FACTORS AFFECTING THE COMMUNICATION AND ADOPTION OF FAMILY PLANNING METHODS IN MIRUKA, NYAMIRA COUNTY

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A thesis presented to the School of Communication of Daystar University Nairobi, Kenya

In partial fulfillment of the requirements for the degree of

MASTER OF ARTS in Communication

August 2020
FACTORS AFFECTING THE COMMUNICATION AND ADOPTION OF FAMILY PLANNING METHODS IN MIRUKA, NYAMIRA COUNTY

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FACTORS AFFECTING THE COMMUNICATION AND ADOPTION OF FAMILY PLANNING METHODS IN MIRUKA, NYAMIRA COUNTY

I declare that this thesis is my original work and has not been submitted to any other college or university for academic credit.

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ACKNOWLEDGEMENTS

The process of this study was not without its challenges but through it all many stood out for having my back. First, I acknowledge my two supervisors, Ms. Winnie Mbatha and Dr. Leah Komen, who helped me conceptualize and eventually develop this proposal. They have corrected me over and over without tiring and while it seemed like I was taking forever to complete my work they have kept on encouraging me. I also acknowledge Sr. Prof. Agnes Lando whose advice saw me start writing and conceptualizing this proposal earlier. My two research writing lecturers, Dr. Mondi and Dr. Mike Chege, cannot go without mention as most of this work was developed under their tutelage and guidance. My two examiners, Ms. Anne Mwende and Mr. Hesbon Owilla, have been quite critical in coming up with the final report of the research and their input is immensely appreciated.

At a personal level, fellow student Nurah Ali’s support was immense. She took it upon herself to make sure that my movements in and out of the university were smooth despite my physical challenge. At home, my wife, Hellen Osiemo has taken adequate care of the family while I spent long nights either in seclusion or in school developing this thesis.

Many more have motivated, advised, corrected and implored upon me to keep moving and today am here. You may not be mentioned here but deep in my heart your names are engraved. Thank you.
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LIST OF ABBREVIATIONS AND ACRONYMS

CBD   Community Based Distributor
CYP   Couple-Years of Protection
DHS   Demographics and Health Survey
FP    Family Planning
FP/RH Family Planning and Reproductive Health
FPAK  Family Planning Association of Kenya
FPP   Family Planning Policy
FPSP  Family Planning Service Project
GOK   Government of Kenya
IEC   Information Communication Education
KDHS  Kenya Demographics and Health Survey
KII   Key Informant Interviews
KNBS  Kenya National Bureau of Statistics
MDGs  Millennium Development Goals
NCPD  National Council for Population and Development
PPFP  Postpartum Family Planning
PS Kenya Population Services Kenya
TFR   Total Fertility Rate
UNFPA United Nation Population Fund.
WHO   World health organization
ABSTRACT

The purpose of this study was to find out the factors that affected the communication and adoption of family methods in Miruka, Nyamira County. Its objectives were to determine the myths and misconceptions that existed in Miruka in Nyamira County about family planning, establish existing challenges in communication and adoption of family planning methods and find out the channels of communication preferred by Miruka residents about family planning methods. The study used qualitative research while purposive sampling technique was used to select study respondents. Interview schedules and focus group guides were used in data collection and the collected data was thematically analyzed. It was established that the participants mainly got family planning messages through radio, television and Facebook but preferred radio. The myths and misconceptions expressed by participants in regard to adoption of family planning include associating the methods with some ailments such as respiratory infections, failure of some of them to work as expected failure to conceive for quite long after stopping family planning and the side effects of the methods. The study concluded that adoption and use of family planning was limited by the myths, misconceptions and real body reactions that were associated with the family planning methods. Key findings included the fact that spousal input, social networks and hearsay are key in the adoption/non-adoption of family planning. The participants also had preferred channels with radio leading among them. The study recommends that strategies to increase awareness of various family planning methods at the community level need to be initiated to promote informed uptake and dispel associated myths and misconceptions.
impeding their adoption. Furthermore, there is need to design messages that have both partners in mind.
DEDICATION

I dedicate this study to my wife, Hellen Moraa, for her support and understanding during the long nights spent on this document. I also dedicate it to my son, Nyagwoka Monubi, who has always given me the reason to work harder towards the completion of this document. Further dedications go to the rest of my family: my father, David Mboga and mother, Isabella Nyagwoka; brothers, Vincent, Cliff, Eddie; and sisters, Susan and Rose. Last and but not least, this study is dedicated to one friend whose support cannot be measured: Nura Ali.
CHAPTER ONE

INTRODUCTION AND BACKGROUND TO THE STUDY

Introduction

It took thousands of years for the population of the world to grow to one billion people. However, after that it has taken only 200 years to grow seven times to the current population of 7 billion (United Nations Population Fund, 2020). Whereas this might turn out to be a blessing for a couple of countries, it does turn out to be disaster worthy mitigation in others. Population growth in Kenya has followed the same world trends of growth but at a rate of 2.7% and without being in tandem with other facets of the economy, that growth has remained to be a subject of concern and for which Kenya has tried to seek solutions for (World Bank, 2017).

Major amongst the government’s strategies to curb this problem is carrying out a series of communication campaigns and initiatives aimed at encouraging adoption of family planning. Most of them are yet to catalyze the required change in terms of population numbers through well planned families. Studies that have been done in the recent past identified effective communication as a key determinant in adoption of family planning messages. For example, a study done in Talensi District of Ghana identified the need for male involvement and to address misconceptions about family planning (Apanga & Adam, 2015). This study thus sought to find out if such gaps in the communication of campaign messages had an effect in the adoption of family planning in totality.
Background to the Study

Kenya is a developing country that continues to experience exponential growth in terms of population and average growth in other economic indicators. The latest census conducted in 2019 pegged the total Kenya population at 47 million (Kenya National Bureau of Statistics, 2019). According to a report released by the Ministry of Planning in the year 2011, the Kenyan population was growing at a rate of 1 million people annually (World Bank, 2017). This is despite a series of family planning awareness campaigns that have been conducted over the years intermittently. There have also been a number of auxiliary campaigns targeting other aspects of reproductive health including safe use of contraceptive methods.

One organization that has been central to family planning effort and campaigns is the Population Services Kenya (PS Kenya). PS Kenya is behind the Tunza Family Network and contraceptive use campaigns labeled Femiplan and C-word (PS Kenya, 2016). The Tunza Family Network began in the year 2008 and now operates Tunza clinics in 39 counties in Kenya including Nyamira County, PS Kenya has a dedicated team of 300 behaviour change communication officers who aim at creating demand for contraceptives through various initiatives including small group discussions. The team of communication officers is otherwise known as Tunza Mobilizers shortened as TMs (PS Kenya, 2016).

Population Services Kenya was the brain behind the controversial ‘Weka Condom Mpangoni’ advert, a nationwide campaign message disseminated through TV to encourage use of condoms amongst unfaithful couples. The advert centered on condoms
as easily accessible contraceptive partly to prevent pregnancy and secondly to curb HIV transmissions.

In the year 2004, PS Kenya produced Kenya’s first large scale abstinence campaign, *Nimechill*, a mass media abstinence campaign whose objective was to increase self-esteem and confidence among 10-15-year-old youth in regard to delayed sexual debut. The aim of the campaign was to make abstinence “cool” and normal and to reduce peer pressure regarding having sex. The campaign slogan was ‘*Ni poa Kuchill*’ coined around common slang amongst urban and peri-urban youths (PS Kenya, 2016).

According to the National Council for Population and Development, there are over 1.1 million whose need for contraception cannot be met. This translates to around 26% of all Kenyan women that are in need of contraception (National Coordinating Agency for Population and Development, 2010). Yet, from the examples of the campaigns above, it is evident communication is central to the success of these efforts. The design, the choice of words, medium and frequency must factor in lessons learnt from the failure or success of previous campaigns but in this case-failure.

Nyamira County is one among the 47 counties in Kenya under the new constitution. It is also one of those areas that have experienced high population growth leading to over subdivision of land to uneconomical sizes and thus making their utilization less viable as an economic activity (Nyamira County, 2015).

Miruka is a small village on the southern side of Nyamira County neighboring Homa Bay County. Most homesteads in Miruka have less than an acre of land for all their food production just like many other parts of Nyamira County. Administratively, Nyamira County is divided into 5 administrative units, namely Nyamira, Nyamira North
Borabu, Manga and Masaba North. Nyamira County continue to witness a marked increase in population. Chances are communication campaigns undertaken so far have gaps and thus not received well enough to curb this reality.

Statement of the Problem

The unmet need for family planning by women in Kenya mentioned in the background to this study has been partly attributed to ineffective messaging in the series of communication campaigns that have done in the area of family planning.

Ochako et al. (2015) elucidates this assertion through a study funded by Population Services International. The study with participants from Nyanza, Coast and Central regions concluded that awareness and knowledge about family planning does not translate to usage. Ochako’s findings signify the existence of a communication gap in the dissemination of communication messages. In his that study for instance, it was evident that the uptake of contraceptive methods was greatly affected by myths and misconceptions. It was also discovered that a lot of factual information had been distorted through social networks which exaggerate some of the effects. Among the reasons mentioned is that contraceptive implants could render them infertile while others expressed fear of retaining menstrual blood. Another fear expressed was that some contraceptives could cause someone to bear an abnormal child or even cause cancer.

Other factors that were significant to subsequent communication design were real fears such as weight gain, heavy and extended menstruation while some others also mentioned a lack of or reduced sexual desire. Men tended to associate contraceptives with promiscuity expressing openly that a woman on pills was prone to having extra marital affairs and only use contraceptives as a preventive measure from being exposed
to pregnancy something that definitely needs to be countered through effective messaging. It was also quite evident that other parties other than the women themselves mattered in decision making on whether to adopt family planning or not. As far as decision-making process, the patriarchal nature of the society also placed the male partner at the center of the decision-making process.

More communication issues that desire more localized studies are highlighted in a different study by Harrington (2019), where men indicated a desire to be included in FP programs. Men also voiced various concerns when women covertly decide to adopt family planning methods including leading to strained relationships. Limited couple interaction and communication about family planning was also mentioned as a contributory factor to the effective communication of family planning and thus address unmet contraceptive needs.

This study sought to establish whether similar communication challenges as evidenced by the studies above could be hampering the effective messaging and communication of family planning methods in Nyamira County given that the studies above are for regions far removed from the target population. This study also expands the scope of research to include most popular communication channels preferred by the target population in order to refine both the design and the dissemination of the messages.

It is apparent that the existing messages do not address the fears, myths and misconceptions and other possible factors that could be a barrier as far as the above studies are concerned. However, more important is the fact such a study is more significant when it is localized.
In a study in Nyamira County, findings revealed that over 46% of women were not on any contraceptives (Nyamira County, 2015). This is a significant number to any communication specialist involved in designing family planning communication campaigns.

This is despite efforts by the National Government, County Government and Non-Governmental Organizations.

Purpose of the Study

This study sought to find out the factors that affected the communication and adoption of family methods in Miruka, Nyamira County.

Research Objectives

1. Determine the myths and misconceptions that existed in Miruka in Nyamira County about family planning.
2. Establish existing challenges in communication and adoption of family planning methods.
3. Find out the channels of communication preferred by residents of Miruka in Nyamira County about family planning methods.

Research Questions

1. What myths and misconception existed in Miruka in Nyamira County about family planning?
2. What challenges existed in communication and adoption of family planning methods?
3. What were the channels of communication preferred by residents of Miruka in Nyamira County about family planning methods?
Justification for the Study

This research tried to build on previous researches on the communications affecting family planning adoption. However, in this particular study, this was limited to Miruka Village in Nyamira County. This study attempted to bring out the idea that there is a disregard of some key communication paradigms and ignorance and existing social realities that affect communication which consequently affected the attainment of desired numbers in terms of adoption of family planning. This communication breakdown had in turn led to a continual rise of unmet family planning needs.

Schiavo (2011) brings out this point more clearly by explaining that the key role of communication is to create an environment in which information can be shared and effectively utilized by the intended audiences. The communication is thus informed by an understanding of the audience’s taboos, beliefs, lifestyles and norms. Pearson and Nelson (1991) define communication as shared meaning. This meaning can only be shared if it is mutual and it can only be mutual if this study is done.

