



Constrained Agency: Perceptions, Attitudes and Experiences of Somali Refugee Women on Family Planning

A Research Paper presented by:

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Kenya

in partial fulfillment of the requirements for obtaining the degree of
MASTERS OF ARTS IN DEVELOPMENT STUDIES

Specialization:

Population Poverty and Social Development
(PPSD)

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The Hague, The Netherlands
December 2012

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Declaration

I declare that, this is my original own work submitted for MA degree in Development Studies at International Institute of Social Studies of Erasmus University. It has not been submitted for any other degree to another institution for examination.

Dedication

I dedicate this work to all Refugee women and to MaBelle, who will always have a special place in my heart

Acknowledgements

The writing of this thesis would not have been possible without the support and help of many people, whom I am truly indebted to in one way or another. Though, I would have loved to mention everyone by name, but that may not be possible in these pages provided here.

In a special way, I give thanks to my parents; Peter Kiura Gatune and Rose Muthoni Kiura for believing in me and taking me to school. Without their love, support and constant prayers, I would not have reached this far. I am also grateful to my brothers and sisters, especially, Purity Kiura and Patrick Nyaga, for taking care of my daughter MaBelle while I was away. My heart felt gratitude also go to my close confidante and *Baba* MaBelle- Collins Nyadida, for providing the much needed moral and intellectual support throughout this journey. It is hard to forget the role he played in guiding my research orientation toward interpretivists predisposition. May Almighty God continue to protect and bless you all.

I am truly grateful also to my workmates and friends in Kakuma refugee camp like Jeremiah Orina, Abraham Mutheki, Yonah Abok, Raphael Nyambala (NCKK), Lucy Ng'ang'a (NCKK) Abdi, Kiza and Habibo for their support, encouragement and invaluable assistance they provided during the period of my fieldwork, especially for the logistical help I was accorded in accessing Kakuma Refugee Camp, and locating research participants. But more importantly, this study would not have been possible at all, without the refugee community who contributed to it, in a special way, as research participants- many thanks to them all, for selflessly dedicating time and providing me with valuable information which informed the gist of this study. May Almighty God protect and bless you all.

But more importantly, I wish to recognize and appreciate the generous intellectual support I received from my supervisor Drs. Loes Keyzers and Second reader Dr. Wendy Harcourt, who went beyond professional duty to provide unlimited time and necessary guidance in helping me reshape and think beyond the familiar terrains of writing and theorization. I will also forever remain grateful for the small PPSD family-many thanks to Dr, Mahmood for challenging us to think and conceptualize our RP topics in time, without forgetting the warmth of people like Azwar, Saikat, Bash and Joan, who kept life glowing even in the most difficult of circumstances. May God protect and bless you all.

Special mention and thanks to Windle Trust Kenya, who provided me with an opportunity and work environment where my desire and interest to pursue postgraduate studies were honed, but above all, my studies in The Netherlands would not have been possible without the financial support given to me by NFP.

Last but not least, I also acknowledged varied assistance offered to me by Dr. Marangu Njogu of Windle Trust Kenya, Prof. Charles Nzioka of University of Nairobi, and Prof Okumu Bigambo of Moi University-Eldoret. Above all, I thank Almighty God for his providence and having brought me this far.

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List of Acronyms

DRA	Department of Refugee Affairs
FGDs	Focus Group Discussion
FGM	Female Genital Mutilation
FP	Family Planning
HIV/AIDs	Human Immunodeficiency Virus / Acquired Immuno- deficiency Syndrome
ICPD	International Conference on Population and Development
IRC	International Rescue Committee
IUD	Intrauterine Devices
KRC	Kakuma Refugee Camp
LWF	Lutheran World Federation
MAPS	Most At risk Populations
MDGS	Millennium Development Goals
NCCK	National Council of Churches in Kenya
NGOs	Non-Governmental Organizations
PRB	Population Research Bureau
STIs	Sexually Transmitted Infections
UNAIDs	United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
WFP	World Food Programme
WHO	World Health organisation
WRC	Women Refugee Commission

Abstract

Despite the recognized importance of Family Planning in reproductive health, efforts to maximise its' gains, experiences numerous setbacks, especially, in developing nations, where commitments and attention focused on HIV/AIDS pandemic may have significantly overshadowed it, to an extent that, it only occupies a peripheral compartment within discourses on reproductive health interventions. As a result, this study sets out to make a case for Family Planning by questioning the dynamics which influences contraceptive acceptance and use among Somali refugees with a view of providing empirical evidence, where current practices regarding family planning, health education and promotions may be reshaped and improved, and at the same time, make available a status data on sexual and reproductive health behaviors, which have been found to be visibly missing out on health surveillances among refugee community. In order to achieve this, two main research questions, on how the prevailing perceptions, attitudes and experiences of Somali refugee women influence and shape contraceptive use, and on how, women interacted with service providers and surrounding environment in ways which influences their contraceptive choices. These were interrogated through a qualitative case study with, 33 research participants in Kakuma refugee camp in Kenya. The resultant data were analyzed qualitatively, using five steps of thematic data analysis, which are transcription, open coding, axial coding, selective coding and writing of research report. Findings from the study demonstrated that, majority of Somali refugees rarely used contraceptives, while quite a number of women would wish to use contraceptives to plan their families, reasons such as cultural and religious practices, misinformation, illiteracy, and counterproductive approaches towards reproductive health in general, militated against such contraceptive acceptance. Hence, Somali refugee women emerged as having constrained agency when it came to decisions regarding family planning, as a result of such intersecting complexities.

Relevance to Development Studies

Family Planning has been recognised and applauded as a significant component in achieving millennium development goals. With three years remaining into 2015, MDG deadline, it could be important to make appraisal of possible gaps that may require re-intervention on current practices. One way in which this could be approached may be to question glaring limitations inherent in current intervention practices in reproductive health, hence the relevance of this research topic.

Keywords

Family planning, contraceptives, refugees, Somali women, intersectionality and agency.

Chapter 1

Introduction

Family planning (FP) practices, especially use of modern contraceptives, seem to remain a complex problem and challenging among most communities in the contemporary society, despite huge leaps of gains registered in some parts of the world, like the Latin America, (Frost and Dodoo.2009:45, Fahimi and Ashford 2005), since it was launched more than 50 years ago. The meaning of family planning as used in the context of this study, is adapted from World Health Organization (2012) assertion that, ‘Family planning allows individuals and couples to anticipate and attain their desired number of children and the spacing and timing of their births’, and which is recognized by such scholars like Paek et al. (2008), could be ‘achieved through the use of contraceptive methods, which is considered to represent (modern) family planning behaviours’.

In that regard, it may be argued that, FP may not only be a technical matter of deciding to use contraceptives or becoming a ‘family planning acceptor’ (as the jargon goes) but underneath it, seemingly, lie constructs as experiences, perceptions, attitudes, cultural and religious practices which conspires a web of intersecting power relations and categories that may affect behaviour of women as targeted group.

Harris and Smyth (2001:12) distilled this notion when they pointed out that, reproductive health, generally, cannot be delinked from ‘conditions of poverty and insecurity in which many women and men in developing countries live’ in, and such circumstances, intuitively may be considered worse among vulnerable groups of persons like refugees or displaced persons.

This study focuses on refugees, and by definition, and in the manner in which the term has been operationalized in context of this paper, is adapted from Article 1 of the 1951 UN Refugee Convention, which describes *refugees* as ‘persons who lives outside their country of nationality or habitual residence, have a well-founded fear of persecution because of their shared identity of race, religion, nationality, membership in a particular social group or political opinion, and are unable or unwilling to avail themselves for protection of that country, or return there, for fear of persecution’(UNHCR, 2002, cited by Ellis et al. 2007).

As vulnerable persons, refugees lives in conditions of poverty and insecurity. In fact, once refugees find themselves in the host countries, it is recognized that, in amidst of these conditions, they face challenging tasks of reconstructing their ‘material lives and cultural identities’ which have been severely hampered with (Keyes 2000 cited by *Ibid*: 461). Consequently, this process of reconstruction and adjustment to new environments may be argued, to have its formative stages in *a refugee camp*, where refugees first find themselves when they flee from their countries of origin. In that regard, a refugee camp, seem to provide an amphitheatre where many issues related to refugees’ wellbeing are generally at play, hence, several questions regarding the process of reconstruction and adjustment may become noteworthy to interrogate through empirical studies, not only with a view of improving services in the immediate environ-

ment, but more urgently, to address such concerns as health, which are intertwined with poverty and insecurity.

This study has therefore, problematized reproductive health, with a particular focus on family planning among refugees of Somali origin, as one of the key issues related to refugees' health and wellbeing, which is worth exploring not only from a medical perspective, but also from a social scientist's perspective, which indeed, accentuates the notion and critiques of feminist health advocates, who submits that, reproductive health should not be merely addressed as a medical matter *per se*, (Harris and Symth 2001:12), but also warrant behavioural model's perspectives.

Throughout this study, and with the help of WHO's conceptualization of FP, the term has been operationalized to include practices, which may both be considered as traditional methods and those considered as modern methods (use of contraceptives) as understood largely by refugees. In that regard, *FP practices* is basically localized to refer to both traditional and modern methods, while *FP methods* refers only to modern contraceptives of birth control (which may both be artificial or permanent).

This study was conducted in Kakuma Refugee Camp (KRC) in Kenya. Kenya as a country plays host to more than half a million refugees of Somali origin. In Kakuma refugee camp alone, there are approximately 47.7% Somali refugees (**see Appendix 5 for statistical information**), making them the largest group of nationality of refugees currently being hosted by Kenya. However, the main concerns of this research were premised on the assumptions that, women refugees of Somali origin have unique reproductive health needs, and rarely use FP methods; hence, there emerged a social and even academic justification to explore the nuances that could be rooted in such behavioural practices.

But more importantly, as a vulnerable group, the situation surrounding refugee women of Somali origin may be considered quite intricate, in the sense that, majority of women have got no formal education, and religious and socio-cultural norms seem to underpin almost all spheres of their livelihood, in a manner that sound and informed decisions regarding their reproductive health needs are quite sticky to navigate, (Degni et al. 2008:191). Hence, it was theorized that women's agency is constrained to an extent that, the ability to make independent decisions regarding their desired number of children, spacing, timing of their births and even the ability to have equal bargaining powers in marriage set up are highly compromised.

The interest in family planning and reproductive health concerns of Somali refugee women can be seen in context of the more general and official policy interest in family planning, contraceptive prevalence rates, and unmet demands for contraceptives in the region. For instance, the needs for contraceptives remain higher in Sub-Saharan Africa generally, especially with heightened awareness campaigns which have so far characterised HIV/AIDs pandemic, since it became a national priority in health sectors of various governments and even NGOs in the developing nations. In retrospect, it may be naturally apparent, that this in turn has created a huge contraceptive demand. In fact, it has been noted, that, a large number of women do not want to carry more pregnancies, however, they do not use contraception to prevent conception as have been observed by such scholars as Bongaart and Sinding

(2009: 39). Citing Singh et al. (2003), Bongaart and Sinding have indicated that this number of women could be estimated at 137 million. Similarly, the unmet need for contraceptives may also be attributed to a huge number of young populations who have so far entered their reproductive age, since, past projections, in Sub-Saharan Africa population, indicated that, 43% of the total population was younger than 15 in 2005, meaning that, there may be about 43% additional needs on contraceptives currently, than what was there, five or six years before. Indeed, this could further be evidenced by the fact that, from '2000 to 2015, the number of contraceptive users in less developed countries may rise by more than 200 million women, an increase driven by rising demand and population growth' (PRB 2004), -making the subject of FP use a concern which need to be redressed.

Another reason for this widening gap of contraceptive needs could also be argued to have emerged from government's spending and general lack of commitment from the international donor community with regard to funding towards family planning programs, which has largely changed and shifted to HIV/AIDS related programs, leaving family planning, a less prioritised area in reproductive health, generally. This is evidenced by Bongaart (2008), cited by Bongaart and Sinding (2009: 43), that, between 1995 and 2008, donor funding for family planning programs reduced by 30% while that committed to HIV/AIDS programs rose by a whopping 300%, despite the recognized centrality which FP practices, could play, especially, even in the preventions of HIV/AIDS, if it is effectively implemented and consistently adhered to.

In that regard, this study may be viewed therefore, as an attempt to restore family planning debate onto the international agenda, by unpacking some of the nuances which surrounds prevailing perceptions, attitudes, and experiences of Somali refugee women, as one area which could significantly illuminate existing gaps regarding use or non- use of modern contraceptives in particular. It does this by drawing from current debates surrounding family planning practices generally, and principally from a primary data generated during a field study conducted with 33 research participants, between, 26th July- 18th August, 2012, in Kakuma refugee camp in Kenya.

1.1 Framing the research issue

As have been implied above, refugee women's empowerment is hindered by a wide variety of factors, which include illiteracy, poverty, economic dependency and limited participation in decision-making processes. Among the Somali women for instance, cultural practices like female genital mutilation (FGM), marrying women at an early age and polygamy as enshrined in Islamic jurisprudence, are just some obstacles which have wider implications on reproductive health and long term livelihood options, among others. Hence, the power relations between woman and men of Somali refugees struck as highly subdued.

It could be represented symbolically through the notion advanced by Greenstreet and Banibensu in Harcourt (1997:69) who have succinctly reiterated that, 'there is a common view that a woman should quietly submit to her husband anytime he demands sexual relations and nothing women can do to stop men from their sexual urge since they will always get it even if the women refuse'. Indeed, nowhere is such a conjecture, more apparent than, the settings of

a refugee camp, where the woman person finds herself faced with many obstacles in their attempt to reconstructs their vulnerabilities.

