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SOURCE OF FAMILY PLANNING INFORMATION IN KENYA.

by

J. Hugo Gachuhi

JANUARY, 1973

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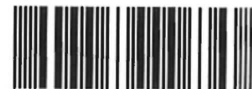
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SOURCE OF FAMILY PLANNING INFORMATION IN KENYA

by

J. MUGO GACHUHI

ABSTRACT

In diffusion of innovation process, adoption generally depends on what is being adopted. Its adoption or non-adoption will depend on how it is being introduced, to whom and by whom. Thus, if the source of information is not credible, chances are that the innovations will be adopted very slowly or not at all.

Adoption of family planning contraceptives also follows the basic diffussion of innovation theory, with the exception that family planning is much more closer to the peoples lives, values, culture, etc., than any other innovation that change agents introduce to the people.

In a major survey in Kenya on family planning knowledge, attitude and practices (KAP) 4,164 respondents representing all provinces, ethnic group, religions, socio-economic groups, male and females etc., were asked if they had heard about family planning and from whom or what sources. By far the majority of respondents get their family planning information from friends. Mass media such as radio, books, television, newspapers, etc., while they are source of information, they are not as influential as friends.

The paper also considers the relationship between respondents perception of child survival and willingness to adopt family planning contraceptives. The available data indicate a significant number of respondent still think that more children under the age of five die now than they did in the past.

The paper concludes this section by saying that since available family planning methods are women oriented, and since it is the women, whether urban or rural who consider the death of children to have increased, chances are that adoption and use of contraceptives will not improve until there has been a positive demonstration that modern health care can ensure survival of children, or until such time that the population has been educated in basic health services.

HUSBANDS AND WIVES, FRIENDS AND MASS MEDIA:
THE SOURCE OF FAMILY PLANNING INFORMATION.

In adoption process, the question of who influences who, how and under what circumstances is very important. Infact it is considered so important by the diffusion students that it has a central place in innovation and diffusion literature.[1] In family planning, one would assume that who influences who should also hold an important place. In effort to find out the best channels for delivering family planning messages to the Kenyan diverse population, it has become necessary to find out who is talking about family planning and to whom. The important question of the content of family planning conversation e.g. both negative and positive, will be a subject of future investigation. In the present discussion we examine the source of family planning information.

"Have you heard about family planning from the following people?[2] /see Table 1 Page. 2_7. By far, friends, especially for women respondents, are the main source of family planning information. Mass media, e.g. radio, television, newspapers, magazines etc, play a very limited role as source of family planning information particularly as far as the women are concerned.

This is an important observation because, most family planning campaign as well as services are female-oriented. This has been so because of the historical development of planned parenthood movement throughout the world. Women have been the major users of contraceptives with or without their married partners knowledge.

It is possible that because of the present unimportance of mass media,National Family Planning Program has not as yet invested heavily in these forms of communication. The emphasis to date has been on face-to-face communication for motivating family planning clientele. In fact this form of communication is considered so important by propagators of family planning that heavy investiment will be made in the next five years.[3]

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1. See for example, Evarret M. Rogers, Diffusion of Innovation, N.Y. The Free Press, 1968. Modernization Among Peasants: The Impact of Communications. N.Y. Holt, Rinehart, and Winston Inc. 1969. Ronald G. Havelock, A Guide to Innovation in Education ISR, University of Michigan, 1970. R.G. Havelock, Planning for Innovation Through Dissemination and Utilization of Knowledge, ISR, University of Michigan, 1969.

2. This and other question sin this paper are from a National Survey by The Family Planning Association of Kenya 1970. Where data is from different sources, identification of source will be made. The present question is No.28 of the FPAK survey.

3. In the proposed five year family Planning Development Plan. face-to-face communicators will be increased from the present level of under 50 to 600. A 1200 percent increase: See the Kenya National Family Planning Programme: Five Year Plan., Nairobi, Ministry of Health, 1972.

Table 1 which compares the family's monthly income with the source of family planning information indicates that there is a strong relationship between the amount of income a family has and the awareness of the existence of family planning services.[1] Perhaps this is to be expected. The higher the individuals' income, the greater the chances that he will have had more years of formal education and thus the more the likelihood that he has or will have access to reading material including family planning as well as access to other forms of mass media. As Table 1 indicates, friends play the most important role in communicating family planning information for both the man and the woman. Male friendship seem to play a greater role in terms of imparting general knowledge information and perhaps even in helping an individual reach a personal decision.

TABLE 1

SOURCE OF FAMILY PLANNING INFORMATION IN KENYA
COMPARED TO FAMILY'S MONTHLY INCOME.

SOURCE OF INFORMATION	INCOME*									
	Below 100/-		101 - 500		001 - 1000		1001 - 3000		Over 3000	
	M	F	M	F	M	F	M	F	M	F
Friends	37	19	47	29	57	42	53	57	67	80
Radio	18	3	16	6	26	17	42	27	0	60
Wife	11	4	14	7	24	17	35	36	50	60
Teacher(s)	11	1	8	2	15	8	20	16	33	20
Doctor	9	4	11	8	17	16	27	29	33	60
Newspapers	9	0	10	2	24	8	30	21	50	60
Books	7	2	11	4	25	14	32	32	17	50
Posters	7	0	6	0	7	0	24	3	0	0
Health Clinics	4	6	5	12	7	23	27	42	0	60
Social Works	4	1	11	2	16	5	29	14	33	10
Mother	4	0	1	1	1	3	1	4	0	10
Magazines	4	0	6	1	15	7	30	23	17	20
Family Plan.Clinic	2	4	2	7	2	15	17	32	0	50
Politicians	2	0	2	0	4	0	7	0	0	0
Religious Leaders	3	0	4	0	5	0	11	3	0	0
Base	561	669	1062	776	348	276	148	95	6	10

*Income is calculated in Kenya Shillings. Percentage may add to more than 100 because of allowed multiple responses.

