INFLUENCE OF CULTURAL PRACTICES ON THE WELLBEING OF WOMEN REFUGEES IN IFO 1 CAMP DADAAB KENYA.

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A Research Project Submitted in Partial Fulfillment of the Requirements for the Award of the degree of Master of Arts in Project Planning and Management of the University of Nairobi

2016

DECLARATION

This research project is my original work and has not been submitted for a degree or any other award in any other institution.

Signature…………………………………………………………..

Date……………………………………………………….

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L50/73900/2014

This Research Project is my original work and has not been submitted for a degree or any other award in any other institution.

Sign..Date......................................

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DEDICATION

This Research Project is dedicated to all my family members.

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ABBREVIATIONS AND ACRONYMS

CEDAW	Convention on the Elimination of all Forms of Discrimination against Women
CRC	Convention on the Rights of the Child
DRC	Danish Refugee Council
FGM	Female Genital Mutilation
GBVC	Gender-Based Violence Clinic
GBV	Gender Based-Violence
GBVIMS	Gender-Based Violence Information Management System
NACOSTI	National Commission for Science, Technology and Innovation
SGBV	Sexual and Gender-Based Violence
SPSS	Statistical Program for Social Scientists
UK	United Kingdom
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
WHO	World Health Organization

ABSTRACT

This study set out to establish the influence of cultural practices on the wellbeing of refugee women in Ifo 1 camp Dadaab Kenya. The objectives of the study was to examine how Sexual Violence influences the wellbeing of women refugees; to determine how Female Genital Mutilation influences the wellbeing of women refugees; to establish how the age at marriage influences the wellbeing of women refugees; and to assess how use of family planning methods influences the wellbeing of women refugees. The study was conducted as a cross-sectional survey; target population was 36,128 women refugees in Ifo 1 camp Dadaab, 100 women were identified as the sample size by use of formula, $n=N/1+N(e)^2$. Simple random sampling design was used, structured interviews to obtain information and questionnaires as data collection tools. Data was then analyzed, summarized and presented in form of frequency tables, percentages and proportions. 100% of respondents reported to have experienced or knew someone in the camp who had experienced sexual violence. Sexual harassment was reported to be popular as a form of sexual violence with majority of perpetrators being intimate partners or husbands. Majority of women (M= 4.27; SD=1.299) had undergone or knew someone who underwent through FGM in the camp, while excision, as a type of FGM was the most popular. Women (M= 4.52; SD=0.1154) got married or knew someone in the camp who got married before attaining age of 18 years, majority reported to have married voluntarily. Most women were using or had used family planning methods. Majority of women reported that sexual violence, FGM, Age they got married and women not using family planning methods caused them either unwanted pregnancies, low self-esteem, STIs, family breakages/instability, withdrawal behaviors, stigma and gynecological complications. There was correlation between each of the independent variables of sexual violence, FGM, age at marriage and use of family planning methods and wellbeing of women refugees. The findings of the study can be used as baseline information especially for Gender-Based Violence projects. The study will also inform UNHCR GBV protection programmes in Dadaab refugee camp, for their Country Operations Planning (COP) and for refugee set up worldwide. The study will provide knowledge which expounds on other studies carried out by researchers on impact on health and education. The Kenyan government, through the ministry of public service, youth and gender affairs will use the research findings in strategic planning and will also inform gender-based programs. The study recommends awareness creation and advocacy for more women and girls to pursue education beyond primary level and also to have those that have never attended school, get enrolled in school and agencies in camps to create employment opportunities. Sharing of family burdens or responsibilities by both men and women, sensitization on harmful cultural practices and their effects is necessary for change of mindset by communities, a rights-based approach is recommended and more psychosocial support services will ensure effective response to sexual violence, FGM, girls who are married before attaining age of 18 years and use of family planning to reduce its impacts and help survivors cope with the rampant effects.

CHAPTER ONE
INTRODUCTION

1.1 Background to the study

Many cultures have different and important traditions which mark different transitions of life, bring together communities, or pass on traditional virtues to their next generations. These cultures represent aspects of togetherness, care and sense of behaviour according to age, stage of life, gender, and social class. Many of these traditions promote social togetherness while others undermine the physical and psychological wellbeing and integrity of people, more so, women and girls.

Many cases for women, absence of conflicts does not necessarily imply the end of conflict-related sexual violence. studies demonstrates that fleeing from war and repression to refugee and IDP camps and settlements can only offer a certain degree of protection from violation since women are not safe from (sexual) abuse there. Most refugee and humanitarian aid agencies acknowledge the vulnerability of women and girls as most target group for Gender-Based and Sexual Violence and implement measures to protect and empower them. Sexual and gender-based violence still pauses a challenge even after efforts by developmental and international agencies to eradicate it.(K. Ulrike, S.Elizabeth)

According to UNICEF, close to 130 million women have undergone FGM while about 2.5 million of the women are at a risk of being done FGM (Murphy, 2006). About 100,000 women and girls, were reported to be risking death from FGM-related complications every year (Abbas, 2006). In Africa, mostly Female Genital Mutilation is experienced in 28 African countries (Jabre et al., 1997). FGM prevalence will always vary adversely from one country another and community to community. (M. Rahman, Z.Toubia, 2000).

In some African countries, communities practice female genital mutilation to symbolize a woman’s transition into womanhood, while for others, FGM is a way to sustain virginity, control sexual desires, improve hygiene, avoid promiscuity, and to increase chance of women to bear children. In most cases, men from Somali community would refuse to marry a woman who has

not undergone the cut. FGM in some communities is said to be a religious practice but the Koran or the Bible cannot proof for its existence.

FGM, in some countries, is followed by other subsequent celebrations and is also believed to be a rite of passage. In Eritrea, female genital mutilation is carried out at an early age as young as 2months, 6 years in Mali and 10 years in the Central African Republic. Ethiopians usually carry out the cut few days after child is delivered, while the Sudanese people do it at around the age of 12. (C. Light, M. Royal). Almost all Somali women have undergone female genital mutilation as compared to Tanzanian females.

Adolescents and children below 18 years in many parts of the world are said to be getting married despite efforts by governments, international and development agencies carrying out campaigns and advocacy to discourage and stop child marriage. According to the State of World Population Report 2005, averagely 50% women in Asia and in Africa who are averagely got married before their 18th birthday (UNFPA 2005). When a woman gets married before age of 18, she is a high risk of early pregnancy and other delivery complications also for the child, which in turn causes the woman to end her schooling (Unicef 2001; Unicef 2005). In the recent years, international organizations and NGO's have carried out advocacy campaigns against marriage before age of 18 years, through preventive and response interventions that create awareness on the negative influence which in turn encourages parents or guardians not to give up their daughters for marriage and again opens up doors for other better and beneficial activities instead of the cultural perception of getting married earlier and becoming child brides. Brac's Adolescent Development Programme in Bangladesh is a perfect example that is already in place, implementing livelihood activities, awareness creation on social and health issues, and promotes socialization and peer education among teenagers. Another example is Berhane Hewan project implemented in Amhara parts of Ethiopia. This is as a result of combined forces between New York based Population Council and the Amhara regional government that takes the community dialogue approach within community, and motivates the girls to take up school seriously by providing incentives. There have been similar projects being funded or receiving assistance from the World Bank, UK Department for International Development, and Nike Foundation.

Use of contraceptive by women has increased tremendously. By end of 2008, 63% of women in their early 30s who were married or at least in a union with someone from the opposite sex were said to be using some form of family planning (I. Warriner 2012). However, despite considerable increase in family planning advocacy, there is still a slow pace of use of contraceptives. The use of family planning methods, for the past ten years has gone up, was lesser in the 1990s and the increasing need for family planning which is unmet is still high in many African countries. The society structure in Somalia, believe in both Islam religion and cultural belief is patriarchal. For instance, the book of Quran requires wives to submit to their spouse. Husbands will always have the last word and especially in matters that concerns family. This has resulted to most Somali women believing that the survival of their marriage depends on the number of babies they deliver for their husbands. They say "Allah provides" and so the number of children or when to start child bearing is not a subject of discussions between married people. Modern family planning methods are against religious and cultural beliefs in Somali, and according to WHO survey in 2006, about 1.2 percent of married Somali women used family planning methods. (Leigh & Sorbye 2010). In Somalia, large families or closely spaced families risk death for both mother and infant, but still the use of family planning is being opposed due to strong religious and cultural beliefs.

In Kenya, about 45 percent of women who experience physical or sexual violence, the perpetrators were either husbands or intimate partners, according to Kenya's 2008 and 2009 Demographic and Health Survey. Traditional values that promote male dominance and ownership, social values which condone brutality against women, and also lack of or weak legal structures contribute to the existence of SGBV in Kenya. SGBV has been practiced in all communities, for example for in Kenya's case; increased cases of GBV were recently recorded following the accusations that the government tempered with the election results in 2007.

Some cultures believe that marriage before age of 18 years enables long period of fertility. The age at marriage for women is rising slowly, as it is the case in most developing countries, but other African countries like Nigeria, women are getting married earlier as much younger women are preferred as brides due to the belief that they are less likely to have HIV infection. Marriage before age of 18 years is most experienced developing countries and in Southern part of Asia. In Bangladesh, almost 47% of women at 15 years are already married. In Guatemala, India, and

Niger, the percentages of women who marry below age of 18 years are 12%, 18%, and 50 % respectively.(C. Light, M. Royal)

Young married girls are at risk of sexual violence by intimate partners and exposure to sexually trans- mitted infections, including HIV. Marriage would mean end of a girl's education and limits her opportunities in other trainings. Child marriage constitute almost 100% of early pregnancies, complications during pregnancy and delivery, which are the second leading cause of loss of life among women who are averagely 17 years. (Women's Refugee Commission 2016)

The Zaatari Refugee Camp in Jordan, which has a population of about 80,000 people, is one of the largest refugee camps in the world. Refugee camps have remained crowded and unable to fully meet the increasing refugees' needs, despite the increasing efforts by international and developmental agencies, for example, almost 68per cent of refugees in Syria do not live in formal camps. UNHCR had registered over 3 million refugees by end of August in Syria, with over 100,000 asylum seekers being registered every month and about 3,000 refugees being registered daily. According to the UNHCR an estimate of close to 4 million refugees will have been registered by December 2014 (International Rescue Committee: 2014). Mostly, women and children are the people said to have fled Syria in the past 3 years. Approximately most of the refugees and asylum-seekers in Kenya have fled insecurity for fear of prosecution back in their home countries since the 1990s. in the 1990s, UNHCR established Kakuma refugee camp, located partly in the Northern and partly in the western region of Kenya in the district of Turkana near the borders of Sudan, Ethiopia and Uganda and covers a total area of approximately 26Km2 and is home to close to 84,000 refugees of 9 different nationalities. Dagahaley, Hagadera and Ifo 1 camps in Dadaab were put up in the 1990s. In 2011 Ifo II and Kambioos camps came to existence as a result of close to 135,000 refugees came to the camps as new arrivals due to severe drought in Somalia. Hagadera being the largest camp currently holds over 80,000 refugees with about 25,000 households. Kambioos, on the other hand, is the smallest camp with fewer than 20,000 refugees.

In July 2011, it was reported that more than 900 people were arriving from Somalia in need of food and material assistance, largely due to the drought in Somalia. The influx reportedly placed great strain on the existing resources, as the capacity of the three camps was about 85,000,

whereas the camps hosted almost 450,000 refugees in of July 2011. Médecins Sans Frontières, one of the international agencies implementing health programmes in Dadaab, asserted that the numbers would. Dadaab was ranked as the largest refugee camp in the world, which still is until today despite a recent drop in numbers due to the voluntary repatriation.

1.2 Statement of the problem

In 1992-3 when sexual violence occurred, the most affected were refugee women at the camps of Dadaab. Beatings and sexual assault of refugees were the order of the day. Cultural and religious beliefs often influence the reproductive health of women. These traditions are evident in areas such as childbearing, access to maternal health facilities, use of modern family planning, gender inequalities and female genital mutilation. Somalis nationals are still tied to clannism, does not matter whether living in urban areas, pastoral nomads or farmers. (Deyo, 2012).

Somali women are believed to be objects of bearing children and minimal value is placed on their wellbeing. According to the World Health Organization (WHO), In Somalia only 2% of women who are delivering, do it in the health facility or are supported by professionally trained staff. This implies that majority of Somali women deliver at home on their own, or with the help of traditional birth attendant or friends, this is can be largely blamed on culture. Female genital mutilation is widely practiced as a custom in Somalia, recording 98%, the highest rates of circumcision in the world. Female genital mutilation is one of the reasons for delivery complications and causes of infant and maternal mortality in Somali.

In the early 1990s, more than 200 incidences of sexual violence (rape) were reported in Dadaab camps. Establishing of security systems and strengthening of the existing ones in the camps scaled down the reported cases to about 85 cases per year in the 1990s. In January 1998, close to 170 women in Ifo 1 camp experienced rape (O. Wrjhwkhu.). According to the GBV prevention and response agencies in Dadaab camps, GBV Still remains a major protection concern that needs to be addressed and prioritized by all stakeholders if the rights of women and girls are to be promoted and protected. According to the statistical data generated from the consolidated GBV IMS, cases of sexual violence, rape, forced marriage, and psychological or emotional abuse are still rising affecting many refugees and asylum seekers per year in Dadaab, about 1,500

incidences of sexual and gender-based violence were reported in 2013 as compared to 1,200 cases reported in 2012 (UNHCR Interim Report_Dec_2015.). This indicated that more survivors and people were now reporting GBV cases which were improved by strengthening of reporting and data collection systems and also sensitization and advocacy campaigns done to encourage reporting by survivors. DRC was identified by UNHCR to provide psychosocial activities in Ifo 1 camp in June 2013; this has also contributed to this increase in reporting. Also, data collected by DRC and entered into the GBVIMS since January to November 2014 showed that about 150 incidences were reported by survivors as compared to only almost 90 cases reported in the last 6 months of 2013.

