

***A Cry for Life:***  
***Understanding the Risk Factors***  
**Somali Pastoral Women face**  
**In Northern Kenya**

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## **ABSTRACT**

### ***A CRY FOR LIFE: UNDERSTANDING THE RISK FACTORS SOMALI PASTORAL WOMEN FACE IN NORTHERN KENYA***

How is violence defined in Somalia? and for what purpose? What is considered 'violent action' and what not? To what extent is gendered violence present in East Africa and even tolerated? What about cultural justifications for conflict and conflict-related crimes? How does a *just-war mentality* manifest itself in Somalia and help us understand the factual contingencies involved in moral judgments about violent conduct and war decisions? How is conflict resolved locally and to what is the role of traditional governance, which is diminishing? How measurable is the human face of grief and suffering in conflict, which is almost always female?

This paper seeks to examine the health status and risk factors Somali pastoralist women in Northern Kenya encounter. Although the proposal is broad in scope, its central objective is to document, study and analyse the circumstances under which these women are surviving within the confinement and vulnerability of social and political factors. The paper undertakes to describe the specific experiences of Somali pastoralist and internally displaced women as well as the impact of life-threatening factors such as violence, conflict and displacement on their health and sources of livelihood. In so doing, this research hopes to understand the complex medical configuration systems that these women are dependent on for their health and healing needs, including traditional medicine in times of insecurity as defence mechanisms.

Some of the methods it intends to use are; groups discussions, participant observation techniques and open-ended interviews. The conceptual framework of this paper serves to highlight some of the relationships that may exist between the general health status and latent risk factors pastoral women face. The use of statistical analysis will determine if there are significant associations between certain health status indicators and factors such as age, ethnicity, geographic location, nutrition, lifestyle factors, socio-economic status, use of preventive health care and the physical environment. The data will be captured from respondents by use of questionnaires and later analysed by use of the Statistical Program for Social Sciences (SPSS). It should then be possible to see which factors influence these women most in their daily struggle to stay well and healthy.

This paper is an integral part of an on going post-doctoral research which will be conducted in northern Kenya and will convene in the period January – April of 2006. The research will be executed under the kind supervision, affiliation and auspices of the Intermediate Technology Development Group (ITDG) and the African Medical and Research Foundation (AMREF Flying Doctors), both operating in northern Kenya.

*Key words: health, pastoralist women, IKS, ethnicity, conflict and violence, gender and vulnerability, East Africa*

## **CHAPTER 1: INTRODUCTION**

This paper seeks to examine the health status<sup>1</sup> and risk factors pastoralist women in Northern Kenya face. Although the proposal is broad in scope, its central objective is to document, study and analyse the circumstances under which these women are surviving within the confinement and vulnerability of social and political factors. The paper undertakes to describe the specific experiences of pastoralist and internally displaced women as well as the impact of life-threatening factors such as violence, conflict and displacement on their health and livelihoods sources, using the ethno-systems approach as a framework and fundament for the methodology and fieldwork. In so doing this research hopes to understand the complex medical configuration systems that these women are dependent on for their health and healing needs, including traditional medicine.

### **1.1. Background information: Mandera**

Mandera (see Map 1. in appendix) is a district in the North Eastern Province of Kenya with a population of some 400,000 people (census report - 1999). Somali people largely inhabit the region. The district is located at the far tip of northern Kenya, a point where borderlines of Kenya, Somalia and Ethiopia merge. Geographically, Mandera is isolated from the rest of the country, with no accessible roads. Its harsh climatic conditions, lack of rains and poor water resources denied agricultural activities which the rest of the country enjoys. According to Nadifa Osman (2004:14), these and many other factors render the region economically and socially disadvantaged in comparison to the larger eastern Africa.

Osman further articulates the harsh realities the communities in Mandera are suffering such as long standing droughts, violence and famine. According to her, government resources are mismanaged and bureaucratic ineptitude is causing the entire situation to go unattended. And whether it is by default or design, the region is neglected by its own government and by extension the rest of the world. On education for instance, schools in the region have been unable to qualify students to proceed to universities. Of all the 6 major universities in Kenya with almost a student capacity of 100,000, there were only 25 students from North Eastern Province. Among the 25 students, none of them were in the sciences. There were only 2 girls among the 25 students (pp.23).<sup>2</sup>