1. The assumption is ofcourse applicable in many other innovative areas.

From the above Table, it seems clear that mass media, perhaps with the exception of the radio, is currently not playing a major role in diffusing useful information, and especially to those people who would need it the most. This includes family planning information. If our earlier assumption that there is a likelihood that those with high family monthly incomes also have more years of education and thus have multiple sources of information; it would seem that the corrolary is also true, e.g. those with low incomes have fewer years of education and may have limited sources of information especially on new innovations including family planning. If this is true, the extensive and expensive usefulness of printed literature such as posters, pamphlets, books, newspapers and so forth, as far as our general population is concerned is questionnable. Furthermore, the fact that it costs money to buy the newspapers, magazines, radio etc. may have a significant bearing on why those with low incomes have not received their family planning information from these sources.

In that case then, perhaps family planning campaigns should concentrate on face-to-face communication as the most viable form of disseminating family planning information. While undoubtedly this form of communication is expensive, available data seem to indicate that face-to-face communication has a greater diffusion impact among the population than any other form of communication presently available in Kenya. It should be remembered that the goal of informing the public about family planning is not just so one can claim that they have heard about it, but rather, after hearing and evaluating the information, it is hoped that one will effectively adopt contraceptives. Expensive and slow as face-to-face communication is, it has an added advantage of legitimatizing the new innovation in a country where illiteracy rate is high.

From a programm administration's point of view, one would want to know, if, after hearing about family planning from whatever sources, does a person adopt contraceptives? The questions can be answered by means of an example. If for, example, there are more people who adopted family planning contraceptives after they listened to the radio than did those who heard from friends, the conclusion should be obvious. That resources invested in radio campaigns have greater yield than those invested in employing face-to-face campaigners. It is clear from the data we have however, that face-to-face communications for family planning is by far the most important channel of diffusing the contraceptive information. The ideal situation ofcourse would be to utilize all available channels of communications. However, resources should be allocated only after a careful analysis of the different media impact and priority be

given to those channels that will give the highest dividends and in the shortest time possible.

Before analysing Table 1 in greater details we need to raise a question which seems to be the most important one in family planning campaigns both here in Kenya and elsewhere. Why is that that not as many people adopt contraceptives as claim to have heard about and approve of family planning? Is it that those people who have heard of family planning and who approve of it have not been convinced of its importance to their own lives, or is/it that the message channels are not considered legitimate? We shall attempt to deal with these questions later in this discussion. Suffice at this point to say that in Kenya more people claim to have heard about and to approve of family planning. Yet few of them have adopted family planning. However, it is well to remember that at this point in family planning educational campaigns, the service system does not seem prepated to handle a large number of family planning acceptors who may want to be provided with services. The problem here is one of personnel and the number of service centers, e.g. health centers and hospitals, etc., One would want more family planning clients needing services than to first have service available without anyone taking advantage of them. It is argued that even though health facilities (within whose premises family planning services are provided), are not uniformly available throughout the country, actual motivation and recruitment of clients should continue. When the demands are great enough the family planning management would be in a stronger position to demand additional manpower to meet the expressed need.

Returning to the income table, Table 1, we note the source of information in family planning distribution by income, and sex. As has been clearly demonstrated, few people in Kenya earn more than 3,000 shillings a month.[1] Those who do are among the top civil servants, academicious and successful business elites. Though they are important interms of national leadership, they are too few in relation to the total population. As has been hypothsized in this paper, the more education one has, the better the chances that he will have a high income. It is also hypothesized that the more education and/or the higher the income a person has, the greater the chances that he will have more friends who are influential. Thus, at least based on the data we have,

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1. See International Labour Office, Employment Incomes and Equality: A Strategy for increasing productive employment in Kenya, Geneva Switzeland, 1972.

as far as the source of information on family planning is concerned, it seems that the more education one has, and the higher his income is, the more important friends become and perhaps the greater the chances that those friends will positively or negatively influence his opinion. Friends seem to be the source of most vital information. Among the high income group this seems to be especially so for the women who can be said to be the "Standard Setters". Subsequently, and as noted in Table 1, friends, while they are still the important source of family planning information for all the people, they are more significant interms of influence when compared to a person's monthly income. As one's income decreases, so does the importance of friends' as source of important information.

Friends as source of important information become significant when we consider other information source on family planning. It might be instructive to briefly discuss each source of information in comparison to income.