Significance of the Study

This study would be of great significance to subsequent design of communication messages targeted at Nyamira County residents. The findings of this study would contribute in filling the communication gaps in regard to family planning methods. The eventual aim is to enhance government efforts in reducing population growth.

However, this study is more significant in addressing the specific communication concerns of family planning messages in Nyamira County. In the era of devolution, specific counties have to assess their own challenges and provide unique solutions and Nyamira County government would find this study quite significant in planning and
policy making. Furthermore, a lot of factors that may go into the design of family planning messages may not apply equally across the country. There are always unique regional and cultural factors that cannot be covered by blanket studies. Health communication should be people centered, and research based (Schiavo, 2011). This study would thus be of great benefit to media and communication practitioners in the area of development communication in identifying unique social and cultural factors in Nyamira County and tailoring communication campaigns appropriately.

Assumptions of the Study

The study made the following assumptions:
1. That participants had come across family planning messages
2. That there were a number of communication elements that affect the awareness and adoption rates of family planning.
3. There were myths and misconception that affected communication and adoption of family planning.
4. There were challenges faced in the communication and adoption of family planning methods.
5. Certain channels of communication were preferred in the communication of family planning.

Scope of the Study

This study was limited to Miruka Village in Nyamira County. Miruka Village is part of Nyamira County which is one among the 47 Kenyan counties under the new constitution. Miruka Village neighbors Homa bay County to the Southern part of Nyamira County. This is an area that has continued to experience increasing pressure in a
number of resources like land. This increasing population amongst many other factors has been attributed to poor family planning (UNFPA, 2020). Secondly, the campaigns to inculcate family planning amongst the target population had not met the desired objectives.

In a study done by Nyamira County government and incorporated in its first integrated Development plan for 2013-2017, over 46% of women in Nyamira County are not using contraceptives. The total unmet need for family planning in Nyamira County stands at 34% and the total fertility rate at 4.2.

Limitations and Delimitations of the Study

Family planning is an expansive area of study. Each region has cultural, economic and behavioral factors that cannot be applicable to every other region. It was thus not possible to conduct a fully representative research for the whole country. In this case then, the researcher limited the study to Miruka Village in Nyamira County. Financially it was impossible to conduct tens of interviews in Nyamira County. The researcher thus utilized purposive till saturation method while targeting key informants to help accurately mirror the rest of the population using Miruka Village.

Another constraint was that due to rural urban migration, most couples in Nyamira County just as other regions could be living apart. Due to the diminished factors of production most breadwinners have opted to work in the city while supporting their families back at home. Nonetheless, the researcher planned to use phone interviews for participants that would not be reached physically though eventually that was not needed.
Definition of Terms

Family Planning: It is a voluntary means through which couples anticipate and attain the desired number of children and the desired spacing (World Health Organization, 2016).

Unmet Need: This is the gap between a sexually active individual’s reproductive intentions and contraceptive behavior or use (WHO, 2020).

Myths and misconceptions: A myth in health communication is defined as an unscientific proposition which is also untrue while a misconception is defined as a mistaken thought or idea (myth, 2009)

Health Communication: Health communication is the multifaceted approach to reach various audiences with the goal of influencing their behavior in order to improve health outcomes (Schiavo, 2011)

Summary

This chapter has introduced the topic on factors affecting the communication and adoption of family planning as a method of population control amongst females of child-bearing age in Nyamira County with a focus on Miruka village. The researcher briefly explained the concept of Family Planning and also described the challenges that necessitated this study. In this chapter, the researcher took time to highlight the statement of the problem, the purpose of the study, the objectives and research questions. The chapter further comprised the scope and significance of the study, limitations and delimitations and the definition of terms that were used in the study.
CHAPTER TWO

LITERATURE REVIEW

Introduction

This chapter presents theories that are relevant to this study, literature review that related to the stated purpose and research questions. It also provides the empirical review and the conceptual framework to show the relationship between the independent and dependent variable. It reviews the health belief model and gives a foundation for its use as the most appropriate theory. The journey of family planning in Kenya and India and the lessons learnt thereof are reviewed.

Theoretical Framework

This study was based on the health belief model. The HBM is a health communication theory which posits that personal beliefs influence behavior. The theory came into being in the 1950’s to explain why free Tuberculosis Screening Program organized by the United States of America government did not succeed as envisaged. The key proponents were Geoffrey Hochbaum and Irvin Rosentock who at the time were social psychologist who worked the US Public Health Service (Hochbaum, 1958). The HBM has now emerged to be one of the most widely theory in the study of health communication.

Health belief model has four main theoretical constructs and two additional constructs which were added as improvement to the original theory. They are illustrated below.
Perceived seriousness

Perceived Susceptibility

Perceived Benefits

Perceived Barriers

Motivating Factors/cues to action

Additional Constructs

Self-Efficacy

Perceived Seriousness

Perceived seriousness is based on a person’s beliefs about the severity of a disease or given medical or medical-related condition (Janz and Becker, 1984). A person’s beliefs are influenced by two main things: the existing medical knowledge about the situation and the perceived impact of that disease on the general wellbeing of a person. A condition may be perceived to be more severe if it directly impacts a person’s daily capacity to work hence reducing a person’s ability to earn his daily income, among many other reasons. For example, before the discovery and general usage of Antiretroviral Drugs, the HIV Virus was perceived to be more serious (Atuyambe et al., 2008).

The images shown to advocate for responsible sexual behavior were of emaciated and wasted patients. Many people took cues from such images and were motivated to change behavior. However, currently, a lot of people with HIV are healthy people. As opposed to earlier campaigns which targeted responsible sexual behavior to curb the
spread of HIV, many campaigns nowadays are aimed at encouraging people to get tested with the promise that they can still be able to lead a long healthy life if they know their status and can follow through with the antiretroviral dosage.

Perceived Susceptibility

Perceived susceptibility is a powerful personal perception to adopt a new behavior. A person will be more prompted to adopt healthy behavior if he feels due to his current behavior; he is at high risk of contracting a certain disease or acquiring a certain condition. For instance, in Kenya, incidences have been reported of old men who prefer to have sex with young women due to their perception that they are at lower risk of contracting HIV from young children. It is also common to find out that more women than men go for breast cancer screening despite the fact according to medical experts, breast cancer can affect both genders. Women feel that they are more susceptible to breast cancer hence the increased response, while men feel that just because they do not have protruding breasts they are not at risk (Atuyambe et al, 2008)

However, it is not always the case that perceived susceptibility leads to the adoption of advocated behavior. According to Lewis and Malow (1997), despite the fact college students are at higher risk of contracting HIV due to their unsafe sex behaviors, they do not seem to adopt safe sex. Thus, the drive to adopt health behavior becomes stronger when perceived Susceptibility is combined with perceived seriousness to create a perceived threat (Champion and Skinner, 2008). This explains the incidences of mass adoption of health behavior. For instance, the consumption of meat declined heavily in Germany in 2001 after an outbreak of mad cow disease, scientifically known as Bovine Spongiform Encephalitis. Though the disease does not affect humans, scientists explained
that the consumption of meat from affected cattle could lead to a human variant that was fatal.

Perceived threat has also come in handy in the treatment of Tuberculosis. Tuberculosis patients are encouraged to be very strict on their dosage lest they develop drug resistant strains of Tuberculosis. There are very few incidences of such strains reported maybe because it takes long to complete a dosage of Tuberculosis and patients would rather not do it again.

Perceived Benefits

This is a person’s opinion to the value of the new behaviour. A person would be more driven to adopt a new behavior if it reduces his chances of getting a disease that is a perceived threat. For example, in shunning cow meat in 2001, German residents were looking at the value of their decision in helping them avoid a disease that was fatal. In campaigning for adoption of new behavior, the people must be made to perceive the benefits of the new behavior. In the campaign for family planning, only those who perceive the health, social and economic benefits of a small and manageable family are able to heed. However, the perception is usually the opposite, others perceive a bigger family as economical as they would have more people to work on the farm depending on the cultural orientations of the target community.

Perceived Barriers

According to Janz and Becker (1984), perceived barriers are the most significant in determining behavior change. For advocated for behavior to be adopted, the benefits of the new behavior must outweigh the consequences of continuing the old behavior. The benefits of adopting family planning must outweigh the consequences of failing to plan
one family. These benefits can be in form of improved quality of life as opposed to having a big unplanned family that puts pressure on the existing resources. Some may opt for quantity over quality and thus there is need for a compelling appeal that makes unplanned families undesirable.

Motivating Factors

Other than the theoretical constructs of perceived seriousness, there are other factors that move people to act on their perceptions. This includes personal experiences, proximity to people with personal experiences, constant interaction with information that heightens their perceptions. For instance, a family that has lost one of their own due to birth complications as a result of poor pregnancy spacing would be more motivated to adopt new behaviour. Either, a person that constantly comes across TV campaigns, newspaper coverage and radio announcements of a particular health issue in this case family planning would be more driven to find out more about the behavior and act on it.

Self-efficacy

To adopt a new health behavior, one must feel sufficiently able to adopt the advocated for behavior. This is called self-efficacy (Bandura, 1977). One may not adopt an advocated for behavior even if he is aware of the benefits if he feels he has no capacity to adopt it. The choice on whether to adopt family planning may depend on others factors such as patriarchal societies where a woman is incapable of deciding on her own whether she will adopt a behavior or not. The capacity might also be in terms of affordability and availability.

Relevance to the study
Family planning is a health behavior whose main aim is to create an environment of stability amongst nuclear families by helping families make wise choices on the number of children and efficient gapping in order to be able to provide for them their basic and other needs. Family planning debates usually raise all kinds of emotions due to the varying cultural, educational, and social backgrounds of the targeted populations.

However, amongst the youth and educated population, it is taboo to think of siring beyond three children. In fact, even three is a crowd. For this reason, the health belief model comes in handy, for it raises issues of perception and how they affect the adoption of family planning. These perceptions are as a result of the varying educational, cultural, and social backgrounds, as noted above. This model will help us categorize all the perceptions that can occur when conducting family planning and the remedies thereof. The design of communication messages on family planning has a direct bearing on how the targeted respond to the messages.

Do messages given challenge inherent perception, or do they skirt the issue and thus give room to the status quo where myths and misconceptions, religious beliefs, and social networks remain a force against the messaging?

The health beliefs model avers that messages can only achieve optimal behavior in the intended population if they target the constructs, which are perceived barriers, benefits, self-efficacy, and threat. A more simplified explanation is that people are more likely to adopt family planning as a health behavior if they feel that it can affect them (susceptibility) either, it can have serious consequences(severity), and if they believe that family planning in itself other prevent serious consequences can also have additional value(benefits). However, they must also have little or no hindrances to the advocated for
behavior, which in this case is family planning (barriers). Later a person’s ability to adopt a behavior was adopted (self-efficacy). In the case of family planning, self-efficacy is literally the availability of family planning services and the power to make decisions that may be limited depending on the age of the target or the culture and nature of the society (Jones et al., 2015).

General Literature Review

Family Planning in Kenya

Kenya was the first country in sub-Saharan Africa to adopt an official family planning program in 1967 (K’okul, 1991). Kenya has had a chance to mess in the past but that may no longer be tolerable. It is assumed that as a result of the many years of experience that the country has been handling family planning interventions, Kenya would be by now employing the most effective programs and strategies. To a good extent, the country has covered a good mileage. The reduction of numbers in the country must always be keen to changing demographic trends.

The only we can then be able to create strategies relevant now, and in the future, it is advisable that we trace the history of family planning in Kenya. Below is a timeline that loosely captures the history of family planning in Kenya.

1958: Local family planning associations receive international financial assistance from the particular field.
1960: Local family planning associations to serve multiracial populations in Nairobi and Mombasa.
1962: the family planning association of Kenya is established and becomes affiliated with the International Planned Parenthood Federation. The first post-independence census reveals an extremely high rate of population growth.
1965: sessional paper no 10 is issued and includes a call to moderate population growth. A national family planning program is recommended. 1966: a circular is issued announcing the establishment of the National Family Planning Program. 1967: a second circular is issued emphasizing training and the offering of family planning services free of charge. 1969: census indicates that the rate of population growth is very high.

