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INTEROGATING REFUGEE RIGHTS TO HEALTH: A CASE OF PSYCHOLOGICAL HEALTH OF REFUGEE CHILDREN IN KAKUMA REFUGEE CAMP, KENYA.

BY

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DECLARATION

This research project report is being submitted in partial fulfillment of the requirements of the Post Graduate Diploma in Migration Studies.

I hereby declare that the work presented in this research project is entirely my own other and has not been presented for an award of diploma or degree in this or any other University for examination or Academic purposes.

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Declaration by the Supervisor

This project has been submitted for examination with my approval as the university supervisor

Signature…… Date……11/10/2020……

MR. MURIMIRI MAATHAI

DEDICATION

This research work is dedicated to my mother Abigail Mwalenga for her moral support during this study.

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ABBREVIATIONS AND ACRONYMS

ACEs	:	Adverse Childhood Experiences
ARC	:	Alien Refugee Certificate (issued by the DRA)
CFS	:	Child-Friendly Spaces
DRA	:	Department of Refugee Affairs
DRC	:	Democratic Republic of Congo
FMR	:	Forced Migration Review
GBV	:	Gender-based violence
HDI	:	Human Development Index
ICRC	:	International Committee of the Red Cross and Red Crescent societies
IDP	:	Internally displaced person
IOM	:	International Organization for Migration
IP	:	Implementing Partner
KISEDP:		Kalobeyei Integrated Social and Economic Development Programme
LWF	:	Lutheran World Federation
MRC	:	Mandated Refugee Certificate (issued by UNHCR)
NEP	:	North Eastern Province
OAU	:	Organization of African Union
PTSD	:	Post Traumatic Stress Disorder
RCK	:	Refugee Consortium of Kenya
RSD	:	Refugee status determination
SCUK	:	Save the Children
UNDP:		United Nations Development Plan

UNHCR: UN High Commissioner for Refugees

UNHCR: United Nations High Commissioner for Refugees

UNICEF: United Nations Children's Fund

WB: World Bank

DEFINITION OF TERMS

A child: means any person under the age of 18, unless under the (national law applicable to the child, a majority is attained earlier (Convention on the Rights of the Child, or CRC, Article 1)

Adverse Childhood Experiences (**ACEs**): These are traumatic events that occur in childhood. They include abuse, violence, and growing up in a family substance use problems or mental health problems. (CDC, 2019).

Attachment Relationship: This is a relationship where the child uses the primary caregiver as a secure foundation for the child to explore as a source of comfort and a haven of safety (Waters, et al; 2000).

Best Interests of the Child: This is a primary consideration in all decisions and actions undertaken for and with children including during all protection procedures. (UNHCR, 2017).

Child Protection: These are structures and measures in prevention and response to neglect, violence, exploitation, and, abuse affecting children. (Save the Children International, 2011).

Child Protection System: This entails sets of laws, regulations, and services, policies, capacities, monitoring, and oversight required across all sectors such as health, security, and justice for the protection of risks that children are vulnerable to (UNHCR, 2010).

Family Tracing: This is the process of searching for family members or primary caregivers. It also means a search by the parents. (ICRC, 2004).

Fostering: This means a temporary arrangement or situation where children are cared for in a household outside their family. The birth parents retain their parental rights and responsibilities. (ICRC, 2004).

Separated Children: are those separated from both parents, or their previous legal or customary primary care-giver, but not necessarily from their relatives. (ICRC, 2004)

Movement Pass: This is a legal document issued by the Commissioner for Refugee Affairs to an asylum seeker or a refugee, to facilitate movement outside the designated area. Reasons for issuing the pass include; medical, education, or on humanitarian consideration. (RAS, 2019).

Psychological first aid:(PFA) This is the provision of basic, human support, practical information, showing concern to individuals immediately after a critical event. (Psychosocial interventions handbook,2004).

Reunification: This is the process of reuniting the child and family or caregiver to re-establish long term care (ICRC, 2004).

Refugee: This is a person who owing to a well-founded fear of being persecuted for reasons of race, religion, sex, nationality, membership of a particular social group or political opinion is outside the country of his/her nationality and is unable or owing to such fear, unwilling to avail himself of the protection of his/her country (Refugee Act, 2006).

Refugee Status Determination; This is an examination by a government authority to determine whether an individual who has submitted an asylum application is indeed a refugee or whether his or her situation meets the criteria specified in the applicable refugee definition. (RAS, 2019)

Safe Haven: A location where women, children, adolescent girls who have experienced trauma from sexually-based violence are supported and kept safe.

Social Integration: The process where migrants or minority groups are included in the social structure of the host society (Richard and Victor, 1997)

Social Participation: Active involvement of individuals and groups in a range of mutually productive, interdependent relationships that together contribute to a social richness in our lives. (MacDonald and O'Hara, 1998).

Post-traumatic stress disorder: Is intense psychological distress characterized by horrific memories, recurrent fears, and feelings of helplessness that develop after traumatic events such as life-threatening events, natural disasters, rape. The symptoms include avoidance of stimuli associated with trauma, memory disturbances, social withdrawal, aggressiveness, insomnia. Support and skilled counseling may be needed. (Farlex, 2009).

Migrant: Any person who lives temporarily or permanently in a country where he or she was not born and has acquired some significant social ties to this country. (UNESCO, 2017).

Best Interests (BI) of the child: These constitute the basic standard for guiding decisions and actions taken to help children, whether by national or international organizations, courts of law, administrative authorities or legislative bodies (CRC, Article 3).

Unaccompanied children/minors: These are children who have been separated from both parents and other relatives and are not being cared for by an adult who, by law or custom, is responsible for doing so. (ICRC, 2004).

ABSTRACT

The purpose of this research project was to assess the psychological health of refugee children in Kakuma refugee camp. A refugee child is still a child with all protection needs for his growth and wellbeing. The study examined the risk factors that affected their psychological health and the psychosocial interventions that were suitable to give support to these vulnerable children**.** War and displacement have been observed to cause psychosocial problems and distress to refugee children. The study was focused on assessing the risk factors and possible interventions in addressing trauma and Post Traumatic Stress Disorder (PTSD). Refugee children need special care and legal protection. They should be accorded similar treatment as any other citizen child. Children are entitled to dignity and respect regardless of race, age, and social status. However, most of the children remain invisible in society yet they need special protection and assistance. They have rights to health and wellbeing, personal life and development, protection and safety, and normal family life just like anyone else. Children react differently from the stressful and traumatic events they encounter during the transition. For some, their psychological health is affected. This, in turn, affects their psychosocial development that is their mental, social, emotional, and spiritual wellbeing. Using social exclusion and social constructivism approaches, the study aimed to problematize the psychological health of refugee children in Kakuma refugee camp, Kenya. Various interventions have been proposed to assist and protect refugee children's psychological health. These are community support interventions, incorporation of psychosocial support in both formal and informal education systems for refugee children in camps, offering counseling services and training for teachers, parents, and the children themselves. A more important intervention is individualized care, realizing that every child has different experiences and are affected differently. Some children experience their journey from conflict or persecution through to safety into a different host country with different cultures and environments. Others are born into refugee situations and grow up in refugee camps. The study adopted a descriptive research design in which both primary and secondary data was collected and analyzed in the context of refugee children's psychological and psychosocial health and how this facilitates the full realization of refugee children's right to health. Primary data was collected using semi-structured questionnaires and face to face interviews with various child protection stakeholders. The findings indicated that refugee children observed in schools experienced trauma and stress disorders due to their refugee experiences and daily stressors in the camp. This was exhibited by social withdrawal, depression, and other behaviors. As much as access to health is free, there is more to be done through holistic psychosocial interventions. The study recommended that refugee children's psychological health needs more attention, early childhood education teacher training, community-based approaches, sensitization, more pediatric counselors, and the creation of safe spaces for refugee children in Kakuma.

Keywords: refugee, refugee child, psychological health, psychological well-being, risk factors, psychosocial support, counseling, psychosocial support, counseling

CHAPTER ONE: INTRODUCTION

1.1 Background of the Study

Refugees are vulnerable due to their experiences from their country of origin, their journey to safety or refuge, and settlement in the host country. Displacement, life threat, and economic hardships have a link to PTSD (Thabet, Ibraheen, et al, 2010). A United Nations High Commissioner for Refugees, (UNHCR, 2001-2020) report states that there are 25.9 million refugees globally, the majority of who are hosted in developing countries. Women and children are the first victims of conflict and displacement. They leave behind everything familiar and safe. However, refugee children are easily overlooked and little is known about their mental health functioning (UNCRC, 1989).

Most refugees are hosted in low and middle-income countries according to the World Bank classification where mental health services are absent or inadequate due to lack of specialized human resources and insufficient funding to set up specialized mental health services (Saxena et al., 2007; Kakuma et al., 2011). Refugees are at high risk of developing mental health problems due to myriad risk factors such as experiences of violence and upheaval in their home countries, hardships during the flight and ongoing adversities and disrupted social support mechanisms in refugee settlements (United Nations High Commissioner for Refugees, 2015; Silove et al., 2017) Forced displacement has a psychological impact on refugee children. They experience anxiety disorders, post-traumatic stress disorders, and depression, due to exposure to conflict, torture, death, and separation from their families (Fazel, and Stein, 2002). Most of those affected are unaccompanied children.

Fazel and Stein, (2002), indicate that over half of the global displaced populations are children. These refugee children and adolescents have been reported to exhibit high rates of PSTD, depression, and other behavioral issues even after they have been resettled (Craig, 2009).

This study was informed by the social exclusion theoretical approach and social constructivism theory. Social exclusion is the process whereby individuals are wholly or partly segregated from full participation in their society, (European Foundation,1995). Those who are socially excluded are not included in mainstream society. Saracano, (2001), asserts that society has to ensure equality in terms of access to education and health, rights to justice, employment, and social integration. Refugee children are vulnerable due to protection risks. The mental disorders vary from post-traumatic stress disorder to depression and aggression (Vossoughi, et al 2016). Other than hostile situations such as genocide, political persecution, and torture in the origin countries, refugees face traumatic journeys to asylum countries in camps that have various stressors affecting their mental health (Reedy, 2010). The social constructivist theory states that human development happens in the social environment and that knowledge is constructed through interaction with others (McKinley,2015). This theory by Lev Vygotsky (1978), states that the social and cultural context are major factors in learning where learners are integrated into knowledge community. Hence language and culture determine how individuals learn and perceive the world. That learning is a product of social interaction; hence social integration.

Kenya ratified the 1989 United Nations Convention on the Rights of the Child, (UNCRC) on 30th July 1990. This is an international agreement for children's rights that states that every child has the right to protection, survival, and education, regardless of their race, religion,

and abilities. The Refugee Act 2006 part 17 (g) States that a refugee camp officer shall manage the refugee camp and ensure protection and assistance of vulnerable groups, women, and children. Part 23 (2) states that the Commissioner shall ensure that an accompanied or unaccompanied refugee child shall receive appropriate protection and assistance. It is an emerging customary practice that a child shall be accorded the same protection as any other child permanently or temporarily in any state territory. States take the *prima facie* role in the protection of children while United Nations High Commissioner for Refugees (UNHCR), United Nations International Children's Emergency Fund (UNICEF) and other non-governmental agencies in Kakuma offer the provision of counseling, early childhood education, nutrition, and immunization as complementary to state efforts thus contributing to the promotion of human security. Management of the refugees in Kakuma refugee camp is multifaceted and multidimensional. The Government of Kenya, UNHCR Sub Office in Kakuma, Refugees Affairs Secretariat the Turkana County Government, work together through the office of the Deputy County Commissioner. Institutions in refugee management are States, non-governmental organizations, UNHCR, and International organization of Migration (IOM). UNHCR plays an oversight role in refugee assistance and management Refugee children in Kakuma camp represent 54.2 percent of the total refugee population as of 31st December 2019 (RAS,2019).

1.1.1 Refugee Situation Analysis

According to the World Migration Report (2020), there were some 25.9 million refugees globally as at close of the year 2018. Of this population, 20.5 million are under the mandate of the UNHCR and thus under indirect protection of the global community. This shows the

protracted nature of the refugee situation.

The anatomy of the global refugee crisis tends to assume a cyclic nature where the crisis is concentrated in Africa, the Middle East, and Balkan countries. This seems to be the epicenter of the refugee crisis in the world. Historically the lost teenage boys from Sudan were separated and orphaned after the Sudanese Civil War and were forced to flee to Kakuma. Most of the boys were forced to join militia groups as child soldiers. This has also added to their traumatic experiences. Most of the refugees in camps are vulnerable due to health problems, gender-based violence, psychosocial stress, poverty, harassment, and detention (Global refugee forum, 2019). The UNHCR child protection strategy was initiated due to the many reported cases of early marriage, risks of abduction, female genital mutilation, emotional and psychological abuse. These issues are further compounded by the loss of social support. These risk factors impact negatively on the child's psychological health. According to RAS (RAS Handbook, 2019), 84 percent of the refugees in Kenya are hosted in camps, while 16 percent live in urban areas. Male refugees in Kenya make up 51 percent, while female makes 49 percent. The records also indicate that refugee children and adolescents ages (0 to 17 years) make up to 55 percent of the entire refugee population. Kakuma is one of the most diverse camps (Golden, 2017). Most of the populations are those who have fled civil strife from South Sudan, political persecution in Ethiopia, and long-tern conflict situations in the Democratic Republic of Congo and Somalia (UNHCR, 2017).

There are four camps in Kakuma, and a prominent feature is the conflict between, the refugees and the host community. This resulted in the Kalobeyei settlement scheme to enhance economic self-reliance and local integration for the refugees (Vemuru, et al, 2016).

The goal of the settlement was to integrate 20,000 turkana host communities and 60,000 refugees. The reunification of refugee children is guided by the Convention on the Rights of the Child, international human rights law, and the national legal framework of the said country.

A participatory assessment conducted in Kakuma by UNHCR in 2017, found that teenage girls were forced into survival sex due to lack of basic needs. There is a gap in child protection and rights when it comes to unreported cases and a shortage of protection focal points. Refugee children in Kakuma camp are in foster families, child-headed households, and those with disabilities (EU, Fact sheet, 2018). As most of the refugee children hope to return to normalcy through voluntary repatriation or even resettlement, most are in a protracted situation. Most of the refugee children were born in Kakuma refugee camp.

In Kenya, the Refugee Affairs Secretariat (RAS,2019) estimated the total refugee population of 489,747 as of December 31st, 2019. This puts Kenya at fifth position in the world and third in Africa in terms of the total population of refugees hosted in its territory. According to the Kenya Census (2019), the total population of refugees in the country stood at 479, 194. From this total population of refugees and asylum seekers, Kakuma refugee camp and Kalobeyi Integrated Settlement Project (KISEP) accounted for approximately 191,500 refugees and asylum seekers and 181,440 refugees alone without including asylum seekers as at December 2019. The table 1 below presents a typology of the refugee distribution in Kakuma.

Table 1.1: Refugee distribution by nationality and age in Kakuma refugee camp

Country of Origin	**Total Population**	**Male**	**Female**	**Children**	
				Male	Female
South Sudan	112118	59557	52561	25058	31100
Somali	34146	16936	17210	9562	9073
Congo DR	12752	6770	5982	3681	3530
Burundi	10787	5726	5061	2807	2898
Ethiopia	10232	5378	4854	2661	2685
Sudan	9867	6578	3289	2564	1663
Uganda	1443	740	703	369	382
Others	822	383	439	35	188
Totals	**181440**	**102068**	**90099**	**46737**	**51519**
% of total refugee population	**100**	**56.3**	**49.7**	**25.8**	**28.4**

Source: UNHCR, March, 2020.

From the table above, as of December 2019, it can be realized that there were approximately 98,256 refugee children in Kakuma refugee camp. This is the population of refugees whose health rights are at stake of being abrogated either due to parental negligence or economic inability from the caregivers or government policy to deny them access to health. Given that there is no evidence of the existence of a deliberate government policy inhibiting access to health by refugees, it can only suffice to say that the failure to access this right can be blamed on other factors such as unavailability of services, lack of awareness, quality issues and individual factors in accessing health services. Although the table presents a picture of the children population in Kakuma refugee camp, there are those ages that the likelihood of psychological and psychosocial issues become prominent. Among the age group of 11-17 years, the chances of a child becoming mentally disoriented

due to several factors are higher than in the early childhood years.

