

Research Article,

Challenges Faced By International Non – Governmental Organizations on Enhancement of Refugees Wellbeing in Dadaab Camp, Kenya

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Abstract:

Challenges faced by International non – governmental organizations (INGOs) on enhancement of refugees' wellbeing were complex. Mostly refugees' experiences were debilitating as they struggled with stigma due to mental health conditions, poor social networks due to discrimination faced in the host country, disorientation and insufficient language to communicate or initiate conversations. This study was guided by Trauma Theory and it employed descriptive research design. Both primary and secondary data were utilized in the study. Data collection utilized questionnaires, interviews, Focus group discussions and Observations checklist on accessibility and safety of INGOs' interventions. Data was analysed by statistical Packages for Social Science (SPSS 22). Data was presented in tables, bar graphs and pie charts. The findings of the study demonstrate that INGOs faced language barriers, financial barriers, lack of culturally responsive psychosocial interventions, insufficient security and long-term mental health conditions in enhancement of wellbeing of refugees in Dadaab camp. Most refugees reported their trauma occurrences to INGOs. The study concluded that cultural stereotypes, stigma, fear, Limited knowledge and information about mental healthcare, limited clinical competency and language barrier were major challenges faced by INGOs in enhancement of refugees' wellbeing.

Keywords: Limited clinical competency, Healthcare systems, mental disorders, Cultural stereotypes, Stigma, Language barrier, lack of transcultural care, unfamiliarity with services

Introduction:

Enhancement of social and mental health of refugees has always been a struggle. Studies demonstrate that 85% of the current World's refugees are hosted in developing regions (United Nation High Commissioner for Refugees, 2018). As such Mental disorders remain among the most prevalent, burdensome, and untreated health conditions globally (EEpping-Jordan *et al.*, 2015). Apparently, health and wellbeing is not merely the absence of disease, but results from complex interactions between biological, psychological, social, economic and cultural factors (Wood *et al.*, 2019). Important progress in mental health service development has been made in selected countries of the world (EEpping- Jordan *et al.*, 2015). Yet, despite increasing international focus on action,

major treatment gap remain worldwide; in low and middle –income countries, around 80% of people in need do not receive appropriate services (EEpping – Jordan *et al.*, 2015). Various INGOs involved in enhancement of refugees' wellbeing face massive spectrum of hindrances. Challenges in healthcare delivery to migrants and refugees in high- income countries, the health needs of this increasing population of migrants and refugees are a global challenge for healthcare systems (Brandenbarger *et al.*, 2019). Refugees in Australia are consistently underserved population with higher rates of mental health and infectious diseases (Au *et al.*, 2019). This is compounded by pre- arrival and post- arrival factors including poor care in their country of origin, trauma, prolonged detention, and barriers to appropriate care on arrival (Au *et al.*, 2019).

Refugees themselves might suffer from a lack of knowledge regarding available mental healthcare services (Donnelly *et al.*, 2011). Unfamiliarity with such services (Ellis *et al.*, 2010), concerns regarding the confidentiality of the professional interpreters (Bhatia & Wallace, 2007), and fears that their problems will not be understood by practitioners due to lack of cultural competence (Sandhu *et al.*, 2013). Moreover, conflict affected population are at an increased risk of mental disorders due to frequent exposure to potentially traumatic events, multiple losses, breakdown of supportive social networks and accumulation of daily life stressors related to refugee life (Silove *et al.*, 2017; Miller & Rasmussen, 2010). Rising numbers of migrants and refugees in host countries put migrant's and refugee's health on the public health agenda (Brandenbarger *et al.*, 2019). It is well known that refugees are at high risk of poor mental health outcomes due to pre- displacement events such as high level of trauma exposure, violence and deprivation suffered in their country of origin along with challenges faced during and after the resettlement period (Guajardo *et al.*, 2018). Access to high quality health care is particularly important for these individuals as they face unequal medical treatment opportunities (Brandenbarger *et al.*, 2019).

Newly arrived refugees seek medical advice for a variety of reasons, the most common being musculoskeletal and pain issues, mental and social health issues, infectious diseases and longstanding undiagnosed conditions (Mangrio *et al.*, 2018). This is as a result of Post- migration resettlement stressors such as social- isolation, financial problems, employment difficulties, generational acculturation differences, culture shock and housing that adversely affects refugees' mental and physical health (Mangrio *et al.*, 2018). Challenges faced by INGOs may not only emanate from refugees themselves but other factors also play a role and may affect the refugees health status, including; country of birth, level of ability to communicate in English, community capital, stage of life, and each individual's balance of protective and risk factors (Mangrio & Forss, 2017). Further, Language problems as well as a lack of understanding of how the healthcare system is organized influence help-seeking behaviour and can lead to conflicts with healthcare professionals (Slewa- Younan *et al.*, 2015).

Although many struggle with the physical and or psychological consequences of trauma, the individual's perception of psychological distress often differs from that of healthcare professionals in the host country (Slewa- Younan *et al.*, 2015). This might, in combination with stigma surrounding mental health problems, discourage help- seeking behaviour (Aroche *et al.*, 2014; Moore *et al.*, 2016). The influx of high number of mental health cases in any country has been known to challenge healthcare systems immensely. There are insufficient numbers of mental health care professionals to cover the needs of refugees experiencing impairing psychological distress (Sijbrandij *et al.*, 2017). Additionally, some psychosocial interventions require a highly trained personnel to effectively deliver the treatment. Evidence based interventions such as CBT, NET and EMDR are usually delivered by highly trained specialist mental health care providers. In addition the use of professional interpreters is expensive and is generally perceived by migrants as hindering their treatment (Hadziabdic & Hjelm, 2009). As such, using interpreters from the network of the person, such as family members, can be problematic in the context of psychosocial interventions because of confidentiality and issues around potential vicarious traumatization especially when children are asked to be interpreters (Sijbrandij *et al.*, 2017). Even though refugees have a higher need for healthcare in comparison to others, they face substantial barriers when it comes to healthcare access, barriers that can form as a result of language issues, as well as from cultural and economic aspects (Mangrio & Forss, 2017). Not only can these barriers lead to worse health outcomes for refugees, but they can also add to the stress of being ill in a country where the refugees has only limited or no social network (Moore *et al.* 2016). Placing large numbers of refugees and asylum –seekers in the community over short period of time can create particular challenges for services in high settlement areas (Shawyer *et al.*, 2017).