(1) Radio, Books, Magazines and other Printed matter

In Kenya, it is only within the last two or so years and especially in the last 18 months that radio forums on family planning matters have been held. Since radio and other mass media cost money, for most people who earn under five hundred (500) shillings a month, chances are that this category of people either does not own radios or have limited private access to such media. This is perhaps more true for the rural Kenyan women and the possible explanation might be that these rural women besides not having a radio at home, they are generally busy with other duties —— home, shamba and children to have anytime to listen. It is also possible that these women, even if they had access to the radio, may not be able to listen since most women programs are transmitted during the daytime when most of them are away from home. Further, if we assumed that their low income is related to their low education, and that radio discussions in most cases are either in English or Kiswahili, these rural women, as indeed men, (with the exception of Kenya's coast) may not understand any other language but their vernacular. As a result, we would expect them to have heard very little about family planning from this source or, for that matter, any other source that require knowledge of reading and perhaps understanding another language.

As family income increases, we note an equal increase in radio as source of information among the women with 60 percent of them in the

over 3,000 shillings bracket claiming to have heard about family planning from the radio. We attribute this to the fact that the families in this income bracket, besides having the capital to spend on entertainment/information items such as radio, newspapers, books, etc.; they also have the education necessary to benefit from either spoken words in other languages or from printed messages.

Other sources of family planning information are self-explanatory from the Table I. As the Table shows, again the higher the income, the larger the percentage of people who have heard about family planning. It is instructive for family planning programmers to note the low level of participation from such important groups as the politicians, religious leaders, social workers, teachers and the like. These are the groups which come incontact with the masses of the people every day. Their involvement in family planning education is essential if the program is to be legitimatized. Nevertheless, what we need to perhaps know is whether those people with high incomes, and/who are exposed to the various information from a variety of sources, are they, as a result of this exposure, adopting family planning contraceptives? Assuming that they have or are more likely to adopt family planning contraceptives, and further assuming that this high income group occupies positions of leadership and influence in the Kenyan Society, to what extent are they sharing their knowledge with the rest of the population or even with those in their own socio-economic Strata?

We suspect that diffusion of information among this group is very rapid and that while it is possible that they have talked and will continue to talk with their friends about family planning, they might not as yet have disseminated this information to the many people they come in contact with in their daily activities.

SOURCE OF FAMILY PLANNING INFORMATION ON METHODS. FOR RURAL AND URBAN POPULATION.

It is one thing to disseminate information about family planning movement but quite another to inform people about methods of family information. In Table 2, we present the data on the source of information on family planning methods for rural and urban population The response is in question of "Have you heard about any method of family planning from any of the following people?".

TABLE 2

SOURCE OF INFORMATION ON FAMILY PLANNING METHODS:
RURAL AND URBAN POPULATION.

SOURCE OF INFORMATION	RURAL		URBAN	
	M	F	M	F
Friends	45	27	53	44
Radio	19	6	27	23
Wife	15	9	23	14
Teacher(s)	10	3	15	9
Doctor	12	8	15	24
Newspaper	12	3	23	15
Books	13	6	23	14
Posters	7	0	10	1
Health clinics	6	12	12	28
Social workers	11	3	13	5
Mother	0	0	0	0
Magazines	8	2	17	11
F.P. Clinics	3	8	6	11
Politicians	2	0	5	1
Religious leaders	3	0	8	2

Table 2 Compares well with Table 1.

As in the previous table, friends rank high among both the urban and the rural population. Friends seem to play a major role in disseminating information. In especially the urban areas friendship seem to be important as a source of information perhaps more so than the rural areas. If this is indeed so, the explanation might be that friendship is limited to the small circle of relatives, whereas in the urban centers friendship may not be limited to kinship and close neighbours. We note that there is a greater contact with the doctors, social workers, teachers, politicians and even the religious leaders among the urban populations than there is among the rural folks. In terms of readership of the printed matter, urban population rank higher in every category than the rural population. We suspect that besides the urban population being more exposed to various forms of mass media, this category also constitutes the better educated and better paid group that is most likely to not only hear about family planning or for that matter any other innovations, but this group is perhaps the likeliest to adopt new ideas first!

The figures in Table two, persuade one to conclude that there is a high correlation between education, income, and urbanization to awareness and may be adoption of new information and/or innovation. With the exception of the radio for the rural population, it seems that for the purposes of family planning, clinics and doctors[1] are the most important sources of information for the females population, perhaps indicating the limited professional contact that our rural population gets in the important areas of new knowledge. More effort is therefore called for to be put into the rural areas, not only because family planning is currently tied with maternal and child health care, but also because most of the contraceptives available today are women-oriented and most of our women of reproductive age are in the rural areas. It is the women who frequent the health centers, usually with their sick children. As a result, women are much more likely to hear about family planning and perhaps more importantly, they are much more likely to share family planning knowledge with their womenfolk than the men are likely to do. The fact that more males, whether in the urban or rural areas are able to read than are the females, would also persuade one to conclude that information directly received through the spoken word is much more likely to reach more people, who otherwise would not have been able to get such important information, than information received through print media. Spoken words, especially from relaible persons, are much more powerful and meaningful for the majority of our people than those which appear in print. While education and income for both the males and the females seem to have significant relationship in as far as knowledge of contraceptives are concerned, it does not seem to follow that in a situation where the man has more years of education than his wife, the

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1. In rural Kenya, family planning services are provided within the health clinics and there are few separate family planning clinics which are independently organized. Even the family planning mobile clinics provide their services basically within the operating health centers. With the exception of the physician who sometimes travels with the mobile clinic, rural health centers do not have fully qualified doctors —— the term doctor is here, as is in Kenya, applied rather loosely to apply to both male and female health assistants, who while qualified to give basic health services are not licenced as physicians. For Kenya, however, this category of health assistants is the backbone of the nation's health services and their presence is indispensable. The term "doctor", especially in the rural areas is therefore used to apply to all those people who deal with any and all aspects of illness in health or hospital centers and includes the dressers and even the cleaners! Perhaps this indicates the tremendous regard that the population has for the people who deal with medicines of any kind —— traditional or modern. It is therefore possible that policy makers in developing countries,because of this realization,have always regarded family planning as part of maternal and child care services.

