THE NEXUS BETWEEN PARTICIPATORY COMMUNICATION AND PROSTATE CANCER SCREENING AMONG AT-RISK POPULATION IN WESTLANDS, NAIROBI – KENYA

A Research Project submitted to the University of Nairobi, School of Journalism and Mass Communication (SOJMC) in partial fulfilment of the requirements for the degree of Master of Arts in Communication Studies

K50/88503/2016

Ongala Maurice Ouma

2018
DECLARATION

I, Ongala Maurice, hereby declare that this research project is my original work and has not been presented for award of degree in any other University.

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Ongala Maurice Ouma                        Date

REG. No: K50/55803/2016

This research project has been submitted under my approval as the University supervisor.

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Dr. Ndeti Ndati                                Date
DEDICATION

This is for my lovely wife Maurine Ongala, our charming daughter Zenani Crosby, and my parents Mary Ouma and David Ouma Sewe.
ACKNOWLEDGEMENTS

First, I give thanks to the Almighty God for the grace and providence that walked me through not just this project, but also the whole MA programme at the University of Nairobi. Secondly, my wife Maurine, daughter Zenani, my parents Mary and David Ouma, as well as my siblings – thank you for the moral support, prayers and unending love. These went a long way in helping me to complete this academic work.

I would not have wished for a better supervisor than Dr. Ndeti Ndati who is the Director, School of Journalism and Mass Communication. I laud you for the selflessness and sacrifices you made times without number to guide me in shaping up this study from design to completion. All members of the SOJMC faculty led by Associate Director, Dr. Samuel Siringi, I appreciate you. The quality of this work reflects not only your competence but also your dedication to your students.

I give hearty gratitude to Elder Hezborne Mimba for spending long hours praying with me for the successful completion this programme.

Lastly, I would like to acknowledge the stellar services of University of Nairobi’s Jomo Kenyatta Memorial Library (JKML) from where this thesis was partly written. The management and staff of JKML, your services proved simply splendid and rich. Thank you very much.
ABSTRACT

This study sought to investigate the significance of participatory communication in promoting the uptake of prostate cancer screening among Kenyan men classified as most at risk of developing the disease. The objectives of the study were: to find out the perceptions of men at risk towards prostate cancer screening in Westlands Constituency; to investigate the barriers to prostate cancer screening among men at risk in Westlands Constituency; and to examine the role of participatory communication in bolstering the uptake of prostate cancer screening among men at risk in Westlands Constituency. The study used the Health Belief Model, the Social Learning Theory and the Persuasion Theory, as the underpinning theoretical constructs. Convenience Sampling was used to select participants for the Focus Group Discussions while purposive sampling was used to select participants for the Key Informant Interviews. The study employed qualitative research approach. Interview Schedules and Focus Group Discussion Guides were the main data collection tools. Thematic data analysis method was used to analyse the ensuing data. Narrative method was used to present the analysed data. The study found that men at risk of developing prostate cancer generally have negative feelings and perceptions about the disease, associating it with suffering and death. The study has found that participatory communication is a powerful and suitable method of creating awareness and enhancing uptake of prostate cancer screening among men at risk in Westlands Constituency. The study therefore recommends that the Government of the Republic of Kenya and other stakeholders working in the field of prostate cancer employ participatory communication in their efforts to increase uptake of prostate cancer screening.
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<th>Description</th>
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<tr>
<td>PSA</td>
<td>Prostate Specific Antigen</td>
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<tr>
<td>DRE</td>
<td>Digital Rectum Exam</td>
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<tr>
<td>TRUS</td>
<td>Trans Rectal Ultrasound</td>
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<td>KDHS</td>
<td>Kenya Demographic and Health Survey</td>
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<td>NCDs</td>
<td>Non-communicable Diseases</td>
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CHAPTER ONE
INTRODUCTION

1.0 Overview

This chapter introduces the study by detailing the background, study objectives, justification and significance of the study. Additionally, the chapter looks into the scope and limitation of this study and closes by operationalising key terms used in this study.

1.1 Background of the Study

Prostate cancer is the second most common cancer and the sixth leading cause of death among men globally, according to Jemal et al (2011). In the US, for example, it has been reported that prostate cancer has been the commonest type of cancer that men have been diagnosed with. By estimate, 232,090 new cases are diagnosed annually within the US alone. Out of this number, The US has also recorded a high rate of deaths in men due to prostate cancer; recording about 30,350 deaths (ACS, 2005).

This study further suggested community-based cancer awareness education, which is sensitive to religious and cultural needs, as a way of boosting the uptake of prostate cancer screening in the US. This, by implication, insinuated that even though there may generally be high awareness levels, there is a possible weak link in so far as communicating prostate goes (Thomas, Saleem and Abraham, 2013).

Available statistics also reported that men who are African American have not undertaken cancer screening and coincidentally they have recorded the highest number of prostate cancer incidences (ACS, 2006). It was reported that the African American men do not usually participate in health related issues compared to other men and women Braithwaite
(2001). This is the main reason why the men are at higher risk of prostate cancer due to their ignorance as engaging in health activities would help them prevent it.

In China, however, reports have showed that cases of prostate cancer are low compared to other countries where the report estimates show that 33,000 were diagnosed in 2008. It is estimated though that the rate is growing with the reports showing that about 49,000 might be recorded in 2020 and deaths of about 20,000 men (Ferlay et al, 2008).

In Hong Kong, records of increase in cases of prostate cancer have been increasing over the years. Males in Hong Kong are dying due to prostate cancer as the third common cause of death in 2010. In 2010, there were records of about 1,492 cases of prostate cancer by The Hong Kong Cancer Registry (2010). Out of 100,000 people, 5.5 of them were found to die due to prostate cancer with the age of 28 as standardization.

Regionally, reported incidence of prostate cancer among African-American men is about four times that among native Africans (Hsing et al; Parkin et al, 2000). The much lower reported rates in Africa are attributed to a set of factors including under-diagnosis, under-reporting, lack of screening, a relatively shorter life span, a greater presence of competing morbidity, and a lower prevalence of risk factors. Here, lack of screening comes out prominently as a factor contributing to low incidence. It makes sense therefore, to deduce that the prevalence rate could be higher than the reported incidences due to low screening rates (Ogsebe, 1997; Ogunbiyi, 1999).

For a long time, it was generally accepted that the prevalence rates of prostate cancer in Africa are low, but more recent data suggest that the incidence of prostate cancer in Africa
is rising. In Nigeria, for instance, prostate cancer has become the most common cancer in Nigerian men, accounting for 11 percent of male cancers (Ogsebe, 1997; Ogunbiyi, 1999). One of these recent papers further suggests that these rising rates may be associated with the "westernization" in Africa (Echimane AK, et al, 1995-1997). Interestingly, the two papers list low screening among the major causes of mortality, and ineffective communication as one of the leading factors associated with the low screening in Africa (Oladimeji et al., 2010).

Findings from the Kenya Demographic and Health Survey showed that the awareness of the disease for the 45 –75 age group with the highest risk was 78.1 per cent, but only 2.6 per cent had had an examination for prostate cancer (KDHS, 2014).

Prostate screening is the main diagnosis of prostate cancer. Doctors all over the world indicated that regular screening of cancer may enable early detections of the disease and thus enable early treatments that may be successful in treating the disease. The use of digital rectal exam (DRE) and prostate specific antigen (PSA) are the main screening machines that are found to be more effective in detecting the disease much earlier (Tingen, et al., 1998). Another type of screening is Trans Rectal Ultrasound (TRUS), which is not common in Kenya.

This study set out to examine the nexus between participatory communication and uptake of prostate cancer screening among Kenyan men at risk. Further, the study gave recommendations on steps that can be taken to eliminate the discrepancy between prostate cancer awareness levels and numbers of men accessing screening services in Kenya.
1.2 Statement of the Problem

Available empirical evidence shows that the relationship between prostate cancer awareness levels and uptake of prostate cancer screening is inversely proportional (Wanyagah, 2014). Despite the levels of prostate cancer awareness among men at risk in Kenya standing at a high of 78.1 percent, only 2.6 per cent of these men get screened for prostate cancer (KDHS, 2014). According Kenya Demographic and Health Study (2014), 96% of men in Nairobi have not been screened for prostate cancer although 66% of them are aware of the disease. In North Eastern Province, none of the men had been tested for prostate cancer. Approximately 23% indicated they were aware of the disease (KDHS, 2014). Consequently, late diagnosis of prostate cancer remains high, leading to high mortality rates (Wanyagah, 2014). This study therefore seeks to investigate the centrality of targeted participatory communication in improving this knowledge-behaviour gap.

1.3 Study Objectives

1.3.1 Overall Objective

The main objective of this study was to examine the centrality of participatory communication in warding off barriers to prostate cancer screening among Kenyan men at risk.
1.3.2 Specific Objectives

Specifically, the study set out:

1. To examine the perceptions of men at risk towards prostate cancer screening in Westlands Constituency.
2. To investigate the barriers to prostate cancer screening among men at risk in Westlands Constituency.
3. To investigate the role of participatory communication in bolstering uptake of prostate cancer screening among men in Westlands Constituency.