### **1.2. Background Information: Somalia and the Refugee Situation**

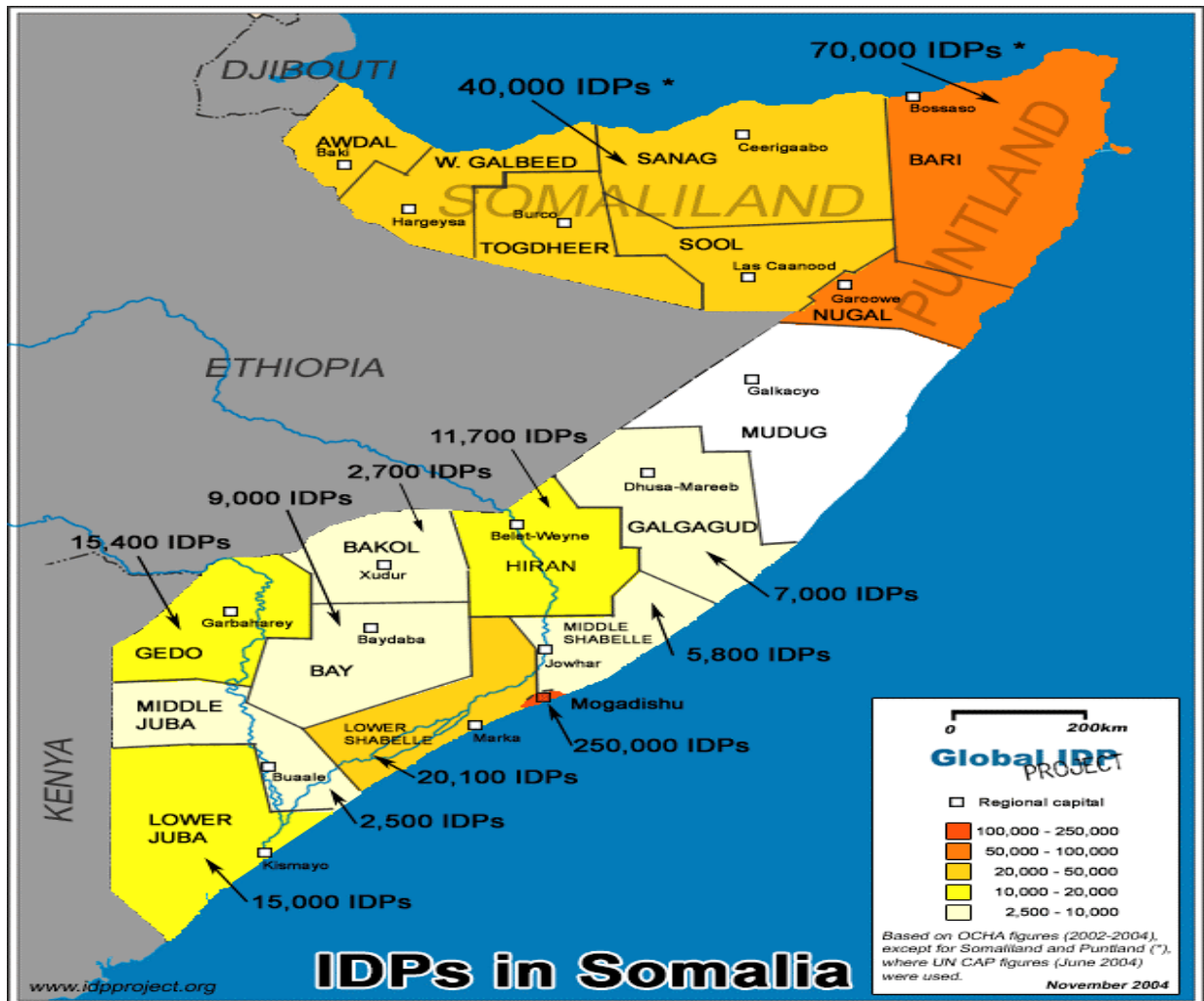
Somalia is located in the eastern side of the Horn of Africa, covering a total land area of some 637, 540 square kilometres (UNDP, 1998). Somalia ranks among the poorest and one of the least educated countries in Sub-Saharan Africa in the UNDP Development Report. Somalis are considered to be culturally, linguistically and religiously a homogeneous people. They share the same language, the same religion (Islam), a common culture and traditions based primarily on pastoral nomadism. However, they are divided along clan lines, and have segmented themselves into a hierarchical system of patrilineal descent groups. For decades, various clans and sub-clans engaged in brutal conflicts for dominance of the political arena. In January 1991, the oppositional forces of which were constituted these clans and sub-clans succeeded in bringing an end to 21 years of dictatorial rule of the then president, Siad Barre. This task was not free from bloodshed and destruction. People, including women and children, were killed in the crossfire, and many

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<sup>1</sup> WHO defines health as “A complete state of mental, physical, and social well-being and not merely the absence of disease or disability” (WHO, 1998). Although some criticize this definition as being unattainable, it is used in this document to represent the ultimate goal of health and human development and goes beyond the biomedical.

<sup>2</sup> Nadifa Osman. 2004. Fellowship Report, A Visit to Mandera. Generation for Change and Growth, University of Minnesota, USA.

were also targeted in order to “cleanse” certain clans.<sup>3</sup> When the opposition groups succeeded in ousting Barre, they faced a major task in forming a new government in the midst of displacement, looting, killings and physical destruction. Friction soon arose among the opposition groups over which clan should govern Somalia. This led to the collapse of the Somali state, total anarchy, a power struggle and clan conflict in many parts of Somalia.<sup>4</sup>



Map 2. Map showing internally displaced peoples (IDPs) in Somalia ([www.undp.org](http://www.undp.org))

According to the United Nations, the civil war in Somalia brought “...more bitter rivalries between numerous faction groups based on *clan* who are engaged in power struggles” (UN Chronicle, 1999, p.12). The civil war in Somalia led to widespread *death*, *destruction* and starvation, forcing almost three million Somalis to flee and seek refuge in neighbouring countries. About a quarter went to Kenya, Djibouti, Ethiopia and Yemen for emergency *humanitarian* assistance. It was also estimated that almost 4.5 million people, almost half of Somalia’s population, were threatened by severe *malnutrition* and *violence*. In addition to deaths and *starvation* caused by the civil war between various groups, Somalia was stricken by *famine*,

<sup>3</sup> Regan Richard J. 1996. *Just War: Principles and Cases*. Catholic University of America Press. USA

<sup>4</sup> <http://www.unhcr.ch/html/menu3/b/62.htm>

caused by *drought* and *insecurity*. Humanitarian aid was a source of power for militia groups, and many vulnerable groups died needlessly because they could not access the food aid destined for them.<sup>5</sup>

## **CHAPTER 2: THE ISSUE AT HAND: VIOLENT CONFLICT, HEALTH AND VULNERABILITY IN MANDERA**

### **2.1. CONFLICT AND VIOLENCE IN MANDERA**

*“We are excluded! We don’t want to die, nobody wants to die.  
The only option we have is to compete with one another for resources”  
(Sago Bargal, Ethiopian, during the 2005  
“Rain, Prosperity and Peace” Livestock herders meeting, Turim, Ethiopia)*

As the above emotional citation shows, pastoralists in east Africa fight to compete against each other for the little resources they have left to share. Conflicts involving pastoralists are often associated with resource competition, cattle rustling and the wide availability of small arms is widespread and of increasing concern. This paragraph provides a useful case to examine in-depth factors which contributing to conflict and issues and priorities for conflict prevention.

First of all, any comprehensive analysis of violence should begin by defining the various forms of violence in such a way as to facilitate their scientific measurement. There are many possible ways to define violence. The World Health Organization defines violence as:

*The intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation on individuals, communities and society at large” ([www.who.org](http://www.who.org)).*

Why is there much violence and hatred among pastoralists in East Africa? And is the clash really about resources or are there other factors that also play equal roles? And would it be accurate to assume what the theories say; that when people have been exposed to violence for a long time, the chance is big that they will see violence as ‘a way of life’ the only language of ‘resolving’ conflict. One would be inclined to make that correlation. But how is violence defined in east Africa? What are considered violent actions and what not and how are these culturally justified? Where does one draw the line?

And what are the causes of conflict in Mandera and what are the moral limits of war conduct and the moral problem of using *threat* against women and girls *as political instruments*.

#### **2.1.1. Factors Contributing to Violent Conflict in Northern Kenya**

Pastoral communities in Kenya and elsewhere in the world face difficult circumstances. They commonly lack vital infrastructure such as adequate roads, schools, markets, and health facilities. Pastoralists are isolated due to poor economic integration with their national economies, and their difficult circumstances are exacerbated by conflict from within and outside of their communities.