information he gains through reading will be transmitted to his spouce. On the other hand, it is likely that a woman will more than likely transmit knowledge (information) to her husband and friends in a much more useful and meaningful form than is the case with the man. As Table 2 shows, more males have heard about family planning from the females (wives perhaps) than the other way around. The point is that if both the woman and the man have high incomes, high education and whether or not they live in urban or rural areas, they are much more likely to discuss family planning matters than the reverse is likely to be.

RELIGIOUS AFFLIATION AND FAMILY PLANNING INFORMATION

Does religion have anything to do with whether certain religious groups give more information about family planning than others? Table 3 addresses itself to this question.

TABLE 3

SOURCE OF FAMILY PLANNING INFORMATION COMPARED TO RESPONDENTS RELIGION

SOURCE OF INFORMATION	RELIGION									
	ISLAM		CATHOLIC		PROTESTANT		TRADITIONAL		NONE	
	M	F	M	F	M	F	M	F	M	F
Friends	33	21	44	30	52	32	66	0	24	7
Radio	17	5	22	8	23	9	6	0	6	1
Wife	9	2	14	10	19	10	28	0	10	1
Teacher(s)	7	1	13	4	14	4	0	0	1	0
Doctors	11	5	12	9	15	11	7	0	3	0
Newspaper	11	1	15	3	15	5	1	0	4	0
Books	7	3	15	5	18	8	1	0	2	0
Posters	6	1	8	0	8	0	0	0	5	0
Health Clinics	3	4	4	13	10	15	1	0	2	1
Social workers	4	1	9	3	14	0	23	0	3	3
Mother	1	0	3	1	2	1	0	0	0	0
Magazines	5	1	9	2	11	4	2	0	1	0
F.P. Clinics	2	5	3	8	5	10	1	0	0	0
Politicians	3	0	2	0	3	0	3	0	0	0
Religious leaders	3	0	4	1	5	1	0	0	0	0
Base	149	146	707	700	1072	991	90	10	200	74

Comparing religion to the source of family planning information, one observes from Table 3 some significant factors. Perhaps the important columns is that one of traditional religion and especially for the women While the percentage base in this column is too small, the figure is still significant in that none of the women interviewed and who professed traditional religion have ever received any family planning information from the various sources of information —— not even from friends! The 66% of the males who claim traditional religion have heard about family planning from friends. We shall discuss this point further after considering some other points.

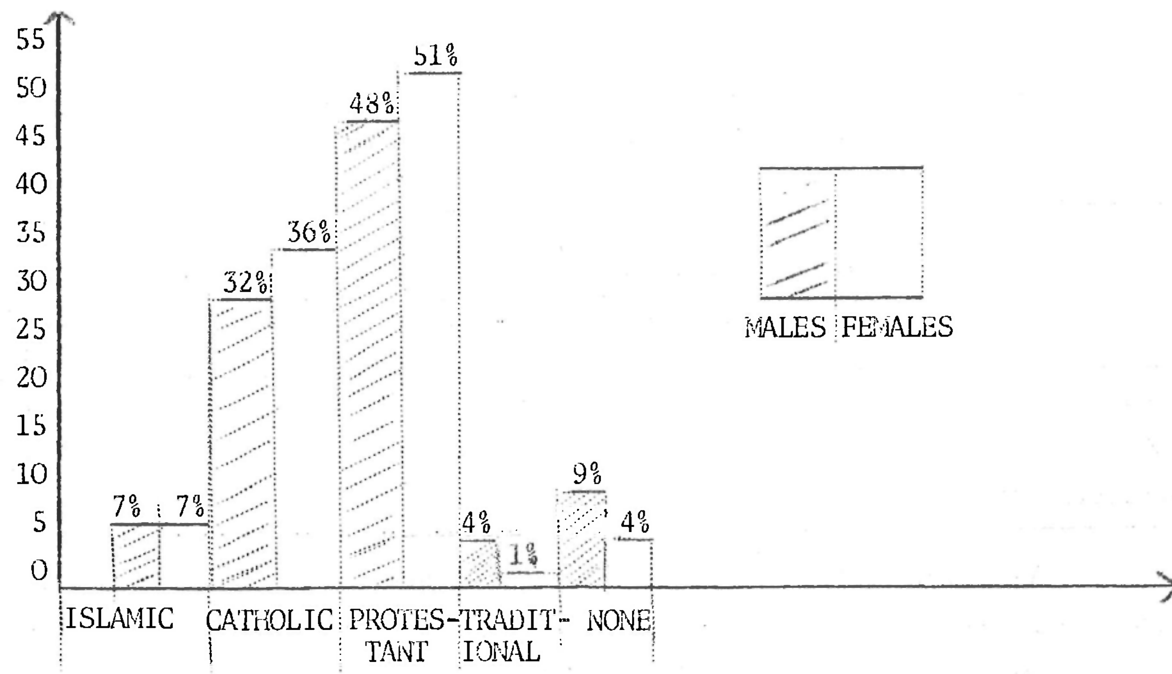
The second point to make about Table 3 is that males, no matter what their religion, have been exposed to family planning information in greater numbers than the females. However, it is of [illegible] importance that when each religion is considered by itself, in regard to sources of information about family planning, more Protestants have heard about family planning methods than those in other religions. The Protestants are followed by the Catholics; followed by those who claim to have no religion. The Muslims[1] are second from the bottom in terms of sources of family planning information. The last group, which we have already mentioned, is composed of those who claim to belong to the traditional religion. The percentage breakdown by religion for both the males and the females who claim to have heard about family planning methods from the various sources can be seen from Figure 1 below.