1.3 Purpose of study

This study sought to establish the influence of cultural practices on the wellbeing of women refugees in Ifo 1 camp, Dadaab Kenya.

1.4 Research Objectives

Objectives of the study were as follows;

1. To examine how Sexual Violence influences the wellbeing of women refugees.
2. To determine how FGM influences the wellbeing of women refugees.
3. To establish how the age at marriage influences the wellbeing of women refugees.
4. To assess how use of family planning methods influences the wellbeing of women refugees.

1.5 Research questions

This study sought to answer the following questions;

1. How does Sexual Violence influence the wellbeing of women refugees?
2. How does Female Genital Mutilation impact on the wellbeing of women refugees?
3. What is the relationship between the age at marriage and wellbeing of women refugees?
4. What is the relationship between use of family planning and wellbeing of women refugees?

1.6 Significance of the study

The findings of this study may be useful to understand sexual violence, female genital mutilation, age at marriage and use of family planning methods among refugee women,

emerging issues and trends and how they influence the wellbeing of refugee women. Researchers may also utilize the findings to expound on other studies carried out, for example, "impact on health and education".

The findings of this study will be useful to Gender-Based Violence prevention and response programmes in Dadaab refugee camps who will more effectively understand the current trend, perception and impact of GBV among refugee women. The analysis can also be used as baseline information especially for Gender-Based Violence projects.

The findings will inform UNHCR programmes worldwide and also their Country Operations Planning (COP), and it also expounds on other studies carried out by researchers on impact on health and education. The Kenyan government, through the ministry of public service, youth and gender affairs may use the research findings in strategic planning and will also inform genders programs.

1.7 Delimitations of the study

This study of three months from August to October 2016, sought to establish how cultural practices influence the wellbeing of refugee women in Ifo 1 camp Dadaab, of area size 12.3 km2 currently accommodating 71,032 refugees 36,128 females and 34,904 males. It involved women refugees living in the camp, covering sexual Violence, FGM, age at marriage and use of family planning methods as independent variables and moderating variables as government policies political influence and legal structures, while intervening variables were literacy levels, attitude and cultural beliefs.

This course of study was preferred because of curiosity about the topic and wanted to shade more light on cultural practices among refugees and its influence on women in Dadaab by revealing certain findings.

1.8 Limitations of the study

Most refugee women were Somali speaking and others from the countries of the great lakes. This paused as a challenge on communication because of the language barrier. Trained translators were used in conducting interviews using structured questionnaires.

Dadaab being a high security risk environment, there was likely to be security challenges while in the field for data collection. We took advantage of the available police escort that provided in the field from 8.00 a.m. to 1.00 p.m. and ensured data is collected within that time.

The study covered some sensitive areas which the participants did not feel free enough to open up and give honest response. Confidentiality was assured and preserved, as participants were volunteers who may have withdrawn from the study at any time and with no ramifications.

Since the study was focused on women, when male translators were involved the responders felt shy to participate. Female interviewers were involved as much as possible and also were reminded to observe work ethics to encourage respondents' participation.

The time allocated to conduct the study, record findings and interpret results was not sufficient. The study was prioritized in order to ensure quality time was spent during this time.

1.9 Assumptions of the study

The women who were picked on gave relevant information in regards to the study, the sample size was a true representative of the whole population in Ifo 1 camp, data collection instrument had all important aspects and components of the construct covered and rrespondents answered questions correctly and truthfully to the best of their knowledge.

1.10 Definition of significant terms

Cultural practices shared knowledge, values, traditions, languages, beliefs and rules that influence the behaviour of a social group or community. These beliefs, behaviors, traditions are sometimes influenced by the environment or certain circumstances whether permanent or temporary.

Wellbeing a state where women are physically and psychologically healthy and are able to contribute to prosperity and successfulness of family and community.

Age at marriage the age at which a woman got married.

Sexual and gender-based violence Physical, Mental, emotional and psychological pain and sexual talks, comments, rape or being forced into sexual relationship in exchange of form of help or favor, based on ones gender.

Sexual Violence use of sexual talks, comments, rape or being forced into sexual relationship in exchange of form of help or favor.

Use of family planning un natural methods like implants, pills, injections, IUDs and condoms used for birth control.

Women Female of age between 15-49 years old. The reproductive age bracket and is believed to be the child bearing age.

Cultural practices

Younger respondents are those women of age between 15-<18 years.

Blocks are households that sections are divided int. For example section E has E01, E02…etc. as blocks

1.11 Organization of the study

The study was organized into Chapters one to five. Chapter one is introduction which comprises background of the study, problem statement, purpose of the study, study objectives, research questions, significance of the study, delimitation and limitations of the study, assumptions of the study and definition of significant terms are discussed. Chapter two reviews literature on sexual violence and the influence on the wellbeing of women, female genital mutilation and the influence on the wellbeing of women, marriage timing and the influence on the wellbeing of women and use of planning methods and the influence on the wellbeing of women.

In chapter three, Research Methodology is presented. It comprises Research design, Target population, Sampling procedure, Methods of data collection, Validity of the instruments used, Reliability of the research findings and data analysis techniques. Chapter four presents the data analysis, presentation, interpretation and discussions. The results are organized based on the themes of the study; sexual violence, female genital mutilation, marriage timing and use of family planning methods. Chapter five gives a brief summary of findings, conclusions and recommendations which was based on the themes of the study; sexual violence, female genital mutilation, age at marriage and use of planning methods.

CHAPTER TWO
LITERATURE REVIEW

2.1 Introduction

This chapter reviews literature on Sexual Violence, female genital mutilation, marriage timing, use of family planning methods and their influence on the wellbeing of women. It also discusses the theoretical framework, the conceptual framework which assesses the influence of sexual violence, female genital mutilation, age at marriage and use of family planning methods on the wellbeing of women and identifies gaps in the literature reviewed.

2.2 Sexual Violence and the wellbeing of refugee women

Most women and girls are the victims of rape than men and boys, but all of us are affected by sexual violence in one way or the other because sexual violence by and large affects community, society, and family apart from just survivors and their loved ones (Board, Protection 2011). World-wide, an estimation of about 55% of sexual and gender-based violence committed by intimate partners or husbands, and women and girls are often the survivors, in the case of abusive relationships. Around the world, majority of women have been beaten, exploited sexually or otherwise abused in her lifetime. The UNHCR guidelines for prevention and response, (SGBV Against Refugees, Returnees and Internally Displaced Persons: 2003). Almost 100 million women and girls from Africa have undergone female genital mutilation. During war in Bosnia, Somalia, Liberia and Peru in recent years, incidences of rape have been reported. More than 90% of internally displaced people in Sierra Leone reported cases of rape, and sexual exploitation. At least 250,000, women and girls were raped during the genocide in Rwanda.

Current studies demonstrates that fleeing from war for refugee and IDPs only offers certain degree of protection against sexual violation, since women are not safe entirely from (sexual) abuse there. Humanitarian agencies acknowledge the vulnerability of women and girls as targets of sexual violence and put interventions in place to protect and empower them. Despite all those measures, prevalence of sexual and gender-based violence is still on the increase, which implies that sexual and gender based violence still pauses a great challenge, as indicated by the overview

of research literature and reports on violence against and amongst refugees with focus on SGBV. (Krause and Schmidt)

Women have been raped by smugglers, or exploited sexually by being given favors or support like passage to safety, in exchange of sex while on the other hand, refugees and internally displaced persons (IDPs) are also at risk of trafficking for sexual exploitation. Some have even been a target for trafficking in transit centers or refugee camps. At least more than 4,000 immigrant women and girls are said to be sexually exploited in Europe. They reported having experienced sexual violence before, during and after their flight to UK, as it is indicated in the refugee council report in 2009. Poorer women and girls are more vulnerable and more likely to experience rape. Most asylum seekers are poor i.e. live on less than 70% of income support that causes women refugee to be living in poverty than other women because of other additional barriers that limit them in education hence limited job market. Women refugees also are more likely to be living in social housing where women are more likely to report of sexual violence more than women in private rented accommodation and more than three times as likely as those in owner-occupied households.

However, sexual violence is not only reported to be happening in refugee camps. Reports by Amnesty International (2009) indicate that women and girls can also face risk of sexual violence in the event that that they leave the relative safety of refugee camps to search for firewood. Families would often send women and girls out to do these tasks because they believe is less dangerous for them as compared for men and boys. They argue that in armed conflict and displacement situations, females are seen to be at risk only of rape, while men and boys are most likely to face death (Marsh, Purdin & Navani 2006).

In Kenya, about 45 percent of women who experience physical or sexual violence, the perpetrators were either husbands or intimate partners, according to Kenya’s 2008 and 2009 Demographic and Health Survey. Male dominance and entitlement that is supported by culture and tradition, social norms that condone or justify violence against women, and weak justice systems and structures are some of the causes behind the existence of SGBV in Kenya. SGBV has been in existence in all societies throughout history and in Kenya recently, women and girls

suffered increased incidences of sexual violence in 2007 and 2008 as a result of post-election violence.

According to the World Report on Violence and Health, sexual violence affects both the physical and mental health status of the survivor. Apart from resulting in physical injury, it is also associated with increased risk of other sexual, reproductive health and mental problems, which have both immediate and long-term influences effects. Both their mental and physical impacts are serious, and may be equally long lasting. Survivors of sexual violence can also be stigmatized by their families and also their social well- being compromised. Sexual exploitation may result in sexual gratification on the part of the perpetrator, its main purpose is frequently as an expression of superiority and dominance over the survivor, and this in most cases is as a result of gender. Often, men who exploit a spouse sexually believe their actions are legitimate because they are married to the woman and that they feel they own them. Sexual violence may be used to punish women for transgressing norms, for example, those that indulge in adultery or drunkenness publicly. Women and men often experience sexual violence when in police custody or in prison as highlighted by the World Report on Violence and Health

2.3 Female Genital Mutilation and the wellbeing of refugee women.

In a joint statement by WHO, UNICEF and UNFPA Female Genital Mutilation was collectively defined as an act, which involves all procedures of partial or total removal of the external female genitalia or other injury to the female genital organs whether for culture or other non-medical reasons, as highlighted by the women's Health's councils' report in 2006. According to WHO definition, there are four types of FGM namely; Clitoridectomy which involves cutting off of the clitoris or part of it or the skin surrounding the clitoris. Excision is when part or whole of the clitoris is cut off with the labia minora, sometimes with excision. Infibulation makes vaginal opening smaller because the seal is covered. To create a seal, the inside and outer labia is cut and positioned and eventually clitoris removed. The "Other type" is where all other painful procedures are carried out to the female genitals for no clinical reasons, for example piercing, incising and scraping.

According to WHO estimates, excision as a type of FGM is very popular among all types, i.e. of all the FGM cases happening in the world, about 80 per cent of them is excision type of FGM. However, infibulation is more severe and pauses more danger to women both physically and psychologically, recent estimates accounts to 15 per cent all cases happening (Female Genital Mutilation / Cutting A Literature Review).

The UNHCR Community Services Unit FGM report 2015 explains how FGM is viewed In Somali: Firauni is removing part of the clitoris and the inner labia and sometimes with or without removal of the labia majora. Mashruu' which has basis in Islam. Alkhitan Alfir'auni is what is referred to as female genital mutilation. Haram implies that is Unlawful. Sunna is Optional mostly used to mean piercing type of FGM. Pharaonic is the total cutting of the clitoris and the labia majora. Pharaonic as a form of female genital mutilation is discouraged by Islam religion. (FGM REPORT Community Services Unit - UNHCR, 2015)

The IOM report illustrates that WHO estimates that about 100 to 140 million women worldwide have undergone FGM, whether as a culture or otherwise (C. Africa, 6), and estimated number of 3 million girls in the world who risk being done for FGM annually. FGM was reported in at least 28 countries in Africa, Asia and the Middle East. There are also other reports on FGM among some ethnicity in Central and South America. (International Organization for Migration 2005). Currently, C. Africa urges that, the practice is largely practiced in Africa, and affects around 28 countries, and also in some parts of Asia like Indonesia, Malaysia and Yemen. Immigrants from these countries reaching Europe, Canada, USA and Australia, have passed on the practice and can be found in these regions among some immigrant populations. Female genital mutilation as a cultural practice is practiced in at least 28 countries in Africa, Middle East and in Islamic Asian countries. The most severe type of FGM (Excision) affects about 130 million women negatively, most of whom were circumcised before age of 15 years. It is mostly practiced in rural areas/homes carried out by older women, or untrained midwives using tools like knives, razors or broken glasses, at home. In most cases, there is no sterilization of the tools used and the procedure is usually in non-clean environments. In urban settings, some families involve doctors to perform the operation.(A. Humanity)

The UNHCR Community services FGM report revealed that 98per cent of the respondents during focus groups discussions and random interviews indicated to have had the knowledge of FGM or have a friend who has undergone FGM and to them it was Sunna type, of which only about 15 per cent of the 98 per cent had knowledge that whether Sunna or Pharaonic, its FGM since they were classifying FGM in two types thus; Pharaonic and Sunna.

