

GUEST EDITORIAL

**EXAMINING FACTORS IMPACTING COMMUNITY BASED
REHABILITATION IN A REFUGEE CAMP - AN EXPLORATORY
CASE STUDY**

Joy Wee*

ABSTRACT

This paper examines factors that impact the ability of refugees within a refugee camp in Kenya to participate in their communities through community-based rehabilitation (CBR). Exploratory case study design was employed. Data triangulation combined observations from teaching encounters, clinics, available reports, individual interviews, and focus groups involving participants from various sectors within the refugee camp.

Themes arising from this study reveal that persons with disability and their families are disadvantaged because of issues relating to distribution systems and physical access, discrimination, security, access to information, and lack of community awareness of the capabilities of persons with disability. The existing emergency mode of operation appears to perpetuate disability. Barriers for persons with disability were reported by all participants from differing sectors in the refugee camp.

Though many barriers exist, CBR seems feasible and ongoing efforts should be encouraged and supported in the refugee camp setting.

INTRODUCTION

There are an estimated 20 - 25 million refugees and internally displaced persons in need of protection (1), largely as a result of war and civil strife, and there are calls for the international community to intervene earlier in complex disasters, with programmes based on sound information (2). The majority of displaced persons come from Somalia, Sudan, Pakistan, Afghanistan, and Iraq, the latter two countries seeing large number of returning refugees in recent years, as external causes of conflict settle. According to the latest statistics,

the largest numbers of asylum claims are made by persons from Myanmar, Somalia, and Serbia/Montenegro, with the majority of Somali applications being lodged in one country, Kenya.

In complex emergencies, characterised by long-lasting administrative, economic, and political social decay and collapse, high levels of violence, ethnic groups at risk of extinction, public health emergencies, internal wars, increased competition for resources between conflicting groups, and displaced populations, vulnerable populations are at greatest risk (3). Where there is conflict, disability is created. The field of rehabilitation developed in response to war-related disability (4), with community based rehabilitation (CBR) having developed in low-resource settings to reach large numbers of persons with disability not living in urban centres (5). CBR is defined by the International Labour Organisation (ILO), United Nations Education, Scientific, and Cultural Organization (UNESCO), and the World Health Organisation (WHO), as a strategy within community development for the rehabilitation, equalisation of opportunities, and social inclusion of all people with disabilities (6). The founding principles of CBR are equality, social justice, solidarity, integration, and dignity for persons with disability (7). The aim is for persons with disability to maximise abilities, and achieve full social integration within communities. It promotes rights of persons with disability to live as equals, and encourages communities to be inclusive (6). CBR is influenced by factors such as economic and social development, cultural and religious beliefs, power relationships within families and in the community (8). CBR engages both professionals and volunteers, often with long-serving volunteers being those who have regular incomes of their own, not being dependent on CBR programmes for their livelihood. Sustainability usually depends upon the ability of local champions and persons with disability to meet regularly and direct local service, educational, and social activities.

In disaster situations, the World Health Organisation has supported CBR approaches for caring for persons with disability; and it is recognised that even in disaster situations, research is required for proper decision-making (9). The situation in Somalia today could be considered a complex emergency, and Somali refugees may well have been exposed to many of the conditions listed above. Since the 1987-1991 Somaliland Liberation war (10), refugees have fled Somalia. After the 1991 conflict, they crossed the border into Dadaab Refugee Camp. Dadaab Refugee camp is located in Kenya, sixty miles from the Somali border, northeast of Nairobi. It covers three locations, separated by around 12 miles: Dagahaley, Ifo, and Hagadera.

Each site has at least 40 000 people. The refugees in it are primarily from Somalia.

A typical refugee camp health system often has a network of health posts, sometimes with home visitors, often resulting in a parallel health system marginally linked to pre-existing services (11). Dadaab is typical in this regard, and is suitable for case study. CARE Kenya, Gesellschaft für Technische Zusammenarbeit (GTZ), and the office of the United Nations High Commissioner for Refugees (UNHCR) work together in Dadaab Refugee camp. Officials at Dadaab Refugee Camp expressed a desire for successful CBR to be established, and had begun some efforts on the ground prior to the initiation of this study. Kijabe Hospital conducts mobile clinics for PWDs in Dadaab, and many persons with disability from Dadaab go to Kijabe Hospital for surgical procedures.

Little is known about volunteer or parental capacity for involvement in refugee camps, where there are many other demands on time. Other pressing concerns may take precedence over providing therapy for a child with disability or assisting persons with disability in achieving maximal independence and gainful employment, particularly as refugee camps face looming food shortages and increasingly stretched resources. In developing a successful CBR programme in the refugee camp, one must explore barriers and facilitating factors to assess feasibility of approach, and to inform programme planning.

The objective of this case study was to explore factors that impact the ability of refugee participants with and without disability to engage in CBR efforts, in order to determine feasibility and recommendations for the CBR in a refugee camp setting.