In fact, given that Somali remains a war torn country and conditions of flights are far from over, while repatriation on the other hand is unfeasible option, it complicates matters further for refugees. But more crucially, these conditions have led to a fragmented family structure, where women and children find themselves in precarious conditions within a refugee camp. As a result, cases where women survive without their husbands, or where children operates households as unaccompanied minors or sole bread winners are quite a common scene. While both women and children emerge as the most affected cadre of refugee population, but women are in more vulnerable conditions compared to men, because the society has raised expectation on them in carrying both reproductive and productive roles, within households and even in the community at large, which is not an easy task, as noted by Greenstreet and Banibensu in Harcourt (1997: 59), who have pointed out that, ‘the high number of children results in high dependency ratio, which has serious implication on women. Women are expected to devote their time and energy to maintaining the dependent population by carrying the burden of housekeeping, childcare and general nurture and upkeep of the family and community’. However, at another level, it emerged that, discourses of masculinity generated by such constructs as societal norms still reigns supreme and complicates these vulnerabilities even further, despite efforts that have been generated by feminist thoughts in providing paradigms for interventions, which recognizes the centrality of women’s empowerment. But the findings of this study reveals a lot of questions and gaps, which require urgent redress within current frameworks of interventions, especially with regard to discourses on FP practices.

Although, such disjuncture have been recognized in the past, but there is still a widely accepted consensus that there are gaps requiring attention, given that, past family planning programs in Africa were unsuccessful in the continent because men were largely excluded from family planning programs, (Adamchak and Mbizvo 1991a:31, Adamchak and Mbizvo 1991b: 325 Oni and McCarthy 1991, Ngom 1997:50). Frost and Dadoo (2009) for instance, have reiterated that, inclusion of men may be important in fertility programs. While Kirmani and Philips, (2011:88) on the other hand, believes that, these early initiatives for instance, ignored and considered such aspect as religion and culture more as barriers, without critically engaging them in a proactive way to foster strategies and explore avenues which could enhance family planning use. The same notion has also been underscored by Benefo and Pillai(2005) who have reiterated that previous studies on FP focused solely on women and ignored men.

As a matter of fact, a recent baseline study, conducted in Kenya in August, 2011, by Women’s Refugee Commission (WRC), in conjunction with, United Nations High Commissioner for Refugees (UNHCR), revealed that religious prohibition and husband opposition were among the most significant barriers to use of family planning among refugee women of Somali origin studied. It further illustrated that, majority of those studied reported knowledge of at least one method of modern contraception; however, there was very little correlation between knowledge and usage of modern contraceptives. Moreover, other barriers cited in the study included, negative attitudes towards the use of contraceptives, stigma among those who were using contraceptives and misinformation about family planning methods, in general. Nevertheless, what remains largely

unclear, as pointed out from the foregoing reviews of such studies and literatures, are what exactly are these attitudes, stigmas and perceptions and how do they affect contraceptive usage among Somali refugees in particular. In essence, what precisely is embodied in men's views concerning the wider question of contraceptive use or how do religion affects contraceptive decisions? Or further still, what nuances underlies the interplay of such factors as revealed through personal stories of individual research participants?

In that respect, available literatures seemed to interrogate, the wider question of family planning use through quantitative approaches which measures variables, thereby leaving very little analytical attention for participant's voices which may be significant in extrapolating how social reality surrounding the phenomenon under study could be constructed. In addition, the foregoing review of studies on sexual and reproductive health data on refugees, indicate that, quite often, such data are visibly missing in national surveillances, which rarely factor in refugee population in general, making this kind of study very significant in bridging that gap.

But more importantly, scholars like Yee and Simon, (2011: 1387), have made it very clear that 'understanding reasons for contraceptive non-use and facilitating women's knowledge and use of family planning methods is critical to improving comprehensive women's health care'. Sentiments which have also been underscored by Green and Kreuter (2005) cited by Obure et al. (2009:666) who believes that, 'the prerequisite to any public health promotion process is collecting data and learning about community perceptions of factors that may facilitate or inhibit adoption of the new intervention'. In fact, Glanz et al. (2008:14) recommends that, 'for health education to be effective, it should be designed with understanding of recipients' health and social characteristics, beliefs, attitudes, values, skills and past behaviour'. Hence the findings generated from this study may represent a significant component in improving reproductive healthcare in general

Therefore, one way of approaching the problem may be to explore, how perceptions, attitudes and experiences among refugees of Somali origin influence their family planning practices by examining psychological nuances which may be behind such reconstruction and how it could constrain, but possibly also enhance women's agency, as this study has attempted.

1.2 Research Objectives and Questions

Generally, this study aims to make a contribution to extant literatures on family planning and women's empowerment as a development concept, by questioning the dynamics which influences family planning use. On that basis, it also attempted to provide an empirical basis for interventions within refugee set up, where current practices regarding family planning and health education and promotions may be reshaped and improved, while at the same time, make available a status data on sexual and reproductive health behaviors among refugees, which has been found to be visibly missing out on surveillance health data from the host country. Therefore in order to achieve these objectives, two research questions related to this topic were posed and interrogated. They are;

1. How do the prevailing perceptions, attitudes and experiences of Somali refugees' women influence and shape FP use?
2. How do women interact with FP service providers and how does the surrounding environment influence their choices?

1.3 Scope of the study

Scope is explained at three levels respectively; content, geographical and methodological scopes. In terms of **Content Scope**, this study focused on Somali refugee women and primarily on finding out perceptions, attitudes and experiences of Somali refugees in adoption of family planning with respect to interrogating the society's dynamics which influence family planning use or non-use in general. In that regard, it delved into investigating how Somali women refugees interact with service providers in seeking family planning services, and how the prevailing/ surrounding conditions in the environment, influence FP choices with broader aim of understanding that such findings, could provide an empirical basis for interventions in the wider question of reproductive health.

At the level of **Geographical scope**, the study was limited and bounded to Kakuma refugee camp, which is in Rift Valley Kenya (See Chapter 3 for detailed clarification of the research site and Appendix 3 for location map).

At the level of **Methodological scope**, the study employed *qualitative case study approach* and exploited interpretivist paradigm to get in-depth information through triangulating various sources of data which could illuminate the research problem. This has been explained in detail in chapter 3, which deals with Research Methodology.

1.4 Limitations of the study

There was limited time available for the study to allow for involvement of as many participants as would have been preferable, however, in-depth interviews were employed to gain a deeper understanding with diverse groups, representing nearly all cadres among Somali ethnic groups and these included, unmarried youths, married couples, religious leaders, and service providers, hence the findings are adequately comprehensive and could thus be argued to be representative of the Somali community.

Secondly, in my view, this kind of study would have been more perfect if it was conducted as a kind of ethnographic research method, where the researcher could spend a considerable amount of time living among the refugee community to practically shadow various FP awareness campaigns to gather as much information as possible, regarding possible intricacies which may be inherent with the research problem. However, engaging with key informants from the community seemed to overcome this limitation, given that they were amply knowledgeable on many issues with regard to the status of reproductive health and how (they) refugees interacted with FP issues within the camp.

Thirdly, given that this is a case study, statistical generalization may not be feasible to other groups of Somali women beyond this particular case, how-

ever, the findings are opened to analytical generalization with group of respondents, with similar characteristics as those sampled here in this study.

Ultimately, this study was conducted during the holy month of *Ramadan* when Muslims were fasting. Since almost all Somali refugees in the camp are Muslims, getting hold of research participants was a bit problematic, and I had to adopt other flexible sampling strategies like snowballing which were initially not envisaged at the proposal planning stages. Furthermore Kakuma refugee camp as an arid environment exhibits extreme diurnal temperatures of about 40 degrees Celsius, which made it difficult to conduct interviews in the better part of the day due to extreme hotness. However, this limitation was overcome by booking and arranging for appointments to conduct interviews with research participants in the morning hours, when they were still energetic and active to dialogue, while service providers (mainly national staffs), were engaged during evening hours when temperatures had dropped to accommodate discussions.

1.5 Relevance and justification of the study

With respect to the views of Bongaarts and Sinding (2009: 39), which have reiterated that, 'Sharply rising energy and food prices have once again raised the specter of the human population outstripping the planet's natural resources'. We as development practitioners, may not avoid being drawn into the questions of fertility and population growth, which as the authors indicates, remain real problems meriting critical attention, especially with respect to Sub Saharan Africa context. However, the question of family planning has been regarded as a delicate issue *per se*, with varied interpretations emanating in questioning its' rationale in human development, but, at the very least, it may not be possible to separate it from conditions of poverty and insecurity as have been argued by Harris and Smyth, (2001:12). Hence, debates similar to those submitted by Bongaarts and Sinding (2009), would always remain relevant as long as there are gaps existing in development practice, with regard to glaring limitations on development issues, which are largely underpinned by rapid population growth as variable. In fact, their argument is centered on foregrounding family planning programs on the international agenda, by responding particularly, to pessimists' critics who seem to perceive family planning as insignificant policy intervention toward rapid population growth in general.

Moreover, access to contraceptives worldwide has been recognized as a reproductive right for all, both woman and men, irrespective of their status in the society, making any perceived limitation on this particular subject, a human right violation. One of the agreements in the ICPD Programme of Action (1994), was the 'rights of men and women to be informed and have access to safe, effective, affordable and acceptable methods of family planning of their choice as well as other methods of their choice for regulation of fertility which are not against the law, and right of access of appropriate health care that will enable women to go safely through the pregnancy and child birth, and provide couple with the best chances of having a healthy infant' (Sen and Batliwala 2000:2).

Indeed, ICPD programme of Action was hailed as a major turning point towards women rights and empowerment, gender equity and development.

However, the contemporary realities as perceived by drawbacks cited in family planning acceptance, represents a huge contradiction with aspirations of a 1994 ICPD programme of Action. In her work on *Body Politics in Development*, Harcourt has discussed that Cairo Agenda was engulfed with contradictions and questioned, if it reached consensus, or if deliberations agreed were compromised along the way. It concerns her and others, like me, that what was deliberated and agreed are still far from being successful more than a decade later (Harcourt 2009:42).

Yet, population growth as have been argued out by Frost and Dadoo, (2009:46), is not necessarily bad for development, but 'the rapid upsurge of African populations clearly increases competition for limited resources that must be shared among more people'. In their view 'social infrastructures like schools, health systems, clean water suppliers, and waste management are severely strained by population growth', but more importantly, women suffers the greatest burden in the process, making questions of power relations, urgent matters to be redressed. It is therefore, reasonable to suggest that, the link between high fertility rates and rapid population growth brings women's reproductive health into question, and by extension, gender equality and women's empowerment at large. The Millennium Development Goal (MDG) summit, recognized how gender equality and women's empowerment could act as channels to meeting MDGs, (World Bank Development Report 2012:3, PRB, 2004). For instance, the report cited that, gender equality and women's empowerment could help promote universal primary education-MDG2, it could reduce under-five mortality-MDG4, it could also improve maternal health-MDG5, and finally reduce the likelihood of contracting HIV/AIDS-MDG6. Hence, there is no doubt that effective practice and implementation of the use of contraceptives have direct link in fulfilling MDG4, 5 and 6.

However, in retrospect, the choice of this research topic also draws from my personal motivation and engagement with refugees as a development worker in Kakuma refugee camp, where I came face to face with gruesome realities of poverty which faced Somali women and their households in general as they struggled to reconstruct their lives, yet underneath such struggles, a range of factors intersected in a way that the process of reconstruction remained largely, an elusive endeavor for many. This research is therefore an attempt to give a voice to their struggles and experiences with regard to the wider question of family planning use, by raising pertinent issues which may form subjects for further academic explorations.

1.6 Organization of the paper

This paper is divided into six major chapters. This first chapter has provided an introduction into the main concerns which the study problem is anchored; generally, it has given insights into current debates surrounding family planning, research problem, research objectives and questions, the scope and limitations of study, relevance and justification of the study, in the context of Somali refugees. While, the second Chapter is a literature review on some of the extant studies and literatures informing current debates and conceptual

framework used in this study. The third Chapter is the Research Methodology, focussing on how field work was conducted and rationale guiding various decisions undertaken in that regard. It is then followed by Presentation of the Study's findings as chapter four, and the discussion of the findings, as chapter five, and finally concludes with Chapter six, which contains personal reflections, concluding remarks, and suggestion for further research.

Chapter 2 Literature Review

2.1 Introduction

In this Chapter, I have provided a review on some of the extant literatures on the wider subject of family planning and how it relates to the topic of refugees studies, indicating the existing gap in knowledge, followed by insights and debates emanating from the broader topic of family planning with similar aim for justification. Finally, it integrates expository literature on the conceptual framework, with discussions centering on the concepts of intersectionality and agency.

2.2 Family planning among refugees

Literature reviews, indicates that, there is so much that has been written on family planning world-wide, yet literatures on the same, is very thin with regard to studies that have been conducted among refugees. Scholars like Ellis et al. (2007: 460) for instance, have mentioned such studies as (Carta et al. 2005, Kinzie, Sack, Angell, Manson, and Rath 1986, Porter and Haslam, 2005, Sack, Angell, Kinzie, & Rath, 1985) as examples of studies in the wider area of refugee studies. However, they also share similar assumptions about the limited studies available on refugees. In fact, they reiterate that, ‘although, there have been a number of studies, with refugees, particularly, since the mid-1980s’, but the field is still in its formative stages, as ‘a more mainstream topic of research’ as indicated by (Lustig, Kia-Keating et al. 2004, cited by Ellis et al. (2007)). The same thoughts also resonate with Vargas (1998: 35) who on the same line of argument, admits that, ‘the decade of the 1980s saw a significant increase in the refugee studies literature, *but* much remain to be done’ on that respect. Although, these commentaries illustrates trends about refugee issues in general, but the same notions, may also underscore the scenario with respect to the wider question of family planning as a subject on its own merit.

