From the Field

Disability Studies Quarterly
Summer 2002, Volume 22, No. 3
pages 53-65 <www.cds.hawaii.edu/dsq>

People with Disabilities (PWDs) and Genocide: The Case of Rwanda

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> When you watch TV and see caravans of refugees you hardly ever see PWDs. That is because most of the time they were left behind and most probably their loved ones perished with them (Ruwumbara, 1998).

In practice genocide and disability are intertwined, but in much education and analysis they are not. When the Associated Press described New York state curricular requirements it mentioned "an effort to understand how reprehensible genocide is" in the second paragraph, but accepting "students with disabilities" in the eighth (Stashenko, 2000).

Both objectives are important, but they are not as unrelated as often appears. This article is intended to facilitate the comparison of the 1994 genocide in Rwanda with other genocides. I examine a subset of the population, disabled people, and examine the 1994 genocide in Rwanda and its aftermath in asking whether a focus on people with disabilities (PWDs) would enhance our understanding. I conclude that preliminary indications are that it would, especially when compared with other genocides.

I. The Concern of This Article.

This article extends work which I did earlier in examining genocide and PWDs in general and in specific the Nazi and Cambodia genocides (Blaser, 2001). In this section I briefly discuss meanings of genocide and the topic of disability in a global context.

A. Genocide. The study of genocide reflects a division between those who use it to describe a variety of forms of mass killing and those who reserve it for the killing of particular groups following the UN Genocide Convention's limitation to a "national, ethnical, racial or religious group" (United Nations, 1948, Art. II). That language is also contained in a United States statute, S1851. Destexhe argues that Rwanda meets those criteria and therefore qualifies as

genocide, but Cambodia under the Khmer Rouge does not.

Indeed when debated the draft declaration that resulted in the Convention contained the language "political groups." But governments chose to remove that language as reported in detail in Kuper. The killing of disabled people and the killing of political minorities are subjects of human rights agreements, but not subjects of the Genocide Convention. Political groups, although not PWDs, were included in the draft convention but excluded later based on claims "that their inclusion would jeopardize ratification by states who saw it as an intolerable interference in their domestic affairs and an impediment to their national security" (Ratner and Abrams, 2001, 34).

Markusen and Kopf (1985) wisely drew on Charny (1982) in arguing for "more inclusive, rather than exclusive, definitions of genocide." Charny (1982) "objected to what he calls 'definitionalism,' that is, 'a damaging style of intellectual inquiry based on a perverse, fetishistic involvement with definitions to the point where the reality of the subject under discussion is lost'" (1982:59)

United States' narrowness in defining "genocide" is paralleled by other countries' implementing statutes. Although the Ethiopian Criminal Code does include "political groups," the general tendency is to include the same four as the United States and United Nations (national, ethnic, racial, and religious). This pattern is evident in the statutes of Bolivia, Poland, Mexico, Spain, Russia, Yugoslavia, Albania, and Tajikistan. Australia had a proposal to include "gender, sexuality, political affiliation and disability" which won criticism for challenging the conception of Raphael Lemkin who coined the term "genocide" (Sunday Age, 2000:26).

Although interesting, the debate over definitions of genocide is beyond the scope of this article. It is undisputed that genocide occurred in Rwanda in April of 1994 and my present concern is with PWDs during and after the genocide.

B. PWDs. By global (though not regional) standards Rwanda is a poor country. Because of this poverty proportionally more disabilities are caused by untreated health problems and environmental pollution. There is also a smaller proportion of those disabilities that accompany old age or result from the modern technology used in offices. For our purposes the World Health Organization definition of disability is adequate: "Any restriction or lack (resulting from an impairment) of ability to perform an activity in the manner or within the range considered normal for a human being" (Despouy, 1993:11). The proportion of people who meet the definition is variously estimated at between ten and twenty percent. Before the genocide Rwanda would probably have been toward the lower and of this range, not because of a high quality of medical care as much as because severe disability would be accompanied by death.