METHOD

This instrumental, interpretive, exploratory case study of Dadaab Refugee Camp, representing a typical refugee camp, was conducted in collaboration with officials on the ground in July 2006. Case studies contribute uniquely to our knowledge of individual, organisational, social, and political phenomena, according to Yin (12) and are preferred when examining contemporary events, where behaviours cannot be manipulated. Through case study, one can gain a rich picture by using multiple data collection tools (13).

Socio-cultural and physical factors that may influence CBR were explored through community focus groups and individual interviews. Multiple sources of evidence were used, included

records and observations in addition to the interviews and focus groups.

Ethics

Unique methodological problems are encountered in refugee populations, due to community suspicion, high mobility, and status differences; most refugees may never have experienced non-threatening interviews, and may fear future reprisals due to normally accepted procedures such as signing consent forms for research purposes (14). They may be reluctant to take part in interviews. For this reason, and for reasons of high rates of illiteracy, verbal consent has been obtained in some studies after the description of the study being provided (7). In this study, forms were available for literate persons able and willing to sign, in English and in Somali. Use of thumbprints or verbal consent options was offered for those who were illiterate, after verbal explanation of the study through an interpreter. Verbal consent was audio-recorded if desired. Ethics approvals were obtained through the Queen's University and Kijabe Hospital Research Ethics Committees. The protocol, developed in conjunction with collaborators of the organizations involved with persons with disability in Dadaab, was approved by collaborating officials of the UNHCR.

Data collection

Focus groups and potential participants were assembled in each of the three sites with the assistance of the sole rehabilitation professional employed at the refugee camp, in charge of CBR efforts. Composition and demographics of focus groups and individual participants were specified sequentially by the primary investigator, for breadth of representation, as data was collected. Demographic information and the presence of post traumatic stress disorder (PTSD) symptoms, defined as daily nightmares or intrusive thoughts about past violent events, was obtained for focus group participants, as it is well known that this condition may affect refugees in high numbers (15). All forms and questionnaires were translated beforehand into the Somali language. Interpreters were used for participants from minority groups, so that they could converse in their mother tongues.

Structured interviews of persons with disability, parents of children with disability, family members, refugee camp staff, health personnel, and administrative staff were conducted at Kijabe Hospital, a collaborating centre, and in Dadaab Refugee Camp, to determine barriers

to CBR, including personal factors such as symptoms of PTSD. Potential participants, with and without disabilities, were identified by the occupational therapist according to criteria specified, and consent was obtained. Two main open-ended questions used were: 'Discuss barriers facing persons with disabilities and rehabilitation in the camp' and 'What might improve rehabilitation efforts?' Discussion topics for focus groups were determined by periodic review of data as the study progressed, as is typical in exploratory case studies. All interviews and focus groups were conducted through local interpreters in participants' own languages. Observations based on informal interviews of staff, clinical experiences, and field notes on organisational structure, were made by the principle investigator, a practising rehabilitation physician. Available documents and records kept by Kijabe Hospital and Dadaab Refugee Camp organisations regarding persons with disability were reviewed. Reports about the refugee camp and the situation in Somalia were collected over the following 7 months. These methods provided multiple sources of evidence for triangulation and verification. Available resources and caregiver roles were documented. Geographic, socio-cultural, and economic factors were obtained from participants and available reports.

Data analysis

Demographic data is reported, using descriptive statistics. All data was entered onto an Excel® spreadsheet. Qualitative data was described, compiled and coded for individual interviews, focus groups, reports, and observations. Aggregates of data for categorization and relevant meanings were developed. Then the data was combined to identify major emergent themes, where data from two or more sources shared common themes. Key issues and concepts discussed are generalised to theory (12).

RESULTS

A potentially influential unplanned factor was in place at the time of the data collection: for the previous 8 months, the resettlement office had a targeted project concerned with the protection of persons with disability who were affected by issues of insecurity and those who were victims of torture. Care was taken to state that the current project was unrelated to the resettlement project, which may have led to increased interest and participation by persons with disability. The resettlement project came to a close simultaneously with the end of the data gathering of this project.

An environmental audit report of Dadaab Refugee Camp from December 2005 (16) indicated that 97.5% of the refugees in Dadaab were Somalis, primarily from the Darod clan, whose former occupations were primarily as pastoralists, farmers, traders, and civil servants. Though the numbers of men and women were noted as 64,919 and 63,676 respectively, it was acknowledged that numbers were rarely constant. Administrators indicated that refugees are not counted if they have not received either tokens or ration cards, due to a lengthy backlog of application processing.

There were 3 health posts and 1 hospital in each site, one site with a substandard operating theatre that had been erected with temporary intent. One occupational therapist, and 5 CBR workers at each site comprised the CBR staff, all but two of whom were men; one of the women was not present during the data collection period due to personal obligations. CBR workers were refugees who had received some training, and were provided with non-monetary incentives for their efforts. Data from CARE indicated that there were a total of 3776 persons with disability registered in the refugee camp in July 2006. The CBR programme provided refugees with basic therapy and education, and where appropriate, facilitated provision of assistive devices such as wheelchairs, artificial limbs, or gait aids.