In relation to rights awareness and FGM, 30 per cent knew about women and girls rights and 50 per cent of the respondents indicated that tradition and lack of knowledge on FGM among women and girls rights is leading to high rate of women and girls rights violation in relation to FGM, since it was established that mostly the decision for a young girl to undergo FGM is done by parents and mostly the husband makes the decision and the wife consents to it and the young girl obeys it without any objection and in instances where the woman objects to it, it is the reason enough for a marriage separation, though at times the wife just takes the girl child for FGM without the knowledge of the husband. The exercise also established that 80 per cent of FGM takes place in the camps due traditional practices and beliefs and 5 per cent due to peer pressure at school and a further 5 per cent due to marital submission and beliefs for a woman to satisfy their future husband (s), find a decent marriage or maintain the marriage. While this is the case on the ground, the exercise further revealed that 70 per cent of women and girls feel justice systems and exercising rights on FGM issues are prejudiced towards men and hence not exercised by women, hence violated.

FGM is a mainstreaming issue because it is strongly linked to culture, besides being a health and human rights issue. When mainstreaming is not achieved or is difficult, it often results to community resorting to more strict and tough cultural practices. In such a case, talks that involve cultural identity shows differences of different communities, especially when immigrants are settling in a new country where culture allows women to freely express themselves and have more freedom of speech and their human rights are respected. A study by PATH (2012) shows that in Kenya, 30 per cent of women supporting the existing of FGM enable to prolong and avoid immorality by girls and women. In Nigeria, 36 per cent also supported the existence of FGM, while 45 per cent of men supporting its existence agreed that FGM helps to curb immorality and prolongs virginity amongst women. In some community practicing FGM, it is believed that it is a proof of virginity, therefore increasing chance of unmarried women to obtain partners to marry.

In Côte d'Ivoire, 36% of women were said to be in favor of or support the idea of continuation of FGM after they got married. FGM is also believed by some communities to be causing the survivors to remain faithful to their partners, for example, 51% of women in Egypt believe that FGM helps to reduce prostitution.

To identify the prevalence, trends, and reasons for conducting FGM, and factors associated with it with regard to women's wellbeing, community dialogues, cross-sectional house to-house interviews were conducted among at least 858 females of reproductive age, in Kersa district, Ethiopia. The study revealed that purpose of FGM was to reduction sexual aggressiveness by women. The majority of the respondents (92.3%) had undergone FGM and almost 68.8% were not aware of any health-related problems associated with FGM. The conclusion of the study was that most women knew about the negative reproductive health effects of FGM and at least they had experienced these effects themselves, and yet, only a few had tried to stop the practice and the majority were okay with it and had taken no action to stop it. (Wondimu,Yirga, Nega, Mengistu, & Arja, 2012). This may be attributable to the fear of distancing themselves from the cultural beliefs and fear of stigmatization or victimization. According to Balogun et al. (2013), health problems associated with FGM are maternal and neonatal mortality and morbidity. Obstetric outcomes are experienced more by women who have undergone FGM than those who have not. In a Demographic and Health Survey in Burkina Faso, Ghana, Kenya, Nigeria, Senegal, and Sudan, women attending for delivery and had undergone FGM, showed risks of caesarean section, post-delivery bleeding, extended maternal hospital stay, infant resuscitation, stillbirth and low birth weight. FGM is estimated to lead to an at least one to two prenatal deaths per 100 deliveries. (Banks et al. 2006). A study on female genital mutilation and obstetric outcomes by the World Health Organization (Lancet, 2006) also cited similar risks among women who had undergone FGM. It was also observed that the risks more with more extensive forms of female genital mutilation, for example infibulations.

Women who underwent FGM were at more risk of psychosexual difficulties than the ones who did not, as reported by El-Defrawi et al., (2001) and by Karim (1993). Statistically significant difficulties and also less sexual desire were found in women who underwent FGM the same as lack of sexual desire, less initiation of sexual activity with husbands and being less likely to experience climax (Khaled and Vause, 1996; Thabet and Thabet, 2001). Other researches have

also illustrated that when their clitoris is destroyed in the event of FGM, they blame it on the most sensitive part of their bodies, and for example, they would identify their breast to be the most sensitive area (Nwajei and Otiono, 2003).

2.4 Age at marriage and the wellbeing of refugee women

The UN asserts that a companionship with a child who is below age of 18 years, as a spouse, is referred to as child/ early marriage. The Convention on the Rights of the Child (CRC) and the Convention on the Elimination of all Forms of Discrimination against Women (CEDAW) term child marriage as against the law. According to WHO estimates, that almost 39 000 children below age of 18 worldwide engage in child marriage. This could also mean that about 140 million girls will marry as child brides before their 18th birthday, while almost 50 million will be living as wives when they are 15 years and below by the year 2020. In the UNFPA report "Marrying too Young," it is indicated that girls from rural areas and from not well-to-do families who are also not so well educated bear high risk of getting married before they attain 18 years, than their their counterparts from well-off families and also who are well educated. Early marriage refers to any union whether formal or otherwise, where a girl, before 18 years lives with a partner as a wife. (UNICEF 2005; Forum on Marriage and the rights of women and girls 2001). UNIFPA 2006 defines early marriage as any marriage when one of the spouses is below age of 18 years, during this time, especially for the girl, her physical, mental, and psychological being is not well matured to bear all the responsibilities that come along with being a wife and a mother. Child marriage may take place with or without formal procedures, and under civil, religious or customary laws.

Despite the much efforts put in child protection programmes, prevalence of marriage among children remains worldwide. (Wahhaj 2014). According to the State of World Population Report 2005, about 45 per cent of women in Southern Asia and Africa who are aged around 20 years had married before their 18th birthday (UNFPA 2005). Marriage before age of 18 years often results to unplanned/early pregnancies besides the health risks for the mother and the child, and force the couples, especially the female to inconsiderably end her education (Unicef 2001; Unicef 2005). In recent years, developmental agencies have made efforts in their protection programmes to discourage marriage of girls before age of 18 years, through interventions that

advocates for ceasure of the practice, that provide assistance for parents to postpone marriage for their children and also the school going children to be encouraged to stay in school. This also provide school going children opportunities to equip themselves with skills and other alternatives to a routine trend of early marriage and early motherhood. Brac's Adolescent Development Programme in Bangladesh is a perfect example that is already in place, implementing livelihood activities, awareness creation on social and health issues, and promotes socialization and peer education among teenagers. Another example is Berhane Hewan project implemented in Amhara parts of Ethiopia. This is as a result of combined forces between New York based Population Council and the Amhara regional government that takes the community dialogue approach within community, and motivates the girls to take up school seriously by providing incentives. There have been similar projects being funded or receiving assistance from the World Bank, UK Department for International Development, and Nike Foundation.

The union of marriage is a crucial phase of life and the age one decides to do so may impact on them and have lasting aor short lived impacts, argues Sighn and Samara. Most women have their first births in before the second year of their marriage union in developing countries. Hence, marriage before age of 18 years typically goes along with childbearing at a young age. Early pre-disposses young women to great health risks and, if she carries the pregnancy to term, the risks are exegerated for the newborn baby by poor living conditions and lack of maternal and child health care services. Furthermoere, women who get married befor the age of 18 years are likely to make motherhood the only important role in their lives hence forget to improve other areas in their lives like some formal training or education and seek employment, improve their work experience and their own personal growth, thereby putting their marriage at risk. Marriage before age of 18 years has mostly been associated with divorce in the long run. Eventually, when marriage is broken, the woman faces economic challenges especially for women who are single parents, often they are the sole providers for their families or children.(Singh & Samara, 1996)

Some commentators suggests that a universal age of marriage is not achievable because different societies understand differently what it implies to be a child as well as different socio-economic and cultural realities. Bunting (1999) proposes that different governments should be allowed to legalise marriage before the age of 18 years of age, but that it is again their duty to demonstrate

that this age at marriage does not result in any discrimination or pychological or psycosocial effects for women.

The International Rescue Committee report “Are we Listening?” of 2014 asserts that Around the world in times of instability, adolescent girls often face specific risks because of their gender and role in society. Marriage before the age of 18 years is one of the commonest form of gender-based violence that adolescent girls face. Statistics reveal that marriage before age of 18 years and forced marriage is a world wide problem i.e. almost one-third of the world’s girls are married before the age of 18. Marriage before the age of 18 years and forced marriage adversly impacts on adolescent girls differently than their male counterparts. For example, in Jordan, less than half of 1% of marriages registered from 2005 to 2013 involved boys under age 18.22. According to the analysis highlihted in the IRC report, all known Syrian girls who married at average age of 16 years, 16.2% of them married men who were older than them for atleast, compared to 6.3% for Palestinian girls and 7.0% of Jordanian girls who got married early. (International Rescue Committee report “Are we Listening?” 2014).

Child marriage as human rights violation, has consequences for the survivors who are mostly women and girls. Most of these marriages are arranged without the knowledge or consent of the survivor. (Children's Dignity Forum 2008)

According to UNICEF (Early Marriage as a Barrier to Girl’s Education 2001), averagely 45% of women in in Central and West Africa are married compared as compared to almost 30% in East, Northern and Southern Africa.(B. Jeannette 2001). There is also very little credible source of data about marriages of children under the age of 14, and even less on those below the age of 10. However, it is estimated that, in 2002, almost 52 million girls below 18 years of age were married worldwide, about 25,000 are being married off each day and 100 million were married off by 2012. The prevalence of child marriage is common mostly in remote parts of Tanzania, where they have not prioritized education. (Children's Dignity Forum 2008)

African Union in campaign to end Child Marriage in Africa found out that communities are very much tied to tribal connections and hence allow marriage of women before they reach age of 18 years as a seal of such connections. For example, Telefa a traditional Ethiopian practice whereby

a man kidnaps and rapes the girl and later demands marriage because she is carrying his child. Averagely, one study found that the average age an abducted female gets married was 13 years. A new feature film, Difret, documents the 1996 high-court legal decision that ruled out telefa as illegal, but the practice is still being embraced especially in the northeastern of Ethiopia. In South Africa, the practice of abducting young girls and marrying them off is called ukuthwala, often with the knowledge and permission of parents. This is more rampant in rural areas, like the Eastern Cape and KwaZulu-Natal. The girls are all the time under-age, some as young as below eight years. Trokosi is a cultural practice in rural parts of Ghana, Benin and Togo where a young girl is given to the shrine as a way to cleanse the sins committed by a man, within the family. This practice has been in discussions since the early 1990s which reflects the contrast of traditional and modern perspectives. In Uganda and other African countries, parents, family and community leaders often arrange the marriages for young girls without the girls being involved. Marriage before the age of 18 years has become a commercial process where the girl is "priced" and so is her sexuality and reproduction. Educated girls are more likely not to accept to undergo FGM, this is why in Tharaka Nithi Kenya, most girls are subjected to FGM at a very early age. This again makes community members to find new ways of conducting FGM on girls before they are mature and cannot make decisions on their own, as a result, girls drop out of school and opt for marriage and expect to be treated as grown-ups or mature women.

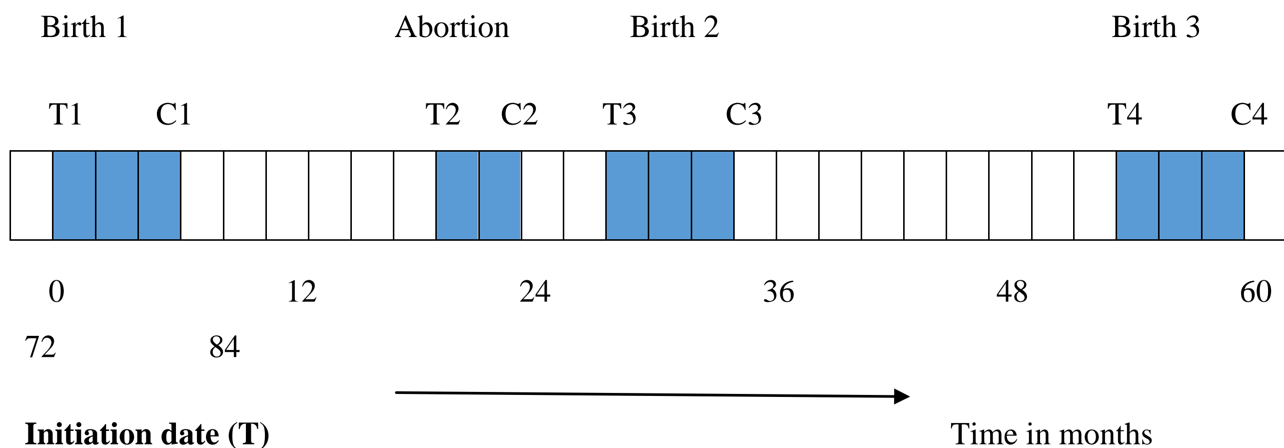
2.5 Use of family planning methods and the wellbeing of refugee women.

There has been significant global increase in the use modern methods of contraceptives by women. By 2009, an estimated 63% of women aged 15–49 who were married or in a union were using some form of contraception (I. Warriner 2012). However, despite the fact that family planning programmes have also been given priority, the rate that the use of contraceptive use has improved has also slowed down and the rate of usage differ from region to region. In the past decade, the rate at which contraceptive usage increased annually was lower than in the 1990s and family planning needs remains moderately unmet in many regions of the developing countries. Recommendations for birth spacing made by international organizations are based on information that was available several years ago. Recent studies supported by the United States Agency for International Development (USAID) have suggested that longer spacing between births is more advantageous, while publications by the World Health Organization (WHO) and

other international organizations recommend delaying at least two years between pregnancies to in order to lower reduce infant and child mortality rates, and also has other health benefits to the mother. (Report of a WHO Technical Consultation on Birth Spacing: 2005)

Child spacing

As shown in the below figure, each square represents three months. All pregnancies have initiation date (T) and outcome date (C), at which the pregnancy ceases with either a birth or other termination.