1.4 Justification of the Study

This study was necessitated by the fact that prostate cancer is one of the leading causes of deaths among men in Kenya and other parts of the world yet very little effort is directed at improving targeted communication around the disease, with particular regard to uptake of screening. This has seen a rise in prostate cancer related mortality, high awareness levels among at-risk population notwithstanding.

1.5 Significance of the Study

The findings of this study will assist health communication experts and prostate cancer practitioners in gaining a better understanding of the existent communication gaps and perceived barriers to screening, and how to more effectively address them. Specifically, data analysis on the identified barriers may provide valuable information toward addressing the gap between high awareness and low uptake of screening, thus more early diagnoses hence, reduced cancer mortality rates.
This study will thus address the Global Sustainable Development Goal number four, which involves working towards achieving universal healthcare for all. It will also assist in fast tracking the realisation of the Social Development Pillar of the Kenya Vision 2030, since no meaningful development can happen in a sick and ailing society. Currently, the Government of Kenya has embarked on an economic transformation initiative dubbed the Big Four Agenda. The study findings provide invaluable data to enhance Government of Kenya’s Big Four Agenda, which has universal access to healthcare as a core pillar.

1.6 **Scope and Limitations**

This study sought to investigate the significance of participatory communication in promoting the uptake of prostate cancer screening. The study population were men classified as having a higher risk of developing prostate cancer. Specifically, the study used 25 men between 65-75 years old. Geographically, the study was conducted in Nairobi County and the sample drawn from Westlands Constituency, which has five Wards namely Karura, Kitisuru, Parklands, Kangemi and Mountain View. This study employed qualitative approach – qualitative data was collected, analysed and presented.

1.7 **Operational Definitions**

i. **Prostate Cancer:** Malignant mass or tumour occurring in the prostate gland.

ii. **Prostate Cancer Screening:** The principal screening tests that are used to detect prostate cancer including the digital rectal exam (DRE) and the prostate specific antigen (PSA). The DRE entails the healthcare professional inserting a gloved finger into the rectum to palpate the prostate for hard and lumpy areas. The PSA is
a blood test in which blood is taken from the male and examined to detect the amount of a protein made by the prostate called prostate specific antigen.

iii. **Barriers to Prostate Cancer Screening:** Negative aspects of the anticipated behaviour such as being afraid to go for screening, screening costs too high, ignorance, doctors hours not convenient, fear of prostate examination, fear of impotence after cancer treatment, have to wait to long, no insurance coverage, being treated rudely or unkindly by healthcare workers, embarrassment.

iv. **Participation in Prostate Cancer Screening:** Annual screening with the PSA and/or DRE.

v. **Men:** For the purposes of this study, the term men was used to imply the general male population

vi. **Men at Risk:** The men who are 40 years old and above

vii. **Chiefs’ Baraza:** Community participation and consultative meeting between local administration and the community
CHAPTER TWO

LITERATURE REVIEW

2.0 Overview

This chapter discusses several empirical studies on the possible relationship between effective communication and prostate cancer screening among Kenyan men at risk. Related research studies conducted within and without Kenya are discussed in so far as perceived barriers to prostate cancer screening go, and examine the place of participatory communication in averting these barriers.

2.1 Global Cancer Burden

Cancer caused 8.2 million deaths worldwide in 2013, out of the 14.9 million new infections that year, in 2013, it became the leading cause of death after cardiovascular disease from 1990 where it was the third leading cause of death (GBD, 2015). This is a clear indication that the threat of cancer at the global level is alarming.

In 2010, the reports indicated that 36% of African Americans and 47% of Canadians had undergone screening for prostate cancer (Patel K, Kenerson D, Wang H, Brown B, Pinkerton H, Burress M, et al., 2010). There are lower rates reported in China. A 12% and 29% rates were reported in Taiwan (Chung, Hsieh, Liu, (2003); Lin, Li, Cheng, Wu, Kao, 2011).

The factors that affect men not to undertake cancer screening have been investigated on different studies. These factors include; low knowledge, embarrassment, family histories of cancer, urinary symptoms and recommendations from physicians (Conde, 2011;
Ferrante, 2011). Other factors that can predict prostate cancer are; age, attainment in education, income, coverage of insurances and marital status (Patel et al, 2010; Göbl et al, 2011; Richardson et al, 2007). Obesity, medical visits and perceptions of health are other factors that also contribute to having prostate cancer.

2.2 The Prostate Cancer Scenario in Africa

For a long time, it was generally reported that there were low rates of cases of prostate cancer in Africa, but the current reports are showing that prostate cancer cases are on the rise. 11% of men in Nigeria have been diagnosed with prostate cancer and it has been recorded as the commonest type of cancer in most men (Ogsebe, 1997 & Ogunbiyi, 1999). One of these recent papers further suggests that these rising rates may be associated with the "westernization" in Africa (Echimane AK, et al, 1995-1997). Interestingly, the two papers list low screening among the major causes of mortality, and ineffective communication as one of the leading factors associated with the low screening in Africa. Another study suggested (Oladimeji et al., 2010).

2.3 Disease Burden in Kenya

Most of the developing countries are faced by Non-communicable Diseases (NCDs), which are the main health issues that cause death, this will continue and higher reports will be recorded by 2030 (WHO, 3013). Ferlay et al. (2013) estimate that in Kenya, 40,000 new cancer cases and 28,000 cancer deaths occur each year, making cancer the third leading cause of mortality and accounting for 7% of all annual deaths in the country. According to the World Health Organisation 2014 Country Profile, after infectious diseases and
cardiovascular diseases, Kenya now fights cancer as another cause of morbidity. WHO puts the figure of new cancer in Kenya annually at 37,000, slightly lower than Ferlay et al. It however agrees that more than 28,000 deaths occur per year (WHO, 2014). The report indicates that the leading cancer among Kenyan men is prostate cancer.

It has been found that most of the reported cases of prostate cancer in Kenya are reported at a late stage and treatment options are low as per The Kenya Medical Research Institute (KEMRI) (Kenya MOH, 2011). Challenges such as late diagnosis, lack of accuracy, inadequate information on prostate cancer, lack of enough treatment areas, lack of personnel and equipment contribute to the high morbidity and mortality rates.

Upon diagnosis, Kenyan men and their families begin a journey of information gathering around prostate cancer and its various forms of treatment, information which they might have had previously but didn't action. Such men have to consider the impact a treatment may potentially have on their quality of life and, frequently, they experience decisional conflict and require emotional, financial and psychosocial support.

As shown above, prostate cancer is one of the most problematic health challenges presently facing Kenyan men. Critically low uptake of prostate cancer screening by Kenyan men who are at risk remains a serious challenge in combating the menace, as delayed diagnosis results into decreased survival rates. The demographic cadre of Kenyan men classified as most at risk of developing prostrate cancer has exemplary awareness levels but very low uptake of screening services. This contributes the high cancer related deaths in the country annually, and it is imperative that the threat is addressed and contained.
2.4 Importance of Early Screening

More than 70% of all prostate cancers are diagnosed in men older than 65 years of age. When one attains the age of 50, chances of developing prostate cancer become even more pronounced (Jones & Wenzel, 2005). Most of the reported cases are of men who are above the age of 65. Early diagnosis has been identified through research as the most important step towards fighting cancer (American Cancer Society, 2016). For diagnosis to be done, a patient has to be deliberate about getting screened for the disease.

It was reported in Ghana that 83% of the men had elevated PSA levels of prostate cancer and 95% had prostate cancer out of the 196 men according to the outpatient Department of Komfo Anokye Teaching Hospital (Rebbeck et al., 2013). Lack of awareness on prostate cancer was found to be the main challenge of most men in Nigeria; the man were not also aware of screening and serum PSA test for cancer (Ajape et al., 2009). 108 patients sampled in Kenya showed that the high rates of prostate cancer were due to lack of screening (Ngugi; Byakika, 2007). (Magoha; Ngumi, 2000) also added that early detections of the disease helped in successful treatment of the cancer.

In Kenya, there are two main tests to ascertain the status of one’s prostate: the Prostate Specific Antigen (PSA) test and the Digital Rectal Examination (DRE) (KDHS, 2014), which is done using a gloved finger to check for growths or abnormal enlargements of the prostate gland. The DRE is a very uncomfortable process for most men while most of them don’t know that they have the option of PSA test in most health facilities in Kenya.
Modernized techniques, which include DRE, PSA and TRUS, are effective in detecting most of the cancers (Zeigler-Johnson et al., 2008). Screening has been recorded as the main detection method of cancer globally according to a review done by (Ngugi; Magoha, 2007).

2.5 Prostate Cancer Awareness Versus Screening Uptake in Kenya

There is relatively meagre empirical information in Kenya regarding the awareness levels of prostate cancer as compared to information available on cervical cancer, breast cancer and other cancers. However, available information indicates a very high awareness levels on prostate cancer among Kenyan men.

Findings from the Kenya Demographic and Health Survey have indicated that the awareness of the disease for the 40-75 age group, which has the highest risk, was 78.1%. This study however, puts screening rate of the same age cadre at only 2.6 % (KDHS, 2014). According to Paul Wanyagah (2014), 84.6% of Kenyan men aged 40-75 were aware of prostate cancer, 16.4% being not aware. In a study conducted in Nairobi in late 2013, Wanyagah explains that the high awareness levels did not translate to more men at risk taking up the prostate cancer screening services.