Napier *et al.* (2018) observed predictors of food insecurity and coping strategies of women asylum seekers and refugees in Durban, South Africa. Napier *et al.* (2018) averred that, majority of asylum seekers and refugees in South Africa are women and children, and they are the most vulnerable in a population. These women have to cope with a variety of challenges of not only settling into the new camp or host country but also adjusting to a

new culture and language, and more often than not Xenophobia and crime situation (Napier *et al.*, 2018). A large number of asylum seekers and refugees in South Africa thus survive through personal networks and family support (Napier *et al.*, 2018). Poverty and food insecurity, leading to low food accessibility and poor dietary quality, can thus have a detrimental effect on their health and quality of life (Napier *et al.*, 2018).

Physical and psychological stresses that many refugees and asylum seekers undergo in their countries of origin, during transition and on arrival in the host country, can increase the risks of mental health problems with variable effects across the range of refugee and asylum seeker population (Shawyer *et al.*, 2017). Access to healthy foods specifically in urban areas where most asylum seekers and refugees are based, is often difficult and depends on many factors such as distance to shops and access to transport, availability of affordable quality foods and lack of nutrition knowledge (Napier *et al.*, 2018). There has been therefore need for the healthcare, food, shelter, employment and security for refugees affected by conflict (Beogo *et al.*, 2018). Refugees and asylum seekers flee their countries because of persecution, war, and or violence and many are exposed to torture and trauma (Ziersch *et al.*, 2020). Such pre- migration factors and also post migration factors including challenges settling in a new country like learning a new language, securing employment and making social connections, mean that refugee status is associated with poorer health outcomes, particularly mental health (Ziersch *et al.*, 2020). Even though refugees have a higher need for healthcare in comparison to others, they face substantial barriers when it comes to healthcare access because of language difficulties and economic and cultural aspects (Mangrio *et al.*, 2018). Differences in access to health care for migrants are shaped by language barriers, sociocultural factors, and migrant's lack of awareness of available health services, cultural barriers and structural barriers (Delilovic *et al.*, 2018). Understanding the refugees' experience of access to healthcare are important factors for improving their health as access to healthcare has been found to be a leading health indicator (Mangrio *et al.*, 2018). While there was great need for specialized health care only a small percentage of refugees sought a professional help, waiting until problems becomes critical before reaching specialist psychiatric and mental health services (Guajardo *et*

al., 2016). The main reasons for such included; stigma associated with mental health problems, inability to recognize mental disorders, lack of knowledge of treatment and intervention available in the host country and migration challenges such as cultural shock, lack of knowledge of the new country and its system, financial constraints and low language proficiency (Guajardo *et al.*, 2016).

Within a conflict setting, access is affected in multiple ways; supplies are interrupted or reduced, specialised staff is difficult to train and retain and physical access is reduced due to damaged infrastructure and barriers (Leone *et al.*, 2019). Further, psychological barriers to access are increased as fears for safety can prevent people from trying to access services or alter the frequency/timing of use (Leone *et al.*, 2019). Many of the challenges of addressing the health care needs for this growing population of immigrants and refugees are therefore new and unfamiliar to care providers and health care organizations (Wylie *et al.*, 2018). High levels of trauma and migration stresses among war refugees have profound significance in mental health care, where services generally are poorly equipped to meet the complex mental health needs of survivors of war and torture (Wylie *et al.*, 2018). Lack of funding for providers to deliver mental health services, lack of access to medications, stigma against persons with mental health problems, and lack of political will have all been identified as potential barriers to implementation of primary care mental health services (Gwaikolo *et al.*, 2017). Moreover, lack of proficiency in host country's language represents a substantial barrier to the identification and treatment of health problems in refugees (Morina *et al.*, 2017). Such language barrier may also contribute to the lack of adherence to treatments, delays, misdiagnosis, unnecessary examinations and incorrect treatments (Bempong *et al.*, 2019). They further include the limited transcultural knowledge, skills and practices among care providers, as well as systemic time constraints that undermine the ability to carry out a fulsome sociocultural assessment (Wylie *et al.*, 2018). Furthermore, timely access to clinical care delivered by competent and compassionate healthcare providers (CHPs) is essential to prevent adverse consequences and begin a survivor's physical and emotional healing (Smith *et al.*, 2013). Lack of understanding of what constitutes mental illness on the side of mental health care professional may present a barrier to

accessing care, due in part to differences in cultural perceptions of mental health (Slewa -younan *et al.*, 2014). Consequently, limited clinical competency and negative attitudes among healthcare providers (HCPs) inhibit care seeking, lead to poor quality services, and contribute to survivors' re-traumatization (Smith *et al.*, 2013).