This study focused on the age group that can be diagnosed with PTSD given it's the enlightened age. The Refugee Affairs Secretariat (RAS) records show that out of the total population of refugees in Kakuma refugee camp as of 2019, 78% were women and children. This indicates the magnitude of the vulnerability of the refugee population and the complexity of the need for protection and inclusion. According to UNHCR, (2017), there were 109,672 refugee children below the age of 18 years. Out of this total number of refugee children, 45 % were girls.

1.1.2 Refugee Children Experience

Refugee children in camps are at risk of mental health problems due to factors such as poverty, malnutrition, language barriers, post-traumatic stress symptoms of parents, the protracted refugee situation in the camp, harsh environmental factors, and poor health conditions (Montgomery, 1998).Generally, psychological health disorders develop in children due to the transition from a war or conflict zone to an unfamiliar socio-economic and cultural environment (Rutter, 1999). Protracted refugee situations like the one in Kakuma refugee camp have cast uncertainty on over their futures. This leads to distress on the side of the parents and an inability to provide physical and emotional support for their children.

There is no universally accepted definition of the term, ''Refugee Child'' (UNHCR, 1987). This study will refer to the above as refugees and asylum seekers up to the age of 18 years. The 1951 Convention and its 1967 protocol states, that a child with a well-founded fear of being persecuted for one of the stated reasons is a 'refugee". Article 1 of the United Nations Draft Convention on the Rights of the Child states that a child means every human being

below the age of 18 years unless, under the law applicable to the child, a majority is attained earlier. Article 22 states that State parties shall take appropriate measures to ensure that a refugee child, whether accompanied or unaccompanied by his or her parents shall receive appropriate humanitarian assistance and appropriate protection in cooperation with United Nations Organizations and Non- governmental organizations. The assistance would be to trace and reunify with the family and if not given protection like any other child. (OHCHR,1996-2020).

Refugee children are children first, they are dependent and vulnerable (UNHCR, 1994). Conflict, natural disasters, wars, and displacement or uprooting affect the psychosocial functioning and integration of refugee children. Interventions are urgently needed in ensuring their long-term recovery and wellbeing. Children have special needs in aspects of health, among other areas. All interventions should be having the best interests of the child where their physical, psychological, cultural, and social development needs should be met (Ressler, et al., 1987).

The most vulnerable refugee children are those who are unaccompanied, those separated from their parents, those who are disabled, and those who have been in a protracted situation in the camp. Long periods of stay in the camp and dependency expose children to depression, anxiety, passive, and aggressive behavioral patterns. (UNHCR, 2005). Refugee children often end up in a vulnerable state where they have lost their identity, normal cultural, social, and economic environment due to their young age and refugee status. This vulnerable group of people suffers socio-economic losses that affect their ability to function as parents.

The parents also become anxious and distressed (UNHCR, 1994). According to (Lustig et al 2003, Berman 2001, Pumariega et al 2005, and Fazel & Stein 2002,) the refugee experience is divided into linear stages such as the pre-migration, migration, and post-migration stages. Pre-migration stage is often characterized by an environment with armed and or political, conflict, violence, and war. The given state or government cannot provide protection from persecution, torture, and threats to the children and their family members (Lustig, et al., 2004). The situation in the pre-migration stage causes forced displacement from their homes in search of asylum and refuge.

The migration stage is characterized by risk factors such as dangerous migration journeys, separation of families, and even death. Family separation changes the roles of the children, in that they are forced to head households or take on adult responsibilities to care for their siblings. This factor harms their peer interaction and school attendance. Some of the refugees are detained and some end up in refugee camps (Mohamed, 2012). The post-migration stage is where the asylum seeker or refugee settles in a host country awaiting a durable solution to their plight. A large percentage of the refugees in the host countries experience trauma due to the unfamiliar and hopeless conditions and loss of family member's social structures and networks, material possessions, and lack of access to common goods and services. Most of them are marginalized and discriminated by the host community. It is here that they have to adjust and develop coping mechanisms (Papadopoulos, 2001). Despite these dire situations in new environments in host countries, (Mohamed 2012), in her study on the mental health and psychological well-being of refugee children, found that most refugee children were able to cope, survive and even thrive. These refugee children adapt to their environment and became resilient.

The above risk factors in each stage of the refugee experience affect the child's emotional, social and material needs and hence are put at risk of developing psychological health issues (Fazel and Stein, 2002). An extended stay in camps like Kakuma refugee camp may adversely affect refugee children because to them it is an artificial environment (UNHCR, 1994). Their movements are restricted, they live in poor conditions, face discrimination, and are dependent on aid. Separated and unaccompanied children who head households mostly experience depression (UNHCR, 1994). Protracted situations affect resettlement and reintegration especially of refugee children who have been born in the camps. UNHCR, other partner organizations, and the community, therefore, cooperate to provide psychosocial programming for refugee children and adolescents to strengthen resilience. Prickett, et al;(2013),

1.1.3 Post-Traumatic Stress Disorder (PTSD) in Refugee Children

To (Kuttikat 2010), the effects of physical and mental trauma are long-lasting. They are like a sore scar on the face of a person. PTSD is stress and trauma related to a migrant's psychological health. This can be linked to the length of stay of the refugee or migrant in the host country or community and their ability to adapt to the host community environment. An increase in stress can be due to factors such as social and cultural barriers (Weishaar, 2008) as well as the "political economy" of their stay in the host country. Post-traumatic stress disorder is characterized by exposure to a highly stressful experience or event. According to (Mohamed, 2012), it is characterized by a decrease in sleep, anger, numbed responsiveness, avoidance of stimuli associated with the traumatic experience, and re-experiencing of the traumatic event. Other psychological outcomes related to traumatic events are depression, anxiety, irritability, and restlessness.

The affected feel emotionally detached and have sudden outbursts of anger, they experience headaches, abdominal pain, depression, low mood, loss of interest on pleasure, poor performance in school. Refugees have an increased rate of post-traumatic stress disorder and anxiety (Steel, et al., 2009). War, transition incidences such as detention, and daily stressors post-migration are risk factors to the impaired psychological health of refugee children (Van Ijzendoorn, et al., 2003). The above condition may be characterized by aggressiveness and disorganized behavior due to exposure to extreme events ((Woodcock 2000). These disorders pose a great challenge to social integration in the host community. There is a need for trauma-sensitive interventions. The emotional wellbeing of a refugee child is dependent on both access to specialized health services and psychosocial support from the family and the host community. However, in most cases the parents could also need counseling or separated or in distress and unable to parent or provide for the children.

1.2 The Research Problem

There has been a lot of focus on refugee access to public goods and durable solutions but little focus has been given on research on how to support the psychological health of refugee children and adolescents (Hodes et al.,2018; Persuad, 2017). There is more room for further research on the status and psychosocial interventions that would assist refugee children. Studies such as that by Ferget and others reveal that refugee children experience trauma from their countries of origin, during their flight and in the country of asylum (Ferget et, al 2018). The more traumatic events, the more the increase in the likelihood of psychological disorders. Other researches have been conducted to reduce the gap in refugee children mental health data in Africa and elsewhere juxtaposed to host community children in the same environment or habitation. Proper psychological interdisciplinary health

interventions cannot be effective without taking into account how many children are affected by traumatic events that lead them to become vulnerable refugee children (Golden, 2017). Psychological health issues also tend to be gender-specific, the psychosocial needs of refugee adolescent girls are different from those of boys, yet these issues have not been taken into account (Samuels, et al,2018). Refugee children are physically abused, abandoned, tortured during their flight to safety. The negative effects of forced migration sometimes continue even in asylum countries. These are but not limited to physical abuse, loss and or death of family members, observing violence and conflict, and general human rights abuses. Most of the data of those affected are those who seek help. A study by (Miller and Rasmussen 2010), found that exposure to violence, loss of family members, child sexual abuse war, in conjunction with daily stressors such as scarce resources and overcrowded spaces and isolation contribute to psychological distress. (Foa and Rothbaum, 2009), states that most refugee's trauma survivors still recover psychologically after some time. The children in the camp are vulnerable, those exposed to forced displacement, and those who are born in the camps. Another study by (Panter-Brick, et al 2009), on children's mental health, stated that their exposure to beatings or sexual abuse at home or the host community-led to different symptoms of depression and PTSD. This is an indicator that refugee children are affected during conflict and post-war settings.

Despite the many studies done through interviews and perspectives of the parents and children (self-reporting interviews), (Heptinstall, 2004) the psychological needs and well-being of refugee children have never been fully recognized and appreciated for comprehensive action-taking. This study sought to assess the psychological health of refugee children from the perspective of their teachers, social workers, protection officers

in different organizations. In trying to assess the psychological health of refugee children, this study sought to answer the question: Are the interventions on the management of the psychological health of refugee children in Kakuma refugee camp effective.

1.3 Research Questions

(i) What is the status of the psychological health of refugee children in Kakuma refugee camp?

(ii) Are the interventions on managing the psychological health of refugee children in Kakuma camp effective?

1.4 Research Objectives

The general objective of this study was to examine the implementation of the child refugees' right to health as enshrined in the Universal Declaration of Human Rights and the African Charter on Human and People's Rights together with the UN Convention on the Rights of the Child.

The specific objectives were:

i) To examine the psychological wellbeing of refugee children in Kakuma camp.

ii) To examine the effectiveness of the psychosocial interventions in managing the psychological health of refugee children in Kakuma camp.

1.5 Significance of the Study

The findings of this study were useful for finding gaps for further research on the management of refugee children's psychological health in Kakuma refugee camp and any other refugee camp. Further, the research brought out a wider understanding of the psychosocial needs of refugee children. With this understanding, evidence-based policies will be developed to manage the psychosocial health needs of these vulnerable persons. The findings will assist in the formulation and implementation of policies on refugee children in Kenya by the Government and Non- governmental organizations. The findings will also be informative to practitioners such as child protection officers in various refugee organizations.

1.6 Justification of the Study

This study was premised on the understanding that new knowledge needs to be generated on the interface between the psychological needs of refugee children in refugee camps as a strategy towards enhancing government and other stakeholders' capacity in managing the psychosocial needs of these vulnerable persons.

The findings of this study were important in informing evidence-based policy formulation on the management of refugee children's needs. It was also important in addressing the research gaps existent in the country since not many pieces of research have focused on the psychosocial wellbeing of refugee children. This area of research has mostly been unexplored thus resulting in a knowledge gap.

CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction

This chapter provided a critical analysis of key areas of literature relevant to the research questions. It reviewed the theory identified and explained the conceptual relationship of the study. The discussion in the chapter was on the role of education and parental support on refugee children's psychological health, the vulnerability of unaccompanied and separated children, the psychological health, and psychosocial interventions. Lastly, it brought out the summary of the knowledge gap.

2.2 Theoretical foundation

The study on refugee right to psychological health was premised on two theoretical approaches namely the social exclusion theory and social constructivist theory.

2.2.1 Social Exclusion Theory

The study took the theoretical approach of social exclusion which is associated with Renee Lenoir (1974) as its theoretical framework. Gijbers and Vrooman (2007) studied 10 European Member states. They discovered that there are factors that lead to social exclusion. Minority Rights Group International (2010) emphasized that minority groups such as refugees can experience social exclusion from the host community. It becomes very difficult for most of the refugees to adapt to the new host environment and culture which is in most cases hostile. Social exclusion is the process whereby individuals are wholly or partly segregated from full participation in their society, (European Foundation 1995).

Refugees can be said to be partially segregated from the host society given that they are restricted to special residential areas designated as camps. The encampment policy applied to refugees such as in Kakuma camp is meant to segregate the refugees from the local host community. The refugees can only be allowed outside the refugee camp after obtaining an authorization from the camp management in the name of a movement pass.

According to (Garvranidou, et al 2008), social exclusion can have a more negative effect on the wellbeing of these already psychologically affected refugee child populations. Such children tend to be withdrawn and have challenges in social integration. Hence, the need for initiating policies that enhance social inclusion. Gijbers and Vrooman, and Garvranidou et al studies were to find ways to reduce social exclusion through policy intervention and in the case of refugee children through psychosocial interventions that enable them to socially integrate with the rest of the refugee population and the host community. To be socially included, refugees need emotional, economic, linguistic, and cultural support. Social exclusion presents a multidimensional outlook. It can take economic exclusion, social, and cultural exclusion. Economic exclusion indicators are a lack of basic needs, access to government provisions, social services, and social security. An economic exclusion means being left out of the mainstream economic structure and life of a society. Social exclusion meant a lack of social cohesion and integration. Cultural exclusion is indicated by the lack of moral and normative obligations or responsibilities towards the family and the host community. Whatever form of exclusion results from failure to craft policies and strategies mainstreaming the large society into the economic, social, and cultural aspects of society. Those who are socially excluded are not included in mainstream society. (Saracano 2001) asserts that society has to ensure equality in terms of access to

education and health, rights to justice, employment, and social integration. Generally, refugees are viewed as an isolated group that is socially excluded from society due to limitation or deprivation of physical, social, and economic needs. More so refugee children suffer more exclusion and isolation than the host country's children. This is worse where some of the refugee children came into the country as unaccompanied or separated from their parents and siblings are extremely vulnerable. These children are dependent on humanitarian aid and the host community to settle, socially integrate, and lead wholesome lives. In the context of refugee children, the study focused on psychosocial interventions to reduce the effects of trauma, discrimination based on race, language barrier, or status towards bringing about social inclusion of these children in the host community. This can be experienced through social acceptance, social integration in education facilities, social bonds, and social networks with peers and primary caregivers, and their teachers in schools.

Refugee children already have past traumatic experiences due to displacement and disruptions from their origin countries to the host country. Some become unaccompanied and others are separated from their family members. Less attention is paid to refugee children and yet they are one of the most vulnerable groups. They have been excluded socially from their families, social networks, school, and familiar environment. Interventions in support of the psychological health of refugee children bring out important social networks. Refugee children need social bonds.

And social networks (Save the Children, 2004). They also need access to education, health, housing and employment, stability, and safety which is facilitated by knowledge of the host culture and language (Ager and Strang, 2004). To (Zetter et al. 2002), refugees generally have experiences that make them excluded socially through lack of access to material needs, public services like health and education, racial or ethnic discrimination.

2.2.2 Social Constructivism Theory

The social constructivist theory states that human development happens in the social environment and that knowledge is constructed through interaction with others (McKinley 2015). First proposed by Vygotsky, (1978), social constructivism states that the social and cultural contexts are major factors in learning where learners are integrated into a knowledge community. The theory emphasizes the important role of social interaction and social processes. This applies to refugee children and how their refugee experiences, affect them negatively by causing psychological trauma and how they can experience social integration through psychosocial support from parents, primary caregivers, their peers, counselors, social workers, their teachers in schools, and the community as a whole. Hence language and culture determine how individuals construct and deconstruct the world around them buy attaching images and symbols to what they see in the environment. Social constructivism posits that learning is a product of social interaction where two different but related people meet with zero knowledge of the others social and linguistic competence but due to ability to form social networks, persons end up sharing verbal and non-verbal signals that become common among them thus forming a language or form of language. This is broadly called social integration. Social integration presupposes a commonness of environment, emotions, world views, signs, and symbols, language, tolerance to cultural

diversity, and meaning of certain elements within the society. The social constructivist theory emphasizes the important role of social interaction and social processes. This applies to refugee children and how their refugee experiences, affect them negatively by causing psychological trauma and how they can experience social integration. through psychosocial support from parents, primary caregivers, their peers, counselors, social workers, their teachers in schools, and the community as a whole.

Refugee children's experiences are factors beyond their normal imagination. The new refugee situation they are cast in leaves them socially and psychologically torn into different constructs of the sweet past before being driven away, their migratory constructs, and the present life in the refugee camp. These various experiences leave refugees with disjointed social construction that is anathema to their psychological and psychosocial wellbeing. Through the social constructivist theory, the various life images of refugees can be pieced together into a single story either by the use of images/pictures and words that add meaning to their mental health.

While social exclusion theory looks at the segregation of refugees at various stages including segregation of refugees on various grounds within the refugee camps, social constructivist attempts to reconfigure this segregation grounds to be points of unity and social inclusion. The reconstruction of already excluded refugees should be done to all categories of refugees.

2.3 Empirical Literature Review

2.3.1 Protection of Refugee Children

According to UNHCR (2012), the standards and principles that guide child protection are; best interests of the child, non-discrimination, and child participation. UNHCR acts to protect refugee children by ensuring their safety, access to asylum legal procedures, and ensuring that those with protection needs are given support. Interagency cooperation and coordination by UNHCR and partner organizations because child protection is multifaceted. It cuts across education, nutrition, water and sanitation, and camp. health. Child protection risks in this context are, sexual and gender-based violence, mental health and psychosocial distress, child Labour, unaccompanied and separated children, and physical and emotional distress (UNHCR, 2004).