In fact, available studies on family planning with refugees may be said to be very scanty, and even those few which have attempted to foreground on the subject of FP, have concentrated on the lives of immigrants, and refugees living or resettled in the diaspora, disregarding, circumstances which could be observed in the parent or developing countries. Hence, there is very little data, to illuminate the subject of family planning among refugees in camp settings, in the manner which this study has attempted. Indeed, there is none that I know of which has treated this topic within its present scope as I have outlined in Chapter one above. Although, studies such as Kohan et al.(2011) and Degni et al.(2008) may be considered as examples relating to this subject, but, as have been reiterated, only represents findings emanating from the diaspora set ups. While, others like, (Birman 2005, Ellis et al. 2007, Hopkins 2007, Tilbury 2006) have explored the ethical dilemmas and methodological issues inherent in conducting research with immigrants and refugees, again, they have restricted their findings and focused on the realities of the diaspora set ups. Nevertheless, what may be commonly available in terms of literatures and studies on reproductive health and family planning among refugees, are in the form of baseline studies conducted in-house,

within humanitarian agencies, to determine status reports, without paying attention to the kind of rigor expected of an academic scholarship. However, this paper has benefitted from such reports and to a greater extent owes its factual and interpretative debt to findings emanating from such studies as (PRB 2004, WRC 2011), and those cited by Sonneveldt, Shaver, and Bhuyan(2008) which include(IAWG 2004, 1999, WRC 2003, 2006).

However, on the other hand, one notable study, which may be considered closer to this, is, Degni et al. (2008), in the sense that, it has also focused on the ‘attitude towards and perceptions about contraceptive use among married refugee women of Somali descent’. But, it differs from this study, from the fact that, it studied refugees living in Finland, and rather foregrounded its analytical attention and findings on views derived from religious beliefs regarding the use of condoms in particular and other contraceptive methods, through mixed method approach, as its’ research design, without interrogating the underlying nuances behind religious beliefs.

2.3 Debates on family planning

Generally and more importantly, this study has also benefitted from insights offered by such scholars as, Bongaarts and Sinding (2009), Frost and Dodoo (2009), World Development Report 2012 by Wong (2012), Yee and Simon (2011), Fahimi and Ashford (2005) on the broader aspect on family planning.

Bongaarts and Sinding (2009: 39) for instance, have invoked the demographic pressure on resources, which may be directly linked to rapidly growing population in developing countries. They have reiterated that, ‘sharply rising energy and food prices have once again raised the specter of the human population outstripping the planet’s natural resources’, making a justification to investigate nuances which may be associated with such concerns. Although, their argument is largely anchored on the urgency to re-establish family planning debates on the international agenda by deconstructing pessimists’ views, which regard family planning as unimportant issue, but equally subtle in their voices, is a concern to interrogate avenues, like family planning practices, through which such problems may be viewed to have originated from. The same sentiments are also echoed by Frost and Dodoo (2009:46), who have noted that, ‘the rapid upsurge of African populations clearly increases competition for limited resources that must be shared among more people’. Generally, they submit further, that, ‘social infrastructures like schools, health systems, clean water suppliers, and waste management’ may be severely strained by rapid and unplanned population growth.

Indeed, earlier attempts to address the population pressures was the Malthusian positive check approach proposed as the most appropriate check to lower the population by controlling fertility through sexual abstinence (Crook 1997: 81, Gould 2009: 50-51), but this have been proven overtime to be unfeasible. In fact, the Malthusian approach has been widely disapproved and criticized by such scholars like Boserup who believed that, ‘population growth can act in some

circumstances as a stimulus rather than an impediment to economic change' (Gould 2009: 63).

That notwithstanding, however, various development paradigms have also demonstrated a direct link between high fertility rates and rapid population growth, hence, reproductive health is an issue tied up with gender equality, and women's empowerment in general. Accordingly, the Millennium Development Goal (MDG) summit recognized how gender equality and women's empowerment could act as channels to meeting MDGs, (World Bank Development Report 2012:3, PRB 2004). The report noted that, gender equality and women's empowerment could help to promote universal primary education as enshrined in MDG2, it could reduce under-five mortality as expressed in -MDG4, it could also improve maternal health-MDG5, and finally reduce the likelihood of contracting HIV/AIDS-MDG6. Furthermore, WRC, 2012 have also reiterated the need and concerns to address sexual and reproductive health needs of displaced persons in crisis settings in order to achieve MDGs which target poor countries. In one of their studies, they pointed out that, a 'study of refugee women in Tanzania revealed that 39% of women who sought family planning services discontinued their visits due to their husbands' disapproval, making exploration into such nuances, a worthwhile undertaking. This may be quite intricate, in areas prone to crisis, where displaced persons are unaware of the benefits of family planning and, unable to access it, or know their reproductive rights, or cannot access it because supplies at their local clinics are inadequate. In fact, WRC, 2012 report highlighted that, 'Women and adolescent girls in refugee and internally displaced settings struggle with unwanted, unplanned and poorly spaced pregnancies; this is often due to lack of access to counselling, contraceptives and information' services. Therefore, inability to access FP services in that regard may be regarded as a threat to the wellbeing of families and refugees in general.

Hence, the centrality of family planning as a basis towards addressing issue of gender equality and women's empowerment in general and in relations to meeting the above mentioned Millennium Development Goals may not be overstated. Like Yee and Simon, (2011: 1387), 'understanding reasons for contraceptive non-use and facilitating women's knowledge and use of family planning methods is critical to improving comprehensive women's health care'. Since, 'it is estimated that 200 million women (and their spouses or partners) in developing countries would like to delay or avoid pregnancy but presently lack access to the necessary services and commodities' as viewed by (Fleischman and Moore 2009:2). In fact they emphasizes that, if FP was accessible by everyone, multiple achievements would be realized, because, lives would be saved by reducing infant mortality, maternal and child mortality, improved maternal, child and family health as well as reducing teenage pregnancies. Moreover, it could lower abortion cases which result to about 68,000 estimated maternal deaths and health complications, hence if the unmet need for contraception is recognized, about 52 million unintended pregnancies would be prevented. But more importantly, it promises, economic and environmental benefits in the society, if effectively implemented.

The connection between reproductive health and development were first recognized at the landmark International Conference on Population and Development held in Cairo in 1994. However, as noted by such scholars like, Harcourt, (2009:42), some of the resolutions passed during the Cairo conference

have not been sufficiently addressed to date. They include, (a) spelling out a comprehensive plan for empowering women and making family planning universally available as part of a package of reproductive health care, (b) calling for greater attention to men as partners in reproductive health. But as pointed out by Fahimi and Ashford (2005:1) for instance, ‘investing in reproductive health rarely ranks high on the list of national priorities’, making a case for the need for further reflection on this subject. A claim which has evidently been proven by the kind of laxity devoted into implementations of family planning programs in developing countries. Bongaart and Sinding (2009:43) revealed that, funds committed by donors and developing countries towards HIV and AIDS program increased by almost 300%, while those devoted for family planning programs decreased by 30%. These scenarios calls for restoring family planning debate onto the international agenda as captured succinctly by Cleland et al. (2006).

2.4 Conceptual framework

This study has used the concepts of intersectionality, and agency as frameworks for extrapolating findings emanating from this study. To begin with, the approach is anchored on a feminist analysis, which according to Harris and Symth, (2001:12) recognizes the fact that, ‘problems of reproductive health are related to gender- based power relations, which systematically disadvantage women and girls’. However, as embodied in the concept of intersectionality, the use of family planning methods is a practice hindered by wide ranging issues which intersect and constrains the agency of the women person, as it were, hence the idea of *constrained Agency* which depicts women’s inability to take control of their body, which emerges strongly from this study, is literary restricted, given the evidence from the findings about perception, attitudes and experiences of Somali refugee women on the subject of family planning. In that sense, as a researcher, I approached Family planning from a social constructivism predisposition, enquiring after social conventionalization, perception and knowledge construction in everyday life, (Flick, 2004 and Schwandt, 2007). More on this theoretical orientation has been explored in detail in chapter six.

2.4.1 Intersectionality

As mentioned above, this study adapts the concept of intersectionality as conceptualized by Davis (2008:69), who has defined it, as, ‘the interaction between gender, race, and other categories of difference in individual lives social practices, institution arrangements, and cultural ideologies and the outcomes of these interactions in terms of power’. In fact feminist scholars like Helma et al(2011:8) recommends that, ‘Intersectionality approach challenges us to look at the different social positioning of women (and men) and to reflect on the different ways in which they participate in the reproduction of these relations [and] as we do this, intersectionality serves as an instrument that helps us grasp the complex interplay between disadvantage and privilege, a requirement to which objections have sometimes been raised’

On that regard, it premises on the assumption that, the use of family planning methods among refugee women of Somali origin is intersected with multiple categories. Granted that, as Davis (2008) submits, intersectionality acknowledges differences among women, and thus my own intersectional location view

sub-Saharan African women as a broader category, and within it, there is a refugee whose experiences of exclusion and subordination may not be similar with other sub-Saharan women, and within this category of refugees, there is a Somali woman refugee, and further, there is a Somali bantu woman and a Somali- Somali women, whose experiences of vulnerability, for instance, and subordination may be radically different from one another.

Consequently, other intersecting factors which may influence FP use are viewed under this framework of Intersectionality. In this particular case study, the decision to make a choice on use of FP methods is dependent on authority from men and discourses nurtured from religious and cultural practices within the society. Scholars like (Pollert 1996, Verloo 2006 and Yuval-Davis 2006) cited by Winker and Degele (2011:55) assert that 'the structural level consists of identifying concrete relations of power and then analysing their interrelatedness and changes'. Hence, it is from such interplays that the concept of intersectionality appeals to extrapolate the findings mined from this study.

2.4.2 Agency

Agency on the other hand, has been basically defined by Kabeer (1999:438) as the 'ability to define one's goals and act towards it.' As a concept, it could provide analytical lens or framework under which the products of intersecting factors may be extrapolated in a manner in which they collude to influence women's decision in use family planning practices. Broadly, Kabeer (2005) cited by Kohan et al.(2011:3) admits that, 'empowerment is the development of abilities in individuals that enable them to make their basic life choices' hence agency may be viewed as a coefficient to the development of these abilities or acting towards a defined goal or objective(s). How the Somali refugee women themselves perceive and experience a sense of agency in relation to Family Planning, and how it is constrained or enhanced will be investigated, rather than assumed. Further reflections on these concepts have been presented in relation to the study's findings in chapter six of this paper.

Chapter 3 Research Methodology

3.1 Introduction

In this chapter, the approach and method used in the study is explained, the research site, and sampling strategies, and data generation techniques are also highlighted. The data analysis process is then stated next, and finally, the ways in which the issues of trustworthiness and ethical concerns were addressed generally.

3.2 Research design

This study was founded on the relativist/ interpretivist paradigm that largely operates on the premise that knowledge and the way it is studied is dynamic, contextual, and may be dependent on the perspectives of various participants, be they researchers, policy makers or other consumers of such knowledge (Denzin and Lincoln 2005, Creswell 2009). Most researchers and even development interventions have treated refugees as a homogenous group without being cognizant of intrinsic differences like culture, religion and background experiences, which in my view, are very significant in shaping the way Somali women may view their individual realities or constructs individual experiences. Moreover, this subject under study is of a social nature, and as a researcher I went into the field with an acknowledgement that, decisions guiding individuals on the choice of contraceptives use or non- use may vary, even decision guiding different families on their desired family size or the number of children they wish to have, vary from one family to the next and may be shaped by different reasons which can only be extrapolated from subjective understanding of individual research participants or families- hence the notion of social constructivism(Flick,2004 and Schwandt,2007). As a result, I adopted a qualitative case study method, which from a theoretical perspective places a strong emphasis on examining these subjective experiences of research participants, (Jwan and Ong'ondo 2011:30-34; Hammersley and Atkinson 2007: 8).

3.3 Research site, sampling methods and data generating techniques

3.3.1 *Research site*

This study was conducted in Kakuma refugee camp which is located in Northern part of Rift valley in Kenya and near, Kenyan – South Sudan border, between 26th July-18th August, 2012, (see Appendix 4 for location map). As at August 2012, there were 100, 748¹ refugees in Kakuma with the population of refugees of Somali origin being estimated at 48,024 (47.7%), although there are

¹ Source UNHCR camp population statistics August 2012

cases of continuous influx of refugees from Sudan and Somali from time to time, making definitive estimates a bit fuzzy at any given point. The camp host refugees from fourteen (14) nationalities which include Southern Sudan, Sudan, Rwanda, Congo, Uganda, Burundi and Somalia, while other minority representation are refugees from Iran, Congo Brazzaville, Cameroon, Tanzania and Zimbabwe. Kenya Government, Department for Refugee Affairs (DRA), manages the camp with UNHCR, who are assisted by other local and international based NGOs, who provides other humanitarian services to refugees and on a smaller scale, to the host Turkana² community. International Rescue Committee (IRC) and National Council of Churches in Kenya (NCCCK) sampled in this study are some of these NGOs, who are directly, concerned with providing health care services. The refugees rely mainly on food ration provided by World Food Programme (WFP), while others ventures into small scale trading within the camp to supplement their livelihood. Refugee lives in semi- permanent shelters which are constructed by NCCCK, while Lutheran World Federation (LWF) provides water from drilled bore holes which is pumped to various strategic locations within the camp. KRC is in Arid and Semi- Arid environment, with diurnal temperatures ranging between 30 to 40 degrees, making it difficult for arable farming. Movement is also restricted and passes are required for refugees who wished to travel out of Kakuma's environs to any other part of the country.

