	17	97
Primary	57	2	4	7	70
Secondary	19	4	3	3	29
Tertiary	2	0	2	0	4
Total	156	6	11	27	200

The employment status of the respondents compared to their level of literacy according to Table 4-13 explains that only 17, representing 8.5 % of the total respondents were employed permanently (with full-time job security) or on contract (temporary job security) by organisations at the camps. It also shows that of those respondents who had attained a secondary level of literacy only 7 out of 19 were employed permanently or on contract. This may be explained by discrimination against the people with disability in employment, despite their levels of literacy.

Table 4-14: Comparison of employment status by gender

Gender		Employment Status				Total
		Unemployed	Permanently employed	Employed on Contract	Self employed	
Gender	Male (number)	99	4	8	17	128
	%	77	3	6	13	
	Female (Number)	57	2	3	10	72
	%	79	3	4	14	
Total Numbers of both genders		156	6	11	27	200

Both male and female respondents found it difficult to obtain employment at the refugee camps. As with previous data suggesting higher levels of discrimination against women, though, only 7% of the female respondents were found to have contract or open employment, this figure was 9% for the men. The only area in which women were more likely to be employed than men was in self-employment and this would seem to be an area that is less susceptible to discrimination.

4.2.2 Concepts of Disability and Related Beliefs among the Somali Refugees

Table 4-15: Respondents perceptions of how non-disabled people describe people with disabilities

Description	Frequency	Percent
Negative	198	99.0
Negative and Positive	1	.5
No response	1	.5
Total	200	100.0

Almost all of the respondents interviewed (99%) indicated that the non-disabled people at the refugee camps described the people with disabilities negatively and used terms detested by people with disabilities. Negative descriptions reported included nicknames ('Naanaays') referring to the type of disability of individuals such as 'Dhadol' (deaf), 'Indhool' (blind) or 'Doogon' (fool), the latter term referring to individuals with intellectual disability. The strength of this result was further demonstrated by Haw, (see case study 3) who stated:

They see you as someone who is nothing in the society. Once you become a disabled [sic], you cease to be respected and they dare call you bad names and even abuse you on the streets.

These terms are generally considered derogatory, mocking and discriminatory by the people with disabilities at the camps, as is shown in Table 4-16.

Table 4-16: Responses of people with disabilities to descriptions given to them

Opinion about description	Frequency	Percent
Negative attitude	195	97.5
No response	5	2.5
Total	200	100.0

The majority of respondents (97.5%) considered the community to have negative attitudes toward people with a disability (see Table 4-16). The negative effects that respondents referred to were humiliation, demoralisation and isolation which were reported to be caused by negative descriptions given to people with disabilities.

Despite what happened to Xawa (see case study 3), her situation was not better off at the Dadaab refugee camp. The description given to her was equally humiliating, demoralising and at times frustrating. She said:

If they brand me names, if they abuse me on the streets at my age, obviously you will be disheartened, discouraged and feel neglected by the community when you really want their support especially considering what happened to me. [referring to the rape and violence she experienced]

Table 4-17: Causes of disability according to Somali culture and traditions

Causes of disability	Frequency	Percent
Curse	66	33.0
Diseases	48	24.0
God's plan	30	15.0
Spirits	26	13.0
Tattooing and traditional medicine	14	7.0
Nomadic life	10	5.0
No response	5	2.5
Poor diet	1	.5
Total	200	100.0

A substantial number of respondents stated various causes of disability according to Somali culture and traditions. However, the most common response (33%) considered curse as the cause of disability. This was also expressed by Abdi (see case study 2)

The Somali community assumes and believes that disability results from a curse. They therefore, discriminate. For example, in marriage, they say that if a disabled person marries, he or she will bring forth a disabled child.

References to the effects of nomadic life included such instances as accidents caused by animals, especially the camel, harsh climatic conditions and attacks by wildlife.

Table 4-18: Depiction of disability in oral narratives, sayings and proverbs

Depiction of Disability	Frequency	Percent
Negative	145	72.5
No response	39	19.5
Positive	10	5.0
Both positive and negative	6	3.0
Total	200	100.0

The majority of the respondents (72.5%) depicted the description of disability in oral narratives, sayings and proverbs as being negative. These negative responses depicted the people with disabilities as outcasts, strange and evil beings, powerless and problematic persons. Positive responses depicted people with disabilities as talented,

pious persons deserving of respect. The participants who did not respond could either be ignorant of the oral traditions or unwilling to recount the humiliating contents that the oral traditions have regarding persons with disabilities. It is important to note that the oral traditions (wise sayings, narratives, proverbs, songs etc) that were collected from the respondents reflect their own experiences and world-views. Some may be mutations of the original Somali oral traditions. This study was interested in oral traditions, as the respondents understood them since that is what directly influenced their lives. The researcher hopes, in future, to compare what was collected against what is considered original Somali oral traditions.

Table 4-19: The opinions of people with disabilities regarding their own condition

Belief about condition	Frequency	Percent
Hopeless and unbearable	88	44.0
I am equally human	50	25.0
Accepted as God's will	34	17.0
Reversible if better treated	27	13.5
No response	1	.5
Total	200	100.0

The opinions of people with disabilities regarding their own conditions shows that a good percentage (44%) of the total respondents felt their condition was hopeless and unbearable. Another 25% felt that they were equally human and that their condition was 'normal' for them. Some (17%) were resigned and simply accepted their condition as God's Will and yet another 13% considered their condition reversible if they were to receive better medical treatment.

Table 4-20: Perceptions of the Somali community towards disability

Perception of community	Frequency	Percent
Negative	192	96.0
Indifferent	7	3.5
No response	1	.5
Total	200	100.0

Table 4-20 illustrates that the majority of respondents (96%) viewed the perception of the Somali community towards disability as negative. The negative perceptions included the view that people with disabilities are dependent and burdensome. Indifferent responses included the view that people with disabilities are merely tolerated in the society.

Table 4-21: Causes of disability of most refugees in the Dadaab camps

Causes of Disability	Frequency	Percent
War in Somalia	161	80.5
Diseases like polio	19	9.5
Poor diet	10	5.0
No response	6	3.0
Others	3	1.5
Accidents	1	.5
Total	200	100.0

The cause of disability reported by most refugees in Dadaab was related to war in Somalia. This category represented 80.5% of the total respondents. Diseases like polio were also frequently reported (9.5%) and responses categorised as ‘others’ included, parental curses, association with evil spirits, God’s act and the evil eye.

Table 4-22: Causes of respondent’s own disability

Causes	Frequency	Percent
War/bullet injuries	95	47.5
Diseases like polio	54	27.0
Born that way	22	11.0
Accident	16	8.0
Others	5	2.5
Nomadic life	4	2.0
Poor diet	3	1.5
No response	1	.5
Total	200	100.0

Four relevant causes of respondent’s disability as listed in Table 4-22 include war in Somalia (47.5%), polio (27%), born disabled (11%) and accident (8%). Together they constitute the majority (93.5%) of the total responses. Many of those respondents categorised as ‘war/bullet injury’ indicated that their disability resulted directly from the civil wars in Somalia. Some respondents, in informal interviews with the researcher, stated that when they were injured in the conflict they did not get early and adequate medical intervention on arrival in the camp. Others have developed disability due to the complications of their injuries which have not been corrected, such as bullets lodged in their bodies or others who required expensive surgical procedures which were not considered as a priority. This category also included people who have developed psychological problems related to post traumatic stress as a result of rape and torture.

A good example is that of Xawa (see case study 3). She explained that her disability resulted during the civil war in Somalia when it happened that in her family her brother and husband were both killed in cold blood and also she was violently raped in front of her children. The aftermath of that horrible event caused her *murug* (depression) and *fakir culus* (deep anxieties) which shattered her life dreams. She also explained that because she did not get immediate medical treatment, the impact of that night may have caused her further loss of sight (blindness) and disability.

Table 4-23: Factors contributing to disability within the Dadaab camps

Factors in camps	Frequency	Percent
Diseases	79	39.5
Poor diet	63	31.5
Poor medical care	25	12.5
Violent conflicts	13	6.5
Post-war trauma and stress	6	3.0
Accidents	6	3.0
Others	5	2.5
No response	3	1.5
Total	200	100.0

Some important factors which have a significant contribution to disability within the Dadaab camps as illustrated in Table 4-23, include diseases (39.5%), poor diet (31.5%), poor medical care (12.5%) and violent conflicts (6.5%). These categories account for 180 (90%) of the total respondents. Poor diet at the refugee camps resulted in malnutrition leading to poor growth of children, blindness, malfunctioning of bones and many other deficiencies, which are all associated with disabilities directly or indirectly. The ‘Others’ category refers to respondents, especially parents, who attributed disability of their children to poor injection procedures by auxiliary nurses at the health centres.

4.2.3 Treatment of People with disability in the Dadaab camps

Table 4-24: Interaction of non-disabled Somali refugees with people with disabilities in the camps

Interaction with non-disabled	Frequency	Percent
Poorly	106	53.0
Very poorly	63	31.5
Well	22	11.0
No response	6	3.0
Very well	3	1.5
Total	200	100.0

The findings in Table 4-24 generally demonstrate that there was a poor level of interaction between people with disabilities and the non disabled community at the refugee camps. The two responses categorised as ‘poorly and very poorly’ together accounted for 84.5% of the total respondents interviewed. Poor interaction included regular harassment and discrimination. Very poor interaction included total isolation and segregation of people with disabilities.

Table 4-25: Participation of people with disabilities in programs within the refugee camp

Participation in programs	Frequency	Percent
No	124	62.0
Yes	73	36.5
No response	3	1.5
Total	200	100.0

Respondents’ answers to the question: “Do you participate in any programs within the camp?” are shown in Table 4-25. The level of involvement of people with disabilities in the refugee programs such as education, training, rehabilitation, health and resettlement programs shows that only 36.5% were actively participating and benefiting from such programs while a majority of respondents (62%) did not benefit and participate in any of the programs within the refugee camps.

Table 4-26: Responsibilities of people with disabilities within the camp.

Responsibilities in the camps	Frequency	Percent
Yes	45	22.5
No	150	75.0
No response	5	2.5
Total	200	100.0

Respondents’ answers to the question: “Are you given any responsibilities within the camps?” are shown in Table 4-26. A substantial number of people with disabilities (75% of the respondents) admitted that they were not given any responsibilities at the refugee camps. Even those given responsibilities (22%) explained to the researcher in an informal discussion that their leadership roles were not recognised or appreciated by camp managers. Although they served as representatives of a block or section and on Community Based Rehabilitation (CBR) committees, they did not receive any

payment or incentive for their services at the camps as compared to the non disabled refugees.

Table 4-27: Services people with disabilities benefit from in the camp

Services	Frequency	Percent
Educational	57	28.5
social and recreational	1	.5
Basic like food, water and shelter	56	28.0
Medical	28	14.0
Rehabilitation	23	11.5
None	33	16.5
No response	2	1.0
Total	200	100.0

The services most frequented by people with disabilities in the refugee camps included educational services, basic services such as food, water and shelter, medical and rehabilitation services. These services accounted for 82% of the total respondents. Only one respondent seems to have benefited from social and recreational services such as sports and 33 (16.5%) did not benefit from any of the services in the refugee camps.

Table 4-28: Nature of conflicts experienced by people with disabilities in the refugee camps.

Conflict in camps	Frequency	Percent
Inter-personal	154	77.0
Inter-clan	7	3.5
Organisational	23	11.5
Banditry	6	3.0
Others	1	.5
No response	9	4.5
Total	200	100.0

Table 4-28 shows that 154 Respondents (77%) identified inter-personal conflict as the main source of conflict experienced by people with disabilities in the refugee camps. Interpersonal conflicts arise from bullying, insults and stoning by children. Organisational conflicts arise from poor management of services provided to the refugees by implementing agencies.

Table 4-29: Difficulties people with disabilities face as refugees in the camps

Difficulties in camps	Frequency	Percent
Economic	91	45.5
Social	72	36.0
Educational	17	8.5
Rehabilitation	7	3.5
medical	6	3.0
Security	6	3.0
No response	1	.5
Total	200	100.0

People with disabilities in the Dadaab refugee camps identified three main difficulties based on social, economic and educational issues. However, the largest group of respondents (45.5%) cited economic issues followed by social (36%) and 8.5% mentioned educational difficulties.

Economic difficulties included lack of employment opportunities, basic necessities and funds to support entrepreneurship. For example, how to start a new business to generate income at the refugee camps.

Social difficulties included negative community attitudes and discrimination against individuals in relation to the services available at the camps. Educational difficulties included lack of sufficient Special Education Teachers, difficulties acquiring materials and equipment and poor access to adult literacy, especially for the visually disadvantaged.

Table 4-30: Treatment of people with disabilities in the camps

Equal Treatment	Frequency	Percent
No	174	87.0
Yes	21	10.5
No response	5	2.5
Total	200	100.0

Respondents' answers to the question: "Are people with disabilities treated the same as non-disabled people in the camps?" are shown in Table 4-30. The general response to this question was in the negative. Most of the respondents (87%) answered "no" and indicated that they were not happy with the way they were treated at the refugee camps. Lack of equal treatment was described as not receiving an equal share of

resources and opportunities such as educational services, employment and resettlement opportunities

Table 4-31: Respondents’ opinion regarding the treatment of people with disabilities in the camp

Opinion about Treatment	Frequency	Percent
Should be changed	111	55.5
Unfair	80	40.0
No response	9	4.5
Total	200	100.0

The kind of treatment people with disabilities received in these camps based on the respondents’ opinions was described as “unfair” or “should be changed” by 95.5% of respondents (see Table 4-31).

Table 4-32: The main disadvantage of having a disability in the camps

Disadvantage of disability	Frequency	Percent
Economic	109	54.5
social	39	19.5
Educational	37	18.5
No response	8	4.0
Medical	3	1.5
Insecurity	3	1.5
Psychological	1	.5
Total	200	100.0

Since it seemed important to identify the main disadvantages of having a disability in the refugee camps, a question was asked related to this (see results in Table 4-32). Having a disability in the refugee camps seems to have been associated by respondents with deprivation of three important services; educational, social and economic services. Responses categorised as psychological included trauma and stress caused by deprivation and fear of war. Responses categorised as insecurity included fear of attack by enemies.

Table 4-33: Treatment of families with a child with a disability in the Somali community.

Treatment of family	Frequency	Percent
badly	174	87.0
well	14	7.0
same	8	4.0
No response	4	2.0
Total	200	100.0

Table 4-33 reports results related to the effects on families of having a child with a disability. Respondents who acknowledged that families with a child who has a disability are treated ‘well’ or the ‘same’ as families with non-disabled children together represented only 11% of the total respondents. Responses that claimed that families with people with disabilities are treated badly seemed to have the highest number of respondents (87%) and comments referred to included isolation by neighbors and relatives and the belief that the family was cursed. However, considering the harsh conditions in the camps and the general poverty level, it was heartening to see that some respondents (11%) indicated that families with children with disabilities were treated the same as others or ‘well’.

Table 4-34: Type of education provided to children with disabilities in the camps

Type of Education	Frequency	Percent
Inclusive	107	53.5
Inclusive with limited special attention	82	41.0
Special education	8	4.0
No response	3	1.5
Total	200	100.0

Table 4-34 reports comments on the type of education provided for children with disabilities. By ‘inclusive education’ the respondents meant putting both children with disabilities and non-disabled children into one classroom and providing them with the same curriculum. Inclusive but limited responses included lack of Special Education Teachers, deficient teaching aids such as Braille machines, hearing aids, books, posters, insufficient special facilities and lack of educational assessment centres for children with special needs. While these figures may appear positive considering the general poverty and poor conditions, the next question provided data that indicated that the responses to the educational needs of children with disabilities are limited (see Table 4-35).

Table 4-35: Comparison of education provided for children with disability and those without disability

Comparison of Education	Frequency	Percent
Poorer	152	76.0
Same	43	21.5
No response	5	2.5
Total	200	100.0

The question related to the quality of education provided for children with disabilities as compared to those children without disability indicated that most respondents (76%) considered this to be poorer for the children with disabilities (see Table 4-35). In the researcher’s informal conversation with respondents as well as Special Education Teachers in the field, this was attributed to untrained teachers, lack of special facilities and the fact that children with a disability find it difficult to go to school due to lack of mobility equipment such as white canes, artificial limbs (prosthesis), wheelchairs, and hearing aids. Children with disabilities also have little chance to compete with non-disabled children in schools and scholarship opportunities.

Table 4-36: Rehabilitation or training provided in the camps for adults with disabilities

Rehabilitation available	Frequency	Percent
None	103	51.5
Limited	93	46.5
No response	4	2.0
Total	200	100.0

Table 4-36 shows responses to a question about the rehabilitation or training opportunities in the camps. The high number of respondents who answered “none” (51.5%) explains that a majority of adult people with disabilities who need training and rehabilitation are not receiving such services at the refugee camps. Limited rehabilitation included vocational training given to some disabled and non-disabled refugees. It includes leatherwork, carpentry and apprenticeships program such as electrician, welding, auto-mechanics, plumbing, sewing and secretarial courses.

4.2.4 Challenges Facing Somali Disabled Refugees in the Dadaab Camps

Table 4-37: Quality of life in the camps for a person with disability

Life in the camps	Frequency	Percent
Extremely difficult	163	81.5
Difficult	25	12.5
Normal	6	3.0
No response	6	3.0
Total	200	100.0

The perceived quality of life experienced by people with disabilities in the Dadaab refugee camps is shown in Table 4-37. The quality of life attempted to measure the

multi-dimensional aspects of physical, social, economic and emotional subjective well-being of people with a disability at the refugee camps. These encompassed financial/economic and social hardships faced by people with a disability.

This was evaluated by respondents as extremely difficult or generally difficult (94%). Only 6% considered it “normal” and were able to cope with the situation at the camps or were undecided.

Table 4-38: Comparison between life for a family without a person with disabilities and that of a family with a member who has a disability.

Comparison	Frequency	Percent
Better	179	89.5
Same	7	3.5
Worse	6	3.0
No response	6	3.0
Other	2	1.0
Total	200	100.0

The quality of life, which is generally measured by the external financial support other than resources available in the camps, seems to be better for families without a member who has a disability rather than families who have a member with a disability (see Table 4-38). A substantial representation of respondents (89.5%) indicated it was “better” for families without a member with a disability (see Table 4-38) and in the researcher’s informal conversations, many of the respondents told him that they had no other financial support other than what they receive from agencies operating in the camps. Responses categorised as ‘other’ stated that it all depends on the financial background and the amount of remittances they receive from relatives who have been re-settled in another country.

Table 4-39: Gender-based challenges that Somali disabled refugees face in the camps

Gender based challenges	Frequency	Percent
Same for all gender	95	47.5
Females suffer most	95	47.5
No response	8	4.0
Males suffer most	2	1.0
Total	200	100.0

Table 4-39 illustrates the nature of gender-based vulnerability and challenges perceived by people with disabilities living in the Dadaab refugee camps. While

almost half of the respondents (47.5%) indicated that the challenges were similar for both genders, almost half of the respondents (47.5%) reported that the challenges faced by females with disabilities were greater and only a few respondents (1%) thought that the challenges faced by males were greater than those for females.

Considering that the number of females sampled in the overall research was smaller than males, it is likely that the results on this question would have been very different if there were an equal number of males and females.

Table 4-40: Age-based challenges that Somali Disabled Refugees face in the camps

Age based challenges	Frequency	Percent
Same for all ages	74	37.0
Children suffer most	45	22.5
Old people and children suffer most	32	16.0
Old people suffer most	23	11.5
No response	18	9.0
Teenagers suffer most	8	4.0
Total	200	100.0

The challenges experienced by people with disabilities relating to age indicated that the largest group (37%) stated that it was the same for all ages (see Table 4-40). However, when we consider which group of people suffered most, the number of respondents who stated that children suffered most was high (22.5%) as compared to the other age categories.

Table 4-41: Respondents’ awareness of agencies that assist people with disabilities

Initiatives in the camps	Frequency	Percent
Yes	124	62.0
No	60	30.0
Don't know	10	5.0
No response	6	3.0
Total	200	100.0

Respondents’ answers to the question: “Are you aware of any initiatives in the camps that assist people with disabilities?” are given in Table 4-41. The majority of respondents (62%) answered “yes” they were aware of agencies that assisted people with disabilities but also a significant number (almost a third of the total respondents) were not aware of these agencies at all. Those who answered “no” also included

respondents who told the researcher that they had never stepped out of their camps or even visited the Dadaab main office located in Dadaab town.

Table 4-42: Respondents’ recommendations

Recommendations from respondents	Frequency	Percent
Better education	66	33.0
Resettlement	44	22.0
Better economic opportunities	22	11.0
No response	18	9.0
Others	15	7.5
Better medical care	14	7.0
Social awareness	11	5.5
Better rehabilitation	10	5.0
Total	200	100.0

Respondents’ answers to the question: “What should be done to improve the lives of people with disabilities?” are shown in Table 4-42. Generally, many people with disabilities were positive that something could be done to improve their lives and outlined various recommendations. However, 110 (55%) suggested better education and resettlement opportunities. These two aspects were most favoured, it appeared, because of the capacity to empower people with disabilities. And this was also confirmed in the researcher’s informal discussions with respondents.

Resettlement and access to education has the potential to make the person with a disability active and productive in society and, as stated by Soloo (see case study 1),

once you have good education and skills you will be in a position to challenge the attitude of the community.

Table 4-43: Marital challenges of people with disabilities:

Marital Challenges	Frequency	Percent
Yes	163	81.5
No response	26	13.0
No	11	5.5
Total	200	100.0

Respondents’ answers to the question: “Do you encounter any marital challenges as a result of your disability?” are given in Table 4-43. Most of the respondents (81.5%) indicated that they encountered marital challenges as a result of their disabilities. Respondents in an informal discussion explained that these challenges were related to

negative attitudes to people with disabilities, discrimination, exorbitant bride price and delay in marriage, especially for women with disabilities.

4.3. DATA RECEIVED FROM FOCUS GROUP DISCUSSIONS

This section used data from the target groups interviewed collectively in the focus group discussions which included members of Associations of Parents with Disabled Children (APDCs), people with disabilities, Special Education Teachers and Section Leaders who were also Community Leaders.

Three focus group discussions were carried out in each of the three camps: Ifo, Dagahaley, and Hagadera. Each focus group discussion had fifteen members selected in such a way that they were representative of parents of children with disabilities, people with disabilities, special education teachers, and community leaders of both genders. All the focus group discussions held agreed that the nature of the names used to refer to people with disabilities among the Somali community were negative. The negative responses include use of derogatory words or phrases which humiliate persons with disability by referring to their peculiar impairments. Examples of these included elements which singled out physical traits such as ‘indhol’ (blind), ‘lugoole’ (physically handicapped) or commented on particular behaviours such as ‘mashquul’ (confused).

Table 4-44: Causes of disability according to Somali culture and traditions

Focus Group Number	Causes of Disability
1	accidents, curse, God's act, trauma, diseases
2	accidents, curse, God's act, disease, trauma
3	curse, Nomadic life, spirits
4	curse, spirits, God's act
5	curse, God's act, spirits
6	curse, God's act, accidents, diseases
7	God's act, curse, spirits
8	violence, diseases, accidents, spirits
9	war, curse, spirits, inheritance

In a number of focus group discussions (6) as explained in the above table, the dominant causes of disability according to the Somali culture and tradition were associated with curse, accidents, God’s plan, evil spirits and diseases. These same

causes were also dominant and featured in the individual interviews as explained in Table 4-17.

The depiction of disability in oral narratives and proverbs was universally agreed to be negative in the focus group discussions. This was in agreement with the findings reported in the individual interviews (see Table 4-18). Most of the narratives and proverbs are used to justify the discrimination and humiliation of disability as well as ridiculing the people with disabilities and to explain how they are considered unlucky and disliked. These negative responses therefore, depicted the people with disabilities as outcasts, strange and evil beings, powerless and problematic persons.

Table 4-45: Attitude of people with disabilities towards their own condition

Attitude to own condition	Frequency	Percent
Positive	6	66.7
Negative	1	11.1
Some think positively others negatively	2	22.2
Total	9	100.0

In six out of nine sessions (see Table 4-45), most of the respondents were of the opinion that people with disabilities had a positive attitude toward their own conditions. These positive attitudes included the ability to participate equally like the non-disabled members in the society if they only receive their rights and opportunities and are not discriminated against in services in the refugee camps.

Conversely, the perception of the Somali community towards disability was viewed negatively in all sessions (see also Table 4-20). These responses appeared to be related to the fact that the Somali community considered people with disabilities to be dependent and unproductive, especially in a nomadic environment, and the community would not, therefore, involve them in decision making or in matters of inheritance among many other issues.

Table 4-46: Interaction of non-disabled persons with people with disabilities

Interact	Frequency	Percent
Poorly	6	66.7
Well	2	22.2
Very poorly	1	11.1
Total	9	100.0

The level of interaction of non-disabled persons with people with disabilities in the refugee camps was found to be poor by both the focus groups (see Table 4-46) and in the individual interviews (see Table 4-24). Obviously, such poor levels of interaction had a direct impact on the life of people with disabilities in the camps.

Table 4-47: Interaction of people with disabilities among themselves

Interact	Frequency	Percent
Very well	7	77.8
well	2	22.2
Total	9	100.0

The level of interaction among people with disabilities themselves was regarded as ‘very well’ as shown in Table 4-47 and in the researcher’s informal discussions with people with disabilities in the camps. These responses appeared to be due to the fact that people with disabilities indicated that they have a better understanding of themselves and willingly shared information through the CBR committees.