Of the 581 respondents interviewed in the study, a majority (95.9%) had never been screened for prostate cancer and only (4.1%) had ever taken up prostate cancer screening (Wanyangah, 2014).

2.6 Knowledge-Behaviour Gap

The way people behave while seeking for health determines their practices and how they seek form treatment when sick for themselves and those other family members. Men are
the head of families and their decision on health in the family determine the health of other family members, but it’s unfortunate that men do not participate in health activities. Their participation should be improved through; establishment of men’s clinics, counselling sessions and testing of HIV and other diseases and screening and treatment for prostate or testicular cancer (Crum, Spencer & Amling, 2004) and (UN, 2011). Poor health among black American men was also due to urinary symptoms and accompanying bothers (Sarma, Wallner, Jacobsen, Dunn, & Wei, 2008). Taken together, these studies suggest that enhanced cancer information, participation in health decisions and disease manifestations promote men’s health seeking behaviour.

It is interesting, however, to note that despite high prostate cancer awareness rates, the uptake of screening services remains low. Lack of awareness on prostate cancer was found to be the main challenge of most men in (Ajape et al., 2009). (Magoha; Ngumi, 2000) also added that early detections of the disease helped in successful treatment of the cancer. This knowledge-behaviour gap makes an important case for this study.

2.7 Barriers to Prostate Cancer Screening

Weinrich et al (2000) point out that the two main barriers to prostate cancer screening in the US are high costs of lack of knowledge. This then means that awareness is not necessarily knowledge. While knowledge is objective, awareness consists of the subjective experiences of an observer. Other prominent barriers to screening among African American men include continued mistrust of the medical community and negative attitudes toward specific screening tests (Weinrich et al., 2000).
According to Wanyagah (2014), most Kenyan men who are at risk of developing prostate cancer exhibit reluctance to screening for several reasons. There are only two screening methods in Kenya, the DRE and PSA tests. For the DRE tests, most men at risk are uncomfortable with fellow men or other women who are not their wives, touching their prostate glands. This is almost a taboo in most Kenyan communities and has posed a great hindrance to screening uptake even when the screening is done free of charge or at subsidized rates. As for the PSA blood test, cost and lack of awareness of the alternative come in as major inhibitors (Wanyagah, 2014).

2.8 The Role of Participatory Communication

Participatory communication requires first of all changes in the thinking of ‘communicators’ (Servaes, 2005). Communication experts are often rendered a bit too verbose and pushy if they don't listen well to the target audience and respond only according to the needs of the audience. It requires much more imagination, preparation and hard work to have dialogical learning, than just awareness creation campaigns. Servaes (2005) further suggests that it is far easier to prepare and give lectures and simply create awareness, than to carry out effective participatory communication. He says this could possibly be a valid reason why we have two ears, but only one mouth.

The ability to listen well and communicate efficiently are thrived by communication. Not on the ability to disseminate information, but the ability to receive and appreciate communication needs of target audiences. Lack of not being listened to drives people to being voiceless (Thomas, 1996). These are needed in order to have an action oriented communication situation where each segment of message sent ends up with a call to action,
which in this case, is uptake of prostate cancer screening. However, according to Thomas L. (1996), those that receive information are affected the same way as those that speak it.

This study will delve deeper into the role of participatory communication in improving the prostate cancer-screening uptake in Kenya.

2.9 Theoretical Framework

This study was guided by one psychological health behaviour change theory and two major communication theories. These are the Health Belief Model by Irwin Rosenstock et al, the Social Learning Theory by Albert Bandura and the Persuasion Theory.

2.9.1 The Health Belief Model (HBM)

Health behaviours are predicted and explained through a psychological model known as the Health Belief Model (HBM). Individual’s attitudes and beliefs are focuses on by this model. Hochbaum, Rosenstock and Kegels who worked in the Public Health Services in the United States developed this model in the 1950s. A program on free tuberculosis health screening that had failed led to the development of the model. This model has been used in various health issues such as HIV/AIDS and other risk related disease.

2.9.1.1 Core Assumptions and Statements

The HBM model looks at the factors that influence one to decide on taking a health relation such go for cancer screening if;

i. He/she is convinced that there are possibilities to avoid a certain health condition such as cancer.
ii. If he/she is convinced that if he takes the action, the health condition will not adverse or rather can be successfully treated

iii. If he/she is convinced that the action that he/she is about to take is conformable and they should take it with confidence.

Perceived susceptibility, perceived severity, perceived benefits, and perceived barriers are the four factors that helped in the spelling out of HBM. These factors were established with the power people ad to undertake an action. Behaviours of individuals are responsible for the power they have to act. Another factor that HBM emphasizes on is the confidence that one has on undertaking the action. In 1998, Rosenstock and others suggested this concept to help the HBM better fit the challenges of changing habitual unhealthy behaviours, like overeating, smoking and being sedentary.

The beliefs people have on health related problems, the benefits of undertaking the intended actions, the engagement self-efficacy, lack of self-efficacy, and behaviours in promoting health are what Health Belief Model entails (Janz et al., 1984; Rosenstock, 1974). This model must be triggered by how individuals behave especially on health related issues (Janz et al., 1984; Rosenstock, 1974). This model is thus in sync with the problem statement in which there is a low uptake of prostate cancer screening. The model will help assess men at risk’s beliefs about prostate cancer, perceived benefits of prostate cancer screening and barriers to prostate cancer screening uptake. The model further supports participatory communication through its cue to action component.
2.9.1.2 Health Seeking Behaviour

The health-seeking behaviour of a people determines their personal health practices and seeking of medication when sick as well as the health of other family members. Although men, as family heads, determine decisions regarding their health and that of the households (UN, 2011), their participation in the public health sector which is often lacking, can be improved through men's clinics, and merging health services such as HIV counseling and testing with screening and treatment for prostate or testicular cancer (Crum, Spencer, & Amling, 2004). Similar studies among black American men showed that worsening urinary symptoms and accompanying bother were associated with poor health care seeking behaviour (Sarma, Wallner, Jacobsen, Dunn, & Wei, 2008). Taken together, these studies suggest that enhanced health information, participation in health decisions and disease manifestations promote men’s health seeking behaviour.

2.9.2 The Social Learning Theory

The second theory used in this study was the Social Learning Theory, advanced by Albert Bandura in 1977. The observation of how people behave, their attitudes and the results from these two is what influences this theory. The attitudes and behaviour of people are the reason why the BHM model was formed as these to also guide people on how they undertake actions (Bandura 1977). Cognitive, behavioural, and environmental influences determine how the Social learning theory undertakes its actions.

For instance, the behaviour of most Kenyan men at risk of developing prostate cancer not going for screening despite high awareness levels, as shown by the available empirical information, may have been influenced by environment (cultural beliefs, social biases,
group stereotypes and personal prejudices) or counter-cognition (a negating knowledge with stronger influence than that which they ought to hold).

This theory fundamentally departs from the limited effects of mass media paradigm and bases its argument on the environment or conditions of the health facilities at which prostate cancer screening takes place. It argues that the condition of the health facilities or otherwise the prostate cancer diagnostic centres have some influence on the health seeking behaviours, particularly prostate cancer screening uptake by Kenyan men who are at risk of developing the cancer. Such conditions would range from the sex and age of the healthcare providers to the type and mode of prostate exam done at the facilities.

2.9.3 The Persuasion Theory of Mass Communication

The concept of persuasion originated with the Greeks in 1930s, when Charles Carnegie first published his book *How to Win Friends and Influence People*. Aristotle, one of the Greek originators of this theory, shows how successful politicians are impacted by how rhetoric and eloquent they are. Between 1940s and 1950s, In Kenya, there are two main tests to ascertain the status of one’s prostate: the Prostate Specific Antigen (PSA) test and the Digital Rectal Examination (www.12manage.com).

Today, Persuasion Theory is theory of mass communication that deals with messages aimed at subtly changing the attitudes of receivers. Like the Limited Effects theory, Persuasive Theory holds that the success of messages is by how well the opinions of the receivers are embedded Wallack (1989). Therefore, this should be the focus of any campaign – including prostate cancer awareness campaigns.
According to Wallack (1989), Persuasion Theory interposes filter in consideration to the stimulus-response mode. Such a filter could be individual specificities such as The observation of how people behave, their attitudes and the results from these two is what influences this theory of healthcare services, in this context, prostate cancer screening. Persuasion Theory postulates that a three-phase model makes up the process of communication as shown in figure 2.1 below:

![Persuasion Communication Model](image)

*Figure 2.1: Persuasion Communication Model*

The concept underlying persuasion is that the primary reason why information is given is to influence the receivers’ behaviours.

2.9.3.1 **Audiences in Persuasion Theory**

Wallack (1989) points out four major psychological factors have been identified that aid the persuasion theory. These are:

- **a) An Audience is Interested in Getting Information:** The message should be designed in a way that the people’s attention is captured even of those that seem not to be interested in the message at that moment.
b) **Selective Exposure:** The ideas and opinions that the receivers have should be supported in the message.

c) **Selective Perception:** The message delivered may sometimes be misunderstood as the receivers interpret according to how they feel right. The interpretation is determined by how the message was delivered: the level the giver of the message showed and the attitude that the receiver had towards the message.

d) **Selective Memorization:** The receivers tend to keep or memorize a message that is more coherent to them. The length of the message also determines the receivers keeping. The shortness of the message makes it easier to be memorized. Receivers do not mostly remember the source of the message more than the message itself. Low credibility communicators are affected more by the latent effect.