With respect to schooling, there existed 17 primary and 3 secondary schools. In addition there were several Islamic schools and adult education centres. Two police posts existed in each of the three sites, and one in the separate administrative hub. Historically, few records of administrative decisions and changes were kept at Dadaab; much of what was shared with respect to historical decisions by non-governmental organisations (NGOs) involved with persons with disability was through oral reports of current staff.

Twenty-two refugee participants, 9 women and 13 men, were interviewed individually, including five able-bodied persons, two of whom were not affected by disability in the family; these were a religious leader and a wheelchair technician. Six were caregivers of children with disability, 2 able-bodied persons had parents with disability, and 11 were persons with disability. The persons with disability included indeterminate gender (1), burn contracture (2), cerebral palsy (2), extremity dysfunction (3), amputee (2), traumatic brain injury (2), blindness (3), deafness (1), polio (2), and age related disability (2). The age range of persons with disability was 1 month to 63 years (mean age 27.5 years 14), and that of interviewees was 19 to 63 years. Adults had arrived in Dadaab Refugee Camp as early as 1991, and as

recently as 2004; four participants had children with disability who were born in the camp. Two participants had deformities that did not affect physical function, yet reported being severely disabled in daily life because of the attitudes towards their deformities.

Of these participants, 10 had received no formal education, 6 received some education at the primary school level, one received some secondary school education, 4 received post-secondary education, and 1 was educated in a religious school. Three refugees came from Ethiopia, and the rest from Somalia. Two did not have relatives in the camp. Economic background (in country of origin) was identified as ‘low income’ by 5, ‘middle income’ by 13, ‘high income’ by 2, and undeclared by 1. One teenage participant had never earned a livelihood. Seven reported having experienced symptoms of post-traumatic stress disorder as described above, and four additional participants reported regularly experiencing negative feelings of fear, sadness, or anxiety.

Table 1. Top daily priorities described by interviewees (number of persons reporting each activity in brackets)

	#1	#2	#3
Able-bodied (n=5)	Work (3); Take children to school (1); Pray (1)	Work (4); Obtain water (1)	Procure food (2); Caregiving (1); Volunteer
PWD(men, n=7)	Work (7)	Procure water (1); additional work (1); Additional study (1); Therapy (1); Housework (2); Leisure (1)	Maintenance (1);Chores/ Procurement (3) Leisure (2)
PWD(women, n=4)	Work (1); Housework (2); Procure water (1)	Housework	Housework (2); Help family (1); Volunteer (1)
Caregivers (men, n=3)	Work (2); Pray (1)	Look for work (1); Pray (1)	Procure food (1); Caregiving (1)

Caregivers (women, n=5)	Procure water/ firewood (2); Work (2); housework (1)	Housework (4); caregiving (1)	Caregiving (2); Procure food/ water (2); Housework (1)
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PWD = persons with disability

Table 1 summarizes what refugee participants reported as their top 3 daily priorities. For the most part, they involved duties to support their families. One participant reported prayer as a top priority. Most ranked work or housework as the top priority, and a close second was procurement of water, firewood, and food. Six participants reported that they could not rely on anyone to assist them if they required assistance.

Nineteen of these 22 indicated that they might be able to assist CBR efforts through the following: provide transportation (2); help people make or repair things (2); teach (3); counsel (6); provide practical assistance (5); share resources (2); mobilize the community and work on changing attitudes (4). However, as one participant described, *'a hand that is helping others gets tired very quickly.'*

Table 2 describes the focus groups that were conducted. Focus group number 2, comprised of refugee camp staff, who identified common impairments they encountered. They identified the most common causes of disability as gunshot wounds and poliomyelitis. Approximately half the disabilities they encountered were due to cerebral palsy, strokes, contractures, amputations, deafness, cognitive and psychological problems, visual impairments, and epilepsy. These were also reflected in the records of the mobile clinics that Kijabe Hospital holds at the refugee camp. Less commonly reported disabilities were related to cleft lip, spina bifida, burns, spinal cord injury, tuberculosis of the spine, muscular dystrophy, hydrocephalus and microcephaly, dwarfism, meningitis, Ricketts, elephantiasis, imperforate anus, those who received circumcisions, vesiculovaginal and rectovaginal fistulae, and albino trait. Of 54 persons with disability participating in focus groups, 21 reported symptoms of ongoing post-traumatic stress disorder (PTSD), while another 19 reported fear and a history of having witnessed violence.