One of the major barriers to scaling up mental health services in low- middle income countries is the scarcity and unequal distribution of specialist mental health professionals (Luitel *et al.*, 2015). These barriers are majorly faced by INGOs during enhancement of refugees' wellbeing. Complex trauma, such as that resulting from war, displacement and resettlement, can make mental health assessments difficult for health care organizations or care providers with limited experience and training in trauma – informed care, leading to misunderstanding (Wylie *et al.*, 2018). Besides trauma, baffling Key issues wreck mental health professionals, which include systemic factors such as legal restrictions; provider level barriers such as lack of awareness of regulations, reluctance related to cultural differences and competence, and capacity constraints particularly for psychotherapy; and individual – level factors such as lack of trust, unfamiliarity, and irritation of the host country health system, financial access to care in systems which are not free of charge at point of use but rather rely on health insurance or reimbursements and general perceived discrimination (Asfaw *et al.*, 2020). Although culturally diverse populations have distinct mental health needs, partially because of the social, political and historical factors shaping their migration trajectories; what is consistent among these groups in an underutilization of existing mental health services relative to the local populations (Mollah *et al.*, 2018). Lack of transcultural care has been only one of a range of access barriers in mental health care that lead to the underutilization of mental health services by immigrants and refugees, and these barriers exist both at the individual and the system levels (Wylie *et al.*, 2018). While there is great need for specialized healthcare, only a small percentage of refugees will seek professional help, waiting until problems becomes critical before reaching specialist, psychiatric and mental health services (Guajardo *et al.*, 2016).

Contributing to their likelihood for poor health is a difficult migration journey that may include migration from countries experiencing violent

conflicts, forced migration at short notice and living in refugee camps, along with unfavourable social determinants of health (Woodgate *et al.*, 2017). However, immigrants and refugees experience poor patient- provider communication due to language barriers, non-professional interpreters, physician being too busy to listen or lacking empathy with their health concerns, inadequate referral to specialized care resources, inadequate social support, differences in expectations, and lack of culturally responsive care (Woodgate *et al.*, 2017). Others are challenged by socio-cultural differences and economic difficulties (Woodgate *et al.*, 2017).

According to Murphy *et al.* (2018), where there are barriers to mental healthcare utilization among refugees and asylum seekers, effective treatment for mental disorders may be especially challenging in low middle income countries currently or recently engaged in armed conflict, where the likelihood of mental disorders such as posttraumatic stress disorder, depression and anxiety is increased and health systems are destabilized (Murphy *et al.*, 2018). The effect of Conflict in low-resource setting and non-western countries complicated the uptake of primary mental health care as refugees could never travel to the mental health facility due to disorientation on their mental state and in ability of not being in touch with reality (Rawlinson *et al.*, 2020). A significant challenge in refugee mental health is willingness to access care (Slewa – Younan *et al.*, 2014). Resettled refugees are therefore significantly less likely than general population to utilize hospital services, despite a higher prevalence of trauma related mental health disorders (Slewa – Younan *et al.*, 2014). It is estimated that four out of five people with mental illness in low and middle income Countries (LMIC) receive no effective treatment and mental health is often one of the lowest health priorities in those settings (Luitel *et al.*, 2015). Mental health problems among refugees and asylum seekers were often mis - or underdiagnosed and this resulted in low treatment coverage which led to negative long-term treatment outcomes and ultimately higher healthcare costs (Mueller *et al.*, 2010).

Potential effects of untreated mental health disorders including; personal suffering and distress, poor social functioning, lower productivity, and increased likelihood of physical illnesses particularly chronic conditions for which treatment

adherence may be impacted (Murphy *et al.*, 2018). Additionally, refugees are a population particularly vulnerable to disorders of both physical and mental health even after resettlement (Slewa-Younan *et al.*, 2014). International non-governmental organizations especially Medicins Sans Frontieres Psychologists working in Dadaab reported treating PTSD with alarming frequency, citing persecution, torture, and war in their home country as root causes (Onyiego, 2011). Not only did refugees in Dadaab camp suffered from PTSD but they also developed anxiety and depression as mental illness that are triggered due to persistent exposure to conflict. However, very few Dadaab refugees received the breadth of services they needed to work through their trauma, if they received services at all (Chen, 2016).

Refugee migrants tend to underutilize health services, engage in risky health behaviour and fail to receive timely health care (Kikhia *et al.*, 2021). A variety of reasons account for these phenomena, including deficits in education, low income, lacking awareness of available resources and linguistic/cultural barriers (Kikhia *et al.*, 2021). Therefore, despite the up scaling of mental health care to enhance refugee wellbeing, still mental healthcare uptake among refugees remains low.

Theoretical Framework

This study was guided by Trauma theory. The main proponent of this theory is Mollica (1999). He postulates that, trauma survivors have innate capacity to heal themselves in conjunction with medical psychological intervention. According to Mollica (2006), there is a healing force hidden in all of us that is always striving for survival. In Trauma theory, doctors are criticized for overdependence on medication treating trauma and mental health practitioners for over emphasizing the brutal facts of the trauma experience in their attempts at debriefing (George, 2010). Another Trauma theorist who has given Trauma theory meaning is (Kroll, 2000). He contributes some noteworthy thoughts on Trauma theory by agreeing that trauma and fright are hardwired into human biology. Kroll (2000) believes that particular psychological reactions to trauma are influenced by the cultural norms of how individuals are expected to respond to threat, injury and loss. Mollica (2001) argue that, it is critical for healing that victims of violence play an active role by not only telling, but also interpreting their trauma stories. Storytelling

coaches Doctors, Social workers and therapists to guide survivors as they navigate through the horrifying details during the storytelling process (Mollica, 2006).