### 2.9.3.2 Messages in Persuasion Theory

Regarding the message, persuasion theory identifies four factors that facilitate and reinforce the persuasion process (www.12manage.com):

1. **The Reputation and Credibility of the Communicator:** This implies the acceptance of the message by the receiver. If the producer of the message is considered not credible or reliable, the level of persuasion for that particular message is low.

2. **The Order of Statements:** Two schools of thought are considered in this aspect. Defined positions should be included in the beginning of the message while other receivers suggest that they should be put at the end.
iii. **Completeness of Statements:** Receivers indicate they prefer persuasion to be in support of the statements and contradictions according to their opinions. The message should also include the receiver’s opinions.

iv. **Announcement of Conclusions:** Conclusions should be omitted from the message or leave them implicit.

### 2.9.3.3 The Persuasion Formula

A scientific formula has been identified by Petty & Cacioppo (1986), following a rational approach to persuasion. Values, beliefs and motivators have been identified as key generators of people’s attitudes, while people’s attitudes influence their behaviour. This is illustrated in Figure 2.2 below.

![Persuasion Formula Diagram](image)

**Figure 2.2: The Persuasion Formula**

#### 2.9.3.4 Steps in the Persuasion Process

Petty & Cacioppo (1986) argue that beliefs, values, motives and attitudes determine the application of the first phase of the persuasion theory. Other factors such as surveys, interviews, or applied knowledge are used to convince the audience. Communication of
the messages is used in the completion of the second phase to change an attitude, which will ultimately change the behaviour. This can be done in one of two ways: trying to change the belief or modifying values or motives that drive an audience to mature a belief. This process is difficult since values and beliefs play a key role in individuals’ identities. The easier path however, is to add a new value or motive and use it to determine new attitudes and influence behaviour.

2.9.3.5 Purposes of Persuasion

According to Reardon (1989), the values, beliefs, motives and attitudes of the audience works well to make the persuasion more realistic. Five purposes are achieved through persuasion, which are;

i. **Creating Uncertainty:** When the audience opposes the communicators’ views, the communicators should destroy the audience’s mind through creating some certainties. Their attitude should also be changed so as to create a better environment.

ii. **Reducing Resistance:** The communicator should also be able to change the receivers’ resistance and ensure that they all come to a neutral understanding. The receivers should be convinced to accept the communicators’ opinion in a humble manner.

iii. **Change Attitude:** When the audience receives the communicators’ message in a neutral attitude, then the communicator should be convinced of a strong positive attitude.
iv. **Gain Behaviour:** The communicator should apply skills to ensure that the receivers’ attitude is positive. He should be able to brainwash the audience. They should also be able to convince them to change their attitude so as to be able to take action. The weaker individuals are easier to be convinced.

In its attitude alteration and behaviour change model, the Persuasion Theory best explains how communicators in the field of oncology, including governments and other cancer organizations, can get more men at risk to get screened for prostate cancer early.
CHAPTER THREE
RESEARCH METHODOLOGY

3.0 Overview
This chapter outlines how this study was conducted – from the design of the research, description of the study population and identifying samples, to data collection, analysis and presentation.

3.1 Philosophical Paradigm
This study was underpinned by the interpretive philosophical paradigm. The interpretive paradigm is concerned with understanding the world as it is from subjective experiences of individuals (Hume, 1993). Since the study sought to understand the subjective views, perceptions and experiences of men at risk regarding prostate cancer screening, this paradigm proved best suited to underpin the inquiry.

3.2 Research Design and Approach
This study used a descriptive research design, which is a scientific method that involves observing and describing the behaviour of a subject without influencing it in any way. Many scientific disciplines, especially the social sciences use this method to obtain a general overview of the subject (Shields & Rangarajan, 2013). Thus descriptive research design was most relevant and best suited for this study

3.3 Research Approach
The study employed the qualitative approach. This approach seeks to tell the story of a particular group’s experiences in their own words, and therefore, focused on narratives.
Unlike quantitative research, in which researchers state specific hypotheses and then collect data to empirically test them, most qualitative research employs an inductive approach in which the researcher first collects data and then attempts to derive explanations from those data. As such, qualitative research tends to be more exploratory in nature, seeking to provide insight into how individuals, organizations or groups understand aspects of their worlds (Shields & Rangarajan, 2013).

3.4 Research Method

The study used the Narrative Method. This is a group of approaches that use written or spoken words, which typically focus on how individuals tell their own life stories. Jean and Michael (2000) argue that narrative inquiry uses field texts, such as interviews, journals, conversations, stories, letters, autobiography, field notes, photos and life experience; as the units of analysis to research and understand the way people create meaning in their lives as narratives. For the purposes of this study, in depth key informant interviews allowed the narration of the stories of participants in their own words and world.

3.5 Study Population, Sample Size and Sampling Procedures

3.5.1 Study Population

The total population of Westlands is approximately 247,102 (KNBS, 2010). Out of this population, 124,748 are men. Of the male population, 2,645 are between 65-75 years of age, which account for the study population. This population range was settled on because studies have proven that it has the highest risk of developing cancer (KDHS, 2014). Westlands Constituency has four major wards namely Karura, Kitisuru, Parklands, Kangemi and Mountain View. At the time of this study there existed no empirical
information on the prevalence or incidences of prostate cancer per constituency within the constituencies of Nairobi, Westlands inclusive. Therefore, the choice of Westlands Constituency for this study was informed by the following three major reasons.

Firstly, Westlands Constituency was selected for this study because of the likelihood of occurrences of the phenomenon of interest, in this case, the high numbers of males within the age bracket that is at risk of developing prostate cancer (Creswell, 2011). Being a densely populated area, Westlands provides a relatively higher number of populations within the sampling frame as compared to the other constituencies in Nairobi (KDHS, 2014).

Secondly, the constituent wards of Westlands provide a unique mix of socio-economic strata, which made this an all-rounded, well-balanced study across the socio-economic demographics. Westlands has high suburbs occupied by individuals in the upper class namely Runda, Lakeview, Muthaiga, Highridge and Kitisuru Estates. The constituency also has several middle class and lower-middle class estates such as Mountain View, Parklands and Karura. Additionally, Westlands has notable slums occupied by the lower and working classes such as Kangemi, Githogoro, Deep Sea, Suswa, Kibagare and Kaptagat (http://www.westlandsconstituency.co.ke). This unique mix of social stratification is not found in any other constituencies within Nairobi as the rest have one or two social classes, but not all three.

Thirdly, as Comis, Miller, Aldige, Krebs, and Stoval (2003) have shown, urban populations are more informed hence more likely to take up cancer screening as contrasted with their rural counterparts whose levels of information on health issues are relatively lower. The
location of Westlands within the Nairobi metropolis means the residents have a relatively higher likelihood to access prostate cancer information compared to their counterparts who dwell in rural and semi-urban areas.

3.5.2 Sample Size

From the population described in 3.4.1 above, a sample of 5 men aged 65-75 years were drawn and interviewed while 10 participated in two focus group discussions of 5 each. An additional 10 healthcare workers were interviewed as Key Informants. Thus, a total of 25 individuals participated in this study.

A good sample according to Mugenda and Mugenda (2009), is supposed to be between 10 and 30 % of the total targeted group. Stratified random sampling is unbiased sampling method of grouping heterogeneous population into homogenous subsets then selecting within the individual subset to ensure representativeness. In stratified random sampling subjects are selected in such a way that the existing sub-groups in the population are more or less represented in the sample (Mugenda & Mugenda (2009).

3.5.3 Sampling Procedures

The study utilized convenience-sampling method for the men at risk FGDs and In-depth Interviews, and purposive sampling method for the healthcare workers (Patton, 2002). This sampling technique was used because it is fast, inexpensive and the subjects are readily available (Black, 2010).
In convenience sampling, researchers can obtain a representative sample by using a sound judgment of the qualities of available subjects, which will result in saving time and other resources (Black, 2010).

For the purposes of Key Informant Interviews and the FGD in this study, samples of 15 men at risk were conveniently obtained from Kangemi Market, Parklands Sports Club, Parklands Baptist Church, Loresho Centre, Kangemi Chief’s Camp, Kangemi High School, Uthiru Gichagi Chief’s Camp, Muthaiga Mini Market and Mountain View Estate while the 10 healthcare workers’ sample was purposively obtained from Westlands Medical Centre, Parklands Baptist Hospital and Chiromo Lane Medical Centre. The occupations of men at risk who participated in the FGDs were as follows: 3 retired teachers, 3 famers, 1 ex-military officer, 2 businessmen and 1 retired civil servant. Those who were interviewed were: 3 businessmen and 2 peasant farmers. As for the healthcare professionals, 5 Nurses In-charge and 5 Clinical Officers In-charge were interviewed.