Table 2. Focus group descriptions

Focus Group	Size	Location	Roles of participants
1	2	Kijabe Hospital	Administrators familiar with community based rehabilitation efforts in Kenyan refugee camps
2	8	Hagadera, Dadaab	2 nurses, 1 assistant nurse, CBR assistant, 2 CDWs, 1 health post consultant, 1 CHW coordinator
3	15	Hagadera, Dadaab	9 PWD (1 from minority group), 6 relatives
4	13	Dagahaley, Dadaab	Persons with disabilities
5	4	Dagahaley, Dadaab	2 school officials, 2 CBR workers
6	9	Ifo, Dadaab	PWD
7	8	Ifo, Dadaab	PWD
8	4	Ifo, Dadaab	3 PWD, 1 parent of CWD, minority group
9	9	Dagahaley, Dadaab	Persons with disabilities

CBR=community based rehabilitation
CDW=community development worker
CHW=community health worker
PWD=persons with disability

Observations were made from having conversations with persons with disability during clinics held in each of the three sites, and with various personnel: a clinical officer, a CBR officer, programme managers of CARE, information technology personnel, a community services officer, a resettlement officer, GTZ administrative staff members, a nutritionist, a cook, a nursing supervisor, UNHCR staff, nurses, physicians, a medical coordinator, wheelchair technicians, and in Nairobi, representatives of Handicap International, AfriAfya, The

Association for the Physically Disabled of Kenya (APDK), and CHAS, an ad-hoc group concerned with refugees in Sub-Saharan Africa. In all, 16 reports were reviewed, pertaining to refugee camps in the region, from July 2006 through February 2007. The following themes emerged, common to reports, observations, focus groups, and interviews. Focus groups were helpful in developing a sense of how significant each identified factor was perceived to be in the lives of persons with disability and in impacting CBR efforts.

Emergent themes relating to barriers to CBR

Organisational constraints

From an organisational standpoint, staff participants within NGOs in the refugee camp reported huge budgetary constraints. It is a challenge to fund adequate staff for the needs of persons with disability. Budgets are reportedly determined from year to year, based on available donations, which have declined even as the numbers of refugees flocking to the camp have increased. Ongoing pressures to reduce budgets for Dadaab Refugee Camp are a challenge, and the UNHCR is constantly having to review its mandate in the face of reality. Also, there seemed to be a lack of documentation of meetings, discussion, and decisions made within NGOs, and therefore, limited overall historical organisational memory. When asked about such records, administrative staff indicated that they generally depend on the experiences and memories of those who have been there longer for verbal accounts of past decisions and activities.

Stigma

Discrimination and stigma against persons with disability were reported by persons with disability, able-bodied refugees, and personnel, as the main barrier to the aims of CBR. Verbal abuse was commonplace and experienced daily by many persons with disability. However, physical abuse was also reported by many. Persons with disability from minority groups reported significant difficulties in obtaining appropriate health care, as most personnel were of the majority Somali group, and could not communicate with them. Persons with disability from within these groups report stoning, some on a daily basis, even if they hold positions that are normally respected. Some persons with disability experienced barriers related to cultural practices, such as the expectation of eating with one's right, which may be

impossible for persons with impaired right hand function. Lack of appreciation of the potential of persons with disability to contribute to the refugee community was reported as leading to isolation of, and lack of opportunities for, persons with disability.

Participants reported a history of poor treatment of persons with disability in Somali culture, with some parents not considering schooling for their disabled children, though schooling itself was new to many Somalis, who did not themselves receive formal education in their homeland. Several children reported abuse on the way to school, causing them not to attend school on occasion, and even to abandon schooling after a few months. In situations where teachers punished perpetrators of abuse of individual students with disabilities, revenge-taking was reported. One adult participant reported that her parents did not believe she should attend school as a child, especially when she encountered hostility; children beat her or stoned her; others called her names and made fun of her, '*lay [her] down*' and abused her. One youth with cognitive difficulties was encouraged to use hallucinogens by '*other idle boys,*' and his family reported that '*people beat him.*' Unfortunately, these did not appear to be isolated experiences for persons with disability, according to observations reported by personnel.

At least two reports (17,18), provided by officials, reflected and provided some background to this problem of attitudes, with statistics of '82% very bad, 12% bad, 5% good, and 1% very good' with respect to attitudes (18, page 48). Both reports encouraged the institution of measures to 'help society...assume a kinder, more inclusive, more supportive position in relation to persons who are disabled' (18, page 18). Religious leaders interviewed indicated that such behaviour is not consistent with the religious practices. Religious and elected community official participants indicated that such discriminatory attitudes towards persons with disability must be reduced, and that they would be ready and willing to promote equal treatment of persons with disability.

Social environment

Many participants described a lack of trust in the refugee camp, where tensions between clans and sub-clans are evident. The majority of refugees in Dadaab are Somali. According to many, Somalia has had longstanding conflict and animosity between clans. This continues into the refugee camp. Participants from minority cultural groups (such as Sudanese Ethiopians,

Somali Bantus, Rwandans, Burundians, Ugandans, and Congolese) reported discriminatory attitudes. Businesses owned by persons in such groups are reportedly not frequented by the majority Somalis. Some reported outright discriminatory attitudes related to their minority status. Information sharing does not occur expediently for such groups, and fewer job opportunities are reported. Overall security in the refugee camp was reported as a problem, though this had apparently improved over the years. Female heads of household reported being particularly vulnerable to attacks, due to living arrangements. Many lived in dwellings made of sticks and branches covered with cloth, allowing snakes, scorpions, and other refugees easy entry to cause injury or death.