1971: the government asks the World Bank to help develop an enlarged national family planning program. 1975: a five-year plan that enlarges the national family planning program is established with a budget us$39 million. 1979: a new census indicates that the annual population growth rate is approaching 4% (Donald, 2007). The timeline above shows the commitment that has been shown by a country keen to inculcate a culture that is quite crucial to social development. Throughout this timeline, no mention has been made of the various contraceptives applied and rate of success. No mention has also been made of the success rates in given regions in the country. Much of what was done was national and thus much of the statistics from government documents are also national in nature. This is not to say that there has been no regional analysis of knowledge, perceptions and attitudes towards family planning program in Kenya. That has been done in the backdrop increased sensitization of the advantages of family planning to families and the nation at large. The only challenge, it has been an analysis of the impact of a national program on a given region.

K’okul (1991) presented tidbits of a study done in a village called Samia in the Western region of Kenya. The study comes out with various findings. For instance, one of the participants made a comment that “all families plan to have the deserved number of children one can effectively nourish, clothe, medicate and educate’. This finding can
be interpreted to mean that, it is the wish of every parent in Samia to be able to provide for his or her children. So then, what stops them from employing various methods to achieve that objective? Now, this is a study of a government program on a given region. For future interventions, the results of such a study will be very welcome in developing a localized program that addresses such issues as are relevant to particular communities.

According to the study in Samia, the following was a summary of some of the reasons why the women do not adopt contraceptive as a family planning method.

The village woman had distrust of Western made contraceptives particularly because of their side effects. The other reason given as the contraceptives are expensive. Some also said that pills cause severe intrauterine bleeding. Other effects according to this study are that contraceptives cause stillbirths, hormonal change, headaches, dizziness, allergy, abdominal pain and backache. Some claimed that contraceptive use causes foetal disability and sterility and premature maternal drying up during lactation while others claimed an intra-uterine device causes abnormal birth, abdominal birth and backache. It may disappear into the womb or embed itself in the uterine wall or fail to prevent impregnation (K’okul, 1991).

Such statements are what several media campaigns in Kenya are calling myths and misconceptions. It has severally been hammered that only a medical practitioner’s words should be believed. To the policy makers, those are myths and misconceptions but to the village woman who does not have the privilege of interacting with as much information, they are taken as the only truth. To counter this, one needs to apply the relevant development communication paradigms. The distribution of condom in Samia secondary school is counterproductive as it has prematurely heightened sexual activity
among youths. The village women wondered why the policy makers were harassing them on the Western made contraceptives yet there was a higher rate of pregnancies and unwanted births among school going teenagers (K’okul, 1991).

All the above are valid counterarguments yet the researcher believes, they are not new and thus by now policy makers should be dealing with different issues. For instance, according to WHO the IUD is a highly effective, long acting and easily reversible contraceptive. It is possible that the perception held by women in Samia is the same perception by women all over the country but to varying degrees. This has made it to have low prevalence rates in sub-Saharan Africa where Kenya lies (WHO, 2016).

According to the United Nations (2019) the prevalence rate for the IUD in sub-Saharan Africa is 5%. The erroneous beliefs about various contraceptive methods are not only held by village women but ironically by some medical providers too. Jacobstein (2013) averred that some practitioners believe that IUD may cause or worsen cases of anaemia.

In the year 2012, Kenya became a party to Family Planning 2020 (FP2020) which is a global partnership to empower women through family planning interventions. By signing into the partnership, Kenya became part of a community of global leaders and advocates of increased access to contraceptives. While signing the partnership, Kenya committed to establish youth empowerment centers and with an aim of having one in each constituency. Kenya through the Ministry of Health also committed to collaborate more with private organizations, civil society and the general public at both the national and couth levels of government in order to improve access to reproductive health services (Republic of Kenya, 2020)
In a progress report of the year 2019, Kenya had hit its target of 58% contraceptive use by married women in Kenya. Additionally, there has been 9 million additional contraceptive users every year since 2012 (Republic of Kenya, 2019). However, it still notable that 58% is still far from 100% desirable rate and that there is still a regional disparity in what communities consider to be the ideal size of a family. While some communities may consider an average family size to consist of 9 children, some consider 3 and others 1. That means, there is still more work to be done in targeting specific communities through research informed messaging rather than applying a one size fits all kind of intervention.

The Kenyan constitution has made reproductive healthcare one of the rights and thus the Government of Kenya has heavier task of ensuring reproductive healthcare is accessible to all. Besides making promises, it is tasked with making sure that all health interventions are adequately budgeted for and resourced failure to which, it would have gone against the supreme law of the land.

In the year 2012, the Kenya National Commission for Human Rights (2012) released a comprehensive report after a public enquiry into the attainment of sexual and reproductive health rights in Kenya as per the Kenyan Constitution. Under family planning, the commission outlined several barriers as had been motioned by those who managed to give their views. The first barrier mentioned was unavailability of planning commodities. Women complained of frequent shortages particularly of the more desirable long acting contraceptives. This barrier was closely tied to the second barrier, whereby most health workers had no capacity to administer more complicated methods such as implants and IUCDs.
Thirdly, there were cultural barriers whereby some communities believed in having as many children as possible. Areas of Sabaot, Bukusu and Muslim communities were mentioned prominently. In this communities, men also had the final say and most women thus opted for very discreet means of family planning such as injections. In some communities such as Giriama, a woman’s mother-in-law also had some powers. In Kitale, some men attributed use of family planning to promiscuity. They explained that, family planning can also be used by a partner who wants to engage in sex outside marriage without the repercussions of getting pregnant. Other barriers mentioned included lack of information on most suitable methods with some opting for natural or herbal remedies that were highly unreliable. Finally, the cost of family planning services was also mentioned. On a more positive note, most women indicated their desire to space their children, although most felt they did not have the capacity given the factors noted above (KNCHR, 2012).

Interventions and Studies

Several countries have in the past set up different strategies for dealing with the over growing populations. This was and has always been necessary for such countries due to the obvious population challenges. Among them is India which unfortunately was the most challenged. Consequently, it became the first country in the world to have a national policy in 1952 (Rao, 1974). Being a pioneer was obviously going to raise some challenges. First, they had no reference point. Secondly, this was a pretty new challenge and thus they lacked enough information to back up their programs.

The picture we get from this reality is that before 1952, few countries had population challenges. This does not mean there were no population control
interventions. It is just the population challenges were not profound. This hence means that the governing authorities were not seriously concerned. There was no research and accompanying national policies.

Due to the above challenges, the initial programs lacked scope (Rao, 1974). However, it still managed to set running a process that would later attract a lot of research. It led to the development of the necessary relationship between research and policy. This has always needed review as more information and knowledge is made available through further research in various components of population control. Broader programs have also been incorporated; they include population and development, gender perspectives, reproductive health and HIV/AIDS.

All the above perspectives have each received their fair share of attention by researchers and authors because they are approaches in dealing with an issue that is central to Government policy. In dealing with population growth, one cannot avoid talking of birth-rate. According to Prasad (1998), unless birth-rates are controlled, incomes cannot improve materially and at the same time unless incomes improve materially, birth-rates will not fall. Accordingly, it become almost axiomatic that economic development can in the long run bring about a fall in the fertility rates.

According to the above statement, birth rates can be used interchangeably with fertility rates. According to World Bank (2020), fertility is defined as the number of children that would be born to a woman if she were to live to end of her life. Decreased birth rates lead to low fertility; and increased birth rates leads to high fertility. When India was initiating its national efforts on population control in 1952, they were concerned about the fertility rates. There were looking for interventions that would lead
to a drop in fertility rate which would in turn lead to manageable populations. Prasad (1998) introduced an economic aspect of fertility rates by asserting that birth rates control leads to economic development which in turn leads to a fall in fertility rates. This is both right and wrong depending on how you look at it.

Kammeyer (1975) argued that the age-old patronizing attitude and theory that lower class (low economic development) leads to high sexual frequencies and consequently high fertility rates are not true. He argues that this is because; no one has ever conducted a credible research into the issue. It is essence; this then remains a theory used by higher classes of people in society to patronize the lower classes. This then dispels the assertion that economic development leads to a fall in fertility rates; albeit, until a research is conducted. I ‘am glad to add that part of this study will strive to answer that question.

The two-way relationship between research and policy in India led to a number of studies that were, and continue to be, crucial to any country dealing with similar challenges. Amongst all these studies, one area stood out, the area of family planning. Researches surrounding the issue of family planning overrode every other aspect of population control policy. Rao (1974) defined family planning as a composite program involving contraceptive technology, people’s reactions to them and impact of contraception on fertility. Family planning in itself has been termed as a composite program which automatically raises the issue of the blocks that make up family planning in India. These are broken down as fertility studies, knowledge attitudes and practices, contraceptive use, and family planning organizations.
Between 1951 and 1955, 11 KAP studies were conducted in India. Since then several more have been conducted on both KAPs and other areas. This is because demographics are always changing and thus one must be keen to capture any slight changes in demographic trends. It is important to note that fertility declined by 40% in the period between 1952 and 1994 (Adlakha, 1997). Fertility rates in figures declined from 6.0 births per woman to 3.6 births per woman. Even with this success rates, India’s population growth rates remained at 2%. There are valid reasons to explain why even with such success levels, the population still grows.

Population growth and family planning were not being dealt with in isolation. Issues of reproductive health and maternal health were taken into consideration too. This led to reduced death rates. The picture here is that there was a greater success in controlling birth rates than in controlling birth rates. That led to the population growth level recorded in India. So, what would be the situation without family planning? Dire. It would have been an enormous load on the India government. Hence, it is clear that though the war has been fought well, has not been won?

So how did India go through the onus task of making the populations aware and adopt the various family planning methods. Prasad (1998) indicated that family planning awareness was conducted through educative and innovative programs. The message that was hammered severally, through the mass media was ‘we are two, we have two children’. The objective was highlighting the beauty of small families. Up to this point, the idea of spacing had not been highlighted yet but then it was expected that to have small families, spacing was inevitable. Before this message, both ideas -spacing and small families - were none-existent (Nembiakkim, 2008).
Chandra (1987) gave an inkling of how the messages were crafted. He says that the messages were crafted to appeal to the health and welfare of the family. This message was about securing better health for the mother and her capability to bring up children. During the initial 5-year period of India’s program, about 300 urban clinics, and 2000 rural clinics were to be set up. This shows that, though India’s program had no reference point, they had the insight to preach water and provide watering points. After hearing the message, it was obvious that, the people needed to visit the clinic to get more information and adopt the programs.

By initiating all these interventions, the India government had recognized that, “the steep rise in population can thwart all attempts to plan for improvement in the quality of life of people, particularly those living below the poverty line” (Chandra, 1987, p. 53). On 25th May 1981, The Indian association of parliamentarians also noted that the pressure of numbers will deny development to those very segments of the society for which development is needed. The Indian Government and leadership demonstrated their genuine concern about population growth and how it would affect the lower classes for which development was really needed.

One child policy in China

China is most famous for taking one of the most drastic steps towards reducing the fertility rates of its people. Though the efforts to curb population growth began as early as 1949, more definite steps towards this end started taking shape in 1978 when China’s population hit the one billion mark. By 1980, the one child policy was now applied across many parts of China with a few exceptions here and there until September
of the same year when the official communication for strict adherence to one child policy was made by Communist Party of China (Pletcher, 2017).

The communication was thus an indirect suggestion that the people in China were to consider using whatever family planning methods were available to them. This strategy worked as the fertility rates dropped to below two children per woman. According to The China Research Foundation the population growth rate between 2000 and 2010 was at 0.57 percent. However, this was not without problem or challenges. The structure of China’s population changed exponentially. The percentage of members of the population aged above 60 doubled from 7 percent to slightly over 13%. At the same time the percentage of children between 0-14 dropped to 16 percent from 33% (China Development and Research Foundation, 2012).

These were not the only challenges. The sex ratio became more skewed as the culturally the population preferred boys to girls and thus used whatever means to terminate pregnancy after scanning. Abortions and infanticides became rife. Another consequence of this policy is that most families chose to hide any second child from the authorities thus denying them government support and facilities. It is from this background and on the recommendation of the China Research and Development Foundation that the Government of China reviewed the One Child Policy to accommodate two children. The start of the year 2016 marked the beginning of a new era for Chinese people after 40 years of strict adherence to One Child Policy (Evans, 2016).