Table 4-48: Level of participation of people with disabilities in programs within the camps

Participation	Frequency	Percent
Minimal	6	66.7
Adequate	3	33.3
Total	9	100.0

The level of participation of people with disabilities in various programs within the camps was described as ‘minimal’ in 6 out of the 9 FGD sessions held in the three camps (see Table 4-48). As already noted in table 4-25, many of the individual respondents also indicated that they do not participate in the programs in the camps. Therefore, respondents in both individual and group interviews raised their concerns about this lack of involvement of people with disabilities in refugee programs within the camps and, similarly, eight of the nine focus groups said that the level of involvement of people with disabilities in work and employment in the camps was minimal (the other group described this as ‘adequate’).

The level of participation of people with disabilities is further explained by reference to Table 4-49 that considers the reported level of responsibilities entrusted to people with disabilities.

Table 4-49: Responsibilities entrusted to people with disabilities within the camps

Responsibilities	Frequency	Percent
Minimal	6	66.7
None	3	33.3
Total	9	100.0

Similar to the discussion of the individual interviews (see Table 4-39), the majority of focus groups (7/9) stated that female people with disabilities suffered most and were more vulnerable, given the conditions at the refugee camps. Also, most groups thought that both the elderly and children suffer most in the camps (7) and two groups thought that the children suffered most. This is in contrast to the individual interviews where the majority of respondents stated that age-based challenges were the same for all ages (see Table 4-40).

A summary of how people with disabilities face the challenges in the camps is shown in Table 4-50 for each of the FGDs.

Table 4-50: How challenges that people with disabilities face are addressed

Focus Group	How challenges are addressed
1	do little if anything
2	little consideration
3	no consideration
4	support from community leaders, agencies and camp committees
5	support from community and religious leaders
6	support from family members
7	support from family members and religious leaders
8	support from family members and religious leaders
9	support from social workers and community leaders

The overall view in this table indicates that immediate family members and religious leaders play a significant role in addressing the challenges and needs of people with disabilities in the Dadaab camps. The table further reveals that other stakeholders such as the Somali community and agencies do little on issues affecting the people with disabilities and therefore have not addressed their needs and problems adequately.

Table 4-51: How grievances are addressed within the camps

Focus Group Number	How grievances addressed
1	through agencies, disability committees
2	through camp committees, letters to agencies
3	through community development sector
4	through disability committees
5	through disability committees
6	through disability committees and comm. dev. sector
7	through disability committees, letters to agencies
8	through disability committees, letters to agencies
9	through songs, drama, letters to agencies

In at least four of the groups, it was expressed that grievances of people with disabilities are addressed through disability committees or so called CBR committees which are only established in each camp by the CARE agency. This implies that people with disabilities have little or no access to other organisations operating in the camps and therefore their grievances are neglected. It also shows that people with disabilities have no direct contact with these organisations since the CBR committees mostly comprise people with disabilities who are given nominal roles and responsibilities as discussed above and therefore, have limited powers. The magnitude of their grievances is further portrayed by the use of letters and songs as a symbol of limitation. The expressions of such grievances in songs were even apparent during the World Disability Day celebration (December 3) which was also attended by the researcher.

Table 4-52: Projected future of Somali refugees with a disability

Projected future	Frequency	Percent
Depends on steps taken now	7	77.8
Definitely very grim and bleak	1	11.1
Bright	1	11.1
Total	9	100.0

Most groups (7/9) agreed that the future of Somali refugees with a disability depends on the steps taken by implementing agencies and the community. The responses categorised as ‘depends on steps taken now’ stated that the future depended on initiatives of the implementing agencies to improve the welfare of people with disabilities as well as the transformation of the attitude of the community and people with disabilities towards disability.

4.4 CONCLUSION

This chapter has presented the data collected from the field using frequency tables and summaries of the results. The data provide evidence from the respondents regarding the plight of the Somali disabled refugees in the Dadaab camps as well as the prevailing concepts of disability. These data are discussed and evaluated in the next chapter.

CHAPTER FIVE

5.0 RESEARCH FINDINGS AND DISCUSSION

5.1 INTRODUCTION

Chapter four presented the analysis of the data collected during the field research in the Dadaab camps. The analysis provides a factual background for the explanations, interpretations and discussion that this chapter attempts. Information from individual case studies is used not only to reinforce the findings received from individual interviews and focus group discussions but also to provide insights and in-depth information into relevant issues that were captured only in the case studies. The discussion in this chapter is guided by the following research questions about refugees in the Dadaab camps:

- What is the prevalence of disability amongst Somali refugees ?
- How do the Somali community define disability?
- What are the major causes of disability among the Somali community?
- How does the quality of life of people with a disability compare with that of non-disabled refugees?
- What are the aspirations, needs, and challenges of people with a disability? and
- How can a comprehensive approach to community rehabilitation relevant to Somali refugees with a disability in Kenya be developed?

This chapter explores each of these questions in light of the data collected during fieldwork.

5.2 THE PREVALENCE OF DISABILITY AMONG SOMALI REFUGEES

It has been estimated that 7 to 10% of the world's general population live with disabilities and if extrapolated out of the world's 19 million refugees, there are between 2.5 and 3.7 million refugees with a disability (WHO as cited in Refugee International, 2004).

In January 2005, the total population of persons with disabilities in the Dadaab camps registered with the CBR/CARE was 3,073 including male and female children and adults. This is illustrated in Table 5-1 below, which is adapted from the CBR/CARE Database:

Table 5-1: Number of people living at the Dadaab camps registered as having a disability, organised by age range in years, gender, and type of disability.

Age Range	0 To 17		18 to 59		60 and above.		Total	Percentage.
	Male	Female	Male	Female	Male	Female		
Type of Disability.								
Physical Disability	267	184	386	293	105	101	1336	43%
Sensory Disability	166	156	125	93	89	89	718	23%
Mental Disorder	78	62	116	85	42	27	410	13%
Multiple Disabilities	39	31	55	58	27	22	232	8%
Chronic Medical Conditions	50	52	37	30	18	19	206	7%
Intellectual Disability	51	49	21	19	15	16	171	6%
Sub-total.	651	534	740	578	296	274	3073	100%
Percentage.	21%	17%	24%	19%	10%	9%	100%	

From Table 5-1 it can be observed that:

1. 1,687 people are male representing 55% and 1,386 are female representing 45% of the total number of persons with a disability.
2. The most prominent disability group are those people with a physical disability (43%).
3. Interestingly, the age group containing the largest percentage of people with a disability (43%) was the 18 to 59 year age group, 38% were 17 years old or younger, and only 19% were 60 years and above.

It must also be noted, though, that the researcher was informed from discussions with the CBR coordinator, as well as from other respondents, that there are many cases of persons with disabilities in the camp who have not been identified because parents,

neighbours and relatives are not willing to expose the persons with a disability due to fear of discrimination and stigmatisation.

Given the above information, it is evident that the prevalence of persons with a disability could have been more accurately assessed had joint evaluation exercises been initiated by all the agencies. The researcher's data was only based on CARE's documents and it was difficult to find any other accurate data about persons with a disability from other agencies. The researcher's perception is that the UNHCR database underestimates the number of people with disabilities living in the camps.

Many Somali refugees became disabled as the result of violent encounters in the civil wars. Other war related factors that are responsible for the debilitating impairments include: conflict-related intentional and accidental injuries (including from land-mines), malnutrition, both infectious and non-infectious diseases, the refugee experience itself, emotional trauma associated with conflict and displacement, and the ageing of refugees who remain for prolonged periods in the camp situation (Refugee International, 2004).

In table 4-8, which indicates respondent's disability status, respondents were grouped into six levels of disabilities. This evaluation tool was also in use in the CBR/CARE database. The results demonstrated that 67.5% of the respondents had physical disability and overall, the male respondents had a higher prevalence of physical disability. This can be explained by active participation of males in the war in Somalia.

In protracted wars and conflicts, men are most actively engaged and, therefore, the risk of injury and physical disability is high. Protracted refugee situations, as in the case of Somalis, pose additional difficulties as discussed in the foregoing chapter, especially when uprooted refugees lack educational and economic opportunities and where their prospects for durable solutions are limited. This is often the case in host countries where local inhabitants also struggle to survive, as already documented in the literature review in Chapter two. This competition for survival may instigate further conflicts leading to multiple disabilities (for those victims who had disabilities) and new cases of persons with disability.

5.3 THE CONCEPT OF DISABILITY IN THE SOMALI COMMUNITY

As explained in the publication of the International Classification of Impairment, Disability and Handicap (ICIDH-1, WHO, 1980), an official distinction was made between ‘impairments’ (at the level of physiological, anatomical, psychological functions), ‘disabilities’ (the loss of ability to perform an action due to impairment) and ‘handicaps’ (the inability to fulfill one’s normal roles as a result of impairment). But Bickench et al. (1999) argued that even the definition of ‘Disability’ based on the ICIDH-1 definition, made implicit assumptions that ‘handicaps’ are complex forms of ‘impairment’ and fails to provide a clear framework for determining the relationship between the external forces (that is, social, economic and cultural factors) and internal forces (or the causes of the impairment) and, therefore, he contended that various interest groups played a significant role in a collective definition of disability as follows:

- The medical model focuses on the prevention and rehabilitation of physical and mental impairments.
- The economic model focuses on potential loss of labour skill capacity.
- The social political model focuses on the disability phenomena, stigmatisation and the discriminatory nature of society.

Thus, it is worth noting that, the universality of the definitions of ‘Disability’ have changed over the past two decades and these changes have resulted from disability prevention policies, human rights movements and policies, labour policies, and the conceptualisation of people with disabilities about themselves.

From informal discussions and interviews, there appeared to be no distinctive borders between what may be considered ‘disease’, ‘impairment’ and ‘state of disability’ in the camps. Many operational words are used in the camps to explain the state of disability. For example, ‘Curyan’ (chronic illness), ‘Intah’ (physical injury) and ‘Dadka Lixaadka Laah’ (people who are impaired).

The only Somali word that was close to the World Health Organisation definition of ‘disability’ was ‘Naafo’. This is the term CBR/CARE use in the rehabilitation projects

and labelling centres for vocational rehabilitation training in all the three CBR centres in the Dadaab camps. But this word is also deficient in the following respects:

- Generally it tends to cover individual persons who have mobility deficiency (especially focussing primarily on amputees), those who have physical malfunctioning or those with serious limb injuries.
- Persons with learning difficulties, hearing problems, blind or low vision, or those with strange behaviours, chronic tuberculosis, backache and asthma are all not clearly included or regarded and recognised as Naafo.
- The term is limited in meaning compared to modern understandings of disability and only covers those with very visible physical impairment and these are hardly representative of the Somali population of people with disabilities.

In any community, cultural conditions have a strong influence on human behaviour, worldviews, perceptions, values and attitudes. Haralambos and Heald (1980, p. 3) define culture as learned and shared “skills, knowledge and accepted ways of behaving...the collection of ideas and habits” which are transmitted from generation to generation. Culture is described as including both material and non-material aspects of social life, which facilitate cooperation, order, problem solving and stability in society. Bilton et al. (1981, p. 12) assert: “Human beings are able to develop and pass on their culture by means of language, which is of course, itself a product of culture. Language has to be learned in the same way as other elements of a culture and, once this has been accomplished, the individual can acquire the rest of his or her culture.” Language often reflects and shapes the way we view the world. Use of words can powerfully influence community attitude, both positively and negatively, and impact on the lives of others. As was evident in the field research in the Dadaab camps, there is lack of a uniform definition and commonly understood conception of the term ‘disability’ even in the cultural context. This has opened up an opportunity for people to use words and phrases that are commonly regarded as derogatory to refer to disability. Some words, by their very nature, degrade and diminish the people to whom they refer. Others perpetuate inaccurate stereotypes that affect adversely the person’s sense of individuality and human dignity. In the Dadaab refugee camps, people with a disability have to endure a variety of labels that serve to set them apart

from the rest of the community. This was found to be a serious obstacle to the efforts aimed at rehabilitation and assessment of the needs of refugees with a disability.

Although the use of nicknames has been common among the Somali community, such names were traditionally given to specific groups and persons that were known to all indicating, for example, genealogical status of a person or family, meritorious achievements of a person in oratory, leadership, economics and, to some extent, physical ability in work and war (Mohammed & Ruhela, 1994). Perhaps this had positive value in the historical context in previous times. Through it, the community honoured exemplary conduct and achievements and encouraged people to aspire to noble goals. However, as was evident in the fieldwork, the camp situation permitted the transfer of this tradition, in an inverted way, to the community of people with disabilities. Rather than honouring the persons with a disability, the labelling degrades and humiliates them. This creates psychological and social problems.

The findings in Table 4-15 explain how the non-disabled people identified and described people with disability at the refugee camps by using their disabling conditions. They regarded them negatively and used terms detested by people with disabilities. Negative descriptions reported included 'Naanaays', nicknames referring to the type of disability of individuals such as 'Dhadol' (deaf), 'Indhool' (blind) or 'Doogon' (fool) referring to individuals with intellectual disability. The persons with a disability generally considered these terms derogatory, spiteful and discriminatory. When persons with a disability were asked about the descriptions given to them (see Table 4-16), 97% considered the Somali community at the refugee camps to have a negative attitude towards them. The negative attitude was reflected by the humiliation, demoralisation and isolation caused by the negative descriptions.

The derogatory names used to refer to persons with a disability were further reinforced by the degrading depiction of disability in Somali oral narratives, sayings and proverbs collected from the Somali refugee community. In this research, 72.5% of the respondents, as indicated in table 4-18, reported that oral narratives portrayed persons with a disability negatively. The negative responses depicted people with a disability as outcasts, strange and evil beings, powerless and/or problematic persons. Examples of such oral narratives, sayings and proverbs include:

- *The rest of the birds flew away but a hen is always there at home.* This means that persons with disability (likened to a hen which is a domestic animal as opposed to birds that fly) are dependent and vulnerable individuals who are immobilized. They require assistance from the rest of the community. This saying needs to be reformulated. With effective rehabilitation, persons with disability can be assisted and enabled to function effectively in society in a way that defies the image of a docile and immobile being who is incapable of taking charge of his/her life.
- *Real disaster is that which can cause blindness and limbleness.* This saying depicts physical disability as a terrible calamity. It exaggerates the effects of disability to an extent that makes persons with a disability “hopeless”. It implies that physical disability is a sign of a shattered life that is beyond redemption. This may hinder people from seeking rehabilitation by making them demoralized and resigned to their “terrible fate”. The saying needs to be reformulated in order to reflect disability as a reality that can be moderated and lived with. Rehabilitation needs to be seen as a positive way, counteracting the deleterious aspects of disability.
- *An evil person is he who lacks a leg or an eye.* This is a mutation of the saying above. Disability is regarded as a punishment for evil. According to the teachings of Islam, this is not true. The saying needs to be reformulated in line with Islamic teachings.
- *Someone who is mad on Friday removes his clothes on Thursday.* This proverb originally meant that problems could be detected early. The teaching intended is that people need to be alert, in order to identify symptoms of trouble and act early enough to avoid pain and loss. However, in the context of the refugees with a disability, the proverb is used adversely to discourage participation. When a person with a disability makes suggestions in a meeting, for instance, she is not taken seriously. Instead the proverb is used to silence her and insinuate that the ideas suggested are senseless- they are indicators of insanity! It would be useful to correct misinterpretations and misuse of original proverbs. Community elders who are conversant with the original oral traditions can be useful in such an effort.

- *A story about three persons who were blind, deaf and lame respectively. The blind man said, “I can see a cow”. The deaf man said, “I can hear it too”. The lame person concluded:” Lets go and touch it”.* Though the narrative may be seen to mean that nothing is impossible to persons with disability, it is often used to ridicule persons with disability who actively seek to participate in social activities. The story is used to sarcastically point out that empowerment efforts by persons with disability are pretentious and futile. This defeatist attitude needs to be corrected by demonstrating the positive impact of rehabilitation in remedying disability.
- *Once you become disabled, it is very difficult to get out of it.* This reflects the resigned attitude the society has towards disability. It implies that the society finds no remedy for disability. Awareness about rehabilitation can be useful in counteracting this belief.
- *Disabled people only know how to sleep.* This saying means that persons with disability are lazy and idle. It reflects the fact that in the refugee camps, persons with disability hardly find an opportunity to be gainfully employed in economic activities. This can be counteracted by providing examples of refugees with disability who are actively employed in economic and social activities in the camp as well as providing opportunities for others to prove their ability.
- *One who is cursed has the power to curse as well.* Since many people regard disability as a curse, persons with disability are regarded as having the power to curse. If a blind person, for instance, manifested great talent, she is regarded as dangerous (waa qatar). People marvel at her and say: “What if she had sight! No wonder God made her blind, otherwise, she could have turned this world upside down!”. The implication is that any talent manifested by persons with a disability is regarded as magical and extra-ordinary. Effectively, credit is never given to the person displaying such talent merely because the person has a disability. This attitude needs to be corrected by creating narratives that reflect persons with a disability as normal people who have human characteristics and who need to be integrated in the total life of the community.

The few oral narratives, sayings and proverbs that were positive, on the contrary, depicted persons with a disability as equally human, talented, created by God and deserving of respect.

Examples of such positive oral traditions include:

- *Do you know that God did not lack limbs to give to the physically handicapped but God created them that way so that the rest of the community can learn and reform?* This saying implies that the community needs to handle disability with reverent care because God cares about how persons with disability are treated. As created by God, persons with or without disability have a common source and are all answerable to God. This saying discourages oppression of persons with disability and advocates responsible care of them.
- *When God wants to display His power and authority, He creates people with no ears, eyes and hands.* Like the saying above, disability is regarded as an issue that has religious implications. It is intended to teach society empathy, respect, and love to fellow humans and extreme reverence for God. The saying is useful in correcting erroneous religious beliefs about disability.
- *Disability is not inability.* This is a popular proverb in many cultures that depicts persons with disability as equally human and capable of being self-reliant. The proverb is useful in encouraging inclusion and participation of persons with disability in social activities.

The negative responses depicted people with a disability as outcasts, strange and evil beings, powerless and/or problematic persons. The few oral narratives, sayings and proverbs that were positive, on the contrary, depicted persons with a disability as talented, pious persons and deserving of respect. The negative responses included the view that people with a disability are dependent and burdensome and, therefore, are merely tolerated in the society. Soloo (see Case Study One) conceded that the negative depictions of disability in the Somali culture affected him adversely. It makes disability seem like a chronic disease that one has to bear grudgingly because the community does not give persons with disability adequate support and respect. He added:

if the community despises you at all levels, You are out of place and you fear making any effort to liberate yourself. Thus, disability becomes a disease, you must learn to live with it.

The labelling and descriptive systems discussed here may have had a strong influence on the Somali community's conceptualisation of disability which tended to focus only on the physical aspect of an individual being and ignored other important non-physical attributes and capabilities of persons with a disability. Consequently, the community seems to have ignored the abilities, interests, and desires of persons with a disability. The researcher's argument is that an individual's physical limitations should not hinder the appreciation and recognition of his/her other significant abilities. Indeed, derogatory labels only serve to perpetuate disability by entrenching community attitudes and stereotypes that inhibit genuine efforts towards alleviation of disability or rehabilitation. This is evident in Table 4-33, which demonstrates how the community treats its members who have disabilities. Seventy eight percent (78%) of the respondents stated that generally, neighbours, family members and fellow refugees isolated the persons with a disability. However, one would expect that neighbours, family members and fellow refugees would be the very people expected to provide moral and material support to persons with a disability. Such isolation of persons with a disability emanates largely from the belief that families with members who have a disability are cursed and that the general refugee population, whether disabled or non-disabled, has to struggle for the scarce resources available.

Groce (1999) stated that every community's culture has its own explanations for why some babies are born with disabilities; why some people have disabilities; how these children and adults with disabilities are to be treated; and what responsibilities and roles are expected of family members, helpers, and other members of the society. Thus, to understand and build on the families' and community's cultural interpretations of disability, it is essential to create partnerships with parents of children with a disability who are receiving special education services and rehabilitation. Hopfenberg et al. (1993) argued that parents' beliefs about the nature of disability are related to parents' beliefs about, and participation in, treatment and intervention. Consequently, optimal outcomes for children and adults with disabilities can only occur when professionals create a bridge, from the inhibiting cultural view of

disability shared by parents and the community, to an enlightened and multifaceted perception of the disability, its cause, its acceptable treatments, and the available sources of formal and informal support.

The first step to an enlightened understanding of ‘disability’ is to find a clear, precise and commonly accepted definition of the concept. A conceptual clarification of ‘disability’ is an essential first step to building the foundation for any fruitful discussion regarding improving the services offered to the persons with disabilities. However, the goal of bringing together the several different schools of thought on disability and the disablement process remains elusive. Achieving a commonly accepted conceptual understanding is one of the primary challenges facing the field of disability research and the Somali community is not exceptional, as will be discussed in the next chapter. The notion of a basic elementary definition of the concept of disability is lacking in the understanding of disability among the Somali refugee community.

5.4 THE MAJOR CAUSES OF DISABILITY AMONG THE SOMALI REFUGEES IN KENYA

Table 4-17 outlines the participants’ views on the causes of disability according to Somali culture and traditions. The question asked was: *What are the causes of disability according to the Somali culture and traditions?* Respondents provided the following factors as causes of disability based on Somali culture and traditions:

- Curse (habaar) is believed to be the source of many afflictions and diseases that cause disability. Somalis are brought up to respect their parents and to seek advice and blessings (du'a) and the lack of respect and esteem brings forth habaar (curse). In the researcher’s informal discussions with elders and members of the refugee community, it was discovered that Somali people associated bodily malfunctioning and certain disorders to curses (habaar). Parents, the maternal uncle and elders are all feared to be capable of generating curses, especially when an individual fails to fulfill obligations assigned to him/her in the religious teachings or within the community setting. Certain groups of people, especially those born with certain unique characteristics, are also believed to possess powers to curse. Such groups would include those born with early milk teeth, those born with bloody eyes

(ildiig) or those born with some strange physical appearances. Those who are poor in the community are believed to cause 'dhejiis' (a type of infliction of an evil eye mostly associated with belief from elderly Somali women). Disability was attributed to a curse by 33% of the respondents.

- Another group claimed that spirits play a role in causing disability. This was the view of 13% of the total respondents. This group believed that spirits have an influence on the physical appearance of an individual as well as his/her character.
- Some 15% of the respondents took a religious view (specifically, Islamic religion). They regarded divine will as the main cause of disability. Consequently, fatalistic and deterministic attitudes exist amongst many of the Somali people since divine will is regarded as irreversible and infallible.
- Diseases were regarded by 24% of respondents as a major cause of disability. Among the nomadic Somali community, diseases emanating from lack of access to health services (especially from prenatal, birth and post-natal injuries), lack of access to inoculation programs, and poor health awareness are very common. Other related factors included harsh nomadic life that makes the Somali community prone to accidents caused by animals (especially the camel), insect and snakebites, harsh climatic conditions and attacks by wildlife.
- Some 7% of the respondents felt that traditional tattooing methods (especially using fire) and traditional medical practices also contribute to disability. This is so because such practices are carried out in unhygienic conditions and without the benefit of sufficient understanding of the complex nature of the human body.
- Finally, only one of the 200 respondents (0.5%) linked poor diet to disability. This reflects the lack of information on issues that cause disability within the community, especially when it is clear that many diseases and disabilities can be caused by malnutrition and other dietary problems.

The cultural explanations of disability identified above, however, do not adequately account for disability within the refugee camps. Table 4-21 summarises the responses given to the question: *What contributed to the disability of most refugees in Dadaab*

Camps? The majority (81%) of the respondents attributed disability in the Dadaab camps to wars in Somalia. This demonstrates the destructive nature of war and conflicts, which make victims suffer from many disabilities. Such disabilities include those associated with burns and orthopaedic problems caused by land mines, fractures and amputations. It is worth noting that while findings in table 4-17 had a high number of respondents linking disability to the cultural factors, table 4-21 linked it to wars in Somalia and very few respondents stated cultural factors. This shows Somali culture and traditions are not sufficient in explaining disability. Factors that contribute to disability within the camps are summarised in table 4-23. The question asked of the respondents was: *Are there any factors that contribute to disability within the Dadaab camps?* The findings indicated that diseases, poor diet, poor medical care and violent conflicts caused disability in the Dadaab camps. This highlights that some refugees escape war in their home country only to become disabled within the camps where they have gone to seek safety. Malnutrition appears to be the main cause of disability within the camps. The findings indicate that a comprehensive understanding of causes of disability requires one to transcend cultural explanations and seek other factors as well. Culture, however, has an influence on the attitude that Somali people have towards disability and persons with disability.

According to a joint World Food Program (WFP) and UNHCR nutrition evaluation review mission which took place in November 2005, high levels of macro and micro nutrient deficiencies and malnutrition were identified in the Dadaab camps (WFP, 2007). Malnutrition generally affects many people and causes diseases, disability and even death (WHO, 2003). When refugees do not receive adequate food to meet their daily energy needs, women and children become vulnerable and may suffer from the effects of malnutrition.

Mothers and babies form an inseparable biological and social unit; the health and nutrition of one group cannot be divorced from the health and nutrition of the other (WHO, 2003, p. 6). Children may suffer mostly from, kwashiorkor - a form of malnutrition caused by lack of both protein and energy-giving food in the diet. From informal discussion with Somali refugee parents, many felt that their children were eating well, but based on the researcher's observation (the researcher's assistant was sighted), refugees are provided mainly maize grains, which are high in energy but low

in protein. In addition to this, even when swellings on the children's bodies were visible to the research assistant as a sign of oedema from kwashiorkor, Somali parents preferred traditional curative explanations to accepting that the food available in the family was inadequate. It was difficult to help them understand the link between a balanced diet and prevention of disease and disability.

Some common types of malnutrition are:

- Protein Energy Malnutrition (PEM).
- Vitamin A deficiency, which causes exophthalmia and blindness.
- Endemic goitre, which is caused by iodine deficiency. and
- Nutritional anaemia.