In a research carried out by Mohamoud Adan of Intermediate Technology Development Group (ITDG)<sup>6</sup>, the patterns of conflict in northern Kenya are complex and there are many factors that

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<sup>5</sup> US Committee for Refugees (USCR). 1989. *Somalia, World Refugee Survey*. Washington. USA

contribute to the risk of violent conflict involving pastoralists, as they have tended to become mutually reinforcing (Jamal: 1997). Some conflicts within and between pastoralist communities, such as raiding and cattle rustling have a long history and have to some extent become an aspect of traditional pastoralist culture. Aden further goes on to say, that such 'traditional' conflicts have become increasingly destructive and less manageable (pp. 17). In this report the major causes of conflict mentioned among the pastoralist include;

- ◆ Limitations to intensified cattle rustling and production of illicit arms,
- ◆ Inadequate policing and inadequate state security arrangements,
- ◆ Diminishing role of traditional governance systems,
- ◆ Competition over control and access to natural resources such as pasture and water, land issues between the pastoralists and political incitements
- ◆ Clan warfare
- ◆ Increasing levels of poverty and idleness amongst the youth
- ◆ The flow of refugees into northern Kenya

Additionally, the recent killing of some 60 people in August of 2004 in northern Kenya's Marsabit district demonstrated a frequent pattern of conflict between communities living in arid areas over *scarce resources and inter-communal animosity* exacerbated by *political rivalry*.<sup>7</sup> In July of 2005, hundreds of armed raiders believed to have been members of the Borana ethnic group attacked villages inhabited by the Gabra community in the Turbi area of Marsabit, near the Kenya-Ethiopia border. Some 170 people were killed, including 32 children. At least 7,000 people fled their homes following that raid. Furthermore, in similar incidents, dozens of people were killed and thousands displaced around the Kenya-Somalia border between January and March of 2005 in clashes between two Somali clans, the Murule and the Garre.<sup>8</sup>

According to Abdul Ibrahim Haro, coordinator of the Conflict and Disaster Project in the Eastern Africa office of the Intermediate Technology Development Group (ITDG), competition for resources among Somali clans around the Kenya-Somalia border had also caused recent feuds between the Garre and the Murule clans in Mandera. The resources include *pasture*, water and *business opportunities*. Furthermore, the demarcation of parliamentary constituencies in Kenya's north-eastern Mandera district has also had the effect of dividing the pastoral communities along clan lines, creating animosity among people who might have shared grazing land before the delineation of political boundaries. Across the pastoralist world, conflicts with others over land, boundaries, traditional routes and government policies play out in a myriad different ways. But when conflict turns inwards, its violence seems to the outsider like a self-inflicted wound.

This is particularly true in East Africa where levels of raiding and retaliation between pastoralists have spiralled out of control and levels of fear and mistrust are so high that it seems impossible to find solutions that last. Meanwhile, Kenyan authorities announced just last month, the closure of the country's border with Somalia after Marehan militia crossed the frontier in two separate incidents during which they killed one person and stole 39 head of cattle from Mandera district. The conflict between the Borana and the Gabra communities in Marsabit should also be seen in

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<sup>6</sup> Ruto Pkalya & Mohamud Adan & Isabella Masinde: 2003. *Conflict in Northern Kenya A Focus on the Internally Displaced Conflict Victims in Northern Kenya*. ITDG, Kenya.

<sup>7</sup> Central Bureau of Statistics, Ministry of Planning and National Development, Government of Kenya (accessed October 8, 2004); available from <http://www.cbs.go.ke>

<sup>8</sup> [www.africaonline.com/kenya](http://www.africaonline.com/kenya)

the same light - *rivalry over resources, accentuated by local politics*. The Borana, Burji, Gabra, Rendile, Samburu and Turkana communities inhabit Marsabit district (idem).

### **2.1.2 Assessing the Health Risk Factors Pastoral Women Face in Times of Conflict**

Violent conflicts have very negative and severe impacts on the communities that are involved in these conflicts.<sup>9</sup> This literature study highlights several consequences of violent conflicts, which are negatively impacting on the community under focus. Loss of human life, property, displacements of large segments of the communities, disruption of socio-economic activities and livelihoods, increased violence between communities, have a negative impact on the health of women in general and *especially* on nomadic pastoral women. The reasons for pastoral women's greater vulnerability are not only physical *but also social*. During natural disasters, conflict or displacement, pastoralist women's physical and social vulnerability increases. Also, the fact that women bear children exposes them to a range of potential problems that men do not experience, such as,<sup>10</sup>

- ◆ Stress and malnutrition endangering the health of pregnant and lactating pastoralist women and their children
- ◆ The extended network of family support during pregnancy and lactation is lost
- ◆ Traumatized pastoralist women may have no practical or emotional support
- ◆ Young, single, widowed or disabled pastoralist women may be at particular risk of sexual violence
- ◆ The breakdown of family and social networks can force many young girls, running women-headed households, to offer sex in exchange for food, shelter or protection
- ◆ Women's authority to control their own reproductive lives may be eroded by the social changes associated with conflict and displacement
- ◆ Women may be pressured to become pregnant to replace the depleted population
- ◆ Access to health care facilities that meet reproductive health care needs is often lacking
- ◆ Discrimination against women in general in education, employment and social status
- ◆ Laws that reinforce women's economic dependence on men, including for economic survival.<sup>11</sup>

In the absence of a well-functioning health surveillance system, current and reliable data is essentially non-existent. The literature I am reading for this study and for this specific theme date back to the 80's and 90's. While exact rates of maternal and infant morbidity and mortality are unknown, there is a general consensus that Somalia experiences some of the worst health outcomes in the world, with an average life expectancy estimated at 47 years and a high maternal mortality ratio births. Basic reproductive health needs such as personal hygiene; safe delivery; pre and post-natal care; treatment for complications of pregnancy, delivery and post-partum period; family planning information and services; and prevention and management of STDs including HIV/AIDS, are areas that are very poorly explored and underrepresented.<sup>12</sup>

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<sup>9</sup> Cook, Rebecca J. 2003. *Reproductive health and human rights: integrating medicine, ethics, and law*. Oxford University Press. Oxford.

<sup>10</sup> Sherr, Lorraine / Wiley / 2000, *Women, Health and the Mind*, Chicago Press, USA

<sup>11</sup> Prof Joop T.V.M. de Jong, *Mental Health, Trauma and Culture*, Amsterdam

<sup>12</sup> Bitar D, 1992. *Reproductive health in refugee situations: review of existing reproductive health indicators*, Geneva: United Nations High Commissioner for Refugees (UNHCR).