Purposive sampling on the other hand is a non-probability sampling method used to select participants based on specific pre-determined characteristics of a population, in conformity with the objectives of the study (Crossman, 2018). Thus, Nurses and Clinical Officers in the field of Oncology were purposively selected based on their positions, knowledge of prevalent issues around prostate cancer and access to records that would back up their answers regarding screening uptake.
<table>
<thead>
<tr>
<th>Sn.</th>
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<th>FGDs</th>
<th>In-depth Interviews</th>
<th>Key Informant Interviews</th>
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<td>Retired Teachers</td>
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<td>Ex-military Officer</td>
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<td>8</td>
<td>Clinical Officers In Charge</td>
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<td>9</td>
<td>Nurses In Charge</td>
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<td><strong>Totals</strong></td>
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Table 3.0: Occupational Distribution of FGD Participants, In-depth Interview Respondents and Key Informants

3.6 Data Collection Methods

Key Informant Interviews and Focus Group Discussions were the main data collection methods for this study. Data was collected using Interview Guides and FGD guides as the main tools. These were administered to adult males between 65-75 years within each of the five Sub-Counties of Westlands, Nairobi. The two tools were piloted and improved before full-fledged data collection ensued, to guarantee quality in terms of clarity, objectivity, reliability and precision. The pre-test location was Kilimani Sub-County in Dagoretti North Constituency, which neighbours Westlands Constituency. This area was chosen because it has nearly similar social and demographic distribution with most Westlands Sub-counties (KNBS, 2010). A total of 3 males aged 65-75 years – which is approximately 10% of the sample size – were interviewed for the pre-test phase.
The data collection instruments, though in English, were carefully discussed in Kiswahili where such need arose, to ascertain language barrier had no adverse effect on the quality of data collected. The questions were simple and straightforward, but deep, for ease of response by the respondents. The instruments captured information on demographics, socio-economic status, feelings and perceptions on prostate cancer screening methods, barriers to prostate cancer screening and the role of participatory communication in boosting screening uptake. A total of 10 Key Informant Interviews, 2 FGDs with 5 participants each and 5 In-depth Interviews were conducted.

3.7 Data Analysis and Presentation

Thematic data analysis method was applied in this study. Thematic analysis recognized the extent to which the stories respondents told or the responses they gave provided insights about their lived experiences (Sandelowski, 1994). For example, it was used in this study as a strategy to get more insights on the experiences of men who discovered that they had a prostate lump, or other signs and symptoms related to prostate cancer. This therefore is an analytic process that helped the study to detect and understand the main narrative themes within the accounts that the respondents gave about their experiences with prostate cancer communication, and its role in their screening uptake decisions.

Findings from Key Informant interviews and Focus Group Discussions were corroborated with the findings of past studies in the literature review section and differences discussed accordingly. To summarize, the research findings were matched with the objectives of the
study in order to examine the extent to which the objectives of the study were met. The data was then arranged into themes and the information presented in narrative form.

3.8 Validity and Reliability

Reliability is the consistency of a measure that ensures consistency of a test. In this study, the same sets of Interview Schedules and FGD Guides were administered to the corresponding categories of informants or otherwise respondents, and during the two FGDs respectively, giving responses that only differed by respondent characteristic and perceptions of the subject matter, rather than the design effect. In addition, the conditions under which the measurements (administration of the tools) took place were standardized by minimizing external variations such as fatigue and boredom. Thorough briefing, and crosschecking entries on the tools further reinforced this.

Lastly, these instruments were adopted in this study because they reduced the bias of the researcher since the respondents gave answers in their own words (Kothari, 2004). In doing so, the instruments allowed a high level of credibility, transferability, dependability and confirmability.

3.9 Ethical Considerations

In the conduct of this study, various ethical issues were considered. A certificate of fieldwork was obtained from the University in order to seek permission and affirm the credibility of the research (see Appendix C). This also aided the consenting process just before the questionnaires were administered. All the information obtained from respondents was solely used for the purpose of this study. The interviewees/respondents
were told this well in advance during the consenting process. They were properly sensitized on the purpose of the study after which they were requested to sign a consent form – this was optional though.

After fieldwork, necessary corrections were effected in accordance to recommendations by the School of Journalism and Mass Communication Board of Examiners and a Certificate of Corrections duly obtained (see Appendix D). Finally, the document successfully underwent a thorough plagiarism test as per the University policy and a Certificate of Originality obtained (Appendix E).
CHAPTER FOUR
DATA ANALYSIS AND INTERPRETATION

4.0 Overview

This chapter encompasses a detailed presentation, an in-depth analysis and an incisive interpretation of the data collected. The specific objectives of the study largely guided the data analysis process, alongside other parameters.

4.1 Response Rate

Out of an anticipated sample size of 30 key informants and participants, a total of 25 people successfully responded to the interview. Of these, 10 were two Focus Group Discussions with men aged 65-75 years, 10 were Key Informant Interviews with health care workers in the field of Oncology, particularly Prostate Cancer while 5 were In-depth Interviews with men aged 65-75. The two categories of Key Informant interviews had 100% response rates while the FGD had 50%. The overall response rate was thus 83.3%, which is above the recommended threshold of 75% (Baruch; Holton, 2008), and provided sufficient empirical data for analysis.

4.2 Perceptions on Prostate Cancer Screening

Most key informant interview respondent and participants in the focus group discussion felt that prostate cancer screening was a torturous event and thus they had reservations for accessing it. Others felt it is very important to be done, but it is quite uncomfortable (with reference to DRE exam), which makes it not worth the while altogether. One respondent declared:
“It is not a good experience at all and I wouldn’t advise anyone to go for it! Leave alone the pain, how can you take your scrotum to be touched by another man all in the name of prostate cancer screening? That’s an abomination in my culture. They need to be creative and think of other ways to do that test of theirs, otherwise I would never go back, that was my first and last!”

In addition to the above excerpts, the inquiry found out that the most frequently used adjectives and phrases by respondents to answer this question were: “It’s terrible”; “I don’t like the process”; “It’s disgusting” and “It’s annoying”.

The study therefore, unearthed strong negative feelings about prostate cancer screening process among respondents. Hence, in keeping with the Persuasion Theory and the Social Learning Theory, a collection of negative feelings (attitude) and taboos (belief) about the prostate cancer screening process have contributed to the poor uptake of screening (behaviour). The Persuasion Theory discusses these (negative) beliefs or feelings only hand in hand with perceived benefits to action, where the variable that outweighs the other influences the action Wallack (1989). For instance, if there are more negative beliefs, feelings and attitudes about prostate cancer screening than the perceived benefits of going for the screening, then there is likely to be low screening. On the flip side, where there are more positive feelings, beliefs and attitudes, or more perceived benefits of action than the negative beliefs, then the prostate cancer screening rates will shoot higher.

The Social Learning Theory on the other hand, supports the findings of this study in its persuasive argument that apart from observing what others do, people also learn to act in certain ways from the prevalent environmental conditions in their immediate contexts,
associated with the actions in question (Bandura, 1977). Consider this FGD excerpt as a case in point:

Q: How would you describe the uptake of prostate cancer screening among your fellow men in Westlands Constituency? Please explain.

P 1: Most of my friends shy away from the screening and I understand them because it's a very torturous experience, from what I hear.

P 2: I don't have a friend who has gone for prostate cancer screening, not that I know. I think it because those sisters (nurses) are very young; the age mates of some of our daughters and our cultures prohibit being touched on the genitals by women who are not our wives.

This study found out that unfriendly healthcare workers, uncomfortable touch in the prostate glands during DRE and cultural inhibitions are some of the prevalent issues surrounding the prostate cancer screening environment, which men at risk are expected to plunge into, but since they are not pleasant or persuasive factors, they can only be counter-productive in so far as screening uptake goes.

These factors, in most cases, were not experienced first hand by the respondents, but “learnt” from subjective experiences of the few men who had accessed the screening services. Other respondents who were rather moderate in their answers felt that it was
important to be screened but an alternative screening method was needed rather than DRE, clearly showing they were ignorant of the existence of other screening methods such as PSA.

4.3 Barriers to Prostate Cancer Screening

From the focus group discussions, men at risk and healthcare professionals interviews, the following emerged from this study as the top barriers to prostate cancer screening among men in Kenya.

4.3.1 Fear of Perceived Pain and Undesirable Outcome

This study revealed that most men at risk of developing prostate cancer tend to think that the screening of prostate cancer is quite a painful and torturous procedure. On the contrary, this is not true. This rated as the number one barrier to screening as 8 out of 10 key informants gave it, among others, as a reason for non-participation in screening. Asked why they had not considered getting a DRE test, two participants in the focus group discussion responded as in the excerpt below:

P 1: Isn’t that pain just too much? Weve ni mwanaume kama mimi (you’re a man like me)... just imagine someone squeezing your balls (prostate glands) even for one minute only... imagine that kind of pain!

P 3: I hear most people who go there must come with positive test results. More like everybody has prostate cancer! I’d rather not confirm it because what I don’t know won’t hurt
Thus, the study revealed that fear was a crucial inhibitor to screening uptake among men at risk. However, the responses of the healthcare workers pointed to the contrary. They indicated that there was just a little discomfort during the Digital Rectal Examination that cannot be classified in remotest sense as pain. The study has therefore corroborated the findings of Conde (2011), which indicated that fear of pain, and of the outcome of medical tests are key barriers to health seeking.

This study upheld the position of Janz et al. (1984) who have shown in the HMB that such fears may result into widespread beliefs, but which may falter when subjected to tests of objectivity since they are based on the subjective feelings of individual and not proven scientific premises. Klapper’s Limited Effects theory also attempts to explain this phenomenon, where men at risk make decisions against prostate cancer screening based on the experiences and positions of their peers and not the significance of the screening itself, or other facts that may be available.