One of the most important adverse effects of malnutrition is that it makes the body unable to defend itself against infection and disease. Thus, the refugee nutrition problem needs a holistic approach involving health care professionals, a good community sanitation program and effective immunisation campaigns. Apparently, the root cause of malnutrition in the Dadaab camps is that food is not regularly available in adequate quantity and quality for the refugee population, yet appropriate feeding practices are essential for attaining and maintaining proper nutrition and health.

Children need to be well nourished during the pre and post natal periods of their lives since good nutrition can have profound effects on their health status, ability to learn, communicate, socialise, reason and adapt to the environment. Human milk remains the single most important nutritional and bioactive substance readily available to newborn babies (Kramer & Kakuma, 2001). Therefore, breastfeeding can be important, especially when availability of food is a problem as is the case in the refugee camps. This is because:

- It can help save life and reduce illnesses. Breastfed children are less likely to contract diarrhoea, respiratory illnesses, childhood lymphomas and disabilities.
- Breast milk helps to protect children against bacteraemia, meningitis, botulism and juvenile diabetes, which are all capable of causing various forms of disabilities.

- Breast milk can help prevent intellectual disability and instead foster optimum cognitive development, higher levels of attention and, subsequently, better educational achievements.

This study considers the encouragement of good breastfeeding practices as an important component in the prevention of disability among children in the refugee camps.

5.5 COMMON NEEDS, ASPIRATIONS, AND CHALLENGES OF SOMALI REFUGEES WITH DISABILITY

5.5.1 Nutritional Issues

Since 1991 to date, refugees in the Dadaab camps have largely depended on rations provided by the international community through UN agencies and NGOs. As Verdiram (cited in Horst, 2004, p. 67) observed, any institution (organisation) that forces refugees to depend on rations is obliged to ensure the distribution of sufficient food. Refugees in the Dadaab camps are under the care of the UNHCR (the main funding body) and the food ration is distributed under the World Food Program (WFP) every 15 days. However, the rations are not enough and sufficient food distribution in these camps is far from the reality.

Refugees in the Dadaab camps are given rations as described below:

- The most recommended kilocalories are 2100 per person but refugees get much less than this. It first depends on availability of food to feed the huge refugee population and availability of resources. It also depends on situations on the ground and the agricultural seasons. Since these camps are located in arid areas of the country, they regularly experience droughts such as those experienced in the periods: 1992-1994, 1996-1997 and 2004-2006. As reported by Save the Children Fund (SCF 1999), in 1997 during the 'El Nino' phenomena, food distribution was reduced since roads to the camps were made impassable and the amount of kilocalories was drastically reduced.
- At the time of the researcher's fieldwork (September 2005), each person was provided 3.5 kilograms (Kg) of mealed cereals or wheat flour, 3.5 kg of whole maize or sorghum, 0.9 kg of pulses, 0.375 kg of oil, 0.6 kg of corn soya blend and 75 grams of salt every 15 days. Each refugee was provided with only 240

grams of soap every two months. The rations are necessary conditions for survival in Dadaab and are distributed on the basis of all people being equal and having equal rights. But they are certainly not a sufficient condition for decent and healthy living.

- The firewood distribution which was started in 1998 to help control rape incidences in the camps provides 10 kilograms of wood (30% of the refugees' need) for consumption, distributed in the form of a general ration to all households for 1 month. This ration is usually exhausted within the first 10 days (EPAU 2001, CARE, 2006).
- Non-food items such as blankets, tarpaulins, jerry cans, kitchen sets and mats are not regularly distributed and are issued depending on household size. To buy other essential items, the refugees also sell part of these non-food items. Therefore, all sections of the refugee population remain very heavily dependent upon the general ration for their main source of dietary energy. Only a small fraction of the ration is sold to obtain extra food supplements such as milk, sugar and meat (SCF, 1999).
- Food is also provided for supplementary and therapeutic feeding targeting the vulnerable groups such as children under five years, expectant and nursing mothers, tuberculosis outpatients, and hospital patients.

Nutritional surveys are regularly conducted in all the camps to quantify global and severe malnutrition among children, identify high risk groups, assess the nutritional trends and evaluate the impact of the selective feeding programs. Although these surveys are useful and suggestions are provided to adjust refugee-feeding programs, the recommendations are affected by budget cuts and operational costs. SCF (1999) noted that the general ration distribution was deficient in micronutrients such as: Vitamin A, B2, C, Niacin and absorbable iron.

It is clear from this discussion that Somali refugees depend on food distribution for their survival. This tends to impose on them a sense of dependency, which hinders their motivation and energy to initiate tangible economic activities. Harrell Bond (cited in Moore, 2005) in her argument against imposed aid on refugees, stated that, because refugees are assigned a supplicatory role, they embrace the attitude of dependency. She argued that refugees in dependent camp situations do not support

each other, do not cooperate, and have generally “destructive and anti-social behaviour,” all because they have the “dependency syndrome,” imposed on them by relief agencies (Moore, 2005).

5.5.2 Security Concerns

Protecting the world’s vulnerable refugees and displaced people is the core mandate of the UNHCR. The agency executes its mandate in several ways:

- Use of the terms and conditions stipulated in the 1951 Geneva Refugee Convention.
- Providing basic human rights for refugees and displaced groups.
- Helping civilian refugee voluntary repatriation programs, supporting the integration of refugees in the countries of asylum and assisting them in resettlement in a third country.
- Providing legal protection through extensive international law treaties; working with governments and organisations providing asylum systems, advocacy, food and shelter, education, medical care and rehabilitation programs.

The UNHCR’s ultimate purpose in establishing these camps was to protect the refugees and secure their life, as well as providing basic humanitarian assistance. Somali refugees having fled from countries that have experienced protracted and very brutal forms of armed conflict, find themselves with no viable livelihood. Without freedom of movement, with few economic or educational opportunities, with insufficient and declining assistance over time, the Somali refugees have almost no immediate prospect of finding a solution to their plight. The UNHCR (2006, electronic resource) defined a protracted refugee situation as “one in which refugees find themselves in a long- lasting and intractable state of limbo. Their lives may not be at risk, but their basic rights and essential economic, social and psychological needs remain unfulfilled after years in exile. A refugee in this situation is often unable to break free from enforced reliance on external assistance”.

This definition accurately describes the condition of many Somali refugees in the Dadaab camps but does not reflect on how these refugees actively engage in finding solutions for themselves. The Somali refugees have lived in exile and have been

restricted to camp situations for more than a decade, yet the political failure to find durable solutions has led to precisely the kinds of protracted situations that have degraded them. Unable to return to their homeland, settle permanently in their country of first asylum or move to a third country, the Somali refugees have no other immediate option than to be confined indefinitely to camp life, or holding areas, often in volatile border zones. Their predicament is similar to that of the tens of thousands of refugees who stagnated in camps in Western Europe in the 1950s and 1960s. Gerrit van Heuven Goedhart (High Commissioner for Refugees at the time), called those camps “black spots on the map of Europe” that should “burn holes in the consciences of all those privileged to live in better conditions” (UNHCR, 2006, electronic resource).

First, the location of these camps (a few kilometres from the borders of Somalia) neither provides protection nor offers any viable livelihood for the refugees. The prevalence of idleness, aid-dependency, a legacy of conflict and weak rule of law, are potential factors that can induce fresh cycles of violence. Security in and around the camps is still problematic. Although, during the field research for the study, the widely reported incidence of rape and armed attacks greatly declined, clan conflicts and personal intimidations were still regular.

5.5.3 Income Generation and Employment

The activities of international NGOs provide most of the job opportunities to the refugees and are in most cases, a source of refugee livelihood. For example, CARE employs 1200 incentive refugees and this gives them considerable purchasing power in the camps (CARE, 2006). ‘Incentive’ refers to the money paid to refugees employed directly by the UNHCR or by one of its implementing partners in the camps. The incentive refugees are employed in a variety of jobs with different levels of responsibility and work, such as teachers, loaders, Community Development Workers, auxiliary nurses, secretaries, school inspectors, cooks, cleaners, and doctors. But their wage earnings do not correspond to salaries paid to Kenyans for the same job, yet the workload and the length of hours at work is the same. This inconsistency in remuneration exists because, to earn a full wage, refugees would require a work permit from the Kenyan authorities, which is difficult to obtain.

NGOs also try to promote income-generating activities since not all the refugees can be on their incentive payroll. CARE provides loans through its Economic Skill Development Program (ESDP). Mat and basket weaving, soap production and shoe making, sewing and carpentry and other apprentice courses were initiated with an aim to provide skills as well as generate income opportunities (CARE, 2006). But these projects have a limited impact.

The alternative individual activities pursued by refugees to generate income include:

- Families would send their young daughters to better-off refugee families or local Somali families to work as maids and earn some money.
- Some families would also send their young adolescent boys to herd and graze animals either of refugees or local Somali inhabitants, from dawn to dusk, to earn money depending on the number of animals herded.
- Other refugees allow young men and boys to use wheelbarrows to carry luggage for refugees (including the disabled) from distribution centres. They also carry loads for visiting passengers arriving from other parts of Kenya or operate within the camps from one block to another for small fees.
- Some women risk going into the area surrounding the camps to collect firewood for their own consumption and for sale, although this brings very little profit.
- Some families have access to ‘remittances’ from relatives in Diaspora or may have ‘a resettled relative’ who regularly sends remittances to assist families at the camps. Such remittances are invested in business to generate income. SCF (1999) and Horst (2004) referred to better-of relatives in Diaspora as the ‘household connection’ who determine the wealth in the camps. The wealthier households assist their kin or clansmen through a ‘system of patronage’ in earning an income, particularly by giving credits to operate small business. Households without any form of remittances or income generating activities largely remain destitute.
- Some refugees engage in both large scale and small scale business activities within the camps as shop owners, hotel owners, vegetable sellers, clothes sellers, house builders, cereal store owners, maize mill owners, barbers and tailors.

Another important element considered in the first part of respondents' personal information was their employment status. The question, the results of which are presented in table 4-9, required them to identify their level of employment. They were asked to state if they were unemployed, employed permanently, employed on contracts or if they were self employed. This was considered important because:

- It would help to determine the respondent's supplementary source of income.
- Evaluate their degree of reliance on relief assistance.
- Assess the capacity or the degree of economic vulnerability of persons with a disability as well as their capacity to support and care for their children and families.
- Compare the basic living standards of persons with a disability with that of non-disabled refugees.
- Compare the disability categories most affected by unemployment.

The results in tables 4-11 to tables 4-14, show a comparison of respondents' employment status from various aspects such as disability category, marital status, levels of literacy and gender disparity. For example, in table 4-11, the majority of people with a disability (78%) were unemployed and an insignificant number employed permanently or on contracts. From those respondents with intellectual disabilities, mental disorders and with chronic medical conditions, only 2 (out of 200) respondents were self-employed and they were excluded from permanent or even contract employment. People with a disability in the Dadaab camps find it hard to generate supplementary income to support their families and heavily depend on relief support.

Important information on income issues is provided in Table 4-12, which illustrates the respondents' level of employment, by their marital status. While 22.7% of divorced and widowed respondents were employed or engaged in self-employment activities, only 15% of the married respondents were either employed or self employed. Table 4-13 demonstrated that, even a relatively high level of educational achievement in the camps (secondary level of literacy) did not influence the

employment opportunities for the persons with a disability. An insignificant number (3.5%) of respondents were employed permanently or on contracts.

In table 4-14, the female respondents with a disability were double disadvantaged in employment opportunities. As with previous data suggesting higher levels of unemployment for persons with disabilities, women with a disability were even more marginalised and vulnerable in these results. Only 7% of the female respondents were found to have contract or open employment while this figure was 9% for the men.

These findings lead to the following issues:

- The degree of unemployment among persons with a disability is very high in the Dadaab refugee camps. This explains why they would find it difficult to realise self-reliance even after receiving relief assistance.
- People with a disability are least involved in the so-called ‘incentive refugee’ workforce and this explains the extent of marginalisation of persons with a disability by NGOs operating in the camps.
- Persons with a disability with families find it hard to support their families. Without supplementary income, it is most probable that this would increase the incidence of malnutrition and prevalence of disabilities in the affected families of persons with disabilities.
- Though one would expect that a high level of education for persons with a disability has the capacity to empower them, this is not reflected in these findings. Apart from their educational achievement being unrecognised, persons with a disability suffer marginalisation also in the provision of education services in the camps. It is, therefore, most probable that persons with a disability were discriminated against in employment opportunities due to their disabilities.
- Women with a disability were disadvantaged because of their gender and disability and the trend in the data was toward less employment for women with a disability than for men (see Table 4-14). This may explain why more female respondents were engaged in self-employment than the male respondents because they were finding it difficult to be employed permanently or on contract in formal organisations.

- Those with acute disability, especially intellectual disability, mental disorder and chronic medical conditions were excluded from the camp employment opportunities and this may reflect the negative attitude of the refugee community and NGOs towards people with these types of disabilities.

5.5.4 Discrimination

Certainly, persons with a disability in the Dadaab camps face many challenges related to safety and fairness in activities of daily life. They feel sad and in despair because they encounter discrimination on several fronts including education, access to services and rehabilitation, resettlement programs, employment opportunities, and financial assistance. Persons with a disability are in some cases also more vulnerable to physical and violent attack as well as sexual abuse. They are often the last to receive food, water, and other services in the camps and are viewed by many as a burden to be left behind by their own community.

A major observation made during the field research was that Somali refugees with disability in the Dadaab camps struggled to empower themselves and to claim greater participation and equality to influence the society within which they live, but little priority was given to them to ensure that they had the best opportunity to lead a normal life and achieve reasonable self-reliance. A good example is one of my respondents, Xawa (Case study 3) who had tried to join a women's group with fellow refugees without disability in order to access credit from CARE micro finance program. She was striving to become self-reliant economically. Unfortunately she was isolated and rejected by the non-disabled members of the group. The narrative Xawa applied in her efforts includes a vision of an integrated society whereby all persons regardless of their status in society work together and mutually support each other. She has a positive self-concept and this makes her interact with non-disable women in the women's group. She regards herself with dignity and strives to be self-reliant. Indeed, after the non-disabled women rejected her, she sought a like-minded woman with disability and together opened a shop. Xawa exemplifies determination and courageous initiative that some refugees with disability exhibit in the camps. The narrative those who are opposed to the efforts of persons like Xawa use consist of discriminative attitudes and prejudices. They regard persons with disability as

incapable, dependent and parasitic. Xawa's case exemplifies the two narratives mentioned above as evident below:

One of the difficulties I have faced as a person with disability is isolation and discrimination. I decided to join a women's group with fellow non disabled women. We applied for a soft loan from CARE micro finance program. Just after one month, my fellow women reported to CARE that they cannot work with a disabled woman. They stated clearly that a disabled woman could not work with them. I reported back that I too was not willing to work with them unless they changed their discriminative attitude.

I joined my fellow disabled people since I could not work with people who discriminate and despise me. I am currently running a shop with a mentally challenged woman and a deaf woman. I decided to work with those who understand my situation. To be independent is now my goal. I obviously understand the challenges and the difficulties ahead of me but I cannot sit to see my children die or feel left behind by their fellow children. I have to work hard. This is the pleasure of a mother even if she has a disability.

My message to other persons with disability is that one should not sit and wait just because he has a disability. In fact, one should strive to work and meet people. She should forget the disability and be mobile looking for jobs and anything that can sustain the family. One should also try to integrate into the society and make her presence felt so as to be accepted by the community. Let us work together as a team and a family to eliminate discrimination. Let us not sit and lament but forge out our way into the community. If one resigns, his life and dignity is adversely affected. Let us assist ourselves so that others can also assist us.(Xawa, case study 3)

In the researcher's previous study among the Somali community of Garissa District (Siyat, 1999), it was found that polygamy and divorce rates were high among the Somali community in the District. It was therefore anticipated, in relation to this study, that the prevalence would be even higher in the refugee camps. While no questions were asked about polygamy, there was a question related to marital status,

but none of the male respondents indicated that they had been divorced and 48% indicated they were single (see Table 4-7). For female respondents, 60% were either single, widowed or divorced. From this, it appeared to the researcher that marital status of people with disabilities was lower than for non-disabled members of the community. The apparent lower marital status for both genders can be attributed to:

- Discrimination resulting from their disability. Somali refugees with a disability find it difficult to marry or remarry due to the high level of discrimination experienced in the camps. This was supported by informal discussions with persons with a disability as well as the opinions expressed by those participants whose opinions have been reported in the case studies previously.
- The financial costs associated with marriage in the Somali traditions are unaffordable for many refugees with a disability. This makes it hard for persons with a disability to marry and have a meaningful family relationship.
- Isolation emanating from the negative community attitude to persons with a disability and lack of socialisation programs in the camps.
- Refugee life itself and the related dependency syndrome leads persons with a disability to poverty.
- Cultural beliefs, which associate disability with curse and misfortune cause isolation and neglect. One of the symptoms may be slow integration of persons with a disability with non-disabled people particularly in marriage and poor socialisation in the society because of the stigma associated with disability.

5.5.5 Shattered Dreams

Some respondents like Soloo, Abdi and Xawa (see Case studies 1, 2, 3) reported that one great challenge in their lives is shattered dreams. Soloo, for instance, hoped to be a professional footballer but during the Somali civil war, both of his legs were destroyed. Such persons become frustrated. They perceive few options left for themselves in occupational terms. They also feel disadvantaged when it comes to competing for opportunities alongside non-disabled persons. Abdi, witnessed with horror the raping of his own wife. One of his eyes was injured. It took him a long and painful period to re-order his life after his dreams were shattered. Xawa was raped in front of her children. She was battered and bruised by militiamen. Consequently, she lost her sight and became physically handicapped. Her husband was also violently

killed during the Somali civil war. This experience was degrading, shameful and psychologically disturbing. She described the experiences as destroying all her future dreams and hopes.

5.5.6 Coping Strategies

Refugees with disability adopt various strategies to enable them to cope with refugee life. Soloo (case study 1) pursues education vigorously believing that it will help him cope better in life. Abdi (case study 2) adopts reflection as a coping strategy. He focuses more on his strengths rather than weaknesses and disability. He also chooses to ignore negative comments made in relation to him. Xawa (case study 3) prefers to withdraw and mind her business. She works very hard to prove to those who look down upon her that she is as capable and dignified as any other person in the camp despite her multiple disabilities.

5.6 THE QUALITY OF LIFE OF PEOPLE WITH DISABILITY IN COMPARISON WITH THAT OF NON-DISABLED REFUGEES

Somali refugees with disability generally appeared to live unfulfilled lives in comparison to refugees without disability. They reported feeling marked out for discrimination. Economic discrimination also meant that the refugees with disability were unable to cater for their basic needs. Social and psychologically, they reported being made to feel inferior, unimportant and powerless. Their poor quality of life was attributed to the following:

- That non-disabled members stare at them especially at their unique type of physical impairment. This makes them feel out of place.
- That the community does not take them seriously especially when informed that persons with a disability are capable like any other person in the community. Thus, they look down upon them because they are seen as different in their physical appearance, behaviour, and communication skills.
- That they do not feel they can participate fully because of lack of proper awareness about disability amongst the community and organisations that are meant to support and serve them.
- All the refugee camps demonstrated lack of cultural compatibility between actual CBR activities and the community response to disability issues. Thus, the existing community traditions, structures and networking activities were

not responsive to the needs and challenges of persons with a disability and their families.

- That they do experience conflict at the water taps, food distribution centres, schools and health centres and also were abused on the street and even sometimes stoned by non-disabled children.
- That many children with a disability were still hidden away from schools, abused, oppressed and exploited by community members.
- That, significantly, they did not have the same opportunities as other community members in terms of access to services, participation and fair treatment in community life. Thus, children and adults with a disability in the camps found their human dignity violated because of the community's tendency to demean, marginalise and dominate them.

In Chapter Four, Table 4-19, individual respondents were asked to state their opinions regarding their own conditions. Respondents had mixed reactions, which reflected the general perception of disability among the Somali as follows:

- 1 One group felt that their disability was not permanent and could be changed. However, they were of the opinion that this could only happen if they received better medical treatment. This group of respondents demonstrated the hope and desire to fight disability but felt that lack of better medical treatment was a barrier to well being in the refugee camp. This group represented 14% of the total respondents.
- 2 Another group was resigned and accepted their condition as God's will and felt that any medical treatment or rehabilitation would not alter their condition.
- 3 The third group of respondents, which represented the largest single group (44%), felt that their conditions were unbearable and hopeless. They felt extreme hardship living with disability in the refugee camps. This state of hopelessness may have been brought about by the following conditions:
 - Negative community attitude to their condition.
 - Lack of goodwill and support from the community and other organisations. At a workshop that the researcher facilitated in Ifo, people with physical impairment were brought to the workshop in

wheelbarrows. Many had no wheelchairs and felt uncomfortable in the seminar.

- Poor staffing, especially with regard to rehabilitation, medical treatment and facilities.
4. The last group of respondents (25%) reported feeling able to cope with disability. They felt that their condition was normal, like any other person in the camp, and they had demonstrated coping strategies to deal with their disabilities. It is most probable that this group represented those respondents who had disability experience at an early stage and had made adaptations to their conditions both physically and psychologically.

5.7 THE PREVAILING EDUCATIONAL AND REHABILITATION APPROACHES TO DISABILITY IN THE CONTEXT OF SOMALI REFUGEES IN KENYA

5.7.1 The Nature of Refugee Education in the Dadaab Camps

According to UNHCR (1996), since the 1960s, refugee education has been a fundamental aspect of UNHCR operations and access to basic education has been a priority. It provides this in all its phases of operation through various implementing agencies in the Dadaab camps. Education can be an important tool and a vital element in restoring hope for many refugees fleeing from their homes and conflict zones. Generally, the Somali refugees face a special situation with respect to access to education when they first arrive in the camps. First, they are resident in a country other than their own, and are therefore disconnected from their own country's education systems and institutions. From informal discussions with Somali refugee students, learning Kiswahili (the Kenyan national language), which is a compulsory subject in the Kenyan School curriculum, has been their greatest challenge.

There have also been instances of political, legal or administrative obstacles to their education as well as practical problems of access which operating agencies had to sort out. The type of education in the Dadaab camps is in line with UNHCR refugee education policies which aim to support durable solutions (repatriation, integration into the host country and resettlement into a third country) but is based on the Kenyan curriculum. The languages of refugee populations, incorporating peace-building messages and survival skills are also included. However, although these programs are

geared towards the overall refugee participation, under-represented groups such as girls and people with a disability continue to experience marginalisation. There is lack of institutional preparedness in relation to policies, staffing, training and funding the general programs and activities.

The findings in Table 4-5 show respondents' distribution by their level of literacy or educational achievements. This was based on the Kenyan system of education and curriculum (referred to as 8-4-4), which is operational in the Dadaab refugee camps. In this system, the basic literacy unit is the primary level of education and refers to the numeracy skills obtained in the elementary grades of classes 1 to 8 in the Kenyan schooling system. The secondary level of literacy refers to the skills obtained during high school education from Form 1 to Form 4. The tertiary level of education, which is the highest, refers to the advanced knowledge and skills obtained either at the university, middle colleges, and junior technical institutes or village polytechnics. At the university, the training takes four years (hence 8-4-4; eight years in primary school, four years in secondary school and four years at the university).

Dadaab refugee camps have primary and secondary education units but have no single recognised technical institute. However, specific organisations sponsor refugees through scholarships to undertake courses, which are urgently required. Once these refugees complete their courses successfully, they return to the camps to work as an 'incentive refugee' workforce in various sectors. Sometimes consultancy teams are invited to offer training to improve the skills of these 'incentive refugee' workers at the camps during holidays. CARE has played a major role in the provision of this type of service and is also one of the leading organisations with the highest 'incentive refugee' workforce (CARE, 2006).

The findings in Table 4-5 confirm these discussions and therefore reflect the trends. For example, so far, only 2% were able to achieve tertiary education, 14.5% had achieved secondary education and 35% had achieved primary education. However, this does not mean that respondents obtained their level of education at the camps. The focus of the research was limited to respondents' levels of educational achievements at the time of the research and not how and where they achieved these

results. It must also be noted that 48.5% of the total respondents had not achieved any form of education. Again, this further explains the degree of marginalisation of persons with a disability and the difficulty of accessing education services as well as lack of opportunities to expand their knowledge and skills.

Table 4-6 provides a comparison of respondents' levels of educational achievements by gender (primary to tertiary). The male respondents had higher levels of educational achievement in all of the categories examined (see Table 4-6). In conversations with Somali persons with a disability, their strong sense of energy to participate in the education institutions was noted, as well as their general view that high levels of educational achievement would make a difference in their lives. However, lack of such educational opportunities for refugees with a disability were apparent and, furthermore, women in this study were clearly even more disadvantaged than the men having, for example, almost twice the level of illiteracy than men (69% cf. 37%). The discrimination indicated by these data are a matter of concern.

The gender imbalance indicated in the table relating to educational achievements can be attributed to the following factors:

- The traditional Somali male preference, which gives more education opportunities to males.
- Women and girls in the traditional Somali family are mostly occupied in the domestic chores and often find little time to engage and compete with their male counterparts in other fields outside home. They are therefore disadvantaged in relation to participating in formal education.
- Early marriage is rampant among the Somali community culture and tradition. In the refugee camps teenagers are commonly married to old men (Siyat, 1999; UNHCR, 2006; UNICEF, 2006) and this means that these young girls miss out on reaching their educational potential.
- Some parents and relatives did not take their children to schools in order to protect them from abuse. This may be more of a consideration for young girls than for young boys.