Furthermore, like most women throughout the world, Somali refugee women encounter dangers in pregnancy and childbirth. Infants born to Somali refugees also face risks. However, the general assumption that refugee status worsens the risks and outcomes of pregnancy is supported by the data found in literature. A study in Chile examined the relationship between pregnancy complications (including premature rupture of membranes, pre-term contractions and haemorrhage) and the socio-political violence (such as bomb threats, military presence and demonstrations) that occurred regularly in the border region of Chile from 1985 to 1989. Although the study did not focus on the Somali displaced population, the effects of exposure to ongoing violence is relevant to conflict situations. After controlling for potential confounding variables, the researchers found that women who lived in neighbourhoods with high levels of violence were *five times* as likely as those who lived in areas with low levels of violence to experience pregnancy complications.<sup>13</sup> The primary explanation extended for good pregnancy outcomes among refugees is the availability and use of health services.

The Somali refugee situation in northern Kenya can provide insights into the refugee aid regime, its exclusion of women in policy and the connection between Pastoralism and Development. The Somali pastoral crisis is very much a Somali women's issue due to simple facts:

- ◆ Somali women are the majority of the refugee population,
- ◆ As the majority, Somali women bear the burden in the refugee's struggle for survival, and
- ◆ Despite being the majority, Somali women are rarely consulted and / or included by the relief agencies in the policies that affect their lives.
- ◆ Due to Cultural reasons, Somali women face a lot of hardships, as they are seen inferior to men. Somali girls, from a young age are told and taught to be good housewives and their bringing up is tilted to this direction. During conflict or wars Somali women find themselves without skills, not able to read and to do enterprise.<sup>14</sup>

The pastoral literature and pastoral assistance agencies often portray pastoralists (especially women) as victims and as being extremely vulnerable. While there might be some truth in that, the result of this belief is that they are largely excluded from policy development and implementation of refugee assistance programs, as vulnerability is seen as potential danger. The important role which they play in the pastoral communities' survival is ignored.<sup>15</sup>

## **2.2. THE HEALTH OF PASTORAL WOMEN AND SOCIAL POLICY**

Although no systematic study has been carried out on the health status and risk factors pastoralists face in northern Kenya, women are known to make up a significant proportion of the people most affected by conflict and disastrous social policies. Owing to the fact that health services is rather problematic and in short supply in the region, these women opt to make use of traditional medicine. This is culturally determined with tuberculosis and malnutrition as the main problems in Mandera. Modern health care is very limited and a traditional system of birth attendants, herbalists, bonesetters and spiritual healers still prevails.

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<sup>13</sup> Olila S, Igras S and Monahan B, *Assessment report: issues and responses to sexual violence, Dadaab refugee camps, Kenya*, 16-23 Oct. 1998, Nairobi, Kenya, and Atlanta, GA, USA: CARE.

<sup>14</sup> Shukria Abdirahman Dini. 2001. *A decade of Libo; Perpetuated Dependency, The Burden of Displacement and Untapped promise of Somali Refuge Women in the Dadaab refugee Camps of Kenya*. York University press, Canada.

<sup>15</sup> Refugee Community Building Conference proceedings. June 27 2004. Marriott Hotel Session: *Somali Bantu Resettlement in Kenya*. Nairobi, Kenya.



As a result of the conflict and health problem, the Kenyan government through the provincial administration has deployed extra security personnel in the area to 'keep peace' and 'keep the warring parties apart'. The district commissioner then moved to the affected areas to reassure the community and build confidence. His arrival, conversely, was greeted with much suspicion, doubt and mistrust.

On the international level, the Kenyan and Ethiopian presidents have met to map out strategies for cross border security cooperation and curbing of small arms trafficking. The Kenyan government faces a lot of criticism as it recently announced the closure of its borders. Also Kenya's low paced assistance against environmental disasters, sparked more tension between Somalis and Kenyans.<sup>16</sup> It is important to understand that the conflict in northern Kenya is not between Somalis, but also between Kenyans and Somalis, and Somalis and Ethiopian pastoralists. An example of environmental degradation is rainfall seasonality. Rainfall seasonality affects forage availability, livestock production and ultimately the livelihoods of the people.

Information on agricultural food production and livestock production, women's diet intake and health status as well as nutritional status can be collected. The information can then be used in the project to effect changes in policy, management, economic or ecological conditions. For example, if policy or management decisions suggest an increase or decrease in the flow of income or food energy, we can, based on the current nutritional status indicators, suggest the impact of these decisions on human welfare and food security by sex and age.

Human-environment interactions are iterative processes and for various reasons pastoralists are associated with climate dangers and as vulnerable people as they are at a high risk of negative outcomes as a result of climatic events that overwhelm the adaptations they have in place. Vulnerability to environmental changes and social insecurity occurs due to variation in frequency or duration of those changes or because people are constrained economically, socially or politically from responding adequately to those changes.<sup>17</sup>

### **2.2.1 Reproductive Health as a Human Right**

Reproductive and sexual health is central to what it means to be human and is of critical importance at an individual, societal and global level. Whilst the importance of reproductive health is being increasingly recognised, its definition, the concepts it encompasses and information to describe and monitor it are still poorly developed. The International Conference on Population and Development held in Cairo in 1994 provided a major international forum for considering the breadth of issues concerning reproductive health. The Conference concluded that:

*Reproductive health implies that people have the capability to reproduce and the freedom to decide. Implicit in this last condition are the rights of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family health, as well as other methods of their choice for regulation of fertility which are not against the law, the right of access to appropriate healthcare services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. In line with the above definition of reproductive health, reproductive health care is defined as the*

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<sup>16</sup> Abdel Ghaffar M. Ahmed: 1999. *Pastoral Land Tenure and Agricultural Expansion: Sudan and the Horn of Africa*. With Salah Shazali, International Institute for Environment and Development, Dryland Programme.

<sup>17</sup> UNHCR, Executive Commission of the High Commissioner's program, Standing Committee, 17<sup>th</sup> Meeting, Statistics and Registration: A Progress Report of Kenya's refugee, Feb. 7, 2000.