Refugee children have protection risks. Due to the refugee situation at the tender age, most end up with mental and psychological challenges that require a response from their caregivers and society in which they abide. The mental disorders vary from post-traumatic stress disorder to depression and aggression (Vossoughi et al 2016). Other than hostile situations such as genocide, political persecution, and torture in the origin countries, refugees face traumatic journeys to asylum countries in camps that have various stressors. This affects their mental health (Reedy, 2010).

2.3.2 Unaccompanied Children

According to Mohamed (2012), unaccompanied children are those under the age of 18 years old and are outside their country of origin, seeking asylum without the company of an adult or close relative. Separation and isolation from one's community and family lead to loss of social support for the children (Miller and Rasco, 2004). According to (Russell,

1999), unaccompanied children are those children who are separated from both parents, and nobody has primary responsibility for them. These children could have witnessed the death or separation of their parents and left alone. These are most vulnerable due to increased risks of sexual exploitation, emotional abuse assault, neglect or denial of basic rights and other forms of exploitation or abuse not just in the camp but during their flight to refuge. Some lack any form of documentation and refuse to talk due to trauma. Such children need child-sensitive interviews. In the absence of UNHCR intervention programs, unaccompanied children are at risk of domestic violence, child recruitment, sexual abuse, and early childhood marriages (UNHCR, 2017-2019).

Some of the unaccompanied children assume adult responsibilities and end up heading households in the refugee camps. This is because their families are fragmented or they lost their parents and they have to remain as a unit as siblings. Some are given caregivers by the agencies that deal with refugees in the host countries. Another important way of supporting refugee children who are separated from their families during the conflict and forced displacement is through family reunification. Hodes, et al. (2008), in their survey in London on the posttraumatic stress symptoms of both accompanied and unaccompanied refugee children found that unaccompanied refugee children experienced higher levels of post-traumatic stress symptoms compared to those accompanied. Unaccompanied and separated children need to be identified early so that family tracing and reunification procedures can be undertaken. This is all with the focus on their access to psychological health support.

2.3.3 Separated Children

A separated child is one who is separated from both parents or previous legal caregiver but not necessarily from his or her relatives (ICRC, 2004). The physical and psychological wellbeing and survival of these children are at risk because their parents and family are not present. Hence they need interventions aimed at family tracing, child care, and reuniting them with their families. In assessing children's refugee claims, there is a need for expert assessment. If the refugee child is unaccompanied or separated, there needs to be a guardian and a legal representative for the best interest of the child, (ICRC, 2004).

Armed Conflict and displacement cause many children to become separated from their parents (ICRC, 2004). According to ICRC, (2004), separation occurs when fleeing from danger, during an evacuation, or when children are abandoned or given over to other caregivers. Their parents could still be in the country of origin or a third country. All information about these refugee children must be collected during interviews with the child or any other person who can give information about the child or his or her family.

2.3.4 Social Integration for Refugee Children.

Social integration is a multidimensional process. It is also a two-way process between the immigrant or refugee and the host community. Children need social support to integrate well. Their migration experiences need to be understood so as their sense of purpose and livelihood can be restored (Kushminder, 2017; Li & Obamehinti, 2016). This is the process whereby the refugee becomes socially included by the host community, without losing their values and their identity. It entails non-discrimination based on race or religion any other factor that differentiates them from members of the host society.

Social Integration focuses on immigrant's adaptation to the local language, customs, and

values and therefore building social networks with the host community through daily interactions (Jacob, 2008). According to Wang, et al (2012), some of the indicators of social integration are intermarriage, learning the local language and local culture. These factors facilitate the immigrants to access rights and services as the locals of the host country. Social integration for refugee children depends on pre-migration and post-arrival migration experiences. Most of them have experienced pre-migration trauma through physical torture, witnessed killings of family members and friends, and starvation (Craig, et al, 2009). In the country of asylum, factors such as language barriers, homelessness, and lack of access to social services also increase their levels of stress. This affects their social integration and levels of PTSD (Stenmark, et al, 2013). Internalized traumatic events affect the child's wellbeing and development (Melzak, 2009). The handbook on psychosocial interventions (2004), posited that psychosocial interventions in this context include; regular playgroups with peers, drama activities, and youth clubs.

A Longitudinal study of 46 Cambodian refugee children by (Kinzie, Boehnlein, et al, 1990), found that post-traumatic stress disorder (PTSD) manifested at 40% on the onset and after 3 years, the rates increased to 48%. Children in such conditions of forced migration remained vulnerable and depressed. State parties to the Convention on the Rights of the Child have the obligation to ensure that a child seeking refugee status, whether accompanied or unaccompanied shall be accorded humanitarian assistance and protection. (UNHCR, 1987). Interventions such as family group interventions, psychosocial support, and school-based approaches to both refugee parents and children are needed to ensure their psychological wellbeing (McCloskey, 1996). Aspects to consider in managing these conditions for refugee children are accommodation centers as they wait for Refugee Status

Determination and Reporting centers. Refugee children's needs vary; this could overwhelm the institutions, agencies, and health facilities based in refugee camps.

2.3.5 The Role of Education on Refugees Children's Mental Health

A study by Prickett, et al; (2013) found that attendance to school was the most important protective factor for refugee children in Rwandan camps. That school attendance was a safety net and a place where they learned about their rights and improve their future prospects. The study also found that those out of school were reported to feel hopeless and risked sexual exploitation. It is important to note that it is normal for students of many ages to learn together in a single classroom. This is due to a few classrooms and because refugee children join schools after they are registered. However, almost half of them have no access to education. And yet self-reliance and access to durable solutions require elementary education. According to Winthrop and Matsui, (2013), refugee children need education so that they can improve their sense of livelihood and have hope for the future. High-quality education for refugees is important (UNHCR Global Review for education, 2011).

However, there seems to be a lack of awareness of the rights. According to UNHCR, Education Strategy (2012-2016), an education program was established in the Kakuma refugee camp in consultation with the respective Ministry of Education and other partners. Non-governmental organizations (NGO'S), have also provided opportunities for vocational training. More so, going to school for refugee children restores normalcy and predictability through peer networks and daily routines.

There are 13 pre-schools, 21 primary schools, and 5 secondary schools. Ninety-two percent of primary eligible refugee children have enrolled and only six percent for those eligible for secondary school (UNICEF, 2018). This is an indication that 94 percent of those eligible for secondary education are out of school. Fifty-seven percent of the teachers in the schools are also under qualified, they lack training and experience to teach refugee children education strategy in the camp has been hampered by insufficient learning materials such as textbooks, crowded classrooms, and lack of electricity and sanitation facilities, socio-economic factors, and cultural traditions. Vocational training for the youth is not enough and the youth at the camps are vulnerable to protection risks. Yet, education and vocational training for refugees adds to their agency in social participation and prevents them from being socially excluded in society, (Bai, 2006). Kirk and Winthrop (2007) state that refugees who were teachers in their countries of origin do not remain in their profession due to challenges in professional development opportunities, financial challenges, and in chances of being hired. For the local teachers, the working conditions are too harsh. The language of instruction and the education curriculum also brings challenges to both the refugee and national teachers. The children are expected to learn in English and Kiswahili. Language barriers can hinder the chances of employment, resettlement, and re-integration.

Some of the public schools that have a percentage of refugee pupils located in Kakuma refugee camp are Angelina Jolie, Fuji, and Lokituang. There is also a community-based school known as Kismayo (Mendenhall, et al 2015). Public schools are funded by UNHCR. The community-based schools were funded by the refugee community.

Concern was expressed on conflict amongst refugee students from different nationalities due to their backgrounds and vulnerable situation. (Mendenhall et al 2015). Most of these children have a background of trauma and are also in need of psychosocial support. The role of schools and the community cannot be underestimated as protective factors from trauma and stress that results from the refugee experiences. Attending school gives refugee children a sense of predictability in their lives. However, adjustment to the new school environment, education level, and the system will depend on adaptation levels and language literacy. High levels of PTSD were associated with lower language levels (Bronstein and Montgomery, 2011). Social integration in the school is two ways, between the school attending refugee children and the teachers. Strong friendship bonds and peer support are experienced in schools.

The role of schools for refugee children is of importance in identifying their psychological health status and facilitating access to their care (Craig, et al, 2009). Education is the surest road towards a sense of purpose and dignity (UNHCR, 2018). It is one of the tools for the transformation and dignity of refugee children. Globally only 50, % of refugee children have access to primary education and only 22 % attend secondary education, 1% attend university (UNHCR, 2016). Schools for refugee children in the camp enhance their behavioral, and social adaptation. It is important for social integration. They also help in monitoring their academic progress and individual competencies and act as stable social support (Werner and Smith,1982). According to (UNHCR, 2005), there is a positive effect when refugee children go to school. Schools provide a sense of social security and stability after displacement. It assists in social skills development that could have stagnated.

Due to traumatic events of displacement. A school is a place that gives refugee children a sense of belonging and acts as a temporary space for security (Michelle and Dryden-Peterson, 2018). School attendance for refugee children creates a sense of normalcy in them hence breaking the cycles of disruptions and family and cultural uprooting. School going refugee children are allowed to mingle and play which is a fundamental aspect in a child's psychological, physical, and social development. Tolfree (1996) stated "Play is a window to the psychosocial well-being of a child'. According to (Mohamed, 2012), each host country should develop a comprehensive refugee education policy. That parents and the local community at large should be involved in supporting the refugee child.

2.3.6 Family Reunification for Separated Refugee Children

Refugee children can access health facilities and interventions in the campH. A study on community-based child protection in refugee camps in Rwanda by Pricket et al;(2013) respondents had a general view that a child's family was the main source of protection where they got support and counsel from. However, a study by True et, al (1993), found that the psychological state of parents affects children as well, in that parents with (PTSD) had an increased risk of their children experiencing the same disorder. Psychological parental distress has a psychological impact on children (Luckman and Bach-Mortensen, 1995). For most children identified with protection needs a family environment is the best for their psychological health and growth.

Family tracing plays a very essential role in refugee families. Family reunification requires tracing; this is the process where family members or close relatives or extended family are sought after by the parents or a search for the children by the parents, (ICRC, 2004). In this process, the protection of the child should be paramount. This can be done through proper

verification where the validity of the relationship between the child and the family member is confirmed. Tracing between countries requires interagency cooperation and collaboration for example with International Rescue Committee, United Nations Children's Fund and the National Red Cross and Red Crescent Societies which have the mandate to trace families and children across the borders.

2.4 Legal and Policy Frameworks for Management of Refugee at Kakuma Refugee Camp

Despite the international legal framework on the rights of the child, national legislation and institutions may not promote the best interests of refugee children. Refugees in Kakuma camp are already physically excluded. They are not allowed to integrate freely with the host community and they are dependent on aid. The refugee legal and policy frameworks in Kenya are pegged on both national and international legal instruments. The national instruments are the Kenya Citizenship and Immigration Act 2011, the Refugees Act 2006, and the Refugees bill, 2019 (IOM, 2015a).

The regional and international instruments are the 1951 Convention Relating to the Status of Refugees, the 1967 protocol and the AU Convention Governing the Specific Aspects of Refugee Problems in Africa (1969), African Charter on Human and People's Rights (ACHPR, Banjul, 1981) ratified by Kenya in 1992, Convention on specific aspects of Refugee Problems in Africa (1969) ratified in 1992, African Charter on the Rights and Welfare of the Child (1990) that Kenya acceded to in 2000 among other instruments that indirectly provide for state obligations in ensuring the mental health of refugees. According to Maina (2016), the implementation of the refugee protocols has undergone different phases. That the refugee law is currently seen as an instrument of security than of protection.

During the first stage (the golden age,) the Government of Kenya was in-charge of refugee management and allowed free movement and access to work. Most of the refugees from Ethiopia, Somalia, and Uganda were economically and socially integrated. Between the year 1991and 2007, there was a huge influx of refugees in Kenya. This led to the set-up of Kakuma and Daadab camps located close to the borders with the origin countries.

2.5 Psychosocial Interventions for refugee children

According to the Psychosocial Framework of 2005-2007 of the International Federation defines psychosocial support as "a process of facilitating resilience within individuals, families, and communities.", The focus of restoration of families and individuals here is on community involvement. A refugee child has a right to health which is defined by the World Health Organization as "a state of complete physical, mental and social well-being''. Psychosocial well-being is when an individual is mentally and physically healthy, is in an environment with support systems and social networks, and can relate to the culture and values of the society he or she lives in. (psychosocial Interventions handbook,2004). In this regard, there needs to be child participation and community involvement. Examples of these interventions include but not limited to, home-based care, outreach or home visits for families with disabled children, counseling services for the parents, and a community Centre for group counseling.

Article 39, part 1 in the standards set in the Convention on the Rights of the Child states that every child who is a victim of any form of neglect or abuse has the right to physical and psychological recovery and social reintegration (UNHCR, 1994). The psychological wellbeing of refugee children is important because they are developing and in need of

family security and stability. They lack family support is characterized by family separation, strife, child abuse, neglect, and abandonment. The best way refugee children can be assisted psychologically is by helping their families and in turn helping their host community (UNHCR, 1994). Interventions are mechanisms involving individuals, households, different subgroups, and members of the community that helps refugee children overcome psychological distress. According to (Crowley, 2009) interventions can be categorized into; Community-based, school-based, family-based, and individual-based.

Social support can be provided through the local community such as local refugee organizations, local administration, and even church support in the provision of emotional and material resources. Factors such as the quality of the food ration, the quantity, the timing, and the nutritional components result in nutritional deficiencies. (Chang 2001). This affects their psychological wellbeing by affecting their mental functions. This leads to little interest in learning, poor memory and academic performance, and poor psychosocial skills. These can be seen as mechanisms that can assist to reduce stress and support the refugee child to develop well. (Berman 2001, Lustig et al, 2004), classified these interventions into three groups; family support and good relations with one of the parents, child-friendly environment with support from teachers, healthcare providers and relatives, the disposition of the child, and how they respond to the new environment. Cases of child abuse or child labor are mitigated through and foster family placement.

Other interventions for psychological wellbeing as stipulated by the UNHCR, refugee children guidelines on protection and care include but not limited to, restoring normalcy in family functions, ensuring predictability such as enrolling them in schools and having playgrounds in refugee camps, as a coping mechanism for the stressful environment.

The guidelines also recommend support groups for the children to share their experiences. Interventions for unaccompanied children involve urgent tracing of their parents, maintaining communication, and eventually reduction of daily stressors (Bolton and Betancourt, 2004).

The figure below is a pyramid of the types of psychosocial support services.

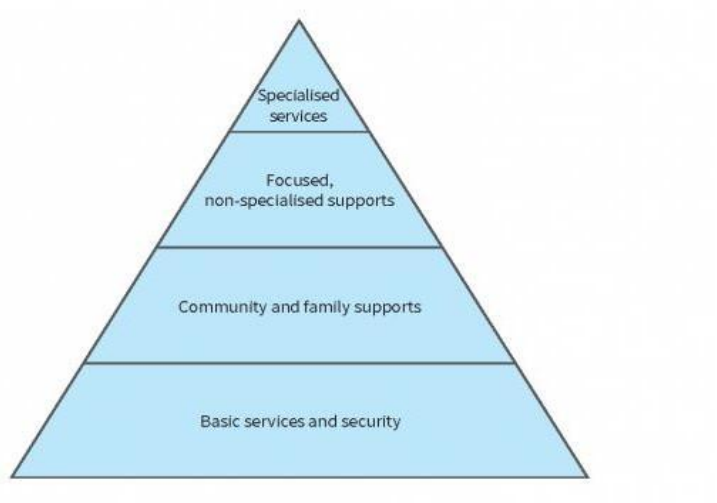


Figure 2.1: Intervention pyramid for Mental Health and Psychological support of emergencies.

Source: Inter-Agency Standing Committee (IASC) (2007). Guidelines on Mental Health and Psychosocial Support in Emergency Settings.