This policy has been termed by analysts as the most despised policy. This probably explains why China remains the only country in the world to have gone that route before making an about-turn in 2016. This is a clear sign that effective
communication remains the most viable option for population control. Communication burdens the target population to respond to the communication as opposed to burdening government officials with the responsibility of enforcing it. The burdening gets heavier when the government is forced to do forceful sterilizations (Beech, 2016).

Health Communication Challenges

Effective communication remains a central factor in the dissemination of family planning messages. It is for this reason that it becomes important to critique effective dissemination of family planning messages without using various communication paradigms as a basis. In a report titled *Understanding Behaviour Change* prepared by Katrin Prager for the James Hutton Institute, she notes that many campaigns are still based on traditional communication models which assumed that lack of information is the key reason why people behave or act in a certain way. This linear traditional model assumes that exposure to such information leads to an automatic change in behavior. In the field of behavioral change communication, nothing can be further from the truth (Prager, 2012).

Prager (2012) pointed out that behavior is very resistant change and goes ahead to mention the following reasons: that people are creatures of habit yet most communicators aim at achieving maximum gain with minimum effort. There is also an agreement with other scholars that dissemination of information and exhortation are the least effective ways of influencing behavior even if that information is about real health risks such as smoking, obesity and HIV.
In a report for the World Bank titled *Broad Challenges in Health Communication*, a few of the issues that have come up in the history of health communication were highlighted. In the area of Polio campaigns, for example, politicization and rumor-mongering were found to have been a major issue, despite the relative success of the Polio campaigns. Some communities also believed that there were communities that believed that they had bigger issues to deal with than Polio (Deane, 2007). In most African communities, poverty and the struggle for a daily living is usually regarded as the bigger issue.

Africa was declared polio-free in August 2020 by the World Health Organization which is a key milestone in health communication, but most health communicators would aver that this milestone may have been achieved earlier, were it not for politicization and rumor-mongering. In Kenya, the rumor-mongering was led by the Catholic Church and edged on by a small sect. Koech (2015), in a published news article sought to find out why the most senior Catholic leader in Kenya, Archbishop John Njue, would lead the catholic masses against what the world considered to be the ultimate solution to the historical health problem. In the article, the catholic bishops were terming the Polio jab as unsafe and the need for further tests before it could be used. Speaking to the writer of the article, Archbishop John Njue alluded to tests that had been done in Nigeria, which found the vaccine to be unsafe. The government was obviously quick to dismiss the argument as it called upon the church to leave matters of health to health experts. However, a rejoinder by a Polio Ambassador in the name of Harold Kipchumba could have made all the difference (Koech, 2015).
The above example shows that there is need for more ambassadors for health related behavior. These are people who have already suffered the consequences of unhealthy behavior. Deane (2007) mentions the need for a community mobilization strategy involving all community leaders and stakeholders.

Empirical Literature Review

Knowledge on family planning methods is important for making choices to initiate use of contraceptives among women. A study carried out by Republic of Kenya (2009) to provide information on levels and trends in family planning knowledge and use in Kenya revealed that although the knowledge of family planning was universal, 95% of women aged 15-49 knew at least one method of family planning. The survey further revealed that knowledge and use of family planning was increasing. It indicated that 98% of all married women were able to identify at least one family planning method. The most commonly used contraceptives were female sterilization at 7%, injectable contraceptives at 11%, pills at 10%, periodic abstinence at 7%, IUD at 5%, condom 2% and Norplant at 2% (Republic of Kenya, 2009).

Further, the study showed that 25% of married women wanted to space or restrict the number of children but did not use any contraceptive method thus a risk due to the chances of high fertility rate and consequently high rate of population growth. The study further revealed that the difference in fertility among women was due to the role played by education which created awareness. Low fertility rates occurred if there was access to good jobs, resources for family planning among women and improved literacy (Republic of Kenya, 2009).
Timothy, Wawire, and Mburu (2011) did a study in Kenyan slums to assess the level of contraceptive knowledge and use and also identify factors that led to contraceptive usage. The study revealed that 51% of the respondents were aware and used majorly used contraceptives to avoid pregnancy and prevent sexually transmitted diseases, while 49% avoided contraceptives since they infrequently engaged in sex, they were not married, pregnancy, lack of support from spouses and need for children. The study further indicated that the mostly used family planning methods were pills at 33%, condoms at 35%, intrauterine device at 4% and injection at 19%. This study further revealed that use of family planning methods was highly used by women aged between 20-39 as opposed to those under 20 years and above 39 years. The 49% of women who embraced family planning methods were aged between 20-29 years, 41% were between 30-39 years but those above 50 years were found not to be using any contraceptive method. The findings of these studies clearly indicate that the rise in knowledge and usage of contraceptives was due to sufficient communication (PS Kenya, 2016). From the above analysis of family planning in Kenya, it is clear that different factors played a major role in family planning adoption. The factors include level of awareness, income level, education level, communication, area of residence and accessibility.

A youth reproductive health survey on adolescents aged 12-19 years indicated that generally, the adolescents had limited knowledge of family planning methods and their effective use (Awusabo-Asare, Biddlecom, Kumi-Kyereme, & Patterson, 2006). It was noted that 90% of the adolescents studied were aware of one form of modern contraceptives. The male condom was largely the only known form of contraceptives and their awareness of other contraceptive methods was quite low. In regard to pills, males at
55.7% and females at 52.7% had some knowledge of its usage. In regard to the Intra Uterine Device, males at 23.1% and females at 23% knew of it. Similarly, there was 55.5% and 56.5% awareness on the use of injectable contraceptives in the males and females, respectively. On the use of implants, 17.6% of the males and 18.7% of the females knew of it. At 20.1% and 18.4% males and females respectively had knowledge on emergency contraceptives. The condom had highest knowledge level as 90.6% and 87.9% of the males and females were indicated as knowing this method. The least known contraceptive method among the adolescents was the foam or jelly at 15% of the males and 11.8% of the females (Awusabo-Asare, Biddlecom, Kumi-Kyereme, & Patterson, 2006).

A separate study in Kilifi and West Pokot revealed that despite a wide choice of contraceptives, the residents were limited to only a few due to lack of information. Out of 49 women who took part in FGDs, none was using Intra-Uterine Coil. 90% of them were on injectable contraceptives, 6 percent on long term pills while a negligible number were on emergency pills (Ngethe, 2014). This ideally means that the women were only using what was available and not necessarily what was suitable. On other barriers, other than availability, women in West Pokot mentioned fear of side effects such as bleeding, lack of sexual desire, backache, giving birth to deformed children, and cost.

In Kilifi, their belief in witchcraft unexpectedly came up as a barrier to family planning. According to them, they had to have many children, so that in case a few are snatched through witchcraft, they would have more remaining (Ngethe, 2014). The women elaborated that their belief is, if you get five children, then one belongs to the lord, one to the witches, and only three are yours. The idea that family planning is a
Western concept was also entrenched in some participants who pegged their desire to have more on children on the biblical call that they should procreate and fill the world.

Bankole and Malarcher (2007) carried out a study of four sub-Saharan countries, including Uganda, Malawi, Ghana, and Burkina Faso. It was noted sex education was key in regular use of contraceptive use among adolescent men. Adolescent males who had received any form of sex education in school indicated that they were considerably more likely to consistently use the condom as related to their age mates who had not had any sex. Illustrating how to use a condom appropriately appeared to have positive results as male adolescents who had been trained how to use the condom via demonstrations were more likely to engage in condom use during sex.

In another study by Lebese (2015) in Nagpur University in South Africa, the teenage respondents indicated that the lack of knowledge on contraceptive use was one of the leading causes of teenage pregnancy. With knowledge and a good understanding of family planning methods and their uses appeared to be an important step towards the general acceptance towards initiating or using contraceptives in sex (Khan & Mishra, 2008). Contraceptives knowledge was basically poor, students were misinformed, hence rendering usage low even though they had positive attitudes towards the use of contraceptives, they believed that it was particularly unsafe for female users even though contraceptives were available leading to underutilization of contraceptives (Relwani et al., 2012).

In Kenya, though there was awareness on contraceptive use during a study to ascertain the knowledge, perception and information that the teens in Kenya had regarding contraceptives, it indicated that the knowledge was shallow as some of the
respondents could not distinguish the fact that condom was the same as contraceptives (Miano & Mashereni, 2014).

Inaoka, Wakai, Nakamura, Al Babily, and Saghayroun (2009) stated that there have been myths about perceptions and fears of side effects of contraceptive methods comprising weight gain, cancer risks and excessive bleeding. News about these complications can spread easily, produce counterproductive impacts among potential users, and indeed keep them way (Inaoka et al., 2009).

A Bangladesh study by De-Graaf (2001) highlighted that women stopped using injectables due to wrong information about their side effects and their importance because of to lack of information and counseling. In Morocco, it was also observed that misleading information and fear of side effects limited access to contraceptives (Westoff & Bankole, 1998). The side effects fear can be overcome by good communications and information, particularly via community-based distribution initiatives (Omondi-Odhiambo, 2008).

In most communities, discussing sexual issues is a taboo area for men and women. Additionally, men and women are often afraid of being rejected by sexual partners, particularly if the discussion on sexuality occurs at the beginning of a relationship. As a result, they may feel uncomfortable talking reproductive health concerns like sexual history or contraception (Drennan, 2008). Further, a husband might suspect his wife being promiscuous or unfaithful if she tries to discuss contraception with him.

A study in Ethiopia revealed that another reason for stopping contraceptive use was the disturbance on the menstrual cycle (Weldegerima & Denekew, 2008). Another
study in Kenya showed that the rate of discontinuation increased from 28 percent in 1998 to 33 percent in 2003 and was associated with side effects associated with family planning methods like pills and injectables (Westoff & Cross, 2006).

Knowledge of family planning methods on its own does not automatically translate into action or practice (Magnani et al., 2002). In contrast, Maharaj (2001) found that the knowledge that contraception can prevent or delay pregnancy is an essential first step for their acceptance and subsequent use. However, knowledge of the different types of contraceptive methods by itself is insufficient to bring about significant change in behaviour that reflects correct usage (Gage-Brandon & Meekers, 2007). In other findings on male attitudes to family planning citing the example of Uganda, almost every respondent had heard of condoms, but only 10% knew how to use one correctly (Maharaj, 2001).

With specific reference to condoms as a form of contraception Varga’s (2005) study found that there was considerable resistance to the use of condoms by both males and females as it was linked to promiscuity, lack of trust and was regarded as physically uncomfortable. These findings are further supported by a study conducted by MacPhail and Campbell (2001) who found that the youngsters were of the opinion that condoms were not a preference in steady relationships as they would reduce sexual pleasure which they regarded as integral to their relationship. In addition, the use of a condom with a permanent regular partner may be interpreted as a sign of infidelity and untrustworthiness. For example, if a partner initiates a discussion on condom use it might suggest that he/she suspects his or her partner of being infected or even worse that the partner is hiding his or her own status (Varga, 2005). This link between condom use and
lack of trust has been confirmed by a Durban study by Tillotson and Maharaj (2001) who discovered that young males used condoms when they did not trust their partners either because they did not know them well or suspected her of having multiple partners.

Mfono (1998) found that girls were reluctant to use contraception (for example the pill) because of the importance they placed on physical appearance and self-image, as they believed that some methods resulted in weight gain.

![Conceptual Framework](image)

*Figure 2.1: Conceptual Framework*

Source: Author (2020)

Discussion
According to this conceptual framework, the process of decision making begins at the design of the message by addressing the perceptions of the intended audiences and making sure the message makes the intended feel susceptible enough to change behavior. The messages should address other factors that come into play before one makes a decision based on the perceived benefits. According to this framework based on the health belief model, information is sieved through social networks, past information, personality, religious beliefs, and husbands, among others. Eventually the person starts to look at the intended behavior and its benefits before action is finally taken.

Summary

This chapter has looked at how relevant family planning is to the policy makers. The policy makers have to rely on credible empirical studies done frequently in the course of program implementation to ensure that such programs do not get out of hand. It is not lost to us that some have argued against family planning terming it as a western tool for colonization (Mwaura, 2005). The argument posited that the agenda of the western countries is to destroy African values and impose western way of life. Mwaura (2005) has lumped together the promulgation of women’s rights and gender equality as some of the weapons that the west uses. This view that family planning is a western concept is also rife among Muslim societies (Tamale, 2011).