3.3.2 Sampling methods

A total of six (6) key research participants were purposively sampled in this study, and five (5) key informants who are the service providers were also purposively sampled. However, given that this study was conducted during the Holy month of *Ramadan*, I also relied on snowballing technique to get other participants, especially, for the 4 focused group discussions (FGDs), since majority of potential research participants could not be located easily, given the reason above. A total of twenty two (22), research participants participated in FGDs, which were conducted once. The profile of all research participants, their background information and date in which the interviews or FGDs were conducted is provided here as an **Appendix 2**.

I had targeted to purposively sample key informants from both NCCCK and IRC, which are the only two NGOs dealing with the issues of reproductive health, however, this was not possible with service providers from IRC, because, potential participants, who were better positioned to respond to the kind of information I was soliciting, were out of office during the entire period of the field work, hence, service providers were mainly drawn from NCCCK.

3.3.3 Data generation techniques

I used mainly two techniques of data generation – interviews and Focused Group Discussions (FGDs). The interviews were open ended, and were meant to last between 30 minutes to 1 hour, in order to allow for in-depth questioning and probing, however, it took longer than that, because I had to use trans-

² One of the 42 Kenyan tribes. They are semi nomadic pastoralists bordering Uganda to the West, Ethiopia and South Sudan to the North.

lators in conducting the interviews and even facilitating FGDs. The interviews and FGDs were conducted in the language of participants (*Somali*) and audio recorded where it was acceptable to the participants, however, where it was not possible, I relied on note taking technique.

I also used shadowing technique, as discussed by (Mcdonald 2005, Roan and Rooney 2006), on one of the research participants *Mama Ifra* to observe and made notes on her work, which mainly entailed being a reproductive health mobilizer in Somali refugee community. Her work basically involved going round the community to give advice to Somali women on issues related to the wider question of reproductive health, and to distribute female condoms to those who may need them. I also took pictures which captured relevant information on sign posts as they appear within the camp to provide information related to reproductive health. Ideally, I used all these different data sources as a form of triangulation, which as discussed by (Jwan and Ong'ondo 2011), is recognized as a source of strength of qualitative research approach.

3.4 Data analysis

The data have been analysed qualitatively, following the five steps of qualitative data analysis as discussed by (Braun and Clark 2006:87, Creswell 2007:156-157, Jwan and Ong'ondo 2011:105). I began by transcription, where I turned audio recorded data into transcripts with the help of my two translators who assisted me during data collection process. After reading the transcripts severally, I did open coding, where I identified and labelled various chunks of data with terms and phrases which summarized the running ideas emanating from the data. This was then followed by axial coding- where I eliminated overlapping codes and merged others into single units. The process then proceeded to selecting codes with similar ideas running through them and grouping them into single categories which empirically formed themes. It is these themes that emerged to answer research questions which the study set out to interrogate. A list of these themes is provided in the next chapter as the findings of this study.

3.5 Trustworthiness of the study

This is a very important aspect in qualitative research; I adopted Guba's typology developed to ensure trustworthiness in qualitative research which is different from positivists' conception of validity and reliability, as discussed by Shenton (2004: 64), who explained that, Guba's (1981) categorization includes, credibility, transferability, dependability and confirmability, which has also been extensively discussed by Jwan and Ong'ondo, (2011: 129-46). Specific strategies which were undertaken to ensure this is discussed below.

3.5.1 Credibility

First, I adopted well-established research methods, as explained above, and took care about such aspects as sampling methods, returning transcriptions to research participants who confirmed the accuracy of the information they gave me, through a process of co-reflection and member checking. Gen-

erally, I ensured that, all those who participated in this research, did so willingly. I also used multiple sources of data as indicated above to triangulate the findings of this study. In addition, I sought debriefing sessions with my supervisors, who offered valuable insights with regard to the course of approaches I needed to employ in data analysis, and even field work process in general.

3.5.2 Transferability

This refers basically to the extent to which the findings generated here, could be transferred to other studies. I have ensured this by providing sufficient information surrounding the context of the study, which group of people participated here and the time under which this study was carried out, and generally, a thick description on the entire research process. In that case, there is room for analytical generalization of the findings to other contexts with similar characteristics as described here.

3.5.3 Dependability

I ensured this by voice recording all formal interviews and self-transcribed the recorded data to ensure that my data presents a higher degree of accuracy of the information the respondents gave me. The use of multiple methods of data generation techniques as outlined above was also incorporated with additional view to ensure what Shenton (2004:71) refers to as 'prototype model' which can be replicated if similar procedures of inquiry were to be followed in carrying out such a study in the same context.

3.5.4 Confirmability

This concept, as have been reiterated by Shenton(2004), may be regarded as the qualitative investigator's comparable concern to objectivity. In this study, I have taken steps to ensure that it would be possible to follow all the data sets to their sources and a logical structured framework is employed to organize and interpret data as I have outlined above. I have ensured this through triangulation –seeking multiple data sources to corroborate views and representations given by respondents.

Given my previous experience of working with refugees in Kakuma refugee camp, I am aware of the possible biasness which might have seeped through the study as a result of power differences, existing between refugee participants, and I. Having held a senior position as a national staff in the refugee camp, I must acknowledge that some of the respondents readily agreed to participate in this study, because of the perceived influence, I may have as a representative of the organization which provided them with some humanitarian services. In retrospect, I was even asked by some, if I could assist them find sponsors in Europe who could help fund their adult education program or even get opportunities to study abroad.

All the above strategies considered, I believe that the findings of this study are trustworthy enough to be used as a basis for policy intervention and even admissible among research community as a worthwhile contribution to the field of reproductive health and development studies in general.

3.6 Ethical considerations in the study

Ethical issues related to conducting research with refugees have been extensively discussed by various scholars such as (Birman 2006, Ellis et al. 2007, Hopkins 2007, Tilbury 2006 and Vargas 1998) as I have highlighted in chapter two. As such, I went into the field quite aware of the fact that, issues of family planning adoption were quite sensitive, and especially among refugees. To begin with, I notified Department of Refugees Affairs Kakuma Branch, of my plans and intention to carry out a field study in Kakuma refugee camp and elaborated in detail the kind of information I was seeking from refugees and even service providers in general, after which I was granted permission and access to conduct this study.

Since, I was to visit and conduct interviews in places of residence where research participants lived, I took precaution and veiled my head and neck with *hijab*³ and dressed in a *burqa*⁴ as is the cultural practice expected from women in the Somali and Islamic cultures, hence I was readily accepted among the refugees and made my research participants, especially, men, feel at ease to interact with me and take part in the study, without unnecessary suspicion which would have been the case, had I dressed otherwise. In that regard, prior to fieldwork, I established rapport with service providers and inducted two research assistants (male and female) who accompanied me throughout the entire period of fieldwork and acted as translators, and guides who referred me to participants who could be receptive in participating in this kind of study.

However, before engaging in any actual data generation process with research participants, I sought and obtained their informed consent verbally, and adhered to the principles of confidentiality and anonymity, by explaining in detail, and spelling out what the interview expected of them and at the same time giving them option to withdraw from the study, if they so wished to. After transcription, I took the transcribed data back to the respondents to confirm if the information they had given me during the interview were accurately presented in the manner that put them under no risk of any kind. However, many of them, especially refugees, told me that it was okay even before I began re-reading the transcripts back to them. But, for service providers, who are national staffs, proved very supportive and spent a great deal of their time, assisting me to flesh up issues they thought needed more representation in the data.

Ultimately, I used pseudonyms to protect the identity of research participants who participated in this study. Hence, I can say that key ethical concerns of anonymity, confidentiality, avoidance of harm, member checking and honesty (Jwan and Ong'ondo 2011) have been greatly upheld.

Conclusion

In this chapter, I have clarified and justified my research design which is *qualitative case study*, and detailed the entire research process with regard to such

³ A piece of cloth worn to cover the head and neck

⁴ A very long dress covering the entire body except, hands and feet.

aspects as how I sampled the participants, data generation process and techniques (mainly interviews, and Focused Group Discussions) and subsequently explained how I analysed my data and navigated through ethical concerns in the study. Findings of this study are presented in the next chapter.

Chapter 4 Findings of the Study

4.1 Introduction

In this chapter, findings of the study are presented as themes with sets of selected categories which have gone into deriving the themes. The findings are responses to the research questions which the study sets out to interrogate, which are (a) How do the prevailing perceptions, attitudes and experiences of Somali refugees' women influence and shape FP use?, and (b) How do women interact with FP service providers and how does the surrounding environment influence their choices? (Interview guide is provided as an Appendix 1). Each theme is presented and explained with a view of demonstrating how it was empirically constructed from the data sets, which reveals perceptions, attitudes, and experiences of Somali refugee women on family planning.

4.1 Findings from the study

Using a qualitative case study approach, discussed in the previous chapter, four (4) focus group discussions and eleven (11) individual, face to face, interviews were conducted with a total of thirty three (33) research participants, which included refugees, and service providers (both men and women, married and unmarried persons). Refugees who participated in individual face to face interviews, are identified as Ikra, Saleh, Nuria, Amina, Mama Ifra and Imam, while service providers included Bakumba, Ajukon, Raps, and Risper (all names are pseudonyms). The rest are grouped in FGDs, captured here as FGD1,2,3 and 4. The results of the findings demonstrated eight (8) main themes over, perceptions, attitudes, and experiences of Somali refugee women in adoption of family planning practices in Kakuma refugee camp in Kenya. Table 1 below shows these themes, and some selected coded remarks technically helpful in writing this chapter. However, a comprehensive list is provided as Appendix 3.

Table 1: Shows main themes and coded remarks, derived from focus group discussions and individual interviews over Perceptions, Attitudes and Experiences of Somali refugee women in adoption of FP methods.

THEMES	CODED REMARKS
Meaning(s) attached to Family Planning methods	[FP is about Spacing children & preventing conception.] [Entails having children one can take care of comfortably/manage], [FP regulating number of children one wants to have.] [Breast feeding for 2 years as FP practice.]
Religious and Cultural Beliefs	[Belief that religion discourages use of FP.] [Religion do not prohibit FP however, it is against condoms early sex before marriage]. [Belief that one cannot get pregnant when breast

	feeding]. [Belief that any FP method which kills sperms is tantamount to murdering a human being].
Women's view on Contraceptive use	[Women are subservient despite level of education] [Those practicing FP are productive & can manage their families better] [It is women's responsibility to seek FP information/ services from the clinics]. [Women expressed need for spacing -2 years]
.Men's view on Contraceptive use.	[The use of contraceptives is perceived as refusal to bear more children.] [Men allow contraceptive sometimes during the resettlement.] [Seeking for FP info/ service with regard to FP methods is a preserve/ women business.] [Women are married to deliver babies (reproductive role).]
Prevailing perceptions on Contraceptives.	[Contraceptives lead to infertility.] [FP (understood as use of modern contraceptives) is a westernized concept meant to control Somali population] [Condoms are relegated for (associated with) risky sexual encounters not regarded as FP method] [Lubricants in condom cause cancer (perception)]
Experiences encountered with Contraceptive use.	[Fear of being divorced / conflict with the husband as a result of FP usage.] [Continuous bleeding menstruation disappear/ does not come at all.] [FP is good since it helps manage family- reduces cost.] [Female condom is reported as noisy during sex hence not preferable]
Prevailing attitudes attached to contraceptive use.	[Positive response towards FP among some] [Reports on a certain degree of awareness on FP] [Efforts to adopt/ incorporate knowledge into practice is still wanting.] [Both positive & negative attitudes towards FP exists.]
Provision of FP (service and means)	[No confidentiality on the patients seeking FP services from the clinics] [Buy pill from illegal private vendors since they are assured of confidentiality]. [Female condoms are limited as opposed to male condoms (expensive).] [Need for qualified personnel to administer some FP methods.]

4.1.1 Meaning(s) attached to Family Planning practice

The meaning of *FP practice*⁵ was found to be varied, among various cadres of people who participated in this study. However, one common idea which was found to run throughout the concept is that, it is a way of child spacing and nothing else, and could be conveniently carried out through traditional methods, which seemed safer, compared to modern methods, which were largely seen to endanger users in one way or another. However, for some refugees, as was reported by participants in FGD2 & 3, it meant, raising children in a healthy manner and also regulating the desired number of children, couples would wish to have in their lifetime. Yet, others also understood the practice only, as a process of continuous breastfeeding of a baby for two years, without the knowledge of any existing modern forms of contraception, while other also operationalized the concept to mean, the use of oral and injectable contraceptives only.

4.1.2 Religious and Cultural Beliefs

Beliefs that religions discourages or prohibit *FP methods*⁶, like use of male condoms, sex before marriage or even that, FP methods which kills sperms are viewed as acts of murder, are some of the constructs, which emerged from the transcripts to create this theme.

Generally, it emerged very strongly from the data, that religious and cultural beliefs, play a significant role in the whole question of family planning. In fact, there was a strong sense expressed by most refugees, both men and women who participated in this study, that, it was against Islamic norms to use, contraceptives, since the FP methods are largely perceived as attempts aimed at rejecting the role of child bearing, a decision which they believed, only Allah could make. Indeed, this assumption was very common, when participants, were asked if they had any desired number of children, they planned to have in their lifetime. But the overwhelming response was that, “*as many as God can provide*” (captured from FGD1, 2, 3 & 4). Some participants in the individual interviews were even surprised that, such a question could be framed and asked of anyone.