Many lower estimates of the number of PWDs are made, primarily because of definitions that are very restrictive. They may, for instance only include people who use wheelchairs

or take advantage of services for deaf and blind people. The number of people who could use these services or could use wheelchairs would be much greater. Thus an estimate of 300,000 (in a country of several million) was designed to suggest a high rate of disability (Agence France Presse, 2000, citing a report of the Fund for the Survivors of the Genocide [FARG] and Rwanda's government).

Choices of numbers and precise terminology are not concerns of this article. Use of the term "PWDs" is useful shorthand, especially regarding Rwanda's genocide, because although it was self-evident to PWDs that they were people, too often to perpetrators of the genocide it was not. (In other contexts, use of the "people first" vocabulary is rightly criticized as a "disability last" vocabulary.)

C. Evidence. The admittedly sketchy evidence in this article reflects three shortcomings:

1. The first is a lack of systematic information gathering. We do not have a reliable census and even the rudimentary attempts at data gathering seldom take into account the complexity of disability issues. For instance, of the multitude of people who experienced trauma during or after the genocide, many would be "disabled" under various classifications although exactly which would differ widely.

2. Second is the tendency to regard PWDs exclusively as "victims." The second element of James Charlton's subtitle, "empowerment" tends to be overlooked while the first, "oppression" is emphasized in accounts of Rwanda's genocide (1988). This reflects a pattern in coverage of PWDs: disability is seen as an explanation of oppression, but not as an obstacle to empowerment. This analysis relies on such sources and so may have a similar limitation.

3. And third, a corollary of the first shortcoming, is the tendency to ignore cultural, social, and economic differences. Even in a wealthy country, it may be a physician who informs a person about a severe disability regarding which she/he was unaware. In Rwanda the chances are great that the disability would remain undiagnosed. What we have, and this article reflects, are partial accounts. The full disability picture is unquestionably greater.

II. Background to the Rwanda Genocide.

This account is based upon others that are far more detailed and reflect the authors' direct contact with the society, politics, and culture of Rwanda. (Several such accounts are included in the bibliography. My favorite is Prunier (1997). The Gourevitch (1999) and Keane (1996) volumes are also particularly and informative.) Key events are identified in the chronologies in the Destexhe (1995) and Keane (1996) volumes. Destexhe (1995) begins his in 1885; Keane (1996) his in 1918. My identification of events will be much more cursory.

A. Precursors to Genocide. Ethnic, occupational, demographic and colonial bases for the genocide have been identified each with some, though not complete, validity.

Observers tend to label the genocide in Rwanda as an example of "ethnic conflict" although analysts such as Gourevitch (1999, 47-48) validly point out the problems that accompany a quick and simplistic analysis. Nevertheless victims of the genocide were primarily Tutsi and perpetrators primarily Hutu. Traditionally the Tutsi had raised livestock and the Hutu had been cultivators.

The distinctions often overlapped due to such factors as intermarriage and a common language, but were reified when registration was introduced by the Belgian colonial authorities in 1926 and then made mandatory with the 1933 census. This facilitated efforts to identify the names and addresses of people to be killed.

The genocide was preceded by many other massacres. Ben Ruwumbara (1998), from whom I quoted at the beginning of this essay, is a refugee from one in 1959 which he also called a "genocide." Destexhe (1995) called it a "bloody Hutu revolt" with 20,000 Tutsi massacred (78). Keane (1996) offers an account of the founding of the perpetrators of the genocide, the Interhamwe in 1990/91: "The Rwandan army begins to train and arm civilian militias known as Interhamwe ('Those who stand together')"(195).

The years were accompanied by diplomatic efforts to secure the return of exiles, mainly Tutsi, and to bring about multiparty democracy. One outcome of these efforts was the Arusha Protocol under which there was a reluctant agreement to allow for the return of refugees and to permit multiparty democracy. Neither promise would be fulfilled.

The necessity for committing some resources to ensure change was recognized at the United Nations through a series of programs all of which were inadequate to stop a series of massacres and ultimately the 1994 genocide.