The above intervention pyramid shows that provision of basic needs such as food and water is essential for sanitation, nutrition, and shelter. Lack of these needs affects social relations and psychosocial wellbeing. Focused non-specialized support interventions are needed for individuals and families suffering from moderate psychological disorders, while specialized services refer to professional and complex social interventions by trained staff for individuals or families who are experiencing severe psychological disorders. These

services also include referrals to mental health facilities, psychotherapy, and cognitive-behavioral treatments. Community and family support enhances resilience and creates an environment where the refugee children can have a sense of normalcy (Elbedour, et, al.,1993). A good example is the trained teachers in schools. In this regard services like family tracing and reunification for refugee families are psychosocial interventions that are essential (psychosocial interventions,2004). The above types were provided by Government agencies, NGOs, and international organizations. Psychosocial wellbeing and socio-emotional learning in the Syrian refugee response also focused on the psychosocial wellbeing of the parents such as stress management (Soye and Tauson 2018). The study found that other than post-war and conflict as causes of trauma, daily stressors are also factors that cannot be ignored. There needs to be a holistic approach in interventions that cater to the children's material, social and emotional needs. In conclusion, the handbook of psychosocial intervention (2004), recommends that the best practice is to ensure early identification and psychosocial responses to the affected refugee children to reduce the number of severe psychological cases.

2.5.1 Community and Family Support

A study by (Samuels, F. et al 2018), on adolescent girls in Liberia, Sri Lanka, and Gaza, post-conflict settings concluded that nuclear or extended family support and affection is crucial for the self-worth of refugee children and adolescents. It is a coping mechanism for refugee children who experience psychological trauma. Those families create encouraging environments, a sense of protection, and security.

On the other hand, the study found that the same families can be sources of daily stress through violence or conflict in the home, separation or migration of one of the parents,

heavy workloads, and sexual abuse. The relationships between children and their parents are the most significant (Bowlby 1973). The mother's role in a refugee child's adaptation and emotional wellbeing is very important according to (Ajdukovic and Ajdukovic 1993). Children are attached to their mothers, and hence loss or threat of loss of parental figures causes psychological stress in the children. The effect of these relationships can be seen in the children's self-esteem, emotional wellbeing, and learning abilities in school (Howe, 2005). Parents and caregivers should be involved in psychosocial programs and interventions.

2.6 Actors in Refugee Management

The primary responsibility of the management and protection of refugees lies on the shoulders of the host state. Anchored on the principle of protection, the host state has the primary mandate to protect a package of human security to refugees without discrimination as to status or nationality. The principles of protection, non-discrimination, and *non-refoulment* are customary international law principles in the management of refugees globally. In adhering to these universal refugee protection principles, states are expected to be guided by the principle of *pact sunt servanda* (actin good faith) and unilaterally without expecting similar action from other states.

The protracted nature of refugee situation and the magnitude of the problem, the extent of vulnerability of the refugees, and the hesitation by states to take responsibility in refugee management resulted in the establishment of a body for the management of this group of persons. On 14th December 1951, the United Nations High Commission for Refugees (UNHCR) was established by UN resolution 319(iv) from the United Nations Office on refugees. UNHCR'S oversight role in refugee assistance and management is enshrined in

Article 2 of the 1967 Protocol and article 35 of the 1951 Convention on the Status of Refugees to ensure that States uphold their commitments in protection and management of refugees. The UNHCR has a specific original global mandate which is to provide international protection to refugees and persons of concern such as asylum seekers, stateless persons, returnees, and internally displaced persons. Its humanitarian role is in assisting refugees with temporary solutions such as camp management and provision of humanitarian assistance in the camps and durable solutions such as local integration, voluntary repatriation, and resettlement. The UNHCR also assists with financial grants, food, shelter, and basic infrastructure such as schools and health clinics for refugee children as a way to promote human security for refugees apart from providing humanitarian services.

The UNHCR works in close collaboration with the Government of Kenya, the Turkana County Government, the Refugee Affairs Secretariat (RAS), and other United Nations agencies and Nongovernmental organizations. Partner organizations are, but not limited to, International Organization of Migration(IOM), Lutheran World Federation (LWF) is providing child protection, early childhood development, primary education, peace and safety for refugees in Kakuma and Kalobeyei settlement, Danish Refugee Council (DRC), International Committee of the Red Cross(ICRC); Refugee Consortium of Kenya offer refugee advocacy and raise awareness to the refugee situations in Kenya, Jesuit Refugee Council (JRC), Windle International Kenya (WIK) among other actors. Refugee assistance needs proper coordination and cooperation with various institutions and communities so as to implement refugee policies (IOM, 2018). Collaboration in refugee assistance is thus at the core of UNHCR/ Government efforts in refugee management.

2.6.1 The Role of the United Nations High Commissioner for Refugees (UNHCR)

A refugee child is every refugee under 18 years of age (UNHCR, 2005). The focus areas regarding children in this institution are sexual exploitation, violence, and abuse, education access for the children. UNHCR, in partnership with other Non-governmental organizations, supports the establishment of safe school environments (UNHCR, 2005). The safe environment is to keep them occupied protect them from risks such as forced labor, sexual-based violence that happen in refugee camps. Psychosocial interventions should hence focus on both younger boys and girls and adolescence in secondary schools.

The psychological health of refugee children requires a multidimensional approach. There is need for diverse psychosocial support to the children and their family members (Ferget et al, 2018) Child protection strategy requires an interagency child protection response whereby, the Kenyan Government partners with NGO's. In addition, and critical is a community and family-based approach, culture-sensitive interventions, facilitating access to education and health, availability of trained interpreters and translators to work with refugee families, professional counselors, psycho-educational programs, and gender-specific screening. It is important to note that parents have also experienced trauma and are also in need of counseling services to be able to regain their parental roles. Having a refugee status changes child-rearing practices and culture. According to WHO (1996), child-rearing practices change because refugee families are no longer able to provide for their children's physical and emotional needs. The family unit no longer holds. UNHCR'S role concerning refugee children is both rights-based and community-based.

The older refugee children are more vulnerable due to family responsibilities, such as heading households, in cases of orphaned refugees. UNHCR is guided by the Convention

on the Rights of the Child in caring for refugees, unaccompanied, and separated children.

According to the UNHCR, (2017), in the child protection strategy, it seeks to work in partnership with other child protection agencies, States, children, and communities. It takes a family and community-based approach in caring for the children regardless of race and place of residence. The community-based approach would be used to care for unaccompanied children. More specifically to this study UNHCR also has a strategy to provide psychosocial services to children and their family members through counseling and to increase access to the child-friendly environment in Kakuma refugee camp. It has a role to fund so as to strengthen the policies and capacity of teachers in schools to ensure child-sensitive health management and legal services. Another strategic approach is to appoint child protection officers or counselors in schools. Mainstreaming child health protection in social institutions such as education is important in building a safety net for refugee children and is likely to boost their livelihood (UNHCR, 2017).

2.7 Summary of the Knowledge Gap

Fazel, et al (2018) found that psychological or mental health conditions were prevalent among refugees. A study of Syrian refugee children by Forget, et al (2018), found that 26% of children aged below 6 years exhibited PTSD, while 33% of the children aged 7 years and above exhibited the same. In a longitudinal study by Stauffer, (2009), found that extreme events that refugees experience affect parents as well as children. Depression and trauma experienced by parents strain their attachment with their children. Hamilton et al. al. (2000) found that refugee children endure multiples stress and loss such as loss of family and friends, violence, torture, separation of families, resettlement cultural changes among other experiences. The host country experiences are in most cases unsafe and unpredictable.

Many studies on the psychological health of refugee children have made conclusions that exposure of traumatic events such as torture and witnessing the death of loved ones, coupled with daily stressors of the camp or settlement in the country of asylum, they have a high risk of developing psychological disorders (Fazel, et al, (2010). Threats to life, forced displacement, livelihood challenges are all risk factors for Post-traumatic stress disorder (PTSD), emotional and behavioral problems. Daily stressors in a refugee 's life include but are not limited to language barriers, stigmatization, discrimination, assumption of early responsibilities in their homes, a sense of insecurity and safety, exposure to violence (Fazel, et al;2012). It is important to note that not all refugee children experience psychological stress, some children develop resilience especially when they get psychosocial support from their families and the host community (Thabet (2009). Kroening et al;(2016), stated that family separation and disruption in education in a child's refugee and resettlement experience have an impact on the emotional social and physical development. Refugee rights to psychological health are therefore enhanced by factors such as non-discrimination and inclusion of marginalized and vulnerable children and child participation. The guiding principles in the framework for the National Child Protection System for Kenya (2011), state that child participation means that children must be involved at all levels in the child protection system.

Most studies agree that pre, post-migration, and resettlement in host countries are major sources of psychological stress and trauma for refugee children and adults. Adverse childhood experiences for refugee children such as parental separation, physical and emotional neglect or domestic violence pose long term effects such as depression, and even physical health problems (Harris, 2008). Hence there is need for access to cultural and

psychosocial interventions by the community and healthcare providers so that they can be able to reverse the effects of trauma (Birman and Tran, 2008). Most studies have only focused on the physical health of the child whilst their psychological health also requires attention to ensure their wellbeing. Much attention has not been given to this aspect of child health and further research is welcome.

2.8 Conceptual Framework

This study is grounded in the conceptual framework below.

Independent Variable (IV) **Dependent Variables (DV)**

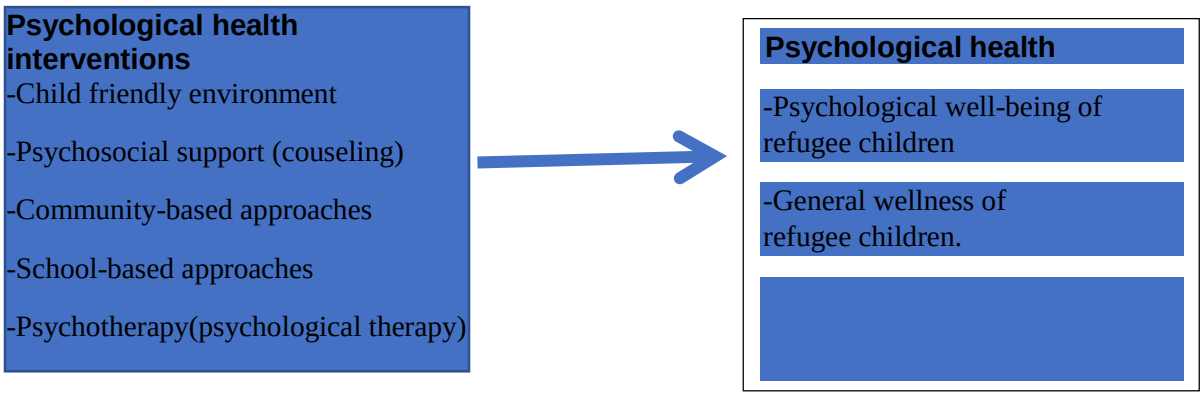


Figure 2.2: Conceptual Framework,2020

Source: Research data, 2020

This study relies on two types of variables to determine the validity of the subject under study. These are the independent variable and the dependent variable(s). The independent variable in this study is the psychological health interventions in Kakuma refugee camp. This was the examination of interventions to guarantee the psychological health of these children, and the challenges impeding the realization of this right were investigated for analysis.

The right to health is a universal right under international and domestic laws in Kenya. Kenya has ratified various international instruments on health and mental health some of which are obligatory thus the state cannot abrogate from them. Dependent variables in this were meant to test the validity of the objectives that inform the research. Such dependent variables were an examination of the psychological and general well-being of refugee children.

CHAPTER THREE: RESEARCH METHODOLOGY

3.1 Introduction

This chapter described the research design, study population. It also described data collection and analysis methods. The research was to assess the psychological health issues that refugee children experience as a result of traumatic events pre to post-migration up to entry in Kakuma refugee camp. It was also to assess the psychological health interventions.

3.2 Research Design

This was a descriptive research, seeking to describe the psychological health of refugee children in Kakuma refugee camp, Turkana, Kenya to obtain both qualitative and quantitative data on psychological health variables. Both primary and secondary data were used. For secondary data, a case study analysis was done involving a literature review on available publications on the topic and an examination of Government statistics,the Refugee Affairs Secretariat and UNHCR.

3.3 Data Collection

The study relied on both primary and secondary data. The Primary data collection tools were in form of questionnaires and scheduled structured face to face interviews administered to purposively selected teachers of refugee schools, counseling staff, and schedule interviews conducted with agency members and child protection workers with organizations like Kenya Red cross, Lutheran World Federation and Handicap International, officials and health practitioners to collect both qualitative and quantitative data. The interview questions were flexible in terms of the flow of the interview, thereby giving room for the general inclusions and conclusions that were not initially intended to

be derived regarding the research subject matter. With that in mind, there are risks that the interview may deviate from the prespecified research aims and objectives (Gill & Johnson, 2002). Secondary data on refugee children were sourced from the UNHCR reports, Refugee Affairs Secretariat Reports and the Refugee Consortium of Kenya. The questionnaire collected data on the psychological health issues that most refugee children face according to the views of the teachers in the schools they attend. They also addressed the interventions given in terms of psychosocial support and coping mechanisms of refugee children in Kakuma.

3.3.1 Sources of Data

For this study, secondary data was gleaned from past researches on the same subject, published books, and journals including online journals, project publications, policy reviews, the internet, and newspaper/magazine publications. However, this study could not be complete and original without primary data. Primary data was also vital in corroborating the evidence adduced in secondary sources. For this purpose, primary data was collected from the field in the Kakuma refugee camp on the rights to health of refugee children with a focus on their psychological and psychosocial well- being.

3.3.2 Data Collection Instruments

This study relied on the administration of questionnaires and interviews with key informants such as child protection officers. To ensure validity, the research instruments were tested through expert opinion. They were presented to the supervisor who checked on the objectivity of the questions. A total of 51 questionnaires were distributed by the researcher to a sample group of participants while 7 key informant interviews were arranged with key resource persons who are involved in the management of the

psychological welfare of children in the camp. The key informant persons included health caregivers, home caregivers, child protection officers' government official and refugee affairs administration.

3.4 Study Population

This study was focused on refugee children in Kakuma refugee camp 1. According to UNHCR data, the entire refugee camp had a total of 543 teachers as at 2017, manning 21 primary, 13 preprimary and 5 secondary schools. School enrolment was established to be 56% for pre-primary,92% primary and 6% for secondary.The teachers provide more than just educational needs. They are the second parents to the refugee children. For this study, a sample population of 61 school teachers drawn from the 543, were purposively selected for questionnaire administration. This population was sufficient given the time constraints of the researcher and other limitations. There are approximately 98000 refugee children in Kakuma camp and Kalobeyei Integrated Settlement project. Interviewing 61 school teachers implied one teacher representing approximately 1,607 children. This meant to ensure that the responses received were representative of the children's population.Teachers were better placed respondents given that they spend most of their time with the refugee children and some have professional understanding of their vulnerable situations.

3.5 Data Analysis

The research relied on both qualitative and quantitative data from the interviews and questionnaires. Quantitative data entry and analysis was done using R, a statistical computing platform which uses code scripts that interpret data and results represented in tables and figures. This was done to ensure the data collected was verifiable. To ensure

validity, the research instruments were tested through expert opinion. The researcher presented the questionnaires and interview questions to the supervisor to check for their objectivity in the study.

3.6 Ethical Considerations

The consent of individual respondents participating in the research study is standard procedure. The study guaranteed confidentiality and anonymity to all individuals participating as respondents through the interview guides and the questionnaires. All participants in the research were informed of the purpose and scope of the research. Authorization to access Kakuma refugee camp and Kalobeyei Integrated Settlement was sought and granted by the Government of Kenya through Refugee Affairs Secretariat. They were presented to the RAS camp manager's office in the form of a letter. The content of the permit contained the reason for academic research and that adherence to all security requirements at the camp was mandatory.

3.7 Scope of the Study

The primary purpose of the research was to assess the psychological wellbeing of the refugee children and determine the effective psychological interventions in managing their health at Kakuma refugee camp. Assessing the whole population to arrive at generalization would be impracticable, if not impossible. To make it practical geographically, the study was carried out in the oldest selected schools in Kakuma 1 refugee camp, Turkana County in Kenya. The study was restricted to examining the interlink between refugee status and access to psychosocial services as one of the psychological health needs as enshrined in the Universal Declaration on Human Rights.

This was done through the analysis and synthesis of objectives set out in this study. Dependent and independent variables were developed to test the validity of the objectives of this research.

CHAPTER FOUR: RESEARCH ANALYSIS

4.1 Introduction

This chapter is a discussion of the presentation and interpretation of the research findings. The research took place in five primary schools and seven secondary schools in Kakuma 1 refugee camp, the oldest camp with the oldest schools. The findings were given from questionnaires and semi-structured interviews undertaken with various stakeholders.