However, there were other dissenting voices, represented by characters such as Ikra, who reiterated that, she would have wished to have four children in her lifetime, but if her husband wanted more, she was willing to comply and have as many children as he may wish to bring up. Indeed, such belief that the use of condoms as FP method was not permitted by Islamic religion, was very strong, and for that matter, such notions were applicable for any other contraceptive methods, which were perceived to kill sperms. Even though, not explicitly expressed, but this notion of rejection was widely held among married participants, who viewed use of condoms, as being a preserve for people who involve in risky sexual behaviours. Generally, there was a resounding consensus, that Islamic religion does not encourage use of modern artificial or permanent contraceptives, (referred in this study as *FP methods*). Such views were rep-

⁵ Refers to both traditional and modern methods of birth control(see chapter 1)

⁶ Use of modern methods of contraceptives

resented by the voices of participants who were in favour of the so called traditional methods; however, one participant remarked that;

“I think my religion is not against family planning as long as it helps families to manage their children. I think the holy Quran talks of spacing children, a mother is supposed to breastfeed for two years to allow the child to grow. One cannot get pregnant when breastfeeding”(Interview with Nuria).

While another one also pointed out that;

“Our religion does not allow use of condoms or early sex (sex before marriage). It also does not refuse practice of FP but it does not comply with the use of condoms. One of my Shiekhs⁷ said that in case you have problem in raising children, practice FP”(Interview with Saleh).

In effect, those who expressed misgivings with FP methods, favoured traditional means, which included continuous breast feeding for two years, withdrawal(though not common with male participants), abstinence or the cultural practice of FGM which emerged was done in such a way that it discourages penetrative sexual encounters before one is legally married. Indeed, these thoughts and beliefs were also supported and shared by the Imam⁸. One participant, in the first FGD captured here as (FGD 1), noted that,

“we men can marry and have sex with another wife if one is pregnant. Which means marrying more than one wife is a method of FP” (Male participant, FGD-1).

4.1.3 Men’s view in Contraceptive use

Although it emerged that, men interviewed in this study, seemed to be receptive of family planning, but only on particular contraceptives methods, which could only be used for child spacing purposes, as opposed to those which prevented reproductive function of child bearing (permanent methods). As have been outlined elsewhere, that decision was left for Allah to make. Indeed, they were very particular on some methods they preferred, like oral and injectable contraceptives, but not such FP methods as the use of Intrauterine Devices (IUD) and transplant which featured as unpopular methods among majority. IUD for instance, was found to be uncomfortable and men could feel it during penetrative sex, among partners who used them as contraceptive methods. One participant pointed out that, “Men said that, they can feel the metal device during intercourse” (A female participant, FGD 1)

However, in contrary to what men said, it emerged very strongly from women participants, that men generally disliked the use of any FP method. Indeed, they confessed that, women who use contraceptives were largely perceived by men, as act of outright refusal to bear children, hence, such attempts to use contraceptive methods, could result into violence, divorce, or even prompt men to marry additional woman, who would be willing to fill in the reproductive role, expected of women in the society. One participant named

⁷ An Islamic religious leader, who teaches Quran and Islamic religion.

⁸ An Islamic religious leader, who teaches Quran and Islamic religion.

Ikra, for instance, confessed that she was willing to bear many children if her husband wanted, in order to discourage him from marrying another wife, while Nuria on the other hand, was divorced by her first husband because she was using contraceptives. She said that;

“I used it for around 5 years. I was young then and I did not want many children. However, I lost my husband as a result” (Excerpt from Nuria).

Indeed, that particular incidence made Nuria, very unwilling to listen to any advice which could encourage her to reconsider the use of contraceptives at any stage in her life. Incidentally, it also emerged that, the only time men seem to encourage their wives to use contraceptives, was when they were faced with resettlement plans as a family. Because, one of the resettlement policies is that, any expectant member of a family under resettlement plan will have to wait for at least one or two more years, before her family, is reconsidered for resettlement process. However, there was a strong sense of belief among men who confessed to favour FP methods that, the duty to seek FP information and services were solely for women to undertake; though in the end, men seemed to be key decision makers on the kind of choices of birth control methods. These constructs generally represented men’s views and role in the use of contraceptives.

4.1.4 Women’s view in Contraceptive use

Generally, women interviewed agreed that FP is good for spacing purposes, because it allows for healthy babies and women who spaces their children, had time to engage in other income generating activities, which could support their households. One such participant is Amina, who is 26 years old and has three children, spaced within a span of 8 years, 4 years and 1 year, and thus, was able to engage in income generating activity to add on the monthly ration received from UNHCR. She is employed as a refugee reproductive health motivator where she is able to earn a monthly stipend of around 40 Euros. When asked what she thought about FP methods, she said that;

“I see it is a good way since it makes women work easily. Like me I can manage to work for NCKK because my first born and my second born are in school. I cook for my last born in the morning and leave her with my neighbour when I go to work. FP helps a woman to space children and also bring up few children which is good because I afford to buy for them meat, clothes and shoes which are not provided by UNHCR” (Excerpt from Amina).

On one hand, education seems to be a factor in enlightening women to be knowledgeable on issues of contraceptive use, however, it emerged that, despite education levels, decisions to use FP methods, were very much dependent on permission and authorisation from men, (husbands). However, it was also established that most Somali women in the camp have never been to school or had low levels of primary education, hence were quite illiterate and could hardly communicate in English, which is the common language used in the camp, among refugees, and thus, the more reason I had to interview or facilitate FGDs with assistance from translators.

Although, most participants, concurred with their male counterparts, that it was women’s duty and responsibility to seek FP services, since, they were the

ones to use them, nevertheless, in cases where STIs were diagnosed, women admitted that both partners had a responsibility to seek advice and medical attention from the hospital. Yet, that rarely happened, and men were quick to point fingers at their wives, accusing them of secretly using some FP methods, which contained pathogenic substances.

4.1.5 Prevailing perceptions on Contraceptive use

Some of the prevailing perceptions, found among refugees and service providers in this study are that FP is a westernized concept advanced by developed countries like USA in order to control Somali population, which they perceived as a threat to their general ideology of controlling the world. And in most instances, FP methods were viewed something which was being imposed on them indirectly. For instance, one male participant noted that;

“Some believe that practicing FP destroys fertility, and more or less it is viewed in my Somali community, as a Westernized concept which is largely aimed at reducing the population of Somalis. Somalis are everywhere and that might be causing a threat to the globe” (Excerpt from Saleh).

In connection to this, there was a perception that use of contraceptives may lead to infertility or even STIs and HIV/AIDS. These perceptions seemed to have been nursed by experiences witnessed, and shared from some community member who had developed weird hormonal reactions with particular forms of contraceptives. Indeed, there was a feeling that, lubricant in condoms could even cause cancer and other sexually transmitted diseases, which largely confirms their perceived notion that the attempt to make the use FP methods was a westernized ploy, aimed to exterminate the population of Somalis. In that connection, there was also a very strong assumption that condoms are meant for risky sexual encounters, or those who engage in sexual encounters before it is legalised through marriage, because of the reason to prevent pregnancy which culturally is a taboo among the community if one is not legally married. However, there were also those who perceived FP methods as means through which people could attain their desired number of children, allow spacing and generally be able to plan their lives in a manner which enhances the general wellbeing of the families.

4.1.6 Experiences encountered with Contraceptive use

The experiences reported by interviewees on the use of contraceptive were very diverse. One particular case is that of Nuria, who was divorced by her former husband on account that she was using oral contraceptives secretly without her husband consent. When she was asked if she would consider using pills at any given time in her life again, she reported that;

“No, after first marriage experience I stopped. My husband divorced me because I was using pills. I don’t want to hear about FP this time” (Interview with Nuria).

Other respondents also reported cases of violent encounters with their husbands when they use contraceptives. They sometimes use it secretly, because of the perceived hostility from men and other members of the community towards FP use. At another level, there were reports about continuous bleeding or total disappearance of menstrual cycle associated with the use of FP meth-

ods, making others reluctant to adopt FP methods. Indeed, one participant noted that;

“FP is good when used well but it can be harmful. In my experience as a worker with NCKK, there is one case of Somali woman in the community who was fitted with a Norplant but it disappeared in her body. She has complained about the use of FP and she discourages others from considering FP in general. However from daily encounters, I can say that Somali women are generally reluctant to accept FP” (Excerpt from Imam).

Although, the use of female condom, was reported to have gained acceptance among most women, but it was cited as very ‘noisy’ during sexual intercourse, and as such was not preferable in the camp setting where all family members slept under one roof, with other family members, thereby endangering privacy of users.

4.1.7 Prevailing attitudes attached to contraceptive use

There was a widely held consensus among study participants that, Somali refugees have negative attitudes towards contraceptive use, this attitude varied depending on which part of Somali country refugees hailed from. Those who came from urban or peri-urban centres, where they had interacted with such services, were quite receptive on applying advices given from service providers, while those who came from rural setups, where such services were poor, were found to be sceptical and generally hostile to community mobilisers who offered information regarding FP.

However, service providers admitted that there was a positive response being noted with various families and particularly with women opting to use injectable and oral contraceptives, which emerged as the most preferable FP methods majority, were willing to embrace in the camp. However, there was a concern noted among NCKK health motivators in FGD1, and interview with Mama Ifra, who reported that most Somali refugees were sceptical about NCKK, because it was perceived as a Christian based organization, hence advising people of Islamic faith about reproductive health services was a conflict of interest. In fact, cases of stigmatization were reported, about those who were known to use FP methods, and in most cases these users were even branded as prostitutes on that account by members of the community who view FP use as a deviation from Muslim faith.

Generally, some attitudes attached to contraceptive use, were found to be as a result of bad experiences which were being shared across, especially originating from those who had encountered strange side effects with some FP methods.

4.1.8 Provision of FP

Research participants reported that there was no confidentiality of patients or individuals seeking FP services from the main IRC hospital. Refugees employed as translators and even service providers gossiped and reported back to the community those who were using FP methods, or those who went to seek FP information from the hospital, thereby heightening threats and fears of

stigmatisation which was associated with adoption of FP methods. As a result it emerged that, there were illegal shops within the camp, where private individuals dispensed contraceptives, to those who feared going to the main hospital for services. In such instances, it emerged that, refugees could conveniently buy oral and even injectable contraceptives without jeopardising confidentiality concerns, which were rampant at the main hospital. One participant noted that;

“There many vendors in Camp offering FP. Some workers are Somali Women; however people rarely visit those clinics, because, the same people are the one reporting you to the community. So people opt to go to vendors in the camp who sells pills illegally. It is safer because confidentiality will be observed, but they are extremely cautious, they can’t sell to strangers, because they fear people at IRC and police” (Interview with Ikra)

It also emerged that there were few qualified personnel who could administer FP methods, hence refugees resorted to methods which were cheap and easy to self-administer like oral contraceptives without going to the main hospital, which is also very far away from some localities in the camp. Conversely, some service providers also noted that, female condoms were quite expensive as compared to male condoms, and could only be distributed to those who needed them on request, a process which also endangers confidentiality concerns raised by refugees.

Chapter 5 Discussions of the Findings

5.1 Introduction

To achieve the objectives of this research which are set out in Chapter one, discussion of the findings has been centred and organized around the individual research questions which the study prompted to address at the beginning.

5.2 How do the prevailing perceptions, attitudes and experiences of Somali refugees' women influence and shape the FP use?

The findings revealed that, negative perceptions emerged to be a common factor, which highly impact on contraceptive adoption on a larger scale. These perceptions as reflected from the study are products of discourses and notions based on misinformation, unpleasant experiences of victims who have encountered side effects from hormonal reactions with some FP methods used, and generally, prevailing mis-interpretations of Islamic religious norms. These responses are captured and discussed under three key areas; (a) Misinformation and formal education, (b) Religion and culture, and (c) Conditions of the camp. However, since, there seem to be overlaps between them, the following discussion has not isolated them crisply in that manner.

Although, the whole question of FP use and acceptance, is not without some form of misconceptions at any given point, but as the findings of this study consistently indicates, such constructions have been largely necessitated by inadequate information available on FP use, especially in this set up, where health concerns are challenged by other more pressing needs like food and security. While Degni et al. (2006: 191), may be right when they underscored the fact that, Somali country, given its' history of protracted conflicts and political instability, may be having poorly developed health services including those of family planning, hence could explain some gaps observed in this respect, but, given the fact that, majority of respondents studied, had already been in KRC, or lived in the environment for more than three years on average, it could explain and illuminate the fact that there may be existing drawbacks with current intervention practices on FP use in the camp.

This study reveals that illiteracy and low levels of education may be playing significant roles on how these social constructions have been built and nurtured, however, this begs the question, at what level exactly should various FP awareness program begin? Is it with educating women to reduce widespread illiteracy and empower them on their rights as human beings, or direct attention straight towards enhancing acceptance without addressing these nuances first? In fact, findings from this study demonstrated that illiteracy and language barrier in particular, hinders consumption of the available FP information offered in the camp. On the other hand, Islamic religion emerged as a defining factor which has been consistently used to negotiate contraceptive decisions.