B. The Genocide. On April 6 a plane carrying Rwanda's President Habyarima was shot down and all aboard were killed. Hutu extremists were displeased by what they viewed as the President's caving in to Western demands for multiparty democracy. Radio broadcasts blamed Tutsi rebels and urged that revenge be taken against the Tutsi population and their sympathizers.

An unprecedentedly intense genocidal campaign followed. The perpetrators were the members of the interhamwe and although the precise number of dead is not known, estimates are of at least several hundred thousand deaths and possibly a million. An analysis of what could and should have been done is far beyond the scope of this article. Suffice it to say that the author is persuaded by the account in Gourevitch (1999, 102-105). Gourevitch (1999) relies extensively on the Canadian United Nations Assistance Mission to Rwanda (UNAMIR) commander, Romeo Dallaire, who argued that the incipient genocide could be foreseen and that a commitment of five thousand troops at the proper time could have stopped the genocide. Instead, the United Nations' force was reduced and the genocide proceeded unabated. The end of the genocide is generally marked as the defeat of the "Hutu power" forces by

the Rwanda Patriotic Front (RPF). This occurred in July with the genocide having lasted roughly one hundred days.

As indicated above, although the General in charge of UN forces had recommended their increase, they were decreased to the point that they could not stop or even mitigate the genocide. There was an initial reluctance even to use the term, accompanied by an unwillingness of the international community to commit resources.

C. Post-Genocide. Although the greatest concentration of deaths designated as "the Rwanda genocide" occurred between April 7 and 30, 1994, a high rate of violence and a climate of intimidation existed for years afterward. As the British organization African Rights reported, " Fortunately, not all the survivors who have been attacked have been killed. A number have been subjected to extreme violence, resulting in life-threatening injuries" (African Rights, 1996, 39).

Two tribunals were established whose purpose is to hold leaders of the genocide responsible, one inside Rwanda and the other the International Criminal Tribunal for Rwanda sitting in Arusha, Tanzania. Some leaders have been held accountable in Belgium. One instance is described in this excerpt that also indicates that commonly sought areas of refuge were not safe:

> Mukangango forced hundreds of Tutsis hiding in the convent to leave on April 21, 1994, knowing they were going to be killed; Mukabutera provided gasoline on April 22, 1994 that was used to set ablaze a building where 500 Tutsis were hiding near her convent and health center outside the southern Rwandan town of Butare (Prevent Genocide International, 2001a).

III. The Propositions.

I have applied several propositions to the Nazi and Cambodian genocides (Blaser, 2001). Table 1 tentatively applies them to the Rwanda genocide and includes comparison to the Nazi and Cambodian genocides. In addition to disability helping to explain who is "first to go" they also suggest why disability is important in discussing who remains after genocide. The propositions are recounted below and some are examined in detail.

Table 1

Levels of Support for Exploratory Propositions and Genocide

	Nazi Germany	Cambodia	Rwanda
P1 PWDs may be selected as direct targets by a genocidal regime.	Strong	Some	Not
P2 The earliest effects of genocide are likely to be felt by			

PWDs.

Strong	Strong	Strong

P3 Genocidal movements or regimes' perspectives on medicine may have disproportionate effects on PWDs.

Strong	Strong	Not

P4 Genocidal movements or regimes' diversion of resources to carry out the genocide may have disproportionate effects on PWDs.

Strong	Strong	Strong

P5 Genocidal movements or regimes minimizing of contacts with other governments and nongovernmental organization may have disproportionate effects on PWDs.

Strong	Strong	Strong

P6 International organizations and intermediate national organizations may assist PWDs.

Some	Some	Some

P7 Genociders may increase numbers of PWDs in the furtherance of genocide.

Support	Support	Strong

P8 The "survivor syndrome" which is a result of genocide reflects the continuing relevance of disability.

Some	Strong	Strong

P9 Regimes following genocidal regimes are unlikely to deal successfully with issues affecting PWDs.