*constellation of methods, techniques and services that contribute to reproductive health and well being by preventing and solving reproductive health problem (WHO 1998).*

Using these broad concepts, reproductive health, for the purposes of this report, encompasses the reproductive and sexual health of women and young girls during their reproductive lives and includes reproductive outcomes such as fertility, pregnancy, childbirth and diseases of the reproductive organs. Reproductive health is also reflected and measured in this proposal by the physiological, behavioural and healthcare factors that are important determinants of reproductive and sexual health outcomes.<sup>18</sup> The scope of reproductive health covered in this proposal is centred primarily on the 12–49 years age group, and includes the following six key areas of reproductive health:

- ◆ Fertility and Infertility: the child-bearing performance of the population, including birth and fertility rates and the degree of reduced fertility in the population.
- ◆ Sexually transmissible infections: the prevalence of sexually transmissible diseases in the population and knowledge of preventative practices.
- ◆ Family planning: the use of methods to regulate fertility through contraception and induced terminations.
- ◆ Pregnancy and childbirth: the degree of safe and healthy motherhood, including antenatal factors, pregnancy, childbirth, and maternal, foetal and infant health outcomes.
- ◆ Sexual violence and diseases of the reproductive tract: selected female *rapes*.<sup>19</sup>

Reproductive health is about more than just the reproductive organs, and more than just reproduction. It is about how *social and sexual behaviours and relationships affect health* and create ill-health. It is relevant to both men and women, and to persons of all ages. Too often reproductive health has been considered as relevant only to childbearing women of reproductive age. It is true that women bear by far the greatest burden of reproductive health problems and that biological, social, cultural and economic factors increase a woman's vulnerability to reproductive ill health. Reproductive health has to be understood within the context of relationships between men and women, communities and society, since sexual and reproductive behaviours are governed by complex biological, cultural and psychosocial factors.<sup>20</sup> It must be recognised that there is a cumulative effect across the life span of poor reproductive health. Reproductive health therefore requires that a continuum of care be provided to meet good health for mother and child.<sup>21</sup>

Good reproductive health starts from childhood. For example, a female child who is malnourished from birth or subjected to harmful traditional practices *enters adolescence and adulthood with anaemia, physical anomalies and possible psychosexual trauma related to the traditional practice of FGM*. This can increase the probability of obstetrical problems during pregnancy and childbirth. It may also contribute to sexual problems, fear and abuse in a relationship. Effective reproductive health care addresses these problems from birth with

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<sup>18</sup> Central Bureau of Statistics, Ministry of Planning and National Development, Government of Kenya (accessed October 8, 2004); available from <http://www.cbs.go.ke>

<sup>19</sup> Nadifa Osman. 2004. Fellowship Report. *A Visit to Mander: Generation for Change and Growth*, University Of Minnesota

<sup>20</sup> Olila S, Igras S and Monahan B, *Assessment report: issues and responses to sexual violence, Mandera pastoralist regions, Kenya*, 16-23 Oct. 1998, Nairobi, Kenya, and Atlanta, GA, USA: CARE.

<sup>21</sup> Fratkin, E., and K. Smith. 1995. "Women's changing economic roles with pastoral sedentarization: Varying strategies in alternative Rendille communities." *Human Ecology*.

appropriate and *culturally sensitive education* and health care programmes. Pastoral women and young girls should be able to exercise their reproductive rights in order to:

- ◆ Experience healthy sexual development and maturation and have the capacity for equitable and responsible relationships in order to achieve desired number of children safely and healthily
- ◆ Avoid illness, disease and disability related to sexuality and reproduction and receive appropriate care when needed
- ◆ Be free from violence and other harmful practices related to sexuality and reproduction.
- ◆ Address social, cultural and economic factors that increase vulnerability to reproductive ill-health that include restrictions on information about sexuality, contraception, disease prevention, condoms and health care, gender roles and expectations
- ◆ Have the right to protect themselves against harmful diseases like HIV/AIDS as well destructive traditions such as ritual intercourse with a male relative after the death of the husband, female genital mutilation, ritual scarification, tattooing early marriage bloodletting.<sup>22</sup>

Violent acts of gender-based and sexual violence against women and girls (including mass rape) are increasingly common features of war and conflict. This has profound physical and psychological consequences for the women who have been raped, for their families and for future generations. As the situation stabilises in displacement and post-conflict settings, there may be pressure on women to give birth to replenish the population. In some cases this may coincide with pastoralist women's own desire to replace children who have died or disappeared.

There may be an increase in traditional practices such as some harmful traditional birth practices in order to replace lost health care services; and female genital mutilation in an attempt to maintain cultural and religious identity. *The spread of STI/HIV is fastest in the conditions of poverty, powerlessness and social instability that accompany conflict and displacement.* In addition, mass migration may bring a population of low STI/HIV prevalence, with little knowledge of these infections or how to protect themselves, into contact with populations of high prevalence. The overwhelming sense of loss (of home and family) and lack of hope for the future may affect the mental health of women, men and adolescents and can lead to an increase in risk-taking behaviours.<sup>23</sup>

### **2.2.2. Assessment of the Local Capacity to Respond to Reproductive Health Care Needs**

Firstly, along with increased reproductive health needs, there is a diminished capacity within the pastoralist health service, community and family to respond to these needs.<sup>24</sup> For example:

- ◆ Pastoral family and community networks of support and protection may be lost
- ◆ Poverty and loss of livelihood reduce the capacity of individuals and families to protect their health, including their reproductive health
- ◆ Within a conflict zone, existing health services and structures may have been destroyed, health personnel may have fled or been killed, and international aid may not be able to reach the affected pastoral population

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<sup>22</sup> Report *Reproductive health: Meeting people's Needs (WHO/RHT/'03.17)*. 2003.

<sup>23</sup> Lorber, Judith. 2002. *Gender and the Social Construction of Illness*. Alta Mira Press.

<sup>24</sup> Bitar D, 1997. Reproductive health in pastoralist situations: review of existing reproductive health indicators. Indiana. University Press, Geneva.

- ◆ Emergency obstetric facilities may have been destroyed, or may have become inaccessible
- ◆ Where health services continue to function, the needs of combatants may be given precedence over the needs of non-combatants.