However, there seem to be no proof in the literatures or elsewhere, even in the *Quran* or *Sunnah* (Prophet's tradition), which could explicitly indicate that Islamic religion is against FP methods. In fact, leading Muslim Jurists like (Omran 1992, Tamimi 1998, Seetani 1997 cited by Fahimi in PRB 2004) believes that FP is permissible in Islam. The same beliefs could also be extrapolated from Hasna(2003) and Gwarzo(2011) who have discussed that subject, but, these beliefs are quite opposite with the prevailing religious beliefs on FP use in the camp.

Some women, who were for free choice, argued that, it was a personal decision to use FP for one's wellbeing, but that assumption was hardly recognised in their society. For instance Amina confided that she was using FP secretly without knowledge of neighbours since she found it liberating and not at odds with the beliefs of Islamic faith. But despite that, she claimed that at the end of the day she still found herself personally constrained at society level, to freely come out openly and talk about use of FP with others without facing possible threats of stigmatization. As opposed to other women who do not practice FP, Amina is able to work and earn little incentive which gives her more financial freedom and independence from her husband compared to other women, who could hardly manage life on their own without depending on their husbands.

FP use is quite a delicate issue among the population studied here, while it may be assumed that, having many children may be viewed basically as a common traditional cultural phenomenon among Somali refugees, but findings from this study reveals another nuanced dimension. Most families arrive in the refugee camp, having lost their children, like Mama Ifra, and the need to bear more children to replace those who have vanished remains an underpinning resolve for many families. Hence, having more children may be seen as a way of coming to terms with such realities of reconstructing their individual lives and identity as a people, who belongs to a given ethnic group. Children in traditional Somali culture are seen as a source of livelihood and in refugee set up, more children means, larger food basket, because in the context of the camp, many children enables families to be entitled to larger proportion of food rations. In fact, some women incidentally acknowledged that, they were less bothered about taking care of their children, because, they were assured of nutrition supplements provided freely in the camp. Hence, intuitively, such belief may hold a very strong sway against any effort geared towards FP use among such population.

It is therefore quite evident that despite these contradictions inherent with the prevailing perceptions, attitudes and experiences which are counterproductive to goals of self-body freedom or reproductive health, women still come forward to unconstrain their agency, by accessing contraceptives through such un official routes as seen through their efforts to seek out the services from illegal shops where contraceptives could be obtained secretly in manners that circumvent perceived societal barriers they find themselves into.

5.3 How do women interact with FP service providers and how does the surrounding environment influence their choices?

This question contains two parts and is addressed in that manner. Part one, discusses the interaction between the women and FP service providers, while part two foregrounds on how the surrounding environment in the community, could be viewed as constraining towards efforts to use contraceptives or use FP methods.

5.3.1 Interaction with service providers

An aspect which has strongly emerged from the findings is the issue of confidentiality. Given the inadequate staffing in the camp clinics and hospitals, quite often refugee staffs work as subordinate members to assist the few qualified personnel with other services such as language translating, clerks, lab assistants and cleaners. As a result, Somali women who had accessed FP services pointed out that doctor-patient privileged information was being reported back to the community, where users are stigmatized as a result, and because, majority of women would want to visit these clinics in secret, without the knowledge of their husbands, it was a major setback., because, any prevailing decision governing domestic or even reproductive issues were heavily controlled by men, who are non-receptive participants of FP use, hence, could explain, the survival of non-official routes seen from mushrooming of illegal contraceptive vendors within refugee camp.

Moreover, because of the inability to converse well in English Language-which is the *lingua franca* in the camp, it strongly emerged that, Somali women are quite reluctant to visit main hospital and clinics, and instead prefer to seek contraceptive information from the said illegal Somali vendors who could listen to their language and maintain confidentiality concerns.

At another level, it also came out as an issue that, NCKK which is a Christian based organization, was being regarded with scepticism, in their effort to undertake reproductive programs. This was salient in responses given by refugees who are Reproductive Health Motivators, and are employed by NCKK. It occurred that, there was a silent hostility and discrimination attached to them, as Muslims individuals working for a church based organization, which was perceived by their society as quite incongruent with expectation of Islamic faith.

Lastly, it emerged that FP information targets only, married members as opposed to others who may be of reproductive age like teenagers. Though sex for teenagers is culturally prohibited, it emerged from the FGDs that it was a salient phenomenon happening in the camp. Hence, individuals in this bracket seemed to be selectively neglected from consuming FP information or services which could help them navigate the challenging terrain of teenage sexuality.

5.3.2 Quality of services

In this part I wish to explore accessibility, service provisioning, appropriateness, affordability, and ability of means. The distance to the main hospital is not favourable and easily accessible to all refugee communities living in the camp, hence those living from far locations, seemed highly disadvantaged in accessing services, although there were at least three clinics offering similar health services, in the camp, but qualified doctors were few and could only be found at the main hospital. Although, the hospital could be accessed by bicycle or motorbike for those living far distances, but the greatest challenge to that emerged from the fact that, most refugees lack opportunities for employment, and getting money to use for transport is not easy for those who lack the means to engage in any productive work that can generate income. Hence, idleness may be argued to have entrenched women's reproductive roles further, through overdependence on men. A scenario which has also encouraged frequent sexual relationships amongst refugees, to a point where the need for contraceptives may be logically overstretched, as many may also not have the financial capability to buy contraceptives from the so called illegal vendors. In that regard, what comes out clearly is that quality of FP services provided are quite compromised. Client confidentiality is not assured while unregistered vendors in community are not professionally trained to offer quality services hence question of accessibility, service provisioning, appropriateness, affordability, and ability of means by refugees remains a gap to be addressed.

On the other hand, refugees live in shanties which may seem to have implication on some contraceptive decisions they make in their everyday lives. For instance, there were reports that female condoms are gaining popularity among some users, however, one disadvantage raised in the interviews and FGDs is that – it is very 'noisy', hence, users risk violating privacy concerns, where other members of the family lives together in one shelter, which is often the case with many refugees families.

A survey of the camp setting revealed some evidence which may be worth exploring with regard to FP services or appropriateness of FP approaches adapted in the camp. One notable concern is that, focus has mainly been foregrounded on the prevention of HIV/AIDs, as opposed to FP methods, which is being treated as a sub-program with an auxiliary value to the attention and focus devoted to the prevention of STIs and HIV/AIDs. Such approaches could be dependent on donor funding and conditionality, which highly determines the way services are offered, however, this could have implications on FP use in general. Indeed, scholars like Bernstein (2005:131) have pointed out that, the magnitude of HIV/AIDs pandemic in developing countries has shifted funding away from the concerns of FP programs, assumptions which are also shared by Bogaarts and Sinding (2009).

Use of condoms for instance has been identified as a method relegated for risky sexual behaviours which mainly focuses on STIs' and HIV/AIDs prevention, hence, it emerged that, it could rarely be understood as a possible FP method which could effectively prevent conception or unplanned pregnancies if used well and adhered to. Such similar concerns could also be noted with some communication strategies observed in the camp. For instance,

figure 1 below is a sign-post with a communication aimed at behaviour change;



Figure. 1: Shows a sign post placed strategically on Kakuma- Lokichogio highway, which is the leading entrance to Kakuma Refugee Camp.

However, the main information one is confronted with at the first instance, is *abstinence from sex* until marriage. Information which has often been disapproved to be ineffective with regard, not only to HIV/AIDs prevention, but FP practices as well. Moreover, all communications are conveyed in English language, which is not common with every refugee community, especially, with many Somali refugee women, who could hardly read or converse in English.

Then further, one hundred meters away from the above sign post, and into the refugee camp, there is another sign post captured in **figure 2**, which communicate about HIV/AIDs and seem to confirm the kind of attention and commitment given to HIV/AIDs and STIs prevention, as compared to FP. Further 2 kilometres into the camp, there is another sign post captured in **figure 3**, which focuses specifically on FP, but as it were, it has been evidently neglected, and its' location is at a point where it could hardly be noticed by passers-by or targeted refugee audiences.



Figure 2: Shows a sign post placed strategically, approximately 100metres into the camp



Figure 3: Shows a sign post meant to pass FP information, but erected at a point where it is hardly noticeable by passers-by.

In fact, to capture a better view of the picture and information therein, I had to edge away the tree branches which seem to obstruct it, as shown below in figure 4 below.



Figure. 4: Shows how I had to edge away the obscuring branches of tree to get a better view of the information conveyed.

Other, international bodies like UNFPA and UNAIDs have voiced their concerns with respect to addressing such disjuncture around the question of reproductive health as a whole. UNFPA and UNAIDs (2004) called for concerted efforts to include reproductive health that address not only HIV/AIDs, but also recognises family planning services for all. This notion seems to be visibly missing with current reproductive health programs employed in Kakuma Refugee Camp.

In this regard, I also attempted to question if the prevailing perceptions and attitudes which have so far been discussed above, were factored into current FP promotions programs, and it emerged that, service providers were quite aware of these challenges though. NCKK for instance seemed very active with reproductive health awareness programmes among refugees, and in order to enhance their presence among various refugees' communities, they employed community health motivators, who could speak and heighten FP awareness within refugee communities.

In fact, reproductive health mobilizers who participated in FGD1 were Somali refugees, who were considered proficient in the *Somali language* of the target audience, and could thus overcome existing language barrier among Somali refugees.

In addition, as have been noted from the study, some reproductive health motivators' roles were to distribute female condoms to communities where

they hail from and were even trained to offer FP information to those who may need such services at the convenience of their homestead, and within communities where they live. They could even refer individuals with major issues to seek health services from the main hospital. The fact that, these health motivators comprised of both women and men, seem to deconstruct the patriarchal notions that FP was a preserve only for women in the society. But more importantly, religious and community leaders like the Imam and Mama Ifra who agreed to participate in this study, represents how opinion leaders, who may be viewed as gate keepers into various refugee communities were actively engaged in FP awareness campaigns.

Besides, the awareness programs, there were also specialised programs to assist MAPS (Most At risk Populations), with income generating activities to empower them economically. While it may be apparent that this study may not have captured other possible ways in which these perceptions and attitudes have been addressed by service providers, it is significant to note that, findings of this study tend to reveal a lot of gaps and drawbacks inherent with service provisions and which may require a change of practice and approaches within various intervention programs with a view to enhance contraceptive acceptance.

Chapter 6 Theoretical Reflections and Way Forward

6.1 Introduction

This chapter provides the concluding remarks about this study in general, which embodies my personal reflections on women's agency beyond the domain of family planning policy and practice. This has been approached by extrapolating the study's findings against the conceptual framework of intersectionality and agency, which offered a theoretical lens in guiding the research approach to this subject. It is followed by concluding remarks and suggestions for areas for further research in the domain of FP practice.

6.2 Reflections on Constrained agency of Somali women

From the study findings, it emerged that, a number of factors intersect to constrain the agency of Somali women, and make them at the same time, cope with contradictions about the question of reproductive health, which as it were relate very much with imbalanced gender power relations. These categories, which seem to intersect and emanate from the findings, may be extrapolated as culture, religion, illiteracy and social institutions.

Traditional Somali culture has placed pressure on the woman to play a reproductive role without much choice to exercise contraceptive decision-making authority. The interplay of this pressure has been reflected in the personal stories and lives of such character as Nuria and Ikra. Nuria who was married at a younger age of 14, got divorced as a result of using contraceptives to delay child bearing, while Ikra on the other hand, was disowned by her own father because she refused to marry an elderly suitor whom her father had endorsed. In that regard, decision making authority has been so masculinized to an extent that, the agency, which is understood loosely, as the 'ability to define one's goals and act towards,' may be said to have been constrained. However, the action of these two characters may be perceived as efforts to overcome cultural discourses which have defined them as subservient and in the process free their constrained agency. Nuria used oral pills secretly, subverting the perceived authority of her husband, while Ikra on the other hand, defied the demands of her father and even went to the extent of changing her own identity in order to live a life where she could define her wishes as a free person.

Religious discourses on the other hand, legitimize action such as polygamy, and FGM which have implications on contraceptive decisions. Women emerged as unwilling to use contraceptives because they feared being disowned in favour of other wives who may be brought in, to fulfill the roles they may be perceived to have abdicated through the use of contraceptives. Although, as it emerged, religion has not come out explicitly to outlaw use of contraceptives as such, but it has been nurtured in the discourses to an extent that, all spheres of life seemed to be underpinned and conceptualized in terms of what religion

seems to sanction or forbid. In effect, decisions to use particular contraceptives are regulated, and even constrained; hence the woman is unable to define her want freely without censoring it through the supposedly reflective mirror of religion, however, the use of such unofficial routes to secure contraceptives, could be extrapolated as ways, women resorts to in order to free their agency. Such interpretations have also been supported by scholars such as Henderson and Wickmayer (2009) and Weber (2001) cited by Blige, 2010:60) who have argued that intersectionality should provide both micro-social and macro-social levels of analysis, to address questions where at micro-social level, the intertwined social categories and multiple sources of power and privileges impacts on inequality structures within individual lives. While at the macro-social level, systems of inequalities enhance 'production, organization and maintenance of these inequalities', thus leading to distinct structures like inter-generational transfer. Though the contemporary realities in modern society, expects that young people could express intergenerational contestation by contradicting reproduction of such societal norms, but that is always rarely the case.

The interplay of power relations within the household and even within the community at large underscores the assumption that women's struggle in patriarchal society could be perceived more as an attempt to protect their marriages and families, which are transmuted into blind respect and devotion to their husbands, culture and even religion. Harcourt (2009) theoretical framework on body politics is relevant in unpacking these intersecting categories. For instance, a case of Nuria demonstrates the kind of politics revolving around woman's body. At a young age of 14 she was already married off and a wife expected to fulfil all the marital obligations which come with such responsibilities. However, in her attempt to free her agency, she intuitively took the initiative to use contraceptives, subverting all contending discourses in the process. Her experiences and those of other Somali women, represents the kind of challenges women go through in their daily struggles to gain control over their bodies and lives.