Weak	Strong	Weak

Explanatory note: All of the cell entries are mine and represent no more than an exploratory guess. Some of the reasoning behind the entries for Nazi Germany and Cambodia is in Blaser (2001). I am not an area specialist and my intent is only to raise questions about disability and genocide. Degrees of support used here from greatest to least are Strong, Support, Some, Weak, and Not. The nature of support for the propositions will vary greatly. For instance, in Nazi Germany medicine was allegedly the most "advanced" in the world. In Pol Pot's Cambodia, by contrast, folk medicine was preferred to Western medicine. Both had disproportionate effects on PWDs.

A. P1. PWDs may be selected as direct targets by a genocidal regime.

The prototype here is the German Nazi "T-4 Euthanasie" under which lives of PWDs, supposedly "not worth living," were terminated. Unlike in that case, it appears that large numbers in Rwanda became disabled during attempts to terrorize them or

their relatives and subsequent attempts to kill them were botched. Thus of the 300,000 disabled genocide survivors in the FARG study referred to earlier "around 26,000 were missing one or more limbs." Of the 300,000 survivors identified in the report, only 64,000 were employed, earning on average $40 per month. (Agence France Press 2000)

In many cases, though, attempts at killing were not botched and where mobility was impeded death was often the consequence. In many cases individuals escaped death, but did not escape disability either through malnutrition or Post-Traumatic Stress Disorder, discussed below (Neergaard, 1999).

B. P2. The earliest effects of genocide are likely to be felt by PWDs.

We do not have precise data, but do have an abundance of anecdotal accounts: "Under such circumstances they are always among the first victims. Hundreds of them were killed in cold blood leaving orphans and widows without support. The exact number will never be known, but there were many of them" (Nkundiye, 34).

The fate for those with specific disabilities was also reported as by Mutabazi (1998): "The large-scale slaughter of deaf people makes Rwanda the first World Federation of the Deaf (WFD) member country on record to have lost a considerable number of deaf people within a short time." He continued: "Hutu soldiers and death squads killed almost all of the 750 mentally handicapped patients in Rwanda's psychiatric hospital during the slaughter."

There were also attempted killings. One account notes "the occasionally exposed bones, the conspicuous number of amputees and people with deforming scars" (Gourevitch, 1999, 21), with the failure to exact death resulting in an increasing number of PWDs (see P8 below).

C. P3. Genocidal movements or regimes perspectives on medicine may have disproportionate effects on PWDs.

There was not the kind of preference for traditional medicine, as in Cambodia, that led to attacks on Western medicine. There was, however, an attack on doctors and hospitals that did not fit into the ideology of "Hutu power." In the West association of PWDs with the medical profession may be made too readily because many PWDs enjoy long lives with infrequent medical care. In a country like Rwanda, however, and in wartime conditions the connection is much closer. It is for this reason that in international law as codified in the fourth Geneva Convention, hospitals and their staffs enjoy a privileged position of neutrality.

Not so during the Rwandan genocide. After noting that "almost all the doctors at the hospital" were massacred (Prunier, 1997, 250), he suggests an element of "social envy" in the killings. He also quotes a volunteer for Medecins sans Frontieres who reported: "all our Tutsi medical staff, doctors, and nurses were kidnapped and killed in Kigali in April (254).

There were exceptions, but these were very rare. Prunier (1997) reports a case where "a doctor of mixed parentage,

married to a Tutsi woman, was saved from execution six times in a row because of his medical profession" (258-259). He was eventually evacuated to Kenya only to learn that the genociders had killed eighteen Hutu relatives.

D. P4. Genocidal movements or regimes' diversion of resources to carry out the genocide may have disproportionate effects on PWDs.

It may be the service of an elaborate ideology that necessitates the diversion of resources. Here the ideology was very simple: the extermination of some of Rwanda's people by others. Gourevitch (1999, 95) describes the genocide and the ideology which supported it as an "exercise in community building." Expenditure of meager resources for any purpose other than the genocide would therefore be destructive of community.

One of the scarcest resources was medical care, a problem magnified by the killing of medical personnel and the outbreak of cholera. This is discussed in Section C above.