A clear social hierarchy was observed and reported by participants. Officials in the camp, who worked for the NGOs, were at the top of the hierarchy, and they themselves were organized in clear reporting relationships. After them, seemed to come the Somali religious leaders in the refugee camp, elected community representatives, and successful Somali businesspersons. Refugees with compensable duties, such as health workers and teachers, seemed to be more respected than the average refugee, who might be a pastoralist or labourer. Unemployed able-bodied refugees came next in the hierarchy. Men had more status than women, even between similarly-ranked workers. Married women appeared to be more respected than single women or widows. Adults from minority groups were disadvantaged. Children may be more valued if they do not have physical or psychological ailments. Amongst those with disability, people with physical disabilities were somewhat more respected than those with ‘*mental conditions*,’ for whom absolutely no services were available at the time of the study. Persons with disability fared better if they were able to sustain an occupation that is respected, such as teaching religion, or owning a business, and if they had larger social networks, usually comprised of relatives or clanspersons. Previous helpful programmes such as small credit and loan availability and income generation activities had been discontinued for persons with disability, and offered to more able-bodied refugees, due to high levels of unemployment in the general refugee population. Not surprisingly therefore, poverty was common amongst participants with disability.

Male participants reported receiving higher levels of education, having being encouraged to do so by their parents. This was confirmed by school officials, who indicated that more boys than girls attended school; these differences increased with higher level of education. 2005

UNHCR numbers indicated that about 61% of pre-school and primary school students were male; this percentage was not much different for students enrolled in special education (66% male) or adult literacy classes (65% male). In secondary school, the difference between genders was much more pronounced, with 84.5% of students being male. For those children with disability whose parents encourage schooling, insufficient special education training of teachers was identified as a problem, as were inadequate educational facilities, by caregivers of children with disability and by school officials. Special schooling was readily available for blind and deaf children, but not for children with other disabilities.

Health Care

Health care in Dadaab is shared primarily by two organisations: GTZ and CARE. GTZ assumed the medical role relatively recently, having taken over from Medicin Sans Frontieres. The two organisations have increased collaboration in the past year. There is no unifying medical record system within Dadaab to capture continuity of care. In-patients have charts, which are not necessarily retrieved or added to for very short admissions, while out-patients are provided with slips of paper that can fade, tear, or become lost. Sometimes, there can be a problem with locating specific outpatients based on the limited information of their whereabouts (block number and camp). Outside organisations such as Kijabe Hospital and Kangemi also provide care for Dadaab refugees. Everyone who participated indicated a need for improved training at all levels, particularly because of Dadaab's relative isolation. Though specialist training is supposed to reach both GTZ and CARE workers, there was noticeable under-representation of GTZ workers at the sessions provided during the study period. Also noticeably underrepresented were female workers and those with mobility difficulties (eg. requiring accessible transportation). Also evident was the variability in levels of understanding by CDWs. The ones who had received formal training in Nairobi clearly had a much better grasp of concepts. Some of the training currently provided to community workers can also be beneficial to professional staff of GTZ. Medical staff do try to pre-screen and prioritise patients prior to outreach clinics held by external organisations; however, on the clinic days themselves, there is a breakdown in security, and often patients with unrelated problems crowd at the door. Staff members report that arrangement of travel papers for patients takes a long time. The current lack of feedback with respect to how

persons with disability fare, does not facilitate understanding of roles amongst staff in GTZ and CARE.

Access to information and CBR expertise

Some refugees reported a lack of orientation to the camp upon arrival as being particularly difficult, as it may take a long time for persons with disability, or parents of children with disability to find out about resources. Community leaders are regularly invited to attend informational sessions provided by non-governmental organisations (NGOs), but often do not pass information on to persons with disability, until opportunities are past. Persons with disability complain that their voices are ignored at community meetings, and that community leaders often do not attend to their concerns, particularly voiced at the Dagahaley site, where it was difficult to find leaders to interview, partly because they were campaigning for elections. There are some reports of leaders withholding information from persons with disability, until the opportunities are missed, and their selective informing of community members of any incentives, opportunities, programs, or benefits. They report little opportunity for input into community decisions, and no opportunity to hold influential positions.

Many mentioned the insufficient numbers of CBR workers and inadequate medical or rehabilitative care as barriers to optimal function. At the time of the study, there were fifteen CBR workers for the entire camp, with an approximate ratio of one CBR worker for 300 persons with disability, (assuming that all persons with disability, were registered, which may not be the case, given the observed lack of adequate personnel to conduct door-to-door surveys). There was only one fully trained therapist for the entire refugee camp. Some persons with disability reported never having seen a CBR worker, or if they had been seen, felt that the CBR workers could not offer much, or did not keep their promises of providing assistance. Persons with disability generally wanted specific rehabilitation advice, vocational training, and income generation opportunities.