It seems from Figure 1 that among the Catholics and Protestants, women are generally more informed about family planning than the men. Among the Muslims, both men and women are equally informed while the men are more informed among those who have traditional or no religion. Exposure to information and use or adoption of an innovation are two different things. Thus comapring current usage of contraceptives to the respondents religion, we find that there are more people who profess traditional religion using contraceptives than the case is true for other religions who have claimed to have knowledge of contraceptives. Indeed even among the "ever used" categories, those belonging to traditional religions seem to have adopted family planning in greater

1. For a detailed discussion on Muslim attitudes towards family planning, see Olivia Schieffelim (ed.) Muslim Attitudes Toward Family Planning. New York, The Population Council. 1967.

FIGURE I

PERCENTAGES BY RELIGIOU AND SEX WHO HAVE HEARD ABOUT FAMILY PLANNING METHODS.



numbers when compared to others claiming to belong to different religious. see Tables 4 and 5 below.

Are you or your Spouce currently using any method of family planning?

TABLE 4

MALES/FEMALES CURRENTLY USING ANY FORM OF FAMILY PLANNING COMPARED TO THEIR RELIGION.

CURRENTLY USING METHOD	RELIGION									
	ISLAM		CATHOLIC		PROTESTANT		TRADITIONAL		NONE	
	M	F	M	F	M	F	M	F	M	F
Yes	5	5	7	7	4	10	26	0	4	3
No	30	23	44	34	45	31	60	10	35	5
PREGNANT	1	1	1	0	1	1	2	0	0	0

While the percentage of people who are not currently using any method of family planning is highest among those professing traditional religion, the percentage of those using any kind of contraceptive within

this religious group is also highest - even though it is only the men who claim to be using a method.[1]

Have you or your spouse ever used any method of family planning?

TABLE 5.

MALES AND FEMALES WHO HAVE EVER USED ANY MTHOD OF FAMILY PLANNING COMPARED TO THEIR RELIGION

HAVE EVER USED	RELIGION									
	ISLAM		CATHOLIC		PROTESTANT		TRADITIONAL		NONE	
	M	F	M	F	M	F	M	F	M	F
Yes	5	3	7	2	4	4	26	. 0	4	0
No	25	20	38	32	42	28	37	10	30	4
Currently using	6	0	3	0	5	0	0	0	0	0

As noted above, Table 4, we see again that those claiming traditional religion seem to be in the majority when we compare then to responses of those who have ever used contraceptives. According to these Tables, it seems that religion has very little to do with whether or not couples accept to use contraceptives in Kenya. In fact, at no time in the history of family planning movement in Kenya has there been an organized opposition to family planning on religious grounds.[2]

Nevertheless, it will be interesting to compare adoption of contraceptives to the amount of education one has, age and income. Even though, we are still unable to fully explain why those people who claim to belong to traditional religions seem to use some form of contraceptives more

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1. It should be noted that in response to the usage question, both men and women interviewed in many cases answered for their spouses. Thus, it is possible that in the male responses category about contraceptive usage, in this case might refer to the males spouses.

2. For an excellent a ccount of historical development of the family planning movement in Kenya see David Radel "Kenya's Population and Family Planning Policy: A Challenge to Development Communications" in T.E. Smith (ed.) The Population Politics of Family Planning in Developing Countries of the Commonwealth chapt. 4 forthcoming. see Also J. Mugo Gachuhi "Who needs Family Planning?" in Proceedings of the Conference on Psychology and Family Planning. Henry P. David (ed.) Transnational Family Planning Research Institute, 1972. P 9 - 29. Also "Kenyan Youth: "Their Sexual Knowledge and Practice". Institute for Development Studies, University of Nairobi. 1972. Discussion Paper No. 159.

than those claiming to belong to the different religious groups. This factor seems to hold even when we consider the contraceptive methods currently being used or those that have ever been used. This phenomena might be explained (Table 6) by the fact that when methods ever used are compared to religions, these methods turn out to be not the modern contraceptives but the traditional ones and especially abstinence, rhythm and or withdrawal.

TABLE 6

SPECIFIC METHODS EVER USED COMPARED TO RESPONDENTS SEX AND RELIGION.