The realization that telling their story will broaden the knowledge base on the most effective interventions to deal with refugee loss and tragedy also contributes to healing (George, 2010). Trauma theory focuses on self- healing through spirituality, humour, physical exercise, relaxation techniques and good nutrition, rather than depending on long-term handouts(Mollica,2001).Traumatized individuals also heal themselves with the aid of traditional medical intervention(George, 2010). They can use their experiences to help deal with the tragedies of everyday life(Mollica, 2006).Through the application of this theoretical approach, trauma victims may transcend the most horrific events imaginable and go onto lead rich meaningful lives (Mollica, 2006).Trauma theory also gives importance to the severity, duration and proximity of an individual's exposure to the traumatic event in diagnosing posttraumatic stress disorder (PTSD), which is widely considered a medical- based model applied to individuals experiencing symptoms related to their traumatic events (Koren *et al.*, 1999). An advancement, of refugee's self-healing and resilience through telling stories is an important consideration for service providers (Mollica, 2006). Trauma theory encourages service providers not only to employ medical intervention, but also the concepts of cultural contribution and self- healing (George, 2010). Trauma theory in this respect aided the researcher put into perspective Trauma among refugees and how trauma victims may transcend the most horrific events imaginable and go onto lead rich meaningful lives. The theory was also useful to trauma survivors in understanding that, telling their story will broaden the knowledge base on the most effective interventions to deal with refugee loss and tragedy as it contributes to healing.

Methodology:

Research Design

The researcher employed descriptive research design. Descriptive research design as a method of data collecting information by interviewing or administering questionnaire to a sample of population to get their attitude, opinion and habits on any variety of educational or social issues (Orodho, 2003). This study assessed the challenges on enhancement of wellbeing of refugees in Dadaab

Camp, Kenya. Descriptive survey allowed the researcher utilize questionnaires, interviews, Focus Group Discussions guides and observations checklist as research tools.

Study Area

The study was conducted in Dadaab camp, Garissa County in North Eastern region. Dadaab refugee camp is approximately 100km from the border with Somalia (Polonsky *et al.*, 2013). The choice of Dadaab camp was based on the fact that, it was the oldest refugee camp that comprised refugees from various countries in Africa. According to UNHCR Mission Report (2013), Dadaab camp consist of five camps namely; Dagahaley, Ifo1 Hagadera, Ifo2 and Kambioos. The vast majority of the refugees (96%) were from Somalia, with most others from Ethiopia (UNHCR, Mission Report, 2013). As a results of deteriorating humanitarian situation caused by continued conflict in Somalia and by the failure of rains from October to November 2010 , the number of Somalis seeking refuge in Kenya (and elsewhere in the region) has steadily increased (Polonsky *et al.*, 2013).

Map of Kenya showing relative position of Dadaab camp in Garissa County in figure 1.

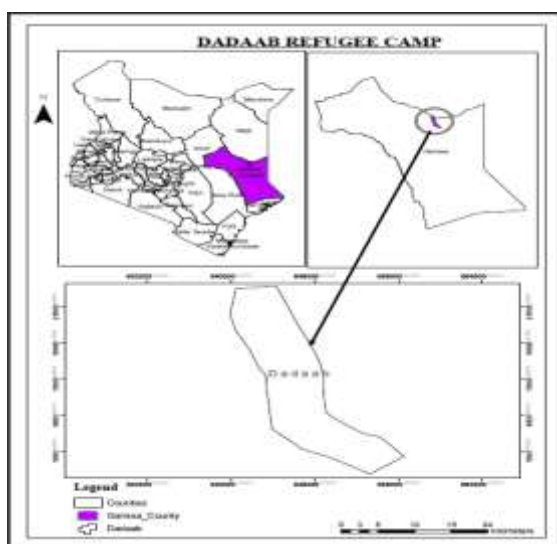


Figure1. Map of Kenya showing relative position of Dadaab Camp in Garissa County Kenya. Source: Researcher, 2019

Study population

The study population comprised of security personnel and camp manager/field officials, Refugees, counsellors and social workers. For this reason, the study targeted staff from International

non -governmental organizations staff and Refugees. The approximated number of registered refugees in Dadaab complex was 235,265 in Ifo1, Hagadera and Dagahaley camps. United Nation High Commissioner for Refugees operational update report of 15th April, 2018 indicated that 58% of Dadaab population were children (UNHCR, 2018). Therefore out of 235,265 estimated registered refugees, 42% which was 98,811 total adult refugees formed the study population in Dadaab camp. The study therefore comprised 24 Key Informants from INGOs, 384 Refugees and 16 traumatized refugees from the camp.

Sampling strategy

The study employed both probability and non-probability sampling techniques. The study applied the formula recommended by Fisher et al to arrive at the sample size, since the target population of the respondents for which the study was based on, was more than 10,000 respondents (Mugenda, 2003). The desired sample population was determined using Fisher’s formula for sample size determination cited in (Mugenda, 2003). As illustrated in Fisher’s formula as follows.

$$n = \frac{Z^{2Pq}}{d^2} \text{ (when target population is greater than 10,000).}$$

Where, n = the required minimum sample size
 Z = the standard normal deviate at the required confidence level = 1.96
 P = the proportion in the target population estimated to have characteristics being measured
 Q = 1-P
 d = the level of statistical significance set (0.05) in this study. Due to the fact that the study area covered by the target population was large, then the sample size of the study would be:

$$n = \frac{(1.96)^2 (0.50) (0.50)}{(0.05)^2} = 384 \text{ Adult refugees}$$

The sample population for the study was distributed as follows; 384 refugees obtained through stratified simple random sampling, 24 key informants purposively sampled, and 16 traumatized refugees by snowball sampling as indicated in Table 1.

Table1. Sample Size for the Study in Dadaab Refugee Camp

Category	Target population	Sample size	Sampling procedure
Adult Refugees	98,811	384	Stratified sampling
Counsellors	6	6	Purposive Sampling
Camp Manager/Field officers	6	6	Purposive Sampling
Social workers	6	6	Purposive Sampling
Security officials	6	6	Purposive Sampling
Traumatized Refugees	16	16	Snowball Sampling
Total	98,851	424	

Source: Researcher Data 2019

Data Collection and Analysis

Primary Data collection was done through the use of questionnaires, Interview guide, Focus group discussions and Observations checklist. Secondary data sources included books, research articles, website searches, records from Dadaab camp and other relevant literature. Quantitative data was coded and keyed into the Statistical Package for Social Scientists version (SPSS 22). Quantitative analysis was statistically used to describe, aggregates, and present the constructs that is, independent variable and dependent variable of the study. Analysis was done based on descriptive statistics and inferential statistics. Under descriptive statistics, frequencies and percentages were used to describe the data sets and results were presented in tables, graphs and charts while, qualitative data was coded and analysed in thematic narratives and in reported verbatim quotation.