Mwaura (2005) continues to argue that the sale of contraceptives is a commercial interest and that the continuing promotion of family planning is part of their agenda to continue holding on to the market. These are invalid arguments in the face of real challenges associated with population growth because it is the wearer of the shoe that knows where it pinches in the most. This chapter has also attempted to frame the right
picture in terms of theoretical framework and conceptual framework. In terms of theory, the health beliefs model was identified as the most applicable.

CHAPTER THREE
RESEARCH METHODOLOGY

Introduction

According to Kothari (2004), research methodology is a way to systematically solve the research problem, whereby various steps are adopted by the researcher while studying his/her research problem along with the logic behind it. Kothari (2009) further defined research methodology as the approach by which the meaning of data is extracted and is continuous and is the way research is conducted. It is also described as the techniques of obtaining data (Mugenda & Mugenda, 2003). It was therefore necessary for the researcher to know the methods which were relevant and applicable to certain problems, thus a researcher should design a methodology for their problem as these methodologies may differ from problem to problem. Sub-sections covered in the research methodology comprised the research design, sampling and sample size, population targeted by the study, data collection tools, procedure of data collection, pretesting, data analysis plan and finally ethical considerations observed by the study.
Research Design

A research design ensures that the study is relevant to the problem and that it has economical procedures for acquiring information (Cooper & Schindler, 2003). In this case, the study sought to capture the emotions, beliefs, opinions, myths, misconceptions, and perceptions. According to Family Health International’s data collection field guide, qualitative studies are used in investigations that seek to understand a given problem from the perspective of the local population it involves. They also seek answers to questions that are not pre-determined (Walsh and Wigens, 2003).

Given that the main purpose of this study is to examine factors affecting the communication and adoption of family planning in the targeted population, a qualitative design was the most appropriate. In order to obtain this descriptive data, the researcher shall use qualitative research methods which are interviews and FGDs.

Population

Nyamira County’s population as per the 2019 census formed the population for this study. Nyamira County is one of the two counties in the Kisii region and one the 47 counties in Kenya. It is one of the most densely populated regions in the country and it is characterized with over subdivision of land. According to the 2019 Kenya population census, the county has a population of 605576 (KNBS, 2019). The population for this study consisted of 290,907 males and 314656 females.

Target Population

The target population was found in Miruka Village, a small village to the southern end of Nyamira County near the border of Nyamira and Homa Bay counties. The
characteristics of the target population are similar to the many other villages within Nyamira County. The research data obtained was thus deemed to be externally valid.

Sampling Techniques

The researcher used purposive sampling method. Rubin and Rubin (1995) defined purposive sampling as one whereby each sample is selected for a purpose usually because of the unique position of the sample elements. Three guidelines are given for selecting participants. One, the participant must be knowledgeable about the arena and field of study, be willing to talk and also be representative of the field of study. A further criterion of selection into the group was being an adult resident of Miruka. For women they were of child-bearing age. However, for the sake of this study, age was limited to 18-54 years with the upper limit allowing those who were in the child-bearing age bracket within the past five years.

The researcher also approached key health workers within the community who were purposely picked for one on one interviews.

Sample Size

The researcher used purposive till saturation to arrive at a final sample size of 4 focus group discussions, three key informant in-depth interviews and 10 personal interviews. This number was arrived at after it became apparent to the researcher that further interviews were not likely to generate any new information.

Three focus group discussions were of exclusive genders-to address discomfort in discussing sex in a mixed gender setting while one was of mixed gender. The focus groups had between 5 and 7 members. The youngest member was 22 years old while the oldest was 65 years for the male participants and 54 for the female participants with the
age criteria being dictated by adult age and child-bearing age. I used the same age criteria for interviews. The Key informant interviews targeted health workers from the three most popular health centers. Each focus group discussion lasted approximately one hour while each interview lasted approximately 30 minutes.

Data Collection Instruments

Interview schedules

The study used interview guides to conduct both personal interviews and run focus group discussions. They were identified as the most effective in addressing questions on media preferences, reasons for adoption or lack of adoption and perceived benefits or barriers. Personal interviews were used to get more information on the rate of usage, reasons given, partner participation and fears expressed by their clients. The questions were based on three topical issues; messages, perception and how they relate to the messages. The information was captured on audio and video recorders for easier reference during analysis. This helped to reduce the time it took to get the desired information and also add value to the data obtained (Sanderson, 2009).

Data Collection Procedures

The researcher used a team of research assistants who were trained to effectively administer the research instrument. The team of research assistants first underwent a one-week training on how to accurately capture reliable information and how to assist the participants.
Pretesting

Lucienne and Chakrabarti (2009) elaborated that the aim of a pilot study or a pretesting of the research instruments is to identify potential problems that may affect the quality and validity of the results. The pretest study helped in revealing the ambiguous questions contained in the interview schedule. This also helped in pretesting the recording equipment to make sure they had better resolution or easier to use by the research assistants.

For that reason, the setup of the pretest study should be as close as possible to intended real research. The instruments used were interview schedules, focus group discussions and observation. The pretest took place in Basi village, where 8 adults participated. Six of them participated in a FGD, while the rest 2 were interviewed.

According to Ruxton and Colegrave (2011), it is illogical to let a small pitfall render a 3-month research useless, yet that pitfall could have been handled with a three-day pilot study. Any researcher is advised to have at the back of his mind a cynical devil’s advocate who would want to poke holes into every detail of the research process. Without adequate fine tuning, the research data may be challenged.

Data Analysis Plan

All the instruments used to collect data were collected from the participants and research assistants respectively. The information was in a set of notes and recordings as per the interview schedule questions. The researcher themed the information obtained. This stage involved classifying and categorizing individual pieces of information using the key questions in the interviews and discussions (Babbie, 2015). Given this was a
qualitative study, the analysis aimed at finding patterns and themes in the massive amount of textual, audio and video data expected.

During the analysis, the researcher was concerned with how factors such as religion, myths, misconceptions, education availability and affordability of contraceptives affected the adoption of contraceptives. The data was analyzed qualitatively.

Ethical Considerations

Resolving ethical dilemmas is one among the many ways of ensuring the validity and reliability of the research report to be generated (Sieber, 1992). Further, Sieber challenged researchers to incorporate ethical problem solving strategies into their methodology. As regards to the above advice, the researcher made several provisions to ensure the research was conducted as ethically as possible.

Permission was sought from both the institution of learning and the Ministry of Education before the commencement of the data collection process. Confidentiality and anonymity was a key concern during the drafting and administration of the data collection instruments and the research instrument did not provide room for personal identity. Residents under the age 18 did not participate in this research.

The purpose and objectives of the study was read to the participants who upon agreeing to take part in the study, signed a consent form indicating that they were ready and willing to participate in the research. This was to protect both the researcher and the participant form possible legal bottlenecks in the course of the research. Furthermore, the researcher acquired a research permit from the National Commission for Science, Technology and Innovation (NACOSTI). The data collected was then stored electronically and beyond the reach of third parties.
Summary

Chapter three has provided a detailed methodology that will be used in the study. It has examined the research design, population of the study, sampling and sample size and data collection instruments. It has also discussed pretesting of instruments, data collection procedures, data analysis plan and ethical considerations. Hence the chapter clearly shows how the researcher will go about collecting data. Chapter four examines data analysis and interpretation of responses from the study.

CHAPTER FOUR

DATA ANALYSIS, PRESENTATION AND INTERPRETATION

Introduction

This chapter presents qualitative data analysis obtained from focused group discussions (FGDs) and Key Informant Interviews (KII) on factors affecting communication and adoption of family planning methods in Miruka, Nyamira-Kenya. Information from FGDs and KII was analyzed through themes with results presented in the form of verbatim. The recorded audio was transcribed manually in notepads and transcribing verbatim was used. The textual data was then read through in order to identify themes in the data. The transcribed text data was then put under themes using Microsoft word (MS-word). The various themes that were identified were coded under preferred channels of communication about family planning methods, existing challenges in communicating family planning methods and adoption, existing myths and
misconception about family planning. These themes were manually interpreted and structured using thematic content analysis.

Analysis and Interpretation

Responses

The study was guided by interview schedules for both focus group discussions and key informants who consisted of health workers and adult residents. All the questions were effectively and sufficiently answered. This implied that the responses were adequate to analyze and draw conclusions.

Demographic Factors

The interview schedules and FGDs involved both males and females of age above eighteen years. The participants in the FGDs were categorized according to gender for reasons of expelling fear among participants in order to obtain the required information on family planning. For KII, one-on-one interviews were done. The gender difference accounted for the difference in the way discussions flowed and asking of critical questions in each group and also had a possibility of presenting intergenerational ideologies on issues related to family planning.

A majority of the FGDs comprised women, one comprised both males and females and one comprised only males with a majority of the participants being 24-40 years with minority aging above 50 years. The younger participants (those below 40 years) from the FGDs had different ideologies from those of slightly older participants.
(above 40 years). Therefore, there is a possibility of obtaining the information on family planning based on early ages and the latter (those who are modernized).

Media frequently used to obtain information

To find out the sources of information in the area of study, the participants were asked to state the media they frequently used to obtain information. Many of the participants in the FGDs used radio and television to get messages on family planning, others obtained information through internet and social media while very few obtained information through Facebook and mobile phones. The mostly preferred radio stations were *Radio Maisha*, *Citizen*, *Egesa*, *Minto*, *Kisima* and *Milele*.

Other participants not only obtained information on family planning through the media but also from health workers, neighbors, and friends. One of the female participants stated as follows:

> I was staying at my parents' house when I gave birth to my first child and when I sought advice from my friends I was advised to practice family planning in order not bear another child since I was not married.

Another female participant stated as follows:

> I got the information from a hospital and the reason for family planning is to give allowance for children to grow.

Other two participants stated that they obtained information from health workers with the sole reason of having manageable family size.

Alternatives to receiving messages from the mass media

Apart from the most frequently used medium used to obtain information, the researcher expressed interest to know other alternatives the participants used to obtain information.
A majority of the participants obtained information from Newspapers/Magazines as an alternative source of information, others obtained information on Mobile Apps, social media, while few obtained information on family planning through Poster/Billboards, phone calls, Brochures, Public meetings and Journals. The public meetings included women meetings, *barazas* (informal public gatherings) and churches through seminars.

Of the information obtained from the media, the study targeted family planning messages. Participants were asked to state whether they had come across a family planning message before and how they would describe it. All the participants were in affirmative to the statement. Some participants were up to date on family planning message as the last time they had come across family planning message was on the same day they were participating while for others it was one week prior to the study, three weeks, one month, two months and three months prior to the study. The last time other participants came across family planning messages was the previous year (2019), 2018, 2017, 2016 while others stated that the last time they came across family planning message was five years ago and early 2013. This implied that the participants were up to date on family planning.

During the FGDs, the study revealed that family planning information was at hand as early as 1996 as was echoed by one-female participant:

*I came across family planning in 1996 when I gave birth to my first child so as to have spaced children.*

Description of the family planning message
Those who affirmed that they had come across a family planning message before they had varied descriptions of the message. They expressed their views on the family planning message they came across which was both positive and negative. Some of the participants stated that the message was not satisfactory, inefficient, informative and helpful but with side effects as echoed in the following sentiments:

The message did touch on case studies of people already up-taking the FP programs, one method or the other. They gave their experience with the methods. Myths about the family programs were also touched on (Nyamweya Keith, 30 years).

It is a method which allows people to attain their desired number of children and determine the spacing of pregnancies. This is achieved through the use of contraceptives (Tom Michira, 27 years).

This was supported by another male participant as stated in the following sentiment:

It is a way of controlling the number of children one will have and the intervals between their births (Wesley, 26 years).

Other participants received the message negatively because of the side effects of some of the family programs while others who were on family programs felt that no one was to advise them on which method is the best as echoed in the following sentiments:

Women using pills for a certain period of time make their reproductive cells inactive for the said period (Boaz, 24 years).

The message I didn’t receive it positively since before we were talking and using the FP programs. Who are the ones to give us the best method to use? (Kevin, 43 years).

This was supported by responses from focus group discussions as illustrated by the following remarks from some of the participants who affirmed to be informative.