4.2 Demographics

Research respondents were from Kakuma Refugee Camp 1. The respondents were teachers who voluntarily agreed to take part in the study. They were interrogated using questionnaires on several issues, some including refugee psychosocial health interventions, and possible intervention outcomes regarding these children in the camp.

A total of 51 self-administered questionnaires (SAQs) were responded to out of the targeted 61, giving a response rate of 84%. This is above the recommended response rate of 60% for social science research. Thus the study was representative of the general population.A good percentage of the respondents (41.2%) were teachers who had served for 1-2 years in Kakuma refugee camp, followed closely by those who had served between 3-5 years and 6-8 years at 39.2% and 13.7% respectively. Only a small proportion (5.9%) of the respondents had served the camp for more than 10 years. The figure below is a presentation of respondents by years of service.

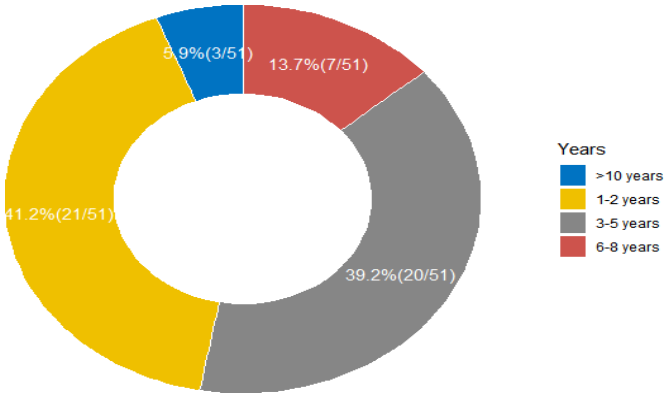


Figure 4.1: Presentation of respondents by years of service

Source: Research Data 2020

According to the respondents, on average, approximately 1834 children are currently unevenly spread across 12 schools in Kakuma 1 refugee camp, with Fashoda Boys Primary School enrolling the highest number of refugee children (19.6%). Bhaar-El_naam Girls Primary School came second at 17.6%, with Kakuma Refugee Camp Primary School and Unity Primary School following closely at 11.6%.

The schools with the least proportion of refugee children were Vision Refugee Secondary and Napata Secondary Schools both at 2%. Further details of the status of education of refugee children in Kakuma 1 Refugee Camp are listed in the table below

Table 4.1: Education Status of refugee children in Kakuma Refugee Camp

Education Facility	%
Fashoda Boys primary	19.6% (10/51)
Bhaar-El_naam Girls Primary	17.6% (9/51)
Kakuma Refugee Camp Primary School	11.8% (6/51)
Unity Primary School	11.8% (6/51)
Pokotom Secondary School	7.8% (4/51)
United Refugee Primary	7.8% (4/51)
Green Light Secondary School	5.9% (3/51)
Kakuma Secondary School	5.9% (3/51)
Somali Bantu Refugee Secondary School	3.9% (2/51)
Kalobeyei Settlement Secondary School	3.9% (2/51)
Vision Refugee Secondary School	2.0% (1/51)
Napata Secondary School	2.0% (1/51)

Source: Research data 2020

More than half of the schools sampled in Kakuma 1, (68.8%) are composed of students who are refugee children only, while approximately a third of the schools (31.2%) are composed of a combination of both the local community and refugee children. None of the schools witnessed only the local community children population.

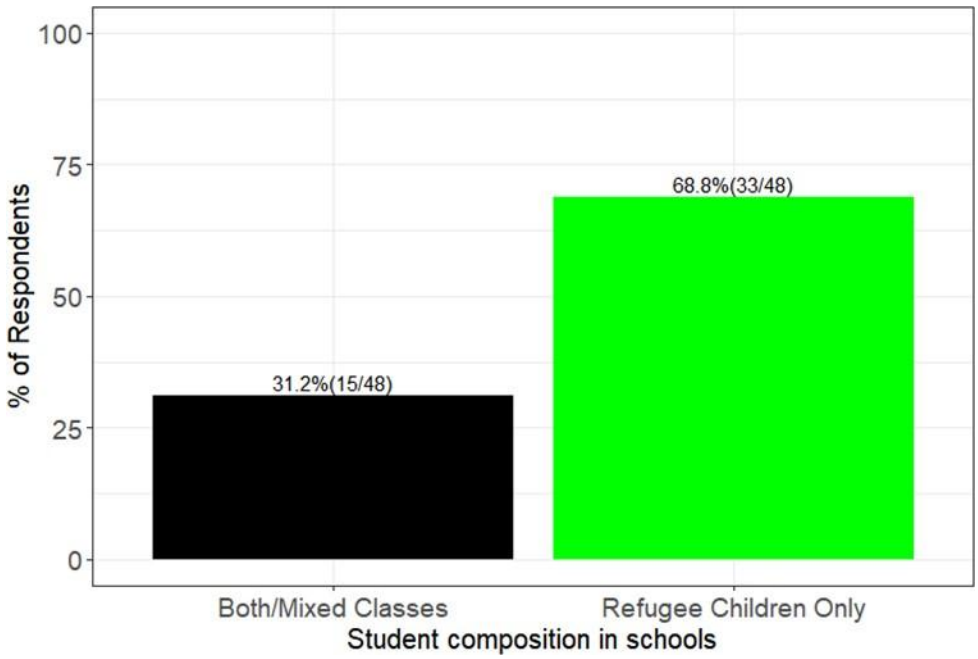


Figure 4.2: Children composition in the schools

Source: Research data 2020

For schools with students who are refugees only, an understanding that they share a common status as refugees plays a critical role in their social interactions. Bound by the same background, the students quickly got to know themselves and easily mingled with one another, and in the process started to promote peace as mixed students. In cases where they shared the language of communication (Kiswahili, English, or mother tongue), the speed of interaction would be faster and much easier. These students mostly interact during sports activities. On the other hand, students in schools with mixed groups (consisting of both the local community and refugee children) shared nothing in common, hence mostly interacted in-group/classwork discussions, through co-curricular activities, sharing reading materials (such as texts books) and by playing (form groups like football groups). In some cases, they interacted in debates and inter-cultural dances.

4.3 Behaviors among refugee children in schools.

The researcher aimed to find out from the respondents the most common behaviors among refugee children in the sampled schools in Kakuma 1 refugee camp. Figure 4.3 below illustrates commonly observed behaviors among the refugee children in schools.

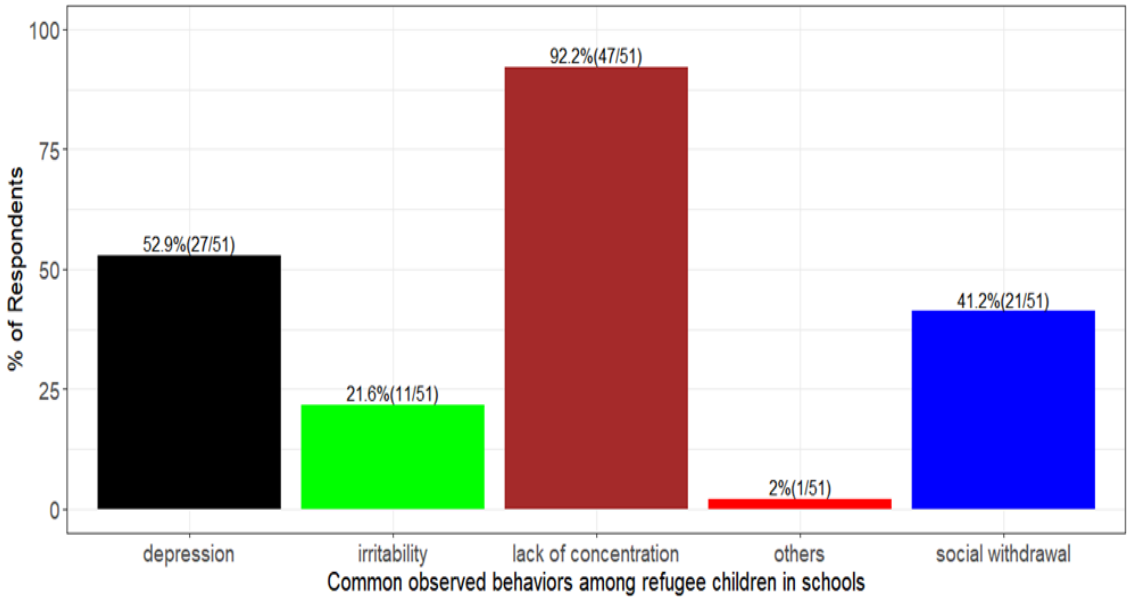


Figure 4.3: Commonly observed behaviors among refugees' children in schools

Source: Research data 2020

Most of the respondents (92.2%) mentioned that lack of concentration is the most common observed behavior among refugee children in schools. Even though more than half (52.9%) of the total children suffered from depression, a considerable proportion (41.2%) exhibited social withdrawal. On contrary to this, there exists a slightly smaller percentage (21.6%) who exhibited irritability. These behaviors were observed to be quite often (51%) among the refugee's children, with a sizeable percentage consenting to the behaviors occurring often (39.2%). Other behaviors (2%) were not observable by the teachers.

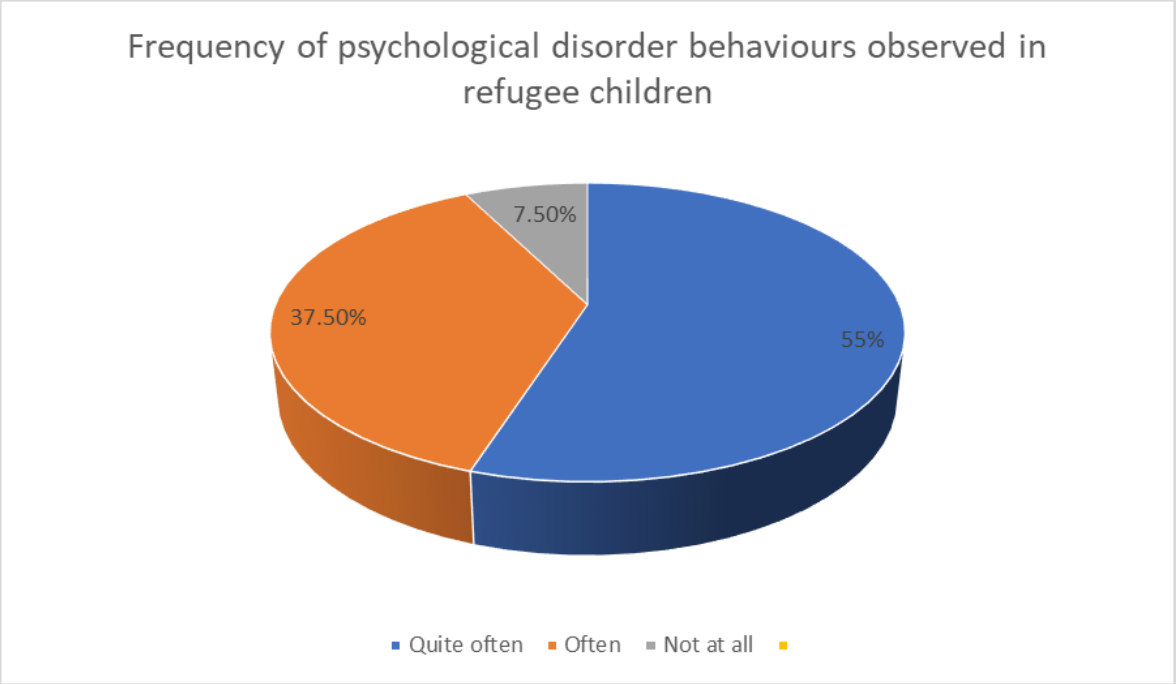


Figure 4.4: Frequency of psychological disorder behaviors observed in refugee children.

Source: Research data 2020

The figure above clearly shows the frequency of observed common behaviors linked to psychological stress in refugee children. (55%) indicated that these behaviors were observed quite often. Often observed were 37.50% while only 7.50% did not observe any of the behaviors. To further understand respondents' views concerning the gender observed to portray the commonly observed behaviors in schools, the researcher asked several questions relating to the behaviors. Figure 4.5 below gives a summary of the findings from the respondent

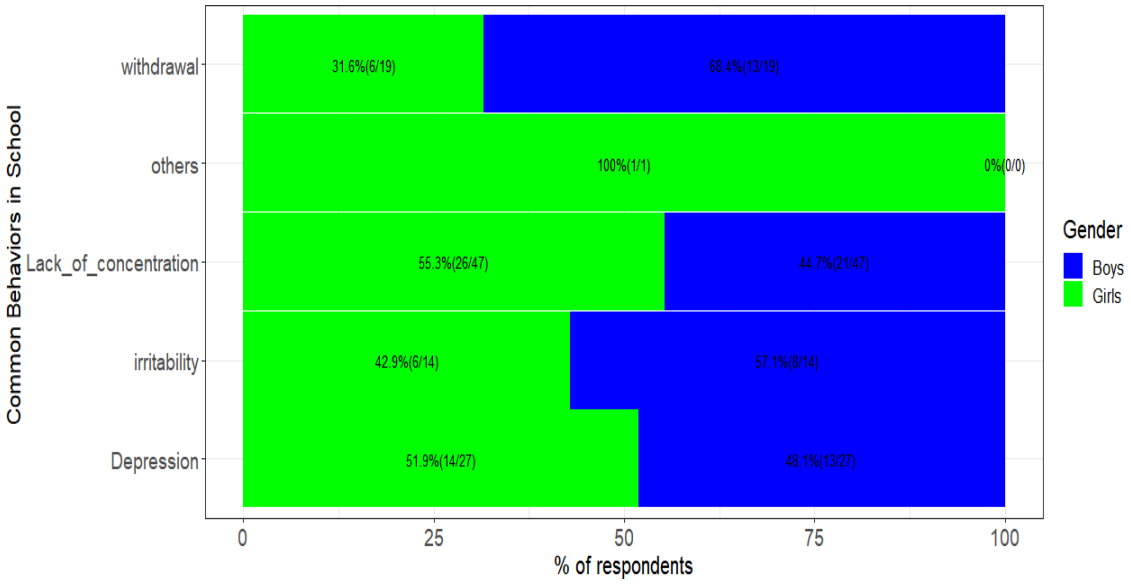


Figure 4.5: Common behaviors in school based on gender

Source: Research data 2020

Girls were more depressed (51.9%) and lacked concentration in schools (55.3%) than boys were, while social withdrawal (68.4%) and irritability (57.1%) dominated boys more than girls. Noticeable (100%), only girls portrayed other behaviors as figure 4 above.

4.4 Interventions in managing the psychological health of refugee children

The study also sought to assess the effectiveness of the psychological interventions in managing the psychological health of refugee children. Further to this, intervention mechanisms undertaken in schools were assessed and depicted in Figure 4.6 below.

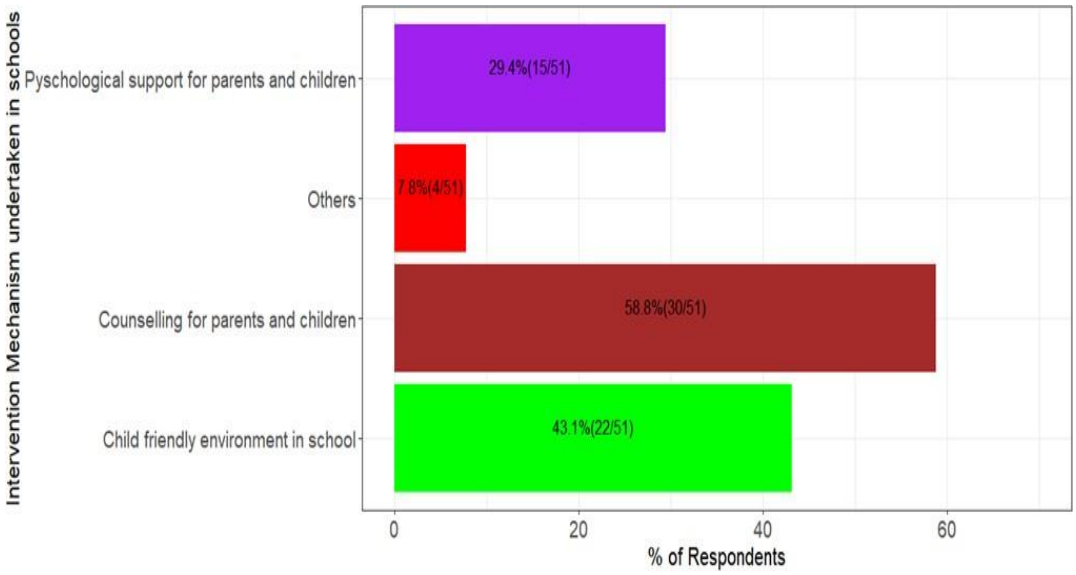


Figure 4.6: Intervention mechanisms undertaken is schools.