5.7.2 The Type of Education for Children with Disabilities in the Dadaab Camp

In matters of education, people with disabilities need to have equal and ‘inclusive’ education and training services and, therefore, teachers and trainers must include people with disabilities in their academic programs (Frank, 1999). Frank considers inclusive education as a better education for all participants in the schooling system. Table 4-34 reported the type of education provided to children with disabilities. These data show that 53.75% of children with disabilities received education in a mainstream classroom. However, while described as ‘inclusive’, this just meant putting both non-disabled children and children with disabilities into one classroom and exposing them to the same curriculum. However, ‘inclusive education’ is more than this. An ‘inclusive education’ refers to schools, centres of learning and educational systems that are open to all children and that ensure all children learn and participate fully. UNESCO (1994), promotes inclusive school communities as the most effective way of combating discriminatory attitudes, creating welcoming communities, building an inclusive society and achieving education for all. In order to achieve this, the following steps need to be taken:

- Policies, schools and teachers must accommodate the diversity of needs that pupils with disabilities have and include them in all aspects of school-life.
- All stakeholders in the education program must be involved in the process of identifying barriers within and around the school that may hinder learning and participation of all children -disabled or non-disabled – in order to enable effective learning and participation within the mainstream school system.
- Any form of barriers, which hinder the learning process of all children, should be removed or reduced.

Therefore, just placing both non-disabled and disabled children into one classroom or exposing them to the same curriculum is not sufficient for achieving inclusive education. At the school level, inclusive education seeks to address the learning needs of all with “a specific focus on those who are vulnerable to marginalisation and exclusion” (UNESCO, 1994, electronic resource). Inclusive education needs to be underpinned by the following principles and practices:

- Every child has an inherent right to education on the basis of equality of opportunity.

- No child should be excluded or discriminated against on the grounds of race, gender, language, religion, disability, poverty or other status.
- All children can learn and benefit from educational opportunities. Therefore, schools must adapt to the needs of children rather than the children adapting to the needs of schools.
- All children's views must be listened to, and taken seriously to enhance equal opportunity and maximise fully the levels of participation. Commentary on the Dakar Framework for Action (UNESCO, 2000 Para 33 electronic resource), states that, "In order to attract and retain children from marginalised and excluded groups, education systems need to respond flexibly, must be inclusive, actively seeking out for children who are not enrolled and respond flexibly to the circumstances and needs of all learners".

In Table 4-34, 41% of the respondents reported that the education offered did not adequately address the special learning needs of persons with disabilities. Deeper probing revealed that the schools lacked enough special education teachers and teaching aids such as the Braille machine, hearing aids, books and posters. There were also no learning assessment centres for children with special needs. Additionally, poor funding inhibits the purchase of special facilities to meet the needs of children with disabilities. These deficiencies are also reflected in the results reported in Table 4-35 where 76% of the respondents reported that the quality of education provided for children with disabilities is poorer compared to that given to children without disabilities.

On further questioning, it was found that the respondents attributed this poor quality of education for children with disabilities to the following factors:

- Lack of community understanding about education for children with disability.
- Most special education teachers work as 'incentive employees' and are therefore ill trained or have no special education training to adequately provide quality education services for children with disabilities.
- An acute lack of sufficient teaching aids and other equipment such as hearing aids, Braille machines and writing frames.

- Many refugee parents who have children with disabilities are reluctant to take their children to schools because they are skeptical about any subsequent economic benefits for the family. This is due to their belief that disability is a sufficient enough burden for their children and making the children stay at home is a way of protecting them.
- Most parents had no means of transporting their children to schools. Children with disabilities found it difficult to go to school by themselves due to lack of mobility equipment such as white canes, artificial limbs, wheelchairs and hearing aids.

The above factors resulted in the poor quality of education for children with disabilities in the Dadaab camps and adversely affected their learning. Poor school attendance and academic performance of children with disabilities, compared to those without disabilities, were also associated with these barriers to learning. Therefore, schools in the Dadaab camps have failed to adequately accommodate the needs of all children with disabilities.

The concept of community rehabilitation aims to achieve three key objectives: (a) Decentralisation of resources, (b) improve quality of life, and (c) achieve effective participation including equal opportunity and social inclusion. These objectives will be discussed in the following section.

5.7.3 Decentralisation of Resources.

It is important and relevant to decentralise community responsibilities and resources, both human and financial, to the levels that vulnerable members in the society are able to access. The research findings in Chapter Four (see Table 4-26) indicated that persons with a disability in the Dadaab refugee camp were not given any form of responsibilities or financial opportunities to improve their livelihood. Three quarters (75%) of the individual respondents admitted that they were not given responsibilities and that those who were given responsibilities were merely block or section representatives in the CBR committees. As a result, they were not entitled to any form of payment for their services compared to the non-disabled refugees. Their plight was further emphasised in Table 4-29 which highlights the economic, social and educational difficulties persons with a disability generally face in the Dadaab camps.

In Table 4-49, six out of nine focus group discussions in the camps reported that the level of responsibilities entrusted to persons with a disability was “minimal”. The general picture created by these findings is that of inadequate participation of persons with disability in rehabilitation processes and programs.

The economic difficulties included the lack of employment opportunities, inadequate micro-finance to support entrepreneurship and general basic necessities. The social difficulties included mainly the discrimination against persons with disabilities. Educational difficulties included lack of sufficient special education teachers, special facilities and equipment for the education of children with disabilities and lack of adult literacy for people who are visually disadvantaged. Therefore, it is argued that having a disability in the Dadaab camps is associated with deprivation of three important services: educational, social and economic services as is portrayed in Table 4-32, and 4-37. These findings indicated lack of equitable access to social, economic and educational resources and opportunities for persons with a disability.

5.7.4 Improving the Quality of Life

Community rehabilitation aims to introduce intervention programs such as education, vocational training, social rehabilitation integration and disability prevention that motivate development and improve the quality of life for people with a disability.

In table 4-37, 94% of the respondents described the quality of life for people with a disability as being extremely difficult or generally difficult. The quality of life, in this context, referred to the capacity of the refugees to cater for their material and non-material needs using privately generated income to supplement what refugees receive as relief in the camps. As shown in Table 4-38, 90% of the respondents supported the argument that the quality of life was better and more favourable to refugee families without a disabled member than for families with disabled members. In Table 4-50, only the immediate family members of persons with a disability and the religious leaders showed concern in addressing the challenges and the needs of people with a disability. Respondents generally felt that important stakeholders - the Somali community and operating organisations - do little in addressing issues affecting persons with a disability and especially in meeting their rehabilitation needs.

Evidently CBR committees which are only operational in the CARE establishment also have nominal roles and have little contact with other organisations, especially the UNHCR. Consequently, the committees do not have the capacity to adequately address the grievances of persons with a disability. Instead, persons with a disability are left in the state of resignation and only use letters and Somali songs to explain their experiences in the camp, especially during official occasions and functions. This study, therefore, observed that prevailing educational and rehabilitation services given to people with a disability in the Dadaab refugee camps have failed to satisfy the ‘participation’ and ‘access’ criteria of the CBR model. Consequently, the services have not significantly uplifted the quality of life of most persons with a disability in the camps. Therefore, there is a need to enhance improvement of the capacity and skills of people with a disability and facilitate community involvement to encourage them to participate fully in the economic, social, educational and political life of the community to improve their quality of life in the camps.

5.7.5 Towards Achieving Effective Participation, Equal Opportunities And Social Inclusion

This objective can only be implemented through the joint efforts of people with disabilities, their families and communities, and the availability of appropriate educational, health and social services. Promoting self-determination of people with a disability by supporting projects where people with a disability become the main actors would appear to be the best means of intervention. However, this does not seem to have been achieved in the Dadaab refugee camps.

The findings in Table 4-24 (individual interviews) and in Table 4-46 (focus group discussions) demonstrated that the level of interaction of persons with a disability with non-disabled Somali community members in the Dadaab camps was poor. It was characterised by regular harassment, discrimination and isolation of persons with a disability. This was also highlighted in Table 4-30. Yet in Table 4-47, the level of interaction of persons with a disability among themselves was reported as “very well” since they had better understanding of themselves in the camps. But most persons with a disability were not happy with the way they were treated in the refugee camp especially pertaining to shared resources, opportunities in education services, employment and resettlement programs. The responses reported in Table 4-31

indicated that participants felt that such unfair treatment needed to be changed. The desire for change appeared to be an indication that persons with a disability desire recognition, respect and inclusion. This would be a significant step towards their rehabilitation.

Another key factor facilitating the stated objective of CBR is the participation of persons with a disability in the rehabilitation services. This study assessed the level of participation of persons with a disability in the Dadaab camps, both in the individual interviews and in the focus group discussions. The level of participation of many persons with a disability in the refugee programs was found to be “minimal” (see Tables 4-25 & 4-48). Of the individual interviewees, 62% stated that they did not participate in the refugee programs and 6 out of the 9 focus groups reported minimal participation of persons with a disability. For example, Table 4-27, indicated that only one of 200 respondents (0.5%) had received social and recreational services, and 51.5% of the respondents considered rehabilitation and training to persons with a disability to be non-existent in the camps (see Table 4-36).

Community Rehabilitation also aims at enabling the communities to assume responsibility for all their members, including those with disabilities, to maximise their physical or mental abilities, access locally available resources, services and opportunities, and achieve full social inclusion for all children and adults with disabilities. This is only possible when the community leaders and organisations serving persons with a disability come together and discuss a variety of disability issues and options. Both the individual interviews and focus group discussions demonstrated how difficult it was to achieve this objective in the Dadaab refugee camps. The respondents pointed to the widening gap between the Somali community, the relief agencies and the people with disabilities in the camp. This gap inhibits multi-sectoral collaboration. There is an urgent need to correct this situation so as to promote collaboration, community ownership and full participation of people with disabilities in all refugee activities in the Dadaab camps.

The previous discussions have presented the wide spectrum of service approaches available to refugees with disabilities. These ranged from CBR interventions such as micro financing of the activities of persons with a disability, education, vocational

training, medical services and the provision of other social welfare services at the community or religious levels. However, it was noted that these interventions were not fully developed. They were facing many challenges ranging from policy limitations as well as lack of active disability advocacy within a disability rights framework. In order to achieve a truly effective community rehabilitation approach and promote inclusion of people with disabilities, both micro and macro activities need to be integrated in the mainstream refugee program. This may be achieved in the following ways:

- The UNHCR (the biggest funding body) can adopt a twin track approach which aims to target persons with a disability (and other vulnerable groups) and integrate their voices and needs within the broader refugee project cycle.
- The UNHCR could also create a strong enabling environment and encourage communities through its implementing agencies to address the voices and needs of vulnerable groups by providing ‘quality education’ and fair resettlement programs.
- The refugee programs can be streamlined to adequately address the needs of persons with disabilities. A multi-sectoral approach that involves all the stakeholders could be used to formulate, implement, monitor and evaluate refugee programs. Persons with disabilities need to be included and be fully represented in such programs.
- It is important for all project staff to be equipped in terms of knowledge, skills, attitudes, and other resources related to disability and modern CBR approaches. Relevant agencies and institutions, like the UNHCR, and CARE need to encourage the employment of persons with a disability as facilitators and project managers in areas of disability concerns so as to ensure self-representation and greater inclusion in disability matters.
- Owing to historical, cultural, environmental and social barriers mentioned in this chapter, people with disabilities (especially those with multiple disabilities) can only participate in the process of decision-making if they are included in the entire refugee projects and cycle. Thus, it is important to balance the participatory and demand-driven approach of disabled refugee programs with the social, economic, medical, educational and resettlement needs as part of a rights-based paradigm. Involvement of qualified persons

with a disability in administrative roles may help in reviewing and ultimately transforming the prevailing negative attitudes towards disability in the refugee camps.

5.8 CRITICAL ISSUES IN THE WAY FORWARD

From the foregoing discussion, it is appropriate at this point to suggest the following critical issues that need to be addressed if a positive “way forward” is to be charted for people with disabilities in the refugee camps. It would seem that awareness of the Somali community needs to be raised on the following issues:

- That in any community, the needs of adults/children with disabilities are first and foremost the same as the needs of any other adults/children. Persons with a disability need to have equitable access to health, social, financial and educational programs.
- That people with disabilities are able to help themselves. What they need is involvement in program planning , implementation and evaluation.
- That the main problems facing persons with a disability are related to the community’s poor attitudes and lack of awareness, rather than to disability itself.
- That rehabilitation knowledge and skills can be made available to persons with a disability. With basic training and locally available resources, community-based rehabilitation programs can have long lasting benefits to refugees with a disability.

It is clear from the Researcher’s data and other observations that disability is currently an ‘invisible’ issue in the Dadaab refugee situation. To make it ‘visible’ will require risk and bold experimentation but the alternative of leaving the situation as it is will lead to a sure deterioration in the conditions for people with disabilities in the refugee camps.

Historically, there have always been people with impairments who required and received the support and comfort of their family group. However, supporting family members with developmental and life long severe and multiple disabilities is a new experience for Somali families and communities. The care and support of people with

severe disabilities has never been part of the collective experience and history of Somali nomadic communities. There does not exist a body of knowledge that has evolved over time that enables communities to articulate and communicate their needs in supporting family members with severe disabilities, as is the case in many developed countries. Therefore, families and the broader community require an intensive awareness and education process that provides:

- 1 An understanding of the causation of disability.
- 2 A language that describes and analyses their experiences with disability in a culturally affirming way.
- 3 An understanding of the services that can support individuals with disabilities and their families.
- 4 An understanding of the concepts of rehabilitation and strategies that support the inclusion of people with disabilities in community life.
- 5 An understanding of the support needs of carers (families with/of persons with a disability).

5.9 CONCLUSION

This chapter has discussed the concept of disability within the context of the Somali refugees with disability. It has established that while war in Somalia and related factors have contributed to disability among the Somali community, cultural mindsets perpetuate disability and undermine the existing efforts to alleviate it. Education and rehabilitation, which would be a viable means of addressing the issues associated with disability, are inadequate in the refugee camps. The chapter acknowledges the efforts made by international agencies to help and support people with disabilities. However, it notes that more needs to be done if the Somali refugees with disability are to live dignified and functional human lives. The next chapter attempts to show how a comprehensive approach to community rehabilitation can supplement the current initiatives in the Dadaab refugee camps as well as elsewhere in the Somali community.

CHAPTER SIX

6.0 COMMUNITY REHABILITATION AS AN ALTERNATIVE APPROACH

6.1 INTRODUCTION

The focus of this study was to examine the situation of Somali refugees with disability in Kenya. The aim was to clarify and describe the concept of disability as it relates to the Somali community in the refugee camps, as well as to develop recommendations for a comprehensive plan for community rehabilitation. The previous chapter has clarified and discussed the concept of disability in relation to the Somali community in the Dadaab refugee camps. It has also pointed out the prevailing educational and rehabilitation approaches used in the camps. This chapter attempts to develop a framework for a comprehensive approach for community rehabilitation relevant to Somali refugees with disability, which can complement existing rehabilitation efforts.

This chapter first recapitulates the findings of the study regarding the concept of disability among Somali refugees and the prevailing rehabilitation efforts. This provides the background against which improvements are suggested and justified. The suggested improvements are embraced in a suggested comprehensive approach to community rehabilitation, which is developed and examined later in this chapter. Finally, the researcher suggests practical steps that can be used to implement the comprehensive rehabilitation approach in the Dadaab refugee camps in Kenya.

6.2 THE CONCEPT OF DISABILITY AMONG SOMALI REFUGEES IN KENYA

This study has observed that Somali refugees conceive disability as a state of being characterised by observable malfunctioning. The following causes of disability were identified: War, disease, divine will, cultural practices, poor diet, poor medical attention and poverty.

Persons with disability are discriminated against and negatively labelled in their community. This stigmatisation of disability inhibits participation of persons with disability in community life as well as personal advancement. Consequently, many

refugees with disability are frustrated, resigned and dependent on others for their basic survival needs.

In the Dadaab refugee camps, persons with disabilities complain about poor nutrition, insecurity, unemployment and discrimination. Though most of the interviewed persons with disability are pessimistic about their fate, there are some who regard disability as bearable and work hard to live a fulfilled life like other non-disabled persons.

6.3 PREVAILING REHABILITATION EFFORTS AT THE DADAAB REFUGEE CAMPS

The rehabilitation efforts that are prevalent at the Dadaab refugee camps can be categorised into the following: *Emergency* rehabilitation, which provides basic necessities to refugees and *Medical-developmental* rehabilitation, which provides assistance of a medical/economic nature.

The international community mandates that the UNHCR respond to refugee crises and provide emergency relief—food, shelter, medical supplies and necessary logistical support focussing on both short-term and long-term assistance. Prolonged civil conflicts in Somalia and refugee camp life have led to an ongoing crisis and emergency rehabilitation is given to the conflict victims as the first step. Emergency rehabilitation is undeniably very helpful to refugees. It enables them to settle down in a new environment and re-organise their lives once again. However, technical and policy matters related to refugees make emergency rehabilitation alone insufficient in providing integral well-being for persons with disability in the refugee camps.

The United Nations High Commissioner for Refugees (UNHCR) defines a ‘refugee’ as a person who has fled his/her country of nationality (or habitual residence) and who is unable or unwilling to return to that country because of a ‘well-founded’ fear of persecution based on race, religion, nationality, political opinion or membership in a particular social group (UNHCR, 2006). This definition of the Refugee Convention (1951) is still used by governments and international organisations despite the fact that there is no universally accepted definition of ‘persecution’ and various attempts to formulate such a definition have met with little success (Brigaldino, 1995).

Persecution may be considered as encompassing serious violations of human rights, threats to life, infliction of serious social and psychological harm, barriers to freedom of movement and freedom of expression. However, the term continues to be misunderstood and is often used inconsistently in every day language. For example:

- The reasons for persecution must be because of one of the five grounds listed in article 1 A (2) of the Refugee Convention: race, religion, nationality, and membership of a particular social group or political opinion. Persecution based on any other grounds is not considered.
- Genuine refugees are confused with people migrating for economic reasons ('economic migrants').
- Many persecuted groups who remain within their own country and are not in a position to cross international borders are called 'internally displaced persons'.

Persons claiming refugee recognition need first to be provided meaningful criteria to evaluate their Refugee Status Determination (RSD) effectively and efficiently based on all the International conventions and treaties. For example, the 1951 refugee convention, 1967 protocol and the 1969 Organisation of African Unity (OAU) convention governing specific refugee problems in Africa.

Unfortunately, the definition of 'a refugee' from the 1951 UN Convention and the 1967 Protocol explains the feeling of fear common to all refugees but does not reveal the different characteristics of refugee groups and individuals and the unique personal resources they possess. Therefore, to ignore refugee community differences in culture, demographic information and personal need can have negative effects in both short and long term rehabilitation planning.

In discussion with camp managers during fieldwork, they often raised two principal arguments with regard to refugee management:

- That refugee groups differ and it is impossible to treat each group differently.
- There are simply not enough human or financial resources to plan and implement numerous special programs to meet numerous special needs from a planning and management perspective.

These arguments appear legitimate. However, it is extremely precarious to treat all refugees as if they were the same and expect them to respond similarly to each program. It is possible to recognise categories of differences that call for different programs. In particular, these categories include: gender, family status and size, and disability status and age. Lack of attention to these categories limits the existing rehabilitation efforts in the Dadaab refugee camps.

It has already been documented in previous chapters how the Dadaab Refugee Camps are unsafe and unsustainable due to unpredictable, volatile refugee flows. Camp inhabitants rarely have sufficient food, water, shelter, education, vocational training and health services and these shortages have often been sources of community conflicts. However, the UNHCR and its partners, through concerted efforts, have managed to reduce the level of insecurity widely reported in the early 1990s. Some of the measures taken to achieve this goal include:

- Building the capacities of the local police force in the three camps.
- Introduction of programs (Local Assistance Project LAP) targeting pastoralist communities to reduce conflicts with the refugees in sharing the resources.
- Continued support of the firewood projects intended to limit movement of women refugees into areas where they may be at risk of sexual violence.

While emergency relief addresses the immediate needs of the refugee population affected by a conflict crisis, independent NGOs' initiatives also focus on developmental support strategies that aim to improve the welfare of the refugees. These interventions include medical services, micro financing, education and vocational training. It is true that the refugee crisis disrupts economic and social development for the people involved. A short-term relief mechanism is not a proper solution to refugee problems. Long-term rehabilitation and development plans were first ignored in the establishment of the Dadaab refugee camps. The international community was not adequately prepared to provide a better long term solution to refugee camp life and to protect the interests of vulnerable groups or help them develop coping strategies. Consequently, refugees with disabilities have been left alone to suffer discrimination as discussed in chapter five.

Both international and local organisations operating at the Dadaab camps need to improve their response to the plight of the refugees with a disability from a more holistic perspective. Increased coordination, systematic exchange of information and a better working relationship can help reduce the negative effects of discrimination and marginalisation experienced by the groups of refugees with a disability. Therefore, organisations need to readjust and streamline their policies to meet the challenges. CBR, as a new alternative instrument of intervention, may be used as a central reference for guiding different interventions at different levels in the conflict circles between refugee communities, people with disabilities themselves, and service providers in the camps.

6.4 CONCERNS THAT NEED TO BE ADDRESSED

In situations like those in the Dadaab camps, emergency rehabilitation needs to encourage the provision of relief and rehabilitation based on the individual's entire needs; physical, social, economic, and psychological, while at the same time, providing rehabilitation and sustainable recovery in the longer term. Livelihood-based approaches to support improved relief and rehabilitation interventions for people who have experienced brutal civil wars and post-war hardships, seems to have much potential value. However, continued distress causes disruptions that last for years and this may create permanent changes in people's lives. Recognition of individual differences and factoring these differences into rehabilitation programs remains a challenge at the Dadaab refugee camps.

The cultural and religious backgrounds of the Somali refugees play a significant role in causing and/or perpetuating disability. Some cultural and religious beliefs and practices condemn persons with disability as evil, lazy, burdensome and helpless. These fatalistic and pessimistic attitudes deprive persons with disability of dignity, self-esteem and the motivation to strive and thrive in society. However, a careful examination of the dominant religion (Islam) does not suggest prejudice against people with disabilities. Prevailing rehabilitation efforts do not seem to address these cultural and religious impediments.

The prevailing rehabilitation efforts are mainly external initiatives that tend to be implemented using a top-down approach. This does not provide the refugees adequate

opportunity for participation. Given the entrenched stigmatisation and discrimination against persons with disability among the refugee community, it becomes extremely difficult, if not impossible, for many Somali refugees with disability to determine their destiny. Poor representation and participation of persons with disability remains a challenge in all rehabilitation programs.

Although education may be one viable way of rehabilitating refugees with disability in the camps, many children with disabilities are not taken to school. The formal schooling system merely places pupils with disabilities and non-disabled pupils together and subjects both to the same curriculum. This passes as ‘inclusive’ education. The child with disability is then left to adapt to the needs of the school. This demotivates many pupils with disability, leading to truancy. The concerns of the affected children are not adequately addressed, mainly because their parents or other persons with a disability are not involved in decision making at the educational institutional level.

This study suggests that CBR is the preferred rehabilitation model for the Dadaab camps because it is capable of achieving the following:

- Normalising the lives of distressed persons with disability and motivating them to participate in improving their lives.
- Restoring and promoting positive self-image and self-reliance among persons with disability.
- Helping to breakdown cultural, social and economic barriers that impede persons with disability from participating meaningfully in their social environment.
- Enabling people with disability to access equitable opportunities, quality services and own programs of their choice that benefit them; and
- Introducing mechanisms that give persons with disability control over their lives and freedom from isolation, discrimination and stigma associated with their disabilities.

6.5 COMMUNITY REHABILITATION AS AN ALTERNATIVE APPROACH

CBR is a community development strategy distinguished by its focus on the rehabilitation, equalisation of opportunities, and social inclusion of all people with disabilities. It is implemented through the joint efforts of people with disabilities (including their organisations and families), non-governmental organisations, communities, government institutions and the private sector. Community-based rehabilitation (CBR) promotes close collaboration among the various stakeholders to provide equal opportunities for all people with disabilities in the community (ILO, UNESCO, WHO, 2004).

According to UNESCAP (2006) and from the perspective of the International Disability and Development Consortium (IDDC, 2003) on CBR as a relevant and effective strategy, the distinctions of CBR include that it:

- Promotes respect for human rights as well as participation of persons with disability.
- Enables persons with disability to access equal opportunities irrespective of age, sex, type of disability and socio-economic status.
- Aims at enabling people with disabilities to identify, develop and use their physical and mental abilities and thus become responsible agents in society.
- Sensitises communities with regard to the rights of people with disabilities. The community is encouraged to respond empathetically to the needs of persons with disabilities. Thus social integration and harmony is fostered.
- Aims at alleviating poverty and expanding the role of persons with disability in community life.
- Perceives disability broadly to include barriers to participation, a violation of human rights. It thus addresses attitudes, practices, systems and policies that contribute to disability; and
- Perceives rehabilitation as holistic attempts to enhance the quality of life of persons with disability as well as other members of the community which are not imposed but are formulated, implemented, monitored and evaluated with the active consent and participation of the beneficiaries.

Given the merits above, the WHO (2005) has identified CBR as a viable strategy for rehabilitation since it equalises opportunities, reduces poverty and advocates the active involvement of persons with disability in community life. However, the WHO acknowledges that people's needs and concerns are diverse and no one CBR intervention can be universalised. Instead, innovative interventions need to be formulated that adhere to the general principles of CBR, as outlined above. This study follows this advice in proposing the following CBR approach to the problems facing Somali refugees with disability in the Dadaab refugee camps, Kenya.

6.6 A COMPREHENSIVE APPROACH TO COMMUNITY REHABILITATION RELEVANT TO SOMALI REFUGEES WITH DISABILITY

Mpagi (2004, p. 87) asserted that comprehensive rehabilitation includes

all measures aimed at reducing the impact of disability for an individual, enabling him or her to achieve independence, social integration, a better quality of life and self-actualisation. It includes not only training of persons with disability, but also interventions in the general systems of society, adoptions of the environment and protection of human rights.