Secondly, according to Osman, in Mandera there is ‘*only one poorly equipped and poorly staffed hospital*’. In a recent trip to Mandera, Nadifa Osman, a Somali female researcher who has done extensive research in Mandera, the highest cause of maternal and infant mortality was *Septicaemia*.<sup>25</sup> When she interviewed the only doctor in the entire hospital system of the district, he proclaimed that Mandera “is a forgotten region and it direly needs the world’s attention”. He farther indicated that even though there are high birth rates in the region, population growth is insignificant because of high infant mortality.<sup>26</sup>

### **2.2.3. Assessing the Institutional Responses to the Reproductive Health Needs of Pastoral Women**

Apart from traditional maternal and child health services, the reproductive health of women in conflict is frequently neglected among pastoralists and internally displaced persons. It may not be considered a priority, and in some instances reproductive health problems may even be compounded by inappropriate institutional responses. The reasons for this may include the following:

- ◆ In the emergency phase of a humanitarian response, attention is necessarily focused on acute life-saving interventions. Less visible problems such as STD’s, HIV/AIDS, female genital mutilation, the complications of unsafe abortion, gender-based and sexual violence and other traumas are frequently neglected
- ◆ If the crisis approach of the initial response continues long after the initial catastrophe has passed, the *less visible problems* may continue to be neglected in the stabilisation phase.
- ◆ The gender approach needed for successful reproductive health interventions may be lacking at institutional level, or it may be disregarded in altogether
- ◆ Different relief agencies may provide different vertical services for different pastoralist groups. This will meet some, but not all reproductive health care needs of nomadic pastoralist women
- ◆ Relief workers may be neither aware of reproductive health needs nor trained to meet those needs and they may not know how to develop and plan an integrated pastoralist-gearred programme of reproductive health care
- ◆ Relief organisations and health personnel may not have the knowledge, skills or attitudes needed for the slow-paced, participatory approaches that are required to bring about changes in sexual behaviour and reproductive health care of pastoral women
- ◆ Relief workers may be reluctant to raise sensitive issues relating to reproductive health due to cultural taboos
- ◆ Few health personnel may have experience in dealing with the victims of sexual violence

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<sup>25</sup> (Septicaemia is a serious, rapidly progressing, life-threatening infection that can arise from infections throughout the body, including infections in the lungs, abdomen, and urinary tract. It may precede or coincide with infections of the bone, central nervous system, meningitis or other tissues and can leads to adrenal collapse, shock and even death. Septicaemia can begin with spiking fevers and chills, rapid breathing and heart rate, the outward appearance of being seriously ill. These symptoms rapidly progress to shock with decreased body temperature (hypothermia), falling blood pressure, confusion or other changes in mental status, and blood-clotting abnormalities evidenced by hemorrhagic lesions in the skin (<http://www.nlm.nih.gov/medlineplus/>).

<sup>26</sup> Idem

- ◆ Services may sometimes be provided in ways that do not respect the dignity of the pastoral recipients and their right to make free and informed choices.
- ◆ Alternatively, there may be opposition to the provision of some reproductive health services for religious or cultural reasons.<sup>27</sup>

These guidelines attempt to address each of these issues so that high-quality, comprehensive reproductive health services can become a reality for pastoral populations affected by conflict and displacement.<sup>28</sup>

#### **2.2.4. Measuring Vulnerability**

After having explored the different health risk factors that pastoral women face, the need to embark on ways and methods that could potentially contribute to effective preventive measures is vital. Specifically, my interest goes out to the Kenya government's policy on preventing vulnerability. Vulnerability analysis in relation to poverty, ecology, conflict and geographical location as well as pastoral women's socio-economic status could provide a common and shared methodological platform for development co-operation policymakers. At the same time, it could act as a direct link towards conflict prevention strategies and strengthen, monitoring and evaluation mechanisms as it promotes beforehand analyses, more preventive measures, and a continuous process of assessment to measure dynamic changes in development. To be able to address vulnerability, we need to be able to measure it, so that we can identify the risk factors. Since vulnerability is a relatively new field, there are only a limited but growing number of studies measuring it. Mandera should be an area of highest priority, given the extent of violence and human suffering.

Whatever the risk factors, globalisation plays a big role. The poor are perhaps the least able to take advantage of opportunities presented from globalisation, since activities that have higher returns tend to have higher risks, as well, and this group is least able to deal with the downside of risk, "not only because of their own limited resources, but also because they tend to have less access to public resources" (pp.123). This indicates the importance of developing policies and tools geared to assist the most vulnerable in managing risk, so that they can grow along with the rest of the country.<sup>29</sup>

According to Robert Holzmann (2002);

*Globalisation has "poised [the world community] to reap the fruits of global comparative advantage. Together with advances in technology and more open political systems, there is "a unique opportunity for unprecedented social and economic development poverty reduction and growth." Yet, at the same time "the exact same processes that allow for welfare improvements also increase the variability of the outcomes for society as a whole and even more so for specific groups.... Globalisation-induced income variability combined with marginalization and social exclusion can, in fact, increase the vulnerability of major groups in the population (pp. 14-17)*

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<sup>27</sup> John. C wood. 1999. *When men are women, Manhood among Gabra Nomads of East Africa*, Wisconsin Uni. Press. Wisconsin. USA

<sup>28</sup> Hendrix, Susan L. / Mosby / 2002, *Topics in women's health*, Sage publishers. London.

<sup>29</sup> Holzmann, Robert. 2002. "Risk and Vulnerability: The Forward Looking Role of Social Protection in a Globalising World," in *Poverty and Social Exclusion in North and South*, ed. by E. Dowler and P. Mosely. London: Routledge.

The poor or rather the less fortunate, also tend to experience greater consequences from negative shocks such as drought or war, again because of fewer private and public means to deal with the shocks. Expanding our thinking from poverty alleviation to vulnerability reduction helps us think more about the causes of poverty, and especially how the vulnerable make choices now that try to minimize the effect of negative shocks in the future. It points to a wider set of policy instruments that open up new opportunities for the poor. Vulnerability is related to equity in that many of these policy instruments will require resources from those who are better off, either through taxes or through a shift in policies removing advantages enjoyed by the wealthy, and transferring the advantage to the poor. In order to provide this, the extent to which vulnerability occurs needs to be measured. This could be done for instance by using the *Integrated Modelling Assessment of Security* (IMAS) method, for example in relation to poverty.

The IMAS method is used to measure and understand human-ecosystem vulnerability and in so doing improve prospects for establishing an appropriate and sustainable balance between food security and natural resource conservation in the pastoral regions of East Africa. The assessment system will integrate compute modelling, geographic information systems, remote sensing, and conflict and field studies. The system will enable alternative policy and management strategies to be objectively explored, debated, implemented, and reassessed. Assessments will be made based upon modelling, and participatory involvement from stakeholders at the community level. The results of the assessment will then be used by land managers and policy analysts to develop environmentally and economically sustainable plans of resource utilization. The results of ecological changes or developmental innovations are felt primarily and most directly at the household level, in terms of changes in income, food security and nutritional status. Impacts also have to be assessed at the community and regional levels because land-use and other decisions are often made at these levels as well as at the individual household level.