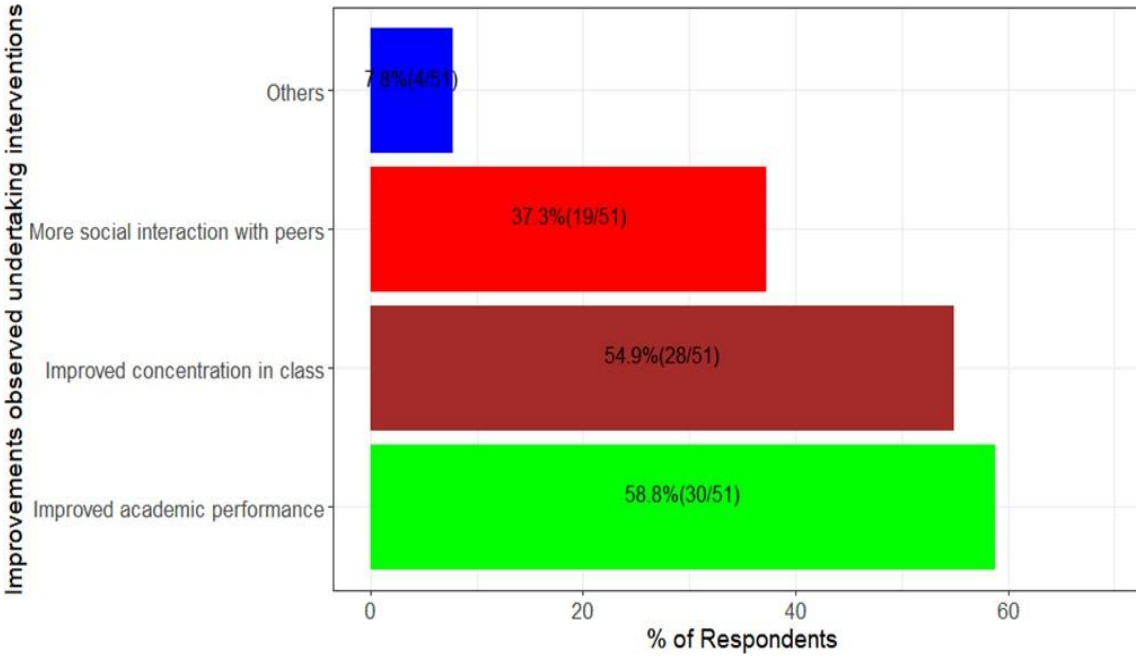
Source: Research data 2020

According to the respondents, counseling for parents and children (58.8%) was the most popular psychosocial intervention undertaken in schools to manage the common behaviors. Moreover, creating utilized psychosocial intervention. A child-friendly environment in schools (43.1%) as an intervention was also adopted. Psychological support for parents and children (29.4%) was the least intervention mechanisms undertaken in the school to manage these behaviors as shown in figure 4.6 above.

4.5 Improvements observed after undertaking intervention mechanisms

After undertaking several interventions mechanisms, the researcher further sought to establish the resultant improvements observed in the refugee children's behavior. Figure 4.7 illustrates the summary findings in detail.

Figure 4.7: Improvements observed after undertaking interventions mechanism



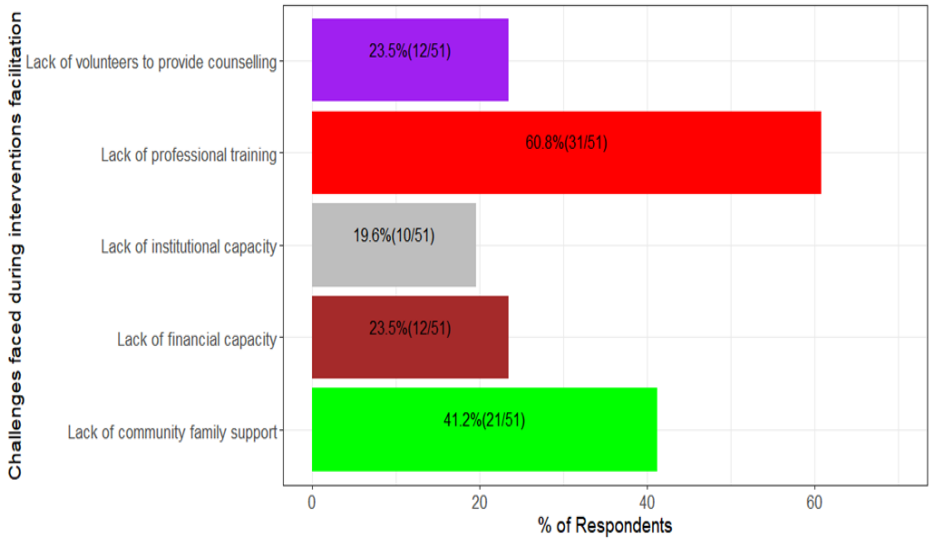
Source: Research data 2020

Approximately more than half of the respondents (58.8%) reported an improved academic performance among the students upon adoption of the interventions. Furthermore, slightly more than half of the respondents (54.9%) noted an improved concentration in class among the students. There was also a considerable increase in social interaction with peers (37.3%) after the intervention.

4.6 Challenges faced in Psychosocial Interventions

The study also sought to find out whether there were any challenges faced when implementing the interventions among refugee children. The findings were represented in Figure 4.8 below.

Figure 4.8: Challenges faced during intervention facilitation



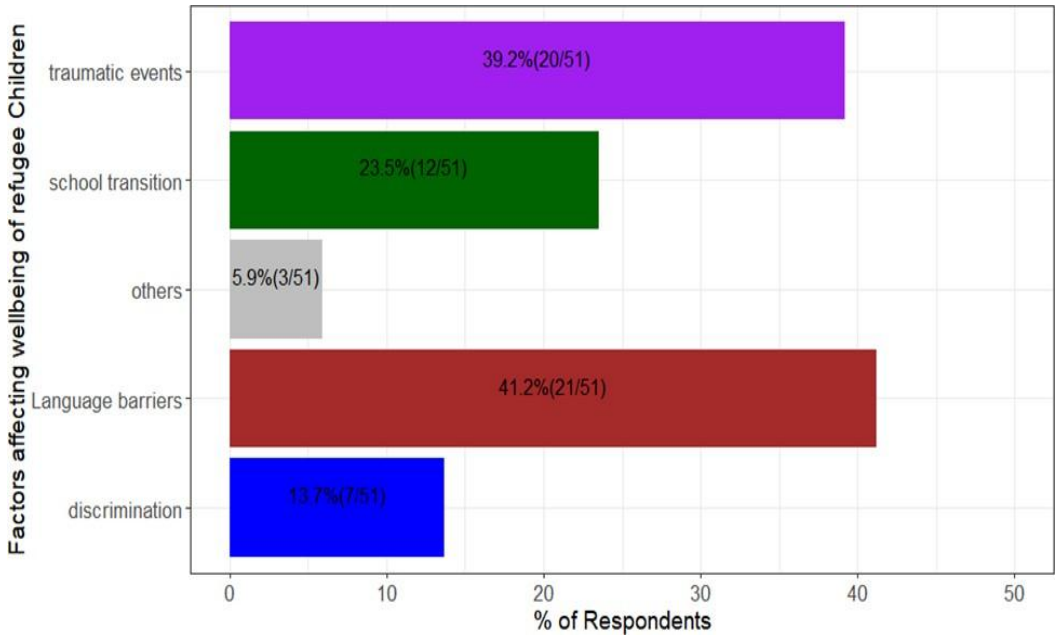
Source: Research data 2020

Lack of professional counseling training (60.8%) stood out as the main challenge faced during intervention implementation among refugee children. This was followed closely by lack of community family support (41.2%), lack of financial capacity (23.5%), lack of volunteers to provide counseling (23.5%), and lastly lack of institutional capacity (19.6%).

4.7 Factors that affect the wellbeing of refugee children

Overall, the researcher asked questions to determine factors that affect the wellbeing of refugee children. The response was as captured in Figure 4.8. Noticeably, language barriers (41.2%) and pre and post-migration traumatic events (39.2%) were the most highlighted factors that affect the wellbeing of refugee children within the refugee camp. Cases of school transition from a school outside Kakuma refugee camp or from a Kakuma based school (23.5%) and discrimination (13.7%) were also listed to affect the wellbeing of refugee children as represented by figure 4.9 below.

Figure 4.9: Factors affecting the wellbeing of refugee children



Source: Research data 2020

4.8 Findings from Questionnaires

The questionnaire responses indicated that most of the refugee children came to the camp traumatized by the refugee experience. They are mostly withdrawn from the rest of the school community. The study findings indicated that refugee children in Kakuma refugee camp experience psychological stress symptoms such as depression, irritability, lack of concentration, and withdrawal. Most schools undertook counseling for parents and children who are identified as affected psychologically.

Counseling was the most accessible intervention for refugee children in schools. Psychosocial support for parents was the least accessible intervention because it involves outreach to the affected communities. After the interventions, most of the children showed

improvement in academic performance and concentration in class. There was more social interaction with peers. Challenges in interventions were lack of training in professional counseling for teachers and lack of community and family support. According to a perspective from the refugee youth and language integration report (2016), language barrier is a challenge to social integration. Refugees lack the time and opportunity to learn English. This makes them experience isolation, marginalization, hopelessness, and depression. Lack of confidence among peers in class makes them a target for bullying. Language affects cultural orientation and adjustment.

4.9 Face to face structured Interviews

Key informants were selected based on their knowledge, relationships, and expertise regarding a research subject (Freedman et al., 2007). In the current study, different stakeholders who were selected had a special relationship with the phenomenon under investigation and sufficient and relevant work experience in interacting with refugees in various capacities.

The structured interviews were face to face interviews on qualitative data collection and their observations and experiences with the refugee children in various institutions. The advantage harnessed from this interview was that the people chosen to conduct the interviews were people who managed the refugee children, it helped in reducing non-response rates; (Fisher, 2005, Wilson, 2003). These included stakeholders and child protection officers from local non-governmental organizations and various agencies in Kakuma. The organizations were Handicap International, LWF, Warldof, Public health officer(MOH), International Rescue Committee, Refugee Affairs Secretariat, and a Community leader at Kakuma camp. The mental health officials were those with regular

patient contact. Interviews were conducted in March 2020.

Some sample questions that were included in the semi-structured questionnaire were the following:

5. If the students are mixed as indicated above, how do the two groups socially interact with each other in class and as they play?

……

……

6. If the students are only refugees, how do they socially interact as compared to the mixed group?

……

……

4.9.1 Interview responses from the Refugee Affairs Secretariat Camp Manager

An interview by the RAS Camp manager informed that refugee children who receive international protection performed better in schools than the local children. They have access to free health services, education, and some are accorded scholarships through international partner organizations.

They also have access to free health services both in Public Health facilities and Agencies like Kenya Red Cross and the International Rescue Committee(IRC). Most of the unaccompanied refugee children are fostered/ placed in foster families. This is because, according to the camp manager, an observation was made that many unaccompanied children lived together without any adult, and they formed gangs and fought each other. Another observation made was that refugee children in the camp were sexually exploited, trafficked and smuggled, HIV transmission and early childhood pregnancy prevalence were high due to vulnerability. They also engaged in survival sex to be able to get some money to buy basic needs. He also added that records show that 60 percent of the women in

the camp are single parents. These daily stressors, in turn, affect the refugee children psychologically. The lack of a father figure and provider is a major factor for dysfunctional families and that most men are dependent on the women. Parental conflict, especially among mixed family muslin refugees, was also prevalent. Refugee girls risked rape from family and relatives.

4.9.2 Interview with Mental Health Doctor Kenya Red Cross Kakuma

The doctor informed of several cases that were observed as causes of psychological health in refugee children in the camp. They deal with children and adolescents, accompanied, unaccompanied, and separated refugee children. Hopelessness is a major risk factor whereby, most children come with the hope of a better life in their host country. They flee from conflict, war, and persecution to get some relief. However, they are disappointed by the environment in the life in the camp. Their expectations are different from reality due to scarcity of food and social amenities and despair. They need a constant reminder of the reality that they may stay encamped for a long period before they secure a durable solution. This was a source of depression for most of them. He also encountered school dropouts, early childhood pregnancies, children born with autism due to stress and poor diet of their pregnant mothers. He also reported a lack of sufficient food and nutrition**.** Since refugee children get food rations it is in most cases insufficient He stated that malnutrition in children affects their physical and cognitive development. Lack of clean sufficient water, lack of a sense of security from themselves. Cultural issues that are enforced on refugee children such as Female Genital mutilation and early marriages for the young girls, were also sources of trauma for refugee children.

The respondent focused on the fact that they partner with other organizations such as the

Danish Refugee Council, and Handicap International. That all these organizations dealt with different aspects of the refugee child. He also noted that psychological disorder interventions such as counseling were long term approximately 6 to 12 months. These services also required outreach to the camps to follow- up the children in their families. The outreach also helped in identifying unreported cases of affected children Specialized cases of psychological health are given priority for resettlement. He stated that there is a need for more community health workers and volunteers who have basic counseling skills. Refugee child cases that needed psychosocial support in the camp were in large numbers. They provides special treatment like therapy for mental cases.There is very little done concerning community-based approaches. This he observed is because of the lack of basic needs that they already had to deal with. Children with disabilities and autistic children require special psychological interventions.

They provide safe spaces for both children and parents where the children have play areas or compounds for play therapy while the parents are engaged in some occupations such as tailoring or weaving baskets. They have safe shelters for children who have been threatened due to reported rape cases and they fear of victimization. The safe houses are made available to them until they feel it is safe to go back home.

4.9.3 Interview with Area Manager of Lutheran World Federation at LWF at their LWF compound.

The organization deals with child case management and protection**.** It is the main child protection agency for refugee children in Kakuma refugee camp**.** Cases handled by this organization are accompanied, unaccompanied, and separated refugee children. He reported that; most refugee children come with trauma from their country of origin. The

psychological health issues of refugee children are many. They are exposed to death, parents getting raped, domestic violence, and forced recruitment as child soldiers. Refugee boys are exposed to the use of guns as young as 8 years old. The boys also experience sexual abuse. The girls are sexually abused even by relatives and have to flee the household due to threats. In this case, they are placed in safe shelters until it is safe for them to go back home.

He noted that it is not easy to notice that refugee children have psychological disorders. The teachers do not understand them because they perform poorly and are in most cases have poor self-regulation. This leads to stigmatization and discrimination by their peers and the local community. The demand for school is too high, yet, some children do not access schools. He noted that refugee children love to go to school in comparison to the host children. The classes overcrowded so the children don't get the required attention from the school teachers or protection focal teachers. This means that it's even hard to identify those with psychological issues.

He informed that the interventions undertaken in assisting identified children with psychological health issues were conducted by sending professional counselors and social workers to assist the refugees with settlement and integration in the host country. The organization provides basic needs like food and shelter for the refugees and psychosocial support. Lutheran World Federation has created a structure known as a child protection working group**.** This group studies or follows up on the emerging and existing issues in refugee children. They also manage the reception centers where they identify child protection cases. Herein there is basic assessment, identification, and referrals. It is also a psychosocial center for counseling.

The organization is part of an interagency collaboration with partner organizations dealing with child protection and psychosocial interventions such as Danish Refugee Council (DRC), Norwegian Refugee Council (NRC), and AAR Japan that deals with secondary schools, Windfall International Kenya and ISRAID, Jesuit Refugee Service (JRS).Danish Refugee Council provides psychosocial interventions to refugee children and adolescents through empowering them with life skills and training in vocational skills. They also provide protection focal teachers for each school in Kakuma refugee camp. Windfall international Kenya sends specialized counselors in 21 primary schools and International Rescue Committee provide mental and psychosocial experts These experts are trained identification of signs of trauma, psychosocial first aid skills basic counseling skills. These agencies collaborate to provide a holistic approach to refugee child protection and psychosocial assistance. They are guided by the National Protection policy, the UNHCR protection strategy, and the Lutheran World Federation child protection code of conduct.

