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Post-Civil War Experience and Women with Disabilities in Nigeria

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ABSTRACT

This work examines post-civil war experience and women with disabilities in Nigeria, fifty years after the War. Literature is replete with conditions or dimensions of disabilities created by the Nigerian Civil War. Both men and women were wounded and amputated during the war. Some have died, some are still alive. Often times, the war-induced people with disabilities (PWDs) have lived in abject poverty and not received adequate care or assistance. In fact, they have been subjected to series of inhumane treatment by the society they fought to keep united. Painful enough, people with disabilities are often excluded from development policies and programmes that concerned them. Community-Based Rehabilitation is central to the achievement of satisfactory empowerment of PWDs, because of its capacity to be implemented through the combined effort of people with disabilities themselves, their families, organizations and communities and the relevant governmental and non-governmental health, education, vocational, social and other services. The core of this study is that a cost-effective strategy should be employed to reach women with disabilities within their own communities. This approach makes use of existing community services and promotes inclusion instead of exclusion. As advocated by Obiozor and Koledoye (2011), government authorities and stakeholders must ensure that WWDs benefit from the gains of the 1993 Nigeria with Disabilities Decree, and access quality healthcare, literacy, security, vocational and special education and democracy, especially through community-based rehabilitation strategy.

Keywords: *Community-based Rehabilitation (CBR), education, Nigerian Civil War, People with Disabilities (PWDs), 3R policy.*

INTRODUCTION

The deplorable conditions of people with disabilities in Nigeria and other developing countries are increasing, and have become a global issue. The incidence couple with the burden of disability in the aftermath of the Nigeria civil war on both men and

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women fifty years after is gaining a global recognition. Estimate by World Health Organization (WHO, 2011) shows that about 2.5 million Nigerians now live with at least a disability, with approximately 3.6 million having significant difficulties in functioning. Heavy bombardments in the course of the war created various degrees and dimensions of disability on the citizens, ranging from blindness and physical impairments or disabilities caused by gun-powder and gunshots or bullet-hits to other emotional disabilities due to traumatic experiences during the war.

Observably, despite such scale of casualties, the rehabilitation services, in the country, is limited and meets not more than 2% of those in need, in the very country they fought to keep united, (Suwaiba, 2008 cited in Ihenacho 2009; CBM, 2008). Evidence and experience shows that the introduction of the 3Rs policy of reconstruction, rehabilitation and re-integration of the war-induced persons and affected areas, have had serious modifications of most policies which in recent times, had systematically excluded men and women with disabilities, as well as the surviving veterans who sustained some forms of disabilities, from development programmes of the government, (Lang and Ukpah, 2008; Onota, 2007 and CBM, 2010b). As echoed from the war, fifty years after, this segment of Nigerian citizens consistently, suffers institutional and attitudinal discrimination, faces barrier in all aspect of the society, such as education, employment, healthcare, transportation, polities and justice, among others. This study therefore examines lessons inherent in the post-civil war experience of women with disabilities in Nigeria.

THEORETICAL UNDERPINNING

This study adopts the social model of disability approach which sees systematic barriers, negative attitudes and exclusion by society (purposely or inadvertently) as the major contributing factor of disability, and thus, sought for Community Based Rehabilitation (CBR) strategy, an integral disability inclusive approach which aimed at promoting inclusion instead of exclusion of persons with disabilities (PWDs) within their own community. It is anchored on the social model disability approach, as advocated by Oliver (1983), Wallerstein (1992) Ekong (2007) and UPIAS (2010). The origin of this approach can be traced to the 1960s (Oliver (1983). Although the specific term emerged from the United Kingdom in the 1980s, the major proponent of this model is a British disabled academic, Mike Oliver, who in 1983 coined the phrase social model of disability, (UPIAS, 2010). He focuses on the idea of individual model (of which the medical was a part) versus a social model, derived from the distinction originally made in 1975 between impairment and disability by a United Kingdom Disability Organization, known as the Union of the Physically Impaired Against Segregation (UPIAS) (Oliver,

2006). However, Oliver did not intend the social model of disability to be an all-encompassing theory of disability, but rather a starting point in reframing how society views disability.

The social model of disability is of the assumption that the issue of disability is socially created problem as the consequence of institutional and social discrimination, as well as exclusion of persons with impairments (Oliver, 2004). The model further holds that disability is caused by the way society is organised, rather than by a person's impairment (Oliver, 1990). It is a reaction to the dominant medical model of disability, which in itself is a functional analysis of the body as a machine to be fixed in order to conform to normative values (Ekong, 2007). It identifies systemic barriers, negative attitudes and exclusion by society (purposely or inadvertently), as the main contributory factor in disabling people (Lang and Upah, 2008).

The social model of disability further proposes that people can be disabled by a lack of resources to meet their needs (CBM, 2010a). It focuses on issues such as the under-estimation of the potential of people with disabilities to contribute and add economic value to society, if given equal rights and equal suitable facilities and opportunities as others (Okoye, 2010). Thus, an integrated disability inclusive approach via CBR programme, is most likely to be ensured. This therefore affirms the submission of Wallerstein (1992), that in as much as CBR empowers people, (including those with disabilities) it is a social-action process which promotes participation of the people, organizations, and communities towards the goals of increased individual and community control, political efficacy enhances the livelihood and social inclusion of the people.