Participants reported disrepair and a lack of equipment and supplies. The high cost of obtaining such equipment through the common market, if available, was often prohibitive. Lengthy authorisation and ordering processes, and challenging logistics for procuring materials were reported by staff. Supplies that arrive from Nairobi may not be what are required. Staff

reported that when appropriate supplies come in, they are quickly distributed. A lack of adequate storage facilities limited bulk ordering.

Many organizations in Kenya have the expertise to contribute to CBR in Dadaab, though they all indicate that such efforts are dependent on funding by the UNHCR. For example, the Association for the Physically Disabled of Kenya (APDK) has expertise in many areas from acute to community rehabilitation, while Handicap International and AfriAfya have expertise in advocacy and community education. Some organisations already provide outreach, but participants indicated that stronger linkages with local hospitals could be developed.

The list of persons with disability held by CARE had only 3776 persons listed for the month of July, 2006. This represented an estimate of less than 3% of the population, well below expectations. In fact, at the clinics held during the study period, many unregistered persons with disability were seen; this under-representation may be related to a lack of sufficient personnel.

Physical environment and access

The challenging sandy terrain, large distances between sites, and warm climate were also viewed as barriers to community participation for persons with disability. However, multi-storey buildings are rare (only one existed at the time of the data collection). Another issue concerning access is the distance some are required to travel to access services, coupled with the lack of affordable or available transportation. Access at food and fuel distribution centres was poor for persons with disability, who are often unable to enter through usual entrances and are disadvantaged in queues for rations. This, along with distances of water supply stations and of procuring water, obliges many persons with disability to rely on others to obtain their rations and necessary supplies. Many reported that they are sometimes taken advantage of by others, having their rations absconded. For some persons with disability, it was observed that physically accessing the hospital took weeks, and only occurred when neighbours decided to bring them in personally rather than waiting for months for medical issues to be addressed through usual channels of access. Environmental access within schools is also poor for children with disability, with a lack of appropriate toilet facilities, educational assistants, and supervision. Additionally, no emergency planning for persons with disability seemed to be evident, according to those who reported being left to fend for themselves in a

large fire in one of the sites in 2004.

Rations and financial support

An observation of the refugee population at Dadaab was the varying degrees of wealth existing within the camp, yet the level of support from UNHCR is fixed for each refugee who obtains a ration card. Apparently, refugees who did not need their rations would sell them off in exchange for cash. Such diversion of needed rations to those who do not use them remains a drain on the finances of the NGOs involved.

A micro-credit programme previously available to persons with disability had been redirected several years earlier towards the able-bodied unemployed populations by the responsible NGO, with the reason being that there were too many unemployed able-bodied refugees in the camp. Refugee camp officials also encourage use of a Group Savings and Loans programme, which depends upon wealthier refugees lending money to the group. Participants reported that the Somali community is not accepting of loans with interest charges associated with them, as it goes against their religion, and some respondents indicated the low likelihood of finding loans from within the refugee community itself, as persons with disability are themselves among the poorest refugees, and non-disabled persons are liable to be considered foolish risk-takers if they lend money to persons with disability.

Potential solutions offered to overcome barriers

The majority of participants indicated that they would be able to assist in supporting CBR in some way, though training and compensation for effort would be required. Participants offered various suggestions to improve integration and life for persons with disability. Some suggestions related to organizational aspects, such as support programmes and improved security, while others related to fostering values of sharing and compassion within the larger community: '*stop segregating, stop stoning, share community resources.*' Some suggested that profits from income generation should be shared equally, and that the most dependent persons might be afforded jobs most appropriate for them, according to their abilities. Community education was thought important to change attitudes of the general public and parents of children with disability. Proper assessment and rehabilitative care, and supports in the form of accessible

housing, services, training and empowerment of persons with disability were advocated. Disabled persons' groups were felt to be important for empowerment, and they do exist in the camp. However, a reported lack of resources was a problem for them to effectively achieve community change.

DISCUSSION

There are over 18 million refugees in the world, and literature devoted to the assessment of their health needs is growing (19). The objective of this case study was to explore factors that impact the ability of refugee participants with and without disability to engage in community based rehabilitation (CBR) efforts, in order to inform feasibility of the CBR approach for persons with disability in such a setting. CBR programmes have been pursued in low-income countries to address the needs of persons with disability. For example, CBR programmes in Kenya have been initiated by the Ministry of Health, American Medical and Research Foundation (AMREF), The Association for the Physically Disabled of Kenya (APDK), the Anglican Church in the Diocese of Eldoret, International Rescue Committee and CARE Kenya. Programmes exist in Nairobi, Mombassa, Eldoret-Kitale, Kisumu, Nyahururu, and Nakuru. Little is known about factors affecting CBR in refugee camp settings, and it is important to understand these in order to provide programmes and structure that minimize the disparity between refugees with disabilities and able-bodied refugees.