Findings:

Demographic information on refugee household heads in Dadaab Camp

The demographic information of refugee household heads was done through use of questionnaires. A total of 384 questionnaires were administered to the respondents and the response was actualized through follow ups. The demographic information collected through the questionnaires was classified into seven categories; country of origin, age of the household head, gender of household head, marital status, religion, education level and period of stay in the camp.

Country of origin of Household Heads in Dadaab Camp

The study sought to establish the country of origin of 384 Household Heads. The respondents were therefore asked to indicate their Country of Origin of the Household heads and the results in Table 2 indicate that, majority of respondents came from Somalia 254 (73.8%), followed by Ethiopia 41 (11.9%), South Sudan 36 (10.5%), Burundi 4 (1.2%), Congo 4 (1.2%) and Uganda 4 (1.2%) and Rwanda 1 (0.3%) respectively. The respondents' Country of origin was significant, as it underscored the most conflict -troubled country that caused highest displacement and eventual migrations of its populations to the host Country. Study demonstrate that, Somalia, Ethiopia and South Sudan had the highest number of refugees' entrants into the camp, while Burundi, Congo, Uganda and Rwanda had the lowest number of refugees' entrants into the Camp. The findings in Table 2 illustrate the distribution of the respondents as per their country of Origin in Dadaab refugee camp, Kenya.

Table2. Distribution of Respondents' as per their Country of Origin in Dadaab Camp

Respondents' Country of Origin	Frequency	Percent %
Somalia	254	73.8
Ethiopia	41	11.9
South Sudan	36	10.5
Burundi	4	1.2
Congo (DRC)	4	1.2
Uganda	4	1.2
Rwanda	1	0.3
Total	344	100.0%

Source: Field Data, 2019

The displacement of refugees into the host country could be attributable to various causes, which include but not limited to violence, poverty, conflict, persecution and perpetual killing of citizens by the government in the country of origin. Refugees in Dadaab Camp live in constant fear of attacks and insecurity especially from Somalia as there are still influx of the displaced into the camp. Sharma *et al.* (2020) assert that, Somalia has one of the highest rates of child marriage, with 45% of women aged 20 -24 married before the age of 18,

and 8% married before 15 years of age. As such the highest number of entrants came from troubled countries such as Somalia. Refugees are the weakest and most vulnerable category in a conflict – setting (El-Khatib *et al.*, 2013). Violence against lesbians, gay, bisexual and transgender (LGBT) in conflict settings has been recognized by the United Nations as a form of gender based violence that is often motivated by homophobic and transphobic attitudes and directed at those perceived as defying hegemonic gender norm (Kiss *et al.*, 2020). In conflict settings, lesbians, gay, bisexual and transgender people often experience harassment and need to hide their sexual orientation or gender identity (Kiss *et al.*, 2020).

Age of Household Heads of refugees in Dadaab Camp

The study sought to find out the Age of Household heads in Dadaab Camp. Table 2 show that, majority 115 (33.5%) of house hold heads were between 35-55 years of age, followed by 112 (32.7%) of respondents who were between 22 – 35 years of age, which was closely followed by 56 (16.3%) of house hold heads which were between 16 – 21 years of age, and 54 (15.7%) of house heads were between 55 – 75 age. Lastly, 6 (1.7%) of the house hold heads were 75years of age and above. Most of the house hold heads in Dadaab camp range between 16 – 55 years of age as illustrated in Table 3.

Table3. Distribution of Age of Household heads in Dadaab camp

Age of House hold head	Frequency	Percent %
35-55	115	33.5
22-35	112	32.7
16-21	56	16.3
55-75	54	15.7
75 and above	6	1.7
Total	343	100.0%

Source: Field Data 2019

The highest number of house hold heads that participated in the study was 33.5% and ranged between 35 -55 of age, followed closely by 32.7% ranging at 22 – 35 of age, 16.3% that ranged between 16 – 21 of age, 15.7% that ranged between 55-75 of age and lastly, 1.7% that ranged between 75 and above of age. This underscored the age of

house hold heads in the camp. As such, majority of house hold heads that participated in this had wider exposure to conflict and violence, given their age, either in the camp, during migration or in the country of origin.

Gender of Household Heads of refugees in Dadaab Camp

The study sought to determine the gender of Household heads of 384 refugees in Dadaab Camp. Study results indicated in Figure 4.1 therefore illustrate that, out of 337 respondents, the study found out that, majority (181; 53.7%) of gender of household heads were male while only(157; 46.3%) of gender of household heads were female. The gender of Household heads in this study was significant, as it demonstrated the gender of household heads that participated in the study which further demystified their extent of exposure to conflict and post conflict stressors. The Chi-Square value ($X^2_{1,0.05} = 0.264$) depicts a significant difference in the gender of the household heads among refugees as P – value of 0.0233 as shown in figure2.