The social model of disability avers that disability is as a result of the interaction between people living with disabilities and an environment filled with physical, attitudinal and social barriers, and therefore carries the implication that the physical attitudinal and social environment must change to enable people with disabilities to participate fully in the society on an individual basis with others (Ihenacho, 2009). The model shows that lack of appropriate social services and facilities for the people with disabilities and the existence of stigmatising attitudes in the society weighs far greater on the disabled than disability itself.

Disability has been and to a large extent still is, considered an individual problem; impairment or an illness that prevents a person from undertaking daily tasks and participating in society like the non-disables (SAHRC, 2012). The traditional response to this medical view of disability has been the creation of measures and policies that promote segregation and protection with the aim to correct or compensate for the disability rather than including it in public social policies within society and removing barriers (Parahoo, 2000). They are like aliens in their own country. Services that

could contribute to mitigate most discriminatory factors prevail, and barriers and limited opportunities persist for persons with disabilities to participate as full and equal members of society (Kassah, 1998). In Nigeria, there is no disputing fact that, despite some notable enhancement programmes in the promotion of more inclusive service provision and policy on poverty alleviation/livelihood enhancement either provided by government or the private and nonprofit sector, are seldom made accessible to persons with disabilities.

Disability and poverty persist because the relevant institutions do not save their interest and needs (Effiong and Ekpenyong, 2017b). For instance, the education sector continues to exclude a large majority of children and youth with disabilities in its general education system. This is attributed to physical barriers, social stigma, lack of trained teachers, inadequate transportation, absence of policies on inclusive education and the prevailing rigid and conservative methods of Pedagogy. According to WHO, UNESCO and ILO (2004), disability issue is a development issue, so policies and programmes in favour of persons with disabilities should no longer be viewed as a means of rehabilitating and adapting the disabled individual. In this sense, poverty, like other consequences of institutional discrimination, restricts disabled peoples and undermines their ability to fulfill their socio-economic obligations. The social model of disability is the foundation for this perspective.

Oppenheim and Harker (1996), cited in Haralambos and Holborn (2008) observe that high rates of poverty among the disabled are partly due to labour market exclusion and marginalization, and whereas, informed market is serving as the main source of livelihoods for a majority of the working population. Suffice it to say here that the high unemployment rates for non-disabled job seekers poses a major challenge in the country. However, physical barriers, further compounded difficulties, in accessing the built environment of work places and attitudinal obstacles due to social stigma, couple with employers lack of confidence in the capacity of people with disabilities. In general, the lower level of education of people with disabilities further limits their competitiveness in the open labour market.

Community Based Rehabilitation (CBR) programme is an integral part within the general community development, where the hitherto socially excluded persons with disabilities, who would have contributed meaningfully to the nation's socio-economic development, are re-integrated into the society via the removal of all forms of attitudinal and environmental barriers to participation in life (Obiozor and Koledoye, 2011). In this construct, CBR services are functional in terms of integrating this group of people (PWDs) into the country's development agenda in order to maximise their physical and mental abilities, to access regular services and opportunities, and to contribute to

the overall societal function in the ways conceived for the particular position in which they find themselves.

Nigerian Civil War and Persons with Disabilities

The Nigerian Civil War has led to some forms of women disabilities. It is important for the society to know and understand the different types of women disabilities in order to cater effectively for them. These disabilities have been identified by scholars (Heward, 2009; Obiozor and Pang 2009; Ogbonna-Nwaogu, 2010) to include disease or disorder, impairment, disability and handicap. Disease or Disorder refers to something abnormal which occurs within the individual, either present at birth or acquired later, but it gives rise to changes in the structure or functioning of the individuals body (Okoli, 2010). An example is autism, which is a disorder that affects the brain and can result in the inability of the person to excel in social areas, verbal and nonverbal communications and intellectual capacity. Impairment refers to the loss or reduced function of a particular body part or organ (for example, a missing limb) (Okoli, 2010).

Disability exists when an impairment limits a person's ability to perform certain tasks (such as, walk, see, add a row of numbers) in the same way that most persons do (CBM, 2010b). Handicap refers to a problem or a disadvantage that a person with a disability or impairment encounters when interacting with the environment (CBM, 2010a). A disability may pose a handicap in one environment but not in another. A related term, "at-risk", refers to children who, although not currently identified as having a disability, are considered to have a greater-than-usual chance of developing one (Heward, 2009).

Furthermore, Ogbonna-Nwaogu, (2008) identifies the different types of disabilities which are related to what women encountered in the post independent and post-War Nigeria to include: mental retardation or intellectual disabilities; deafness; attention-deficit hyperactivity disorder (ADHD); traumatic brain or head injury; severe, profound and multiple disabilities; orthopedic Impairment; and other health Impairment. The mental retardation or intellectual disabilities disability involves substantial limitations in functioning, characterized by significantly sub-average intellectual functioning concurrent with related limitations in two or more adaptive skills (Goodley, 2001). It is obvious that the War affected the emotional and mental state of some women.