When we get the information from the media, they inform us especially sensitizing us and advocating for medical tests to know our blood type and the family planning method compatible unlike in the past for example injections and pills.
Another participant added that:

*Messages from media especially listening radio inform on going for medical tests to determine hormones in the body and the right family planning method and have made us to inquire more on the method before using it like the injections.*

Reaction to last family planning message received

On every family planning message received, people do react in different ways. The participants were asked to state their reactions on the last family planning message they received. Responses indicated a majority of the participants were both fearful since they didn’t believe in the message and had negative perception because of prolonged of side effects. Other participants stated that the message was appealing, helpful and that they received it well since in this dynamic society family planning is unavoidable and uplifted by the information and felt happy. Some felt that adequate consultation to be done to curb the side effects, the message was good in regulating the number of pregnancies and children to be born, and that some family planning methods are cancerous making them to have negative attitudes. This indicated that participants in the area of study had diverse attitudes towards family planning messages as echoed in the following sentiments by various participants in the interview:

*My reaction was not good because I heard some can extend their effects and when one wants to get pregnant she can’t* (Timothy, 29 years).

*Good. It was to regulate the number of pregnancies and the number of children to be born.* (Gladys, 23 years).

*I did receive it well because in this dynamic society FP is one thing that is unavoidable. My shock was however on the young girls with the help of their mothers, up taking FP programs* (Keith, 30 years).

*According to the message I heard, some family planning methods are cancerous therefore developing a negative attitude towards it* (Wesley, 26 years).

*Fearful since I didn’t believe in it* (Cyrus, 34 years).
Adequate consultation to curb the side effects (Robert, 28 years).

Family planning usage

The majority of the participants stated that they were using family planning and the media message consumed influenced them in different ways. This was evident from some participants in the interviews as indicated in the following statements:

Yes, she uses FP. The information in the media did affect us in the choice of method. The experiences given informed her choice of appropriate method to her (Keith, 30 years).

Yes, she uses family planning and the information from the media affected us in the choice of the best method to use, hence we chose the best method to use (Tom, 27 years).

Family planning was observed to be dominant among the participants who were of young age below 40 years as compared to those who were above 40 years who were the minority and past reproductive age. Another possible reason for not practicing family planning was geared towards culture and religion as supported by one participant in the one of the focus group discussion:

I will not do family planning because I want twelve children and is against God’s will of procreation because God said go and multiply. Personally, I will not do family planning because I will continue giving birth until I have a son even if it is to have twelve children.

However, participants in the FGDs had different views as to why they were not influenced by the media message they consumed for which most men felt that the advertised family planning messages are mostly designed in a way that targets women.

One male participant had this to say:

When you hear the message, it doesn’t target men. It mostly helps women.

This was supported by other two male participants with the following statements:
Most cases when advertising family planning methods, they usually touch on women making it significant to women and men are not included in the advert and therefore men aren’t attracted to it. Also women in most cases are the ones who suggest on family planning and not men. The message should therefore be impactful to men as well.

Another male participant had this to say:

On the advert I saw in the clinic, the pictorial representation on the family planning advert was only a woman. At least they could also put a man to it as inclusive.

However, one participant quoted that:

I think the message involves both partners because when the wife gets pregnant, the husband takes the responsibility for example when she is sick and I admit that the husband takes responsibility for the family.

Issues raised by partners concerning advertised family planning messages

Various issues concerning family planning messages advertised on media were raised by participants in the area of study. A majority of the participants stated that the negative side effects of the methods should be well stated and explained well to the users in the adverts as stated by some in the following statements:

The negative effects of the methods should be well stated and explained to the users (Boaz, 24 years).

The side effects to the body of the method of FP being used in terms of long term and short term and everyone has the best method suitable for them (Tom, 27 years)

That family planning is risky because of the cancerous rumors that are ongoing (Wesley, 26 years).

Some of the issues include the negative effects of methods like contraceptives (Emmanuel, 25 years).

Others stated that major cases on family planning methods don’t adhere to instructions as prescribed by the physician.
Most family planning methods don’t take that period prescribed by physician (Timothy, 29 years).

Major cases on FP method don’t take any period as prescribed by a physician (Gladys, 23 years).

In addition, the participants felt that family planning messages were too open to the young and that the message should be advertised at the appropriate time which they considered to be when children have slept.

Too open to youngsters (Erastus, 51 years).

It is too open to many people (Cyrus, 34 years).

We should raise them after children have slept (Ochieng’, 32 years).

They should be only aired after 9.00 pm if on TV (Mary, 29 years).

Benefits of family planning as presented through communication messages

To assess the significance of the family planning messages on media, the participants were asked to state whether family planning as presented through the communication messages offered any benefit to them. Participants responses indicated that family planning presented through the communication messages offered various benefits to the participants. A majority stated that family planning controls birth rate through child spacing, prevention of abortions and unwanted/unintended pregnancies. For example, all the 10 persons interviewed agreed that family planning offered a great benefit. The same was echoed in the focus group discussions by a majority of the participants. Those who affirmed the benefits added that it contributed to having a health
and manageable families as well as restoring societal moral sanity as stated in the following interview schedule sentiments:

*It was helpful. Gave adequate and comfortable chance to raise the first born child Robert, 28 years.*

*Yes, I have no fear of the number of children I have. I am able to control my family (Wesley, 26 years).*

*Yes, it does, it helped to prevent unintended pregnancy, reduced the need for abortion (Emmanuel, 25 years).*

*Yes. It helps me to avoid unwanted pregnancy (Conceptor, 29 years).*

*Yes, family planning helps one to properly plan and take care of the family” (Timothy, 29 years).*

*Yes, FP enables one to properly take care of the family members and also prevention of infections, for example HIV/AIDS (Gladys, 23 years).*

Other participants stated that communication messages are informative, useful and gave insights on appropriate methods to use and conditions in mothers’ diet that ought to be adhered to.

*The best method to use was the major benefit and the conditions in matters that are to be adhered to. Also the possible outcomes (Tom, 27 years).*

*The insight on the appropriate methods to use was one major benefit and on each method the conditions in matters of diet that ought to be adhered to. Also possible effects (Keith, 30 years).*

*The appropriate methods to use was the most benefit and also the major possible outcomes on the side effects (Kevin, 43 years).*

The benefits of the family planning were also echoed by participants in the focus group discussions as they termed it as inevitable due to some reasons. One male participant (with two children) stated that:

*I have two children (boys) and I saw the plot sub-divided to us by our mother was depleted upon building houses and no other plot to sub-divide to my children and therefore sorted to family planning.*

This was supported by another participant in another FGD who stated that:
In today’s society, economic resources have become very scarce unlike in the old days. Bringing up children involves not only feeding and clothing them but also medication and education. This poses a challenge to us parents. Consequently, many parents now prefer to have just the number of children that they can comfortably take care of, irrespective of their sex. A family that manages to get three daughters would stop at that if that is the number they can bring up comfortably. This is opposed to what used to happen earlier where such a couple would keep on getting more children in the hope of getting sons. We have realized that children are just children, whether boys or girls. What counts is that they should be brought up to become productive members of society.

In another female focus group discussion, one young unmarried woman had this to say:

I was staying at my parents’ house when I gave birth to my first child and when I sought advice from my friends and since I was unmarried, I was advised to go for family planning in order not to conceive again before marriage.

In the same focus group discussion, another female participant stated why she opted to family planning.

I got the information on family planning in the hospital and I opted to do family planning because of child spacing to give allowance for my children to grow.

This implied that the participants in the area of study had knowledge on family planning, most of them practicing it to experience its benefits as elaborated; some of them being controlling birth rate, child spacing, balancing of resources and manageable families, prevention of unintended pregnancies and therefore reducing abortion rates.

However, despite the aforementioned benefits of family planning, some people fail to plan their marriages. In this study, the participants were asked to state if they had experienced any of the challenges associated with failure to plan their marriages in the interview schedules. Responses indicated that the majority had not experienced the challenges due to failure to practice family planning, others had not experienced but had heard from friends sharing their challenges while others had experienced the challenges and also heard from their friends. Therefore, it is possible that a majority of the
participants who had not experienced the challenges of failing to plan for their families were already on family planning while those who experienced the challenges were not on family planning.

Questions and fears left from the communicated messages about family planning

Every good thing lacks no defect. As much as family planning was beneficial, it had the side effects which ignited questions and fears among the participants tailored by the myths and misconception among the participants. In the interview, participants were asked if the communication messages left them with some questions and fears over family planning. Responses indicated that participants had fears and questions, some of the questions and fears expressed by the participants being failure of other family planning methods, failure to conceive for quite long after stopping family planning and questions on the side effects. The fears and question were echoed in the following sentiments in the interview schedules:

*Yes, I always ask myself of the negative effects (Cyrus, 27 years).*

*Yes, for example the cases of study being given, even people talking of the failure of other family planning methods thus others make me fear (Tom, 27 years).*

*Yes, the case studies given rather the mothers up taking the methods, some talked of failure of a method. Others talked of failure to conceive for quite long after stopping uptake of FP method that did get me fear (Keith, 30 years).*

Focus Group Discussion responses also revealed that participants were shunning the method because of perceived rumors which had created anxiety and fear even among those using the method while those not on it, refuse to take the method as illustrated by the following sentiments in women focus group discussions.
I had heard from my friends on the side effects for example one friend who was using pills had persistent bleeding and when I was in the counseling room I wanted a coil but I saw it, I was afraid to carry a foreign object in a sensitive area of my body for years.

Another participant asked:

*When using pills or injections, why does one experience chest and respiratory complications in such a way that breathing rate increases?*

Others feared on the effect of paralysis as echoed by another participant:

*When one has those sticks on their arm, that arm becomes permanently weak and she therefore needs to arrange for someone to assist her with house work for the rest of her life.*

Another participant echoed the fear as she explained on the side effects of family planning and the consequences faced:

*I got irregular periods after insertion of Norplant and mostly what I know is that female sterilization makes the body cold. You even lose desire for your husband and it causes persistent back pain and the wound never heals. This will culminate to a divorce since you cannot offer conjugal rights to your husband.*

In male focus group discussion, it was evident that their fear was centered on vasectomy and the morality of the women on family planning as echoed in the following sentiments:

*Vasectomy is a bad thing and should not be heard here in Kenya. Suppose you marry a woman who is above productive age or who does not give birth and you are supposed to re-marry, how will you be?*

As an advice to young male participants, an elderly participant quoted that:

*Family planning can make you immoral for example a woman with one child can look at their age mates who were married at the same time interval who have more than one child and decide to seek a child outside wedlock with claims that the husband has a fault and you not take full control of her.*

Apart from fears, myths and misconception on family planning, a serious debate rose in both male and female focus group discussions. Given that procreation is as a
result of a conscious, deliberate and planned effort between a man and a woman, a decision on whether or not to adopt family planning depends on the couple concerned. It emerged from female FGDs that a majority of women are weary of bringing up children alone. So under such conditions the woman had no option but to secretly adopt family planning without the husbands’ knowledge. This was evident from the following response:

*Because other husbands are alcoholics, it is us the wives who will see how our children are suffering and decide to go for family planning without the consent of our husbands.*

This was supported by other two female participants who quoted that:

*If my husband refuses to let me go for family planning, I will go secretly and although it is the husband who decides, I will not rely on his word.*

However, one participant’s view on decision making over family planning should be done by the husband as echoed in her statement below:

*Family planning is decided by the husband because is the one who knows his capability to manage the family.*

In male FGDs, it was evident that family planning should be jointly discussed between the partners with final decision bestowed on males as revealed in the following sentiments:

*Now that family planning involves both of us, if my wife does it alone secretly that will be a case. It needs the knowledge of both partners but duration is the challenge.*

Another male participant supported that:

*The final decision comes from the husband but sometimes it changes depending on the hormone difference and it is difficult to the convince wife if she does not want to embrace family planning.*

Communication messages giving confidence on family planning methods available
The participants were asked to state the parts of communication that gave them confidence on family planning. Responses indicated that a majority of participants gained confidence in family planning methods through testimonials from people, through photos of well-planned families and consulting a medic before usage of the method. Others gained confidence through scientific information and television adverts. This implied that the possibility of the participants being influenced by their peers was very high.

Most and least preferred method of family planning

The participants were asked to state the most and least preferred methods of family planning. Responses given gave an indication that a majority of the participants stated that coil and Implants are the most preferred methods of family planning while others stated use of condoms, Hormonal pills, Withdrawal and Cervical caps and IUCDS. Also a majority stated that use of condoms is the least preferred method of family planning as well as Foaming virginal tablets. This implied that Coil and Implants were most preferred family planning methods while use of condoms was the least preferred among the study population in Miruka, Nyamira- Kenya.