SPECIFIC METHODS EVER USED	RELIGION									
	ISLAM		CATHOLIC		PROTESTANT		TRADITIONAL		NONE	
	M	F	M	F	M	F	M	F	M	F
ORAL PILL	1	1	1	1	1	2	0	0	0	0
I U D	1	1	0	0	0	1	0	0	0	0
ABSTINENCE	3	0	4	0	0	0	26	0	2	0
RYTHM/WITHDRAWAL	0	0	4	0	2	0	19	0	1	0
INJECTION BREAST FEEDING	0	1	0	0	0	0	0	0	0	0
CONDOM	1	1	2	0	1	1	1	0	1	0

Table 6 above might be a pointer to something that is also African in as far as birth planning is concerened. A pointer because some African anti-family planning people argue that the use or advocacy of family planning in Africa is something brought by the western society in their ever continuing effort to hold the Africans down, both politically and economically.[1] This type of argument is useless and not worth any serious discussion. It must be kept in mind however. For the purpose of our discussion, we note that as is generally the case in Kenya and perhaps in Africa, people who have not as yet been affected by foreign religions, viz a viz, either christianity and in a lesser degree Muslim, usually tend to be the people with little or no education. In this case, Table 6 shows that, traditionalism, which we equate with non-christianity or Muslim, has a high correlation with both abstinence, rythm and / or withdrawal as methods of family

1. For a details discussion on this theme, see J. Mugo Gachuhi "The Pill and The Family: A Discussion on Family Planning Contraceptives, Fertility Reduction and National Welfare". in Strategies for Improving Rural Welfare. Nairobi, The University of Nairobi, Institute for Development Studies, Occasional Paper No.4, 1971. Pp. 370-386.

planning. This might be an indication that Africans have used these methods of birth control in the past and that these methods are not new to Africa[1] nor do they have much to do with western society or christianity alone. Even though, rythm, withdrawal and/or abstinence are the only methods of family planning approved by the Catholic church, our Catholic respondents do not seem to practice them because of their religion. One can infact go as far as stating that religion of whatever kind is irrelevant to adoption of family contraceptives in Kenya.

Abstinence in Africa, it should be recalled, was widely practiced.[2] It was enforced mainly by means of taboos placed on the married couples and was best practiced in those marriages which were polygamous. It would seem also that the high male responce as to the usage of contraceptives stems from this traditional practice. Hence our conclusion might be that the males were required to show more sexual restraints than the females.

Comparing the percentages of those people who have heard about family planning — figure I, to those who have either have ever used or are currently using family planning contraceptives — Tables 5 and 6 — we note that there is a difference between knowledge about and use of contraceptives. These figures raise important question for the Kenyan family planning program. For example we would want to ask: Why aren't as many people who claim to know about family planning and who approve of family planning availing themselves of services available from the program? Indeed, why is it that only less than 7% of all the people who have heard about family planning are using any kind of contraceptive and even those using them do so very sporadically?

The best answer to these questions would seem to depend on the knowledge we have of the culture within which innovative ideas are being introduced. The nature of innovation itself has a lot to do with adoption or non-adoption.[3] It is on the basis of this reasoning that we suspect that Kenyans are not adopting family planning contraceptives in large numbers, (even though many claim to have heard about and to approve of family planning), perhaps it is not because they dont want to, but possibly

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1. See Angela Molnos: Attitudes towards Family Planning in East Africa, Munich, Weltforum Verlag, 1968. Also, Molnos, Cultural Source material for Population Planning in East Africa. Nairobi, The East Africa Publishing House. 1972 especially Vols. I Review of Social cultural Research 1952-1972 and II, Innovations and Communications. Also see Donald F. Heisel "Attitudes and Practice of Contraception in Kenya". In Demography. Vol.5 No.2.pp.632-641 1968. S.C. Caldwell and C.Okonjo (eds.) The Population of Tropical Africa N.Y. Columbia University Press. 1968.
2. Molnos - Ibid, 1972.
3. See Molnos. Cultural Source Material for Population Planning in East Africa. Ibid, Vol. 2.

because the contraceptives currently available are seriously suspected.[1] Another possible reason for wide-spread non-use of contraceptives might be that, the approach family planning advocates have so far followed might be out of tune with the peoples' traditional values, e.g ethical values. Family planning propaganda as currently being disseminated might be in direct conflict with the Africans sense of good morality and child bearing responsibility.

Assuming that our assertions are correct, it is doubted as to whether the large numbers of people who claim to use natural methods of family planning do so because they suspect modern contraceptives. The point to make, however, is that it would be preferable if easier to administer methods, with fewer side-effects were found. If such methods were found - methods which are developed with the peoples' cultural value, in mind then perhaps many more people might be coming forward for contraceptives and use them long enough to make a difference in the rate of population growth.[2]

Perhaps another barrier to adoption of contraceptives among the Kenyan population might be the perceived chances for the survival of children. In the past, it was necessary for a couple to have as many children as possible because of the high child mortality. Having many children ensured the survival of some to adulthood. These days, as health care has improved and the chances of a child's survival are far better than they have ever been, one would think that parents would not want to have as many children as they did before. However, as we shall see in the discussion below, many of our people, especially those in the rural areas still do not think that chances of childhood survival are any better than they were several years back. We suspect that this is one of the most important barriers to adoption and use of contraceptives among the many people in Kenya who report knowledge of family planning and also approve of family planning. If this is so, few people will infact come forward for contraceptives until they are convinced that modern health care can ensure survival of the few children family planning movement is asking them to have.

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1. For the type of questions Kenyans ask about the various contraceptives, see J. Mugo Gachuhi, "Youth, Reproduction and Population", I.D.S. op. cit. appendix.

2. For details of Continuity rates see Gachuhi, "Who needs Family Planning?" in David (ed). op. cit.

[illegible] ATH:
BOTTLENECK FOR ADOPTION OF CONTRACEPTIVES.