Deafness or hearing impairment involves individuals who have hearing losses greater than 75 to 80 decibels (db), have vision as their primary input, and cannot understand speech through the ear (Helmke, 2006). During the war, many Igbo soldiers and civilians were casualties and victims to heavy artillery shelling and bombardments

which brought about hearing loss, deafness and communication disorders (Obiozor and Koledoye, 2011).

Attention-Deficit Hyperactivity Disorder (ADHD) is a behavioural characteristic which refers to too much activity or general excess of activity. The individual displays inattention, distractibility, impulsivity, and hyperactivity (Heward, 2009). Traumatic brain or head injury is an acquired injury to the brain caused by an external physical force, resulting in total or partial functional disability or psychosocial impairment, or both that adversely affects an individual's performance (Helmke, 2006).

Several people, including soldiers and civilians, returned home after the War with severe, profound and multiple disabilities which generally involve significant disabilities such as intellectual, physical, and/or social functioning (Heward, 2009). Orthopedic Impairment refers to a severe physical disability or orthopedic impairment that adversely affects an individual's educational performance (Heward, 2009). The term includes impairments caused by congenital anomaly (for instance, clubfoot, absence of some member), impairments caused by disease (for example, poliomyelitis, bone tuberculosis) and impairments from other causes (such as: cerebral palsy, amputations, and fractures or burns that cause contractures) (Helmke, 2006). Some women who gave birth after the civil wars had children with such developmental disabilities. Today, they make up the disabled women population who needs rehabilitation (Obiozor and Koledoye, 2011).

The war also made women to suffer from other Health Impairments which involve physical disability resulting in having limited strength, vitality or alertness among others, and include health problems such as a heart condition, tuberculosis, asthma, sickle cell anemia, epilepsy, diabetes, that adversely affects an individual's educational performance (Helmke, 2006). It is lamentable that these forms of disabilities explained above were acquires by women during and after the man-imposed Civil War rather than through genetic processes.

Lessons on Women and Disability Inclusivity in the Post-Civil War in Nigeria

Women and disabilities are universal phenomena that affect every human society. The 50 years post-civil war experience of women with disabilities in Nigeria forms the onus of this study. As a woman in Africa and Nigeria in particular, Gender comes with a number of challenges, constraints and opportunities, while the aspect of disabilities create more concerns due to several reasons, such as cultural, traditional, health and socio-economic problems (CBM, 2010). Amulu and Abu (2010) describe gender as culturally prescribed social roles and identities of men and women within a society, whose practices, varies from community to community. While disability, according to

Oliver (2004) is caused by the way the society is organized, with the existence of stigmatizing attitudes, weighing far greater on the disabled than disability itself, this work study contends that the issue of gender and disability, in this regard, are socially created problems, consequent upon institutional discriminations and exploitation of the vulnerable people, mostly the women, in the society. Given the historical account on the justification of gender in the society, Haralambos, Holborn and Heald (2008) have observed that in the Bible, the original sin in the Garden of Eden was that of a woman, who tasted the forbidden fruit, tempted Adam (a man) and had ever since, paid for it. In the Book of Genesis 3:16, the Lord said to Eve (a woman): I will greatly multiply thy sorrows and thy conception; in sorrows thou shall bring forth children; and thy desire shall be to thy husband, and he shall rule over thee". Also, the book of Ephesians 5:22 and 23b further affirm the above narratives on women's subjugation and subordination to male authority in every human society. Studies by feminists as well as sociologists and anthropologists show that there is virtually no human society in existence that women do not have an inferior status to that of men (Haralambos, Holborn and Heald, 2008). Scholarly works are replete of theoretical and empirical discussions of women inequality and second-class status in the society (Barron and Amerena, 2006; Lang and Upah, 2008; Amusat, 2009; Amulu and Abu, 2010; Chung, Packer and Yau, 2011). These are just to mention a few.

The literature seems to be inundated with variety of reasons that accounts for women subjugation in societies they (women) are numerically dominant. The kaleidoscope hinges this on issues of marginalization, male domination, cultural practices, abuse of religion, poverty, economic and social instability (Ogbonna-Nwaogu, 2008; Ihenacho, 2009; Jibrin, 2009 and Okoli, 2010). This is also the general belief that is not only in Nigeria, but in most part of African societies. It is a parochial society, where men are favoured in all things, and entitlements generally protects the interest of men to the exclusion of the needs of women, (that is to say, the rights to inheritance).

Furthermore, studies by Amulu and Abu (2010) show that in many communities in the country, women have fewer resources and opportunities than men. This inequality between men and women is also true among PWDs. But women with disabilities (WWDs) in Nigeria face more challenges in their daily life than their men counterparts. Generally, WWDs face huge discrimination in three specific areas: as a woman experiencing gender discrimination, as a disabled person experiencing prejudices around difference in abilities and poverty. In the words of Lang and Ukpah (2008), gender in relation to disability shows that poverty hits harder on WWDs than the men, probably, due to the patriarchal nature of property ownership structures in the country. It is quite unfortunate to say that fifty years after the civil war in Nigeria, WWDs are mostly

among the poorest of the poor. This situation has been described by most feminists in the country as feminization of poverty (Ogbonna-Nwaogu, 2008). The WWDs in Nigeria, often times, were used for sacrifice or to attract favour or destruction from the gods of the land. They were seen as over-dependent on their families and mostly unheard when it comes to decision making. In order words, they were at the receiving ends of every decision-making processes in their families (Ihenacho, 2009). Interestingly, women who were the greatest victims of the war having lost everything including husbands, children, lands and dignities as a result of abduction and gang rapes, still strive to transcend their sorrows and experiences of the horrific violence, loss and persuasive trauma, to rebuild their lives and communities (Ogbonna-Nwaogu, 2008), whereas the common perception of disability intervention in the country, is often, in terms of charity and welfare. Consequently, this view point is a significant factor that inhibits the social inclusion of PWDs to enhance their livelihood in the society.