Advice to daughters to practice family planning

Participants were asked if they could advise their daughters to practice family planning. The majority were in affirmative. Those affirmed backed up their response with a reason that they will only do that when they have reached marriage age.

Similar responses were observed in focus group discussions as indicated by the following statements:
When I got the message on family planning, I thought of advising my daughter. I also advised my sisters and village friends and now they have manageable families and spaced children.

This was supported by another participant as follows:

I had observed the problems faced by women who have young non-spaced children and I decided to advise my young daughter and daughters-in-law.

Key Informants Information

Key informant information indicated that the average clients who visited the clinics for family planning per day were 4-10, 6-10 and 10-20. These clients had reasons as to why they went for family planning as indicated in the interview schedules:

They say they improve maternal health and child survival by helping women avoid becoming pregnant too early or late. They also say they come to reduce the number of abortions overall especially unsafe abortions (Edward, 42 years, health worker).

Others come to control the number of children to get during birth, to have a period of getting children and to reduce the number of abortion cases which are high nowadays (Ruben, 35 years, health worker).

They come to prevent the sexually transmitted infections for example HIV/AIDS, others come for the control of the number of children they want to give birth to and avoiding the high rate of abortion (Milkah, 57 years, health worker).

Their responses indicated that the clients went for family planning with specific reasons which included reducing number of abortions, improving maternal health, child survival by helping women avoiding becoming pregnant too early and to prevent the sexually transmitted infections.

On face to face interviews with key informants who were specialists in family planning, they had this to say concerning the most common reason why people go for family planning.
(KI₁, Rackden medical hospital, 5-10 patients daily)

The problems in Nyamira county men are so irresponsible so women are the breadwinners and when they give birth to many children it becomes a problem.

(KI₂, Nurse Nyamaiya Sub-County Hospital, 20-30 patients daily)

The main reason as to why they come is to limit the number of children they give birth to in order to be able to take care of the few they have.

Key informants also revealed the greatest fears people express when refusing or opting out of family planning. Responses indicated that the greatest fears people express to join or opt out of family planning or specific methods of family planning are the negative effects of various family planning methods. This was indicated in the interview schedule.

The negative effects to the body for example the use of the coil have been expressed like there is one who used a method for five years and it had an effect to the body (Edward, 42, health worker).

People fear of the negative effects to the body when using the FP method. The birth rate increases when not using the FP methods (Ruben, 35 years, health worker).

Most express negative effects to the body though they partly admit that it has helped them in the regulation of the number of children being born (Milkah, 57 years, health worker).

Similarly, face-to-face interviews with key informants revealed the same as echoed by one key informant here:

(KI₂, Nurse Nyamaiya Sub-County Hospital, 20-30 patients daily)

You find one can bleed, fatten, grow thin and when she sees such side effects she comes and says they are not good for them and request to be removed or to change to a different method.

The nurse added as follows:

Some say you can be barren, not working for example if you insert a Norplant you get a lady saying that nowadays I don’t use this hand of mine, it aches, I don’t receive periods normally, being fattened and say that the blood has accumulated in the uterus.
Rates of usage of the family planning methods by general observation

Concerning the rates at which family planning methods were used, the Key Informants observed various reasons that geared to high usage of family planning methods. Responses in the interview schedules indicated that the attention of people to family planning methods is drawn by the observed benefits of family planning methods and high living standards. Use of IUCDs is highly recommendable because of fewer side effects as compared to other family planning methods.

*Nowadays use of contraceptives is very high due to the high living standards and high economic development, it is also expensive (Edward, 42 years, health worker).*

*People have highly recommended the use of IUCDS as compared to other FP methods which have negative effects, the birth rates have been regulated easily (Reuben, 35 years, health worker).*

*Infections have reduced due to the introduction of FP, the number of birth rates have been regulated (Milkah, 57 years, health worker).*

One Key Informant on a face-to-face interview affirmed that a rate of usage of family planning is high.

(KI₂, Nurse Nyamaiya Sub-County Hospital, 20-30 patients daily)

*It’s a bit high because this message is passing through maternal health departments and when they come for services we capture them and give them the information and from this you get more clients coming.*

The nurse also observed on the most preferred and least preferred methods of family planning in the following quotes:

*The most preferred method of family planning is injection because some husbands don’t want their wives to practice family planning and therefore they sneak to hospital for the services and this one is cost effective in terms of time whereas the least preferred is use of the coil because it is inserted virginally and therefore positioning the client needs some time and there is a rumor that the coil may go to spinal code, brain which is not true and this makes them fear.*
Gaps identified professionally from family planning campaign messages

Key Informants information revealed some existing gaps in the family planning campaign messages. Responses indicated that the family planning campaign messages have a potential to generate an immediate demand for family planning services but have limited opportunities in assessing the behavior change as indicated in the interview schedules:

*There is evidence from quasi-experimental designs indicating that mass media campaigns can generate an immediate demand for FP services and are associated, accessibility to communication network messages for FP (Edward, 42 years, health worker).*

*We should undertake vigorous situation analysis of current efforts and associated gaps in family planning and on this basis we should support such opportunities (Reuben, 35 years, health worker).*

*We should contribute to existing family planning research and we should also have planning questions to ensure communication is accessible, also design a behavior change campaign and identify the best channels for message delivery (Milkah, 57 years, health worker).*

This was supported by face-to-face interviews in the following statements:

(KI2, Nurse Nyamaiya Sub-County Hospital, 20-30 patients daily)

*The advertised family planning messages should direct the clients to seek more information about a particular method from health specialized in health facilities.*

The Key Informant also added that:

*The men should be sensitized and given information as far as family planning is concerned, they are much far behind.*

Summary of Key Findings

The key findings as revealed from both interview schedules, FGDs and KIIs include:
1. A majority of the participants used radio and television to get messages on family planning. Similarly, a majority of the participants in the FGDs stated that they obtained information through radio, television and Facebook with mostly preferred radio stations being Radio Maisha, Citizen, Egesa, Minto, Kisima and Milele. The main alternative source of information was Newspapers/Magazines.

2. Most of the participants had come across a family planning message before as early as 1996 evident during FGD. The study responses also indicated that the majority of the participants the last time they came across a family planning message was 2019 whereas others came across it within the past one week of which they described it as informative.

3. There was a challenge of fear since most didn’t believe in the message and had negative perception because of prolonged side effects of which some stated that the negative side effects of the methods should be well stated and explained well to the users in the adverts and that the message should be advertised when children have slept as they are too explicit to many people including youngsters.

4. A majority of the participants stated that family planning controls birth rate, enabling one to properly take care of the family members and also prevention of infections and has helped in preventing unintended pregnancies and reduction of abortion as well as adequate child spacing.

5. A majority of the participants gained confidence on family planning methods through testimonials from people. Coil and Implants were most preferred family planning methods while use of condoms was the least preferred.

6. Some of the questions and fears expressed by the participants included failure of other family planning methods, failure to conceive for quite long after stopping family
planning and questions on the side effects. FGD guide responses also revealed clients were shunning some methods because of associated effects which had created anxiety and fear even among those using the method while those not on it, refuse to take the method. These included persistent bleeding, chest and respiratory complications, becoming permanently weak, irregular periods after insertion of Norplant, sterilization making the body cold and losing sexual desire for their partners and persistent back pain and the wound never heals.

Summary

This chapter has presented data, analyzed it and then delved into an interpretation of the same. The researcher presented data in form of descriptions and narratives as provided by the respondents. The next chapter gives the discussion of the findings, recommendations and conclusions of the study.

CHAPTER FIVE

DISCUSSIONS, CONCLUSIONS AND RECOMMENDATIONS

Introduction

This section presents discussion of the findings made from this study, a conclusion derived from the study findings as well as recommendations in line with the study objectives and study conclusions. Areas for further research are also proposed herein.

Discussions of Key Findings

Myths and misconception about family planning
The first objective aimed at determining myths and misconceptions that exist in Miruka about family planning. The study found the common myths, misconceptions, and beliefs among the participants centered on side effects, religion, and social aspects. Failure to conceive for quite long after stopping family planning and questions on the side effects was reported by a majority of the participants.

Focus Group Discussion responses revealed a great misconception that using pills result to persistent bleeding, brings chest and respiratory complications, Norplant results in paralysis and irregular periods. Participants also believed that family planning results in female sterilization, making the body cold and losing sexual desire for your husband culminate to a divorce since you cannot offer conjugal rights to your husband and the wound never heals.

In FGDs that had male participants, the misconception on vasectomy and the morality of the women on family planning was revealed. This was evident as a majority of male participants argued that vasectomy is a bad thing and should not be heard here in Kenya citing that it amounts to castration and he becomes like a woman and can neither speak with authority nor take up any position of leadership in society and that the woman would be scorned by her colleagues if they knew her husband has undergone the procedure. The males also argued that family planning can make you immoral for example a woman with one child can look at their age mates who were married at the same time interval who have more than one child and decide to seek a child outside wedlock with claims that the husband has a fault and you cannot take full control of her.

These findings concur with those of Inaoka et al., (2009) study on correlates of visit regularity among family planning clients in urban Yemen that of a Bangladesh study.
by De-Graaf (2001) on increasing contraceptive use. The findings of the studies indicated that there have been myths about perceptions and fears of side effects of contraceptive methods comprising weight gain, cancer risks and excessive bleeding and that women stopped using injectable due to wrong information about their side effects.

All these also concur with previous studies by Ochako et al. (2007) and K’Okul (1991). However, it is also worth noting that to some of the participants, effects such as excessive bleeding are a reality which had also been noted in the same researches earlier. For instance, in the study by Ochako et al. (2007), women also reported excessive weight gain, lack of sexual appetite and trouble conceiving after pulling out of family planning. This was similar as observed in this study about the myths and misconception on family planning methods among participants in Miruka.

The same issues came up in Ngethe (2014) where women in West Pokot County reported that they shunned family methods due to fears of bearing deformed children, lacking libido, bleeding and having back aches. However, the findings in this study were parallel to a FGD conducted in Kilifi where women mentioned that their motivation to bear many children was due to witchcraft where they feared remaining childless after losing their children to witchcraft (Ngethe, 2014). One of the participants in the FGD stated as follows:

*Ukipata watoto watano, mmoja ni wa mungu, mmoja ni wa mchawi na watatu ndio wako*

Existing challenges in communicating family planning methods and adoption

The second objective was to establish existing challenges in communicating family planning methods and adoption in Miruka, Nyamira-Kenya. Data collected from
Interview schedules indicated that a majority of the participants were not influenced by any message from the media and this was supported by some of the reasons obtained in FGDs for which most men felt that the advertised family planning messages are mostly designed in a way that targets women.

One male participant had this to say:

When you hear the message, it doesn’t target men. It mostly helps women.

This was support by other two male participants as follows:

Most cases when advertising family planning methods, they usually touch on women making it significant to women and men are not included in the advert and therefore men aren’t attracted to it. Also women in most cases are the ones who suggests on family planning and not men. The message should therefore be impactful to men as well.

Another male participant had this to say:

On the advert I saw in the clinic, the pictorial representation on the family planning advert was only a woman. At least they could also put a man to it as inclusive.

This indicated that family planning messages were not inclusive since males felt isolated by the information. Other participants raised an issue that the messages should be advertised when children have slept and that they are too open to many people including youngsters giving an implication of wrong timing and the message reaching wrong receivers. This reflects the nature of the society in Miruka where matters and discussions of sex are strictly forbidden in public and worse if children are involved.

These responses were in tandem with those Drennan (2008) who argued that in most communities, discussing sexual issues is a taboo for men and women. Additionally, men and women are often afraid of being rejected by sexual partners, particularly if the discussion on sexuality occurs at the beginning of a relationship and that a husband might
suspect his wife being promiscuous or unfaithful if she tries to discuss contraception with him. The results of this study cover the challenges of family planning messages in relation to the audience, time of conveying the message and inclusivity of both partners in marriage.