A human ecology and the economic component of the IMAS is being developed to address processes at the *household level*. The end users of the IMAS include pastoralists, both male and female, as well as other stakeholders in East African pastoral/wildlife systems. A measurable impact of the IMAS is increased food security for humans, including women and children. Although the majority pastoral women do not own livestock they *do* have control over food acquisition and distribution and are an integral component of their communities. Pastoral women, *do* make some decisions and have control on the income from sales of milk, milk products and skins. With reduced herd size, the quantities of these products are decreasing and thus the role of women in their control is also decreasing. There are cases where women own some animals but they cannot make major decisions, for example on how to dispose of them without the husbands' permission.

Vulnerability is a forward-looking and stochastic poverty prediction, based on past observations of experiences and shocks to prevent future disasters. Prevention is better than cure. To properly measure vulnerability to poverty, one would need a relatively long panel of a representative national sample, measuring income or consumption at the household level. Since this type of data usually does not exist among pastoralists, assumptions will be inaccurate.

### **2.3. THE BENEFITS OF INVESTING IN REPRODUCTIVE HEALTH**

*“Investments in health care services, including those related to sexual and reproductive health, can make valuable contributions to wider development goals”.*<sup>30</sup>

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<sup>30</sup> Koffi Anan, Occasion of the 70th annual “Women’s And The Girl Child’s Health Conference”, China, 2001.

Current approaches pastoralist reproductive health largely fail to recognise the non-medical benefits of sexual and reproductive health interventions and thus undervalue these interventions.<sup>31</sup> For example, in addition to its medical benefits, pastoralist maternal health care helps families remain intact, enables higher household savings and investment, and encourages higher productivity. Prevention of and dealing with STDs, and treatment for conditions like *fistula* and *infertility*, also reduce social stigma and help parents remain healthy, so they are better able to care for and invest in their children. Healthy families can earn more and save more, spurring economic growth, productivity, additional education and enhanced family care. And each year, some 505,000 fewer children would lose their mothers (who.org). As striking as these numbers are, the personal, social and economic benefits of reproductive services may be even more important. Here below are some of many benefits of having a healthy family;

**2.3.1. At the Individual level;**

- ◆ Greater satisfaction with life and less worry over unplanned pregnancy and greater self-esteem and efficacy, especially for women
- ◆ More decision-making power, especially for women and more time with children
- ◆ Greater educational and employment opportunities, especially for girls and women
- ◆ Improved social status for women and increased opportunity to join social and civic organisations
- ◆ Greater financial security, especially for women and higher productivity and income
- ◆ Reduction in postpartum depression and puerperal psychosis
- ◆ Reduction in stigma related to infertility, abortion and obstetric fistula
- ◆ Increased productivity and income and prevention of infertility and sterility

**2.3.2. At the Family/household level;**

- ◆ Increased ability of women to care for families and stronger and more stable marital relationships
- ◆ Promotion of joint household decision making and less discrimination against female children and more attention and parental care for each child
- ◆ Increased household income and higher health, nutrition and education expenditures per child and fewer orphaned children
- ◆ Improved living conditions through less crowding and more time for mothers to care for children, fewer maternal deaths and fewer children orphaned and higher household income and savings
- ◆ Better support to families by healthy parents and fewer orphans and Greater household income and savings and opportunity for couples to discuss intimate concerns.<sup>32</sup>

**2.3.3. At the Community/society Level**

- ◆ Higher productivity and better incomes and less societal burden to care for neglected children
- ◆ Decreased inequality between men and women and rapid economic growth, higher savings and investment

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<sup>31</sup> Birdsall N, Kelley AC and Sinding SW, eds. *Population Matters: Demographic Change, Economic Growth, and Poverty in the Developing World*, New York: Oxford University Press, 2001.

<sup>32</sup> Olila S, Igras S and Monahan B, *Assessment report: issues and responses to sexual violence, Dadaab refugee camps, Kenya*, 16-23 Oct. 1998, Nairobi, Kenya, and Atlanta, GA, USA: CARE.

- ◆ Improved productivity and reduced public expenditures in education, health care and other social services
- ◆ Lower maternal mortality and lower costs of caring for maternal health complications
- ◆ Higher productivity and investment and fewer orphaned children
- ◆ Fewer families in need of subsidies and higher productivity and investment
- ◆ Reduced public expenditures through prevention of STDs, rather than through treatment.<sup>33</sup>

#### **2.4. THE HUMAN FACE IN CONFLICT: THE INVISIBLE FACTORS**

*Justice may be blind,  
but she has very sophisticated listening devices  
(Edgar Argo).*

The human cost in grief and pain, of course, cannot be calculated. In fact, much of it is almost invisible and incalculable. While satellite technology has made certain types of violence – terrorism, wars, riots and civil unrest – visible to television audiences on a daily basis, much more violence occurs out of sight and in marginalized areas and even in the medical and social institutions set up to care for displaced peoples.

Many of these displaced women victims are too young, weak or ill to protect themselves. Others are forced by social conventions or pressures to keep silent about their experiences. As with its impacts, some causes of violence are easy to see. Others are deeply rooted in the social, cultural, political and economic fabric of human life. Recent research suggests that while biological and other individual factors explain some of the predisposition to aggression, more often these factors interact with family, community, cultural and other external factors to create a situation where violence is likely to manifest itself and leave ugly footprints. Ayan's story best illustrates what I mean.

##### **2.4.1. Case study; Ayan's story**

Ayan Hassan's little eyes gaze up blankly at the AMREF Flying Doctor Emergency flight nurse. She is being airlifted from the Mandera Hospital, near the border of Kenya and Somalia to Nairobi, Kenya's capital city, where she will receive specialized treatment. Like any other 7 year old, she was a playful and cheerful little girl who loved people, especially her grandmother. But sadly, today, all that has changed.

Ayan, is now a rape victim.

On the evening of 27 May 2005 her father, a peasant cart-pusher in Bulla Hawa, Somalia and her mother, a housewife, allowed her to visit her grandmother who she adored. After dinner, she and her grandmother retired to bed on a mat spread on the floor. As is tradition, most huts in Bulla Hawa do not have lockable doors due to the heat at night.

In the late hours of the night, while Ayan and her grandmother were sleeping soundly, an unknown assailant crept into the hut. He grabbed Ayan, putting his hands over her little mouth to stifle her screams and carried her away to a nearby bush. Silencing her, he then proceeded to strangle her and as she passed out he sexually defiled her and left her for dead.