Observably, in a post-civil war era, such as we are, the number of PWDs (WWDs inclusive) living in poverty is disproportionately high and yet, livelihood services in Nigeria, are scarce, and often too costly to gain access (Jibrin, 2009). Many individuals with disabling condition are living in chronic poverty due to their inaccessibility to livelihood opportunities available to others in the country (DFID, 2006). They are routinely denied accessibility to skills acquisition by the family members, and in most cases excluded from employment due to lack of skills (WHO, 2010). However, where PWDs acquire skills, are often compelled into taking up occupations which are below their potentials on the guise that there are limited expectations of what they can do (WHO, 2010).

Many PWDs face barriers to participate in vital activities in their communities and are mostly compelled to live marginal lives; the challenge of assessing livelihood opportunities according to Lang and Ukpah (2008), remains daunting due to the scarcity and non-affordability of rehabilitation services. It is worth mentioning that most PWDs in Nigeria are without work to enhance their livelihood, and consistently suffer discrimination due to some negative assumptions that they are incapable to engage in any livelihood activities in the communities (Effiong and Ekpenyong, 2017a).

To this end, linkages between them and their communities show wide gaps. Thus, consequent upon this exclusionary attitude, PWDs slide back to the society to remain isolated and inactive and hence, lost hope to lead a productive life (Cornielje, 2009; Douglas, 1998; DFID, 2006; Onota, 2007). Community-based rehabilitation (CBR) has being been the antidote to the poor rehabilitation services in most developing countries (WHO, 2010). It is disheartening that the livelihood enhancement of PWDs in Nigeria are hindered by the absence of CBR in most part of the country, fifty years

after the introduction of the 3Rs policy to cushion the effect of the Nigeria civil war on victims (Ogbonna-Nwaogu, 2008).

Disability Issues in Nigeria

The Nigerian government signed and ratified the United Nation Standard Rules on the Equalization of Opportunities for Persons with Disabilities on May 2008, and still, no discrimination legislation has been enacted within Nigeria despite the fact that two bills have been introduced into the National Assembly (Ihenacho, 2009). The common view, held by policy makers and the public at large, is that disabled people and disability issues are charity and welfare matters and not human rights (Lang and Ukpah, 2008). Findings by Onota (2007) corroborate this and have revealed that PWDs are living in an environment that is hostile to their aspirations. Nigerian citizens with disabling conditions are no better off when compared with others living in other parts of the developing world, in terms of the challenges they face they are poor, marginalized and excluded (Lang and Ukpah, 2008). Despite the declaration of full participation in disability agenda of the United Nations by the Nigerian government, PWDs are still faced with these challenges (Michailakis, 1997).

The service of disability issues in Nigeria had identified many factors why the disability agenda continue to suffer. Notable among them are: the absence of disability discrimination laws, lack of social protection, no robust or reliable statistics from either the government or disability development agencies to establish the actual number of PWDS, poor understanding of disability issues by the public, and poor access to rehabilitation services (Lang and Ukpah, 2008; Ihenacho, 2009; CBM, 2010; Mji, Maclachan, William, Gcaza, 2009; Parahoo, 2000). Suffice it to say that PWDs in Nigeria, as observed by Barron and Amerena (2006) are often treated as second-class citizens, shunned and segregated by physical barriers and stereotypes. This discrimination occurs in a range of arena, including the workplace, schools, health centres, recreational facilities, and many societal contexts. As a fall-out of social discrimination, economic marginalization, and a broad range of other human rights violations, PWDs face difficult challenges in living a normal life as they are ignored and sometimes excluded from development policies and programmes (Barron and Amerena, 2006).

It is disheartening that, while some governments and societies have adopted a social inclusion and rights-based approach to disability issues, Nigeria still relies on charity models of assistance and a narrow medical model that focuses on finding medical

solution to limitations caused by a disability and ignores the need to address the vast assay array of limitations created and imposed by discrimination, exclusion, ignorance, and lack of access (Barron and Amerena, 2006).

Disability and Rehabilitation: 50 Years after the Civil War

Over the decades, government of Nigeria has taken important steps to develop policy statements which addressed the demands and rights of PWDs (FRN, 2007). Between 1944 and 1950 was the ordinance on juvenile delinquency, which made provision for the welfare and treatment of young offenders (Ihenacho, 2009). Although the Ordinance on the asylums of lepers, section 15 and 20, was passed in 1948, Ihenacho (2009) asserted further that the first Ordinance on the establishment of asylums and settlement for the lepers (Hansen Disease) was made under section 58 of 1916, and leprosy regulation of 1917.