In Africa, there are different conceptualisations of CBR (20). One is that CBR has always existed in Africa with the historical lack of services. A second is that CBR is simplified rehabilitation. A third is that CBR is an outreach model of professional services. A fourth links both rehabilitation services with education, grassroots organisations, and income generation activities. A fifth puts control directly in the hands of persons with disability in mobilising community support. The concept that most closely fits with the CBR envisioned by participants in this study is the one which links services with education, grassroots organizations, and income generation. This seemed to be consistent both in refugee and non-refugee participants. However, the other conceptualisations also apply, as the setting is affected by lack of services, need for simplified rehabilitation and outreach from other organisations to the refugee camp, and a unified expressed desire by participants in all sectors to empower persons with disability within the refugee camp.

This case study revealed that the refugee camp situation can extend into a settlement situation, as this one has, particularly given circumstances of prolonged complex emergencies (3), as in the case of present day Somalia. This particular refugee camp had been established in 1991. This observation is supported by reports from other refugee camps, describing them more as settlements and cities rather than camps, with complex economies (21), consistent with participant descriptions of procurement of goods and services in this study. Therefore, services planned should be appropriate for a settlement, rather than for a temporary, emergency situation. The data revealed that some disabilities are caused by the limited focus on emergency medical care, and under-emphasis on prevention of medical complications and disability within the medical system. In fact, further health-related problems may arise if health system planning remains at a short-term emergency phase and refugees continue to remain for years (22). Stronger ties with the Ministry of Health in providing care for persons with disability through Garissa District Hospital could facilitate links with APDK, which works closely with the Ministry, and has links to all organisations concerned with CBR.

One major drawback in planning is the yearly budgetary cycle currently in practice, leading to mass firing and re-hiring according to the available budget. With this high turnover of staff, written records of decisions taken by all implementing organisations could be beneficial in providing a historical record of key decisions, and to enable evaluation of failures and successes. Five-year and 10-year plans may be helpful in providing more effective health services and programmes within the refugee camp, even if the budget is unknown from year to year, to shift the approach further towards development and capacity building, as the likelihood is that this emerging settlement will continue to exist for at least another 10 years. The need to search for solutions to protracted refugee situations has been recognised (23). This may need dedicated people to engage in fund-raising and liaisons with other organisations such as international disabled persons' organizations and funding agencies around the world. Some might argue that this may lead to a protracted refugee camp situation, which is not desirable; however, until the source of conflict is resolved, refugees will continue to leave areas of conflict. Overall, better collaboration and coordination between NGOs involved in supporting CBR was recommended.

Whether or not there exists a collective sense of community in the refugee camp is questioned, as there appeared to exist several non-interacting groups of refugees and non-refugee

personnel, and participants reported a general atmosphere of distrust amongst neighbours in the refugee camp, stemming from historical clanism and tribalism, which may be difficult to change. Improved security through the years has likely helped, as may the system of community leadership instituted for each geographic region within the camp. Fostering of responsible community leaders needs to be a focus of intervention; these leaders should be encouraged to consider the needs of persons with disability, as they are also constituents of their communities. Orientation of community leaders to principles of equality, and governance responsibilities of leadership in community development, and the responsibilities of refugees to live under the laws of the host country may be helpful. Where possible, involvement of persons with disability in community decision-making would be beneficial.

The two most common causes of disabilities reported in the refugee camp were violence and infection. As an example, based on observations in clinical care, some children with cerebral palsy were not born with this condition; rather, they developed it after febrile illnesses sustained during early childhood. Prolonged fever can and should be prevented in this modern age, as antipyretic medications are generally affordable and readily available throughout the world. Implementation of prevention in this situation would require some coordination of education and supply within the refugee camp.

Everyone who participated indicated a need for improved training at all levels, particularly because of Dadaab's relative isolation. When specialists come in to provide clinics and teaching, having them transfer knowledge to as many health care providers as possible would maximize use of this resource. Improved access to educational resources was desired. In particular, education of health professionals with respect to preventing and managing disabilities, and better coordination of health care amongst all health sectors was advised, along with increased focus on managing chronic conditions rather than maintaining a narrow focus on emergency care. Better communication about patient care and outcomes was desired by various members of the health sector. Rehabilitation services and education would require that adequate numbers of personnel be retained to meet the needs of persons with disability and their families. Support services should be offered to persons and families affected by more severe disabilities.

The background of violence and trauma also has an impact on this refugee population, as evidenced by the numbers of participants who reported symptoms consistent with post-

traumatic stress disorder (PTSD). Jaranson et al. (15) reported that Somali refugees living in the U.S. who had been tortured had a much higher incidence of PTSD (44% of his refugee population met criteria for torture exposure). Trauma of dislocation may lead to increased incidence of depression and anxiety disorders: It is known that many refugees who have been victims of torture demonstrate signs of post-traumatic stress (24). Literature indicates that certain factors have been found to impact upon people's anxiety state. These include personal or structural religion, which seems to have a protective factor, while caring for elderly or sick seems to cause more anxiety and stress (25). Therefore, caregivers of persons with disability in this refugee camp are likely to suffer from disorders that may make it difficult for them to contribute to CBR efforts, and they may benefit from psychological support themselves.