Initiation date (T)

Outcome date (C)

Figure 1. Child Spacing (WHO 2005)

To make it easier for comparison of findings with other studies, with the wide range of different interval measures used, and in conjunction with known terminology for the suggestions, this report only uses birth-to-pregnancy (BTP) intervals. BTP intervals measure the time between the start of the pregnancy and the live birth that follows (as opposed to other pregnancy outcomes).

Studies cordially used four measures of intervals preceding the index pregnancy. Using the figure above, and taking T3 to C3 to represent the index pregnancy for the purposes of illustration, these can be described as follows: 1. Birth-to-birth intervals: time between the index live birth (C3 in the figure) and the preceding live birth (C1) – note that this measure does not take into consideration the pregnancy T2 to C2 because it results to in a non-live birth; 2. Inter-

outcome intervals: time between the outcome of the index pregnancy (C3) and the outcome of the previous pregnancy (C2) i.e. note that the starting point (as in this case) and/or the end point with this measure can be a non-live birth; 3. Birth-to-conception intervals: time between the conception of the index pregnancy (T3) and the previous live birth (C1) – note that this measure also leaves out pregnancy T2 to C2 from consideration; 4. Inter-pregnancy intervals: time spent when not pregnant prior to the index pregnancy (C2 to T3 in the figure), these intervals can begin with non-live births. Other studies used true inter-pregnancy intervals, although this term was sometimes used as a synonym for birth-to- pregnancy intervals. Studies occasionally examined subsequent birth intervals (e.g. subsequent birth to birth interval is time passed from the index birth to the subsequent birth – C3 to C4 in the figure).

Around 60 million women all over the world develop complications during pregnancy or delivery, according to J. Davazo, A. Razzaque at al. some of these die, and majority of these deaths occur in developing countries (World Health Organization, 1993; World Health Organization and United Nations Children's Fund, 1996). However, there are no many researches that have linked child spacing with the health of the mother. This implies that when there is small gap in the number of births, it is associated with deaths and also very long gaps are associated with negative outcomes. (Davanzo et al., 2004)

USAID is currently supporting the Optimal Birth Spacing Initiative, which seeks to give direction on how interventions can best promote the required spacing. Understanding the magnitude of the effects of child spacing and identifying the groups that are adversely affected provides candid information that is needed for guiding the formulation of the most effective and suitable policies to improve child spacing.

In African countries, use of contraceptives is still low despite the efforts to increase family planning programmes. A demographic health survey was carried out to asses influence of community factors on family planning methods use for married women and results were compare with other 21 African countries. Factors controlling individual and household level, community level, demographics and fertility norms, gender norms and inequalities, and health knowledge remain significantly associated with contraceptive use, were controlled. (Miriam, Rob & Hamid et al, 2012). In another demographic and health survey, influence of community-

level factors was used to explain variations in the prevalence in modern contraceptive use in 6 African countries i.e. Kenya, Malawi, Tanzania, Burkina Faso, Ghana, and Ivory Coast. There was outstanding relationships were found between most community level factors and the use of modern family planning methods. The study revealed that sociocultural and economic factors influenced the use of modern family planning methods (Rob et al., 2007). Resistance to use of family planning methods is largely linked to high rates of fertility in Tanzania. About 2% of women participated in the village's family planning programs; this was according to the study on cultural barriers to use contraceptives, carried in Zanzibar. Strong religious beliefs (Muslim), male being in decision making positions, ignorance and lack of exposure among other issues, also affect the use of family planning methods. Studies recommended that in order to reduce fertility rates in Zanzibar, there are need to address cultural barriers to family planning must be confronted. (Keele, Forste & Flake, 2005)

The family structure in Somalia is founded on Islam as religion and Somali culture WHO survey in 2006. For example, it is a requirement by the Quran that a woman be submissive to their husbands regardless the circumstances. When it comes to decision making husbands have the final say. Men head the household and women come second to their husbands on all matters, including child spacing issues. As a result, most Somali women believe if they do not bare babies for their husbands, they will divorce them for other women. Because, they believe Allah provides and takes care of people, husbands and wives do not sit together to plan how and when they want to begin having children or how many children they wish to have. Religion and culture among Somali community does not allow use of contraceptives, and according to WHO 2006 survey, it was reported that only about 1.2 percent of married Somali women used modern family planning methods. Despite the strong religious and cultural resistance to use of family planning, it is important to realize that closely spaced families are at a high risk of maternal and infant morbidity and mortality rates in Somalia Leigh & Sorbye (2010).

2.6 Theoretical framework

Some authors have noted that if there is no common understanding of a problem, response will not be consistent, and are likely to conflict. The following paragraph outlines different theoretical views that have been applied in the areas of sexual violence, female genital

mutilation, Age at marriage and use of family planning methods to give different explanations for the phenomena.

The psychopathology model long dominated approaches to sexual assault. Under this model, rapists were mentally unstable and chemically imbalanced individuals who sexually assaulted because they could not control their sexual desires. Rape was believed to be un-common, and was being viewed that rape was as a result of sickness, the model that was adopted and medically aligned and included consequences like castration, psychotherapy, electrocution and hormone treatment. A multi-faceted theory has been formed to explain rape. This theory has been revised and appraised many times, sociocultural feminist and evolutionary perspectives are amalgamated with key psychological factors in order to explain male propensity towards sexual aggression via ultimate and proximate causes (i.e. why versus how mechanisms develop). The reasons why men have an urge to rape is predicted to be because they are evolutionarily programed to prefer impersonal sex, which is likely to be optimized as sexual exploitation. Due to the factors that influence rape, it is predicted that effects of risk factors give favorable conditions for sexual violence for example being too masculine and antisocial.

Ethnocentrism is cultural relativism, (Kelly in 1976) reiterates that behaviour varies from culture to culture and different communities should respect other and embrace other cultures. Cultural relativism demonstrates that there is no international superiority than the ethical rules of all cultures, and this ought to be respected equally. For example, FGM practice that is common in Africa and the Middle East is believed that it lowers the sexual drive for women and reduces infidelity amongst women. On the other hand, FGM is one of the practices being strongly opposed by human rights activists and the women and children rights groups. The driving force behind it is that the cultural practice is in violation of basic human rights over one’s body and one’s sexuality. Cultural relativism promotes the idea that different cultures have different beliefs, morals and values. Cultural relativism demonstrates that, for one to understand another culture, you must try to view things the way people in a particular culture, how people are motivated, how they think, this approach will enable one not to judge other cultures. In the case of FGM, one gets to understand why it is still being practiced among certain communities by at it from their cultures perspective. Having done this, the challenge would now be how to understand the view of those who engage in it.

2.7 Conceptual framework

This stage will involve assessment of independent variables i.e. sexual violence, FGM, marriage timing and use of family planning methods and how they influence the wellbeing of refugee women. Moderating variables and intervening variables are also listed. The conceptual framework was generated by the researcher.

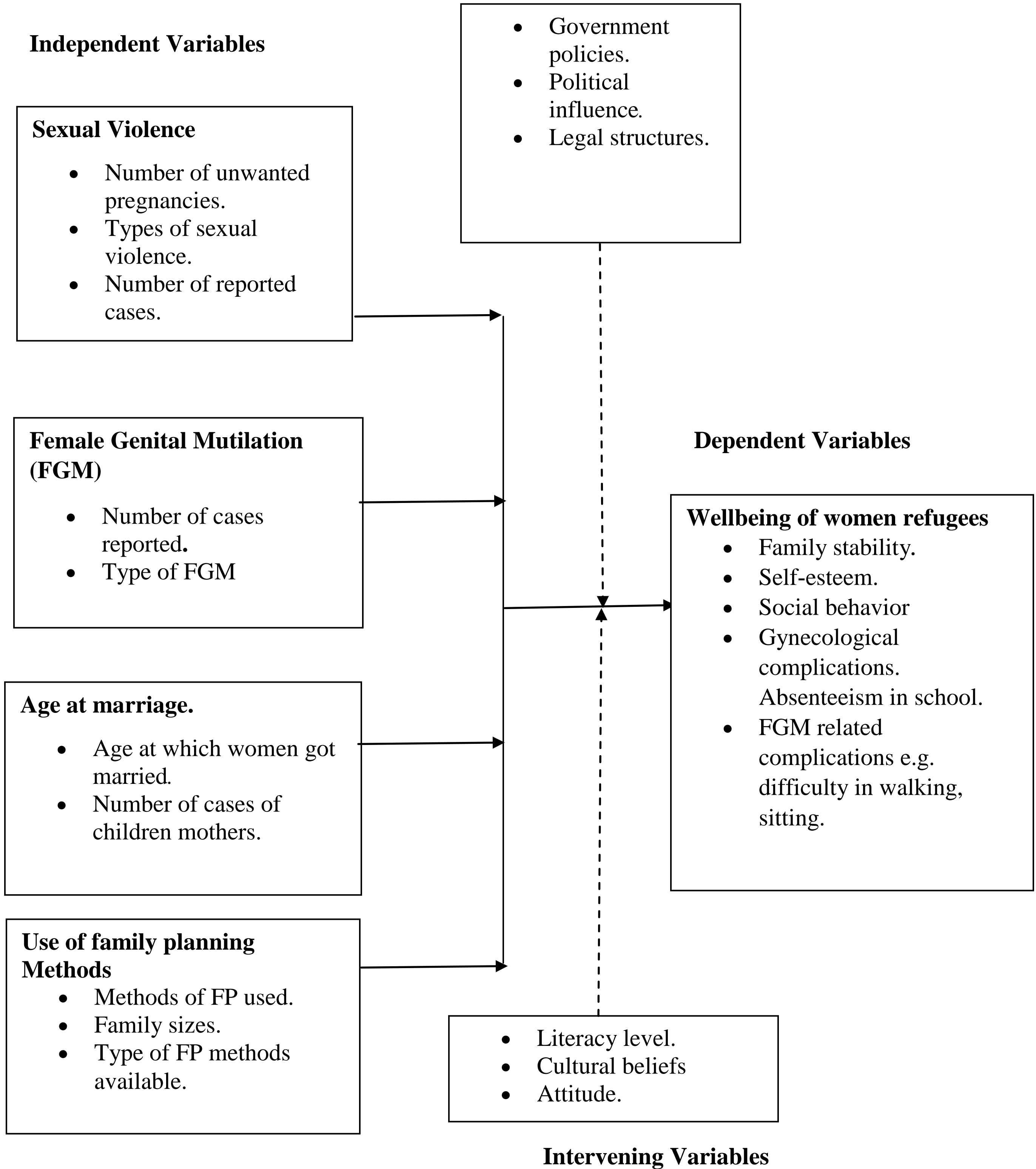


Figure 2. Conceptual Framework

2.8 Explanation of relationship of variables

The conceptual framework has dependent variable; the wellbeing of refugee women, which is determined by independent variables i.e. sexual violence, female genital mutilation, marriage timing and the use of family planning methods. Intervening variables like government policies, legal structures, political influence and moderating variables like literacy levels, community beliefs and practices, availability of health resources, resource control & allocation and economic power are also highlighted in the conceptual framework but not discussed at length in the proposal.

The wellbeing of refugee women will be measured by family stability, withdrawal symptoms, self-esteem, physical nutrition status, gynecological complications, number of children/pregnancies, absenteeism in school and female genital mutilation related complications like difficulty in walking, sitting or playing.

Sexual violence as an independent variable will be measured by number of unwanted pregnancies, types of sexual violence, number of reported cases and availability of response and prevention mechanisms, as indicators. Female genital mutilation will be measured by number of cases reported, type of female genital mutilation and availability of response and prevention mechanisms, as indicators. Marriage timing will be measured by age at which women got married, number of cases reported, number of children mothers and availability of response and prevention mechanisms. Number of cases reported, methods of Family planning used, family sizes, type of family planning methods available and availability of family planning services at the camps will be indicators to measure use of family planning methods.

2.9 Knowledge gap

The literature reviewed on sexual violence and the wellbeing of refugee women, female genital mutilation and the wellbeing of refugee women, age at marriage and the wellbeing of refugee women, use of family planning methods and the wellbeing of refugee women, does not explain

in details how the social, mental and psychological, spiritual wellbeing of women is impacted on, but instead focuses more on the physical (medical) wellbeing.

My investigation will address the gaps and build on the existing research in the area of influence of cultural practices on the wellbeing of refugee women, with a special focus on sexual violence, female genital mutilation, marriage timing and use of family planning method, by making sure I include questions that are easily comprehendible in the interviews that address the social, mental and psychological wellbeing of refugee women. I will also ensure that the interviewers bring out questions in a way that is easily understood by respondents, during the pre-testing of questionnaires.

2.10 Summary of the literature review

The overview of research literature and reports on violence against and amongst refugees with focus on Sexual Violence demonstrates that, for many women, the end of conflicts does not represent the end of conflict-related sexual violence. Current studies argue that escaping from war and repression to refugee and IDP camps and settlements only offers a certain degree of protection against violent assaults since women are not safe from (sexual) abuse there. Several refugee and aid agencies recognize the vulnerability of women and girls as targets of sexual violence and implement measures to protect and empower them. In spite of that, there is an increase in the recording of crimes which indicates that sexual and gender-based violence constitutes a particular challenge. FGM is so deeply embedded in many African societies. It is a way of initiation one to the phase of womanhood with strongly embedded, ancestral links. Continued practice of FGM has largely been linked to culture and religion beliefs that are being preserved, and also as maintenance of feminism, virginity and a confirmation of a good wife in future.