E. P5. Genocidal movements or regimes' minimizing of contacts with other governments and nongovernmental organization may have disproportionate effects on PWDs.

This example from United Press International was one of many: "The French humanitarian organization Doctors Without Borders says a government helicopter in Rwanda (Friday) has fired two rockets at one of its vehicles in the south of the country" (1994).

Genocides like Rwanda's are made easier by inattention from the international community. Both then President Clinton and United Nations Secretary General Kofi Annan acknowledged responsibility for the inattention that allowed the genocide to occur. They both promised attention to the consequences of the genocide, borne disproportionately by PWDs.

F. P6. International organizations and intermediate national organizations may assist PWDs.

Often religious organizations may serve as a buffer. In Rwanda, however, going to a church for sanctuary often increased chances of death. Prunier (1997) suggests that the Islamic community was in some ways an exception to this rule. During the genocide, intermediate associations' claims of neutrality were of no avail. Indeed "centres and associations devoted to disabled people were ransacked and destroyed" (Nkundiye, 1997, 34).

Similarly with the Rwanda National Association of the Deaf which had enjoyed support from two Swedish agencies. "But the effect of the war rendered Swedish Handicapped International Aid Foundation/Swedish National Association of the Deaf unable to continue funding them" (Mutubazi, 1998). Mutubazi goes on to detail programs of donors from Denmark and Finland with an eye toward reconstruction after the genocide.

After the genocide many outside aid groups were hampered by threats of danger and challenges to their neutrality. Some were forced out or chose to leave, but others remained.

G. P7. Genociders may increase numbers of PWDs in the furtherance of genocide.

Here there is an abundance of anecdotal evidence. Nkundiye (1997) reported: "new cases of amputees without prostheses, ...deaf people without hearing aids, along with many traumatized people" (34). The technology of the genocide, carried out principally by machete, contributed to the number of PWDs. Gourevitch (1999) describes a visit to a hospital with "'all machete cases'...multiple amputations, split faces swollen around stitches" (194).

Diversion of resources is another major way of increasing numbers of PWDs. Lewin (1975) has reported that brain damage due to malnutrition may jeopardize 70 percent of the world's population. Neergaard (1999) observed that "Even brief periods of severe malnutrition can damage a young child's brain, resulting in long-term learning disabilities or other problems." Rwanda has been exempt from many of the harshest African famines. One of the consequences of the genocide was that some people received food while others did not. In theory refugee camps would have been places where everyone would get food. In practice Neergaard (1999) reports that "adults may steal unaccompanied children's share."

H. P8. The "survivor syndrome" which is a result of genocide reflects the continuing relevance of disability.

Although conditions after the genocide could scarcely be called stable, we do have unsurprising findings that go well beyond the anecdotal. To back up their estimate that "PTSD's prevalence may approach 20% in the adult population" Wulsin and Hagengimana (1998) offered the following data: "Fifty percent (79 out of 157) met DSM-IV criteria for a psychiatric disorder...The average number of traumatic events...reported by each subject was fifteen." Undoubtedly there were also many traumatic events that were unreported.

One attempt to address the problem was undertaken by the Mennonite Central Committee. An assumption was the inappropriateness of the Western mental health model with a hope to "create space" for partnerships with societies including Rwanda's (Brubacher, 1996).

I. P9. Regimes following genocidal regimes are unlikely to deal successfully with issues affecting PWDs.

For the Rwanda Patriotic Front (RPF) obtaining power and stopping the genocide were not easy tasks so it is not altogether surprising that dealing with issues affecting PWDs was problematic. The organizations that do exist have been able to survive if not thrive with the new government, but all suggest that things could be better.

Nkundiye (1997, 34) notes a government role in facilitating creation of the General Association of Disabled People of Rwanda, but urges assistance from the international community. Although on the whole he was pleased by post-genocide developments in Rwanda, a representative of the Uganda National Association of the Deaf acknowledged: "Admittedly, a considerable number of years will pass before Persons With Disabilities in Rwanda attain... [a] development level comparable to their Ugandan counterparts" (Mutabazi, 1998).