Worthy of note is that this Ordinance made provision for compulsory identification and placement of lepers in the asylum and providing consequences for not releasing any leper in one custody law on the educational planning for the handicapped was passed. This gave authority to the ministry to define and make provision for special methods appropriate for handicapped education (FRN, 2004). In 1957 special service law was passed in Lagos (Ihenacho, 2009), and this made provision for special service for the pupil who required it. In 1962, statutes of Northern region on the service of the handicapped were enacted (Lawal-Solarin, 2012), and thus, these authorized the ministries to provide special schools for the handicapped. In 1944, Northern Nigeria Education law was promulgated to ensure adequate supply of train teachers and the supply of sufficient facilities for their training (Ihenacho, 2009). In 1969, the decree that formed the National Commission for Rehabilitation was enacted (Ihenacho, 2009). It made provision for the 3Rs policies of reconstruction, rehabilitation and reconciliation of war victims and the war affected areas in the country (Ihenacho, 2009).

In 1972, Federal Government order on grant-in-aid was passed. This made provision for only grant-in-aids but not procedural guideline on the services of the disabled. In 1976, the direction on the Universal Primary Education was given, and this granted an indirect opportunity to educational services for the handicapped though it was not aimed specifically on the handicapped, but at all non-literate Nigerians who had never attended or completed their primary school education (FRN, 2004). Suffice it to state, however, that these few past decades have seen organizations of and for people with disabilities both within and outside Nigeria working to realign and reposition disability as a social and human right (Amulu and Abu, 2010). As these rights are being

achieved, societies should raise the expectations of PWDs to assume their full responsibilities as members of the society (FRN, 2007).

The missionary and voluntary organizations in the past, played significant roles in the rehabilitation of PWDs in Nigeria. Institutionalized technique which was opportunistic and exclusionary in nature was the main approach used as at then (Ihenacho, 2009). Removal of individuals from the community to rehabilitation institutions was the mainstay which, according to Ihenacho (2009), was based on inmate segregation training devoid of community input and not people-oriented. The people living in the communities where government had situated such institutions saw it as a place to be avoided and with minimum concern and interaction, since persons with disabilities were housed there (Onota, 2007).

When people acquire skills in such places were through with their skill acquisition training (quite an insignificant few drawn from various communities within), they now had the onerous task of being accepted and assimilated into the society, as people rejected their-made product. Thus, they lost hope and slid back to the society to remain inactive. In situations where a challenged person is not able to cope, it results in stereotyping, derogatory labeling and depersonalization (Okoye, 2010). According to Adesokan (2003), most challenged persons suffer rejection, isolation, and maltreatment from other members of the society. Challenged persons are shown negative attitudes and in the Traditional Yoruba society terms such as Abirun meaning handicap, Didinrin meaning imbecile, Abami meaning strange person, and Alawoku meaning mentally imbalance are used to refer to them (Adesokan 2003). Lawal-Solarin (2012) submits that challenged persons are seen as objects of ridicule, shame and pity.

People with disabilities (PWDs), as students, encounter barriers in their quest for education. Viney (2006) cited in Lawal-Solarin (2012), rightly notes that they encounter physical access limitations such as retrieving books from the library shelves. Okoli (2010) observes horrors of architectural buildings which have discouraged many challenged persons from having education. Bradley (2006), cited in Lawal-Solarin (2012), opines that challenged students start out with the same qualifications and aspiration as normal students, but because they encounter barriers, they perform poorer. Crisp (2002) affirms that disability can lead to frustration in some cases, and can adversely degenerate to a level that an individual may not be able to actualize his aspirations. Moreover, the inability to cope portrays them as helpless, mindless, suffering and deserving sympathy and alms. However, factors such as age, gender, and type of disability, among others, determine the coping strategy adopted by PWDs (Lawal-Solarin, 2012). PWDs need relevant information to cope with their disabilities. Their information needs, according to Adesina (2003), include: information for

educational development, information for social and personal development (that is, information is needed on assistive devices that could aid mobility), and information for recreational purposes (including materials for light reading). With change in trend brought by the WHO, ILO and UNESCO in 1994, a new paradigm shift in the concept of rehabilitation of new CBR documents, principle and outcome, has become confusing and sometimes wrongly interpreted during the process of implementation, (WHO, 2010b). Changing the mind-set of implementers, and being able to convince government key personal and officers at the three tier levels has been lop-sided. Various research findings further confirm here that the Nigerian population with disabilities do not fully involved in the planning and implementation of programmes that directly concerns them (Onota 2007, Ihenacho 2009, CBM 2010b). Thus, this confirms further, the precarious situation of PWDs in Nigeria.

Over the years, most PWDs in Nigeria are routinely denied accessibility to skills acquisition by their family members (CBM, 2008 and Onota, 2007), and are often excluded from employment, due to lack of skills (Coleridge and Hartley, 2010). Consequently, their exclusion from work imposes a financial burden on the family and the community, thus leading to a loss of significant amount of productivity (WHO, 2010). There are more likely to experience financial difficulties, socio-economic deprivation and discrimination caused by poverty (Nagata, 2007). Skills, according to WHO (2010) are essential for work, and access to work and employment is vital part of the strategy for moving out of poverty (Coleridge and Hartley, 2010). Unfortunately, PWDs commonly face difficulties accessing financial services to support income generating activities. This is as a result of prejudice, ignorance and lack of training and educational opportunities which may have caused significant barriers to several livelihood activities in the country.