4.3.2 Poor Handling by Healthcare Professionals Conducting the Tests

The few men who admitted, from the interviews, to have gone for screening, also complained that they were roughly handled by the health workers carrying out the screening, making the whole experience uncomfortable and unpleasant. From the focus group discussion conducted in August 2018, the participants, though admittedly, they had not been screened for prostate cancer, seemed to hold a strong position that the service providers carrying out the tests were rough and somewhat unprofessional in their trade.
Q: What has influenced your decision not to go for prostate cancer screening all this while?

P 2: Because from what I hear around, it is more painful than circumcision and those ‘doctors’ are very rough on you! *Wacha ikae kwa sasa, sitaki tohara ingine* (applause and cheers from other participants) (let it be for now, I’m not ready for another circumcision).

Comparing prostate cancer screening with other painful experiences such as circumcision like Participant 2 did, is a very strong way to assert the horror associated with the procedure. The applause from the other participants serves to confirm their support of the point, which means as Joseph Klapper opines in Social Learning Theory, the participants have a socially learnt, shared position, that they won’t get screened because prostate cancer screening service providers are rough and unpleasant.

### 4.3.3 Unfriendly Screening Method

This study revealed that most men were not comfortable being examined using fingers (DRE) in their prostate glands, by either sexes. Such men opted not to go for the examination altogether. Additionally, the DRE proved to be the most unpopular prostate cancer test in Kenya since most participants both in the focus group discussion and the Key Informant interviews admitted their dislike for it. This was partly because of cultural beliefs and fear of perceived pain. It is interesting to notice that this discursive construction of prostate cancer screening crystallized into DRE as a screening method, which was used as a major reason not to access the otherwise very necessary service by the most needy people:
Q: Have you ever been screened for Prostate Cancer? Please explain your answer

R 4: No, I hear they touch your ‘manhood’ and I am never comfortable with that

R 1: It is against my culture for another man or woman other than my wife to touch my genitals vile wanafanya during this test

Through this finding, the study is in consonance with the findings of Weinrich et al, 2000, which asserted that negative attitudes and feelings towards specific prostate cancer screening tests, in this case the DRE, is a major barrier to uptake of screening.

4.3.4 Ignorance of Alternative Screening Methods

In their conversations both in the focus group discussion and the Key Informant interviews, most respondents referred to the discomfort and negative beliefs associated with the Digital Rectum Exam. Asked why they couldn't go for alternative screening methods, they indicated DRE is all they know. Take this excerpt of the focus group discussion as a classical example.

Q: I gather that you don't like the test where they touch your genitals; would you then consider participating in another type of test that give the same result of the condition of your prostate glands but without necessarily touching you?
Conde (2011) found out that lack of knowledge of alternative – perhaps more acceptable – screening methods is a major barrier to prostate cancer screening. This study corroborates Conde’s finding since no participant or respondent, save for the service providers, knew of alternative prostate cancer screening methods such as the Prostate Specific Antigen (PSA) test and the Trans Rectal Ultrasound-guided biopsy of the prostate (TRUS). The study further agrees with the position of Weinrich et al (2000), that ignorance of alternatives is a major barrier. The study therefore anticipates that would men at risk be informed of all available options in so far as prostate cancer screening goes, they would make more informed decisions for or against screening, other factors like cost and accessibility notwithstanding.

4.4 Prostate Cancer Communication Gaps

This study found out that there were glaring gaps and pitfalls in the communication of prostate cancer screening. These communication gaps were derived from various responses to a raft of questions concerning awareness and those touching directly on the communication gaps. Responses from the focus group discussion and key informant interviews were triangulated and corroborated systematically, giving the following major communication gaps.

Foremost, this study found out that never has there been seen any prostate cancer-specific campaign or initiative that promote screening uptake – except the general cancer awareness
initiatives that cover all types of cancers. But even the already existent cancer communication efforts in Kenya are conducted haphazardly, devoid of the urgency it deserves, as opposed to systematically. It is crystal clear that professionalism, exuberance and intentionality are absent in the cancer communication initiative and their organizers in Kenya. A respondent pointed out thus;

“Today I see something on TV about cancer, and tomorrow it’s gone. Two years later, another one pops up... are they really serious that they want us to for the test or they just want to scare us that we will die?”

This reveals lack of systematic, more targeted approach to prostate cancer communication. Emphasis seems to be given to breast cancer and cervical cancer, at the expense of prostate cancer, which is a leading threat to life among men, not just in Kenya but the world over (Jemal et al, 2011; ACS, 2005; Braithwaite, 2001 & Hong Kong Cancer Registry, 2010). Moreover, asked which organizations they could remember running any prostate cancer specific campaign, the focus group discussion participants confessed to have witnessed none.

In addition the study also found out that there is only one-way communication during cancer campaigns which happen once a year - in October, Cancer Awareness Month – with no room whatsoever for feedback and questions. There are no discussions whatsoever; therefore the communication methods seen so far have not been engaging. Probed on when he last saw a communication initiative concerning cancer a key Informant responded; “Uhm... lets see... well, I cant really remember the year but I know it was somewhere in the month of October”.
This finding demonstrates a departure from the position of Thomas et al (1996), who stated that in an effective communication environment, the need to listen is not limited to the recipients of information but is relevant also to the conveyor. It is significant to note the congruence between this finding and Joseph Klapper’s postulation in the limited effects theory when he suggests that mass media only has a limited and trivial influence on individuals.

This study also revealed that as a result of lack of targeted prostate cancer specific communication initiatives in Kenya, people at risk don't have the facts and figures on prostate cancer, thus they fail to underscore the importance of screening, hence slackness in their health seeking behaviour. Admittedly, there is exemplary awareness on prostate cancer, but that is only limited to the fact that the disease is a killer and one to be dreaded. Beyond this, the disease is shrouded in more mysterious misconceptions, which are only counter-productive – people at risk see no compelling reasons to take action regarding screening.

The Kenyan media fraternity is not proactive but reactive in reporting/communicating prostate cancer and other cancers in general, the study discovered. Most of the respondents could not remember when they last saw or heard a mainstream media house reporting or covering a prostate cancer case whether in human interest, feature stories or op-ed.

Government Ministries, Semi-autonomous Government Agencies (SAGAS) concerned and other stakeholder seldom hold educational fora and learning cycles with people at risk to propagate and further conversations on the significance of prostate cancer screening and
early diagnosis. This has aided the furtherance of nonchalance and indifference on the part of the people at risk. The excerpt below from the focus group discussion exemplifies this finding.

Q: What do you think can be done to improve uptake of prostate cancer screening between men at risk like you?

P2: Let us be frank, we need to be involved! These guys purport to want us to take up services… but we are never involved in their discussions… what are they hiding? Hiyo ni ngumu bwana (that's difficult, sir)

P4: I think they need to listen to us more… currently they don’t. We need to talk to the government or any other concerned party and tell them our needs…. Maybe that will help them know why we don't like the screening…

This is a glaring gap. The absence of targeted participatory communication initiatives around prostate cancer in Kenya has contributed to the state of lethargy on the part of at-risk population in so far as uptake of screening is goes.

4.5 Role of Participatory Communication in Bolstering Screening Uptake

Four variant levels of participation can be observed in most development projects claiming to be participatory in nature (Uphoff, 1985). These include participation in implementation, participation in evaluation, participation in access/benefit and participation in decision-making.
The primary mandate of this study was to investigate the nexus between participatory communication and prostate cancer screening uptake among the study population. Thus, the study discovered the roles that participatory communication may play in bolstering the uptake of prostate cancer screening. These roles were corroborated, during analysis, into Uphoff’s four levels of participatory development as explained below.

4.5.1 Participation in Decision-making

As has been demonstrated from excerpts in the previous sections of this study, most participants in the FGDs suggested that they “be involved”. By implication, they meant total involvement from initiation, discussions, conceptualization and planning of prostate cancer communication activities to be spear headed by various cancer stakeholders in the country. This, according to Uphoff (1985), can be done through community opinion leaders as representatives, who then trickle down the decisions made, goals and objectives to their constituencies. Such decisions encompass the time, medium, frequency and participants of the particular prostate cancer communication initiative. This allows the men at risk to directly have a say in all the subsequent levels hence total ownership of the whole communication process.

4.5.2 Participation in Implementation

Servaes (2005) said that much more imagination, preparation and hard work is required in order to have meaningful learning and change of perception of men regarding prostate cancer screening, than just awareness creation campaigns. In agreement with this position,
the study discovered that awareness creation is shallow and deficient hence the need for a more participatory, discursive and action oriented communication method.

There is need to involve the at-risk population during Cancer Awareness Campaigns in actively dispatching the communication materials and articulating the actual processes. They are to be actively encouraged and mobilized to take part in the actualization of whichever communication initiatives relating to prostate cancer screening. In this course, they are given certain responsibilities and assigned certain tasks or required to contribute specified resources from their communities, which go a long way in helping achieve the objectives of the initiative.