This is the comprehensive concept of rehabilitation adopted for this study. Rehabilitation of this nature must embrace integral aspects of human well-being. Refugees with disability do not merely need basic assistance in the form of food, shelter, clothing, some medical help and elementary training. As humans, they have higher esteem, and self-actualisation needs as well. Rehabilitation must address this complexity and diversity of human needs. Therefore, based on the researcher's observation, rehabilitation includes a wide range of dimensions and activities from more basic and general rehabilitation to goal-oriented activities. It is important to consider intra-personal, physical, intellectual, and emotional rehabilitation as well as economic, vocational, Socio-cultural, and even geo-political rehabilitation. Thus, with special reference to Somali refugees with disability, this study suggests the following rehabilitation approach based on a holistic view of human needs.

6.6.1 Socio-cultural rehabilitation

This study has established that the Somali culture is generally not friendly and receptive towards persons with disability. The society discriminates against and isolates persons with disability. Even the dominant religion is perceived and

interpreted as condemning people with disability. These negative attitudes need to be alleviated. This study targets religious leaders, acknowledges their leadership role in the society, and proposes that these leaders are actively engaged in the rehabilitation process.

Religious leaders need to be targeted to help discourage the societal response to people with disabilities in regard to negative systems, laws, policies and relationships that currently encourage long standing inequities, discrimination, prejudice, exclusion, devaluation and low acceptance of disability as a legitimate cultural experience. Rehabilitation needs to help the community evaluate critically the prevailing socio-cultural and religious beliefs, norms and practices that predispose persons with disability to discrimination and other degrading forms of treatment.

Specifically, socio-cultural rehabilitation needs to address the following:

- 1 The tendency to conflict which apparently characterises life among the Somali in Africa.
- 2 The widespread myths and misconception that disability is a product of spiritual punishment.
- 3 The claims that disability is a divine punishment, a mark of eternal doom or a perpetual burden to society.
- 4 The discrimination against persons with disability in social life, for instance, in friendship and marriage, and
- 5 Negative depiction of disability and persons with disability in ordinary language, cultural and religious heritage.

At this point it is important to note that Islamic teachings regarding disability have been misunderstood by many people in the Somali community who regard disability as a divine curse or even a condition that is willed by God and on the basis of this discriminate against persons with disability. According to Bazna and Hatab (2005, pp. 5-6)

The concept of disability, in the conventional sense, is not found in the Qur'an. Rather, the Qur'an concentrates on the notion of disadvantage that is created by society and imposed on those individuals who might not possess the social, economic, or physical attributes that people happen to value at a certain time and place. The Qur'an places the responsibility of rectifying this inequity on the shoulder of society by its constant exhortation to Muslims to recognize the plight of the disadvantaged and to improve their condition and status.

Accordingly, Bazna and Hatab (2005) perceived claims that Islam teaches that disability is a divine curse as misplaced and incorrect. Such claims reflect a view of religion that is “tainted” by culture.

The practices of the current day Muslims have been tainted by their local cultures and influenced by outside factors, and their understanding of Islam has been calcified by the accretions of centuries of decay and the stagnation of the scholarship and industry that mark the early period of Islam. (Bazna & Hatab, p. 9).

Islam teaches that all people, regardless of their status in society, should be treated with dignity as ends in themselves and not as mere means. Persons with a disability are subjects who deserve respect and consideration as equal persons. Such clarifications and corrections of religious misconceptions regarding disability can be achieved through socio-cultural rehabilitation efforts using the process of Community Engagement developed by Chavis and Wandersman (1990), and Braithwaite, Bianchi, and Taylor (1994). This community engagement process for this study is founded on the following principles:

- Agents of change: This involves making religious leaders key players, changing the negative attitude of the community on disability.
- Empowerment: Community engagement efforts need to incorporate the notion of empowerment, which is the process whereby people gain control over events, outcomes, and resources of importance. Therefore, to facilitate and empower religious leaders is very relevant to the process.

- **Involvement:** Religious leaders in the Community need to be involved to ensure that all proposed activities are appropriate because, as community leaders, they know the strengths and weaknesses of their community.
- **Participation:** People who reside within the community have the most accurate information and knowledge, and can best decide what aspects of their community need to be changed and how to change them.
- **Diversification:** A diverse range of community members including religious leaders need to be actively involved in the community engagement process to ensure that all proposed activities meet the needs of a diverse population.
- **Collaboration and Networks:** Partnerships between community members and agents of change are an effective way to make positive changes in the community. Thus, a population/community can achieve long-term health improvement and development when individuals and groups become actively involved in the community, working together to effect necessary change, emphasising the importance of community engagement improving the level of participation and inclusion envisioning many new opportunities (Hanson, 1988-89).

6.6.2 Emotional rehabilitation

This study has shown that most Somali refugees with disability are emotionally traumatised. Refugee camp conditions cause distress rather than comfort. Somali refugees with disability are sad and in despair because they fall victim to trauma and stress. The psychological as well as emotional effects make them more vulnerable to an accumulation of multi-factorial trauma.

Negative emotions like fear, guilt, self-blame, low-self esteem, frustration, and resignation among others were reported. These emotions hinder the proper functioning of persons with disability in community life. Two psychological theories, namely cognitive vulnerability and learned helplessness, can inform the condition of these refugees with disability. According to Beck (1983, pp. 265-284), cognitive vulnerability involves irrational thought patterns emanating from anxiety and depression. The irrational thought patterns may include the tendency to overgeneralise and exaggerate issues. Refugees with disability, for instance, can believe that they are

totally useless and incapable of bettering their condition. This would be an exaggeration of their disability which renders them impotent to do what they actually may be able to do. They may also generalise that they are hated and discriminated by everybody merely on the basis of isolated instances of ill treatment. This may antagonise them with even innocent members of society who are otherwise empathetic and friendly to them. Cognitive vulnerability therefore perpetuates emotional trauma, negative thinking and interpersonal conflict (Beck and Emery, 1985). The theory of 'Learned Helplessness' is expounded by Abramson, Metalsky, and Alloy (1989, pp. 358-372) and Abramson, Seligman, and Teasdale (1978, pp. 49-74). Learned helplessness is an attitude of mind that makes the affected person perceive calamities and adversities in life as self-caused, universal rather than local, and permanent rather than temporal. This view of life makes the person concerned pessimistic, resigned and overwhelmed with fear, anxiety, and a sense of powerlessness. This leads to depression.

Oatley et al. (2006, pp. 373-375) document the emotional, cognitive and social challenges that may accompany depression caused by learned helplessness as follows: A tendency to relive memories of loss and failure, irritability, pessimistic interpretation of present and future, lack of initiative, focusing on negative events and rarely attending to positive events, obsessional- compulsive disorders and phobias and decreased social skills. These emotional challenges undermine the social relationships and self esteem of some refugees with disability. Emotional rehabilitation involves countering cognitive vulnerability and learned helplessness. It involves creating a social environment that facilitates cognitive, affective, and moral dispositions that foster a rational and responsive world view among the refugees with disability.

6.6.3 Physical rehabilitation

This dimension of rehabilitation has to do with the provision of adequate material help like food, shelter, clothing, and medical attention. This type of rehabilitation is fairly well provided in the refugee camps. The influx of refugees inhibits efficient distribution of supplies but the efforts made by concerned agencies are remarkable and worthy of appreciation. Improvements can be made in relation to ensuring that persons with a disability receive equitable rations and that unique nutritional needs are

identified and supplied. Distribution points need, therefore, to be designed with people with disabilities in mind.

A relevant concept in physical rehabilitation is *inclusion support* (Klein et al., 2001, p. 106). Inclusion support includes adaptations and accommodations that provide access and facilitate participation of persons with disability in activities. Adaptations refer to equipment used to enable a person with disability to fit into a setting or activity. Adaptations include equipment like wheelchairs and assistive technology to aid communication. Accommodations refer to changes in the larger environment or policies aimed at removing barriers and facilitating access to an environment. Accommodations include access ramps and re-organising procedures for distribution of rations for refugees. The needs of the refugees with disability and the desired outcomes need to be considered as specific interventions and strategies for physical rehabilitation are planned. In addition, the effectiveness of the inclusion support needs to be regularly evaluated.

6.6.4 Intellectual rehabilitation

This dimension of rehabilitation addresses the cognitive and creative capacities of persons with disabilities. Early childhood and special education programs need to be designed carefully in order to stimulate the intellectual, moral and creative capacities of the learners. In order to encourage broad participation of persons with disability, the use of formal and informal avenues for training and learning need to be facilitated. Persons with disabilities irrespective of gender, type of disability, religious or any other status are to be encouraged to participate. The methods of instruction need to be learner-centred and suited to the individual differences that characterise the learners as much as possible. A human rights component as well as conflict resolution skills need to be included in the curriculum. A viable educational approach to intellectual rehabilitation is teaching for thinking as propounded by Paul and Elder (2001).

Teaching for thinking involves infusing thinking skills into subject content in order to empower the learner to take charge of her thinking, belief and action. Such skills include analysis, evaluation, inquiry, decision-making, problem solving and negotiation. This approach counters harmful habits of thinking that may lead to

enmity, violent conflict and discrimination. Such harmful habits of thought include making *generalizations*

that we do not have the evidence to back up, allowing stereotypes to influence our thinking, forming some false beliefs, tending to look at the world from one fixed point of view, ignoring or attacking points of view that conflict with our own, fabricating illusions and myths that we subconsciously confuse with what is true and real and thinking deceptively about many aspects of our experience. (Paul and Elder, 2001, p. xiv).

In the context of this study, teaching for thinking as proposed by Paul and Elder would help the Somali community to interrogate and evaluate the cultural, political and religious beliefs, attitudes and assumptions that breed antagonism and discrimination and replace them with fair-minded beliefs that inform a just social co-existence. Rather than fostering passive conformity to social norms, learners would be empowered to think for themselves and act autonomously but responsibly. The process of learning involved in teaching for thinking is learner centred.

Whitaker (1995, pp. 6-10) describes the factors that are crucial in the learner centred process as: nurturing a positive self-concept in the learner, encouraging learners to define and pursue their own learning ambitions in a friendly and co-operative interpersonal environment, identifying and developing learner potential, encouraging teamwork and dialogue as a way of exploring, expressing and developing learner abilities, values and attitudes, supporting learners to increasingly take responsibility for their decisions and actions and presenting learners with opportunities to inquire into, reflect on and evaluate their experiences.

6.6.5 Intra-personal rehabilitation

This dimension of rehabilitation involves cultivating positive self-affirmation among persons with disabilities. This can be achieved by encouraging Somali refugees with disability to critically examine their lives and discover the potential that exists within them. By carefully identifying their capabilities, challenges and opportunities, they may be stimulated to actively transform their lives. This approach, which is very innovative in this context, may assist people with disabilities to become more assertive and proactive in community affairs.

Social support which involves a network of close relationships characterised by love, acceptance, affirmation and mutual usefulness has been argued to be a viable means of dealing with adversities in life. Social support protects victims of adversities from depression (Brown and Harris, 1978, pp. 10-23). Stroebe and Stroebe (1996, pp. 521-597) argue that the concept of social support is useful in understanding the psychological impact of life events. Typical social support measures that assist victims of adversity to cope include having a confidante, lack of inter-personal friction, inter-personal appreciation, integration in a social network and other forms of practical assistance. Intra-personal rehabilitation is therefore facilitated by an inter-personal environment that includes open communication, inclusion and active participation in relationships and forging of strong bonds with others. Social support is relevant in refugee lives. It makes up for loss or disruption of human relationships that many refugees experience. As Oatley et al. (2006, p. 372) rightly observe,

Not only are relationships the source of most of life's meaning for us human beings, but with loss of important relationships, some of life's meaning drains away. We lose part of ourself. A life lived with the support of strong bonds of attachment and affiliation with a number of family members, friends, and colleagues means that a loss of one relationship may produce profound sadness, but will not entirely deplete life of its meaning.

This study regards social support as helpful in coping with loss of one's own abilities leading to disability. Refugees with disability can draw encouragement, acceptance, moral and material assistance from social support networks. Consequently, they can be empowered to be active and responsible participants in an inclusive community. This fosters self respect and self acceptance among the refugees with disability.

6.6.6 Economic rehabilitation

As the WHO (2005) observed, disability and poverty are inter-related. Economic rehabilitation aims at reducing poverty. Interventions need to promote self-reliance, creativity, planning and decision making capabilities. Somali refugees with disability need both financing for income-generating ventures and opportunities for selling and improving their products. Such income generating ventures could include selling foodstuffs to supplement the rations provided by UNHCR, and recording and

performing music (this could be an opportunity for creating broader awareness about their situation and the challenges they face).

Ncebere (1999) provides practical steps that can be used in the economic rehabilitation of refugees with disability. These steps include: Learning from others; seeking and evaluating information; hard work; an appropriate attitude towards oneself, business and others; co-operative efforts and the habit of saving. Refugees with disability can identify successful business persons who can be models to learn from and emulate. Such persons could be fellow refugees or even refugees with disability who have excelled in an economic activity. Such mentors could motivate refugees with disability to establish income generating activities.

Successful income generating activities are established after careful consideration of information regarding customer needs and consumption patterns, product availability and pricing, capital and skill requirements, legal and other policy requirements, potential challenges and anticipated competition among other relevant factors.

Refugees with disability need to be informed about these factors. Formal and informal avenues through which the refugees can be informed should be established as part of economic rehabilitation.

Emotional and intra-personal rehabilitation can be useful in fostering appropriate attitudes and values that facilitate effective participation in income-generating activities. Such attitudes and values include confidence, courage, optimism, determination, and patience. In addition, negotiation, decision-making, communication, literacy and numeracy skills are useful in business activities. Refugees with disability need to take advantage of available training opportunities in these skills. Co-operative efforts may include pooling financial and human resources together in order to establish a viable income-generating activity. This can be done by carefully forming refugee self-help groups. Such groups are useful because they provide avenues for collective and better informed action. Refugees with disability can complement one another and find strength in their unity.

Finally, another useful step towards economic rehabilitation is the habit of saving. This involves discipline and sacrifice. Ncebere (1999) aptly underscores the need to save even when one is financially constrained. This is particularly applicable to the context of Somali refugees with disability as is evident below:

The process of creating wealth involves saving and investing. But you can save if you have more than you need for your daily life. This is not wholly true. You never have enough. Initially, especially for those with little earnings, it takes discipline, planning, sacrifice and great desire to save in order to invest in a more rewarding project. Savings are not leftovers but sacrifice. There are times when a farmer may sleep with a half-full stomach in order to save his seed. He knows that unless he has seed to sow, he will have nothing to harvest at the end of the season.” (Ncebere, 1999, p.19)

6.6.7 Geo-political rehabilitation

This dimension of rehabilitation recognises that disability has a national and international element as well. The Somali state has disintegrated and the intense conflicts continue to lead to disability. Rehabilitation efforts should seek to stabilise the political situation in Somalia and establish a democratic system of government that Somali people can own and support. Regional and international efforts geared towards prevention of war and other human or natural calamities fall under geo-political rehabilitation efforts. Such efforts include dealing with the problems of poverty and inequity, widening the choice for the potential refugees, strengthening the respect for human rights, improvement of the early warning systems and mediatory capacity of the United Nations and other international agencies, as well as better management of asylum policies (Zolberg, Suhrke, & Aguayo, 1989, p. 259). Institutional reforms that can be useful in lessening conflict include decentralisation and coalition formation which can facilitate liberal-democratic political traditions that encourage flexibility, mutual adaptation of conflicting groups and adoption of distributive policies that are fair-minded (Zolberg et al., 1989, p. 263).

As suggested in this study, the Conflict theory is useful in analyzing the causes of social conflict. According to Abraham (1982, pp.107-118) Conflict theory has identified the following categories of social conflict: conflict arising from social change; conflict over the distribution of social goods; conflict of values; conflict of authority; conflict between the individual and society; wars; cultural invasion; and conflict of ideology among others. This analysis of conflict may enlighten attempts to determine the nature of conflict in Somalia.

Another important concept in Conflict theory is alienation. This refers to estrangement, which can take the following forms. Alienation of an individual from fellow human beings; estrangement of a class of individuals from another class of people in society; and estrangement of an individual from his/her true self among others. This concept is useful in analyzing the plight of Somali refugees with disability who are estranged from their fellow refugees. They are also estranged from realization of their true potential as human beings.

This study advocates the recommendations guided by the theory of Social Reconstructionism according to McNergney and Herbert (2001). This asserts that people are responsible for social conditions, and can improve the quality of life by improving their social order. However, although establishing democratic governance, decision-making, representation, participation, justice, opportunities, empowerment, effective curriculum design, and professionalism in teaching would have given people the capacity to change their condition, it can be argued that this is not practical due to limited availability of resources and infrastructure in the context of African refugee camps. Implementing the suggested recommendations, however, would place the International Community in a better position to meet the needs of people with a disability.

6.7 TOWARDS ESTABLISHING A COMPREHENSIVE COMMUNITY BASED REHABILITATION APPROACH AT THE DADAAB REFUGEE CAMPS

In this section, the researcher proposes what he considers to be practical and useful steps that can be taken in order to introduce and sustain the comprehensive approach to rehabilitation discussed in the previous section. Taking these steps demands a concerted effort among all the stakeholders, namely the government of Kenya and the international community, the refugees without disability, refugees with disability, the non-government organisations, organisations representing the persons with disability, religious organisations, educational institutions and other relevant institutions.

6.7.1 Establishing a Centre for Disability Services in the Dadaab Refugee Complex.

Based on the respondents' recommendations (see table 4-42), it is necessary to create an administrative and service oriented centre that provides opportunities to improve

the quality of lives for persons with disabilities within the refugee community and encourages improvement in the provision of services to support their needs. The establishment of such a centre would ensure that refugees with disabilities enjoy such rights and opportunities as access to health care, education, vocational skill training, employment, healthy family life, social mobility, empowerment and equal community inclusion and participation. These services would be provided in a person-centred manner so that individual challenges related to disability could be addressed.

The key issues that the centre could address include the following:

- Ensure that the basic needs of refugees with a disability, such as food, water, good sanitation, shelter, protection and transport are met.
- Initiate program activities that will help build the capacities of people with disabilities.
- Generate opportunities for livelihood, health, rehabilitation, education and resettlement of refugees with disability.
- Develop and co-ordinate inter-sectoral and multi-sectoral collaboration with all stakeholders in disability affairs.
- Actively involve the mainstream Somali refugee community and the participation of people with disabilities in conflict resolution and peace building activities.
- Promote community ownership, social justice and equal participation in decision-making processes.
- Help to formulate comprehensive policies that would enable organisations working in the refugee camps to understand their obligations to develop disability inclusive infrastructure and processes.
- Address issues of human rights, social justice, and alleviate poverty by using the available resources and facilities.
- Provide necessary logistical support including staff training and development; and
- Carry out research and advocacy in disability affairs so that the needs, challenges and capacities of persons with disabilities can be documented and disseminated. This would facilitate policy formulation and decision making that is based on factual data and accurate information.

6.7.2 Developing a Community Disability Education Manual

Supporting family members with developmental and life long severe and multiple disability is a new experience for many Somali families and communities. The care and support of people with severe and multiple disabilities has never been part of the collective experience and history of Somali nomadic communities. Therefore, the absence of a body of knowledge that has evolved over time to enable communities to articulate and communicate their needs in supporting family members calls for organisations working in the refugee camps to develop a community education manual. This manual could enhance community awareness about the needs, challenges and potential of refugees with disability and their carers. The manual could also be used to educate the refugees with disability to enhance their capacity to cope and utilise their potential despite the challenges they face. The manual could, therefore, facilitate inter-personal, intra-personal, emotional and socio-cultural rehabilitation.

Such a manual would include such topics as:

- Causes of disability.
- Demystifying disability: Evaluation of cultural and religious beliefs about disability
- Human rights
- Disability and Health
- Community Rehabilitation
- Coping with disability; and
- Self evaluation, self-esteem and self-improvement

6.7.3 Improvement of Special Education Facilities and Education Assessment Centres.

The UNHCR and organisations that provide education services in the refugee camps need to develop processes and procedures within the education system that facilitate adequate access to relevant educational resources and facilities to learners with disabilities. Currently, there is a lack of sufficient special education teachers who are competent to teach learners with various types of disability. Most special education teachers work as ‘refugee incentives’ who go through short inconsistent training over the years and face considerable challenges addressing the needs of refugees with disabilities. Apart from training teaching staff, teaching and learning resources also need to be improved.

6.7.4 Funding CBR Programs and Disability Services.

No doubt having CBR programs in the refugee camps to support disability services is a good start. However, such programs and services need to have sustainable financial backing. The UNHCR (which is the main funding body) has no reliable funding to enable implementing organisations to provide the required programs for refugees with a disability. Therefore, the short-term nature of many funded projects limits the capacity of organisations to plan in a strategic manner in order to respond effectively to community needs and retain competent staff. Thus, the UNHCR and other donor organisations need to increase funding in order to enhance CBR programs and other disability services.

6.7.5 Critical Review of Health and Developmental Needs of Refugees with a Disability.

The health care needs of the refugees with a disability need to be given adequate consideration. In order to achieve this, refugees with disability need to be carefully identified and their specific forms of disability documented. Medical needs, in particular, must be identified and addressed promptly. The following suggestions, based on the findings of this study, could provide useful directions:

- Provision of curative health care services against influenza, high blood pressure, diabetic management, HIV/AIDS and malaria.
- Improvement of immunisation.

- Enhanced community awareness regarding early disease detection and intervention.
- Provision of appropriate preventative education and protection against sexually transmitted diseases.
- Prevention of secondary conditions that may develop without adequate treatment of the initial difficulty. Examples of secondary conditions might include posttraumatic stress disorder, chronic depression, physical deformities, and respiratory infections.
- Streamlining referral processes in order to enhance access to specialised services, corrective surgery and other forms of medical intervention.
- Training auxiliary nurses and traditional birth attendants; and
- Increasing the number of specialised therapists for effective and timely assessment of people with disabilities to ensure that there is adequate outreach to all the camps.

6.7.6 Improving Vocational Training Programs in the Refugee Camps.

Vocational training attempts to empower persons with disabilities to become economically self-reliant. Under this approach, persons with disability are equipped with skills that enable them to generate income. Work has the potential to help persons with disability to cope and live dignified and fulfilled lives. It also provides opportunities for social interaction and recreational activities. However, vocational training activities in the Dadaab camps lack resources and continuity. Once refugees with a disability qualify for training, they do not become self-sufficient due to the lack of financial capacity to initiate any tangible income generating activities. In addition to this problem, vocational training in the camps targets the general refugee community, which reduces the chances for refugees with a disability to compete equally with the non-disabled refugees.

Vocational training institutions need to liaise with other stakeholders to ensure that persons with disability graduating from these institutions receive financial support to initiate income-generating projects. It is the contention of the researcher that providing quality vocational training for persons with disability can help foster the following attitudes and values:

- A passion for quality and integrity
- Teamwork and team spirit
- Creativity and adaptability
- Diligence and thrift, and
- Customer focus and time consciousness.

6.7.7 Provision of more opportunities for resettlement for refugees with a disability.

The role of resettlement is recognised as an important instrument of protection within the framework of the UNHCR's supported three durable solutions. Often countries which are involved in refugee resettlement, in close co-operation with the UNHCR, carry out assessment of existing resettlement needs and priorities and allocate their resettlement quota. The UNHCR also encourages countries to take refugees with a disability through its special program called Ten Plus. Countries are encouraged to take only 20 refugees with a disability and their families for resettlement. However, very few countries sign for this program.

Generally, most resettlement countries have strict resettlement criteria; but refugee families with a member with a disability are subjected to even stricter criteria for resettlement. Most resettlement countries unfortunately want 'the cream of the crop' - those who are well trained and educated and who are considered 'physically and mentally perfect', and refugees who have the potential to integrate due to language proficiency and/or historical links. Thus, strict criteria for resettlement has meant that refugees with a disability find it difficult to be resettled (Zolberg et al. 1989, pp.279-282).

As a result of these strict immigration rules, tragic situations have occurred. For instance, it was reported to the researcher that some families have left behind and even disowned their members who have disabilities in order for the rest of the members to be resettled. Refugee families, including people with a disability, have been affected by 'Bufiis' (a disease) produced by the notion of resettlement which affects the psyche of many refugees (see Horst, 2006a & b, for extensive discussion of the 'Bufiis' phenomenon). Equitable opportunities for resettlement need to be

provided for persons with disabilities in order to lessen disappointment like that reflected in Soloo's view regarding resettlement. According to Soloo (case study 1),

You imagine that you got a better country, you imagine your life will improve, you imagine saying bye to poverty, hunger and diseases. But the moment you fail the resettlement process, all types of sickness attack you.

6.8 CONCLUSION

This chapter has proposed useful guidelines for a comprehensive approach to community rehabilitation with specific reference to Somali refugees with disability. It bases the guidelines on the observed need for social reconstruction given that disability has causes and implications that are part of the social fabric. Using the study's theoretical framework, the chapter suggests an enhanced approach to rehabilitation that is cognisant of participation, equal opportunity, empowerment, justice and democratic governance. The approach utilises the principles of CBR and maintains a flexible structure that allows for innovative types of interventions. The chapter also provides practical suggestions for the implementation of a comprehensive rehabilitation approach.

The next and the final chapter in this study provides the summary, conclusions and recommendations linking the findings of the study and the objectives and premises that guided the research.