As mentioned above, in Africans traditions, one of the important factors in a couples' desire for many children was to ensure that, since many died, many children were born so that some would survive to adulthood. The introduction of modern medical services has contributed to the saving of many lives and thus directly contributing to the rapid population increase. If parents were convinced that modern health services can help their children to survive, chances are that parents would adopt family planning much more easily than the case is at the moment. In attempt to find out how parents perceive the chances of their children's survival, we asked the following question. "Do you think more/less / or the same number of children below the age of 5 years die now as they used to in your mothers' time?" Table 7 below gives the answers.

TABLE 7

PERCEPTION OF SURVIVAL OF CHILDREN UNDER 5: MALE AND FEMALES.

RESPONSE CATEGORY	SEX OF RESPONDENT		
	MALES	FEMALES	AVERAGE M & F
More die now	21	25	23
Less die now	64	54	59
Same as before	5	12	8.5
Don't know	10	9	9.5
Percent	100	100	100
Base	2237	1957	

From Table 7, we note that while a large number of people (59%) think few children die now while under the age of 5 years than during their mother's time, a significant number (23%) do believe that more children die now than in the past. This may mean that health services may not have fully reached these people, or if they have, the population concerned has not taken full advantage of the available services. We suspect the explanation is both. However, what is disturbing from family planning point of view is that, if we were to include the "don't know" and "same number as before" to the "more die now" category, we have a cumulative total of 41% of our population still believing that many children still die before they reach their 5th birthday. This is a significant group that perhaps would continue to have

as many children as possible inorder to ensure that some will survive. While we cannot by no means claim that 59% of the respondents who believe fewer children are dying now than in the past are likely to have fewer children than the other group, it is likely that this group is much more likely to accept and use family planning contraceptives than the other group. This is likely to be so if we assumed that children's survival was the only major variable as far as parental desire for more children was concerned.

Looking at the male and female response categories in Table 7, we note that more women than men believe that children die more now than in the past. While the difference between male and female in this category is minor, it is nevertheless a significant difference especially when we recall that modern approach to and methods of family planning are women oriented, Thus, as long as women believe that their children are still threatened by death during their early years, chances are that they will resist adopting family planning. Taking the total number of women who either believe that "more children" die now, or that "the same number die now as in the past" as well as those who claim they "don't know", we find that 46% of all the women, in comparison to 36% of the males with the same views, are not fully convinced that chances for their children's survival have improved. Women, we argue, are important in determining the size of the family they want and whether their husbands believe that children can and are surviving now as compared to the past, will not convince many women to adopt family planning.

Table 8 below compares well with Table 7 above. In Table 8, we compare the responses of rural and urban for both males and females on the same question as in Table 7.

TABLE 8

"Do you think more/less/or the same number of children below 5 years die now as they used to in your mothers' time?" Rural/Urban/male/female response.

RESPONSE	URBAN			RURAL		
	Male	Female	Totals	Male	Female	Totals
More die now	19	15	17	22	26	24
Less die now	70	69	69.5	63	53	58
Same as before	2	10	6	5	12	8.5
Don't know	9	5	7	10	9	9.5
Total	100	99	99.5	100	100	100
Base	354	185	539	1883	1772	3655

From Table 8, we note that there is a difference of perception between rural and urban population and also between urban-rural males and females. The explanation for this apparent difference in perception concerning children's survival might be that health services are better organized and access to health facilities is much easier in urban than the same is true of rural areas. In urban centers you also have more facilities, better equipped and/better facilities manned/than the rural areas have. As a result of this easy access to health services in the urban areas, more children receive medical attention, e.g. early immunization as well as treatment for any ailments and hence more will have better chance of survival in urban areas. The same cannot be said for the rural sector.

Clean and treated water, ease of transportation and perhaps better diets, are all factors that affect health of both the mothers and their children. Since these conditions /are much more likely to prevail in urban than rural environment, they are likely, therefore, to be the contributing factors to the general wellbeing of urban children. As a result then, we note from Table 8 that whereas 17% of the urban male and female think that more children die now than in the past, 24% of the rural respondents believe this to be the situation to-day. Nearly 70% of the urban and 58% of the rural population believe fewer children die now than in the past.

It is noteworthy to point out that there is not a major difference between the rural and urban males or between rural and urban females in their perception concerning the survival of children. While we do not have the figures to show whether urban people who believe more or about the same number of children die now as in the past, are recent migrants from the rural areas, it seems possible that in the urban female category might be recent arrivals.[1] In that case, their responses might be based on their rural experiences. While we do not claim this to be the case, or the only explanation, our knowledge of Africans settlement in the urban areas, where the male migrates first without his spouse, might infact be a plausible explanation as to why this male/female difference in perception exists:

In Table 9 we present data on the same question by comparing the responses to years of education our respondents have had.

"Do you think more/less/or the same number of children below the age of 5 die now as they used to in your mothers' time?

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1. In Kenya, women whether single or wives were discouraged from migrating with their husbands to the urban centers. The colonial attitude did not change until in the late 1950's. Even to-day, most of Kenya's towns are still predominantly males. It is also possible that rural male believes that less children die now than in the past, could be attributed to the fact that males are usually exposed to more information since they are not confined in their homes as much as the women are.