The results are also reveal that health communicators should be sensitive to the nature and culture of the target communities so as not to create barriers of communication. For instance, the results of this study reveal that the target community is patriarchal in nature and that men are entrusted with the final decision. This is the main reason why some participants admitted that they would seek family planning services secretly as quoted below:

*If my husband refuses to let me go for family planning, I will go secretly and although it is the husband who decides, I will not rely on his word.*

Channels preferred

The last objective of the study was to find channels of communication preferred by residents of Miruka about family planning methods. Responses indicated that a majority of the participants used radio and television to get messages on family planning.

Similarly, a majority of the participants in the FGDs stated that they obtained information through radio, television and Facebook with mostly preferred radio stations being *Radio Maisha, Citizen, Egesa, Minto, Kisima* and *Milele*. This is an indication that family planning message reached people of all economic status and literacy levels since the information was conveyed even in local radio stations implying that knowledge on
family planning methods was high. These responses concur with Timothy et al. (2011) study in Kenyan slums in attempt to assess the level of contraceptive knowledge and use and also identify factors that led to contraceptive usage who found that 51% of the participants were aware of family planning indicating that the rise in knowledge and usage of contraceptives was due to sufficient communication. This signifies a need for reliance of local radio stations for disseminating family planning messages. However, there instances where the participants alluded to hearing about the negative effects from their friends signifying a reliance on social networks for decision making. One of the participants said the following:

*I had heard from my friends on the side effects for example one friend who was using pills had persistent bleeding and when I was in the counseling room I wanted a coil but I saw it, I was afraid to carry a foreign object in a sensitive area of my body for years.*

Additionally, some of the young participants also mentioned that beside mainstream media, they also access a lot of information through applications and social media. This essentially means, there is need to utilize new media in dissemination information about family planning.

One of the most revolutionary products in enhancing family planning is cycle beads (Cycle technologies, 2018). Cycle beads is a phone application that can also be used physically where women are trained to use beads to count their safe days and unsafe days. The app, which is already in use in Kenya, Ghana, India, Jordan, Egypt, Senegal is one among many that can be tailored to meet the specific needs of women in Kenya and particularly in Nyamira.

One of the advantages of using an app to offer information and guidance on family planning, it also offers instantaneous data on usage and other variables that can
add value to a health communicator’s communication plan. From a study done by Haile, Fulz, Simmons, and Shelus (2018), there were up to around 356000 downloads within 10 months. A further app survey also revealed a lot more information through responses given by the app users. One of the key informants was categorical on the need to fill the gaps in the communication of family planning methods by saying.

We should contribute to existing family planning research and we should also have planning questions to ensure communication is accessible, also design a behavior change campaign and identify the best channels for message delivery (Milkah, 57 years, health worker).

Contribution to theory

It is evident from the fears expressed that the participants found the perceived threat from the effects of family planning usage to be more serious than the threat of an unplanned family. As they averred, the messages have not been crafted with their personal wellbeing in mind but the wellbeing of the government that’s desires to have low population growth at any cost. Take the example of the participants that averred as below:

When one has those sticks on their arm, that arm becomes permanently weak and she therefore needs to arrange for someone to assist her with house work for the rest of her life.

I got irregular periods after insertion of Norplant and mostly what I know is that female sterilization makes the body cold. You even lose desire for your husband and it causes persistent back pain and the wound never heals. This will culminate to a divorce since you cannot offer conjugal rights to your husband.

These are possible barriers to the uptake of family planning and fit well into the misconceptions that have hindered family planning. The second response goes further to include the fear of one losing a partner which some may consider to be worse than failing to plan the family.
The health belief model becomes a perfect framework through which we can clearly see the barriers to the desired action are in the messaging itself. The failure to address the fears, myths and misconceptions allows their existence as an impediment to the successful adoption of family planning. Given the one sided nature of a mass media campaign, family planning communication can be augmented by other means which may include a contact for clarification and where they exist, they should be prominently displayed alongside the family planning message. Marie Stopes Kenya which is the country’s largest reproductive health care organization has a toll free number which is prominently displayed on its website. Marie also does mobile clinics (Marie Stopes Kenya, 2020).

The example set by Marie Stopes can be adopted by the Government of Kenya through the Ministry of Health. When such issues are adequately addressed, the resultant effect is that the myths and misconceptions will reduce and people will be likely to rely on official channels rather opinions and social networks. However, even if people continue to rely on social networks, the message would have changed to a positive one.

According to HBM, self-efficacy is a person’s confidence in his or her own ability to adopt a certain behavior. In the responses given, it became apparent that this was not true to most women. A good example is this statement by one participant:

*Family planning is decided by the husband because is the one who knows his capability to manage the family.*

Apparently this female participant has given her husband complete charge of her body despite all the perceived threats to her own health if the husband were to bar her from any form of family planning. The question that elicited this response aimed at finding out whether there is need to address women through their partners for effective
messaging and the sample answer above explicitly shows that this may be the case. Given that this study was conducted in a rural community where men also happen to be breadwinners, it makes sense. However, if the same men are made to understand family planning as more a health issue rather than an economic issue, their views are likely to change. The same men who may not want their wives to adopt family planning would also not wish to have wives unhealthy or for the same wives to bear or raise unhealthy children.

Conclusion

Based on the study findings, the following conclusions were made:

1. Family planning methods are shunned because of perceived rumors which create anxiety and fear even among those using the method while those not on it, refuse to take the method. These includes persistent bleeding, chest and respiratory complications, becoming permanently weak, irregular periods after insertion of Norplant, sterilization making the body cold and losing sexual desire for your husband such that one cannot offer conjugal rights to the husband and persistent back pain. These forms part of misconception about family planning methods. There is a gap that needs to be bridged in the design of family planning communication.

2. Coils and Implants are the most preferred family planning methods, while the use of condoms is the least preferred in Miruka. There is negligible use of some methods such Intra-Uterine Devices (IUCDs) and Vasectomy. Most people demand methods depending on what they have heard rather than what they know.

3. Involved decision making between husband and wife on matters of family planning is essential in eliminating distrust and family issues, which may result in domestic violence.
Male partners are not happy with their exclusion from the communication of family planning as they want to have a bigger say in their partners’ decisions in regards to family planning. The community in Miruka is thus patriarchal.

Recommendations

The researcher made the following recommendations based on the study findings:

1. Strategies to increase awareness of various family planning methods at the community level to promote their informed uptake and dispel associated myths and misconceptions with regard to their use should be embraced. Secondly, communicators need to include in their messaging, simple explanations about the difference between hormonal contraceptives and non-hormonal contraceptives and how one should be able to identify which method is likely to work best.

2. Family planning education at both household and community level that targets the woman and her partner more especially males may be employed through print and mass media, chiefs’ barazas, market places as well as newsletters and posters as this is expected to contribute positively towards enhancing awareness of family planning services and the benefits and side effects and making males inclusive in family planning matters. With this understanding, communicators need to go further and provide more information on all the available choices so as to increase male participation through male contraceptive methods given that it was also evident in the research that most families are patriarchal by nature. It also important for communicators to understand why some methods are more preferable than others and work with health experts in designing family planning communication in a way that one would choose a method, not because of its popularity but because it is the most suitable.
3. The issue of male involvement in family planning deserves profound consideration. The use of male-oriented methods: - vasectomy and spousal discussion about matters related to sex and family planning should be enhanced given the fact that in the cultural fabric of the Kisii community, men have the ultimate say in what happens in their households. Specifically, “Male Only Clinics” which have been introduced in many parts of the country by the Family Planning Association of Kenya should be introduced in Nyamira in order to increase awareness and change the attitudes and behaviors of men. The issue of male involvement in decision making can easily be achieved by designing messages that appeal to both men and women. The same messaging can also encourage both partners to make sure they are together whenever; they are seeking information about family planning. If there are messages sent through mobile phones, both parties should also be included.

Recommendations for Further Research

1. As this study was carried out on a small scale in Miruka, Nyamira County, there is need for a further large-scale study in the larger Nyamira County to establish if the findings in this study apply to the entire county. A study can also be conducted in Nyamira Town to find out if urban dwellers share similar sentiments with rural dwellers.

2. A qualitative study to determine how best men can be involved in reproductive health matters, especially in family planning is recommended.

3. The study findings indicated side-effects could be hindering the adoption of some family planning methods. Therefore, a study to assess the prevalence of these side effects and how to minimize their occurrence is recommended.
4. This study found that myths and misconceptions presented a major barrier towards use of modern family planning methods and there is need for a further study to examine how these myths are spread to enable design of strategies to counter these methods. This further study can adopt social network analysis to establish the critical nodes (sources) of the family planning myths.

REFERENCES


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APPENDICES

Appendix A: Interview Schedules for FGDs and personal interviews

My name is Mike Nyagwoka, a Masters Student at Daystar University pursuing a Master’s degree in Development Communication. I am conducting a focus group discussion on communication factors that affect the uptake of family planning amongst residents of Miruka Village as a result of family planning messages disseminated through various media. Your data shall remain confidential. Please by raising hands indicate your willingness to continue with this study.

This discussion is meant to last at least 1 hour.

All members of the focus group discussion shall introduce themselves at the beginning of the focus group discussion.

Topic 1: Messages

1. What media do you frequently use to obtain information?
2. Have you come across a family planning message before and if yes how would you describe it?
3. When is the last time you came across a family planning message?
4. What are the alternatives to receiving messages from the mass media?

Topic 2 Perceptions

1. What was your reaction to the last family planning message you received?
2. Do you use family planning and did the media message you consumed influence you?
3. What are some of the issues raised by you or your partner concerning the advertised messages?

4. Does family planning as presented through the communication messages used offer any benefit to you?

5. Have you experienced any of the challenges associated with failure to plan your family?

Topic 3 Relationship

1. Do the communication messages leave you with some questions and fears over family planning?

2. What part of the communication messages give you confidence on the family planning methods available?

3. What is most preferred and least preferred method of family planning?

4. Can you advise your daughter to practice family planning?
Interview schedule 2 for health workers as key informants

1. How many patients coming for family planning do you serve per day?
2. What are the most common reasons people give when they come for family planning?
3. What are the greatest fears that people express when refusing or opting out of family planning in general or a particular family planning method?
4. What are the rates of usage of the previous planning methods by general observation?
5. What gaps have you identified as a professional from family planning campaign messages?
6. Have you experienced complications from your patients?
Appendix B: Research Permit

This is to certify that Mr. Mike Nyagwisa of Daystar University, has been licensed to conduct research in Nyamira on the topic: FACTORS AFFECTING COMMUNICATION AND ADOPTION OF FAMILY PLANNING METHODS IN MIRUKA NYAMIRA for the period ending: 22/November/2020.

License No: NACOSTEP/19/2854

Applicant Identification Number: 248752

Date of Issue: 22/November/2019

NOTE: This is a computer generated License. To verify the authenticity of this document, scan the QR Code using QR scanner application.
Appendix C: Ethical Clearance

REFERENCE: DU-ERB/1/3/8/2019/000127
Date: 11-10-2019
TO: Mike Njoguwa

Dear Mike,

RE: FACTORS AFFECTING COMMUNICATION AND ADOPTION OF FAMILY PLANNING METHODS IN MERU COUNTY

This is to inform you that Daystar University Ethics Review Board has reviewed and approved your above research proposal. Your application approval number is DU-ERB-000127. The approval period is 11th October, 2019 – 30th September, 2020.

This approval is subject to compliance with the following requirements:

i. Only approved documents including (informed consents, study instruments, MTA) will be used

ii. All changes including (amendments, deviations, and violations) are submitted for review and approval by Daystar University Ethics Review Board.

iii. Death and life-threatening problems and serious adverse events or unexpected adverse events whether related or unrelated to the study must be reported to Daystar University Ethics Review Board within 72 hours of notification.

iv. Any changes, anticipated or otherwise that may increase the risk or affected safety or welfare of study participants and others or affect the integrity of the research must be reported to Daystar University Ethics Review Board within 72 hours.

v. Clearance for export of biological specimens must be obtained from relevant institutions.

vi. Submission of a request for renewal of approval at least 60 days prior to expiry of the approval period. Attach a comprehensive progress report to support the renewal.

vii. Submission of an executive summary report within 90 days upon completion of the study to Daystar University Ethics Review Board.

Prior to commencing your study, you will be expected to obtain a research license from National Commission for Science, Technology and Innovation (NACOSTI) https://www.nacosti.go.ke and also obtain other clearances needed.

Yours sincerely,

[Signature]

[Name]
Secretary, ERB
Appendix D: Plagiarism Report

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