Most literature reviewed in this study, highlights that the existence of FGM, women getting before age of 18 years and use of family planning in Africa is highly influenced by culture and religion. Furthermore, there are also factors that are catalyzing these processes, for example, socio-economic factors like poverty and gender issues. Parents languishing in poverty will always regard their children, especially girls, as burdens and young girls become possible source

of income for the family, where they are exchanged as child brides for dowry or other material assistance. Limited or lack of education and facing insecurity in the face of or after conflict, are other contributing factors. This is also justified through religions in most of African countries. Use of in African is considerably low despite efforts to advocate for family planning by developmental agencies. This is highly linked to community beliefs, gender norms and inequalities, and health knowledge. Religion and culture have possibility of influencing the use of family planning methods among married couples in very outstanding ways. Among the Somalis in Africa, sue of modern family planning method is the same as causing yourself to be infertile in which has consequences for such women in the community. For families who want to plan their families, their most fear is betraying their culture and being discriminated by community for the reason of having fewer children.

CHAPTER THREE:
RESEARCH METHODOLOGY

3.1 Introduction

This chapter talks about the site of research, population size, methods of data collection, analysis and presentation that were used in this study. The aspects discussed here are research design, target population, sampling procedure, instrument used for data collection, how valid the instruments used are, how reliable the research findings are and data analysis techniques used in the study.

3.2 Research Design

This study was conducted as a cross sectional survey. The interviewers were supervised by me, (two females and one male) from Somali and Sudanese communities respectively, who were also trained translators, facilitated the data collection procedures by reading out questions in languages that respondents understood best, and filled in their respondent as it was without interpreting otherwise.

The survey therefore helped us to establish personal contact with the respondents and created a conducive environment that enabled them to feel comfortable to share their experiences and opinions. Secondly, the design was best for this study since follow-up was not necessary; the interviewer met the respondents once and gathered all the information in one encounter.

3.3 Target Population

The target population of the study was refugee women in Ifo 1 refugee camp Dadaab. There are 36,128 refugee females, with majority Nationality being Somalis while the Ethiopians, South Sudanese, Congolese, Burundians, Ugandans, Rwandese, Sudanese, Tanzanians and Eritreans as the minority nationalities. (UNHCR Progress July 2016)

3.4 Sample size and sample selection

The minimum sample size was determined by Yamane formula 1967: $n=N/1+N(e)^2$

3.4.1 Sample size determination

The minimum sample size (n) required for determining the influence of cultural practices on the wellbeing of refugee women in Ifo 1 camp was calculated using the formula;

$$n=N/1+N(e)^2$$

Where n is the sample size, N is the population size and e is the margin of error (Yamane, 1967)

Therefore,

$n=36,128/1+36,128(0.1)^2$

$n=36,128/1+361.28$

$n=36,128/362.28$

$n=99.72$

$n=100$ (was rounded off)

For this study, a sample size of 100 was taken to be adequate representation of the population.

3.4.2 Sample procedure

The interviewers went to the blocks in the camp which are already divided into nine sections according to nationalities i.e. A, B, C, D, E, F, G, S and N, picked respondents randomly, one respondent per family within the desired age bracket (according to UNHCR manifest), until a sample of 100 was reached at. They each had a copy of the letter of transmittal, and an introduction letter from University of Nairobi Department of extra mural studies, which they used to introduce themselves and stated their intensions. Informed consent was obtained from the respondents by signing a consent form before the start of interviews.

3.5 Instrument for Data collection

Structured interviews were used to gather information from the respondents, as feedback was written down on the same questionnaire or marked appropriately. Questionnaire was developed to guide interviewers on the questions to ask, to enable them focus on the topic and also save

time. The questionnaire was both an open ended and closed questionnaire, and took maximum of 12 minutes to interview and write down feedback for one respondent. Interview as a method of data collection was most preferred because most respondents could not read or write in English and so interviews allowed for easy interpretation in a language they could best understand and also provide immediate feedback as it was needed for this kind of research study.

3.5.1 Piloting of the study

The questionnaire was pre-tested at the Ban-Ki-moon conference hall, UNHCR Dadaab at the GBV working group forum for one day, two weeks prior to data collection. After the pre testing, it was adjusted as appropriate to enhance the validity of the data collected.

3.5.2 Validity of the instruments used

The validity of the instruments used for data collection was tested by a pre-test of the questionnaire at the Ban-Ki-moon 11 conference hall, Dadaab at the GBV working group forum involving representatives from the lead agencies in GBV in Dadaab camps, UNHCR protection and community services team and GBV prevention and interviewers, for one day, two weeks prior to data collection. This ensured consistent measurement across time and across the various items in the instrument. The study applied content validity, as a measure of the degree to which data obtained from the research instruments meaningfully and accurately reflect the theoretical concept before the actual study. The feedback from the participants and the GBV experts helped in modifying the questionnaire.

As a way of improving the validity of the responses at the time of the actual data collection, the following measures were taken. First, to ensure confidentiality, all respondents had the option not to answer any question they did not wish to give personal information about or to stop the interview at any time. Secondly, the participants were not asked their names so as to ensure anonymity throughout the process. Thirdly, the interviewers were urged to be sensitive in how they bring out questions to ensure that they were not being judgmental and not too intrusive into the personal life of the respondents. Lastly, interviewers wrote down the respondents' feedback as it was to minimize biasness.

3.5.3 Reliability of the instruments used

The Test- retest method was used to test for the reliability of the instruments used in the study by implementing measurement instrument (questionnaire) at two separate times for each subject, one day after the pre-testing, to the GBV working group for two days. The correlation between the two separate measurements was then computed to ensure consistent measurement across time and across the various items in the questionnaire, with an assumption that there was no change in the underlying condition between test 1 and test 2. The results obtained were consistent for both tests 1 and 2, which implied that the questionnaire used was reliable.

3.6 Data Collection Procedures

Before the actual data collection, University of Nairobi Department of Extra Mural Studies gave an approval by issuing a research letter which was used also to introduce the interviewers to the community and thereafter, a research permit from NACOSTI that was presented to Garisa county offices and UNHCR Dadaab office. Community leaders were sensitized through the camp management agency in Ifo 1 camp which they passed the same information to the community one week prior to data collection. Data was collected by three interviewers, with constant supervision for a period of three weeks by conducting structured interviews and noting down the response. The interviewers each had a copy of the transmittal letter which they read and interpreted to the respondents and clarified all the concerns of the respondents before commencing the interviews. They also read each question on the questionnaire to the respondents as they marked/wrote their responses appropriately.

3.7 Data analysis techniques

The collected data was analyzed using descriptive and inferential statistics. The Spearman Correlation was used to analyze the co-relation between sexual violence and the wellbeing of refugee women, female genital mutilation and the wellbeing of refugee women, age at marriage and the wellbeing of refugee women, use of family planning methods and the wellbeing of refugee women. In addition frequencies and percentages were used to analyze data on the

background information of the respondents. After analysis, data was be summarized and presented in form of frequency tables, percentages, and proportions.

3.8 Ethical considerations

In this study research ethics was upheld. A letter of transmittal was given to respondents before starting the interviews to ensure informed consent of the respondents, with the interviewers introducing themselves and assuring the participants that information given was confidential and just for learning purposes. The participants confirmed their informed consent by their thump prints or signatures while for the younger respondents (below 18years), consent was obtained from their parents or care givers.

In addition, the identity of the respondents was concealed throughout the research process. Some of the questions in the questionnaire may have been uncomfortable for some respondents to answer. It was made clear at the beginning of every interview that answering of the questions was voluntary and that the interview could be stopped at any time or a question skipped. At the end of every interview, respondents were compensated with gift (two packets of sanitary towels per each), although they were not informed at the beginning that they would be receiving a gift so as to ensure voluntary participation.

3.9 Operational Table

Table 3.1 Operational table

Objective	Variable	Indicators	Measurement Scale	Data Analysis Technique
To explore how Sexual Violence influences the wellbeing of women refugees.	Sexual Violence	Number of unwanted pregnancies, Types of sexual violence, number of reported cases.	Interval	Spearman Correlation Analysis
	Wellbeing of women refugees	Family stability, social behaviour, Self-esteem, Gynecological complications	Interval	Spearman Correlation Analysis

To determine how Female Genital Mutilation influences the wellbeing of women refugees.	Female Genital Mutilation	Number of cases reported, Type of FGM.	Interval	Pearson's correlation Analysis
	Wellbeing of women refugees	Family stability, social behaviour, Self-esteem, Gynecological complications	Interval	Pearson's correlation Analysis
To establish how the time of marriage influences the wellbeing of women refugees.	Age at Marriage	Age at which women get married. Number of children mothers.	Interval	Pearson's correlation Analysis
	Wellbeing of women refugees	Family stability, social behaviour, Self-esteem, Gynecological complications	Interval	Pearson's correlation Analysis
To identify how use of family planning influences the wellbeing of women refugees.	Use of family planning	Family sizes, Type of FP methods available.	Interval	Pearson's correlation Analysis
	Wellbeing of women refugees	Family stability, social behaviour, Self-esteem, Gynecological complications.	Interval	Pearson's correlation Analysis

CHAPTER FOUR
DATA ANALYSIS, PRESENTATIONS AND INTERPRETATION

4.1 Introduction

This section presents data analysis as well as the findings of the study on the basis of the following research objectives: to examine how Sexual Violence influences the wellbeing of women refugees, to determine how FGM influences the wellbeing of women refugees, to establish how the age at marriage influences the wellbeing of women refugees and to assess how use of family planning methods influences the wellbeing of women refugees.

4.2 Demographic Characteristics

The study sought to establish the various demographic characteristics of the respondents. These included; Nationality, age, distribution of respondents in the blocks, marital status, position in the family, level of education and occupation. These factors according to Argote, (2000) are critical in any research activity.

4.2.1: Nationality of the Respondents

As presented in Table 4.1, it was evident that majority of the respondents (68%) were from Somali, 18% from Ethiopia, 10% from South Sudan while 4% from either Ugandans, Congolese 0r Burundians. This implies that the camp is dominated by Somali women and at large, Somali people, followed by Ethiopians, South Sudanese and Ugandans, Congolese and Burundians who are very few in population.

Table 4.1: Nationality of respondents.

Nationality		Frequency	Percent
	Somali	68	68
	Ethiopian	18	18
	South Sudan	10	10
	Other	4	4
	Total	**100**	**100**

4.2.2 Age of the Respondents

As seen in the Table 28% of the respondents were age 20-30 years, 45% were 31-40 years, 27% were 41-50 years. Majority of the women in the camp are between the age of 31 and 40 years and very few are between 15 and 19 years.

Table 4.2 Age of the respondents.

Age of the Respondents	Frequency	Percent
15-19 Years	7	7
20-30 Years	28	28
31-40 Years	45	45
41-50 Years	20	20
Total	**100**	**100.0**

4.2.3 Distribution of respondents per section

As seen in the Table 4.3, each section was well represented in the study. Sections A, B, C, D, E, F and N are occupied by Somalis. Part of B and S is occupied by Burundians and Congolese, S is for South Sudanese and Sudanese while part of C, G and part of E is occupied by Ugandans and Ethiopians respectively. N being the largest section in terms of block distribution and population, had the most number of respondents while S, B and C having the minority nationalities were also given a fair chance to participate in the research.

Table 4.3: Distribution of respondents as per sections.

Section	Frequency	Percent
A	10	10
B	10	10
C	10	10
D	10	10
E	10	10
F	10	10
G	10	10
S	10	10
N	20	20
Total	**100**	**100.0**

4.2.4 Marital Status

As seen in Table 4.4, majority of the respondents (55%), were married, 25% were not married, 11% were divorced and finally 9% were widowed. Most of the women in the camp are married.

Table 4.4 Marital status of the respondents.

Marital Status		Frequency	Percent
	Not Married	25	25
	Married	55	55
	Divorced	11	11
	Widowed	9	9
	Total	**100**	**100**

4.2.5 Position if families

As seen in Table 4.5, majority of the respondents (54%) were family representatives while 46% were not family representatives. Most women in the camp are the family representative, this implies that they are the head of their families. They take up most of family responsibilities, for example seeking for any material assistance, documentation or any biometric procedures. This does not include decision making.

Table 4.5: Family Representation

Family Representative		Frequency	Percent
	Yes	54	54
	No	46	46
	Total	**100**	**100.0**

4.2.6 Formal School Attendance

Table 4.6 reveals that 62% of the respondents had attended formal school while 38% did not attend formal schools. Most women in the camp have basic education. It was also noted that women in the camp enroll to schools late.

Table 4.6: Formal School Attendance

Formal School Attendance	Frequency	Percent
Yes	62	62
No	38	38
Total	**100**	**100**

4.2.7 Level of Education

Table 4.7 reveals that 48% of the respondents had attained primary level of education while 14% had secondary level of education, 22% had attained technical education while 2% had attained university education and finally 14% had either attended teachers training colleges and vocational training centers. The literacy level for women is low, primary level and majority being family representatives; it also affects decision making processes for the family.

Table 4.7: Level of Education

Level of Education	Frequency	Percent
Primary	48	48
Secondary	14	14
Technical	2	22
University	22	2
Others	14	14
Total	**100**	**100**

4.2.8 Occupation of respondents

As seen in Table 4.8, majority of the respondents (55%), were unemployed, 25% were employed, and 11% were in other occupations. Most women are not employed, because they don't have time since they also take care of the young ones and being family representative or their level of education limit their job choices.

Table 4.8: Occupation of respondents

Occupation of respondents	Frequency	Percent
Employed	25	25
Unemployed	55	55
Other	20	20
Total	**100**	**100**

4.3 Sexual Violence and Wellbeing of Women Refugees

The first objective of the study was to examine how Sexual Violence influences the wellbeing of women refugees.