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<sup>33</sup> Maryam Niamir-Fuller. 1999 *Managing Mobility In African Rangelands: The Legitimization Of Transhumance*, ITDG Publications, London. UK



Her grandmother, deep in sleep, never heard a sound. At dawn, as the sun was rising, she woke up to find her granddaughter missing. Gripped by panic, she frantically ran around the village calling out Ayan's name, but her calls were met by silence. About to give up, she went to Ayan's parent's house to see if she might have returned home. But she hadn't. Ayan's parents raised the alarm and all the villagers teamed up to search for her.

After an hour's search, she was found alive but lying unconscious in a pool of blood in a bush near the village. Fortunately, she had not been hurt by the vultures and hyenas that are common in Bulla Hawa.

Due to lack of medical facilities in Bulla Hawa, Ayan was taken home to recover. However, her mother noticed that she wasn't making any progress and by the third day Ayan was still *unable to pass stool or urine*.

Concerned by his daughter's health, Ayan's father decided to carry her to the nearest hospital, the only Mandera Hospital, which is some 2 km away, across the Somali border in Kenya. On 31 May 2005, whilst on observation at the Mandera Hospital, a Medical Officer contacted the AMREF Flying Doctor Service Control Centre in Wilson airport, Nairobi, to request a charity evacuation.

Ayan required specialized treatment for the extensive internal injuries she had sustained. The request was accepted by the AMREF Flying Doctor Service and a mercy flight was organized on the same day to airlift Ayan to Nairobi for medical attention.

"By the time we arrived at Mandera, Ayan had regained consciousness and remained stable during the flight, but her eyes were expressionless, as if she was in a deep trance refusing to be part of this world where such evil could take place," said Joseph Munyonyi, an Emergency Flight nurse with AMREF Flying Doctors.

Ayan was taken to Gertrude's Garden Children Hospital, Nairobi, where she had to undergo emergency surgery. Due to the severity of her injuries she will need several further operations. Ayan is still at the hospital where she is recovering. She is also receiving counselling. (Quoted from [www.amref.org](http://www.amref.org)), Nairobi, June 2005.

Ayan's story is not distinctive. There are many more similar cases. The difference is that Ayan was lucky to have been found by the flying doctors and her story is publicised. But there are also many other cases whereby parents refused publicity in order to avoid social ostracism and stigma. Those cases have no faces. However, through my observations, literature explorations, two aspects catch my eye, first of all, the calculated and tactful demeanour of the assailants and the assaults. The victims are kidnapped are assaulted, tortured and sexually abused and left for dead. Attacks of these kind are new in post-war Somalia, or at least as we as we hear. Another dimension to this story is the lack of justice and absence of a legal body to prosecute the assailant. Sadly, even NGOs are not in a position to ensure this, as they continue to treat the symptoms of a complicated and multi-dimensional ethnic conflict.

I am closely following Ayan's sad story. As she progresses, I wonder how many more girls of her age fell victim to this cold-blooded and inhuman act that has dawned on Somali children.

## **2.5. FINDINGS, CONCLUSION AND DISCUSSION**

Firstly, through the literature reviews, I have found out that there is little known about gendered-violence, the reproductive health and needs of nomadic pastoralist women, especially those living in conflict areas in east Africa. Secondly, it can't be left without saying that studies on Pastoralist are male-dominated and the focus has been on issues such as mobility, natural resource management and the environment.

Secondly, contrary to the common assumption that provision of health to pastoral communities in east Africa is challenging, experiences elsewhere in the world have shown to be successful and indeed sustainable. The findings from these researches on health suggest that the presence of certain critical elements in any given conflict situation may increase the chances of a successful health operation. And these elements may include

- ◆ Political will of national governments;
- ◆ Support and facilitation of an international health organisation, such as e.g. WHO;
- ◆ More studies on the specific health experiences and needs by women experts.
- ◆ Investment of resources, including financial, material, and human;
- ◆ Health personnel properly training in skills such as conflict analysis, negotiation, and diplomacy; and
- ◆ The implementation of *Health services tailored to the specific contextual situation and needs of the pastoral communities*

Thirdly, and most importantly, and like Aid policy implementers do, research on conflict and health should not take the symptoms as a reality, but must focus on the deep-rooted causes of ill-health, ill-treatment and traumatic violence in east Africa. One of the most important reasons for undertaking a study on women's relationship to development is seated in the recognition that, despite the increase in awareness and the research on the plight of women, there is still no permanent and long term evidence as of now that gender issues have been taken seriously on the macro-level of analysis. Gender sensitive development is necessary and should be participative and inclusive. Gender sensitivity is of utmost importance because development affects men and women differently due to, among others, cultural and political factors. Violence against women can be prevented. This is not an article of faith and fiction, but a statement based on evidence. Examples of success can be found around the world, from small-scale individual and community efforts to national policy and legislative initiatives.

### **A Public Health Approach to Violence in East Africa?**

Fourthly, by definition, public health is not about individual patients. Its focus is on dealing with diseases and with conditions and problems affecting health, and it aims to provide the maximum benefit for the largest number of people. This doesn't mean that public health ignores the care of individuals. Rather, the concern is to *prevent* health problems and to *extend better care and safety to entire populations*. The public health approach to any problem is interdisciplinary and science-based and it draws upon knowledge from many disciplines, including medicine, epidemiology, sociology, psychology, criminology, education and economics. This has allowed the field of public health to be innovative and responsive to a wide range of diseases, illnesses and injuries around the world. The public health approach also emphasizes *collective action*. It has proved time and again that cooperative efforts from diverse sectors such as health, education, social services, justice and policy are necessary to solve what are usually assumed to be purely "medical" problems. Each sector has an important role to play in addressing the problem of

violence and, collectively, the approaches taken by each have the potential to produce important reductions in violence. Public health is above all characterized by its emphasis on prevention rather than simply accepting or reacting to violence.

The public health approach to violence is based on the rigorous requirements of scientific methods. In moving from problem to solution, it has four key steps:

- ◆ Uncovering as much basic knowledge as possible about all the aspects of violence through systematically collecting data on the *magnitude, scope, characteristics* and *consequences* of violence at local, national and international levels
- ◆ Investigating why violence occurs that is, conducting research to determine: the causes and correlates of violence, the factors that increase or decrease the risk for violence
- ◆ Exploring ways to prevent violence, using the information from the above, by designing, implementing, monitoring and evaluating interventions factors that might be modifiable through interventions
- ◆ Implementing, in a range of settings, interventions that appear promising, widely disseminating information and determining the cost-effectiveness of programmes.

Key recommendations are security should be strengthened and peace initiatives encouraged.

**Appendix 1: Map 1. Showing mandera**



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