CHAPTER SEVEN

7.0 SUMMARY, CONCLUSIONS AND RECOMMENDATIONS IN THE LIGHT OF THE VOICE OF THE RESPONDENTS

7.1 INTRODUCTION

The focus of this study was to examine the situation of Somali refugees with disabilities in Kenya. The aim was to clarify and describe the concept of disability as it relates to the Somali community in the refugee camps, as well as to develop a comprehensive plan for community rehabilitation. The following specific research questions guided this study:

- How do the Somali community define disability?
- What are the major causes of disability among the Somali community?
- How does the quality of life of people with a disability compare with that of non-disabled refugees within the camps?
- What are the needs, aspirations, and challenges of people with a disability in the refugee camps? and
- How can a comprehensive approach to community rehabilitation be developed that is relevant to the Somali refugees with a disability in Kenya?

This chapter summarises the findings of the study in the light of the research questions above. The voice of the people with disabilities is integrated throughout the chapter to highlight the impact of the major issues on individual refugees. Finally, the chapter highlights the conclusions of the study and then makes recommendations for future research.

7.2 SUMMARY OF THE FINDINGS OF THE STUDY

7.2.1 How the Somali community defines disability.

This study established that the concept of disability is not very clearly understood among the Somali. There were no distinctive borders between what may be considered 'disease', 'impairment' and 'state of disability' among the Somali. The persons with disability were described using their peculiar features. Some of the descriptions were offensive and degrading, for instance, *Doogon* (fool) referring to

individuals with intellectual disability. Other names used to refer to persons with disability include:

Jiis/Lugeey-(limper), *Balaa/Iley*-(mono eye or vision handicapped), *Naafo/Boos*-(disabled, weak or aged), *Carrabey* - (voice or speech complication), *Turre/Goobe*-(humpback person), *Cawar*-(someone with *cataracts*), *Madexey*- (abnormal head), *Curyan*-(incapacitated), *Dhagolow*- (deaf or mute), *Gacamey/Gurrey*-(one handed or left handed person), *Doqon/Caran*-(fool) - (Focus group 2, Ifo camp)

Consequently, disability is stigmatised and those with disability are regarded as inadequate, deficient and unfortunate. The responses below depict this demeaning attitude towards persons with disability. A person with disability is regarded as ...

a person of no use...incapable of doing any sort of work...unwanted...one who cannot defend himself from their harsh treatment...(Interviewee 1, Ifo camp)

a vulnerable person who is always in need of assistance. (Interviewee 161, Hagadera Camp)

People believe I am inferior to them and I am of no value in the family and the community. (Interviewee 19, Ifo camp)

The derogatory names used to refer to persons with a disability were further reinforced by the degrading depiction of disability in Somali oral narratives, sayings and proverbs collected from the Somali refugee community. Most oral narratives depict people with a disability as outcasts, strange and evil beings, powerless, dependent and problematic persons. The following are such examples:

Dhagool dhugmaleh {Deafness has no mind.}(Interviewee77, Dagahaley Camp).

The implication of this saying is that the person with this kind of disability is never taken seriously as an intelligent and responsible person.

There is a story of a woman fearing to marry a disabled man because of the burden of carrying his toileting (Interviewee 109, Dagahaley camp)

The implication of this story is that living with a person with disability is burdensome and the lesson that is apparent is to avoid such contact.

Disability of any kind symbolises misfortune (Interviewee 150, Hagadera camp) Disability is therefore dreaded and the person with disability condemned as unlucky or even a bad omen.

Non-disabled person is a rich man (Interviewee 150, Hagadera camp).

The implication of this saying is that a person with disability is condemned to poverty.

The impact of this degrading view of disability upon persons with disability is in most cases very harmful. It demoralises, frustrates and dehumanises them as is evident in the following responses to the question: What do you believe about your own condition?

I am lower than other people due to my disability(Interviewee 195, Hagadera camp)

I cannot work to sustain myself. I have to depend on others(Interviewee 18, Ifo camp)

I perceive my disability as excluding me from the rest of the community. I feel defeated. (Interviewee 98, Dagahaley camp)

The responses above reveal low self-esteem, resignation and frustration of the respondents who were persons with disability. However, this study found some persons with disability who retained self-respect and determination to succeed in life in spite of the prevailing negative view in the community. The following responses are examples reflective of the optimistic and dignified self-attitude in a few persons with disability:

I have limitations but can overcome if there is the right environment. (Interviewee 93, Dagahaley camp)

I am still valuable as a person(Interviewee 169, Hagadera camp)

I am normal. I accept my disability and live on like anyone else. (Interviewee 138, Hagadera camp)

I am like other people though sometimes I need help .(Interviewee 67, Ifo camp)

7.2.2 The Major Causes of Disability among the Somali Community.

War in Somalia was the main cause of disability for most of the respondents. Many persons obtained physical injuries during combat and were left traumatised as reflected in the following responses:

I lost my sight in Somalia due to hunger and hardship. Our home was attacked and gangsters beat me up when I was only 11 years old. I was tortured and we had to walk long distance to escape without food and enough water. I suddenly felt sick and lost my sight.(Cumar, Case study 5)

I became partially blind in 1991 when I was at my village where I was a farmer. One day some militia men came to me and disappeared with all what I had as property. They looted everything. They also violently raped my dear wife in front of me. I could not bear the pain and shame. I tried to save her. Unfortunately, I was overwhelmed by the gangsters. They locked me up. Among the men who were raping my wife was smoking and he pushed the burning cigarette into my left eye in order to keep me from saving my wife. This continued for some time until I was not able to struggle any longer.(Abdi, Case study 2)

Although disability is a plan of God my disability was directly caused by the civil war in Somalia. It was caused by gun shots as well as hardships and hunger associated with the war.(Nastexo, Case study 4)

I am physically handicapped and also visually impaired. So I have multiple disabilities. I became disabled during the civil war. In my own house, my brother was killed. My husband was also killed in cold blood in front of me and my children. I was also violently raped in front of my children. My disability can be accounted for by the evil acts of those men who killed members of my family and raped me. I was left alone and I did not get any medical treatment immediately. The impact of that night totally shattered my life and caused disability.(Xawa, Case study3)

Diseases and poor diet cause disability within the camps. However, disability was culturally explained as a result of curse. Most respondents associated bodily malfunctioning and certain disorders with curses (habaar). Certain groups of people, especially those born with certain unique characteristics, were also believed to possess powers to curse, and evil spirits were also believed to cause disability. Some people in the community regard disability as divinely ordained while others view it as caused by evil spirits. The following sample of views reflect the various opinions regarding causes of disability:

A curse by parents causes disabilities. (Interviewee 141, Hagadera Camp)

Some are born disabled to be a miracle on earth for those who are non-disabled and for them to know that God is the creator of both the disabled and the non-disabled. (Interviewee 1, Ifo Camp).

The community describes me as coming from a family that is possessed by demons or spirits... My epileptic situation is translated as if I am possessed with demons or spirits. Sometimes they even call me mad. (Interviewee 126, Dagahaley camp)

7.2.3 The Quality of Life of Refugees with Disability

Generally, the quality of life of refugees with disability was reported to be poorer than that of refugees without disability. This was due to stigmatisation of disability in the Somali community. The refugees with disability were discriminated against and thus disadvantaged economically and socially. They did not adequately access the social resources that are available in the camp like education, food, and employment, nor were fully involved in decision-making. The following responses provide some evidence for this finding:

People do not even allow a disabled child to play and integrate with the non disabled children (Interviewee 104, Dagahaley Camp)

I am abused, cannot be married, I can't compete with my age mates (Interviewee 51, Ifo camp)

Families with members who have disability do not know any happiness.(Interviewee 21, Ifo camp)

Persons with disability suffer more because they lack access to community resources (Interviewee 166, Hagadera camp)

7.2.4 The Needs, Aspirations, and Challenges of Somali Refugees with Disability

The **needs** of the Somali refugees with disability include: quality and relevant education that is sensitive and responsive to disability, basic necessities like food and shelter, security, employment and income generating opportunities and support from the community among others. These needs are evident in the following views of selected respondents:

Families with disabled members should uplift the standard of the disabled child or member by providing them with quality education. The responsibility of bringing up children is not easy. They should treat them equally and give them love and support (Nastexo, case study 4).

Persons with disability need moral support, better education and medical care (Interviewee 155, Hagadera camp)

In order to improve the lives of persons with disability, what is needed include: improved shelter, special education, specialised healthcare, income generating skills and activities (Interviewee 172, Hagadera camp)

Disabled people need to be given consideration for resettlement (Interviewee 17, Ifo camp).

Resettlement is regarded as a golden opportunity for addressing the pressing needs of refugees with disability. On deeper probing, the interviewees claimed that resettlement offered a fresh opportunity to eat, learn, work, interact and live like a decent human being.

The **aspirations** of the Somali Refugees with disability include: Attainment of self-reliance, recognition of their potential by the rest of the community, fulfillment in life despite disability, integration in community life and participation in the life of society among others. Guided by such aspirations, some refugees with disability have been proactive and assertive with positive results as evident in the following:

One of the difficulties I have faced as a person with disability is isolation and discrimination. I decided to join a women's group with fellow non disabled women. We applied for a soft loan from CARE micro finance program. Just after one month, my fellow women reported to CARE that they cannot work with a disabled woman. They stated clearly that a disabled woman could not work with them. I reported back that I too was not willing to work with them unless they changed their discriminative attitude.

I joined my fellow disabled people since I could not work with people who discriminate and despise me. I am currently running a shop with a mentally challenged woman and a deaf woman. I decided to work with those who understand my situation. To be independent is now my goal. I obviously understand the challenges and the difficulties ahead of me but I cannot sit to see my children die or feel left behind by their fellow children. I have to work hard. This is the pleasure of a mother even if she has a disability.

My message to other persons with disability is that one should not sit and wait just because he has a disability. In fact, one should strive to work and meet people. She should forget the disability and be mobile looking for jobs and anything that can sustain the family. One should also try to integrate into the society and make her presence felt so as to be accepted by the community. Let us work together as a team and a family to eliminate discrimination. Let us not sit and lament but forge out our way into the community. If one resigns, his life and dignity is adversely affected. Let us assist ourselves so that others can also assist us.(Xawa, case study 3)

The **challenges** facing Somali refugees with disability include: Discrimination, inadequate rehabilitation services, and shattered dreams among others. This is made evident in the following sampled responses:

The non disabled are given resettlement in the developed countries but the disabled never received any kind of resettlement. This inequality causes a lot of suspicion, demoralise the disabled person and makes life difficult for him (Interviewee 77, Dagahaley Camp)

One cannot get paid employment due to disability (Interviewee 39, Ifo camp)

Life is very difficult. We are mistreated, given poor medical attention, and no special education.(Interviewee 176, Hagadera camp)

I was disappointed, frustrated, and disturbed psychologically. For many days and months I could not do anything. I was just lying in bed unable to make any decision about my life and that of my children. I felt worthless and could not think that such things would ever happen to me especially before my family and my children (Xawa, Case study 3)

The greatest challenge seems to be overcoming the trauma and discrimination especially when refugee mobility is so constrained and the environment in the camps is not adequately supportive.

7.2.5 The Prevailing Educational and Rehabilitation Approaches to Disability at the Dadaab Refugee Camps.

The rehabilitation efforts that are still prevalent at the Dadaab refugee camps can be categorised into the following: *Emergency* rehabilitation, which provides basic necessities to refugees and *Medical-developmental* rehabilitation, which provides assistance of a medical/economic nature. While Emergency Relief addresses the immediate needs of the refugee population affected by the conflict crisis, independent NGOs' initiatives also focus on developmental support strategies that aim to improve the welfare of the refugees. These interventions include medical services, micro-financing, education and vocational training. The researcher argues that a short-term relief mechanism is not a proper solution to refugee problems. Long-term rehabilitation and development plans were first ignored in the establishment of the Dadaab refugee camps. The international community was not adequately prepared to provide a better long term solution to refugee camp life and to protect the interests of vulnerable groups or help them develop coping strategies.

The educational and rehabilitation approaches used in the Dadaab camps have the following limitations:

- They do not fully involve and include the refugees with disabilities. Consequently, most refugees with disability are not committed to them.
- They are not sensitive and responsive to the unique needs, aspirations and challenges of individual refugees with disability.

- They are only sustainable due to their reliance on donor funding which is not always reliable.

The evaluation above is based on data collected in the field as exemplified in the following responses:

Here at the refugee camps, only the strong ones survive. I am a disabled woman and cannot fight the way men fight. In most cases, I have to forego my rights as a refugee in order to avoid conflict. The non disabled persons are given resettlement, good education, financial support, employment opportunities and many other things but I only receive limited services and denied opportunities for resettlement (Xawa, Case study 3)

From this response one gathers that the demand for rehabilitation services is far greater than the supply of the same. This is expected given the rising numbers of the refugee population. Competition for available services is therefore stiff and seemingly, the strongest (and this could also mean those who are well connected!) get them. Consequently, the most deserving cases are not always the ones that receive consideration first.

UNHCR and other agencies try to support the persons with disabilities. However, demand for disability services is high in the camps and agencies providing services complain of insufficient funds to support these programs. Therefore, it is difficult to meet the needs of all the refugees including the disabled refugees.(Nastexo, case study 4).

The effort made to address the needs of the refugees with disability is commendable. However, the needs are complex and the recipients many. There is, therefore, a need to review how the needs are addressed. This study suggests an approach to rehabilitation which addresses the multiplicity and complexity of Somali refugees with disability.

7.2.6 How to Develop a Comprehensive Approach to Community Rehabilitation at the Dadaab Refugee Camps

CBR is a community development strategy distinguished by its focus on the rehabilitation, equalisation of opportunities and social inclusion of all people with disabilities (WHO et al., 2004, P.2-8). It is a desirable approach because of its inclusive nature, emphasis on participation by all stakeholders, promotion of human rights, commitment to poverty alleviation and holistic view of disability.

In line with CBR, this study has developed the following dimensions of a comprehensive approach to CBR:

- **Socio-cultural rehabilitation:** This aims at alleviating the negative attitudes toward disability that lead to discrimination and stigmatisation.
- **Emotional rehabilitation**
This dimension of rehabilitation addresses the emotional trauma and dysfunctions caused by disability for instance, self-pity, fear, low-self esteem and anxiety.
- **Physical rehabilitation**
This dimension of rehabilitation has to do with the provision of adequate material help like food, shelter, clothing, and medical attention. This type of rehabilitation is fairly well provided in the refugee camps.
- **Intellectual rehabilitation**
This dimension of rehabilitation addresses the cognitive and creative capacities of persons with disabilities. Early childhood and special education programs should be designed carefully in order to stimulate the intellectual, moral and creative capacities of the learners.
- **Intra-personal rehabilitation**
This dimension of rehabilitation involves cultivating positive self-affirmation among persons with disabilities. It can be achieved by innovatively encouraging Somali refugees with disability to critically examine their lives and discover the potential that exists within them.
- **Economic rehabilitation**
Economic rehabilitation aims at reducing poverty. Interventions need to promote self-reliance, creativity, planning and decision making capabilities.
- **Geo-political rehabilitation**
This dimension of rehabilitation recognises that disability has a national and international element as well. The Somali state has disintegrated and intense conflicts continue to lead to disability. Rehabilitation efforts need to stress the need for stabilisation of the political situation in Somalia and the establishment of a democratic system of government that Somali people can own and support. Regional and international advocacy towards this goal is what this study refers to as geo-political rehabilitation.

7.3 LIMITATIONS OF THE STUDY

Several challenges impacted on this study. To begin with, the researcher is visually impaired. This limited his direct access to some relevant literature and observations in the course of the study, especially in Kenya. Much of the literature is not in a form that is appropriate to visually impaired persons. Making up for the visual impairment involved using a sighted guide and seeking alternative ways of accessing information and this was costly in terms of time and finances.

The researcher also acknowledges that, though much effort was expended on methodology, visual impairment narrowed the options of the researcher regarding the technical rigour that could be employed in data processing, especially when using SPSS data editor to generate tabulations and percentages.

Another important issue was that the respondents who were willing to take part in this study were such that their gender distribution was slightly disproportionate to the overall distribution of the population with disabilities in the camps; that is, 64% male and 36% female versus 55% male and 45% female respectively. This limits the extent to which gender related explanations and discussions could be made on the basis of representative frequency of responses.

The researcher also recognises that the views held by persons with disability about non-disabled persons are likely to have been affected by painful experiences of discrimination and stigmatisation. It is possible that some of the responses are generalised perceptions (about attitudes of all non-disabled persons) based on few specific incidences (involving some non-disabled persons). As such, the findings have the limitation of being drawn from the perspective of one group of people- the Somali refugees with a disability – and this has implications regarding the subjectivity of the data. It would be useful and interesting to find out directly about the views of the non-disabled refugees toward people with disabilities. It seems probable that some of the views reported by refugees with disability about the attitudes of non-disabled refugees would be disputed.

Similarly, while conclusions about discrimination against people with disabilities in the camps was reported by the refugees with disability, it was not possible due to time and resource limitations to obtain comparative data from the non-disabled refugees with regard to all of the issues covered by the interview guide. Again, this means that the perception of discrimination by the refugees with a disability may have been greater than the actuality, and further research is needed to determine these differences in quality of life, employment, education, and the other matters covered in this thesis.

7.4 CONCLUSIONS OF THE STUDY

On the basis of the findings summarised previously, this study makes the following conclusions:

- Although war in Somalia is the main cause of disability among the Somali refugees in the Dadaab camps in Kenya, culturally, curses are regarded as the main cause of disability within the Somali community.
- The concept of disability as culturally and socially constructed is inadequate. Consequently, in order to address disability effectively, these cultural constructions need to be carefully evaluated and transformed. A participatory approach in which members of the Somali community, together with their leaders, re-examine the prevailing attitudes and beliefs about disability and consider their implications and the consequences on human well being. This would make the community own the revised humane views toward disability.
- The current efforts aimed at assisting refugees with disability are commendable but there is a need to improve the educational and rehabilitation approaches used to provide services to refugees with disability. The community rehabilitation approach can be used in this effort.
- Effective community rehabilitation needs to address the holistic and contextual dimensions of human existence namely, the physical, intellectual, social, cultural, emotional, and geo-political dimensions.

7.5 RECOMMENDATIONS

As discussed in Chapter 6, this study recommends the following as practical steps towards the implementation of the proposed comprehensive approach to rehabilitation:

- Establishment of a centre for disability services in the Dadaab refugee complex. Such a centre can document relevant disability information and other resources. The required and available refugee services would also be properly documented in such a complex. A database of refugees with disability would be kept and updated in the complex.
- Developing a community disability education manual for community leaders and other staff involved in community rehabilitation. Such a manual can be used for training persons working with refugees with disability.
- Improvement of special education facilities and education assessment centres/processes. The various categories of disability need appropriate facilities for rehabilitation as well as assessment. This would facilitate specialised attention to persons with disability.
- Improved funding for CBR programs and disability services.
- A critical review of the health and developmental needs of refugees with a disability.
- Improving vocational training programs in the refugee camps, and
- Equitable opportunities for resettlement need to be provided for persons with disabilities. This would minimise the psychological impact of *Bufois* and lessen disappointments caused by extreme hardship in the camps.

7.6 SUGGESTIONS FOR FUTURE RESEARCH

This study suggests the following as possible areas for future research:

- How different are the experiences of non-disabled refugees and the refugees with a disability? Data could be collected on the areas covered by this thesis so that a more meaningful comparison could be made of the disadvantage being experienced.
- The role of refugees with disability in conflict resolution in Somalia. Are refugees with disability involved in conflict resolution in Somalia? If they are, what unique contribution are they making in the process and how is the contribution received by the rest of the community?
- The place of technology in the rehabilitation of refugees with disability. Are there technological solutions that may impact on the rehabilitation of refugees with a disability?

- Socio-cultural dimensions of community rehabilitation. How can culture and traditions that impact negatively on the welfare of persons with a disability be reviewed and transformed? And, who are the change agents who may be encouraged to be involved in this process?
- Overall, the implementation and evaluation of the specific recommendations of this study would allow a focus on strategies to improve the quality of life for individuals with disabilities and their families in refugee camps. This may be a beginning to restoring their shattered dreams.

7.7 IN CONCLUSION – THE VOICE OF SOME OF THE PEOPLE

Despite the reported poor quality of life and 'shattered dreams' of the people with disabilities surveyed in the Dadaab refugee camps, it was also apparent that the resilience and optimism of a section of this group shone through. This indicates the basic underlying strength of human nature in dealing with extreme adversity and it is appropriate to finish this thesis with the voice of some of these people and their recommendations.

One of the final questions in the Case Studies (see Appendix 6) was:

What recommendations would you make to refugee agencies and other related institutions that deal with disability and refugee affairs? The answers were as follows:

***Soloo** My recommendations are: Give them opportunities whenever such opportunities occur, e.g., scholarships, employment, training and resettlement. Also the education sector should note that the disabled are marginalised and should not treat them like the non disabled in relation to secondary cut-off points for entry.*

***Abdi** Get organisations' experts in disability issues and development.*

***Xawa** I wish to tell them that they have killed the morale of the people with disabilities. Come close to their needs. Understand them and their emotions. Open the doors for them. Integrate them. Provide them inclusive education and equal facilities so that they too can enjoy schooling. Finally, give them equal opportunities and services just the way you help the non disabled refugees in the camps.*

Nastexo *I would recommend these institutions to increase their resources and provide better education. This is a powerful asset that can uplift their life.*

Cumar *I would say that the disabled people are vulnerable and this is even worse in refugee life. Let the international community stop resettling the Somali community by their tribes. This will only increase ethnic fighting and dominance. Let them consider the real vulnerable groups especially the children, women, the aged and the disabled. These groups need care and rehabilitation as well as vocational training for employment.*

Sahara *Let them appreciate our feelings and treat us equally. The services are for all refugees. For example, we all run away from wars and face common hardships. But some organisations favour certain people for resettlement and neglect us disabled mothers because we have disabled children. This is not fair.*

These words contain messages of hardship and inequity, but also focus on the things that could bring about positive changes in the quality of life of people with disabilities who live in the Dadaab Refugee Camp Complex, and this is the researcher's dream for the future.

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APPENDIX 1

Content of Letter of Introduction to Participants

LETTER OF INTRODUCTION

Dear Sir/Madam/Name,

This letter is to introduce Siyat Abdi who is a PhD student in the Department of Disability Studies at Flinders University. He will produce his student card, which carries a photograph, as proof of identity.

He is undertaking research leading to the production of a thesis or other publications on the subject of “Evaluation of Educational Approaches to Disability and Rehabilitation in the context of Somali refugees in Kenya”.

Siyat would be most grateful if you would volunteer to spare the time to assist in this project. The information that Siyat needs is related to what you can tell him about the lives of people with disabilities in the Dadaab Camps. It is difficult to estimate the length of time of your involvement but it is anticipated that Siyat will need an hour of your time in the first instance with the opportunity to clarify questions that arise from this. Siyat will negotiate this with you directly. The questions that Mr Abdi is interested in are:

1. What are the concepts of disability and related beliefs among the Somali refugees?
2. How Somali people with disabilities are Treated in the Dadaab camps? and
3. What challenges face Somali refugees with a disability in the camps?

Be assured that any information provided will be treated in the strictest confidence and none of the participants will be individually identifiable in the resulting thesis, report or other publications. You are, of course, entirely free to discontinue your participation at any time or to decline to answer particular questions.

Any enquiries you may have concerning this project should be directed to me at the address given above or by telephone on (+61 8 82013448), fax ((+61 8 82013646) or e-mail (brian.matthews@flinders.edu.au)

This research project has been approved by the District Commissioner of Garissa. This research project has also been approved by the Flinders University Social and Behavioural Research Ethics Committee. The Secretary of this Committee can be contacted on + 61 8 8201 5962, fax + 61 8 8201-2035, e-mail sandy.huxtable@flinders.edu.au.

Thank you for your attention and assistance.

Yours sincerely,

Dr Brian Matthews
Lecturer, Department of Disability Studies

APPENDIX 2

Individual Consent Forms

CONSENT FORM FOR PARTICIPATION IN RESEARCH (by interview, focus group, experiment...)

I

being over the age of 18 years hereby consent to participate as requested in the introduction letter for the research project on “Evaluation of Educational Approaches to Disability and Rehabilitation in the context of Somali refugees in Kenya”. I have read the information provided.

1. Details of procedures and any risks have been explained to my satisfaction.
2. I am aware that I should retain a copy of the Information Sheet and Consent Form for future reference.
3. I understand that:
 - I may not directly benefit from taking part in this research.
 - I am free to withdraw from the project at any time and am free to decline to answer particular questions.
 - While the information gained in this study will be published as explained, I will not be identified, and individual information will remain confidential.
 - Whether I participate or not, or withdraw after participating, will have no effect on any treatment or service that is being provided to me.
 - I may ask that the interview be stopped at any time, and that I may withdraw at any time from the session or the research without disadvantage.
4. I have had the opportunity to discuss taking part in this research with a family member or friend.

Participant’s signature.....**Date**.....

I certify that I have explained the study to the volunteer and consider that she/he understands what is involved and freely consents to participation.

Researcher’s name.....

Researcher’s signature.....**Date**.....