4.5.3 Participation in Benefit
This study found out that members of the at-risk population should be allowed to take part in prostate cancer screening from more informed rather than subjective perspectives. In the process, they will continue to invite their peers who still harbor misconceptions and reservations concerning screening. It is not the amount of information passed but concepts understood which matter in participatory communication (Thomas, 1996). This will increase the uptake of screening services, enhance early diagnosis and increase chances of survival.

4.5.4 Participation in Evaluation
Upon completion of a given prostate cancer communication initiative, men at risk are to be invited to critique the successes and failures of it. During these fora, men openly but systematically share their feedback on the best practices and pitfalls. The project leaders
share the progress and gather the reactions of members for learning purposes and for improvement of related future prostate cancer communication endeavors. Next, members are to be invited for planning/decision making for the next round of actions, keeping in mind the recommendation from the previous.

As Thomas L. (1996) opined, communication between people and entities thrives not on the ability to talk fast, but the ability to listen well. Not on the ability to disseminate information, but the ability to receive and appreciate communication needs of target audiences. Men at risk of prostate cancer are not participating in screening and are ‘voiceless’ in one sense, not because they have nothing to say about prostate cancer screening methods and processes, but because stakeholders seem not to listen to them.

This study found out that participatory communication will allow for authentic active listening, which will foster trust between men at risk and prostate cancer services providers much more than incessant mono-directional talking; and will enhance uptake of prostate cancer screening.

4.6 Other Findings

Aside form the key findings discussed above, the study also revealed the following facts, which corroborate with the secondary literature reviewed in Chapter 2 of this study.

4.6.1 Knowledge/Awareness of Prostate Cancer

The respondents demonstrated a high awareness of prostate cancer. Most of their responses revealed accurate information on the nature, signs, symptoms and effects of prostate cancer. Awareness questions asked spanned from what the disease actually is and signs
Information from the focus group discussions indicates that the participants clearly knew of prostate cancer, people at risk as well as general facts on prostate cancer mortality rates in Kenya. In their responses, prostate cancer was defined as “a huge deal”, “deadly disease”, “that terrible thing” and “scary genitals disease”. These terms used to describe prostate cancer denote not just the respondents’ knowledge of the disease but also the seriousness of the danger it portends. The focus group discussion went, in part, as thus:

Q: What is your understanding of Prostate Cancer?

P1: It’s such a painful experience affecting men’s genitals

P4: (Shakes head) It's a dangerous disease of the prostate glands.

It killed my elder brother in less than a year!

P3: It's a painful swelling on the prostate glands, which most often kills if not checked

P5: Cancer of the prostate glands. It is worse than HIV/AIDS

From these responses, there was a clear link between prostate cancer and other variables such as poverty, suffering and death. They indicated a belief that poverty; suffering and death are either a direct or indirect results of prostate cancer. This corroborates well with the Health Belief Model, one of the theories that underpin this study, which posits that people make meaning of their health problems based on their belief systems about health problems, perceived benefits of action and barriers to action. The participants also tended to link prostate cancer with other health conditions known to have caused a lot of pain, suffering, adverse economic effects and death, especially when prostate cancer was
compared to HIV/AIDS. This further emphasized the notion that most cases of prostate cancer are fatal.

Similarly, a majority of Key Informants interviewed demonstrated high awareness on prostate cancer. The following is an excerpt of the responses given when respondents were asked to define or describe their understanding of prostate cancer.

Q: What, in your understanding, is Prostate Cancer?

Informant 1: It's a disease causing swelling and a lot of pain in the prostate glands

R 3: Easy… that cancer that affects men’s genitals! It kills

R 2: Cancer of the prostate glands causing too much urination and pain

R 5: It's a deadly disease that affects the prostate glands and difficult to cure

R 4: Si ni ile cancer ya wanaume? Ile ni noma asana... ogopa! (Isn’t it that cancer that affects men? It’s terrible!

These responses suggest a strong understanding of prostate cancer on the part of the key informants first as a disease exclusively affecting men, then as a dangerous and fatal condition, and lastly as a terrible condition dreaded by most men. The study found these responses to confirm the position of the United Nations that the awareness of prostate cancer is high in Kenya (UN, 2011). The information also corroborates with the findings from the United States which indicate that the awareness levels in so far as prostate cancer
goes is high especially among African America populations (Crum, Spencer & Amling, 2004).

Since awareness was not investigated among the healthcare professionals, the study triangulated responses from focus group discussion with those from Key Informant interviews to get the overall outlook of awareness among respondents, which was exemplarily high.

4.6.2 Prostate Cancer Screening

Generally, the uptake of prostate cancer screening remains critically low, going by the responses received from the key informants and the oncology nurses. All 10 healthcare workers interviewed indicated that Kenyan men hardly walk in for prostate cancer screening unless they have been advised so by their doctors as part of investigating a related medical condition. A section of the cancer nurses interviewed had to cross check the cancer screening registers in their facilities to confirm the screening rates for prostate cancer before they could answer this question and still, they confirmed that the screening numbers were indeed insignificant. This agrees well with the view postulated by Crum, Spencer and Amling (2004) that men have a poorer health seeking behavior compared to their female counterparts, world over.

According to Sarma et al (2008), there is generally poor health seeking initiatives among African American men. This study, even though conducted in Kenya, agrees to a great extent with the findings of Sarma et al. Some of the common possible reasons for non-screening the healthcare workers disclosed they had learnt from their clients were fear of
perceived pain, it’s a taboo in most African cultures to be touched on the private part by fellow men (most healthcare workers in the cancer sector in Kenya are men), and inability to afford the alternative screening method (PSA). An excerpt of the health care workers interviews is shown below.

Q: Could you please tell me you experiences screening prostate cancer patients?

KI 1: For prostate cancer, uptake of screening is very low yet prevalence is on the rise from the available data

KI 10: Most of them (clients/men at risk) shy away from the test

KI 3: They don't like the screening, ni ngumu kuelewa lakini...

(it’s difficult to understand why

KI 5: We have done a lot of campaigns. They know there is a huge risk but they don't come for screening

KI 4: It's the easiest thing to do, in my experience, but the least sought among our services

From this above excerpt, prostate cancer service providers decry the low screening rates, some saying they don't know the reasons for low uptake, while others insinuating that the numerous campaigns done so far around prostate cancer have been futile and barren. From this finding, we see a sharp conformity with the Limited Effects Theory, which holds that the influence of mass media campaigns on the target individuals is limited and sometimes, even trivial. Despite the communication efforts that the cancer stakeholders have done in Kenya, particularly, around prostate cancer, the screening rates remain low. This could also
be interpreted to mean that the communication efforts by different stakeholders around prostate cancer have only served to increase awareness and not screening uptake. Moreover, it brings to the fore that it is possible to have high awareness rate but with low positive initiative.

Majority of FGD participants said they had never been screened for prostate cancer while the other portion had been screened but a few times as opposed to the recommended regular screening. The reasons given by the majority for non-screening included being too busy to go for screening; being uncomfortable with the touch on the prostate glands (scrotum) by fellow men especially for Digital Rectum Exam (DRE) – considered a taboo; being uncomfortable to be touched on the prostate glands by women other than their wives, culturally inappropriate; friends advising it wasn't so important; and being ignorant of alternative screening methods such as Prostate Specific Antigen (PSA) test. The following excerpt from the FGD illustrates the above finding.

Q: Have you ever been screened for Prostate Cancer? Please explain your answer
P 6: No, I hear they touch you ‘manhood’ and I am never comfortable with that
P 4: My friends and I have never thought it’s such a big deal
P 1: That process is very painful, they say, and I don't like inflicting pain on my body
P 8: I am too busy to get that time
According to the Persuasion Theory, people’s belief on the health problem, perceived benefits associated with action and self-efficacy explain engagement in a health seeking behaviour. The above responses indicate that among men at risk in Kenya, there is not enough positive belief on the perceived benefits of going for prostate cancer screening, thus they would rather remain in their comfort zones despite the high awareness levels. Additionally, the Social Learning Theory argues that people learn through observing the behaviour of others and the outcomes of those behaviours. Such ‘others’ are in most cases close associates who bear a significant sway on the opinions and belief of their friends, and are in close and frequent contact with them. This theoretical position was exemplified in some of the respondents who said that because their friends didn't seem to appreciate the screening process as important they have had no reason to screen. This low uptake of prostate cancer screening also upholds the position of Kenya Demographic and Health Survey (KDHS) report of 2014 – especially its quantitative data, which put prostate cancer screening rates in Kenya at 2.6%.
CHAPTER FIVE
SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.0 Overview

This chapter presents a summary of findings, discussions, conclusions drawn from the study and recommendations for possible action by policy leaders and relevant prostate cancer stakeholders. These conclusions are solely focused on addressing the purpose of this study, which was to investigate the nexus betwixt participatory communication and prostate cancer screening uptake.

5.1 Summary

Fundamentally, this study set out to investigate the nexus between participatory communication and uptake of prostate cancer screening among men at risk in Westlands, Nairobi. The first objective was to examine the perceptions of men at risk towards prostate cancer screening in the study area. Analysis results of the data collected in this study indicate that men at risk have negative feelings, perceptions and attitudes towards prostate cancer screening.

After examining the feelings and perceptions, it was imperative to investigate the barriers to prostate cancer screening among the same population for purposes of juxtaposition and inference. Accordingly, this study unearthed myriad barriers, chief among which included: cultural beliefs, negative attitude, fear of perceived pain, and ignorance of alternative screening methods, among others. This finding was in tandem with the positions of Social
Learning and Persuasion Theories. Thus, the knowledge-behaviour disparity in so far as prostate cancer screening is concerned remains wide.