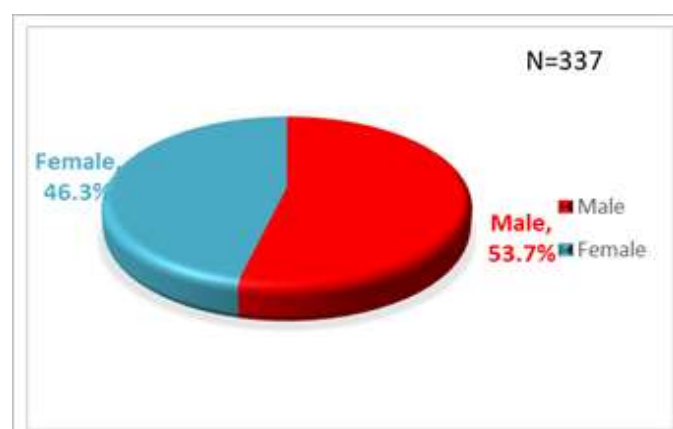


Figure2 Distribution of Gender of household heads in Dadaab camp, Kenya. Source: Field Data, 2019

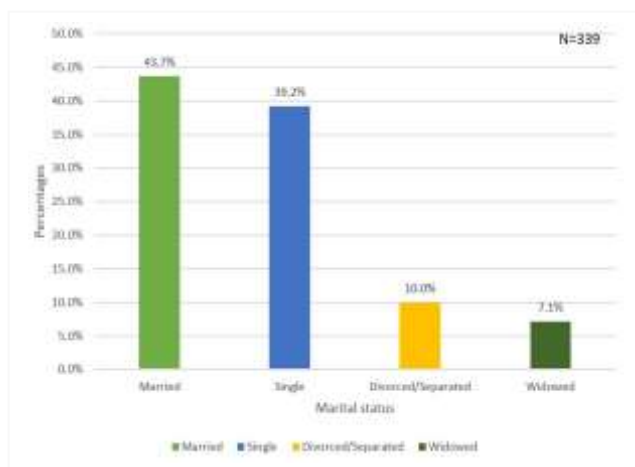
Study demonstrate that 53.7% of male Household heads participated in the study and only 46.3% of female Household Heads participated in the study.

Marital status of Respondents

The study sought to find out the marital status of the household of respondents in Dadaab Camp. Study results show that, majority (n=148; 43.7%) of the refugee respondents were in marriage relationships (n= 133; 39.2%) of the refugee respondents were single (n= 34; 10.0%) of the refugee respondents had divorced or separated from their intimate partners and only (n=24; 7.1%) of the refugee

respondents were widowed. The Chi-Square value ($X^2_{3,0.05} = 26.02$) on the variation of the marital status of the household head respondents was significant at P – Value 0.0310 in relation to the factors that triggered their migration to the Camp.

The difference in marital status of the study respondents was significantly different in this study as it demonstrated that, 43.7% were in marriage relationship while, cumulatively 56.8% of the respondents were either single, divorced/separated or widowed as shown in Figure 3. Such significant difference in marital status of study respondents' demonstrate that the study results were significantly affected by the respondents' marital status.



Source: Field Data, 2019

Study results illustrate that majority of respondents in this study were in marriage relationship. Globally it is estimated that at least one out of every three women experiences violence or abuse at the hands of an intimate partner or non-partner throughout their life time (Contreras – Urbina *et al.*, 2019). Women and girls are at even higher risk of violence in conflict and humanitarian crises due to a number of factors, including displacement, the breakdown of social structures, a lack of law enforcement, the potential further entrenchment of harmful gender norms, and the loss of livelihood opportunities for both men and women in the community among others (Contreras – Urbina *et al.*, 2019).

Religious Affiliation of Respondents

The study sought to find out the religious affiliation of the house hold heads. It was determined by use of four constructs: Islam, Christian, traditionalist and others. Figure 4.3 show, Majority (n=256; 76.9%) of the respondents were Muslim, (n= 67; 20.1%) of the refugee respondents were Christians, (n=9; 2.7%) of the refugee respondents were Traditionalist and only (n=1; 0.3%) of the house

hold heads had other religious affiliation. From the Chi – Square value ($X^2_{3,0.05} = 0.632$) of the variation in the religious affiliation of the household head respondents was not significant at a P – value 0.0603 with regard to the nature of the traumatic experience of the refugees in the camp. However, although majority of the refugee respondents were affiliated to Islam as a religion, closely followed by Christianity, religious affiliation seem not to have connection with the nature and extent of traumatic experiences among refugee respondents. Figure 4 illustrate the religious affiliation of the Household heads respondents in Dadaab Camp.

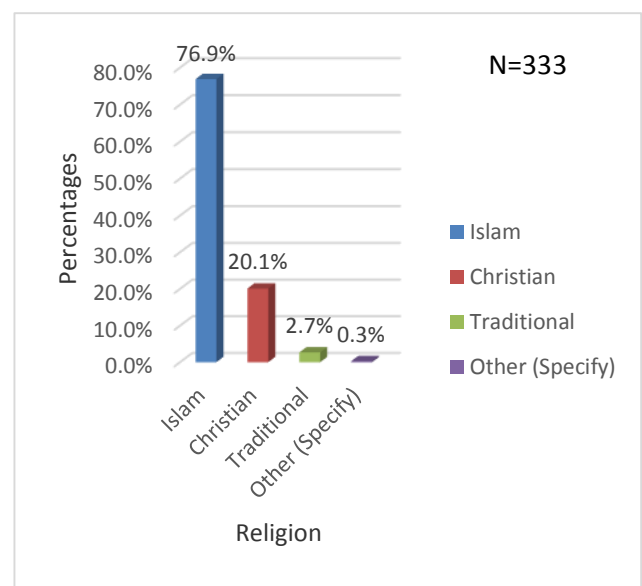


Figure4. Religious Affiliation of house hold heads at Dadaab Camp

Source: Field Data, 2019

Religion has a comprehensive role in the life of Somalis and a belief system, culture and a way of life. Islamic religion for most Somali refugees had influence in their life and interaction with other refugees who were not affiliated to Islamic religion UNHCR (2015). The role of Islam has been crucial in providing a partial and temporary 'horizontal identity' which has helped rival clans overcome their hostility (UNHCR, 2015).