4.3. Form of Sexual Violence

Table 4.9 presents findings with regards to form of sexual violence experienced by the respondents. 100% of respondents reported to have experienced or knew someone who had experienced sexual violence. This demonstrated that sexual violence was being practiced in the camp. As seen in the Table 4.9 sexual harassment was the most common form of sexual violence with (M=4.14; SD=1.11), followed by sexual exploitation with (M=3.887; SD=1.088) and finally rape with (M=3.67; SD=1.025). Sexual harassment was common because it is easy for the perpetrator to get away with a sexual comment or talk, and it is also not easy to prove in a court of law hence justice is always denied. Sexual exploitation and rape were not very popular due to the existence of law enforcement agencies, police and the government of Kenya that ensures survivors get justice or perpetrators are dealt with lawfully.

Table 4.9: Form of Sexual Violence

Form of Sexual Violence	Mean	S.D
Sexual harassment (talks, comments etc.)	4.14	1.11
Sexual exploitation (forced into sexual relationship in exchange of form of support)	3.887	1.088
Rape (actual penetration)	3.67	1.025

4.3.3 Perpetrators of Sexual Violence

As seen in table 4.10 majority of the perpetrators of sexual violence are husbands/intimate partner (M=4.27; SD=1.185), followed by relatives (M=4.11; SD=1.079), then friends/someone known to survivors (M=4.07; SD=1.002) and finally strangers (M=3.96; SD=0.997). Intimate partners think they "own" their partners and would treat them how they please. Sexual harassment by an intimate partner or husband is hard to prove.

Table 4.10: Perpetrators of Sexual Violence

Perpetrators of Sexual Violence	Mean	S.D
Husband/intimate partner	4.27	1.185
Relative	4.11	1.079
Friend/ someone known	4.07	1.002
Stranger	3.96	0.997

4.3.4 Influence of Sexual Violence

As seen in Table 4.11, it was evident that in most cases sexual violence led to unwanted pregnancies (M=4.12; SD=1.123), followed by low self-esteem (M=4.11; SD=0.887), then STI (M=4.07; SD=1.008), break of family (M=3.87; SD=1.321), withdrawal symptoms (M=3.85; SD=0.994), gynecological complications (M=3.67; SD=0.965), HIV (M=3.26; SD=1.096), rejection by community (M=2.98; SD=1.001), poor nutrition status (M=2.65; SD=1.365), and finally mental instability (M=2.08; SD=1.072). Most women reported to have gotten pregnant as

an influence of sexual violence, yet rape was not the most popular form of sexual violence. This implied that although sexual harassment was the most popular form of sexual violence, its influence was not felt mostly by women.

Table 4.11: Influence of Sexual Violence

Influence of Sexual Violence	Mean	S.D
Unwanted pregnancy	4.12	1.123
STI/other infections	4.07	1.008
HIV	3.26	1.096
Rejection by community/family	2.98	1.001
Low self-esteem	4.11	0.887
Break of family/instability	3.87	1.321
Poor nutrition status	2.65	1.365
Mental instability	2.08	1.072
Withdrawal symptoms	3.85	0.994
Gynecological complications	3.67	0.965

4.3.5 Reporting of Sexual Violence

As seen in table 4.12, majority of the cases were reported to the police (M=3.05; SD=1.372), followed by cases reported to the hospital (M=2.98; SD=1.264), agencies (M=2.77; SD=1.221) and finally to community leaders with a mean of 2.05. Women did not prefer to report to community leaders, who lived closely with them or even are relatives because they felt that community would stigmatize them or that they would not get justice they deserve due to the permissiveness of the community.

Table 4.12 How the respondents reported cases of sexual violence.

Reporting of Sexual Violence	Mean	S.D
Police	3.05	1.372
Hospital	2.98	1.264
Agency	2.77	1.221
Community leaders	2.05	1.045

4.3.6 Perception on Sexual Violence

As presented in the Table 4.13, most of the respondents had a problem with sexual violence, while very few believe that it is culturally accepted. Due to advocacy and awareness creation by agencies, most women did not support sexual violence, but there were a few women who thought it is a cultural practice and embraced it.

Table 4.13: Perception on Sexual Violence

Results of Sexual Violence	Mean	S.D
Have problem with It	4.22	1.603
Don't support it	4.19	1.251
Its culturally accepted	1.87	1.354

4.4 Female Genital Mutilation and Wellbeing of Women Refugees

The second objective of the study was to determine how FGM influences the wellbeing of women refugees. The following subsection looks at how this is the case as reported by the respondents.

4.4.1 Reported cases and types of FGM

As seen in the Table 4.14, most of the respondents had undergone FGM or knew someone who had undergone FGM and the most common type of FGM undergone was Excision. The above analysis shows that FGM was being practiced in the camp.

Table 4.14: Reported Cases and Types of FGM

Cases reported	Mean	S.D
Yes	4.27	1.299
No	2.98	1.006
Types of FGM		
Clitoridectomy	3.76	1.007
Excision	4.02	0.997
Infibulation	2.91	0.865

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4.4.2 How FGM influenced Women Refugees

As seen in the table 4.15, it was evident that FGM made women to miss school (M=3.32; SD=1.107), to have difficulties in walking, playing, sitting (M=3.76; SD=1.007), to have a low self-esteem (M=4.02; SD=0.997), to have, mental instability (M=2.91; SD=0.865), to have withdrawal symptoms (M=4.01; SD=1.111) and to have gynecological complications (M=3.99; SD=1.002). FGM had psychological influence on women more than the physical influence.

Table 4.15: Influence of FGM on the Women Refugees

Influence of FGM on the Women Refugees	**Mean**	**S.D**
Missed school	3.32	1.107
Difficult in walking, playing, sitting	3.76	1.007
Low self-esteem	4.02	0.997
Mental instability	2.91	0.865
Withdrawal symptoms	4.01	1.111
Gynecological complications	3.99	1.002

4.4.3 Communities Practicing FGM

Table 4.16, shows that in most cases Ethiopians are the ones highly practicing FGM (M=3.31; SD=1.234), followed by Somali nationals (M=2.87; SD=1.005), then South Sudanese (M=2.65;

SD=0.995), and finally other nationalities which included Ugandans, and Burundians (M=2.03; SD=0.883). FGM was highly practiced among Ethiopian community.

Table 4.16: Communities Practicing FGM

Communities Practicing FGM	Mean	S.D
Somali	2.87	1.005
Ethiopia	3.31	1.234
South Sudan	2.65	0.995
Others	2.03	0.883

4.4.4 Perception of Women towards FGM

As presented in the table 4.17 it was evident that most women think FGM is culturally accepted (M=4.31; SD=1.231), while others have a problem with FGM (M=4.23; SD=1.117) and do not also support it

Table 4.17: Perception of Women towards FGM

Perception of Women towards FGM	**Mean**	**S.D**
Have problem with it	4.23	1.117
Its culturally accepted	4.31	1.231
Don't support it	4.05	1.097

4.5 Age at marriage and Wellbeing of Women Refugees

The third objective of the study was to establish how the age at marriage influences the wellbeing of women refugees. The following subsection presents results on this objective.

4.5.1 Perception of Respondents' for ideal age of marriage

As seen in the table 4.18, majority of the respondents believe that the ideal age for marriage is 18 years and few thought the ideal age at which a woman should get married is 15 years while some do not know the age at which a woman should get married. Most women understand that the ideal age for marriage is 18 years, and yet they got married or allowed their daughters to get

married before the age of 18 years. This could mean that their culture overrides their perception. The other respondents who indicated ideal age of marriage to be below 18 years or dint know, was as a result of low education levels, as majority of respondents had only attained primary level education.

Table 4.18: Perception on ideal age for marriage

Ideal Age	Mean	S.D
15 years	2.21	1.1258
16 years	3.04	1.2247
17years	3.99	1.3452
18 Years	4.88	0.15658
Don't Know	2.42	0.774

4.5.2 Women who got married or know someone who got married before age of 18 years.

As seen in the table 4.19 majorities of the respondents got married before age of 18 years or know women who have been married before attaining the age of 18 years**.** Child marriage was being practiced in the camp.

Table 4.19: Married before/knew someone in the camp who got married before age of 18 years

Got married/know someone who got married before age of 18 years	Mean	S.D
Yes	4.52	0.1154
No	2.07	0.3254

4.5.3 Type of marriage

As seen in that table 4.20, most of the marriages were voluntary (M=3.88; SD=0.997), while the others were forced marriages (M=3.42; SD=0.886). Voluntary marriages before the age of 18 years were an influence of poverty due to the refugee status, ignorance by survivors and parents or as a cultural practice.

Table 4.20: Type of marriage

Marriage Type	Mean	S.D
Voluntary	3.88	0.997
Forced	3.42	0.886

As seen in table 4.21, most of the parents were given gifts in form of cash/material/favor in exchange of marriage. This was driven by levels of poverty as most women were not employed and was seen as a way out, hence most marriages before age of 18 years was voluntary.

Table 4.21: Gifts/favor/support in exchange of marriage

Gifts/favor/support in exchange of marriage	Mean	S.D
Yes	4.07	0.8254
No	2.61	0.3521

4.5.4 How the age at which women refugees got married has influenced their wellbeing.

As seen in table 4.22, it was evident that most marriages lead to unwanted pregnancies (M=4.12; SD=1.123), followed by low self-esteem (M=4.11; SD=0.887), then STI (M=4.07; SD=1.008), break of family (M=3.87; SD=1.321), withdrawal symptoms (M=3.85; SD=0.994), gynecological complications (M=3.67; SD=0.965), HIV (M=3.26; SD=1.096), rejection by community (M=2.98; SD=1.001), poor nutrition status (M=2.65; SD=1.365), and finally mental instability (M=2.08; SD=1.072). Respondents were further asked to state whether marriage before the age of 18 years had any benefits. Out of those who responded 100% argued that marriage before age of 18 years had no benefits. Women who got married before the age of 18 years could not make decisions on the size of families they wanted to have, they did not have knowledge on how to practice safer sex and also regarded themselves with low self-esteem since they saw their peers excelling in schools while they are burdened with responsibilities of being wives and mothers.

Table 4.22: Influence of the age at which women got married

Effects of Marriage to Women	Mean	S.D
Unwanted pregnancy	4.12	1.123
STI/other infections	4.07	1.008
HIV	3.26	1.096
Rejection by community/family	2.98	1.001
Low self-esteem	4.11	0.887
Break of family/instability	3.87	1.321
Poor nutrition status	2.65	1.365
Mental instability	2.08	1.072
Withdrawal symptoms	3.85	0.994
Gynecological complications	3.67	0.965

4.5.5 Communities with most girls below age 18 years who are married

Table 4.23, shows that in most cases Ethiopian community has most girls below age of 18 years who are married (M=3.31; SD=1.234), followed by Somali nationals (M=2.87; SD=1.005), then South Sudanese (M=2.65; SD=0.995), and finally other nationals (M=2.03; SD=0.883). Marriage before age of 18 years was very common among Somalis, but since the existence of Ifo 1 camp in 1991 that was pre-dominantly occupied by Somalis, there has been advocacy and awareness creation by agencies and numbers have since gone down. Since most respondents were Somalis, they could have given wrong feedback about this question, but Somali community also has women below 18 years who are married.

Table 4.23: Communities with most girls below age of 18 years who are married

Communities with most girls below age of 18 years who are married	Mean	S.D
Somali	2.87	1.005
Ethiopia	3.31	1.234
South Sudan	2.65	0.995
Others	2.03	0.883

4.5.6 Perception of women on marriage below age of 18 years

It was evident that most women stated that marriage before the age of 18 years is culturally accepted (M=4.31; SD=1.231), while others have a problem with it (M=4.23; SD=1.117), and do not support it (M=4.05; SD=1.097). Marriage before age of 18 years is being viewed as a cultural practice and that is why majority of women reported to have gotten married or know other women who got married before the age of 18years.

Table 4.24: Women's perception on marriage below age of 18 years

Views on marriage below age of 18 years	Mean	S.D
Have problem with it	4.23	1.117
Its culturally accepted	4.31	1.231
Don't support it	4.05	1.097

4.6 Use of family planning and Wellbeing of Women Refugees

The final objective of the study was to assess how the use of family planning methods influenced the wellbeing of women refugees. The following subsection looks at this aspect of the study.

4.6.1 Women who are using or have ever used family planning methods and methods of family planning

Table 4.25 reveals that majority of the respondents were using or have ever used family planning methods, and majority were now using condoms (M=3.87; SD=0.774), followed by injections (M=3.66; SD=0.993), Pills (M=3.47; SD=1.002), IUDs (M=3.41; SD=1.122), and finally implants (M=2.98; SD=1.117). Most women use family planning methods, this was also evident by the family sizes i.e. most women had family sizes 1 to 3 members, but they are limited by the choice that is available in the health facilities in the camps. Condoms and injections were most preferred methods because it was easy to hide from the rest of the community as Muslim religion does not allow use of un-natural methods.

Table 4.25: Methods of Family Planning being used/ever used

Are you Using/Ever used any Family Planning	**Mean**	**S.D**
Yes	4.22	1.443
No	2.01	0.866
Methods of Family Planning used		
Implants	2.98	1.117
Pills	3.47	1.002
Injections	3.66	0.993
Condom	3.87	0.774
IUDs	3.41	1.122

4.6.2 Reason for Choosing the FP Methods

Table 4.26 shows that most women chose the family planning method because it was the only one available (M=4.26; SD=1.237), was convenient (M=4.09; SD=0.995), and finally because it had no/less side effects (M=3.81; SD=1.022). Most women are unemployed, have low level of literacy hence cannot afford any other method and are limited to the choice that is available at the health facilities. If there was no any method available, the women would not be using family planning.