Concerning challenges in psychosocial interventions, the manager reported that there is a lack of sufficient funds for training and mobilization of support staff. That cultural issues in initiations like female genital mutilation interfered with treatment due to cultural expectations and stigmatization. There is only one safe place for women and one for men in the whole camp who need protection. It can only accommodate 56 people. There is a need for expansion of the existing ones or more are added. There should be more rescue centers. The psychological protection cases are many against only one protection focal point teacher per school. The classes are overcrowded. Family counseling could also be a more effective way of psychosocial support for refugee children.

4.9.4 Interview with the Ministry of Health Public Officer

The Ministry of health public health officer in Kakuma informed that their role was to oversee the provision of health interventions by other related agencies to both the refugees and the host community. They have technical working groups that entail, community health extension workers (CHEWS), community health volunteers, (CHV), the community health extension workers undergo curriculum training and they link the community to health officers in hospitals. The (CHV's) role is to identify the health needs of the refugee children in the community.

4.9.5 Interview with Handicap International Area Manager

This organization handles all categories of refugee children with disabilities that experience psychological disorders. Some have vision impairment, mobility impairment, and cerebral parsley. They are exposed to trauma due to sexual exploitation. The children with hearing, speech, and vision impairment cannot report or express themselves. Refugee children born in the camps are prone to be born with mental and psychological conditions. This is due to poor prenatal care and nutrition, lack of sufficient medication and trauma during conflict and war.

The area manager reported that the organization educates caregivers on how to take care of children with disabilities. These provide home-based care. They provide outreach mobilization of trained personnel to homes. Already there is inclusive education and early childhood development (ECD) training. Schools have been built to accommodate these children. They also provide psychosocial support for the parents of disabled refugee children to avoid stigmatization. They ensure that there are teachers and assistant teachers who provide socio-emotional learning in mixed classes these children.

He informed that refugee children with disabilities are stigmatized both by the community and by their parents. They experience attitudinal stigma and physical stigma. That these experiences are sources of depression for the children.

Lastly, he noted that there is insufficient funding for more caregivers and assistant teachers. There is also a lack of sufficient assistive devices such as wheelchairs, brails, and machines**.** Language barrier is a major problem since these children are not able to communicate when they are raped or exploited.

4.9.6 Interview with Warldof Child Protection Officer

This organization identifies child protection cases and provides child-friendly spaces (CFS'S) for refugee children who report at the reception centers and are identified to have undergone trauma**.** They deal with all categories of refugee children at reception centers. The mission of the Waldorf Kakuma project is to alleviate psychological trauma and promote the wellbeing of children. They work with psychologically traumatized refugee children in the camps. The respondent noted the importance of inter-agency cooperation and coordination at the reception centers. Each agency has a role to play regarding an aspect of the refugee, World Food Program (WFP), provides food rations, Kenya Red cross provides tracing services for the refugee family, Handicap International (HI), Warldolf, Danish refugee council (DRC)and Norwegian Refugee Council(NRC).

Some of the children at the reception centers exhibit social withdrawal and depression. Daily stressors for the refugee children include the harsh environment, insufficient food and water, and dysfunctional families. The officer informed that most of the refugee children at the reception centers arrive with psychological health disorders due to the

refugee journey.

They use psychosocial interventions such as art and play therapy activities for refugee children. Play with other children is a protection factor. It keeps them occupied and reduces feelings of isolation. They create child-friendly spaces for the children. the safe spaces are environments where the children have activities such as painting, beading, modeling, storytelling, and role-plays. Each of these activities helps the children cope with trauma in various ways. The role plays help them express what they went through; the painting also brings out their emotional experiences. These children speak through these activities. For example, the beading helps in eye-hand coordination, to relax, and to build their self-esteem. This approach or methodology gives the children both education and life skills that engage the heart mind and the head to help alleviate effects. The respondent noted that having child-friendly school environments enable socializing in schools which helps the children become resilient. Another intervention they use is teacher training in early childhood care and development(ECD). They use community-based approaches that involve parent representatives, community leaders, and block leaders. The community must be involved because they are the first contact with these children. The sensitization of teachers on trauma issues that children experience is also an important intervention. That they also provide pediatric counselors to give specialized counseling for refugee children who have been sexually and physically abused, witnessed their parents being tortured and killed and unaccompanied children. In short, their interventions are focused on education and child protection.

Regarding challenges faced in psychosocial interventions, she mentioned that there were **i**nsufficient play materials for the refugee children. That the protection centers are few and

inaccessible for most refugee children with protection needs. Another factor mentioned is language barriers, an example was that some new refugee children only speak Arabic. It is a challenge for them to express themselves. Without the hiring of interpreters, refugee teachers' organization staff cannot communicate.

4.9.7 Comparison of the study findings with theory

The study was guided by social exclusion theory and social constructivism theory. Social exclusion theory states that individuals are wholly or partly segregated from full participation in society (European Foundation, 1995). This theory supports the study findings in that refugee children identified with psychological health disorders are stigmatized. Trauma affects a child's ability to function normally at home and in school (Dyregov, 2004). Most score poorly in school attendance and performance. They also exhibit social withdrawal and depression. Stigmatized refugee children end up being isolated and marginalized. It becomes a disgrace for their families to have a child with psychological disorders (Mc Kell, et al, 2017). Stigmatization is also a barrier to refugee access to health services and treatment.

The social constructivist theory states that social and cultural contexts are major factors in learning where learners are integrated into the knowledge community. The emphasis of this theory is on the role of social processes and social interaction. Concerning the study findings, refugee children in schools felt included and interacted through play, cultural dances, group discussions, sharing of resources, and football clubs. Interventions in school such as creating a child friendly environment, counseling and psychosocial support reconstruct their world in the host community. Findings indicated improved concentration and more interaction with peers. However, we noted that one of the major factors affecting

refugee children was language barriers and racial discrimination.

4.9.8 Comparison of the study findings with empirical studies

Most studies agree that exposure to trauma due to various forms of conflict in countries of origin in conjunction with daily stressors in host countries or refugee camps contributes to a high prevalence of psychological distress in refugees (Lurie, 2009, Tribe, 2002). A summary by Mohamed (2012), on her study on the mental health and psychological wellbeing of refugee children, reiterated that refugee experiences have a major role to play on their psychological health.

This is due to exposure to trauma from pre-migration risk factors and marginalization and daily stressors post-migration. The research findings are in line with a study by Fazel and Stein, 2002), where he had a model that showed parental factors, child factors, and environmental factors having an outcome on the psychological health of refugee children. The findings indicated language barriers speech disabilities, pre, and post-migration traumatic events, and the number of camp and school transitions in the child's life were the major factors affecting the psychological wellbeing of refugee children. Mohamed (2012) found that some of the risk factors identified by school staff were pre-migration traumatic events, lack of family networks, isolation, and marginalization. Learning a new language and culture in the host country can be a source of stress for refugee children in the context of this research study, Kakuma refugee camp is multi-ethnic, making it more complex.

Findings indicated that in both mixed and refugee schools, there was a child-friendly environment where the children interacted and socialized in playgroups, football clubs, and sharing of resources, group discussions, in-school cultural activities. There is both social

peer and teacher interaction.

Counseling by teachers and trained social workers is one of the psychosocial support interventions offered to assist refugee children's psychological wellbeing, Fazel, et al (2012). These create a child-friendly environment. The school teachers also indicated that refugee children have a readiness to learn. This is one of the best health interventions for the psychological wellbeing of refugee children to help them build resilience.

CHAPTER FIVE: CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

This chapter was a discussion of the findings of the research objectives. It also presented the summary and recommendations of the study.

5.2 Summary of the Findings.

The above study aimed to establish the right to health of the refugee child in regards to their psychological health in Kakuma refugee camp. It also assessed the psychosocial interventions provided for them by the various agencies using Best Interest Assessment**.** Every intervention on support or assistance should be for the best interest of the child.

Separated refugee children have a right under international law for family reunification. The children are reunited with their nuclear family and direct siblings. UNHCR, IOM in collaboration with the National Red Cross and Red Crescent Societies support the social integration of the reunited family members. The study found that refugee children in Kakuma have a preference for going to school, and teachers are in most cases able to identify those with behavioral symptoms.

Research findings brought out the fact that most refugee children suffer from psychological health issues. According to what was observed by the respondents, they suffer psychological health and social consequences due to parental conflict, separation, divorce lack of father figures and providers, sexual exploitation by parents and relatives, rape, hopelessness, recruitment as child soldiers, and daily stressors. That the most vulnerable are those unaccompanied and separated from their families. These children are attached to foster families. However, they experience emotional and physical neglect. Refugee children with speech disabilities are stigmatized and are not able to express themselves. This makes it difficult for them to access psychological health interventions. Some are born with mental disorders, yet their parents are not aware of the mental conditions and culturally do not believe that they can be medically treated.

The right to health for refugee children in Kakuma camp is upheld in that they can access free physiological and psychological health facilities. However, the findings show that there are very few mental health practitioners who provide specialized treatment as compared to the number of refugee children that need attention. The concerned agencies in the camp provide specialized services, focused non-specialized services, and school-based services, For the refugees in the camp, there basic needs like food rations and security are not sufficient. As much as there is community leadership in the camp, there is interracial conflict in the community. These are some of the daily stressors. The interventions provided by various non-governmental organizations vary as much as the psychological disorder cases vary. Agencies collaborate in the provision of safe houses, vocational training, allocation of protection focal teachers, mental health specialized services. An important finding was that psychosocial interventions are long term and they need outreach

mobilization.

5.3. Psychological wellbeing of refugee children in Kakuma 1

The psychological health of refugee children has attracted global interest among all stakeholders in recent times. Right from the beginning of the migration/fleeing journey through to the treacherous voyage itself and right into the strangle land of a refugee camp with limited support services, the cumulative effect on the psychological wellbeing of a refugee child is unfathomable. Before fleeing the places of habitual residences, children suffer various psychological maladies resulting from the unfolding situation. Wars/conflicts that lead not only to displacement but often times death, the actual story of death which is sometimes witnessed by children, the environmental displacements from natural calamities such as floods, droughts, landslides among others and the impact of this calamities to the psychological health of the child is unknown.

This study established that the psychological health of a refugee child is a total of a myriad of factors as enablers to the development of psychological distress or not. Right from the country of origin, before fleeing for safety, the flight problems, the landing into a refugee camp, and the refugee life all sum up into a real challenge to the wellbeing of a refugee child. However, this study was not designed to look at the psychological wellbeing of refugee children before arrival into a refugee camp. The focus on refugee children means children whose refugee status has already been determined and confirmed. A separate study can only be conducted to establish their psychological wellbeing before, during, and on arrival in a refugee camp.

This study established the inadequate psychological support services available to refugee children right from their arrival into the refugee camp. Most potential refugee children are left to naturally adapt to new life, strengthen their survival instincts that had already been developed during the flight from threats in their places of habitual residence. With the hindsight of their origin, refugees build resilience around linguistic and nationality networks that offer valued information on available livelihood and support services. It is these networks that additionally give psychological support to refugee children through sharing of experiences, open channels for sharing their life histories, challenges, threats, and future. The available psychological health service in the camp, this study established were either poorly managed, lacked necessary facilities, and had their own challenges that aggravates the life of these vulnerable children.

5.4. Intervention in managing the psychological health of refugee children in Kakuma

There should be broad knowledge of refugee's past, pre-migration experience, their concerns, and their current daily stressors. Child refugee experiences should be well researched to identify suitable psychosocial interventions (Stein, 1981).

The psychological health of the refugee population has largely been a neglected subject among scholars and practitioners alike. However, all stakeholders in refugee management are realizing the importance of embedding the psychological wellbeing of children into their refugee management activities. There is increasing adoption of psychological support services right from the moment a case is launched for determination. The psychological management capacity of support staff is also being constantly reviewed and enhanced in line with the emerging needs of the refugee children. These form critical interventions that help to mitigate against adverse effects of the psychological health of refugee children.

Apart from children's specific interventions, this study also noted increasing proactive repackaging of these support interventions targeting specific groups and individuals according to a strategic need that is pragmatically established. Such specificities as age, gendering psychological support services, disability mainstreaming, evaluation of vulnerability levels according to origin regions and countries, family background and availability, education and health factors, religion, and financial needs among others all facilitate the success or failure of psychological services offered.

5.5 Challenges in psychosocial interventions

This study noted various challenges facing the psychological health of refugee children. These challenges can be categorized as individual, interpersonal, environmental/ external challenges. A smart strategy in tackling either challenge should first start with knowledge of the challenge itself before attempting a solution. However, the mere existence of challenges should not hamper efforts at promotion and provision of psychological support services to refugee children.

Most of the refugees have language barriers. Kakuma is a multi-ethnic camp hence communication and social integration is a challenge. This creates adjustment difficulties and isolation. The refugee children population is too big as compared to the child protection officers and professionally trained counselors available. Lack of awareness of this aspect of health is a hindrance to the well-being of the child. Daily stressors and insufficient basic needs make it difficult for the parents and caregivers to give their children the necessary attention. Cultural aspects such as early child marriages and female genital mutilation are adverse childhood experiences that negatively impact the children's psychological health. The girls miss out on going to school which would have helped them

adapt with their peers and ensure a brighter future.

5.6 Conclusion

The study realized that most of the refugee children came to the camp traumatized by the refugee experience. This has an impact on their mental health and learning experiences. They exhibit social withdrawal from the rest of the school community. The boys are more adaptable than the girls. The girls are more preoccupied with house chores when they go back home. They are also victims of early marriages. It is a cultural issue especially with the south Sudanese culture. The family allows this so as to get money for upkeep. However, these are some of the daily stressors that contribute to psychological stress in refugee children in host countries.The findings indicated that refugee children in Kakuma refugee camp experience psychological stress symptoms such as depression, irritability, lack of concentration and withdrawal. Most schools undertook counseling for parents and children who are identified as affected psychologically.

Counseling was the most accessible intervention for refugee children in schools. Psychosocial support for parents was the least accessible intervention because it involves outreach to the affected communities. After the interventions most of the children showed improvement in academic performance and concentration in class. There was more social interaction with the peers.

Challenges in interventions entailed lack of training in professional counseling for teachers and lack of community and family support. Findings also indicated that factors affecting the psychological wellbeing of refugee children includes traumatic events in the refugee experience and school transitions between origin and host country and within the camp. Other symptoms experienced by the children could be personal and unobservable by the teachers or social workers.

5.7 Recommendations

After dissecting the extent refugee children psychosocial health is overlooked, this study came up with following recommendations. The study recommends its consideration on community child counselors who are trained in first aid counseling and identification skills of children experiencing psychological issues. Trained counselors can differentiate between normal lack of interest in school or lack of interest due to depression or Post-traumatic stress disorder.

Secondly, there is a need to employ more teachers in schools that refugees in Kakuma attend, these teachers should be trained to interact with the children. More classrooms should also be built to avoid overcrowding. Education is a very important tool for the protection of these children. Counseling should be part of the curriculum for refugee children.

Thirdly there should be community-based structures for the provision of sufficient food and security. This will reduce the daily stressors and supplement food rations for refugee families.

Fourth, there is a need for debriefing and counseling for staff dealing with refugee children and teachers since they are affected by the intensity and complexity of their work.

Fifth, there should be more sensitization and awareness creation on the effects of trauma on the psychological health of the children to the refugee community in Kakuma camp and on cultural practices that impact negatively on the children's wellbeing. This will reduce instances of stigmatization. It will make them aware of available interventions and that they can still get help and live normal lives like other children. It will enable stigmatized children to go to school and a chance for a brighter future.

Sixth, there should be more sexually gender-based violence reporting centers. (SGBV). This will increase the number of reported incidences and reduce suicide rates. There are a lot of sexual-based violence cases on refugee children even from relatives. This is due to the vulnerability of these unprotected children. The centers should provide professional counseling and support services. More recreation centers should be established to keep children occupied especially during school holidays.

Seventh, more recreation centers should be established to keep children occupied especially during school holidays.

Lastly, child-sensitive interviews and interventions should be done by trained counselors who can produce expert assessments on the psychological state of the refugee child at the reception centers and community-based protection to manage their mental health. Unaccompanied children need a stable environment and emotional security. There should be more family tracing centers to assist in reunifying the family (WHO, 1996).