Education Level of the household heads at Dadaab Camp

Study sought to find out the Educational level of the house hold heads. Study results illustrate that majority(n=117 ; 34.5%) of the household heads had attained Secondary school certificates (n= 61;18%) of the respondents had no education (n=44;13.0%) of the respondents had completed primary school education (n=31; 9.1%) of the

respondents were primary school dropout, 28 (8.3%) of the respondents were Secondary school dropout, (n=20; 5.9%) of the respondents had non-formal education, while (n=20; 5.3%) of the respondents had attained undergraduate and only (n=18; 5.3%) of the respondents had attained tertiary education. The Chi - Square value ($X^2_{7,0.05} = 0.1710$) on the variation of the level of education of the household heads was significant at a P – Value 0.002 with regard to the nature and extent of the traumatic experience of the refugees in the camp. This demonstrate that majority of the Household heads only attained secondary Education in Dadaab camp. Table 4 Illustrate the level of Education attained by the respondents. Study finding reveal that, 5.3% of the respondents had attained tertiary Education and 5.9% of the respondents had attained University education level. However, cumulatively, 88.8% of the respondents had attained Secondary school education and below, while others had no formal education. The fact that majority of the respondents had attained secondary education and below reflects that most of the respondents of the house hold heads had challenges to understand what study sought to establish. The level of Education of the respondents was crucial as it demonstrated the respondents’ understanding of the nature and extent of traumatic experiences.

Table 4. Educational level of the Respondents

Educational level of the Respondents	Frequency	Percent%
Secondary Level	117	34.5
No Education	61	18.0
Primary level	44	13.0
Primary school drop out	31	9.1
Secondary School dropout	28	8.3
Non-formal Education	20	5.9
University	20	5.9
Tertiary	18	5.3
Total	339	100.0%

Source: Field, Data 2019

Period of Stay in the Camp

The study sought to establish the period of stay of the house hold heads of respondents in the camp. Study results in Figure 4.4 illustrate that, majority (n=109;33.4%) of the respondents had been in the camp for 10 – 20 years, (n=107; 32.8%) of the respondents had been in the camp for more than 20 years, (n=73; 22.4%) of the respondents had been in the camp for 5 – 10 years, (n=34;10.4%) of respondents had been in the camp for 1 -5 years and only (n= 3; 0.9%) of the respondents had been in

camp for less than a year. over all, most household heads in this study demonstrates that they had been in the camp for one year and above, and only 3 household heads had been in the camp for less than a year.

The period of stay in the camp was significant in this study, as the period of stay in the camp reflected the experiences acquired as a result of conflict and protracted post-conflict situation in the camp. The results on period of stay of household heads are displayed in Figure 5.

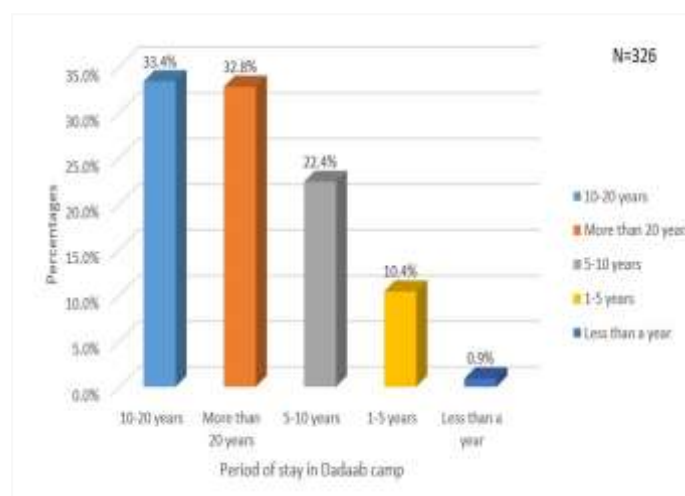


Figure5. Period of stay of house hold head in Dadaab Camp Source: Field Data, 2019

In relation to the inferential statistics, the Chi - Square value ($X^2_{4,0.05} = 24.03$) variation in period of stay of the respondents was significant at a P – value 0.001 with regard to the extent of traumatic experiences of the household heads in the camp. The period of stay in camp was significance in this study, as this reflected the embedded traumatic experiences and mental health conditions of the respondents. The situation of refugee camp in Dadaab is akin to the environment in urban slums of Africa which are characterized by insecurity and lack of basic amenities (Kiruthu, 2014).

Factors such as poor quality of living within the refugee camp, experiences of racism in the host country, joblessness, administration difficulties in the camp and, insecurity in refugees’ status and the longer stay in the host country contribute to the maintenance of mental health disorders and may be responsible for differences between countries (Mahmood *et al.*, 2019). Being a refugee clearly means being at risk for physical and psychological

distress because surrounded within this state is often unspeakable violence (George, 2012).

Reporting trauma occurrences to any International non- governmental Organizations in Dadaab camp

Study sought to establish challenges faced by international non-governmental organizations on enhancement of wellbeing of refugees in Dadaab camp. There were various challenges faced by refugees when reporting trauma occurrences to international non – governmental organizations in Dadaab camp as illustrated in Figure 6.