6. What gender-based challenges do the disabled Somali refugees face in the camps? (***gendcha***)
7. What age based challenges do the disabled Somali refugees face in the camps? (***agecha***)
8. How does the Somali community address the challenges and problems facing the disabled Somali refugees? (***chaladdr***)
9. How are the grievances of the persons with disability addressed within the refugee camps? (***grievanc***)
10. How would you describe the future of disabled Somali refugees?(***future***)

PART TWO: QUESTIONS

A. CONCEPTS OF DISABILITY AND RELATED BELIEFS AMONG THE SOMALI REFUGEES

1. How do other persons describe you within your community? (*desdisab*)
2. Why do they describe you the way they do? What is your opinion regarding this description? (*opdescr*)
3. What are the causes of disability according to the Somali culture and traditions? (*causedis*)
4. Are there any oral narratives, sayings or proverbs relating to disability among the Somali? Explain (*oraltrad*)
5. What do you believe about your own condition? (*owncond*)
6. How does the Somali community perceive disability? (*spercept*)
7. What contributed to the disability of most refugees in Dadaab Camps? (*sdisdab*)
8. What caused your own disability? (*cowndis*)
9. Are there any factors that contribute to disability within the Dadaab camps? Explain. (*fcdisdad*)

B. TREATMENT OF PEOPLE WITH DISABILITY IN DADAAB CAMPS

1. How do non-disabled Somali refugees interact with you in the camps? (*interact*)
2. Do you participate in any programs within the refugee camps? Explain (*prpartic*)
3. Are you given any responsibilities within the camp. (*responsi*)
4. What services do you benefit from in the camps? (*benefits*)
5. Describe any conflicts that disabled persons experience within the camps. (*conflict*)
6. What difficulties do you face as a disabled refugee in the camps? (*difficul*)
7. Are people with disabilities treated the same as non-disabled people in the Camps? (*treatmen*)
8. If people with disabilities are treated differently, what is your opinion regarding this treatment? (*optreat*)

9. What is the main disadvantage of having a disability in the Camps? (***mdisadv***)
10. Are families treated differently if they have a child with a disability? (***fdischil***)

11. What type of education is provided to children with disabilities in the Camps?
(***eductype***)

12. How does education for children with disabilities compare to that provided for children without disabilities? Explain
(***edcompar***)

13. What rehabilitation or training is provided in the camps for adults with disabilities?
(***rehab***)

C. CHALLENGES FACING SOMALI DISABLED REFUGEES IN THE CAMPS

1. What is life like in the camps for a person with a disability? (***lifelike***)

2. How does life for a family without a family member who has a disability compare with that of a family with a disabled member?
(***fdiscomp***)

3. What gender-based challenges do Somali refugees with a disability face in the camps?
(***genderch***)

4. What age-based challenges do Somali refugees with a disability face in the camps?
(***agechal***)

5. Are you aware of any initiatives in the camps that assist people with disabilities (educational/rehabilitation activities)?
(***initiati***)

6. What do you think should happen in the Camps to improve the lives of people with disabilities?
(***recommen***)

7. Do you encounter any marital challenges as a result of your disability? Explain
(***marichal***)

APPENDIX 5

List of acronyms used frequently

- APDC** Associations of Parents with Disabled Children
- AW** African Watch.
- CARE** Cooperative for Assistance and Relief Everywhere
- CBR** Community Based Rehabilitation
- CDS** Community Development Sector
- DRC** Dadaab Refugee Complex
- FGD** Focus Group Discussions
- IDP** Internally Displaced Person
- ICRC** International Committee of the Red Cross
- IDDC** International Disability and Development Consortium.
- NGO** Non-Government Organisation
- NEP** North Eastern Province
- PWDs** Persons With Disabilities
- RAP** Refugee Assistance Program
- SDR** Somali Disabled Refugee
- UNHCR** United Nations High Commissioner for Refugees
- WHO** World Health Organization.

APPENDIX 6

Information on the Participants and Transcripts of the Six Case Study Interviews

Case Study 1 Soloo

PERSONAL INFORMATION

Name used in the thesis:	Soloo
Age	23 years old.
Occupation	Student
Gender	Male
Place of birth	born in Mogadishu in 1982.
Nationality	Somali.
Marital status	Single.
Level of Education	Primary level class eight 2005

DISABILITY HISTORY

State where were you when civil war first happened. Give details of what happened. I was in Mogadishu. I was young boy by then 1991. The war was between the government and the opposition. Later, the war changed its course and became a tribal war. We did not leave immediately. However, the fighting intensified and life became unbearable. So many people were killed. I stayed up to 2000 when I lost my limbs as a result of a gun shots which paralysed both my legs. I was forced to seek assistance and treatment.

- 1. Type of disability** physically handicapped.
- 2. How and when did the disability occur?** In 1998 after a gun shot.
- 3. What caused the disability?** Somali civil wars. The war affected me just when a stray bullet penetrated my left leg and to the right one. I became unconscious and doctors had to cut my legs to save my life. Since then, I became physically handicapped.
- 4. What did your parents and relatives do about the disability?** The only parent alive at the time was my mother. She assisted me accordingly and I was taken to Keisanne Hospital in Mogadishu which was under the care of ICRC. Other relatives were also by my side. The ICRC helped to cure my injuries.
- 5. When did you become aware of the disability?** Obviously, when I lost my ability to walk after discharged from the hospital.
- 6. How did you respond to this awareness?** I felt bad. However, I realized that it's God's plan and I had little option to reverse my situation. It was a great loss to my mother too because I was the only son. This impacted on her negatively but we could do nothing.

7. How did your peers respond to your disability? My friends felt bad and were sorry. However, other children laughed at me and called me names which I dislike. Others have no concern. The only person who can best explain the actual feeling is a disabled person. Others can only give a guess story.

8. What are the prevailing beliefs and customs related to disability in your Community? It depends on situations and circumstances. If you are active and productive, they may have a positive attitude. However, in many cases, the Somali community perceive disability negatively. They consider it unproductive, useless, dead people who only depend on others.

9. How have these beliefs and customs affected you? Such negative attitudes have affected me greatly. Once the community does not give you any support, if the community despise you at all levels, if the community cannot build your morale, then, you are out of place and you fear making any effort to liberate your self. Thus, disability becomes a disease you must learn to live with it.

10. What is your opinion regarding the above beliefs and customs? These traditions and customs are not good. They are not of benefit to the community and the disabled. The PWDs feel neglected by the same community which raised it. The best is to change the attitude. Disability is a natural phenomenon and we must all accept it. The Somali proverb states that the living must expect disability. Therefore, the Somali people should know that the disabled person can learn, be productive and benefit the society if he or she is given an opportunity and support.

11. What difficulties have you faced as a disabled person? I faced many problems and challenges. First of all, I was a good footballer, When I became disabled, I no longer play football. I also felt a lot of pain. Secondly, I lost my expectation and the role I wanted to play in the society. I wanted to be an engineer. All my expectations are now shattered. The community is also adding more pain to my disability. I am even despised by my fellow students in the class.

12. How have you managed the above difficulties? When I recognized my physical disability, when I assessed the response of my community, the only way to get out of my problems was to engage in education. This is the only option I have to help my self. Once you have good education and skills you will be in a position to challenge the attitude of the community.

13. How has disability affected your family life, life in the community, life at school, life at work? Disability has affected me because I have little option in professional skills. It has also caused me constant pain. It affected my family because before I became disabled, I would fetch water for my mum, herd livestock and do much other work. But now I cannot do all that. I depend on my mum to assist me. Disability has also affected my Schooling. I sometimes feel pain and cannot attend classes. I am far from school and sometimes may not be able to reach school on time. I arrive at school at 9.00 instead of 8.00 and miss one period or a lesson. I am not comfortable in the class because I have to share a bench with four other students causing pain and lack concentration in the class. It has also affected my community because I cannot achieve my desired goals to effectively help my community.

14. What message do you have for other disabled persons? My only message to other disabled people is to learn and work hard in school. This is the only way to advance and benefit oneself.

15. What message do you have for non-disabled persons? My message to the non disabled. Help and support your disabled brothers in education, opinion and support. Do not abuse them and stop name-calling. Try to build their morale and stop assuming that they are useless.

16. What message do you have for families with disabled members? My message is that even the disabled child is a gift from God. Treat them well. Do not hide them from the society. Do not place them in risky areas. Take them to school. Should spend equal amount of resources just like the way they spend money on the non disabled child. Give them equal comfort. They too have human feelings.

17. What else would you wish to say about disability? Since disability is natural, both the public and the private sectors must help and provide rehabilitation. The community must change their attitudes. The example of civil war in Somalia should be a lesson. Both the international and local communities must help and support.

DISABILITY AND REFUGEE STATUS

1. What made you seek refuge? I was forced to seek refuge after I became disabled. My mum and I could no longer live in Mogadishu. The raging war and insecurity threatened our existence and we came to the border and requested protection.

2. Describe your experiences in the course of seeking refuge. I did not have any prior experience. We heard from radio that people were seeking refuge at the Kenyan border. My mum and I had to make a long journey from Mogadishu. During this journey for example, we passed many battle fields. At Afgooye, our vehicle was attacked. All able male and female including my mum left me to escape bullets. Luckily I was not killed. We came to Afmadow. Here, there was another fighting. Many were killed. We came to Doble close to Kenya Somalia border. Militia continued the fighting. Many Somali people lost their life. At a tender age, I saw many dead bodies scattered all over. This was not a good experience to my health and psychology. Generally, from Mogadishu to Liboi where my mum registered refugee status, we had many problems and it is difficult to remember the sad encounter.

3. What challenges have you faced as a disabled refugee? I face a number of challenges as a disabled refugee. First, you are a refugee and refugees are refugees—we share many difficulties as refugees. Second, being a disabled refugee, my problems are even more. I am despised by everybody in the camp including UNHCR and other organisations and refugee community. I have no quality education because of my disability. I experience poor social interaction with my classmates, schoolmates and section or block mates. Thus, life is very difficult. Only an idle person can survive in the refugee camp. I am here because my home country is not peaceful. I am secure here but this does not mean that I am comfortable or I like to be in the refugee camp. It is a peaceful prison better than the sound of the hostile guns in Somalia.

4. Describe your life in the refugee camp. My life in the refugee camp is uncomfortable. The non disabled are facing many challenges; what about me a disabled person? Refugee life has adversely affected learning, financially and socially.

5. How have conditions in the camp affected your disability? It has worsened. I have little capacity to advance academically, socially and economically.

6. How is disability regarded by other non-disabled refugees? Just as stated earlier, the non disabled have no concern. They too have their own problems. We are nothing to them since we are competing for the same resources and whatever we get from UNHCR such as food, shelter, education, health as well as training, and employment or resettlement.

7. How do camp administrators treat you? Surely, the way they treat me differs depending on their status. I get good treatment from the staff at the Disability Centre because they have better understanding. Some administrators are ignorant of disability and are stubborn. Others directly show you a sign of dislike. I too dislike them. If they cooperate, I will also cooperate.

8. How do you treat other disabled refugees? I try my level best to accept them and welcome them. I try to organise them. However, if they dislike my suggestions, I just leave them alone. We help each other to survive.

9. What efforts have been made to address the problems facing disabled refugees? I wish the disabled youth would be provided quality education. I wish they would get better schools like Kenyan PWDs. I wish they would not be compelled to learn in congested schools as is in the case of the refugee camps. Currently, the refugees have few trained special education teachers and this is affecting the performance of disabled children. Therefore, it will be of great significance, if we receive quality support to have meaningful results.

10. How adequate are the above efforts according to you? Explain. Currently, the efforts are not adequate. The disabled members are marginalised and the majority are unemployed.

11. What efforts have you made to address your needs and challenges as a disabled refugee? Currently I am in school and I hope I will continue up to university education if I get the opportunity. I strongly believe that education can change my life and the community attitude. Since I cannot do any manual work, I must achieve high academic excellence.

12. What recommendations would you make to refugee agencies and other related Institutions that deal with disability and refugee affairs? My recommendations are: Give them opportunities whenever such opportunities occur e.g. scholarships, employment, training and resettlement. Also the education sector should note that the disabled are marginalised and should not treat them like the non disabled in relation to secondary cut-off points for entry.

13. Have you ever applied for resettlement? Explain what happened. Yes, I applied for resettlement. It has been a difficult task. I wrote to the social sector, but did not get any response. Now I heard the disabled will be given resettlement, I am not sure whether I will get it this time. I keep on trying. I have launched my case because I face many problems as a disabled student and the fact that my country is not yet stable.

14. What is your perception of “bufiis”? BUFIIS is bad! It is a disease. For example, if I am affected by BUFIIS, I may not continue my education or I may perform poorly. All the time, I keep on thinking about it. UNHCR should not induce BUFIIS in to the minds of the refugees. If they are serious about resettling refugees, let them do it once and for all. Stop dividing the refugees in to good and bad refugees. We are all refugees seeking asylum for the same reason. BUFIIS is a disease which has no cure. Stop telling the refugees that we will process your resettlement when they face hardship, hunger and later fail them in the process. This has a serious impact on their life. Many became mentally challenged because of these games.

15. Have you ever experienced “bufiis”? Explain. Yes I experienced BUFIIS although I cannot fully explain how it looks like. It is a disease that affects your psyche and is difficult to explain. You imagine that you got a better country, you imagine your life will improve, you imagine saying bye to poverty, hunger and diseases. Generally, you live a different world of your own. But the moment you fail the resettlement process, all types of sickness attack you. It is difficult to imagine continuing staying in this hard refugee life! Just a miserable life!

Interview carried out on

17th November at Dagahaley Disability Centre.

Case Study 2 Abdi

PERSONAL INFORMATION

Name used in the thesis	Abdi
Age	47 Years old
Gender	Male
Place of birth.	Baydhabo in Bakool region.
Nationality	Somali
Marital status	Married
Level of Education	None.
Occupation	Small scale businessman. Vendor.

DISABILITY HISTORY

State where were you when civil war occurred in Somalia. Give details of what happened. When the civil war occurred, I was in Somalia working as a farmer in my local region. I became a victim of the civil war. I was attacked, I lost all my assets and property and was violently beaten and tortured resulting to my disability

- 1. Type of disability** Mono-eye. I can only see with my right eye.
- 2. How and when did the disability occur?** I became partially blind in 1991 when I was at my village where I was a farmer. One day some militia men came to me and disappeared with all that I had as property. They looted everything. They also violently raped my dear wife in front of me. I could not bear the pain and shame. I tried to save her. Unfortunately, I was overwhelmed by the gangsters. They locked me up. Among the men who were raping my wife one was smoking and he used the cigarette as a tool to prevent me from saving my wife. This process continued for some time until I was not able to struggle any longer.
- 3. What caused the disability?** My disability was caused by a cigarette pricked in my left eye and torture.
- 4. What did your parents and relatives do about the disability?** At that particular time my parents and relatives could do nothing. They too were facing many problems. Everybody was struggling to save life and seek a secure place to hide.
- 5. When did you become aware of the disability?** When my eye healed from the injuries and torture.
- 6. How did you respond to this awareness?** I came to the reality of my disability. Life has more meaning than just losing my eye sight. I still feel that I am not totally disabled. I can do many things the non disabled do.
- 7. How did your peers respond to your disability?** My peer group calls me derogatory names such as Abdi [the mono eyed. The blind, the bad eyed and so on.] However, I cannot stop them. It is normal to them. It is a culture. If I get annoyed, they have no worry or concern. I will be the most hurt and demoralized. So I ignore them and live a normal life despite all the problems.
- 8. What are the prevailing beliefs and customs related to disability in your Community?** The Somali community assumes and believes that disability results from a curse. They therefore, discriminate. For example, in marriage, they say if a disabled person marries, he or she will bring forth a disabled child.
- 9. How have these beliefs and customs affected you?** Yes the Somali customs affect me. If one of my children is called by a neighbour or a friend, the usual call is associated with my disability. They rule out the name of the father. Example, if my child is called Muhammad, he will be called [the son of the mono-eyed.] This is bad. It is even against African naming system.
- 10. What is your opinion regarding the above beliefs and customs?** My feeling is that the community should stop the practice of these customs. The community should be educated so as to avoid or reduce the magnitude of discrimination. If you see a community discriminating against its own people, then, that community is totally ignorant. Thus, there is a need to increase awareness.

11. What difficulties have you faced as a disabled person? Yes I met some challenges. I am a refugee and refugees have many problems. The additional problem is discrimination based on Somali culture and my disability. This is the same in all the Somali communities.

12. How have you managed the above difficulties? I attempted to solve this problem. I admit to have failed. I am overwhelmed by my disability. This is one of the reasons why the community continues to call me derogatory names. They take the opportunity of my disability and the fact that I am a disabled refugee. However, I ignore my problems with the community.

13. How has disability affected your family life, life in the community, life at school, life at work? It has affected my family because we are abused. My children at school are not comfortable. They too are abused by other children. No one can prevent this because it is considered normal by teachers and parents. In my work place, I also encounter many problems including cheating and taking advantages of my disability.

14. What message do you have for other disabled persons? They should not regard themselves as weak. This will worsen their situation in the society.

15. What message do you have for non-disabled persons? They should stop this wrong perception. They should realise that disability is natural and can affect anybody at any time.

16. What message do you have for families with disabled members? They should continue giving support. Show concern and love to boost their morale. They should encourage them all the time. Give them opportunity and encourage that they too have ability and a role to play in the society.

17. What else would you wish to say about disability? I wish to inform the Somali community that a disabled person can do constructive work, train, achieve academic excellence, be a responsible person and have a bright future.

DISABILITY AND REFUGEE STATUS

1. What made you seek refuge? I am forced because of the fact that my country is experiencing violent robbery, looting, killings, rape and other vices which create fear and insecurity.

2. Describe your experiences in the course of seeking refuge. I was tortured on the way, experienced hunger, thirst and separation of my family due to fear of starvation and militia forces who were loyal to their tribal warlords and would kill any of my family if they discover we came from different tribe.

3. What challenges have you faced as a disabled refugee? More of traditional challenges.

4. Describe your life in the refugee camp. My life in the refugee camp is hard. I have problems working during the night because of my low vision. I have no financial capacity to produce or generate profits in my small business activities.

- 5. How have conditions in the camp affected your disability?** Our conditions are adversely affected by refugee life. Conditions at the refugee camps are deteriorating each day and our life continues to be more difficult. The non disabled refugees also share this experience.
- 6. How is disability regarded by other non-disabled refugees?** Weak and unable to do anything.
- 7. How do camp administrators treat you?** Treat us equally.
- 8. How do you treat other disabled refugees?** It is normal
- 9. What efforts have been made to address the problems facing disabled refugees?** No recognisable efforts. They still have many problems.
- 10. How adequate are the above efforts according to you? Explain.** They are not adequate according to me.
- 11. What efforts have you made to address your needs and challenges as a disabled Refugee?** Engage in small business. Change the attitude of the Somali concerning disability. However, I am not successful.
- 12. What recommendations would you make to refugee agencies and other related institutions that deal with disability and refugee affairs?** Get organisations' experts in disability issues and development.
- 13. Have you ever applied for resettlement? Explain what happened.** No.
- 14. What is your perception of "bufiis"?** Bufiis is a disease produced by the notion of resettlement. It causes death by suicide, insanity and prolonged illness.
- 15. Have you ever experienced "bufiis"? Explain.** I have no experience.

Interviewed on 21/11/2005.

Ifo Disability Centre.

Case Study 3 Xawa

PERSONAL INFORMATION

Name used in thesis:	Xawa
Age:	40 years old
Gender:	female
Place of birth:	Jajamaale, Boale region
Nationality:	Somali.
Marital status:	Widowed with two children
Level of Education:	I am not educated but I have hand skills. Currently my children are students one is in class eight this year.

Occupation: I am self employed and all the time I work for what fits and suits myself and my family. So I have a small scale business in the camp.

Where were you when civil war occurred in Somalia. Explain what happened?

I was in my local village Jajama. One night our village was attacked. I could not tell you who were fighting. Many people were killed. Many were injured. We had no hospital. Many who had the chance and ability left the village. We were affected and it was difficult to escape. It was just too risky.

DISABILITY HISTORY

1. Type of disability I am physically handicapped and also visually impaired. So I have multiple disabilities.

2. How and when did the disability occur? I became disabled during the civil war. It happened that as a person and in my family, we encountered many problems from the civil war which greatly contributed to my disability. In my own house, my brother was killed; my husband was also killed in a cold blood in front of me and my children. I was also violently raped in front of my children.

3. What caused the disability? Evil acts of those men who killed members of my family and raped me. I was left alone and I did not get any medical treatment immediately. The impact of that night totally caused me (murug) depression and (fakir culus) deep anxieties which shattered my life dreams and caused me further loss of sight and disability.

4. What did your parents and relatives do about the disability? Whatever my parents could have done, now they are not alive. Also whatever my brothers and relatives could have done, we were caught in between the fire of the militia and everybody ran for security. We were disheartened, demoralised and no one was able to trace their relatives. We were divided and separated by the civil wars.

5. When did you become aware of the disability? I realised my disability when the UNHCR officials uplifted me to the protection centre bordering the Kenya Somalia border. I was taken to a health centre while unconscious for a long time and got treatment and was discharged. Then I realised I lost the ability to walk and see.

6. How did you respond to this awareness? Of course I was disappointed, frustrated, and disturbed psychologically. For many days and months I could not do anything. I was just lying in bed unable to make any decision about my life and that of my children. I felt worthless and could not think that such things would ever happen to me especially before my family and my children.

7. How did your peers respond to your disability? You see my frailness is not cause by old age. It resulted from what happened to me in that incident. I am in my prime age. The frustrations and the mistreatments of the gangsters worsened my conditions. I am in the productive age where I could have worked for my children and family. My disability and hardship has been my greatest challenge. The peer group realized that my disability was caused by that incident and many were very sympathetic to my conditions.

8. What are the prevailing beliefs and customs related to disability in your Community? They see you as someone who is nothing in the society. Once you become disabled, you cease to be respected and they dare call you bad names and even abuse you on the streets. They change your name and brand you foreign names.

9. How have these beliefs and customs affected you? If they brand me names, if they abuse me on the streets at my age, obviously you will be disheartened, discouraged and feel neglected by the community when you really want their support especially considering what happened to me. I wonder whether I am a member of a society that treats its members this way!

10. What is your opinion regarding the above beliefs and customs? I regard these treatments and customs as part of excluding disabled members in the activities and decisions of the community. I also feel that it is a wider scheme of isolating the disabled members.

11. What difficulties have you faced as a disabled person? One of the difficulties is that I decided to join a women's group with fellow non disabled women. We applied for a soft loan from CARE micro finance program. Just after one month, my fellow women reported to CARE that they cannot work with a disabled woman. They stated clearly that a disabled woman cannot share with us and work with us. I reported back that I too cannot work with them. So I joined my fellow disabled people since I cannot work with people who discriminate and despise me. They wanted separation which indicates their attitude. I am currently running a shop with a mentally challenged woman and a deaf woman.

12. How have you managed the above difficulties? I decided to go alone my life and only work with those who understand my situation. To be independent is now my best choice instead of struggling with people who have hatred of disabled people.

13. How has disability affected your family life, life in the community, life at school, life at work? I am a person who cannot leave the house without assistance from people. If I cannot do what the non disabled do, if I cannot work the way the non disabled work, then I have to look for an alternative and strive on my own. I obviously understand the challenges and the difficulties ahead of me but I cannot sit to see my children die or feel left behind by their fellow children. I have to work hard. This is the pleasure of a mother even if she is a disabled.

14. What message do you have for other disabled persons? My message to other disabled persons is that one should not sit and wait just because he/ she are having a disability. In fact, one should strive to work and meet people. He/she should forget the disability and be mobile looking for jobs and anything that can sustain the family. One should also try to integrate in to the society and make his/her presence felt so as to be accepted by the community. Let us work together as a team and a family to eliminate discrimination. Let us not sit but forge out our way in to the community. If one sits, his/her life and dignity is affected. Let us assist ourselves so that others can also assist us.

15. what message do you have for non-disabled persons? I would have reminded them that we are all brothers despite our disabilities. We all come from one father and one mother. We are all one human race sent to this world with one mission, to help one another and build a cohesive society that pleases the Creator of the world. Our disabilities are natural and a plan of God the Almighty and should not divide us. Discrimination and separation will not help us neither will it benefit you. Let us drink, eat and enjoy what God has provided us. We are all born equal but have different talents. Let us work together as one human family recognizing our abilities and shortfalls.

16. What message do you have for families with disabled members? Families with disabled members especially if that member is a disabled child should give equal opportunities to both the disabled members and the non disabled children. They should strive to educate the disabled child and give happiness to all the children in the family. Let the disabled child feel love and compassion. They should never discourage the child or ignore their needs. They should protect and value their life because they too have feelings. Let them share the blessings in the family as well as the developments achieved in the family. Make sure the non disabled members do not embarrass the disabled child by branding him/her abusive names.

17. What else would you wish to say about disability? Generally, I would like the disabled people to bridge the mentality that things will come on a silver plate. Your efforts and determinations can best serve you. They should know that they are vulnerable to many calamities. I would also advise NGOs to give golden opportunities to disabled people

DISABILITY AND REFUGEE STATUS

1. What made you seek refuge? First, I was forced to seek refugee status due to the constant wars in my home country Somalia. Secondly, I had to seek refuge after I became disabled. Thirdly, I really wanted peace. Finally, I wanted International Organizations to help me after I lost many of my family in the civil wars.

2. Describe your experiences in the course of seeking refuge. I experienced many problems. Some organisations close their doors when they see a disabled person coming. Several times I was locked out when I wanted to explain my problems even to UNHCR. This act has disheartened me greatly.

3. What challenges have you faced as a disabled refugee? Here at the refugee camps, only the strong ones survive. I am a disabled woman and cannot fight the way men fight. In most cases, I have to forego my rights as a refugee because of avoiding conflict. I cannot see and run due to my disability. Sometimes I ask myself if International organisations with all its philanthropic aims have neglected me just the way my own community neglected me? The non disabled are given resettlement, good education, financial support, employment opportunities and many other things but I only receive limited services and am denied opportunities for resettlement.

4. Describe your life in the refugee camp. Life at the refugee camp is not good. It is hard. It is full of disappointments. Sometimes I sit down to think about its worthiness. But all in all, the only treasure we have is PEACE. Life at the refugee camp is even worse for PWDs. So it is a miserable life for a PWD but we tolerate because we have no other options or place to go.

5. How have conditions in the camp affected your disability? Conditions at the camps have worsened my disability because I have no other ways to improve my disability. I am in these camps for more than ten years without going any other place. Just depending on relief without rehabilitation at all.