TABLE 9

RESPONSE CATEGORY	YEARS OF EDUCATION											
	No. Ed.		1 - 4		5 - 6		7		8 - 9		10 +	
	M	F	M	F	M	F	M	F	M	F	M	F
More die now	25	30	26	21	22	24	20	20	17	16	15	12
Less die now	50	45	56	54	67	59	63	64	73	71	79	82
Same as before	9	11	10	14	1	11	3	8	2	9	1	3
Don't know	16	11	8	10	9	6	13	8	6	4	4	2
Total	100	97	100	99	99	100	99		98	100	99	99
Base	424	905	400	285	309	263	484		316	129	304	60

Table 9 clearly shows that there is a direct relationship between the amount of education one has and his perception of the decline in child mortality. To fully appreciate the significance of education in the peoples' perception, we have collapsed the figures of those who think more children "die now", "about the same as before" and those who "don't know" in one category - e.g. a category of don't knows. Calculating at the figures this way, one would note that among those who have no education, 50% of the males believe that nothing has improved as 51% of the women with no education similarly do. With increasing years of education, the percentages begin to fall. Thus, 45% and 44.5% male and female respectively who have between 1 and 4 years of education believe nothing has changed. For those between 5 and 7 years of education the figure drops to 36%.

The picture significantly changes with 8 - 9 years of education. 27% of the respondents believe that nothing has changed or they dont know what the situation is. We therefore believe that the more education one has, the more aware he will become of the facilities and services available to him and the better the chances that he will use those facilities and services. We shall briefly deal with the educational point later because we think it is an important variable in adoption of innovations.

Looking at Table 9 again we note that more females than males believe that the situation has not changed since their mothers' time and that more or about the same number of children under five years die now as then. This claim is especially true for those females with six years of education or less. For those females who have ten or more years of edcuation and who hold the view that child death has not changed since the time of their parents, their number declines substantially when compared to the males of the same educational qualifications.

We could attempt to explain this phenomenon in two ways. Firstly, only some of the Kenyan people get to complete seven (7) years of primary education. During the primary school years, the curriculum is the same for all the pupils and thus among those who have attended school up to standard seven, the responses tend to be the same. Secondly, for those who pass the primary school final examination, both boys and girls go to different schools - e.g., an all boys or an all girls secondary school. We suspect that it is in the secondary schools that differences in perception, especially on matters concerning family welfare, begin to emerge and most probably so after the tenth year of education - e.g., the second and third year of secondary education. Our suspicion is based on two reasons: In the first place, not as many girls get to go to secondary school as boys. Secondly, of those girls who qualify to go to secondary schools, they are more likely to leave school before completing their curriculum of study because of pregnancy and/or marriage as well as other reasons.[1] Girls are also likely to take more courses centering on the family and the home, such as domestic science, family life, sewing etc., than the boys are likely to do.

From this discussion the question that needs be asked on behalf of family planning is: As the years of education increase and as perception of the possibilities of all or nearly all children surviving past their fifth birthday, will the desire to have many children decline? Indeed, does the number of years of edcuation one has, the knowledge that modern health care can protect the lives of children and so forth, do these factors have an effect on a persons' desire for more children? The answer is most probably yes.

There does seem to be a positive correlation between education and the number of children one has. As indicated in an earlier study of clinic attendance in Kenya,[2] the more the years of education one has, the likelier are the chances that he will adopt a new idea.[3] Other studies have reported

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1. If one looks at the percentage base on Table 9, there is a higher figure for women without any education. This figure declines as years of education increase again indicating that fewer women get as much education as the men. See also J. Mugo Gachuhi "Youth, Reproduction and Population", for a discussion on knowledge of reproductive organs. In this study, there is also a clear difference between the sexes on the amount of information they have, even when education is considered as a variable.

2. See Gachuhi, "Who needs Family Planning?" op.cit.

3. In another study, Gachuhi, "Youth Reproduction and Population", op. cit., young people with more years of education were found to know more about family planning contraceptives and expressed a desire for fewer children than their [illegible] who had fewer years of education.

the same trend.[1]

We conclude by stating that education is an important component in changing peoples' perception. For the purposes of family planning in Kenya, adult education for literacy, health education for both the young and old alike, as well as other forms of campaigning to convince the population of the changing situation in their lives, all these will be a priority if there is to be wide-spread adoption of contraceptives. Until such time that parents are convinced of their children's survival, little can be expected from them interms of effective adoption and use of contraceptives. Potential adopters of contraceptives will continue to state that they have heard about family planning, and about contraceptives. We also think that as survey after survey demonstrate, many will approve of family planning without themselves adopting any family planning. As long as knowledge such as "survival of children is better now than in the past" is absent, we suspect that contraceptive use will continue to be low. It is paramount, therefore, that family planning be introduced as a part of total package — the family welfare, rather than just as a single development approach. The channels of family planning communications will have to be increased to include all extension agents who deal with the family. Families approached in their totality, chances of their adopting new ideas will be increased. Perhaps development of integrated approach to the family in effort to get them to adopt new ideas, becomes one of the important challenges to those who are intent on bringing in planned change.

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1. See Linda Burgess (ed.) "The Esfahan Seminar Report of a Regional Seminar on Functional Literacy and Family Planning Education, April - May, 1971", New York, The World Education. 1971. P. 10. Also see Ronald Freedman "American Studies of Family Planning and Fertility: A Review of major trends and Issues". Quoted in James T. Faweett, Psychology and Population, N.Y. The Population Council, 1970. P. 37.