Parental role in provision of rehabilitation has increased in more economically advantaged nations, but evidence regarding its effectiveness has been limited (26). In neighbouring Uganda, parent groups have played a role in improving care for children with disability (27). Are parents willing, and able, to offer individual therapy sessions for their children, and how does this impact upon their parental roles? In this case study, some parents were willing and able to assist in the rehabilitation of their children, but at a cost, in terms of not being able to spend time working, or in procuring rations. They have to balance the needs of survival with the needs of their children. Other participants who were parents did express a willingness to help their children with disability with therapies, but they also noted needs for assistance, such as in procuring water and food rations, given the limited time available in a day. Single female heads of household particularly reported being overwhelmed with responsibilities and concerns, and may warrant particular assistance. In some countries, there is a difference in parental health-seeking behavior depending upon gender of the child (28). In this case study, participants did report that boys are favoured with respect to parental advocacy for their education or care. Implementers of CBR should take these values into account and try to provide more support where it is needed. They should also familiarise themselves with issues regarding violence against disabled children (29), which was a serious concern in this setting. Refugees with larger support systems indicated they could help others besides members of their own family, though would expect compensation. Thus, parental participation may be possible, if encouraged and supported by the refugee camp and the general refugee population.

Also clear, is the societal role in creation of disability. It was observed in this case study that though some persons had no physical impairment, they were also disadvantaged in the refugee camp when it came to obtaining employment, due to stigma and discrimination. For example, persons of albino coloration have no physical impairments, and yet are reportedly considered disabled in this culture, because of their physical differences. Discriminatory attitudes can become ingrained into the psyche of persons with disability, as evidenced by some individuals interviewed, in the form of learned helplessness. Such dependency has also been noted by NGO personnel, amongst many of the general refugee population because of the reliance on NGO rations. Involvement of the religious leaders may be beneficial, according to some participants, as such attitudes are not in keeping with the religion of the majority of refugees.

Physical access is a common challenge for persons with disability, and refugee camps are no exception. All public places such as schools, libraries, community centres, distribution centres, and agency buildings should be made accessible, with the elimination of steps and thresholds.

For persons who are not independently mobile, and sole caregivers of such persons, food and ration delivery systems could be developed as community access is being improved (eg. paved pathways).

People from all backgrounds, including religious and community leaders, seemed to agree that CBR efforts need to be improved in the refugee camp. Adequate organisational support for groups of persons with disability is needed, with an emphasis on improving awareness regarding disability issues in the general refugee population. Hierarchical power relations and social structures within refugee camps could be employed in efforts to improve societal attitudes towards persons with disability. Groups of persons with disability indicated that if provided basic tools for organization, they could possibly be enabled to mobilise the community with respect to disability awareness. However, because of the circumstances of refugees, initial support would apparently need to be provided by the organisations responsible for running refugee camps. Therefore, decisions and commitment to CBR would be required at administrative levels. Sustainability of individual efforts to help would apparently depend on appropriate compensation for provision of such assistance. Essentially, these boil down to prioritisation, organisation, collaboration, and funding. Such expectations from refugees, of NGOs running the refugee camp could reflect the so-called 'dependency syndrome' that is

‘said to occur when refugees accept handouts without taking initiatives to attain self-sufficiency’ (30).

The themes arising out of this case study were similar to themes identified in a systematic synthesis of CBR policy and planning, namely management, government, training, funding, collaborating organisations, community involvement, documentation, organisational development and expansion (31), indicating that CBR in refugee camps involve similar issues, and may require similar approaches to implementation of CBR elsewhere.

Limitations of this study include the selection of participants, which necessarily depended upon staff identification of potential participants, both for individual interviews, and focus groups. However, participants seemed quite free in sharing of their views and experiences, including negative aspects of the refugee camp. If there was bias in choosing participants, it was not obvious, given the many aspects for improvement that were identified for personnel to work on. It is possible that the experiences of more severely disabled persons were not reflected in the data.

Case study as a research method can play an important role in examining complex processes that organisations employ, and provide information about effectiveness of initiatives (32). Though case studies cannot be generalised to entire populations, they are generalisable to theory (33). This study has identified factors that impact upon CBR in a refugee camp, and identifies similar themes to those of CBR in other settings, though some differences include focus on emergency care; involving NGOs in the definition of “community”; and a paucity of resources and long-term planning ability.

*Address for correspondence

Providence Care, St. Mary’s of the Lake Hospital Site
Kingston, Ontario, Canada. K7L 5A2
weej@queensu.ca

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Declaration of interest

The author reports no conflicts of interest. The author alone is responsible for the content and writing of the paper.

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