However, where PWDs are made to acquire skills training, they are taught handicrafts, which have very limited market values in rural areas (WHO, 2010). They are frequently channeled into stereotypical occupations which are below their potentials. Thus, non-utilization of their skills become the order of the day as people reject their made products due to stigmatized attitude against them (Ihenacho, 2009). The back lash of the forgoing is that, they have the onerous task of being accepted and assimilated into their communities, and hence, lost hope to lead a productive life. Therefore, sliding back to the society to remain isolated and inactive remains the only option for PWDs (Ihenach, 2009).

Nonetheless, it is an indubitable fact that access to livelihood opportunities is an entry point for an inclusive society (ILO, UNESCO, WHO, 2004), and crucial towards the participation of PWDs in community life, (Coleridge and Hartley, 2010).

Yet, livelihood services (CBR component) are scarce, and often too costly for PWDs to gain access. PWDs remain or become poor due to the inaccessibility to livelihood opportunities available to others in the community (WHO, 2010). Therefore, the challenge of accessing livelihood opportunities remain daunting for most people, particularly, those with disabilities. Some PWDs are caught in damaging circle of low expectations and achievement. They are often compelled into taking up occupations which are below their potential on the guise that there are limited expectations of what they can do (WHO, 2010). In doing this, the PWDs consistently suffer rejection because of their disabilities, and are seen as liabilities and made to face limited opportunities, stereotyping and discrimination. They are without work to enhance their livelihood, due to some negative assumptions by their communities that they are incapable and unable to engage in any livelihood activities (Coleridge and Hartley, 2010).

Furthermore, despite all that has been done to improve the quality of life of PWDs in Nigeria, most communities have continued to view disability as sinful, cursed or people paying for sins of previous births (Ihenacho, 2009). These narratives tends to make the PWDs to be discriminated against, stigmatized and labeled without empowerment, equal opportunities or social inclusion (WHO, 2010 and Lang and Upah, 2008). This exclusion undermines the person's self-confidence, affecting their active participation in the family and community (WHO, 2010). Hence, most of such negative societal attitudes frequently result in their lack of skills, low self-esteem, expectations and achievements in life (WHO, 2010).

Most societal attitudes towards PWDs are exclusionary in nature. Linkages between them and their communities show wide gaps. They are attributed to the deities and divination powers where they are often used for sacrifice or to attract favour or destruction from the gods (Ihenacho, 2009). Whereas Nigeria, despite being signatory to the adoption and ratification of CBR programmes in the country, it is still rare for PWDs to be fully involved in the programme implementation (Onota, 2007; Thomas, 2007 and Ihenacho, 2009). It is disheartening to note that a rehabilitation service which is the last hope of such victims is dwindling, and there seems to notice the almost complete absence of PWDs in the agenda and programmes of governments and NGOs in the country.

Nigeria has been one of the luckiest countries that are witnessing massive presence of International Non-Governmental Organisations, such as the Christoffel Blind Mission (CBM), Sight Savers International, Netherland Leprosy Relief, The Leprosy Mission, Dark and Light International and Liliane Foundation among others (Cornielje, 2009). Also, currently, directory abounds with names of local Non-

Governmental Organisations (Ihenacho, 2009). They are all willing to share in the new world order of participatory management and participatory approach with the government to bring about services that encourage and promote equalisation of opportunities, accessibility and inclusion (Cornielje, 2009).

The main problem at this instance is that there are still gaps currently existing between policy and implementation (Ihenacho, 2009). Creating a separate National Policy for Persons with Disabilities, rather than creating a National Policy on Rehabilitation in general, to encapsulate persons with disabilities is the foremost gap. May be, as at when such a sectional policy was put in place, it held currency, but today's fast faced developing world, new concepts have overtaken separation and put inclusion in place. Nigeria must move away from services and policies which aim at prevention, treatment or fixing of medical problems alone (disabilities) in special schools, special centers, institutions and rehabilitation homes to services which view disabilities as rights and equalization of opportunities.

From the above, it becomes clear that disability is not just a medical or individual issue, but also one with so many social factors and determinants. Hence, the call for community based techniques (CBR), which emphasizes not only on the rehabilitation and empowerment of the individual, but also the elimination of social, physical and environment barriers, and to build communities capable of addressing disability needs and promoting equalization of opportunities (Oladejo M. and Oladejo S., 2011).

Challenges of 3Rs Policy and Empowerment of WWDs in Nigeria

The establishment of the National Commission for Rehabilitation by an enacted decree in 1969 led to the introduction of the 3Rs policy on reconstruction, rehabilitation and re-integration of the victims and war affected areas to address the prevailing needs of the PWDs in Nigeria (FGN, 2007). Consequently, this sectional policy fails to tackle the issue of the reintegration of the victims into their respective communities after the war (Ogbonna-Nwaogu, 2008). It is disheartening to note that a rehabilitation service which is the last hope of such victims is dwindling, and there seems to notice the almost complete absence of PWDs in the agenda and programmes of governments and NGOs in the country.