The interviews should be done by trained counselors or staff to make the children feel

secure and to minimize psychological distress. There should be a follow-up as regards to family reunification and a local child-welfare system. Separated children need community-based care where the child's development and socialization is monitored within his or her community. These children should have their basic needs met, access to schools, and structured activities for restoration of normalcy. However, school teachers need to be trained to deal with separated refugee children to help them deal with behavioral and emotional problems. The refugee children who cannot be reunited with their families depend on community-based care (ICRC, 2004).

Lastly more school-based counseling should be adapted in the schools in Kakuma refugee camp. The schools should have a language Centre where each refugee child can learn English and Kiswahili. Refugee children should be encouraged to go to school.

5.8 Limitations of the study

This study had various limitations that are likely to affect the research outcome. Some of these were; refugee children could not be part of the respondents due to ethical reasons, stigma due to the nature of traumatic experiences, and their lack of awareness of psychological issues. Reminding children or asking them to relive traumatic refugee experiences would be detrimental to them.

Due to the vastness of the area occupied by the camp and time constraints it was challenging to administer questionnaires in more schools. The weather conditions also made some parts of the camp inaccessible due to flooding. Delays in securing relevant authorization for the research was also another significant limitation since it had an impact on the time taken and spent in the field collecting data. These delays were occasioned by

red tapes in the processing of authorizations. The distance between schools in Kakuma 1 the field study point to the school and researcher's habitual abode was another limitation. This stretched the researcher to spend in the field and travel long distances thus impacting the outcome.

5.9 Suggestions for further research

There is room for further research on other refugee camps like the Daadab refugee camp in Garissa County, Kenya. A similar study could also be carried out with children and parents as the respondents rather than the primary and secondary school teachers only. Similarly, for the child protection stakeholders, the use of focus group discussions in research methodology, could be more beneficial since the psychosocial interventions are multidimensional and they require interagency approaches.

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APPENDICES

APPENDIX I: INTRODUCTORY LETTER

INTRODUCTION DEAR RESPONDENT,

My names are Edna Dali Kisombe. I am currently a student at the University of Nairobi and required to undertake a project and subsequently data collection at Kakuma Refugee Camp. My research topic is, interrogating refugee rights to health, a case of the psychological health and interventions regarding refugee children in Kakuma Refugee camp. This will be in fulfillment of the requirement for the award of Post Graduate Diploma in Migration Studies at the University of Nairobi. In your capacity and experiences with refugee children in the camp, schools, health institutions, and as partners involved in refuge child-focused programs and projects with the relevant United Nations and partner organizations, I kindly request your input and cooperation to complete my study. You have useful information and relevant information.

Therefore, I am humbly requesting you to make the contribution by answering the questions in the questionnaire and provide any other relevant information to the above research study. This information will be highly appreciated and will be treated with the utmost confidentiality. You will not be penalized for not responding to the questions.

Thank you,

EDNA, D. KISOMBE.

APPENDIX II: QUESTIONNAIRE

A SURVEY ON THE PSYCHOLOGICAL HEALTH OF REFUGEE CHILDREN. A CASE OF KAKUMA REFUGEE CAMP.

FOR GUIDANCE AND COUNSELLING TEACHER/SOCIAL WORKER

Please note that whatever you share in this questionnaire shall not be used in any other place and shall be confidential for this study.

Kindly tick the appropriate answer or fill the appropriate information where necessary. Do not write your name.

1. Name of the school or educational facility

……

……

2. For how long have you been a teacher/ social worker/ at Kakuma refugee camp?

A. 1 -2 YEARS

B. 3-5 YEAR

C. 6-8 YEARS

D. MORE THAN 10 YEARS

3. Approximately how many refugee children are currently in the school?

……

4. What is the student composition in the school?

A. REFUGEE CHILDREN ONLY

B. LOCAL COMMUNITY CHILDREN ONLY

C. BOTH/ MIXED CLASS

5. If the students are mixed as indicated above, how do the two groups socially interact with each other in class, and as they play?

……

……

6. If the students are only refugees, how do they socially interact as compared to the mixed group? ……

……..

7. Which behaviors have you observed in refugee children in the school?

A. LACK OF CONCENTRATION in class

B. DEPRESSION

C. SOCIAL WITHDRAWAL

D. IRRITABILITY

E. ANY OTHER (S)……..

……

8. How often have you observed the above behaviors in refugee children?

A. Quite often

B. Often

C. Not at all

9. Which gender have you observed to portray more of the behaviors/traits listed above in question number 7 above?
Kindly tick in the appropriate box below.

Psychological behaviors	Boys	Girls
Lack of concentration in class		
Depression		
Social withdrawal		
Irritability		
Any other(s)		

10. What intervention mechanisms have you undertaken in the school to assist the refugee children with the above psychological behaviors?

A. COUNSELING FOR PARENTS AND CHILDREN

B. PYCHOSOCIAL SUPPORT FOR PARENTS AND CHILDREN

C. CHILD FRIENDLY ENVIRONMENT IN THE SCHOOL

D. ANY OTHER(S)……

11. What improvements have been observed in the refugee children's behavior after the above interventions?

A. MORE SOCIAL INTERACTION WITH PEERS

B. IMPROVED ACADEMIC PERFORMANCE IN CLASS

C. IMPROVED CONCENTRATION IN CLASS

D. OTHER (S)……

……

……

12. What challenges do you face in facilitating the interventions mentioned above for the refugee children's psychological health and wellbeing?

A. LACK OF PROFESSIONAL TRAINING IN COUNSELLING

B. LACK OF COMMUNITY/ FAMILY SUPPORT

C. LACK OF VOLUNTEERS TO PROVIDE COUNSELLING SERVICES

D. LACK OF INSTITUTIONAL CAPACITY

E. LACK OF FINANCIAL CAPACITY

D. ANY OTHER (S)…….

……..

……..

13. Which of the factors below seem to affect the wellbeing of refugee children?

A. LANGUAGE BARRIERS

B. DISCRIMINATION (based on religion or and ethnicity) kindly specify

……

C. SCHOOL TRANSITIONS (from a school outside Kakuma refugee camp or from a Kakuma based school)

……

……

D. TRAUMATIC EVENTS/STRESSFUL EVENTS (pre or post-migration into the refugee camp).

E. ANY OTHER(S)……

.....

APPENDIX III: INTERVIEW GUIDE

A SURVEY ON THE PSYCHOLOGICAL HEALTH OF REFUGEE CHILDREN. A CASE OF KAKUMA REFUGEE CAMP.

INTERVIEW GUIDE FOR HEADTEACHERS/ SOCIAL WORKERS/ HEALTH **WORKER/RASPROTECTION OFFICER (heads of these institutions)/ UNICEF//SAVE THE CHILDREN/ REFUSHE/ XAVIER PROJECT AND RAS**

1.Name of Institution or Non-Governmental organization (NGO)……

2.How many refugee children are enrolled in the school? For the headteacher

3.How often have you handled cases of refugee children (unaccompanied/accompanied, separated from their families/parents) cases? (Approximate cases per month) for each case above…….

Unaccompanied Accompanied Separated

4.What in your experience are the psychological problems that the refugee children face in the Refugee Camp? Or in Schools? For both

5.What effective interventions have been adopted by your organization or school in addressing the psychological health of refugee children?

6.Has school attendance been helpful to refugee children who have experienced traumatic events from their countries of origin to seeking refuge in the camp? f *or the headteacher*

7.Does the school offer a physically, socially, and mentally safe environment for refugee children? *For the headteacher*

8.If not what recommendations would you make to improve on the above?

9.What would you recommend as a school institution/ health facility/partner organization as an intervention for assisting psychologically affected refugee children?

10.What challenges do you experience in interventions on psychological health refugee children in terms of counseling, rehabilitation, integration, and reunifying them with their families?

11.What is your observation are the current challenges/daily stressors facing refugee children in the camp?

12.What is your role as a partner organization in providing psychosocial support for refugee children in ensuring their psychological wellbeing? *For the organization*

APPENDIX IV: UNIVERSITY OF NAIROBI RESEARCH PERMIT

UNIVERSITY OF NAIROBI
POPULATION STUDIES AND RESEARCH INSTITUTE

Phone (02) 318262 Ext. 28029
Telex Fax (254) 02-2245566
Telex: 23095 Varsity Nairobi, Kenya

P.O. Box 30197
00100 Nairobi, Kenya
Telegrams Varsity

Ref: Q68/28917/2019

21st February, 2020

TO WHOM IT MAY CONCERN

Dear Sir/Madam

RE: RECOMMENDATION FOR EDNA DALI KISOMBE - FOR DATA COLLECTION

This is to request for permission for the above named student in our Institute who is in her final year undertaking her research project to collect data for the purposes of the research project. Her topic of study is '**Assessing the Management of Refugees in Kenya, a case of Kakuma Refugee Camp.**

Your assistance will be highly appreciated.

Yours faithfully

DIRECTOR
POPULATION STUDIES &
RESEARCH INSTITUTE
UNIVERSITY OF NAIROBI

Anne Khasakhala, PhD
Director, PSRI.

APPENDIX V: AUTHORIZATION TO VISIT KAKUMA CAMP FROM RAS

OFFICE OF THE PRESIDENT
MINISTRY OF INTERIOR AND CO-ORDINATION OF NATIONAL GOVERNMENT
REFUGEE AFFAIRS SECRETARIAT

Website: www.refugeeaffairs.go.ke
E-mail: refugeeaffairs@interior.go.ke
Tel: +254-020-4405057
When replying please quote:
RAS/OPER/22/Vol.VIII (79)

Castle House, James Gichuru Rd
P.O. Box 42227 -00100
Nairobi, Kenya

24, February 2020

James Nyatigoh
Directorate of Immigration Services
Office of the Director General
PO Box 30191-00100
Nairobi Kenya

RE: AUTHORIZATION TO VISIT KAKUMA REFUGEE CAMP

Reference is made on your letter Ref. No. IMM/3/10/Vol1/188 dated 24 February 2020 regarding the above subject.
Authority has been granted to:

Name	Nationality	Passport/ID No.
Edna Dali Kisombe	Kenyan	21696285
Michael Arina Richard	Kenyan	20758893
Yusuf Diba	Kenyan	32177076

to visit Kakuma refugee camp from 9 March-30 April 2020.

The purpose of the visit is to collect data required for their academic research projects which is a mandatory requirement for the award of Postgraduate Diploma in Migration Studies at the University of Nairobi.

This clearance however, is subject to the following conditions:

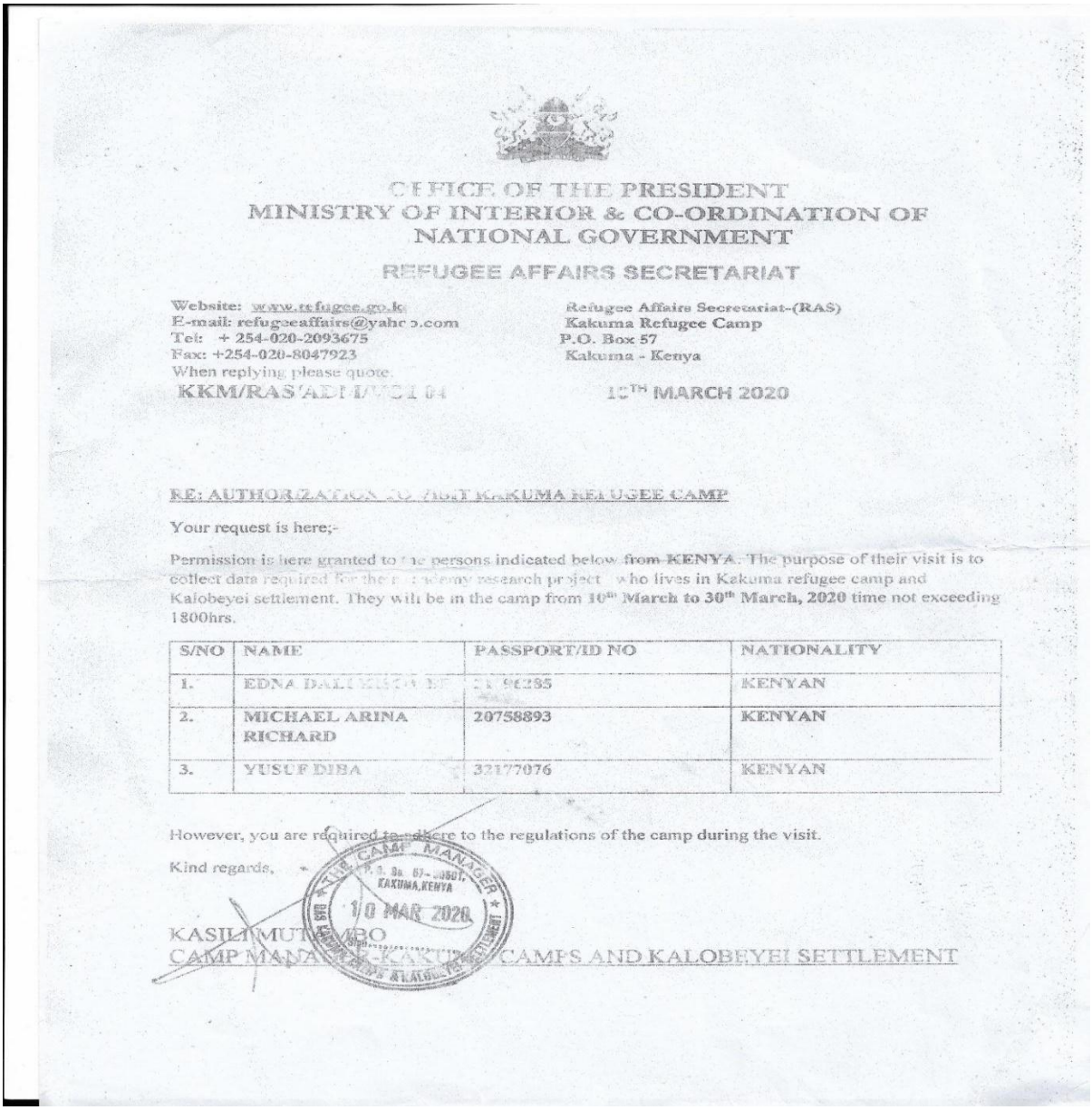
i. Adhere to all security requirements at the camp.
ii. Your stories shall be objective, balanced and in compliance with **Section 33(2) a, b, c** and **d** of the Constitution of Kenya (2010).

On arrival, you will be required to report to the camp manager before transacting any business in the camp.

K. MAKORI
Ag. COMMISSIONER FOR REFUGEE AFFAIRS

Copy to: Camp Manager
Kakuma refugee camp

APPENDIX VI: AUTHORIZATION LETTER FROM THE CAMP MANAGER KAKUMA CAMP AND KALOBEYEI



OFFICE OF THE PRESIDENT
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REFUGEE AFFAIRS SECRETARIAT

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E-mail: refugeeaffairs@yahoo.com
Tel: + 254-020-2093675
Fax: +254-020-8047923
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KKM/RAS/ADM/VOL 04

Refugee Affairs Secretariat-(RAS)
Kakuma Refugee Camp
P.O. Box 57
Kakuma - Kenya

10TH MARCH 2020

RE: AUTHORIZATION TO VISIT KAKUMA REFUGEE CAMP

Your request is here;-

Permission is here granted to the persons indicated below from KENYA. The purpose of their visit is to collect data required for the purpose of my research project who lives in Kakuma refugee camp and Kalobeyei settlement. They will be in the camp from 10th March to 30th March, 2020 time not exceeding 1800hrs.

S/NO	NAME	PASSPORT/ID NO	NATIONALITY
1.	EDNA DALI [illegible]	[illegible] 96285	KENYAN
2.	MICHAEL ARINA RICHARD	20758893	KENYAN
3.	YUSUF DIBA	32177076	KENYAN

However, you are required to adhere to the regulations of the camp during the visit.

Kind regards,

CAMP MANAGER P.O. Box 57-30307 KAKUMA, KENYA
10 MAR 2020

KASILI MUTUMBO
CAMP MANAGER-KAKUMA CAMPS AND KALOBEYEI SETTLEMENT

APPENDIX VII : TURNITIN REPORT

INTEROGATING REFUGEE RIGHTS TO HEALTH: A CASE OF PSYCHOLOGICAL HEALTH OF REFUGEE CHILDREN IN KAKUMA REFUGEE CAMP, KENYA.

by Edna Kisombi

Submission date: 09-May-2020 10:46PM (UTC+0300)

Submission ID: 1320428831

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