6. How is disability regarded by other non-disabled refugees? They have no regard for a disabled person. I already told you that they changed my real name and branded me nicknames which I strongly detest. So why do you keep repeating the question?

7. How do camp administrators treat you? The camp administrators have no chance to see me. They close their doors and are not ready to listen to me. So how can they treat me! Service comes first before treatments. If I am not able to contact them when I am in need, what services can they give me! My wheel chair is a big problem to them and so my disability.

8. How do you treat other disabled refugees? We have an office where we meet and discuss our problems. We encourage each other and exchange ideas. We also support one another with skills and in the programs which aim to help the PWDs.

9. What efforts have been made to address the problems facing disabled refugees? Since 1992, none of the PWD was given resettlement. The last group of Somali refugees from the Asharaf ethnic group was resettled. Recently, UNHCR initiated the first resettlement programmed for the PWD but this was chaotic. Implementing agencies treated the PWD badly. They have never treated the non disabled the way they treated the PWD. Some wanted to take our chance, others corrupted our cards and the whole program is now in a mess. So my friend, the disabled are not liked, only God likes them.

10. How adequate are the above efforts according to you? Explain. Well, there are some programs which have assisted the PWD for example, the vocational training, however, these programs are limited and many disabled do not get them. I must say that there many things which have not been done. The disabled need to develop financially and socially. So both the community and the agencies must do something.

11. What efforts have you made to address your needs and challenges as a disabled Refugee? First I have a wheel chair. So I am mobile. I go to the market to buy goods for sale. Also I do some hand skills by making mats from used polythene papers. I have the capacity to perform and have a brain. If I sit, I will look stupid and prove my disability.

12. What recommendations would you make to refugee agencies and other related institutions that deal with disability and refugee affairs? I wish to tell them that they have killed the morale of the PWD. Come close to their needs. Understand them and their emotions. Open the doors for them. Integrate them. Provide them inclusive education and equal facilities so that they too can enjoy schooling. Finally, give them equal opportunities and services just the way you help the non disabled refugees in the camps.

13. Have you ever applied for resettlement? Explain what happened. Yes. I applied for resettlement. I don't know what happened. I applied the same time with a non disabled person. My friend was honoured and granted resettlement yet I was denied. I strongly feel I missed the opportunity because of my disability.

14. What is your perception of "buiis"? It is a disease which affects people who have a strong desire to get resettlement in a developed country. Such people feel that life in the refugee camps is not satisfying and it is not meeting their needs. I believe that you can do well in any place in the world. Buiis is a disease you create in your mind. Just like love which has no choice. You love a person but it does not mean that the person is everything. We heard of many refugees who left here and are living a miserable life in the developed world.

15. Have you ever experienced "buiis"? Explain. Yes. I tried once. I am a mother who has children. I didn't get any education in my early age. So I had a strong desire to give my children the best education. So since my home country is experiencing civil wars, I wanted a country that my children will advance their education. But I cannot disturb my mind if I miss the opportunities. God has a plan for me and my children. I cannot think of becoming sick because of western countries.

Interview taken at Dagahaley Refugee Camp DDC office.

16/11/2005.

Case Study 4 - Nastexo

PERSONAL INFORMATION

Name used in thesis:	Nastexo
Age:	22 Years Old.
Gender:	Female.
Place of birth:	Kismayu.
Nationality:	Somali.
Marital status:	Not married.
Level of Education:	Up to Primary School Class Three.
Occupation:	NA

DISABILITY HISTORY

1. Type of disability Blind.

- 2. How and when did the disability occur?** During the civil wars, at the time my mother was away in Mogadishu when we were attacked by militia indiscriminately.
- 3. What caused the disability?** Although disability is a plan of God, but my disability was directly caused by the civil wars. It was caused by gun shots, hardships and hunger associated with the effects of the wars.
- 4. What did your parents and relatives do about the disability?** Even if my parents and relatives could do something, they were away at the time and poor and I expected little help.
- 5. When did you become aware of the disability?** I became aware of my disability when I was attacked by the militia from an enemy clan who had no mercy to even children. They assaulted me and did bad things. My Mum was away and I was left to care for my little brothers and sisters. She was also trapped in the war and could not reach us. We starved and were mercilessly attacked.
- 6. How did you respond to this awareness?** Anger, frustration and shock were my first response. However, later I realised my disability and made appeals to organisations to help me.
- 7. How did your peers respond to your disability?** Once my peers discovered my disability, they think I am weak. They despise me, abuse and sometimes come to our house to provoke me because of my blindness and my disability.
- 8. What are the prevailing beliefs and customs related to disability in your Community?** If a person unfortunately becomes disabled, the general community views that person as weak and unable to do any form of work especially those among the community who are illiterate.
- 9. How have these beliefs and customs affected you?** These beliefs and customs have affected me in my social and economic life. I find it difficult to interact freely with my friends and face many financial challenges considering that two of my brothers are also having a disability in the family of six children.
- 10. What is your opinion regarding the above beliefs and customs?** Many of them are out of place and outdated. Some of them are so dehumanising and discourage the disabled to have any meaningful life.
- 11. What difficulties have you faced as a disabled person?** I feel lack of freedom, isolation and neglect.
- 12. How have you managed the above difficulties?** I strive to be normal and try to integrate into the main stream community despite the odds. I also try to cope with my disability and educate myself as a means of helping my self despite the fact that I am overage of school. Imagine a big girl of 22 years in class three. I should have been above that. But disability has seriously affected me to that extent.

13. How has disability affected your family life, life in the community, life at school, life at work? I am the eldest child in a family of six children in which three of them have a disability including myself. So it is difficult for my parents to support us all. The refugee life is also causing extra hardships. The community is harsh to my disability and isolates me since I am considered weak. Currently I am thinking of dropping out from school because it is shame for a big girl like me to be in class 3 and also because here there is no formal education for the adults with a disability in the refugee camps. However, my two brothers who are also having a disability are in school. The paralysed child is in class eight now (2005) and the other who is blind is in class three in the primary school. Of course, we face many challenges at school from teachers, schoolmates and playmates. Every day we report to my mother how we are mistreated at school and my mother thinks of dropping us from the school to protect us but I keep on encouraging her to retain the two boys in school despite all the problems.

14. What message do you have for other disabled persons? Other disabled persons should work hard and show the community their ability to perform. They should not let themselves down. They should organise themselves and learn how to talk instead of keeping quiet when they are suffering and have a need.

15. What message do you have for non-disabled persons? The non-disabled persons should recognize that the PWD are also human beings and have feelings. They feel pain when they are abused and given derogatory names. Instead, they should help. Encourage and give them support.

16. What message do you have for families with disabled members? Families with disabled members should uplift the standard of the disabled child or member by providing them quality education. Responsibility and bringing up children is not an easy task therefore, they should treat them equally and give them love and support. This is my message to the families with a disabled member.

17. What else would you wish to say about disability? People with disabilities should consider themselves. They should improve the quality of their lives. They should acquire quality education and training and participate in community activities. This is something very important.

DISABILITY AND REFUGEE STATUS

1. What made you seek refuge? Our family had to seek refuge in the refugee camps because of civil wars in Somalia and hardship we face to survive. We were also prompted to seek refugee status so us improve our livelihood and seek education.

2. Describe your experiences in the course of seeking refuge. It has been a difficult process and we faced many challenges.

3. What challenges have you faced as a disabled refugee? My greatest challenge is that my family and I totally depend on UNHCR and agencies for relief and rehabilitation. However, we still face many problems relating to income, education and resettlement.

4. Describe your life in the refugee camp. Life in the refugee camp is complicated. No amusement or excitement. You are just a refugee - no rights, no future. It is a boring life of wait and see what will happen next. It has more downs than ups.

5. How have conditions in the camp affected your disability? It has worsened my disability condition. Services in the camps do little to uplift the living standard. The community cannot understand our problems and this has complicated our situation and made us feel the essence of disability.

6. How is disability regarded by other non-disabled refugees? I must say that the elite and the professionals have better relations with disabled community. However, the youth and uneducated ones mistreat the PWD. Unfortunately, the majority are represented by this group.

7. How do camp administrators treat you? Many camp administrators are God fearing people. They assist the PWD. Unfortunately, some of the camp administrators are also refugees and the assistance they can give to the PWD is limited. However, they help a lot in passing vital information to the agencies that provide services. Others lock up the doors the moment they see a disabled person coming to the office. They think he/she is coming to beg or cause trouble.

8. How do you treat other disabled refugees? We have common interests and face similar challenges in the camps. We share information and encourage one another. We have many forums and consultations through the CBR Office.

9. What efforts have been made to address the problems facing disabled refugees? UNHCR and agencies try to support the PWD. However, demand for disability services is high in the camps and agencies providing services complain of insufficient funds to support these programs. Therefore, it is difficult to meet the needs of all the refugees including the disabled refugees.

10. How adequate are the above efforts according to you? Explain. Of course their efforts are not adequate. If there is inadequate funding there is little one can do? The disabled will continue to be marginalised.

11. What efforts have you made to address your needs and challenges as a disabled refugee? My life in this refugee camp is circumstantial. However, I strongly believe if I get a better and peaceful place, my life will improve because I will concentrate on my education and vocational training and help my mother to bring up my two little brothers.

12. What recommendations would you make to refugee agencies and other related institutions that deal with disability and refugee affairs? I would recommend these institutions to increase their resources and provide better education. This is a powerful asset that can uplift their life.

13. Have you ever applied for resettlement? Explain what happened. I have not requested for resettlement. My mother told me that it is difficult for a family with disabled children to be resettled in western countries. So I forgot the whole story.

14. What is your perception of “bufiis”? I have no knowledge about Bufiis because it is a disease that affect those who have hope for resettlement. I hear people talk about it but cannot describe or explain it.

15. Have you ever experienced “bufiis”? Explain. Yes, like any other refugee, when we first came to this camp, I felt my situation would be better if I am resettled in the western countries to give me an opportunity to be educated like the non-disabled refugees. However, my Mum told me that our disability status would not qualify for resettlement and since then, I gave up the whole story.

Interviewed on:
23rd November 2005.
Hagadera CBR Office.
Mother was present.

Case Study 5 - Cumar

PERSONAL INFORMATION

Name used in thesis:	Cumar
Age:	25 years old
Gender:	Male
Place of birth:	Mogadishu
Nationality:	Somali
Marital status:	Single
Level of Education:	None
Occupation:	unemployed

DISABILITY HISTORY

1. Type of disability Blind.

2. How and when did the disability occur? I lost my sight in Somalia due to hunger and hardship. Our home was attacked and gangsters beat me up when I was only 11 years old. I was tortured and we had to walk a long distance to escape without food and enough water. I suddenly felt sick and lost my sight.

3. What caused the disability? I attribute it to hardship and frustration.

4. What did your parents and relatives do about the disability? None could prevent it. They too had their own problems and worries. At that time, everyone was seeking for a peaceful place to stay.

5. When did you become aware of the disability? When I found my ability to see was going down. I was unable to walk alone and my father had to assist me. I cannot remember it all.

6. How did you respond to this awareness? Bitterness and frustration. I was in primary school in Somalia and was doing well. I realized lack of vision will be the darkest moment in my life. This was not my expectation and hope.

7. How did your peers respond to your disability? They branded me all sort of bad names. They also bullied me and made me a laughing stock over my disability. Sometimes they would hide from me and ask me to identify them. Some would even pinch me from the back and play a game as if I was their toy. This made me feel bad. It was a form of torture which disturbed my emotions and caused frustrations.

8. What are the prevailing beliefs and customs related to disability in your Community? The Somali people think disability is a disease which is permanent and difficult to cure. It is believed to be caused by many agents in the society. Once a person becomes a disabled, the quality of life goes down. Then nobody values him/her. The ability to live and perform in the nomadic environment is limited.

9. How have these beliefs and customs affected you? These beliefs and customs have affected my life in many ways. I am isolated and branded nicknames which identify my type of disability. I am not able to get equal education and training to uplift my life. I cannot make decisions or visit friends the way I want. All these problems affect me and my life directly or indirectly.

10. What is your opinion regarding the above beliefs and customs? The existing beliefs and customs in the Somali community are mostly wrong because they think I am nothing if I am blind. Surely, I strongly believe to be a person who can do great things, learn and become just like them and be responsible for his life.

11. What difficulties have you faced as a disabled person? I faced many challenges. Obviously, if you are a disabled person living in a refugee camp, you will face many risks and hardship. Refugee life itself is one of the difficulties. It is a form of disability because you are not free to go where you want or express your mind. It would have been a different case if I would have been in my peaceful country in Somalia. You are aware what is going on there.

12. How have you managed the above difficulties? I try to visit education institutions. I ask questions and make many requests so as to get education. I listen to many radio stations and ask people to give me audio cassettes containing religious literature and other forms. I also request some of my friends to read for me articles and books from Care library. But I get negative response and life becomes difficult.

13. How has disability affected your family life, life in the community, life at school, life at work? Disability has affected my education. I became blind at a tender age. So couldn't work. Even before the civil wars in Somalia, I was facing educational challenges since there were not educational institutions for the blind or for the disabled people. Thankfully, here we have such institutions but due to funding, we are not able to get adequate services. I cannot train because I have no education background.

14. What message do you have for other disabled persons? My message to my fellow disabled people is that disability is not their choice and they should be patient and have confidence. They should not be just idle. They should strive and work hard to liberate themselves and change these wrong perceptions relating to their disability. Finally, they should not be demoralized or feel heartbroken due to their disability. They have the chance to survive and have a meaningful life. You have the capacity for education, employment and economic development. Never try to kill the spirit of their heart.

15. What message do you have for non-disabled persons? First, they should fear God who created them and they should also recognise the humanity of the disabled person. Whatever you need as a non disabled person is also needed by the disabled person. They should avoid ill treatment of the PWD. This will create a fair and just society.

16. What message do you have for families with disabled members? They should know that both children [disabled and the non disabled] have equal rights and needs. They should never discriminate against their own children. No one knows who will be useful to you. You have equal responsibility to your children.

17. What else would you wish to say about disability? Disability is a state of physical inability but does not mean inability. We all have aspects of inabilities yet we are not all disabled.

DISABILITY AND REFUGEE STATUS

1. What made you seek refuge? I was forced to seek refuge when I realised that in my home country peace is not forthcoming. The civil war gave rise to warlords who had no mercy toward women, child, aged or disabled people. They just kill anybody and cause destruction. They contribute greatly to disability and lack of education. So I had to look for a peaceful place where I can learn and become self reliant.

2. Describe your experiences in the course of seeking refuge. It is only better than an insecure country like Somalia. The living standard is very poor and there is general hardship. We have little exposure to the rest of the world.

3. What challenges have you faced as a disabled refugee? My greatest challenge is access to services. It takes me much time to get the kind of services I want. I cannot queue and if I miss my chance is given to another person. Sometimes you are thrown out of the line, abused or knocked down by many people. So, sometimes I miss my due rights to protect my body from harm.

4. Describe your life in the refugee camp. I came to this refugee camp in 1991. First, we were settled in Liboi town some few kilometres from the Kenya Somalia border. Then we moved to Ifo and came to Hagadera camp in 1995. My greatest difficulty is how to achieve education. Truly, the education system here does not accommodate the needs of the disabled people. The services are very poor and the limited contact with my teachers is not enough. However, despite all this, I try my best to learn and normalise my life.

5. How have conditions in the camp affected your disability? Refugee life has affected me in many ways. I cannot get the services. I have to request people to collect my food ration from the distribution centres. You cannot go to market places because there are many barriers and obstacles on your way and children on the street will also abuse and throw stones to provoke you. Therefore, sometimes I have to forsake my rights in order to protect myself.

6. How is disability regarded by other non-disabled refugees? Only few individuals recognize the rights of the disabled people. They mistreat you, abuse and threaten you. They utter words which discourage and demoralise your spirit. Such words traumatise you especially when you are facing all these hardships in the refugee camps. However, there are people who are responsible and discourage or restrain these people from mistreating the disabled people.

7. How do camp administrators treat you? In most cases, it is difficult to see these camp administrators. Again, there are some who work hard and execute their responsibilities. These people are committed to help the disabled people. Others just work on their interests and ignore the plight of the PWD.

8. How do you treat other disabled refugees? I cooperate with them. We assist each other and have no problems.

9. What efforts have been made to address the problems facing disabled refugees? CARE and other organisations working here tried to help and rehabilitate the disabled refugees. However, the process of resettling the disabled refugees was too slow and only started recently after 15 years of neglect.

10. How adequate are the above efforts according to you? Explain. Personally, I feel it's not adequate; more can be done. Again, we appreciate the learning facilities, seminars, trainings and the rehabilitation programs.

11. What efforts have you made to address your needs and challenges as a disabled refugee? I have learnt to walk alone independently. I can go to the market places and buy things by myself. Generally, I can take care of myself independently. I am making all efforts to achieve independent living and minimise my disability.

12. What recommendations would you make to refugee agencies and other related institutions that deal with disability and refugee affairs? I would say that the disabled people are vulnerable and this is even worse in refugee life. Let the international community stop resettling the Somali community by their tribes. This will only increase ethnic fighting and dominance. Let them consider the real vulnerable groups especially the children, women, the aged and the disabled. These groups need care and rehabilitations as well as vocational training for employment.

13. Have you ever applied for resettlement? Explain what happened. Yes. I tried very much. I had a number of interviews and submitted many reports. All the time I am promised for resettlement. Nothing happened so far and I don't know what happens. I am still waiting. I feel that if I request resettlement I will be in a position to achieve good education and improve my life.

14. What is your perception of “bufiis”? If I will be resettled in a peaceful country, yes, I will appreciate to go to such a place. My ultimate aim is to be educated and help my people. So, that desire to leave this camp and go to a better place is in my mind and all of us would like to stay in a peaceful country.

15. Have you ever experienced “bufiis”? Explain. If Bufiis would mean resettlement; yes. I have that interest because I will be able to achieve my goal of getting good education and training.

This Interview was conducted at Hagadera camps.
17th November 2005.

Case Study 6 Sahara

PERSONAL INFORMATION

Name used in thesis: Sahara.
Age: 38 years old.
Gender: Female.
Place of birth: Beydhabo.
Nationality: Somali.
Marital status: Married.
Level of Education: None.
Occupation: Housewife.

State where were you when civil war occurred in Somalia. Give details about what happened? I was at Beydhabo at the time. We stayed at home and then the militias came. They caused mayhem and no one was safe. They dragged many girls from their house and some even didn't return. I saw many people killed. They were not kind to me too despite my disability. It was horrible. They were shooting all over the place. I felt nowhere to hide. I don't want to remember that situation any more.

DISABILITY HISTORY

1. Type of disability I have two of my legs paralyzed and therefore with physical disability.

2. How and when did the disability occur? When I was young. At the time I was staying with my uncle in Mogadishu. I felt severe pain first from my left leg and this continued to the right leg. My uncle took me to a doctor in the city. I was admitted at a private hospital and since my situation was getting worse, the only solution was to be amputated. You see me now use a wheelchair given to me by CARE.

3. What caused the disability? Actually I have little knowledge what caused my disability. I only vividly remember the severe pain I felt at the time. My relatives and neighbors attributed this to traditional causes but I am a Muslim and cannot believe in those stories. It is a normal sickness and I have no idea.

- 4. What did your parents and relatives do about the disability?** My parents-Mum and Dad died and left us five in the family orphans. My paternal uncle adopted us and when I felt sick, surely my uncle tried his level best to help me. However, whatever is the plan of Allah, no one can prevent. I am now a disabled person in this refugee camp. I never anticipated being a refugee and living this horrible life. It is all part of human experience.
- 5. When did you become aware of the disability?** When I felt the pain. I was getting tired and unable to walk. My uncle would pay traditional medicine women to apply some herbs to my legs and do massage. But my situation was not improving. I was also limiting the daily activities as a result of that pain.
- 6. How did you respond to this awareness?** I never expected that events will turn against me. Yes, I was disappointed but could do little. I generally felt bad and state of unbelief.
- 7. How did your peers respond to your disability?** Most of my age mates understood at first. They felt sorry. But later, when it all became clear that my disability was permanent, some withdrew their support and I felt isolated.
- 8. What are the prevailing beliefs and customs related to disability in your community?** I find no positive perception or beliefs. We are called all sorts of names. Our feelings and decisions are not respected because we are considered sick people.
- 9. How have these beliefs and customs affected you?** They have affected the quality of my living and helped to isolate me from the community.
- 10. What is your opinion regarding the above beliefs and customs?** I consider them bad and discriminatory.
- 11. What difficulties have you faced as a disabled person?** I have faced many difficulties relating to my disability. Access to education, health and even socialisation. However, I cannot detail them all here. I share many of the challenges with the rest of the refugees but the disabled people's concerns are not well addressed by organizations in the camps.
- 12. How have you managed the above difficulties?** I have learnt to be patient and have strong trust in Allah. My relatives help me a lot. But when I sometimes face extreme isolation, I cannot help it but to accept my state of disability and the suffering that comes with it.
- 13. How has disability affected your family life, life in the community, life at school, life at work?** I have two children who also have disability. My husband is also disabled. I married him when no one was interested in me. We all depend on assistance from organizations at the refugee camp. This state of affairs affects all of us in the family. Yes, we have limited support, but we must live and survive.

14. What message do you have for other disabled persons? Disability is not the end of life. One can be disabled and again be happy and enjoy life. Let them have salvation of hope and courage.

15. What message do you have for non-disabled persons? I would remind them of the Somali proverb: “Whoever is living, should one day expect disability.” Today it is me with disability, and tomorrow who knows! They should respect my state and stop their isolation of disabled persons.

16. What message do you have for families with disabled members? Such families should be careful how they treat members with a disability. They should not ignore a member just because of his/her disability. All members are equal before their Creator and no one is superior.

17. What else would you wish to say about disability? I would advise them to be strong and learn to cope with their disability. I would also inform them that members of the community do not understand disability just the way the disabled members have limited understanding of their disability.

DISABILITY AND REFUGEE STATUS

1. What made you seek refuge? To escape the wars and to find a place of shelter and peace. Life was unbearable in Somalia and my disability state gave me little hope.

2. Describe your experiences in the course of seeking refuge. The process of coming to this refugee camp was not easy. I came here when sick and tired from the long journey to safety. I am grateful for some individuals who assisted me along the way. I was almost dying of hunger and thirst. But also some people were very aggressive and harassed me. The Kenyan police were also not kind to me at the borders.

3. What challenges have you faced as a disabled refugee? Yes, I have peace and protection from warlords but have still much to worry about. Life is not better than I expected. I depend on people who have little understanding of my needs and my feelings.

4. Describe your life in the refugee camp. I face many challenges. The services are not adequate but I cannot complain. At least I have peace and basic things to survive. However, my future is uncertain because I have no education or any other skills that would help me earn a living. My husband is also a disabled and unemployed. My two children born here are also disabled. My niece who is in her teens helps me and also gives care to my children. She dropped out from school to help me here at home. Although I understand how much she sacrificed her energy to support me and my family, her future would have been better if we were resettled in a third country where she would have possibly improved her life. I have no other relative. Most died in the civil wars.

5. How have conditions in the camp affected your disability? I lost total independent living. I rely on what I get from the service providers. If certain items are not available, then I accept the situation. Sometimes I even find it hard to go for available services because of my disability. The refugee community is also hostile because they too struggle to survive. I think in such a situation, the strong ones become superior over the weak ones.

6. How is disability regarded by other non-disabled refugees? The non-disabled refugees have mixed feelings on disability. Some are good, respectful and feel sorry. Others are too hostile, abusive and discriminatory. Others empathise and would help you all the time. I don't know, maybe we all share common challenges of life. But the general perception of disability at the refugee camps is not good.

7. How do camp administrators treat you? They have no particular way of preference treating people with disability. All depends on how they approach the issues. Sometimes they treat you badly to protect their jobs.

8. How do you treat other disabled refugees? We talk and laugh together and share times of hardship. We consult each other. We socialise and share our experiences. We cannot afford to treat one another badly.

9. What efforts have been made to address the problems facing disabled refugees? I guess you ask me what efforts have been made to address the problems of people with disabilities. Who cares if we are treated well here? Who cares if we have urgent problems at all? The camp managers stay well at the Dadaab Main Office (DMO). They are well protected. Do you think that the filled stomach will ever care for the hungry stomach? We live by the Grace of God!

10. How adequate are the above efforts according to you? Explain. I think the gap is too wide. The many efforts by both local and international staff and the community attitude to people with disability cannot change the situation on the ground. It would have started long before establishing these camps. Look at the multitude of people with needs. We are now harvesting that poor planning and services that are not effective. So their efforts are lost.

11. What efforts have you made to address your needs and challenges as a disabled refugee? As a disabled mother there is little I would have done. Perhaps my priority now is to protect these little ones. But if the situation is like this, I have no hope of seeing them achieving much. I just struggle to give them basic needs that a desperate mother would afford.

12. What recommendations would you make to refugee agencies and other related institutions that deal with disability and refugee affairs? Let them appreciate our feelings and treat us equally. The services are for all refugees. For example, we all run away from wars and face common hardships. But some organisations favour certain people for resettlement and neglect us disabled mothers because we have disabled children. This is not fair.

13. Have you ever applied for resettlement? Explain what happened. Yes. I submitted my application for protection. After waiting for a long time, I was informed that my case was not qualified for resettlement. I have no good explanation for that.

14. What is your perception of “buiis”? It is a disease that affects those who are insincere. They conceal their true identity so that they are resettled in the developed countries. I cannot hide my disability or worry to hide my disability. I cannot disturb or pressurise myself to think about Buiis.

15. Have you ever experienced “buiis”? Explain. No. I applied for resettlement yes, but once my application was rejected, I shelved the whole story. I lost hope.

Interview carried out on:
18th November 2005
Ifo Disability Centre.