Table 4.26: Reason for Choosing the FP Methods

Reason for Choosing the FP Methods	Mean	S.D
It's convenient	4.09	0.995
It's the only one available	4.26	1.237
Less/no side effects	3.81	1.022

4.6.3 Family sizes

As seen in table 4.27, majority of the respondents were between family size 1-3 (44%) and fewest respondents 10% between sizes 8-10.

Table 4.27: Family sizes

Family Size	Frequency	Percent
1-3	**44**	**44**
3-5	**34**	**34**
6-8	**12**	**12**
8-10	**10**	**10**
	100	**100**

Respondents were further asked to state if the use of family planning is a good thing or not.

As seen in table 4.28 majority of the respondents agreed that use of family planning is indeed a good thing (M=4.11; SD=0.883). This was supported by the fact that majority of women were using condoms or injections as a method of family planning and their small family sizes.

Table 4.28: Views of respondents on Family Planning

Use of FP Methods	Mean	S.D
Yes	4.11	0.883
No	2.17	1.001

4.6.4 Influence of not using Family Planning

As seen in the table 4.29, majority of the respondents believe that women who do not use family planning are likely to have unwanted pregnancy (M=4.09; SD=1.095), low self-esteem (M=4.02; SD=0.992), break of family (M=3.93; SD=1.001), poor nutrition status (M=3.45; SD=1.321) and Gynecological complications(M=3.22; SD=0.923). Both age at which women got married and use of family planning resulted in women getting unwanted pregnancy and low self-esteem as major influence. Women who got married before age of 18 years did not use family planning.

Women were also left with the responsibility of planning their families, hence when they did not use family planning methods it also resulted in family instability or broke their families.

Table 4.29: Influence of not using family planning

Influence of not using Family Planning	Mean	S.D
Unwanted pregnancy	4.09	1.095
Low self-esteem	4.02	0.992
Break of family/instability	3.93	1.001
Poor nutrition status	3.45	1.321
Gynecological complications	3.22	0.923

4.7 Correlation Analysis

The Pearson's correlation matrix shown above indicates that there was a positive relationship between each of the independent variables of sexual violence, FGM, age at marriage and use of family planning and wellbeing of women all showing high Pearson's (r) value above 0.5 which is therefore argued that each of the independent variables have a strong positive relationship with wellbeing of women. This correlation explains the level to which one variable moved together with another in explaining the influence of each to access to treatment. Strongest correlation was found between wellbeing of women and sexual violence with coefficient factor of 0.858. Other significant levels included FGM (0.639), marriage timing (0.537) and use of family planning (0.537).

Table 4.30: Correlation Analysis

Factors		**Wellbeing of Women**	**Sexual Violence**	**FGM**	**Marriage Timing**	**Use of Family Planning t**
Wellbeing of Women	Correlation	1	0.858	0.639	0.537	0.537
	Significance (2-tailed)	.000	.000	.000	0.001	0.00
	df	0	100	100	100	100
Sexual Violence	Correlation	0.858	1	0.61	0.494	0.427
	Significance (2-tailed)	.000	.000	.000	0.002	0.001
	df	100	100	100	100	100
FGM	Correlation	0.639	0.861	1	0.878	0.533
	Significance (2-tailed)	.000	.000	.000	.000	0.02
	df	100	100	100	100	100
Age at marriage	Correlation	0.537	0.494	0.878	1	0.913
	Significance (2-tailed)	0.001	0.002	.000	.000	0.002
	df	100	100	100	100	100
Use of Family Planning	Correlation	0.537	0.427	0.533	0.624	1
	Significance (2-tailed)	0.001	0.002	.000	.000	0.002
	df	100	100	100	100	100

CHAPTER FIVE:
SUMMARY OF FINDINGS, DISCUSSIONS, CONCLUSSIONS AND RECOMMENDATIONS

5.1 Introduction

In this chapter, a summary of the findings of the study are presented and conclusions made from the said findings. Recommendations based on the study findings and conclusions are also made. Also, suggestions for further research are given.

5.2 Summary of findings

5.2.1 Sexual violence and the wellbeing of women refugees

100% of Women reported to have experienced or they knew someone who had experienced Sexual harassment (talks/comments etc.), sexual exploitation (forced into sexual relationship in exchange of form of support) and rape as forms of sexual violence. Majority of women (M=4.14; SD=1.11) reported to have undergone sexual harassment (talks/comments etc.), and many of the survivors reported to police. Many respondents (M=4.27; SD=1.185) say husbands or their intimate partners were perpetrators of sexual violence, and also (M=4.11; SD=1.079) reported relatives. Majority (M=4.19; SD=1.251) of women do not support sexual violence while few (M=1.87; SD=1.354) say perceive it as cultural norm.

Most women reported to have had unwanted pregnancies as a result of sexual violence (M=4.12; SD=1.123), low self-esteem (M=4.11; SD=0.887) and sexual transmitted infections (M=4.07; SD=1.008). They also reported breaking of their families/family instability; they have had withdrawal symptoms as a result of sexual violence, gynecological complications, HIV infections, rejection and stigmatization by communities or family members, poor nutrition status and mental instability.

5.2.2 Female Genital Mutilation (FGM) and the wellbeing of women refugees

Most (M=4.27; SD=1.299) respondents reported to have undergone FGM or knew someone who underwent FGM, and Excision was the most popular type of FGM. It was reported to be popular (M=3.31; SD=1.234) among Ethiopian community in the camp, followed by Somalis (M=2.87; SD=1.005), South Sudanese (M=2.65; SD=0.995) and least popular among the Burundians,

Congolese and Ugandans (M=2.03; SD=0.883). Majority of women (M=4.02; SD=0.997) reported to have had low self-esteem as a result of FGM, while others (M=2.91; SD=0.865) developed mental instability. Most women (M=4.31; SD=1.231) perceived FGM as a cultural norm while others (M=4.05; SD=1.087) do not support it. All women (100%) argued that Female Genital Mutilation had no benefits to them.

5.2.3 Age at marriage and the wellbeing of women refugees

Most women (M=4.88; SD=0.15658) reported the ideal age for marriage as 18 years, a few (M=2.21; SD=1.1258) said 15 years while others (M=2.42) do not know. Majority of women (M=4.52; SD=0.1154) got married or at least know somebody in the camp who got married below the age of 18 years, and many of them (M=3.88; SD=0.997) reported that their marriage was voluntary. They also reported that getting married at that age then, affected them for example, unwanted pregnancies, caused them low self-esteem and some reported to have contracted Sexual Transmitted Diseases and Infections. According to respondents, Ethiopian community has highest number (M=3.31; SD=1.234) of girls below 18 years who are married, followed by Somalis (M=2.87; SD=1.005). Most women (M=4.07; SD=0.8254) reported that their parents received either money/material support or form of favor in exchange of their marriage and majority (M=4.31; SD=1.231) perceive marriage before the age of 18 years to be their cultural norm while some (M=4.05; SD=1.097) do not support it. 100% of women argued that marriage before the age of 18 years had no benefits to them.

5.2.4 Use of family planning methods and the wellbeing of women refugees

Majority of women (M=4.22; SD=1.443) agreed to be using or ever used methods of family planning. Women reported that the most popular family planning method used in the camp is condom use. Other methods that women reported to have either used or are using were; Injections, pills, Inter Uterine Devices (IUDs) and implants. Majority of women chose condom use over the others because they said it is the only available method at the health facilities in the camp.

5.3 Discussions

5.3.1 Sexual violence and the wellbeing of women refugees

According to the Kenya's 2008/09 Demographic and Health Survey indicated that at least 45% of women in their reproductive age had experienced sexual violence, with their husbands or intimate partners being the most perpetrators. This situation also applies to the women in Ifo 1 camp where it was reported that sexual harassment was the most common form of sexual violence in the camp with perpetrators being mostly, intimate partners or husbands. The board of protection 2011 indicates that around the world, majority of women have been beaten, exploited sexually or otherwise abused in her lifetime. In Ifo 1 camp, 100% of respondents reported to have experienced or knew someone who had experienced sexual violence. The World Report on Violence and Health demonstrates both the physical, mental and psychological influence that sexual violence has on survivors. As well as causing physical injury, it is associated with an increased risk of a range of sexual and reproductive health problems, with both immediate and long-term consequences. According to this research, it was evident that in most cases of sexual violence led to unwanted pregnancies, low self-esteem, sexual transmitted infections and breaking of families/family instability.

5.3.2 Female Genital Mutilation and the wellbeing of women refugees

WHO estimates that excision as the second type of FGM is the most prevalent of all types and it counts to 80% of all FGM cases. A similar case was also reported by women in Ifo 1 camp. Further researches revealed that 70% of women and girls feel justice systems and exercising rights on FGM issues are prejudiced towards men and hence not exercised by women, hence violated. On the other hand, most women in Ifo 1 camp perceive FGM as a cultural norm which in a way don't allow them to report incidences of FGM or to seek justice. This again contradicts the justice systems hence women rights are sometimes violated by women themselves. The UNHCR community services report asserts that in relation to rights awareness and FGM, 30% knew about women and girls rights and 50 % of the respondents indicated that tradition and lack of knowledge on FGM among women and girls rights is leading to high rate of women and girls rights violation in relation to FGM, since it was established that mostly the decision for a young girl to undergo FGM is done by parents and mostly the husband makes the decision and the wife

consents to it and the young girl obeys it without any objection. Majority of women in the camp think FGM is culturally accepted and that is why they also embrace it.

5.3.3 Age at marriage and the wellbeing of women refugees

The UNFPA report: Marrying too Young, asserts that girls from remote areas who have not gone to school are more likely to get married before attaining age of 18 years than their peers in the urban areas who have gone to school. Magoke-Mhoja (2006) and Katapa (1994) demonstrate that marrying before the age of 18 years is a way of undermining human rights and that has adverse influence on the survivors. The report also indicates that most of these marriages are arranged without the knowledge of the said bride. According to this study, most women who got married below the age of 18 years reported that it was voluntary and also parents received gifts/favor or support in exchange. Cultural beliefs may have influenced the womens' decissions to opt to get married and also poverty that compelled parents to give out their daughters in exchange of some form of favors or material assistance. It is also suggested that there is no universal age of marriage because societies have different understanding of being a child, on the other hand when women in Ifo 1 camp were asked to state the age they thought was ideal for marriage, they gave different ages although majority percieved 18 years to be the ideal age for marriage.

5.3.4 Use of family Planning methods and the wellbeing of women refugees

Women reported to be using condoms and injections mostly as a method of family planning and said because it was the only one available at the health facilities in the camp, however, there is possibility that other methods are available, for example pills. It is known that Muslim religion and Somali culture does not encourage use of modern methods of family planning. This could have been the reason that caused women to prefer condoms or injections over pills since it is not easy to discover or tell whether one has been injected, this way, they can easily hide from neighbours or their spouses/partners for fear of rejection or condemnation, as they will be seen as delinking themselves with culture and religious requirements. Recent studies supported by the United States Agency for International Development (USAID) have suggested that longer spacing between births has more advantages, while reports by the World Health Organization (WHO) and other international organizations suggest waiting at least for two years between

pregnancies in order to lower child death rates, and also has health benefits to the mother. Most women in the camp also agreed that use of family planning is indeed a good thing

5.4 Conclusions

From the study findings discussed above, the following conclusions were made, most women in the camp have attained at least primary school education level, are unemployed/house wives or are house hold representatives regardless of whether they are married or not. Cultural practices; Sexual violence, Female Genital Mutilation, Age at marriage and use of family planning methods were found to influence the wellbeing of women refugee in Ifo 1 camp in Dadaab.

Cultural beliefs and misconceptions play a key role in continued existence of FGM and women getting married before the age of 18 years, thus exposing women to risk of unwanted/unplanned pregnancies, STI and other infections and also resulted in withdrawal behaviour by survivors, low self-esteem, gynecological complications and family breakages or family instability. This explains why majority of women prefer to report to police or agencies when such incidences occur instead of community leaders, when seeking justice. However, majority of women do not perceive sexual violence as a cultural norm, and also do not support it, but majority of the sexual violence perpetrators in the camp are intimate partners or husbands. FGM is highly practiced in the camp and the most common form is excision, which is partial or total removal of the clitoris and the labia minora.

As seen in the findings above, most women got married before attaining the age of 18 years and this was by their own choice, most parents also receive gifts/support or any form of favor in exchange of their daughters. This could be attributed to the high level of unemployment of women in the camp. The choice of family planning methods used among women refugees could be influenced by the availability of the method itself, since most of them are confined within the camp. This is evident when majority of women said they use injections as a method of family planning because it is what is mostly available at the health facilities in the camp.

5.5 Recommendations for policy action

The following recommendations were made based on the findings discussed in this study. First, their needs to be awareness creation and advocacy for more women and girls to pursue education beyond primary level and also to have those that have never attended school, get enrolled in

school. Agencies in the camps should also create employment opportunities to be able to accommodate the women and girls who have gone to school and also have relevant experience Secondly, women and girls to be made known of the livelihood projects available in the camp and be encouraged to participate by adjusting the terms and requirements to be able to accommodate even the most vulnerable women in the camp. Thirdly, there should be sharing of family burdens or responsibilities by both men and women. When women are left alone with the burden of family responsibilities they become vulnerable and especially if they do not any source of income, they are more vulnerable and prone to GBV.

Last but not least, sensitization on harmful cultural practices and their effects is necessary for change of mindset by communities, though it is a process but in the event, behavioral change may occur. A rights-based approach is recommended for women and girls to be aware of what they ought to do to achieve their human rights, the responsibility of agencies to ensure women refugee and girls achieve their human rights and what the government of Kenya, as the host country ought to do ensure women refugees are protected. Self-awareness by women refugees will ensure empowerment to be able to protect themselves, their families and communities at large. Lastly, more psychosocial support services will ensure effective response to sexual violence, FGM, girls who are married before attaining the age of 18 years and use of family planning to reduce its impacts and help survivors cope with the rampant effects of withdrawal behaviour, low self-esteem, family breakages or family instability and enable them restore their lives.