Rwanda is one of the many countries where issues affecting the entire population enjoy at best modest success. PWDs are not exceptions. There have been some indicators of success against overwhelming odds, however. The 2001 Department of State Country Report on Rwanda (released 2002) for human rights suggested characteristics which were not atypical though could be better:

"Although there are no laws restricting persons with disabilities from employment, education, or other state services, in practice few persons with disabilities have access to education or employment. There is no law mandating access to public facilities." (US Department of State, 2002)

This language is also found in several preceding years State Department Country Reports. The FARG study mentioned earlier referred to a 5% budget allocation for services for PWD and the government was to include a member "to represent the disabled in Parliament" (Panafrican News Agency, 2001). Such measures mean that the proverbial glass although mostly empty, is partly full.

IV. Conclusion and Implications

A. Implications for the Study of International Affairs.

The first set of conclusions relates to the study of international affairs. Just as the Rwanda genocide is testimony to the failures of the international community, much post-genocide practice carries with it implicit arguments as to what could/should have been done differently.

Contrasting approaches are represented by the Truth and Reconciliation Commission in South Africa and the International Tribunal on War Crimes in Rwanda, being held in Arusha, Tanzania. Claims have been made, such as those by Stedman (1995), that opportunities for reconciliation are jeopardized when there are war crimes prosecutions.

Against this I would suggest that reconciliation has been possible, as in South Africa, because of recognition of guilt and because of the possibility of Nuremberg-style prosecutions. In Rwanda, by contrast, recognition of guilt and prospects for reconciliation were minimal.

I would suggest that a focus on genocide and PWDs in Rwanda points to the importance of two developments in international practice. First is a greater concern with the accountability of violators of international law other than territorial states.

And second is a greater concern with the range of those whose rights are violated. In this regard it is noteworthy that the Statutes for the Arusha Tribunal and for the International Criminal Court call for the prosecution of rape charges implying that rape has for too long and arbitrarily been accepted as an inevitable accompaniment of war. This suggests that other accompaniments, including the high casualty rate of PWDs, may eventually be no longer accepted as inevitable and instead be heeded as early warnings.

B. The Confluence of Disability and Genocide.

Unfortunately those who study genocide (or make policies

designed to prevent it or to ameliorate its effects) seldom focus on PWDs and those who study disability have given scant attention to genocide. Where the Nazi regime euthanized PWDs the connection has been made by many scholars. The connection also needs to be made for the many genocides like those in Armenia, Cambodia, Kosovo, and Rwanda where PWDs may not have always been specifically targeted as victims, but were disproportionately affected.

Even in those cases the assumption that PWDs were not intended victims may be unwarranted. A Deutsche Press-Agentur (1998) release describing a United Nations team's arrival in Cambodia also noted that "Hundreds of thousands died from overwork, disease, starvation and summary executions, while intellectuals and those with education or disabilities were targeted for extermination."

One can hope that to suggest that genocide may soon recur in Rwanda's neighbors, Burundi and the Democratic Republic of the Congo (formerly Zaire) would be alarmist. Following the analysis in an earlier draft of this article I suggested attention to the status of PWDs as prompted by this item in the Humanitarian Times (1999):

> Humanitarian programs in Burundi threatened by UN pull-out consequent to last week's murders of 2 UN staff. Private non-governmental aid groups feel that international presence & aid can prevent or limit massacres, even as the Burundi army has lately forcibly displaced 300,000 in the last month.

Scores of similar incidents have occurred since then where disability explains who pays more during genocide and who must be the focus of attempts to rebuild. Another of Rwanda's neighbors, the Democratic Republic of the Congo, was the subject of the following paragraph from a Prevent Genocide International (2001b) newsletter: "The vast majority [of 1.7 million deaths] was due to the war related collapse of the region's health infrastructure and delivery of health and nutrition services." Many observers noted that ethnicity was strongly related to who lived and who died. So too was disability and hopefully this exploratory analysis will prompt analyses of other genocides including the Congo's.

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