Similarly, the institutionalized religious doctrines intersect with cultural beliefs in a society which bestows man as the overall head of the house and, such beliefs are inherently subsumed in a patriarchal structure, where women have been relegated as a weaker gender and could only measure their freedom of choice within the acceptable framework. Such discourses imposes socially constructed cultural expectations, which largely emasculate women's ability to have equal power regarding decision making models within households and community at large. In essence, the women's voice does not seem to matter, and the opportunity to be heard or respected has been subtly withdrawn. With respect to matters relating to reproductive health, there are power's hierarchies where men have the voice while women's voices are muted to remain silent spectators in matters to do with their own bodies.

In case women exercise their agency in an attempt to take the reproductive control of their lives through FP use, the society stand to stigmatize and view them as disobedient not only to religion, but to culture and the expectations of marriage institution as understood by the society. Quite often they are even branded as prostitutes, a very common way of putting them down when they do not conform to patriarchal male control or (in this case) Somali gender norms and/or perceived expectation of Muslim faith.

The findings of the study demonstrate stories of women with constrained agency, hence living their lives with little of a choice to take control over their body. Yet they struggle to undo this by using contraceptives without the consent of their husbands or secretly following routes which could insulate them against societal hostilities. The work of Mama Ifra as a reproductive health mobilizer illustrates how power imbalances in the society oppress women. As an educated woman, she knows her rights and respects her religion, however, she find herself in a contradictory situation where her work which aims to liberate women struggling to raise their children is in conflict with the larger beliefs and expectation from the community.

Although, her work involves educating women on FP and the importance of why the use of FP is good for their livelihood, she approaches FP as a health issue for the mother and child's wellbeing in order to *unconstrain* the agency in a way that may be acceptable to the society. But despite such attempts, she is still subjected to cruelties which force some women who believe in her work, to seek services in her house secretly for fear of their husbands. In the process, she has even been branded as a prostitute and her work is viewed with a lot of suspicion among some community members where she lives and works.

Though as the findings indicates that women are exposed to violence from their husbands in case they are caught seeking these services or any information related to FP, but the intersection of different categories may mean that as refugees they have a low social class, as women of Somali descent, they are burdened by illiteracy, productive and reproductive roles within the society, while cultural and religious doctrines reinforced by patriarchy enriches such complexities further, making their effort and struggle to reconstruct and organise their shattered livelihood, a difficult endeavour to navigate.

Masculinity has always existed as element in both Christian and Islamic religion as manifested through creation of heaven and earth, as revealed in the Bible and Quran, its replication in contemporary societies is hard to justify without some degree of illogicality. Though there are different types of masculinities, interpretation of hegemonic masculinity in the 80s was viewed as 'pattern of practice that allowed men's dominance over women to continue' ----- [and] required all other men to position themselves in relation to it, and it ideologically legitimated the global subordination of women to men' (Connell and Messerschmidt 2005:832). However, with the spread of education, culture of entrenching masculinity is slowly dissipating, while it could be argued that, where such transformation is thin, intergeneration transfer of masculinity is a subtle process which could shape and nurture children in a way which reproduces power imbalances.

Indeed, in most African societies, the ecological model of socialization has it that, children are taught and inducted about their roles in the community which is passed from one generation to another. Incidentally, part of what girls are taught and inducted about revolves around being good mothers and wives who respects and venerates their husbands. Sentiments which have been underscored by such scholars like Muge and Bagadhi (1994) cited by Sarab and Izhar (2008:399), when they pointed out that, 'tradition legitimates hegemony

and reproduces power; it is an active co-opting agent and the most powerful means of social incorporation’

In retrospect therefore, it may be argued that, the ability of Somali refugee women to be aware of their power and right to make decisions regarding their reproductive bodies has been emasculated in that indoctrination, perpetuated by a long tradition of patriarchy. Jewkes and Morrell (2012:1729) citing Campbell et al. (2008) and Jewkes & Morrell (2010) has made a case that young women relationships and problems of forced sex, in Sub-Saharan Africa in particular, indicates that, young women are unable to negotiate for safer sex in relationships due to gender inequalities and power imbalances which often characterizes such relationships. Moreover, hegemonic masculinity has been pointed out to make sense of ideals, values and practices of men although women involvement in influencing contours of heterosexual relationships, their ability to accept or defy existing power imbalances is not well comprehended and the assumption may be that women, ‘are on the receiving ends of patriarchal power and almost defenseless when it comes to negotiating heterosexual relations’ (Campbell et al. 2008 & Gavey 2005, as cited by (Ibid: 1730). So, it may be reasoned that, the intersection of these categories conspires in such a way that, the agency of Somali women to define what they want in terms of goals which they can act towards is severely constrained

6.3 Concluding Remarks

This study sets out to fulfill the following major objectives which were to, (a) make contributions to extant literatures on Family Planning and women’s empowerment as a development concept, by questioning the dynamics which influences family planning use, (b) attempts to provide an empirical basis for interventions within refugee set up, where current practices regarding family planning and health education and promotions may be reshaped and improved, and lastly (c) to make available a status data on sexual and reproductive health behaviors among refugees, which has been found to be visibly missing out on surveillance health data from the host country.

It is evident therefore that reviewed literatures on the subject of family planning has contributed to current debate trends on FP use, and through the primary data from Somali refugees, there is a case for an original contribution towards current practices and nuances that influences FP use, like religion, cultural practices, illiteracy and other concerns of development which militate against women’s empowerment in that regard, and which may also illuminate the centrality of re-establishing FP debates onto international agenda. Similarly, the findings may be used as an alternative direction towards implementation of reproductive health in general, with the help and guidance of empirical evidence mined from this study.

Thirdly, findings from the study has consistently pointed out areas of weakness which may be inherent with current policy intervention in the camp life of refugees in general, hence it could be used to reshape various awareness and health promotions programs targeting various audiences with a view of enhancing contraceptive acceptance and awareness.

Lastly, it emerged that, use of FP methods are hindered by various factors bordering from misinformation, religious and cultural practices and short sightedness within current intervention practices, while at the same time Somali women expressed receptiveness despite these challenges, hence the study objectives could be argued to have been adequately addressed in the study.

6.4 Suggestions for further Research

This study was conducted among the population of Somali refugees; however, for effective policy intervention within refugee camp, findings from other refugee groups or populations, on perceptions, attitudes and experiences on family planning, may be more revealing on the current realities on the status of contraceptive use and acceptance among refugees in general.

Secondly, primary data on current contraceptive prevalence and unmet needs are quite thin among refugees; hence efforts to mine survey data on such aspects may be useful for program's evaluation purposes. It would also be of empirical significance, to interrogate contraceptive behaviors of the surrounding host communities living outside the camp, and who are also served by the camp's hospitals, to find out how these could be comparable with refugees, and what it could portend for ongoing efforts in policy interventions on reproductive health within this locality.

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Appendices

Appendix 1 Interview guide

1. Probe on the bio data of the respondents. Pay attention to how long they have lived in the camp, level of education, position in the community, family size and type.
2. Probe on the respondents' perceptions with regard to use or non-use of FP?- examine their understanding and awareness of FP services, ask whether they use or do not use FP and why? Which methods are commonly used and why, their preferred number of children and what they generally think of the use of contraceptives.
3. Probe whether the respondents have use FP services before, their experiences and views with regard to specific FP methods and their general views on FP services in the camp.
4. Probe on the respondents' attitudes, ask what they think of FP, use of contraceptives, what their faith/religion say about use of FP practices and cultural beliefs about children.
5. As for service providers, probe on the respondents' nature of work, how long they have served as FP service providers, challenges they encountered, their views of Somali women using contraceptives.

Specific questions

Section A

1. How old are you?
2. How long have you lived in the camp?
3. Where are you working and in what capacity?
4. What is your level of education?
5. What is your preferred family size?

Section B

1. What do you understand/think of FP generally?
2. Do you use FP and why/why not?
3. How many methods of FP do you know?/or you think are commonly provided in the camp?
4. How many children do you have/wish to have?

Section C

1. Have you used FP before?
2. What are your experience(s) and views concerning FP methods?
3. What are your views concerning FP services provided in the camp?

Section D

1. What do you think about contraceptive use?
2. What do you think your religion/faith says about the use of FP practices?
3. How many children is one supposed to have in your community?

Section E

1. What is the nature of the work you do?
2. How long have you worked in that position?
3. What major challenges do you encounter as an organization and individual in your line of work?
4. What does your work focus on mainly?
5. What are your views concerning Somali women using contraceptives?

Appendix 2 A Profile of the Study Participants

Participants name (Pseudonym)	A brief background information	Date of Interview
IKRA	<p>Ikra works for one of the humanitarian agency as a community mobilizer for Special Needs Education program. Before this study, I had known and worked with her as a colleague on a capacity as an instructor for English as a foreign language (EFL) program. My informal interaction with her may be said to have shaped my interest in wanting to pursue this topic of study. She has lived as a refugee since age 9 dating back to 1992 when she fled war torn Somalia and arrived in Dadaab refugee camp in Kenya. She was relocated to Kakuma refugee camp in 2002.</p> <p>Her story is that, she was raped when she was 9 years old while in Somalia country and at age 14, her father attempted to marry her off to an old wealthy Somalia man in the refugee camp, but she refused. Because of that, her father abandoned her and left for resettlement in the USA with other siblings, disowning her as one of his children. In her words she said that her father told her that, “If you do not want me to prepare your future, get out of my house, I am not responsible for you, and he kicked me out of the house and since I had got a job with IRC after class 8, my refugee colleagues helped me to establish a small tent to live with my fellow Somali Bantus. However, my community neighbours sensing my loneliness, later forced me to get married and I fled away from that community and moved to another section of the camp where I changed my name and even clan, so that I could not be bothered.”</p> <p>At the time of the interview, she was already married and expecting a baby. It emerged that, immediately she got married, she had plans of delay conception, and used pills for a period of 6 months. However, her husband wanted children and if she was to continue with pills, she feared that, he would marry an-</p>	26 th July, 2012

	other wife- so she gave up on the idea.	
SALEH	He is a twenty years old unmarried youth, at the time of the study, he was involved in managing a community Youth group (name withheld), in which Somali youths volunteers to teach fellow Somalis English language, and other basics of literacy. The interview was conducted at his stepmother's house in the refugee camp. His father married two wives. While his mother has six children, his stepmother has seven children.	26 th July, 2012
NURIA	Nuria is one of the new arrivals from Somalia, aged 21. She fled away from Somali because of <i>Al-shabaab</i> threats. She has three children with her first husband who divorced her on account that she was using FP methods (oral pills) secretly. She got married at age 14, and though using FP would help her plan her young life well. She has since remarry and does not wish to use FP methods because of that unhappy incidence with her first husband.	1 st August, 2012
AMINA	Amina, is a 26 year old woman, born in Somalia and left her home country while she was very young. She lost contacts with her parents and siblings. When she arrived in Kenya through Mombasa, a Kenyan woman took her in where she had opportunity to go to school. As a refugee she found it hard to be assimilated into Kenya, and that brief stay has some implications for her refugee status, she said that, "I am in a difficult situation because I was registered as a Kenyan in national examination -Kenya Certificate of Primary Education (K.C.P.E) because it was difficult to register with my identity as a refugee outside refugee camp and the woman who took me in did not know how to handle that, however, I wish to change this because if UNHCR discovers that, they could withdraw my refugee status". She is married and with three children and works as a Reproductive Health Motivator.	7 th August, 2012

MAMA IFRAH	<p>She is 50 and is a community leader who represents her community in various meetings organised by the NGOs and UNHCR. At the time of the interview, she works for NCCK as a reproductive health mobilizer in Somali refugee community. Her work is unique because she distributes female condoms to the women in the community irrespective of the nationality and gives advice in reproductive health matters.</p> <p>She holds a Bachelor of Arts degree in Arabic from Cairo University and got married at age 22, after completing her undergraduate studies. She is a mother of one child, but gave birth to five children. Two sons were killed in Somali and she lost the other three during the flights from Somali. For five years she lived without knowing whether her 3 children were alive or dead, but recently, she was reunited with her last-born son, now aged 14. It emerged that, the boy was brought along by some fellow Somalis who thought his parents had been killed. Then one of Mama Ifra's neighbour who had visited Nairobi heard about the boy's story and connected Mama Ifra to him, who positively identified the boy as hers, (through familiar birth marks in his body). She could not believe and spent the next six months crying with joy and thanking God for remembering her. Unfortunately, five years later, the other two children are still missing, no one knows whether they made it to Kenya or were killed in Somali.</p>	2 nd August, 2012
FGD 1(8 participants)-NCCK	The FGD participants were Reproductive health mobilizers (5 Ladies and 5 men) from Somali Bantu community. All of them were married and had more than two children in their respective families.	30 th July, 2012
FGD 2 (5 participants)	The FGD had 5 female participants (youths) from Somali community within the age brackets of 19- 26. Half of the participants were not schooling despite their wish to continue with their education.	31 st July, 2012
FGD 3 (5 Participants)	The FGD had 5 male participants from Somali community. All of them were volunteers for a certain self- help group, where they teach adults-fellow Somalis, English Language, (Reading, Writing and Speaking). As a group, they identified adult's illiteracy as a major problem affecting Somali community in various efforts to establish a secure livelihood.	1 st August, 2012
FGD 4 (4 participants)	The FGD had four married women. Some had used	4 th August, 2012

pants)	contraceptives before and others did not use at all.	
BAKUMBA	He is a refugee staff, working for one of the NGOs sampled in this study and in the capacity of a supervisor for community health motivators. He first worked with IRC (International Rescue Committee), hence his work experience with these two NGOs enabled him to have a wealth of information related to FP use among refugees, and directly had hand information on how refugees of Somali origin interacted with FP use and services in the camp settings.	30 th July, 2012
AJUKON	She is a national staff, working for one of the NGO sampled in this study, as a Field Officer in charge of Income Generating Activities for Both Refugees and Host Communities. Her work targets MAPs (Most at Risk Populations). This group comprise of: Single mothers, Disabled, Fostered Children, Orphaned and Vulnerable Children (OVCs), Sex and Gender Based Violence (SGBV) Survivors and people living with HIV/AIDs. She is also amply knowledgeable on the status of FP us in refugee camp and outside among the host community, where she serves.	31 st July, 2012
RAPS	He is a national staff and managerial head of Kakuma Sub office with one of the NGO sampled in this study. As a senior national staff, he was knowledgeable on all the activities which his organization dealt with, which included, provision of shelter to the refugees, but more importantly, provision of reproductive health services through awareness sessions on HIV/AIDs and other STIs. The awareness sessions, also had components of family planning which targets empowering most at risk population (MAPs) to cope with the camp life. (See Ajukon for MAPs).	26 th July, 2012
IMAM	The respondent is a refugee and an Islamic religious leader, working as Reproductive Health Motivator among refugees. He was considered knowledgeable on both FP use among the people he serves, and about religious views and how they interacted with FP use.	8 th August, 2012
RISPER	She is a national Staff and a deputy programme manager at one of the organization sampled in this	18 th August 2012.