The main problem at this instance is that there are still gaps currently existing between policy and implementation (Ihenacho, 2009). In as much as every society faces a number of challenges, constraints and opportunities, specific groups in Nigeria, especially women, are vulnerable to abuse and are more likely to be living in poverty (Amulu and Abu, 2010). Little has been done to change their situation. Violence and

exploitation remain a daily threat while these oppressive conditions created different forms of casualties and disabilities; and as a result, women and mothers face risks of abandonment, destitution, chronic diseases and death in their homes and community (Iglesias, 2007). This kind of situation becomes a typical heavy burden on the women's families due to associated long-term illness, diminished quality of life, and poverty situation (Amulu and Abu, 2010). Since the 3Rs have failed to address the problems of WWDs, it is pertinent to advocate for an alternative strategy. Thus, community-based rehabilitation is an option.

Community Based Rehabilitation and Persons with Disabilities in Nigeria

According to the World Health Organization (WHO), (2010), Community-based rehabilitation (CBR) was formulated by the WHO in the late 1970s as a strategy to improve access to rehabilitation services for people with disabilities in low and middle income countries and as part of the broader goal of Health for all by the year 2000 (Finkenflugel, Wolffers and Huijsman, 2005). As indicated in the publication by WHO (1976), the original CBR strategy was to promote the use of effective locally developed technologies to prevent disabilities and transfer knowledge and skills about disability and rehabilitation to person with disabilities, their families and the community at large.

However, since the formulation in the late 1970s, the concept has evolved to become a multi-sectoral strategy, comprising services within Health, Education, Livelihood and Social development sectors (WHO, 2010). It could be argued that it was in this regard in 2004 that a joint position paper by International Labour Organization (ILO), United Nation Educational, Scientific and Cultural Organization (UNESCO) and World Health Organization (WHO) saw CBR as strategy within general community development for the rehabilitation, equalization of opportunities and social inclusion of all people with disabilities. Explained further by ILO, UNESCO and WHO (2004), CBR is implemented through the combined efforts of people with disabilities themselves, their families, organization and communities, and the relevant governmental and non-governmental programmes on health, education, vocational, social and other services. This strategy according to the publication promote the rights of people with disabilities to live as equal citizens within the community, to enjoy health and well-being to participate fully in educational, social, cultural, religious, economic and political activities (ILO, UNESCO and WHO, 2004).

Similarly, Bowers, Kuipers and Dorselt (2015) see community-based rehabilitation as any combination of a number of activities or intervention that can be included in the CBR matrix and are targeted at rights, needs, or inclusion of people

with disabilities. This position further places equal emphasis on inclusion, equality and socio-economic development as well as rehabilitation (Peat, 1997). This also affirms the UN Convention on the Right of Persons with Disabilities (UNCRPD, 2006) which states that comprehensive rehabilitation services including different types of intervention including medical and social are needed to ensure that equal rights and participation of persons with disabilities in societies. Corroborating this, position, Sasad (1998) submits that CBR is a valid and crucial strategy for enhancing quality of lives of all people with disabilities in the community. An attempt that has made it possible for disabled people to receive the help they need to be able to go about their daily activities aided by trained personnel from their communities (Kassah, 1998). Scholars are of the view that a wide variety of very different and complimentary approaches are taken in developing countries to adequately respond to the needs of persons with disabilities (Mitchell, 1999; Sharma, 2007; Cornielje, 2009). To them, in theory, CBR programmes are considered to be the most cost effective approach to improving the well-being of persons with disabilities, in comparison with core hospitals or rehabilitation centres.

Nonetheless, while some scholars see CBR as service provision only, others see it more as an empowerment strategy (Cornielje, 2009). However there are discrepancies or paradoxes between CBR as ideal and CBR in usual practice. Literature has identified that although CBR is supposed to focus on empowerment, rights, equal opportunities and social inclusion of all PWDs, in practice much of the communities have negative attitudes towards PWDs. CBR should be about collectivism and inclusive communities, but CBR workers are stakeholders and individualist who need wages and benefits (CBM, 2010b). Supposedly, CBR should be managed by the community, what is obtainable is that CBR projects often are top-down in approach and run by outsiders without consideration towards community concerns and participation (Cheausuwantavee, 2007). These revelations lay the need for the study.

Interestingly, the community-based rehabilitation (CBR) has been endorsed by World Health Organisation (WHO) as comprehensive intervention strategy that sees to the need of enhancing effective participation in any community by PWD in all countries of the world, including Nigeria (Biggeri, Deepak, Mauro, Trani, Kumar and Ramasamy, 2013). With this, PWDs and their families could work closely to overcome physical and sociological barriers within their communities through a holistic approach to a person and their environment in the areas of health, education, livelihood, social inclusion, skill development and empowerment (WHO 2010).

In Nigeria over the years, regardless of the high number of PWDs, basic services such as rehabilitation is limited and meeting not more than 2% of those in need, in many parts of the country (Jibrin, 2009). PWDs received very little support;

suffer various forms of discrimination and often times, face significant barriers to participate in several livelihood activities in most rural communities in the country (Lang and Upah, 2008). They are often excluded from social, economic and political matters that concern them. The common perception of disability intervention is often in terms of charity and welfare (Onota, 2007). Consequently, this viewpoint is a significant factor that inhibits the social inclusion of PWDs to enhance their livelihood in the society (Ihenacho, 2009).