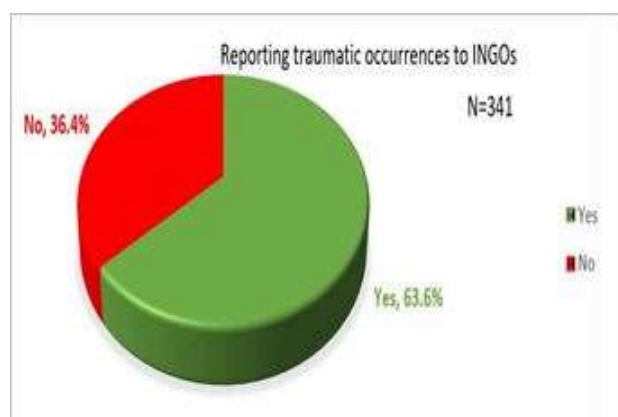


Figure 6. Reporting trauma occurrences to any International non-governmental Organizations
Source: Field Data, 2019

Study results illustrate that, majority (n=217; 63.6%) agreed that they easily reported trauma occurrences to any International non- governmental organizations, while only (n= 124; 36.4%) indicated that they did not easily report any trauma occurrences to any International non-governmental organizations as illustrated in Figure 6. It appears that, most refugees possibly reported their trauma occurrences to any international non-governmental organizations in the camp, while rather a few did not report their trauma occurrences to any International non-governmental organizations in the camp. This was despite the fact that international non-governmental organizations were available in the camp. Failure to report the traumatic occurrences could therefore be attributable to various challenges experienced by refugees in the camp, which includes stigma, mental disorders, language barriers and fear in the host country.

Reasons refugees gave for not reporting traumatic occurrences to any International non-Governmental organizations in the camp

Refugees were asked to give reasons for not reporting traumatic occurrences to any international non-governmental organizations in the camp. Study show some of the reasons refugees gave for not reporting traumatic occurrences to any international non-governmental organizations in the camp as displayed in Table 5.

Study findings on Table 6.3 show that, majority (n=103; 93.6%) of the refugees said that fear was the reason for not reporting traumatic occurrences to the International non-governmental organizations while (n=7; 6.4%) of the refugees said fear was not the reason for reporting traumatic occurrences to the international non – Governmental organizations.

Study findings show (n=98; 90.7%) of the refugees said that cultural stereotypes were the reasons for not reporting traumatic occurrences to the International non-governmental organizations while (n=10; 9.3%) of the refugees said that cultural stereotypes were not the reasons for reporting traumatic occurrences to the international non - governmental organizations. The refugees were asked whether Limited knowledge and information about mental health and mental health services were the reasons for not reporting traumatic occurrences to the International non- organizations, study show (n=94; 85.5%) of the refugees said that limited knowledge and information on mental health and mental health services were the reasons for not reporting traumatic occurrences to International non - governmental organizations while only (n=16 ;14.5%) of the refugees said that limited knowledge and information on mental health and mental health services was not a reason for not reporting traumatic occurrences to international non-governmental organizations. This demonstrate that refugees had limited knowledge and information about mental health and mental health services.

Study sought to find out whether stigma was the reason for not reporting traumatic occurrences to the International non-governmental organizations, Study findings illustrate (n=87; 80.6%) of the refugees said that stigma was the reason for not reporting traumatic occurrences to the international non-governmental organizations while only (n=21; 19.4%) of the refugees said stigma was not the reason for reporting traumatic occurrences to

international non – governmental organizations.

Finally, on whether Language barrier was the reason for not reporting traumatic occurrences to the International non-governmental organizations, Study show (n=95; 88.0%) of the refugees said that language barrier was the reason for not reporting traumatic occurrences while only (n=13; 12%) of the refugees said that language barrier was not the reason for not reporting traumatic occurrences to the International non - governmental organizations. This demonstrate that there were critical reasons which hindered refugees from reporting traumatic occurrences to the International non-governmental organizations in Dadaab camp. Such reasons are shown on Table 5.

Table5. Reasons refugees gave for not reporting traumatic occurrences to the International non-governmental organizations in the camp

Reasons refugees gave for not reporting traumatic occurrences to international non-governmental organizations in the camp	Yes f(%)	No f(%)	Total f(%)
Fear	103(93.3)	7(6.4)	110(100.0)
Limited knowledge and information about mental health and mental health services	94(85.5)	16(14.5)	110(100.0)
Stigma	87(80.6)	21(19.4)	108(100.0)
Cultural stereotypes	98(90.7)	10(9.3)	108(100.0)
Language barrier	95(88.0)	13(12.0)	108(100.0)

Source: Field Data, 2019

Challenges faced by both refugees and International non-governmental organizations in the camp were in consistent with Guedes (2004) when he argued that, there has been a challenge in terms of language where most of the service providers rely on translators because majority of victims in Dadaab refugee camp 98% are Somali speakers who don't understand English, this is likely to be a barrier. Consequently, lack of understanding of what constitutes mental illness may be a barrier to the uptake of mental health care due in part to differences in cultural perceptions of mental health (Yaser *et al.*, 2016). The refugees' arrival in their host country is faced by restriction to employment,

poor sanitation and deteriorating mental health conditions, where by financial barriers deter them from utilization of mental health care. This was inconsistent with Upadhaya *et al.* (2020) when they assert that, some of those barriers include lack of priority and financial resources for mental health care, absence of decentralization mechanism for mental health and low number of primary health workers trained and supervised in mental health. Restrictive regulations to access healthcare based on legal status, linguistic and cultural barriers, lack of information regarding where and how to obtain care, economic barriers, and lack of cultural competence among health provider are major barriers to accessibility (Chiarenza *et al.*, 2019).

Conclusion Of The Study:

The study concludes that, majority 63.6% of the refugees reported their trauma occurrences to international non-governmental organizations Experts in the camp, while just a few 36.4% of the refugees did not report their trauma occurrences to the Experts due to fear, limited knowledge and information on mental health and mental health services, stigma, cultural stereotypes and language barrier. These challenges were hindrance to accessibility of mental health care services by refugees in the camp.

Recommendation Of The Study:

This study recommends that Non Health specialist workers (NHSWs) should be trained on mental health care by mental health care professionals so that they can provide mental health services to the refugees in the camp under close supervision by the Experts. Mental health care professionals in Dadaab camp should consider culturally responsive approach as mental health treatment among refugee as such can easily reduce stigma, fear and cultural stereotypes among refugees and accelerate possible access to healthcare.

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