The third and last objective of the study was to investigate the role of participatory communication in bolstering the uptake of prostate cancer screening among men in Westlands Constituency. The key finding from this study with regards to this objective is that participatory communication will allow for authentic, active listening and feedback, which will foster trust between men at risk and the service providers much more than continued mono-directional communication. This will in turn enhance uptake of prostate cancer screening among men at risk.

5.3 Conclusions

The wide knowledge-behaviour disparity in prostate cancer screening uptake in Kenya is occasioned by an interplay of factors, chief of which include the absence of participatory communication, cultural beliefs taboos concerning the handling of male genitals; negative perceptions and attitudes towards prostate cancer screening; ignorance on the existence of alternative screening methods such as PSA test; and to a smaller extent, failure to appreciate the seriousness of the need for regular and early screening by men at risk. On the flip side, this scientific inquest revealed that participatory communication, properly employed in prostate cancer communication initiatives, will help register an increase in screening uptake among men at risk.
5.4 **Recommendations**

Going by the findings of this study, three key recommendations can be made, in tandem with the study objectives, for improvement of the uptake of prostate cancer screening services among men at risk in Kenya. These have been organized in keeping with emanating barriers to screening uptake.

5.4.1 **Involvement of Men at Risk**

This study recommends that representatives of men at risk be involved in initiation, discussions, conceptualization and planning of prostate cancer communication activities, spearheaded by various cancer stakeholders in the country. Further, men at risk of developing prostate cancer should be actively involved in dispatching communication materials and articulating the actual process through one on one outreaches, Chief’s *Barazas*, town hall question and answer set ups or any other approaches to participatory communication deemed timely and contextually fit.

They are to be actively encouraged and mobilized to take part in the actualization of whichever communication initiatives relating to prostate cancer screening. These measures will ensure incorporation of the target group’s views from the very initial stages of designing such communication initiatives to the latter stages, hence ownership. Most importantly, the information reaching men at risk will advance from just mere awareness creation to a call for action – uptake of screening.
5.4.2 Remove the Barriers

Ignorance of alternative screening methods other than DRE should be combated. There is likelihood that if more men at risk knew of alternative screening methods like PSA, they would actively take up the screening. These screening alternatives need to come out clearly in future prostate cancer communication initiatives. Healthcare professionals carrying out prostate cancer screening tests should encourage clients to refer their peers for screening from an experiential point of view. Through positive peer influence, more men at risk who would otherwise not go for screening will do so.

Men who had gone for initial prostate cancer screening appeared hesitant to take initiative for subsequent screenings, citing rough handling by healthcare workers especially for DRE. There is therefore need to sensitize healthcare practitioners in the field of prostate cancer on how to be more gentle with their clients. Similarly, men at risk ought to be sensitized to the effect that screening and early detection of prostate cancer supersedes taboos as it has the potential to save lives.

5.4.3 More Participatory Communication Initiatives

This study recommends that men at risk be invited to critique the successes and failures of prostate cancer communication initiatives within the country. During these fora, men should be encouraged to openly but systematically share feedback on the best practices as well as lessons for improvement. In this initiative, the project leaders share the progress and gather the reactions of members for learning purposes and for improvement of related future prostate cancer communication endeavours. Next, members should be invited for
planning/decision making for the next round of actions, keeping in mind the lessons learnt and recommendations from the previous.

5.5 **Suggestions for Further Studies**

This study recommends that further scientific inquiries be done to determine the place of culture and cultural beliefs in combating prostate cancer in Kenya and the role of women in bolstering prostate cancer screening among men at risk.
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APPENDICES

APPENDIX A: INTERVIEW SCHEDULE

Section 1: Introduction & Consent

(Establish Rapport) [Shake hands]

My name is Maurice Ongala, an MA Communication Studies student at the University of Nairobi. I am carrying out a study on The Nexus (relationship) Between Participatory Communication and Prostate Cancer Screening Uptake among Men in Westlands, Nairobi Kenya. This is the core purpose of my study.

This study is expected to provide invaluable data to enhance Government of Kenya’s Big Four Agenda, which has Universal Access to Healthcare as a core pillar. It will also assist development communication experts and cancer practitioners to gain a better understanding of the existent communication gaps and perceived barriers to prostate cancer screening, and more effectively address them. This interview is therefore, meant to get your views on the above topic. Your opinion will be held in strict confidence and used for academic purposes only. Moreover, your participation in this study is voluntary. This interview should take about 20 minutes. Would you like us to proceed?

Name of Interviewee/Key Informant (Optional): ______________________

Location of interview: ________________________________________________
Section 2:  Question Schedule for Men at Risk

*General Awareness on Prostate Cancer*

1. What is prostate cancer?

__________________________________________________________________

2. In your knowledge or inference, who do you think is most at risk of developing prostate cancer in Kenya?

__________________________________________________________________

*Screening*

1. Do you know any prostate cancer screening methods?

__________________________________________________________________

2. If yes, which method of prostate cancer screening would you prefer and why?

__________________________________________________________________

3. Have you ever gone for prostate cancer screening?

__________________________________________________________________

4. If (3) is yes, how often do you screen for prostate cancer?

__________________________________________________________________
5. If (3) is no, why? 

__________________________________________________________________ 

6. How would you describe the uptake of prostate cancer screening services among your fellow men in Westlands? 

__________________________________________________________________ 

7. What is your perception or feeling on prostate cancer screening? 

__________________________________________________________________ 

__________________________________________________________________ 

**Role of Participatory Communication**

1. How did you learn of prostate cancer? 

__________________________________________________________________ 

__________________________________________________________________ 

2. Are there any gaps in prostate cancer communication in Kenya and how do you think they can be improved? 

__________________________________________________________________ 

__________________________________________________________________ 

3. *(Explain participatory communication and then ask…)* What role do you think participatory communication can play in improving the prostate cancer-screening scenario in Westlands? 

__________________________________________________________________ 

__________________________________________________________________ 

__________________________________________________________________
Section 3: Question Schedule for Cancer Medical Practitioners

Physician/healthcare professional/medical practitioner experience

1. Could you please tell me about your experiences dealing with prostate cancer patients?

__________________________________________________________________
__________________________________________________________________
__________________________________________________________________

Challenges to prostate cancer screening uptake

1. What, in your experience, are the barriers to prostate cancer screening among men in Westlands? (Probe the following):
   a. What part does fear play in men’s decision to go for screening?

__________________________________________________________________
__________________________________________________________________

b. What is the place of cost in prostate cancer screening?

__________________________________________________________________
__________________________________________________________________

c. What role does handling by health care professional play in men’s decision to screen for prostate cancer?
d. Does a screening method have any bearing on the screening uptake? Please explain your answer.

(Transition: It has been such a pleasure getting your opinion and insights on prostate cancer screening among men in Westlands, Nairobi – Kenya. Allow me now to summarize the information I have captured during our interview)

(Provide a summary per section, confirming if the right information was captured.)

I appreciate the time you took for this interview. Is there anything else you think would be helpful for me to know? Do you have any questions for me?

Thank you very much for time and responses.
APPENDIX B: FOCUS GROUP DISCUSSION (FGD) GUIDE

Men Group, Westlands Area, Nairobi – Kenya

Introduction

My name is Maurice Ongala, a Masters of Arts (MA) Student in Communication Studies at the University of Nairobi. I am carrying out a study on prostate cancer screening among men in Westlands, Nairobi - Kenya.

The purpose of this study is to establish the nexus between participatory communication and prostate cancer screening uptake among men in Westlands, Nairobi - Kenya.

This study will provide invaluable information to enhance Government of Kenya’s interventions relating to cancer treatment besides enabling development communication experts and cancer practitioners to gain a better understanding of the existent communication gaps and perceived barriers to screening. This interview aims to get your views on the above topic. Your opinion will be held in confidence and used for academic purposes only and participation in this discussion is voluntary.

(Fill the demographic details as the participants introduce themselves)

Composition of the group: _______________________________________________________

Date: _____________________________
(Instructions)

Question Schedule

1. What do you understand about prostate cancer screening?
2. How do you feel about prostate cancer screening?
3. How do you obtain information on prostate cancer screening?
4. What do you like about prostate cancer screening? Why?
5. What do you not like about prostate cancer screening? Why?
6. What influences your decision to go, or not to go for prostate cancer screening?
7. Of all the influences you have mentioned, which one is the most important to you?
8. What do you think can be done to improve the uptake of prostate cancer screening among men in Kenya?
9. If you had a chance to tell men in Westlands to go for prostate cancer screening, what would characterize your message?
10. Do you think communication around Prostate Cancer (including uptake of screening) has been done well? Please explain your answer
11. Is there anything that we have missed?

Thank you for your participation in this discussion.
REF: CERTIFICATE OF FIELDWORK

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APPENDIX D: CERTIFICATE OF CORRECTIONS

UNIVERSITY OF NAIROBI
COLLEGE OF HUMANITIES & SOCIAL SCIENCES
SCHOOL OF JOURNALISM & MASS COMMUNICATION

REF: CERTIFICATE OF CORRECTIONS

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