	<p>study, working in the capacity of Reproductive Health Field Officer. She is also a professional trained nurse and has worked in that position in Kakuma and Dadaab refugees' camp for the last 12 years. She coordinates information dissemination on reproductive health and HIV/AIDS advocacy to scale up work on health. They partner with other organization on reproductive health services offered to refugees and surrounding host community.</p>	
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Appendix 3 Main Themes and Categories Derived from Interviews and Focus Group Discussions

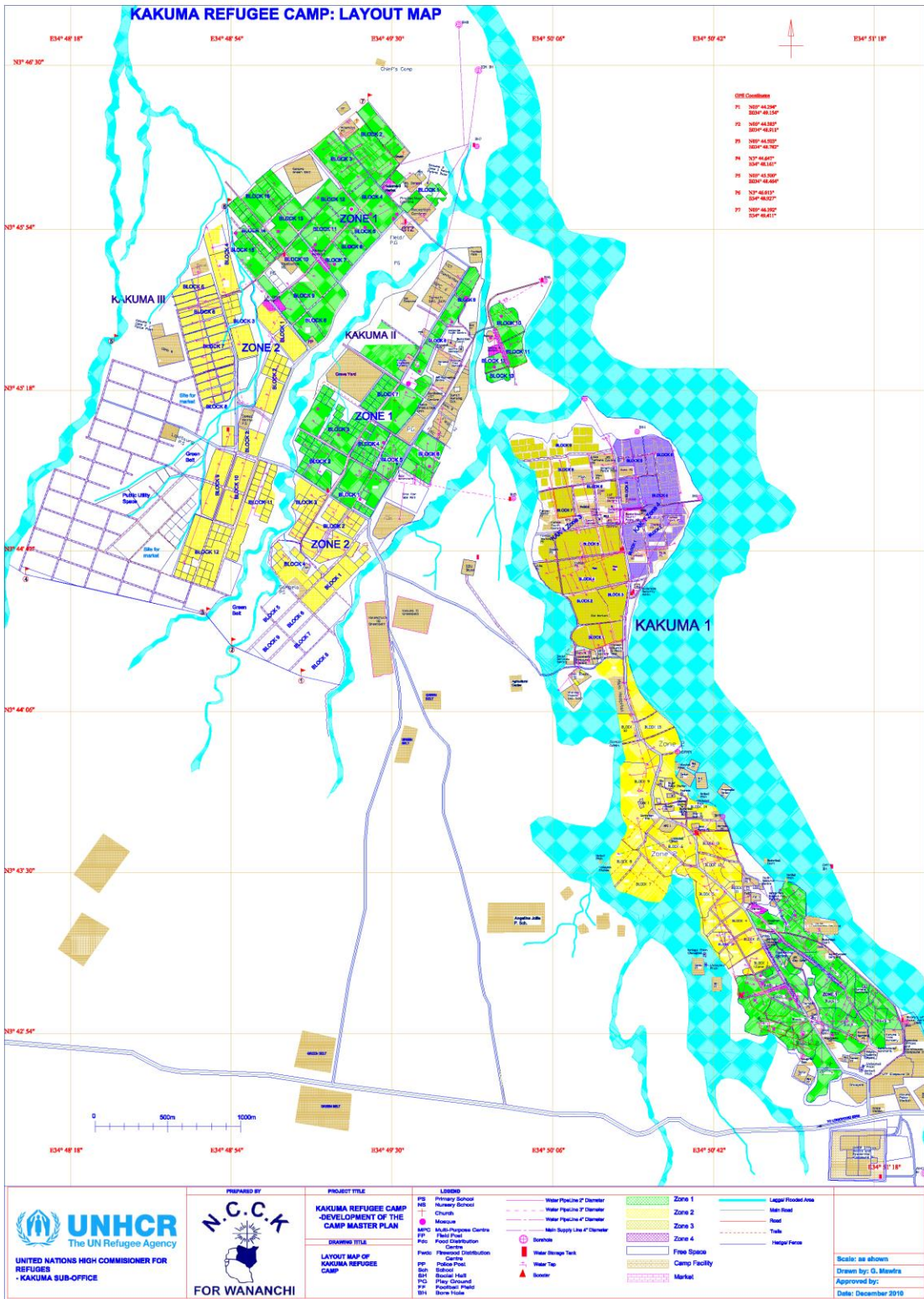
Themes	Coded Remarks
Meaning(s) attached to Family Planning practice.	<ul style="list-style-type: none"> • [FP is about Spacing children and preventing conception.] • [FP is about spacing (planning for future).] • [FP entails having children one can take care of comfortably/manage], • [FP regulating number of children one wants to have.] • [Breast feeding for 2 years as FP practice.] • [Pills and injections helps in delaying conceptions.]
Religious and Cultural Beliefs	<ul style="list-style-type: none"> • [No limit of the number of children] • [Allah provides children.] • [FP is all about spacing] • [Quran prohibits secret engagement with FP without the knowledge of the husband] • [Belief that religion discourages use of FP.] • [In favour of natural methods of FP.] • [Believe that they are harmful effects associated with FP if not used well] • [Religion do not prohibit FP however, it is against condoms/ early sex before marriage. • [Belief that one cannot get pregnant when breast feeding.] • [Belief that any FP method which kills sperms is tantamount to murdering a human being]. • [No one has right to stop children.] • [It's against religion to get pregnant before 2 years.] • [Many children are source of wealth.]
	<ul style="list-style-type: none"> • [A man reserves the inalienable right to marry another wife] • [The use of contraceptives is perceived as refusal to bear more children.] • [Men have the final say on the number of chil-

Men's position/ role in Contraceptive use.	<p>dren.]</p> <ul style="list-style-type: none"> • [Maintaining family legacy] • [Men allow contraceptive during the resettlement.] • [The husband has final decision on number of children to raise.] • [Marrying many wives in different locations (housing)] • [Decision to decide on the number of the children leis with the husband And Allah.] • [Reluctance by men to use condoms as a preferable FP method in marriage] • [Men view seeking for FP info/ service as a preserve/ women business.] • [Women are married to deliver babies (reproductive role).] • [Fathers believe that they have responsibility to control their daughters' future]
Women's position/ role in Contraceptive use.	<ul style="list-style-type: none"> • [Education enlighten women on FP adoption] • [Women are subservient despite level of education] • [Women who practice FP are productive and can manage their families better] • [It is women's responsibility to seek FP information/ services from the clinics]. • [Women expressed need for spacing -2 years] • [Women are not particular on the exact number of children they wish to have.]
Prevailing perceptions on Contraceptive use.	<ul style="list-style-type: none"> • [Modern contraceptives lead to infertility.] • [FP is a westernized concept meant to control Somali population]. • [FP information is given to married people not unmarried persons.] • [Condoms are not viewed as an FP method-relegated for risky sexual encounters.] • [Condom is common among prostitutes.] • [Lubricants in condom cause cancer (perception)] • [Claims on STIs is labelled against use of condoms.] • [Negative perceptions towards use of FP methods.]

	<ul style="list-style-type: none"> • [varied perceptions on FP methods with rural extracts less receptive while Urban – receptive]
Experiences encountered with Contraceptive use.	<ul style="list-style-type: none"> • [Fear of being divorced / conflict with the husband as a result of FP usage.] • [Bad experience/ encounter with use of FP (divorced as a result)] • [Bad experience.(continuous bleeding menstruation disappear/ does not come at all /).] • [FP is good since it helps manage family- reduces cost.] • [Sex workers (from Somali community) have more latitude to use FP methods e.g. condoms.] • [Users of female condom report it is noisy during sex hence not liked by many.] • [Bad experience (negative) with use of FP method (pills) - was divorced.] • [Practice of FP helps children grow healthily]. • [No confidentiality of FP seekers in the camp.] • [The service seekers are stigmatized in the community.] • [Injection as a preferable method.] • [Use of FP makes it complicates subsequent attempts of conception.] • [There are positive and negative effects of FP.]
Prevailing attitudes attached to contraceptive use.	<ul style="list-style-type: none"> • [Positive response towards FP among some.] • [Reports on a certain degree of awareness on FP] • [Efforts to adopt/ incorporate knowledge into practice is still wanting.] • [Mixed positive & negative attitudes towards FP exist.]
Provision of FP	<ul style="list-style-type: none"> • [No confidentiality on the patients seeking FP services from the clinics] • [Buy pill from illegal private vendors since they are assured of confidentiality]. • [There are sufficient FP methods in the camps.] • [Male condom dispenser available in strategic places & female condoms distributed]. • [Programmes on awareness available.] • [Female condoms are limited as opposed to male condoms (expensive).] • [Unmarried members fear going to clinics be-

	<p>cause of lack of confidentiality.]</p> <ul style="list-style-type: none"> • [Somali women reluctant to accept FP.] • [Major challenge lies complications exacerbated rising cases of HIV/AIDs hence dire need to enhance FP] • [Some women go to hospital and ask for injections after awareness.] • [Need for qualified personnel to administer some FP methods.]
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Kakuma Refugee Camp Map



Source: NCCK Kakuma.

Appendix 5 Kakuma Refugee Camp Statistics



by Country of Origin, Sex and Age Group

0 - 4	5 - 11						12 - 17			18 - 59			60+			Grand Total				
CoO	F	M	Total	F	M	Total	F	M	Total	F	M	Total	F	M	Total	F	M	Unk.	Total	%
BDI	279	259	538	270	288	558	133	173	306	589	1,122	1,711	15	4	19	1,286	1,846	0	3,132	(3.1%)
CMR	0	0	0	0	0	0	0	0	0	0	1	1	0	0	0	0	1	0	1	(0.0%)
COB	1	1	2	4	3	7	3	3	6	4	9	13	0	0	0	12	16	0	28	(0.0%)
COD	569	563	1,132	631	653	1,284	341	412	753	1,020	1,469	2,489	20	7	27	2,581	3,104	0	5,685	(5.6%)
ERT	1	3	4	4	4	8	1	5	6	20	67	87	0	0	0	26	79	0	105	(0.1%)
ETH	391	473	864	455	487	942	298	452	750	1,291	2,180	3,471	21	20	41	2,456	3,612	0	6,068	(6.0%)
ICO	0	0	0	0	0	0	0	0	0	0	3	3	0	0	0	0	3	0	3	(0.0%)
IRN	0	0	0	0	0	0	0	0	0	0	1	1	0	0	0	0	1	0	1	(0.0%)
RWA	41	43	84	35	46	81	37	31	68	109	142	251	3	4	7	225	266	0	491	(0.5%)
SOM	4,000	4,002	8,002	5,109	5,527	10,636	3,136	3,841	6,977	10,896	10,736	21,632	467	310	777	23,608	24,416	0	48,024	(47.7%)
SSD	2,415	2,645	5,060	3,614	4,608	8,222	2,598	4,251	6,849	5,935	5,412	11,347	305	90	395	14,867	17,006	0	31,873	(31.6%)
SUD	178	230	408	274	409	683	231	669	900	499	2,134	2,633	10	6	16	1,192	3,448	0	4,640	(4.6%)
TAN	0	1	1	1	1	2	2	2	4	1	5	6	0	0	0	4	9	0	13	(0.0%)
UGA	55	47	102	59	71	130	63	56	119	149	173	322	4	6	10	330	353	0	683	(0.7%)
ZIM	0	0	0	0	0	0	0	0	0	0	1	1	0	0	0	0	1	0	1	(0.0%)
Grand Total	7,930	8,267	16,197	10,456	12,097	22,553	6,843	9,895	16,738	20,513	23,455	43,968	845	447	1,292	46,587	54,161	100,748		
	49.0%	51.0%		46.4%	53.6%		40.9%	59.1%		46.7%	53.3%		65.4%	34.6%		46.2%	53.8%			

Source UNHCR Kakuma

24 Aug 2011