A study by the Department for International Development (DFID, 2000) has shown that under certain conditions, 80% of rehabilitation needs of PWDs could be met through CBR programmes, which are considered fundamental, to enhance the livelihood of PWDs and for fostering their participation in any community and society, at large. In this wise, many of these PWDs require CBR to meet their basic needs to ensure inclusion and participation, enhance their livelihood, and as well as their families, care givers or their community. This study adopts CBR as a strategy for empowering WWDs PWDs in Nigeria. Helander (1993) defined CBR as an approach of ensuring that more persons with disabilities can be reached with good quality and appropriate services as well as taken an active part in community life. As CBR (2010) avers, CBR is a strategy within general community development for rehabilitation, equalization of opportunities and social inclusion of all persons with disabilities. As a community-based strategy, it means that the locus of control and action should be in the local community and with disabled people themselves, families and community members (Momm and Konig, 1998).

Community-based rehabilitation (CBR) programmes are considered as the primary avenue through which persons with disabilities (PWDs) could have access to rehabilitation services (Evans, Zinkin, Harpham and Chaudury, 2001). However, observable evidence has shown that the idea has been jettisoned. For instance, studies by Jibrin (2009) affirms that 53% of 19 million Nigerian population with disabilities have no food to eat and that 16% of the population live in extreme poor communities where only 2% have access to rehabilitation and appropriate services.

However, the description of CBR which better suits our context is that given by ILO UNESCO and WHO (2004) that CBR can contribute towards empowering people with disabilities to maximize their physical and mental abilities, have access to regular services and opportunities and become active, contributing members of their communities and their societies. Chambers and Conway, (1991) and Colaridge and Hartley (2010) observe that most CBR programmes implemented thus far do not result from the creativity and hard work of the local people themselves, but are the products of foreign policy and interest, with the input of foreign man power. Colaridge

and Hartley (2010) further aver that CBR programmes are largely financed by overseas agencies and plans are made to fit donors' requirements; hence, the wide diversity of meanings currently attached to the term CBR. DFID (2006) in its research confirms that people with disabilities are largely excluded from the main development policies and agenda at the international, national and local levels. In all situations, however, the formulation of national policies and legislation with a multi-sectoral collaboration are needed for a successful implementation of CBR programmes in developing countries, with Nigeria inclusive. CBR has attracted various academic studies (Iheanacho, 2009; Elwan, 2007; Jibrin, 2009; Onota, 2007; DFID, 2006) because of its focus on empowerment, rights, equal opportunities and social inclusion of people with disabilities.

Importantly, CBR enhances the livelihood of PWDs, including WWDs. Livelihood is defined as a set of economic activities, involving self-employment, and/or wage employment by using ones endowments (both human and material) to generate adequate resources for meeting the requirements of the self and household on a sustainable basis with dignity (CBM, 2010b). The activity is usually carried out repeatedly (UNDP, 1999). For instance, a fisherman livelihood depends on the availability and accessibility of fish.

According to Chambers and Conway (1991), a livelihood comprises the capabilities, assets (including both material and social resources) and activities required for a means of living. A livelihood is sustainable when it can cope with and recover from stresses and shocks and maintain or enhance its capabilities and assets both now and in the future, while not undermining the natural resource base. This is widely accepted as simple and distinctive. In fact, it is the most suitable definition of livelihood. While providing an outline of a sustainable livelihoods approach for field project development, Rennie and Singh (1996) argue that livelihoods is a more tangible concept than development, easier to discuss, observe, describe and even quantify, and the poor of the world predominantly depend directly on natural resources, through cultivation, herding, collecting or hunting for their livelihoods. Therefore, for the livelihoods to be sustainable, the natural resources must be sustained.

CONCLUDING REMARKS

Some forms of women disabilities are aftermath of the Nigerian Civil War. What is more worrisome is the fact that these WWDs are often neglected to their woes, to the extent that some of them resort to begging as the only option. Some efforts by the government and development partners have not been successful ameliorating the conditions of WWDs and enhancing their livelihood. It is argued in this study that

community-based rehabilitation strategy is capable of enhancing the livelihood of WWDs and ameliorating their poor conditions. As advocated by Obiozor and Koledoye (2011), the federal, state and local government authorities and stakeholders must ensure that WWDs benefit from the gains of the 1993 Nigeria with Disabilities Decree, and to access quality healthcare, literacy, security, vocational, special education and democracy, especially through community-based rehabilitation strategy. All hands must be on deck to ensure successful policy making, planning and implementation of policies aimed at rehabilitation of PWDs, especially WWDs.

Conclusively, this study incorporated the social model perspective, looking at poverty as an outcome of disability within the discourse of disability, poverty and development. However, the research argues that in Nigeria, poverty is still among the most important causes of impairment, thus, demanding a better balanced approach and broader perspective such as a comprehensive social model approach to disability. In other words, a revolutionary shift in thinking from the individual medical model, in which people with disability is required to fit into the norms of an able-bodied society, to a right approach based on the social model in which people with disability have the same rights as anybody else and society must adapt to the needs and rights of people with disabilities. This calls for a consensus mutual agreements by all and sundry in the society, thus, making it a society for all, including those with disabilities.

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