5.5.1 Suggestions for further studies

It would be important to replicate this study with a much larger sample size. There should also be studies on intimate partner violence in Ifo 1 camp, as it stood out that they were the most perpetrators of sexual violence in the camp, and also a research on how to engage men and boys in prevention of GBV is recommended, since generally they are the most perpetrators of violence.

5.6 Contribution to the body of knowledge

This study provides knowledge on the influence of cultural practices on the wellbeing of women refugees in regards to sexual violence, FGM, ate at marriage and use of family planning

methods. It also shows the trends, nature and perception of women refugees on sexual violence, FGM, at marriage and use of family planning methods.

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APPENDICES:
APPENDIX 1: Letter of Transmittal

Sarah Khamala Kitui,

P.O Box 26524, 00100

Nairobi.

Dear respondent,

RE: RESEARCH STUDY ON INFLUENCE OF CULTURAL PRACTICES ON THE WELLBEING OF WOMEN REFUGEES IN IFO 1 CAMP DADAAB KENYA.

I am Sarah Khamala Kitui, a Student at the University of Nairobi, College of Education and External Studies, School of Continuing and Distance Education, Department of Extra – Mural Studies pursuing a Master's of Arts Degree course in Project Planning and Management.

This is a Research Questionnaire on the Influence of Cultural practices on the wellbeing of women refugees in Ifo 1 camp, Dadaab Kenya.

All information given will be treated with confidentiality and shall not be traced to the person of the respondent. Do not write your name on the questionnaire. Please answer all questions to the best of your knowledge.

Thank you for your cooperation in the study.

Sig…………………………. Date………………………………..

APPENDIX 2: Consent Letter

This form should be read and explained to the respondent or guardian in a language that she best understands.

I, ____, agree to participate in this interview by providing relevant information as explained below:

a) I understand that information needed is in pursuit of a research study and I don't expect any assistance as it regards to this thereafter.

   I understand that by providing information, I don't expect anything/favor or payments in return.

   I understand that shared information will be treated with confidentiality and respect, and shared only as needed to provide knowledge.

   I understand that at any point, I have the right to change my mind about sharing information with the interviewer.

b) I have been informed and understand that any information shared will not be specific to me or the incident. There will be no way for someone to identify me based on the information that is shared. I understand that shared information will be treated with confidentiality and respect.

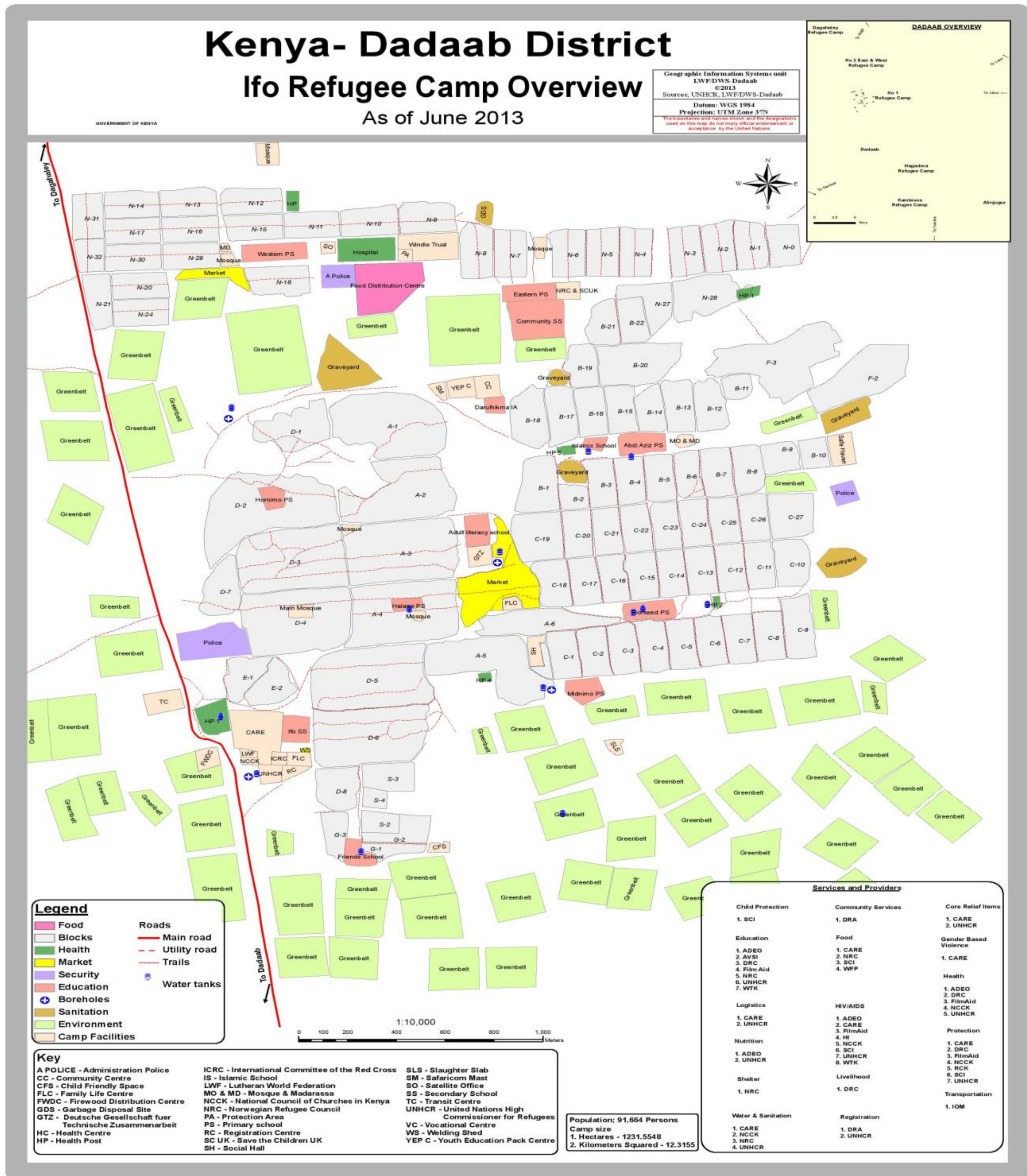
Authorization by respondent

By guardian if respondent is below 18 years

_______________________________________ ____________________

Signature/Thumbprint of client **Date**

APPENDIX 3: Ifo 1 map



APPENDIX 4: Questionnaire

Questionnaire ID No. ----- Start time ------------ Name of interviewer -------------------------------
---------date of interview ---------------------venue---------------

A. Demographic characteristics

I am doing a study on influence of cultural practices on the wellbeing of women refugees in Ifo 1 camp. I appreciate you for taking your time to help us complete the following questions. Your response is voluntary and will be confidential, which means that we will speak in private and that I will not write your name on the questionnaire. Therefore whatever information you share with me today will not have your name on it, and you can choose not to respond to certain questions or discontinue participation at any time.

I would like to start by asking you some general questions about your background and daily life. Are you ready to begin?

No.	Questions and filters	Coding categories	Skip to
Q101	How old are you now?	Age in years ------------ Don't know 0 No response 3	
Q102	Which nationality are you? (Circle one)	Somali 4 Ethiopian 5 South Sudanese 6 Other (specify)---------------------- 7 No response 3	
Q103	Have you ever attended formal school?	Yes 1 No 2	Q 105
Q104	What is your highest level of education?	Primary 8 Secondary 9 Technical 10 University Other (specify)---------------------7 No response 3	
Q105	What is your family size		
Q106	Are you the family representative?	Yes 1 No 2	
Q107	What is your section/block?	------/------	
Q109	Marital status?	Not married 12 Married 13 Divorced 14 Widowed 15 0ther (specify)---------------------7 No response 3	
Q110	Occupation? (circle appropriately)	- - -	

A. Sexual Violence

I would like to ask you some questions about any act or attempt to obtain a sexual act by violence or coercion, unwanted sexual comments or advances, acts that have been done to you by anybody, regardless of their relationship to you. This is a sensitive topic but Please remember that we will uphold confidentiality throughout the whole process.

No	**Questions and filters**	**Coding categories**
Q201	Have you/someone you know ever experienced sexual violence	Yes No
Q202	What form of sexual violence did you/they experience? (circle all that apply)	Sexual harassment (Talks/comments etc.) Sexual exploitation (Forced into sexual relationship in exchange of form of support) Rape (Actual penetration occurred) Other (specify)------------------ No response
Q203	Who was the perpetrator(s)? (circle all that apply)	Husband/intimate partner Relative Friend/ someone known Stranger Other (specify)--------------------- No response
Q204	Where did you report the incident?	Police Hospital Agency Community leader Other (specify)--------
Q205	Was there anything that came up after you sought support at the above named places?	Unwanted pregnancy STI/other infections HIV Rejection by community/family Low self-esteem Break of family/instability Poor nutrition status Mental instability Withdrawal symptoms

		Gynecological complications (specify)----------------- Other(specify)------------------- No response
Q206	To whom? (circle all that apply)	Community leader Relative Friend Other (specify)----------------- No response
Q207	How do you perceive sexual violence?	Have no problem with it Its culturally accepted Don't support it Other (specify)------------------------ No response

C. Female Genital Mutilation (FGM)

These are questions comprising of all procedures involving partial or total removal of the female external genitalia or other injury to the female genital organs for non-medical reasons. These is a sensitive area again but please remember that we will keep all response confidential.

No	Questions and filters	Coding categories
Q301	Have you or someone you know ever undergone FGM?	Yes No No response
Q302	Who are practicing (nationality) it in the camp? (Circle appropriately)	Somalis Ethiopians South Sudanese Other (specify)----------
Q303	Which form of FGM did you/ they undergo? (circle appropriately)	Clitoridectomy (partial/total removal of the clitoris) Excision (Partial/total removal of the clitoris and the labia minora) Infibulation (Narrowing of the vaginal opening

		through the creation of a covering seal) Other (All other harmful procedures to the female genitalia)
Q304	How has FGM affected your/their life?	Missed school Difficult in walking, playing, sitting Low self-esteem Mental instability Withdrawal symptoms Gynecological complications (specify) Other (specify)-----------------------
Q305	How do you perceive FGM?	Have problem with it Its culturally accepted Don't support it Other (specify)------------------------
Q306	Do you think FGM has any benefits to those who undergo it?	Yes 1 No 2

D. Marriage Timing

I would like to ask you questions again concerning the age at which a woman in your community gets married or is supposed to get married. Remember that all the response given here is confidential.

No.	Questions and filters	Coding and categories
Q401	What is the ideal age that a woman should get married?	
Q402	Did you/do you know anyone who got married when they were below 18 yrs?	Yes No
Q403	Were you/they forced or it was voluntary?	Voluntary Forced Don't know No response

Q404	How has marriage at that age affected you/them? (circle all that apply)	Rejection by community/family Low self-esteem Break of family/instability Poor nutrition status Mental instability Withdrawal symptoms Gynecological complications Missed school Other (specify)--------------------
Q405	Do you think marriage for a girl before the age of 18 yrs has benefits?	Yes No
Q406	Which nationality in Ifo 1 has many girls married below the age of 18yrs in the camp?	Somalis Ethiopians South Sudanese Other (specify)---------------
Q407	Did your parents receive anything in form of cash/material/favor in exchange for your/their marriage?	Yes No
Q408	What is your view about women getting married before age of 18yrs?	Have problem with it Its culturally accepted Don’t support it Other (specify)-------------------

E. Use of family planning

Thank you for your patience. This is the last part! The last questions would be about methods used for birth control like implants, pills, injections or inter uterus devises (IUDs) to be able to control ones fertility. This does not include the natural methods. Again, all information given here is private and confidential.

No.	Questions and filters	Coding and categories
Q501	Are you using/have you ever used any family planning methods	Yes No

Q502	Which one? (circle all that apply)	Implants Pills Injections IUDs Other (specify)-------------------
Q503	How did you identify the method?	It's convenient It's the only one available Less/no side effects Other (specify)------------------ Don't know
Q504	Do you think use of family planning is a good thing?	Yes No
Q505	How do women who don't plan their families are get affected?	Unwanted pregnancy Low self-esteem Break of family/instability Poor nutrition status Gynecological complications (specify) Other (specify)---------------------

APPENDIX 5: Permit

NATIONAL COMMISSION FOR SCIENCE, TECHNOLOGY AND INNOVATION

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NAIROBI-KENYA

Ref: No. **NACOSTI/P/16/85128/14010**

Date: **24th October, 2016**

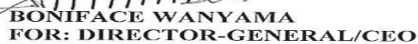
Sarah Khamala Kitui
University of Nairobi
P.O. Box 30197-00100
NAIROBI.

RE: RESEARCH AUTHORIZATION

Following your application for authority to carry out research on ***"Influence of cultural practices on the well being of women refugees in IFO 1 camp Dadaab, Kenya,"*** I am pleased to inform you that you have been authorized to undertake research in **Garissa County** for the period ending **24th October, 2017.**

You are advised to report to **the County Commissioner and the County Director of Education, Garissa County** before embarking on the research project.

On completion of the research, you are expected to submit **two hard copies and one soft copy in pdf** of the research report/thesis to our office.



BONIFACE WANYAMA
FOR: DIRECTOR-GENERAL/CEO

Copy to:

The County Commissioner
Garissa County.

The County Director of Education
Garissa County.

National Commission for Science, Technology and Innovation is ISO 9001:2008 Certified